N432 Postpartum Care Plan

Lakeview College of Nursing

Jerry Williams

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
6/28/21	R. C.	38	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Married	NKDA
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	175 cm (5 ft 9 in)	121.1 kg (267 lb)	Yes

Medical History (5 Points)

Prenatal History: G2 T0 P0 A1 L1; Client states she had a previous miscarriage. She was told that she could not become pregnant because of having polycystic ovary syndrome, greater than 35 years old, and obese.

Past Medical History: Polycystic ovary syndrome; morbid obesity; calculus of kidney; S/P laparoscopic cholecystectomy; horseshoe kidney; seasonal allergies; reactive airway; vitamin D deficiency; GERD; calculus of right ureter; depression; generalized anxiety disorder; migraine; Morton's neuroma of right foot; sleep apnea syndrome; injury of left thumb; sprain of interphalangeal joint of left thumb initial encounter; allergic rhinitis

Past Surgical History: Removal of gallbladder; wisdom tooth extraction; right heel spur surgery; cystoscopy; right tenoplasty; left leg/foot soft tissue procedure; right foreign body removal; right leg/foot soft tissue procedure

Family History:

Father – alive – diabetes	Mother – alive – diabetes, hypertension
Paternal grandfather – deceased – chronic obstructive pulmonary disease	Maternal grandfather – deceased – diabetes, pancreatic cancer

Paternal grandmother – deceased – cancer (unknown type)	Maternal grandmother – alive – hypertension
Paternal aunt – alive – breast cancer	

Social History (tobacco/alcohol/drugs): ~~XXXXX~~Client denies tobacco and drugs; before pregnancy would occasionally drink beer.

Living Situation: Client is married. Her husband was not present at hospital. Client's m~~M~~other was present, and ~~,~~lives with client and her husband. Client's father is deceased.

Education Level: No learning barrier. Client states, "some college."

Admission Assessment

Chief Complaint (2 points): Cervidil (dinoprostone) induction; c~~C~~esarean~~ian~~

Presentation to Labor & Delivery (10 points): ~~XXXXX~~ R. C. was admitted on 6/28/21 at 2320 hours. She is a 38-year-old Caucasian female, G2 P0, who presented to her provider with polyhydramnios. Her gestation is 39w 3d. Her LMP was 9/16/20. Her EDD was 6/23/21 by Nagele's Rule and 7/5/21 by ultrasound. She stated that she had been "pushing for three hours." Her child was "sunny side up." Her induction began on 6/30/21 at 1741 hours after her provider said that her fetus stopped descending. Client delivered a baby girl on 6/30/21 at 1856 hours, 4280 grams (9 lb, 7 oz), 55.88 cm (22 in) long, with APGAR scores of 8 and 9. R. C. is now G2 P1.

Diagnosis

Primary Diagnosis on Admission (2 points):. Cervidil (dinoprostone) induction; cesarean section

Secondary Diagnosis (if applicable):. Polyhydramnios; horseshoe kidney disease

Postpartum Course (18 points)

R. C. was in the fourth stage of labor yesterday (Wednesday, June 30th) as she had her newborn at 1856 hours. Her newborn was induced because of the arrest of descent. Earlier, the client was in the first stage of labor. In addition to the arrest of descent, client had polyhydramnios. According to Ricci et al., (2020) this is a condition which there is too much amniotic fluid. Surround the fetus between 32 and 36 weeks, there could be more than 2,000 mL of fluid. There can be many problems associated with polyhydramnios: low 50minute Apgar scores, increased neonatal birth weight (newborn did weigh 9 lb 7 oz), congenital anomalies, to name a few conditions. It is associated with poorer fetal outcomes. Client states she "pushed for three hours." At 1741 hours, client's provider called for an induction after having used Cervidil. Ricci et al. (2020) states Cervidil is a cervical ripening agent that is highly effective in producing cervical changes independent of uterine contractions. Some women would go into labor and require no further stimulant for induction. Client received a transverse cesarean section. The second (from cervical dilation of 10 cm and effacement to birth of the fetus) and third stages (from birth of the fetus to the birth of the placenta) were eliminated as client's cesarean resulted in a newborn. The provider removed the placenta and other membranes from the uterus. Client is in the fourth stage of labor. Anesthesia will begin to wear off. Pain from the incisions will be felt. There may be gas pains and trouble breathing. Lochia, initially red, discharges vaginally.

This is the continual shedding of the uterus lining (Cleveland Clinic, 2018). Client began the "taking-in phase." She probably contacted friends and family about her newborn. She did say that she was happy because she was told that she could not have a child. Her newborn was her "miracle baby." Client was probably was hungry and tired. On clinical day (Thursday, July 1st), client had minimal output (350 ml) as compared to her input (4334 ml). Her nurse encouraged her to drink more water. We assisted client to ambulate to her door and back to her bed. We briefly assessed her (vital signs; lung and heart sounds). Nurse observed client's sanitary napkin and found lochia was scant. Nurse massaged client's fundus and measured it was 1 cm below her umbilicus. Client had pain distress of two at rest and three on activity.

Postpartum Course References (2) (APA): ~~XXXXX~~

C-Section (cesarean birth): procedure & risks. (2018, June 22). Cleveland Clinic. https://my.clevelandclinic.org/health/treatments/7246-cesarean-birth-c-section

Ricci, S., Kyle, T., & Carman, S. (2020). Labor and birth process. *Maternity and Pediatric Nursing* (4th ed., p. 694, 789). Wolters Kluwer.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.1 – 4.44 (Arora, 2020)	3.76	3.86	**3.26~~H~~**	
Hgb	9.8 – 13.7 (Arora, 2020)	11.7	12.5	**10.5~~L~~**	
Hct	28 – 39	35.4	36.2	**31.2~~L~~**	

	(Arora, 2020)				
Platelets	150 – 450 (Arora, 2020)	282	193	164	
WBC	5 - 13 (Arora, 2020)	12.28	9.32	27.28HL	Usually, a high white blood cell count means that your body is defending itself from an illness or disease and is under stress. However, during pregnancy, it is normal to have a high white blood cell count reading. After all, your body is under so much stress just by being pregnant. A high white blood cell count on its own is no cause for alarm (MedicineNet, 2021).
Neutrophils	40 – 70 (Arora, 2020)	No value	5.65L	23.91LH	Neutropenia happens for one of these reasons: they are used up or destroyed faster than they are produced, or the bone marrow does not make enough neutrophils in the first place (Cleveland Clinic, n.d.).
Lymphocytes	20 – 45 (Arora, 2020)	No value	28.2	4.3L	The reduction of lymphocyte levels in a pregnant woman is a natural consequence of conception, and is a totally normal body process. When conception occurs, and the embryo is awaiting implantation into the uterus, the body makes adjustments withing itself to allow this to happen without hurdles. For the human body, a newly-created embryo within itself is an alien entity, so it is natural for the immune

					system to observe it as something harmful, and reject it. Therefore, the body ends up suppressing the immune system's response by cutting down the lymphocyte count. This allow the embryo to be implanted successfully and grow into a fetus (Nair, 2021).
Monocytes	2 – 8 (Arora, 2020)	No value	**9.7**H	6.8	During the onset of pregnancy, the mother's immune system goes through alterations to avoid attacking the fetus. One of the alterations observed is the increase of monocytes. However, the side-effects of this are that it can lead to certain complication in pregnancy like preeclampsia. To remove these fears, the doctor may advise a test when the monocytes are observed to be too high (Achwal, 2020).
Eosinophils	1 – 6 (Arora, 2020)	No value	**0.8**L	**0.0**L	Eosinophil counts are low during pregnancy, reaching their nadir around delivery. Thus, pregnant women may have falsely low numbers of eosinophils in response to parasitic infection (ScienceDirect, 2007)
Bands	Not applicable	Not applicable	Not applicable	Not applicable	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal

Blood Type	A, AB, B, or O		O^+		
Rh Factor	Negative or positive		positive		
Serology (RPR/VDRL)	Non-reactive or reactive	Non-reactive			
Rubella Titer	Negative or positive			73.20	
HIV	Negative or positive		Non-reactive	Non-reactive	
HbSAG	Non-reactive or reactive	Non-reactive			
Group Beta Strep Swab	Negative or positive	Negative			
Glucose at 28 Weeks	Fasting: > 95 1 hour > 180 2 hour > 155 3 hour >140 (MedlinePlus, 2021)	145	Fasting blood sugar: 82 One-hour: 145 Two-hour: 87 Three-hour: 103		~~Fasting blood sugar: 82~~ ~~One-hour: 145~~ ~~Two-hour: 87~~ ~~Three-hour: 103~~ ~~XXXXX~~
MSAFP (If Applicable)	Not applicable	Not applicable	Not applicable	Not applicable	

Additional Admission Labs Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
No other added values					

Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)		No value	No value	No value	

Lab Reference (1) (APA):

Achwal, A. (2020, April 29). *Is high white blood cells (wbc) count in pregnancy harmful?* FirstCry Parenting. https://parenting.firstcry.com/articles/white-blood-cells-wbc-count-in-pregnancy-know-whats-normal-whats-not/

Arora, M. (2020, May 13). *CBC test during pregnancy: Importance & tests results*. FirstCry Parenting. https://parenting.firstcry.com/articles/cbc-complete-blood-count-test-in-pregnancy-why-you-need-it/

Eosinophil count. Eosinophil Count - an overview | ScienceDirect Topics. (n.d.). https://www.sciencedirect.com/topics/immunology-and-microbiology/eosinophil-count

MedicineNet. (2021, January 21). *What does high white blood cell count mean when pregnant?* MedicineNet. https://www.medicinenet.com/high_white_blood_cell_count_in_pregnancy/article.htm

Nair, A. (2021, February 12). *Low lymphocytes during pregnancy - Should you be concerned?* FirstCry Parenting. https://parenting.firstcry.com/articles/low-lymphocytes-during-pregnancy-should-you-be-worried/

Neutropenia: symptoms, causes, treatments. (n.d.). Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/21058-neutropenia

U.S. National Library of Medicine. (2021, July 2). *Glucose screening tests during pregnancy: MedlinePlus medical encyclopedia*. MedlinePlus. https://medlineplus.gov/ency/article/007562.htm

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	Induction lasted three hours;. dDue to the arrest of the second stage of labor. Cervidil (dinoprostone); cesarean section due to arrest of descent of fetus after three hours. Admitted; provider called for a cesarean section at 1741 hours
Current stage of labor	XXXXXYesterday (6/30/21), client was in the fourth stage of labor, the restorative stage. Her fourth stage began abruptly as she avoided the third stage, having had a cesarean section. She is

	hungry, ready to eat, and cannot sleep. She wants to tell people about her newborn. Skin-to-skin contact with her newborn is important. Breastfeeding will help her uterus shrink toward regular size. Today forward, client will be adjusting physiologically in being a new mother. In time, her body will return to her pre-pregnant state. Her feet will have gotten a little bigger. She will adapt to her pain from her transverse cesarean section and after-pains from breastfeeding. In a couple of months, her lochia will become scant. Client will continue self-inspection for hemorrhage, bladder distention, and venous thrombosis. Meanwhile, client will be caring for her newborn with her husband and her mother.

Stage of Labor References (2) (APA): XXXXX

Fourth stage of labour - why is this protected time so important? (2020, September 9). My Body My Baby. https://mybodymybaby.com.au/fourth-stage/

Ricci, S., Kyle, T., & Carman, S. (2020). Labor and birth process. *Maternity and Pediatric Nursing* (4th ed., p. 460). Wolters Kluwer.

Current Medications (7 points, 1 point per completed med)
7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Zoloft; sertraline	~~albuterol~~ Ventolin HFA; albuterol sulfate			
Dose	50 mg tab	90 mcg			
Frequency	Once a day	1 – 2 puffs, 4 – 6 hours, prn			
Route	PO	Inhaler			
Classification	Selective serotonin reuptake inhibitor (SSRI); Antidepressant	Adrenergic; Bronchodilator			
Mechanism of Action	Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses. An elevated serotonin level may result in elevated mood and reduced depression.	It attaches to $beta_2$ receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate (ATP) to cyclic adenosine monophosphate (cAMP). This reaction decreases intracellular calcium levels. It also increases intracellular levels of cAMP. Together, these effects relax bronchial smooth-muscle cells and inhibit			

		histamine release.			
Reason Client Taking	To treat her depression	To treat her reactive airway.			
Contraindications (2)	1) Concurrent use of disulfiram (oral concentrate) or pimozide; 2) hypersensitivity to sertraline or its components	1) Hypersensitivity to albuterol or its components; 2) Severe hypersensitivity to milk protein (DPI form)			
Side Effects/Adverse Reactions (2)	1) Serotonin syndrome; 2) prolonged QT interval	1) bronchospasm; 2) arrhythmias			
Nursing Considerations (2)	1) Monitor client closely for evidence of serotonin syndrome, such as agitation, coma, diarrhea, hallucinations, hyperthermia, hyperreflexia, incoordination, labile blood pressure, nausea, tachycardia, and vomiting. Notify prescriber. Be prepared to provide supportive care; 2) When therapy stops, expect to taper dosage to minimize adverse effects rather than stopping drug	1) Use cautiously in client with cardiac disorders, diabetes mellitus, digitalis intoxication, hypertension, hyperthyroidism, or history of seizures. Albuterol can worsen these conditions; 2) Administer pressurized inhalations of albuterol during second half of inspiration, when airways are open wider and aerosol distribution is more effective.			

	abruptly.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzymes and BUN and serum creatinine levels.	Monitor serum potassium level because albuterol may cause transient hypokalemia.			
Client Teaching needs (2)	1) Tell patient that sertraline increases the risk of serotonin syndrome and reactions that resemble neuroleptic malignant syndrome, rare but serious complications, when taken with some other drugs. Teach client how to recognize signs and symptoms of these disorders and advise him to notify prescriber immediately if they occur; 2) Instruct female patients to notify prescriber if they are or could be pregnant and to discuss benefits and risks continuing sertraline therapy throughout the pregnancy, as	Advise client to wait at least 1 minute between inhalations if dosage requires more than one inhalation; 2) Tell client to immediately report signs and symptoms of allergic reaction, such as difficulty swallowing, itching, and rash.			

	drug may cause withdrawal symptoms or persistent pulmonary hypertension in the newborn.				

Hospital Medications (5 required)

Brand/ Generic	~~Zoloft (sertraline)~~Lactated Ringers	Pitocin ~~oxytocin~~(oxytocin)	Toradol ~~Ketorolac~~(ketorolac)	Ancef (cefazolin)	Tylenol (acetaminophen)
Dose	983.6 ml / hour	30 units in 500 ml	15 mg	2 g	500 mg tab
Frequency	Once	Over 4 hours	Every 6 hours, prn	Once	Every 4 hours, prn
Route	Intravenous	IVPB	PO	IVP	By mouth
Classification	Intravenous nutritional products	Urotonic	NSAID; Nonopioid analgesic	1st generation cephalosporin; Antibiotic	Nonsalicylate; Antipyretic, nonopioid analgesic
Mechanism of Action	It has value as a source of water and electrolytes. It is capable of inducing diuresis depending on the clinical condition of the client. It produces a metabolic	To initiate or improve uterine contractions in situations where there are fetal or maternal concerns, so as to achieve a vaginal delivery.	Blocks cyclooxygenase, an enzyme needed to synthesize prostaglandins. Prostaglandins mediate inflammatory response and cause local vasodilation,	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan strands. Peptidoglycan makes cell membranes	Inhibit the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation

	alkalinizing effect. Lactate ions are metabolized ultimately to carbon dioxide and water, which requires the consumption of hydrogen cations.		pain, and swelling. They also promote pain transmission from periphery to spinal cord. By blocking cyclooxygenase and inhibiting prostaglandins, this NSAID reduces inflammation and relieves pain.	rigid and protective. Without it, bacterial cells rupture and die.	in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E_2.
Reason Client Taking	A source of water and electrolytes or as an alkalinizing agent	Increase strength of contraction	Treat moderate to severe pain	Pre-op medication; provide surgical prophylaxis	Mild pain 1-3 of 10 or temperature > 38°C
Contraindications (2)	1) Hypersensitivity to sodium lactate; 2) Clients experiencing lactic acidosis	1) Hypersensitivity to drug; 2) Vaginal delivery contraindicated	1) History of GI bleeding; 2) Labor and delivery	1) Hypersensitivity to cefazolin, other cephalosporins or their components; 2) Clients with low urinary output because of impaired renal function, lower dosage is required.	1) Hypersensitivity to acetaminophen or its component, severe hepatic impairment, severe active liver disease; 2) Caution if renal impairment.
Side Effects/Advers	1) Hyperkalemi	1)Uterine hypertonicity	1) Drowsiness;	1) Seizures; 2) Renal	1) Hepatotoxi

e Reactions (2)	a; 2) Fluid and sodium overload	; 2) Uterine tetany	2) GI bleeding	failure	city; 2) Hypotension
Nursing Considerations (2)	(Pregnancy category C) 1) Observe for signs of fluid overload, such as hypertension, bounding pulse, pulmonary crackles, dyspnea, shortness of breath, and so forth; 2) Before infusion, assess the client's vital signs, edema status, lung sounds, and heart sounds. Continue monitoring during and after the infusion.	(Pregnancy category C) 1) May cause asphyxia in fetus; 2) May cause coma and seizure in mother	(Pregnancy category C) 1) Give IV injection over at least 15 seconds; 2) Use ketorolac cautiously in Clients with hypertension, and monitor blood pressure closely throughout therapy because drug can lead to onset of hypertension or worsen exiting hypertension.	(Pregnancy category B) 1) Monitor IV site for irritation, phlebitis, and extravasation; 2) Assess bowel pattern daily; severe diarrhea may indicate pseudomembranous colitis.	1) 4 g daily dosage limit; 2) Acetadote is the antidote for overdose.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Look for signs that indicate continued hypovolemia such as, decreased urine output, poor skin turgor, tachycardia, weak pulse, and hypotension.	Fetal status and contractions of the mother should be assessed and monitored frequently. Monitor blood pressure and electrolyte levels.	Monitor liver enzymes, as ordered. If elevated levels persist or worsen, notify prescriber and expect to stop drug, as ordered, to prevent hepatic impairment.	Monitor BUN and creatinine levels; Obtain culture and sensitivity test results, if possible and as ordered, before giving drug. Monitor fluid intake and output.	Know that before and during long-term therapy including parenteral therapy, liver function test results, including AST, ALT, bilirubin,

					and creatinine levels, as ordered must be monitored because acetaminophen may cause hepatotoxicity. Ensure that the daily dose of acetaminophen from all sources does not exceed maximum daily limits. Monitor renal function in clients on long-term therapy. Keep in mind that blood or albumin in urine may indicate nephritis; decreased urine output may indicate renal failure; and dark brown urine may indicate presence of

					the metabolite phenacetin.
Client Teaching needs (2)	1) Teach clients and families to recognize signs and symptoms of fluid volume overload. Instruct clients to notify their nurse if they have trouble breathing or notice any swelling; 2)	1) Notify provider is there is weakness on one side of the body, trouble speaking or thinking, change in balance, drooping on one side of the face, or blurred eyesight; 2) Notify provider if there is nausea or vomiting.	1) Caution client to avoid hazardous activities until drug's CNS effects are known. 2) Teach client proper oral hygiene measures, and encourage him to use a soft-bristled toothbrush while taking ketorolac.	1) Tell client to report watery, bloody stools to prescriber immediately, even up to 2 months after drug therapy has ended; 2) Tell your provider if taking other prescription, over-the-counter medicines, vitamins, and herbal products for possible drug interaction.	1) Caution client not to exceed recommender dosage or take other drugs containing acetaminophen at the same time because of risk of liver damage. Advise him to contact prescriber before taking other prescription or OTC products because they may contain acetaminophen; 2) Teach client to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic

					overdose.

Medications Reference (1) (APA):

Acetaminophen (Tylenol) Nursing Pharmacology Considerations. NURSING.com. (2019, December 20). https://nursing.com/blog/acetaminophen-tylenol-nursing-pharmacology-considerations/

The best place to learn nursing. Nursing.com. (2021, May 7). https://nursing.com/

The clinical information you need, at your fingertips. Epocrates Web. (n.d.). https://online.epocrates.com/home

Loebl, S. (2020). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Prescription drug information, interactions & side effects. Drugs.com. (n.d.). https://www.drugs.com/

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Eyes open; responding to questions appropriately X 3 to person, place, and time After cesarean section, client in mild abdominal pain distress; no respiratory distress; no chest pain; Overall, client is happy since she was told that she could not ever have a baby.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒☐** **Type:**	 Normal Normal Warm Normal None noted None noted Transverse cesarean section 19 = mild risk after epidural
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head appears symmetrical; no deformities noted; Neck had normal range of motion; no pain on movement; Ears are equally placed on side of head; no pain or hearing deficit Eyes are symmetrically placed in head; no vision issues; Nose is midline; no deviations; no discharge; Teeth appear normal. Good set of teeth .
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	. Regular heart rhythm upon auscultation S_1 and S_2 normal; S_3 and S_4 not present Not applicable. Radial and dorsalis pedis pulses = 2^+ Nail beds pink; blanching < 2 sec
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒☐** **Breath Sounds: Location, character**	. Clear lungs audibly; eupneic

GASTROINTESTINAL (2 points):	.
Diet at Home:	Normal diet
Current Diet:	Minimal salt;
Height:	175 cm (5 ft 9 in)
Weight:	121.1 kg (267 lbs)
Auscultation Bowel sounds:	Low bowel sounds in all four quadrants
Last BM:	LBM unknown
Palpation: Pain, Mass etc.:	
Inspection:	
Distention:	Distended abdomen due to obesity
Incisions:	Over lower abdomen covered by steri-strips
Scars:	Low horizontal cesarean section scar
Drains:	No drains
Wounds:	No wounds
GENITOURINARY (3 Points):	
Fundal Height & Position:	Fundal palpated midline, 1 cm below navel
Bleeding:	Scant
Lochia Color:	Rubra
Character:	Normal
Quantity of urine:	350 ml
Pain with urination: Y ☐ N ☒	
Inspection of genitals:	Genitals not inspected
Catheter: Y ☒ N ☐	
Type:	Foley
Size:	15 French
Rupture of Membranes:	Rupture of Membranes performed during
Time:	cesarean section by provider after induction that
Color:	began at 1741 hours
Amount:	
Odor:	
Episiotomy/Lacerations:	No episiotomy or lacerations
MUSCULOSKELETAL (2 points):	.
ADL Assistance: Y☐ N ☒	3 (Johns Hopkins Fall Risk Assessment Tool for
Fall Risk: Y ☐ N☒	Home Health Care: Medications – psychotropics
Fall Score:	{zoloft} = 3 points) No risk for fall
Activity/Mobility Status:	Slow, steady gait.
Independent (up ad lib) ☐	Yes, up ad lib.
Needs assistance with equipment ☐	No assistive equipment needed.
Needs support to stand and walk ☐	No issue with standing or walking
NEUROLOGICAL (1 points):	.
MAEW: Y ☒ N☐	
PERLA: Y ☒ N☐	
Strength Equal: Y ☒ N ☐ if no -	

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	 Alert Normal Normal Glasgow = 15 Normal 2^{+}
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	. Client has been coping well and is very happy having her daughter after being told that she could not have a child. Her mother has been her support. Client does not appear developmentally delayed or handicapped. Client states she has no religion. Her mom lives with her and her husband. Client is supported by mother and husband.
DELIVERY INFO: (2 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 6/30/21 1856 hours Cesarean 1313 ml Female 8/9 4280 g breastfeed

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	61 regular	118/70	18 regular	36.9ºC (98.4ºF)	98 room air
Labor/Delivery	98 regular	116/81	20 regular	36.9ºC (98.4ºF)	99 room air
Postpartum	60 regular	107/72	16 regular	36.7ºC (98.1ºF)	98 room air

Vital Sign Trends:

- Client's heart rates were within normal limits; elevated during labor and delivery; not brady- or tachycardic
- Client's blood pressures were normal; not hypo- or hypertensive;
- Client's respiratory rates were within normal limits; not brady- or tachypneic;
- Client's temperatures were within normal limits; not hypo- or hyperthermic;
- Client's Oxygen saturation on room air were within normal limits;

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1316 hours	Numerical (0 – 10)	Lower abdomen	5 – rest 6 – activity	Achy	Toradal
1500 hours	Numerical (0 – 10)	Lower abdomen	2 – rest 3 - activity	Achy	Client states pain is tolerable; no need for medication

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Right hand
Date on IV:	6/30/21
Patency of IV:	Yes, IV is patent
Signs of erythema, drainage, etc.:	None noted
IV dressing assessment:	Dry and intact; IV site covered by tagaderm

Intake and Output (2 points)

Intake	Output (in mL)
2984 ml – IV	350 urine

1350 ml – water	

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Examination of the uterus-N	Every 4 hours	Two-handed approach in assessing the fundus / uterine involution as the client's body returns toward her non-pregnant state. U/1 midline
Examination of the bladder-N	Every 4 hours	Client had large input of fluids but low output of urine. Nurse emphasized for client to push more fluids.
Emptying the foley catheter-N	Every 4 hours	Management of output.
Examining of cesarean stitches-N	Every 4 hours	Evaluate area for bleeding, or dehiscence.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Client is in the "taking-in phase."

What evidence supports this? This is the first 24 to 48 hours after giving birth. Clients play a passive role in meeting their own basic needs for food, fluids, and rest, allowing the nurse to make decisions for them concerning activities and care. Clients spend time recounting their labor

experiences to others. They recount their labor to others. These actions bring the birth experience into reality. Now, client and newborn features are identified.

Discharge Planning (2 points)

Discharge location: Client will be discharged to her home.

Equipment needs (if applicable): Client will ascertain a breast pump; mild bottles and nipples

Follow up plan (include plan for mother AND newborn): Newborn will visit pediatrician within 24 – 48 hours; mother will follow-up in two weeks for incision inspection; mother will follow-up in six weeks for postpartum assessment.

Education needs: Breastfeeding education. Attend postnatal education with other mothers.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."
2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational (1 pt each) Explain why the nursing diagnosis was chosen	Intervention/Rational (2 per dx) (1 pt each) Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	Evaluation (2 pts each) • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for infection related to break in the skin as evidenced by cesarean section.	Postpartum women possess an increased risk for infection due to the incision from cesarean section.	**1.** Nurse will inspect cesarean section bandage for signs of infection every two hours. **Rationale** Recognizing signs can thwart off an infection (Wayne, 2019). **2.** Nurse will check Hgb, Hct, and blood loss during cesarean section. **Rationale** Risk of postdelivery infection and	1) Bandage, steri-strips, and lower abdomen show no signs of infection. Goal met. 2) Hgb is within normal pregnancy range 10.5: Range 9.8 – 13.7 (Arora,

		poor healing is increased if Hgb levels are low and blood loss is excessive (Wayne, 2019).	2020). Goal met. Hct is within normal pregnancy range 31.2: Range 28 – 39 (Arora, 2020) Goal met. Quantitative blood loss is severe: 1313 ml (Ricci et al., 2020) Goal not met.
2. Risk for acute pain related to break in the skin as evidenced by cesarean section.	Postpartum women possess an increased risk for pain due to the incision from cesarean section.	**1.** Client will cite numerical pain distress every two to four hours to the nurse. **Rationale** Pain scale establishes a baseline and determines the severity of client's pain (Ricci er al., 2020). **2.** Client will be administered pain medication, as needed. **Rationale** Promotes comfort by blocking pain impulses. Potentiates the action of anesthetic agents (Wayne, 2019).	1) Client rated her pain a 2 at rest and a 3 at activity on numerical scale of 0 – 10. Goal met. 2) Client refused pain medicine as she felt the pain was "tolerable." Goal delayed/available
3. Knowledge deficit related to breastfeeding as evidenced by primipara.	Research shows that mothers feel unprepared, uninformed, and unsupported during the postpartum period as they struggle with physical and emotional issues, infant caregiving, breastfeeding concerns, and lifestyle adjustments. Nurses need to	**1.** Client will return demonstrate proper "latch on and catch on" breastfeeding technique after training by nurse. **Rationale** Nurses can assist and provide one-to-one instruction to breastfeeding mothers, especially first-time breastfeeding mothers, to ensure correct technique (Ricci er al., 2020). **2.** Client will return recite proper breast care (examine breast supply; 24-hour snug bra, condition of the nipples; engorgement alleviation, and so forth) after training by nurse. **Rationale** Educating a	1) Client returned demonstrated to the nurse the correct ways of feeding her newborn. Goal met. 2) Client recited to the nurse the proper ways in caring for her breast. Goal met.

	focus with the limited time they have with their clients.	mother about breastfeeding will increase the likelihood of a successful breastfeeding experience (Ricci er al., 2020).	
4. Risk for ineffective coping related to depression in response to stressors associated with childbirth and parenting.	Ten percent of new mothers suffer from disturbances in function, affect, or thought processes. With her history of depression, there may be more than a ten percent chance of suffering postpartum depression.	**1.** Client will express to her husband, mother, or therapist promptly on times when she cannot handle a situation. **Rationale** Client needs to express her inability to cope so that she can received help and no harm toward the newborn. **2.** Client will understand daily her newborn's cues and their meanings (hunger, soiled, and so forth) as her mother teaches her during the first couple of months of the newborn. **Rationale** Client's mother, who lives with her, can guide her for the first two months so not to feel overwhelmed and accept her new role as a mother.	1) Client expressed to nurse that she will communicate to family or her therapist if any negative situation comes up. Goal met. 2) Client expressed that she will allow her mother to assist her in the first two months in rearing the newborn. Goal met.

Other References (APA)

Ricci, S., Kyle, T., & Carman, S. (2020). Labor and birth process. *Maternity and Pediatric Nursing* (4th ed., pp. 460, 551, 557, 558, 560). Wolters Kluwer.

Scribd. (n.d.). *Nursing Care Plan Postpartum Depression*. Scribd. https://www.scribd.com/doc/279100294/Nursing-Care-Plan-Postpartum-Depression

Wayne, G. (2019, June 1). *10 Cesarean Birth Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/cesarean-birth-nursing-care-plans/6/