N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 07/07/21 @ 1625	**Patient Initials** CG	**Age** 32	**Gender** Female
Race/Ethnicity African American	**Occupation** Walmart factory	**Marital Status** Single	**Allergies** NKA
Code Status Full	**Height** 168.9cm (5'6.5")	**Weight** 95.3kg (210lbs)	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: The patient visited her doctor on 12/01/20, she came in to be seen for vaginal discharge and nausea and discovered she is pregnant. An STD screening was done, and she was positive for bacterial vaginitis and trichomoniasis. Prenatal vitamins and iron supplements were provided to patient, and she was told to follow up in two weeks. Patient went to abortion clinic to have abortion on 01/12/21 but changed her mind once she was there. She then presented to her first prenatal visit the gestational age was undetermined due to time restraints and she needed to reschedule. The next visit was 04/09/21 and she was diagnosed with anemia, high risk pregnancy in second trimester, dichorionic diamniotic twin pregnancy in first trimester, and uncomplicated asthma. Next visit was on 04/21/21 for a routine visit and 28-week labs were ordered, growth was in the 48th and 53rd percentile at this time. G5T3A2L4.

Past Medical History: Allergic rhinitis, asthma, anemia, and trichomoniasis infection.

Past Surgical History: Cesarian section

Family History: No family history listed in the chart.

Social History (tobacco/alcohol/drugs): Patient is a former smoker 0.5 pck/day of cigarettes. Denies use of drugs and alcohol. Patient is sexually active and was not on birth control prior to conceiving.

Living Situation: Lives independently with her two other children.

Education Level: 11th grade

Admission Assessment

Chief Complaint (2 points): Gestational hypertension

Presentation to Labor & Delivery (10 points):

A 32-year-old female was admitted to the labor and delivery unit on 07/07/21. She was admitted for gestational hypertension and had a scheduled repeat c-section per request. She stated that she was in pain and had slight discomfort in her abdomen and had rated the pain 8/10 on the numeric scale. She attempted to lie down elevate her feet, and rest but was not relieved. She did not attempt any form of treatment.

Diagnosis

Primary Diagnosis on Admission (2 points): Gestational hypertension

Secondary Diagnosis (if applicable): Scheduled repeat cesarian section.

Postpartum Course (18 points)

The patient is in the fourth stage of labor after receiving a cesarian section for both children's births. This stage begins with the completion of the expulsion of the placenta and membranes and ends with the initial physical correction and stabilization of the mother (Ricci et al., 2021). This stage initiates the postpartum period. Close monitoring of both the mother and her newborns is done during this stage (Ricci et al., 2021). The postpartum phase lasts longer because childbirth is a long process, and the mother's body is still trying to get back to normalcy

(Ricci et al., 2021). The mother's fundus should be firm and well contracted. It is abnormal to palpate a boggy uterus and warrants a fundal massage. The fundus is located at the midline between the umbilicus and the symphysis, and it slowly rises to the level of the umbilicus during the first hour after birth (Ricci et al., 2021). This patients' fundus was two fingerbreadths below the midline, which is a normal finding. It would be abnormal for it to be above the umbilicus and shifted to the side. The assessment of this stage focuses on monitoring the mother closely to prevent hemorrhage, bladder distention, and venous thrombosis (Ricci et al., 2021).

Vital signs, the amount and consistency of the lochia, and the uterine fundus are usually monitored every 15 minutes. The lochia is red, mixed with small clots, and a moderate flow (Ricci et al., 2021). The lochia slowly develops into a lighter discharge. This patients' lochia was scant and rubra, which is a normal finding. Vital signs were within normal limits. The patient's bladder was non-distended upon palpation, and the patient was able to void regularly. Bowel sounds were active in all four quadrants, which is a normal finding. It is usual for the first two weeks of postpartum to see a decrease in cardiac output (bradycardia) after birth because of the increased blood that flows back to the heart and central circulation after no longer perfusing the placenta (Ricci et al., 2021). Tachycardia warrants further investigation and can be due to hypovolemia, dehydration, or hemorrhage (Ricci et al., 2021). Blood pressure falls within the first 3 to 7 days after childbirth and returns to pre-pregnancy levels by six weeks (Ricci et al., 2021). A significant increase in blood pressure with a headache may indicate preeclampsia (Ricci et al., 2021).

The client is in the taking-in phase, which is the time immediately after birth when the client needs sleep, depends on others to meet her needs, and relives the events surrounding the birth process (Ricci et al., 2021). During the first 24 to 48 hours, the mother has a passive role in

meeting her own basic needs of rest, fluids, and eating food allowing the nurse to make decisions (Ricci et al., 2021). When the mother spends time with the newborn, she identifies the commons features of the newborn (Ricci et al., 2021).

Complications that can arise during the postpartum period include preeclampsia, hemorrhage, or a mood disorder. Risk factors for postpartum hemorrhage include precipitous labor (less than 3 hours), uterine atony, placenta previa or abruptio placentae, labor induction or augmentation. It can also be due to operative procedures, retained placental fragments, a prolonged third stage of labor, multiparity (more than 3 births closely spaced), and uterine overdistention (large infant, twins, hydramnios) (Ricci et al., 2021). This patient is at risk for this due to having twins. Risk factors for postpartum infection include operative procedures such as a c-section, history of diabetes, prolonged labor, catheter use, anemia, multiple vaginal exams during labor, prolonged rupture of membranes, manual extraction of placenta, and compromised immune system (Ricci et al., 2021). This patient is at risk for infection due to having a c-section and a history of anemia. A temperature above 100.4 at any time or an abnormal temperature after the first 24 hours may indicate infection and should be reported (Ricci et al., 2021). A foul-smelling lochia or an unexpected change in color or amount can be a sign of infection as well (Ricci et al., 2021). Fever is often the first signs of infection, but there can also be uterine tenderness, bleeding, and foul-smelling lochia (Boushra & Rahman, 2021). A postpartum mood disorder can be assessed by the women's emotional status and how she interacts with her family, her level of independence, energy levels, eye contact with her infant, posture, and comfort level while holding the newborn, and sleep and rest patterns (Ricci et al., 2021). Some other signs that can indicate a mood disorder are mood swings, irritability, or crying episodes (Ricci et al., 2021). Risk factors for experiencing a postpartum mood disorder are exhaustion, pain, absence of

support system, baby in the NICU, traumatic birth experience, substance abuse, anesthesia, or unwanted outcomes (Ricci et al., 2021). This patient did not show any signs of a postpartum mood disorder, hemorrhage, or infection. The patient does have gestational hypertension, but her vital signs were within normal limits.

Postpartum Course References (2) (APA):

Ricci, S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Boushra, M., & Rahman, O. (2020, July 15). *Home - Books - NCBI*. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books.

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	3.8-5.3	3.61	N/A	3.19	Anemia and patient EBL was 956ml, which is the reason for the low numbers (Ricci et al., 2021).
Hgb	12-15.8	10.9	N/A	9.1	Anemia and patient EBL was 956ml, which is the reason for the low numbers (Ricci et al., 2021).
Hct	36-47	31.7	N/A	27.8	Anemia and patient EBL was 956ml, which is the reason for the low numbers (Ricci et al., 2021).
Platelets	140-440	381	N/A	245	WNL
WBC	4-12	9.40	N/A	8.93	WNL
Neutrophils	47-73	71.8	N/A	N/A	WNL
Lymphocytes	18-42	19.0	N/A	18.4	WNL

Monocytes	4-12	6.7	N/A	6.5	WNL
Eosinophils	0-5	2.2	N/A	0.3	WNL
Bands	0-5	N/A	N/A	N/A	Not drawn

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, B, AB, O	O	O	O	WNL
Rh Factor	+/-	+	+	+	WNL
Serology (RPR/VDRL)	Non-reactive	Non-reactive	Non-reactive	Non-reactive	WNL
Rubella Titer	>10 immune	80.80 Immune	80.80 Immune	80.80 Immune	WNL
HIV	Non-reactive (Negative)	Non-reactive (Negative)	Non-reactive (Negative)	Non-reactive (Negative)	WNL
HbSAG	+/-	Negative	Negative	Negative	WNL
Group Beta Strep Swab	+/-	Negative	Negative	Negative	WNL
Glucose at 28 Weeks	<140	116	N/A	N/A	WNL
MSAFP (If Applicable)	0.5-2.0	Not drawn	Not drawn	Not drawn	Not drawn

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
Calcium	8.5-10.2	7.8	8.2	N/A	Can be due to low dietary calcium intake (Ricci et al., 2021).
Glucose	70-100	99	73	N/A	WNL
BUN	6-20	< 3	< 3	N/A	BUN decreases in pregnancy (Ricci et al., 2021). Renal insufficiency is a common finding with preeclampsia (Ricci et al., 2021).

Creatinine	0.6-1.3	0.6	0.66	N/A	WNL
TP	6.0-8.3	6.2	6.9	N/A	WNL
Albumin	3.4-5.4	2.4	2.6	N/A	Can be cause by preeclampsia/gestational hypertension. Albumin can be lower in pregnancy. Can also result from poor nutritional state (Ricci et al., 2021).
TBil	0.1-1.2	0.5	0.5	N/A	WNL

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)	28-217 mg/dL	36.46	N/A	N/A	WNL

Lab Reference (1) (APA):

Ricci, S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	Patient is a 32-year-old female at 37 week and 3-day gestation. She came in for gestational hypertension and chose to have a repeat scheduled cesarian section on 07/07/21. Due to having a cesarian section she did not experience the stages of labor. Normal times for the stages are (Ricci et al., 2021): First stage: 14-20 hours Second stage: 1-2 hours Third stage: 15-60 minutes
Current stage of labor	The patient is currently in the fourth stage of labor which is the initiation of the postpartum phase (Ricci et al., 2021). In this stage the baby is born as well as the placenta (Greene, 2019). This patient is about 48 hours into the postpartum phase. Her vital signs are stable. Her fundus is firm, midline, and two centimeters below the umbilicus. She is breastfeeding each infant every 2-3 hours taking turns on each breast. She does complain of pain 8/10 on the numeric scale and the intervention to treat was with Norco.

Stage of Labor References (2) (APA):

Ricci, S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

Greene, J. (2019). *The four stages of labor*. The Four Stages of Labor | Kaiser Permanente Washington. https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2Fpregnancy%2Fbirth%2FlaborStages.html.

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

Home Medications (2 required)

Brand/Generic	Prenatal vitamin with calcium, iron, and folic acid	Ferrous sulfate (Iron)
Dose	29 mg	325 mg
Frequency	Daily	Daily
Route	PO	PO
Classification	Vitamin	Antianemic and nutritional supplement.
Mechanism of Action	This medication replaces and prevents losses of vitamins and minerals that are essential to fetal growth and development.	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen.
Reason Client Taking	Deficiency, prophylactic, or replenishment.	Anemia and supplementation.
Contraindications (2)	Peptic ulcer and iron overload	Hemochromatosis and hemolytic anemias.
Side Effects/Adverse Reactions (2)	Dark-colored stools, loss of appetite.	Hypotension and hemolysis.
Nursing Considerations (2)	Can increase liver enzymes. Iron toxicity can be reduced with deferoxamine.	Give with a full glass of juice or water. To maximize absorption, iron should be

		given 1 hour before or 2 hours after meals.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess CBC to look at RBC, Hgb, and Hct. Assess iron levels.	Monitor closely for hypersensitivity. Monitor blood pressure. Monitor for signs of iron overdose.
Client Teaching needs (2)	Store in original container. Take with a full glass of water.	Instruct patient not to chew and solid form of iron, except chewable tablets. Urge patient to avoid foods that impair iron absorption such as dairy, eggs, high-fiber, and whole grain.

Hospital Medications (5 required)

Brand/Generic	Hydrocodone, acetaminophen and bitartrate (Norco)	Ketorolac tromethamine (Toradol)	Cefazolin sodium (Ancef)	Metoclopramide (Reglan)	Oxytocin (Pitocin)
Dose	5-325mg	15mg	2g/10ml	10mg	20 units in 1 liter of LR.
Frequency	Q4h PRN	Q6h PRN	60ml/hr once	Once	PRN
Route	PO	IV push	IV	PO	IV
Classification	Opioid analgesic	NSAID analgesic	Antibiotic	Antiemetic, upper GI Stimulant	Oxytocic hormone agent.
Mechanism of Action	Binds to and activates opioid receptors at sites in the periaqueductal and	Block's cyclooxygenase, an enzyme needed to synthesize prostaglandins.	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross	Antagonizes the inhibitory effect of dopamine on GI smooth muscle. This causes gastric contraction,	Oxytocin is made in the hypothalamus and is excreted in the posterior pituitary. This

	periventricular gray matter, the ventromedial medulla, and the spinal cord to produce pain relief.	Prostaglandins mediate inflammatory response and cause local vasodilation, 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.	linking of peptidoglycan strands. Peptidoglycan makes cell membranes rigid and protective. Without it, bacterial cells rupture and die.	which promotes gastric emptying and peristalsis, thus reducing gastroesophageal reflux. It blocks dopaminergic receptors in the chemoreceptor trigger zone, preventing nausea and vomiting.	increases calcium in the uterine myofibrils which grows the frequency and intensity of the uterine contraction.
Reason Client Taking	To manage severe pain.	To treat moderate to severe pain.	To provide surgical prophylaxis.	To treat postoperative nausea and vomiting.	Patient cannot naturally produce contractions on her own because of the cesarean section surgery.
Contraindications (2)	Acute or severe bronchial asthma or hypercarbia. Significant respiratory depression.	Breastfeeding and using other NSAIDS.	Hypersensitivity to cefazolin or its components. Patients with GI diseases.	GI hemorrhage and hypersensitivity to metoclopramide or its components.	Fetal prematurity, placenta previa.

	Suspected paralytic ileus.				
Side Effects/Adverse Reactions (2)	CNS depression and respiratory depression.	Hemorrhage and anemia.	Seizures and hemolytic anemia.	Suicidal ideation, tachycardia, and hypotension.	Excessive bleeding after childbirth, seizure.
Nursing Considerations (2)	Be aware that patient Is at an increased risk of abuse, addiction, and misuse. Should not be given to a patient with impaired consciousn ess.	Give IV injection at least over 15 seconds. Notify provider if pain relief is inadequate.	Monitor IV site for irritation, phlebitis, or extravasatio n. Watch for evidence of superinfectio n.	Should not be used in patients with depression. Use cautiously in patients with hypertension.	This medication can cause the mother's heart rate to be fast, uneven, or slow. Give this medication intravenousl y or intramuscula rly.
Key Nursing Assessment(s)/L ab(s) Prior to Administration	Assess blood pressure. Assess heart rate.	Monitor BUN and creatinine levels. Monitor CBC for decreased hgb and hct. Assess patient skin for hypersensitiv ity.	Assess bowel patterns. Assess skin for signs of a reaction. Assess for arthralgia.	Assess heart rate. Assess blood pressure. Assess for abnormal behaviors or thoughts of suicide.	Monitor the patient's liver enzymes. Monitor the fetal heart rate.
Client Teaching needs (2)	Patient should avoid hazardous activities. Urge patient to consume plenty of	Take with a full glass of water and sit upright for at least 15 minutes afterward. Advise patient not to	Instruct patient that we are giving the full dose. Tell patient to report water or bloody	Advise against activities that require alertness. Immediately report involuntary movements	Notify the provider if there is yellowing of the sclera or problems with breathing. Patient

	fluids to prevent constipation.	take any other NSAIDS while on this medication.	stools after drug therapy has ended.	of face, eyes, tongue, and hands.	should follow the provider's orders about restricting fluids.

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and responds to verbal stimuli. Oriented to person, place, and time. Does not appear to be in distressed and is on her phone. Appropriately dressed, uncombed hair, and looks fatigued.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin color is usual for ethnicity. Dry Intact Warm Skin turgor is normal. No rashes or bruises seen. Low-transverse cesarian section incision, no erythema or drainage, steri-strips in place. Braden score is 21. No drains present.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head is normocephalic and symmetrical to face. Neck is midline, no tracheal deviation, no palpable lymph nodes. Pupils are equal round reactive to light and accommodating, white sclera, and pink conjunctiva. Extraocular movements are intact. Nose has bilateral patency, no discharge, no polyps.

	The teeth are intact, and dentition is good.
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:**	Clear S1 and S2 auscultated with no adventitious sounds. Pulses are 3+ bilaterally throughout. Capillary refill is less than 3 seconds on fingers and toes. No neck vein distention or edema inspected or palpated.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respiratory rate and pattern is regular. Breath sounds are clear anteriorly and posteriorly. Chest rises and falls symmetrically. No accessory muscle use.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	Patient is on a regular diet currently and at home. Height is 168.9 cm. Weight is 95.3kg Bowel sounds are normoactive in all four quadrants. Last bowel movement was on 07/07/21. Abdomen was semi-soft, slightly tender, pain around incision site. No distention Incision was low transverse cesarian section. No scars, drains, or wounds.
GENITOURINARY (3 Points): **Fundal Height & Position:** **Bleeding:** **Lochia Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:**	Fundal height is two cm below midline of umbilicus. Bleeding is scant. Color is rubra. Character is normal. Patient voids spontaneously, 460ml were measured. No pain with urination Patient does not have a catheter placed. No rupture of membranes due to a scheduled repeat cesarian section.

Episiotomy/Lacerations:	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient does her own activities of daily living. Patient gets out of bed independently. Patient range of motion is active in upper and lower extremities. Patient is not a fall risk using the morse fall scale, fall score is 0.
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:**	Patient moves all extremities well. Pupils are equal and reactive to light and accommodating. Strength is equal in upper and lower extremities. Patient is alert and oriented to person, place, time, and location. Her speech is clear, and she responds to verbal stimuli. She has 2+ DTR.
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):**	When I entered the room, the patient was on the phone with her dad and talking about her birth history with him. He apologized for not being there and she stated, “it is okay I have not told a lot of people.” She seemed to keep to herself, and the father of the baby was not in the room with her every time I went in there. Patient does not follow a religion. Patient has an 11th grade education level. She lives independently at the home she rents with her other two children.
DELIVERY INFO: (2 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Patient delivered two babies, one boy and one girl. The boy weighed 5 lbs. 12.8 oz. The girl weighed 5 lbs. 6.8 oz. They were born on 07/07/21 the female was born at 2031 and the male was born at 2033 via cesarian section. The EBL was 956ml. The male APGAR was 8 at 1 minute and 9 at 5 minutes. The females APGAR was also 8 at 1 minute and 9 at 5 minutes. The patient is breastfeeding and pumping as needed.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	80	110/60	18	36.9	99 RA
Labor/Delivery	89	120/96	18	36.7	98 RA
Postpartum	84	126/78	18	36.7	96 RA

Vital Sign Trends:

The patient's vital signs remained stable throughout prenatal visits, birthing process, and during the postpartum process. Her vital signs are within normal limits. She was diagnosed with gestational hypertension, but the vital signs charted were within normal range. Pulse ranges from 80-89, blood pressure ranges from 110/60-126/78, respiratory rate remains at 18, temperature ranges from 36.7-36.9, and oxygen ranges from 96-99.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0850	Numeric	Abdomen	4/10	Feeling uncomfortable/ unrested	Norco
1400	Numeric	Abdomen	8/10	Discomfort	Norco

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:**	Patient had an 18-gauge peripheral IV catheter in the left lower forearm. IV was placed on 07/07/21. IV flushes without difficulty. No signs of erythema, drainage, or redness. The IV site had a transparent

IV dressing assessment:	dressing over it and it was dry and intact. The catheter was saline locked.

Intake and Output (2 points)

Intake	**Output (in mL)**
Patient is eating and drinking regularly.	1400 ml

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.**
Assess pain (N)	Q2h	Patient rated her pain an 8/10 on a numeric pain scale. She was given Norco to relieve the pain and discomfort she was having in her abdomen.
Assess vital signs (N)	Q4h	Patient vital signs need to be checked every four hours after 48 hours of birth. Vital signs are stable.
Assess fundus (N)	Q4h	Patient fundus is assessed every 4 hours at 48 hours after birth along with vital signs. At 48 hours it should be 2 cm below the umbilicus, which hers was.
Assist with helping the mom position both babies on her breast. (N)	Every 2-3 hours	The mom was in the room by herself recovering so I handed her one baby at a time so she could position them comfortably to breastfeed.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The mother is in the taking-in phase.

What evidence supports this? This is the time immediately after birth where the client needs sleep and depends on others to meet her needs. This is the first 24-48 hours after birth where the mothers take on a passive role.

Discharge Planning (2 points)

Discharge location: The patient is being discharged home to which she lives independently.

Equipment needs (if applicable): Breast pump.

Follow up plan (include plan for mother AND newborn): The patient should follow up with her provider in 2 weeks, and the babies should follow up with their doctor in 24-48 hours of being discharged**.**

Education needs: Patient already has two other children at home, so she has a general understanding. She was reminded of proper ways to breast feed and how often the babies need to be feeding. She was educated on how the babies need to be sleeping at night, each in their own crib, crib empty, and they need to be lying on their back.

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)	**Rational (1 pt each)**	**Intervention/Rational (2 per dx) (1 pt each)**	**Evaluation (2 pts each)**
Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	Explain why the nursing diagnosis was chosen	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	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes,

		intervention and using APA format, cite the source for your rationale.	modifications to plan.
1. Risk for maternal infection related to exposure to pathogens as evidence by cesarian section.	Patient is at risk for infection due to having a cesarian section, and she had a foley during it, and she has an incision that is at risk for infection.	**1.**Monitor temperature, pulse, and WBC count, as indicated. **Rationale:** Increased temperature or pulse greater than 100 bpm may indicate infection. Elevated WBC can indicate infection (Martin, 2021). 2.Wash hands and wear gloves when performing assessment of incision. **Rationale:** Reduces the risk of infection resulting from cross-contamination (Martin, 2021).	Client is free of infection. She knows the signs and symptoms of an infection and agrees to report it.
2. Acute pain related to healing process as evidence by verbalizations.	Patient verbalizes pain in her abdomen and the body is working hard to return to normal at this time.	**1.** Identify degree of discomfort and its sources. **Rationale:** Patient clarifying needs allows for appropriate intervention (Martin, 2021). **2.**Provide comfort measures such as clean dry linens and under pads. Assess bladder fullness. **Rationale:** Promotes psychological and physical comfort and may reduce the needs for analgesia. Ensuring emptying of the bladder can relieve pressure.	Patient verbalizes reduction of pain. She uses the appropriate techniques to maintain control. She makes sure to get enough sleep.
3. Deficient knowledge related to lack of recall as evidence by verbalization of questions/concerns.	Patient needed assistance with attaching both babies to her breast.	**1.** Teach how to properly latch**.** **Rationale:** By doing this it can ensure the baby is receives enough milk and the mother will not have sore nipples (Martin, 2021). **2.** Educate how often	Client engages in efforts to feed her babies on time and with the appropriate latching method.

		babies need to eat. **Rationale:** This can ensure that the babies are getting adequate nutrition.	
4. Deficient knowledge related to information misinterpretation as evidence by questions.	Patient thought that she was going to be able to leave early and she was informed that she had to stay for another 24 hours.	**1.** Assess baseline knowledge and expectations. **Rationale:** This can guide in establishing needs and set priorities (Martin, 2021). **2.** Provide information about assessments and monitoring. **Rationale:** This can help promote a positive attitude and may decrease anxiety.	Patient verbally understands the changes her body is going through and why she needs to be monitored. She participates in decision-making process.

Other References (APA):

Martin, P. (2021, March 29). *Normal Laboratory Values for Nurses: A Guide for Nurses*. Nurseslabs. https://nurseslabs.com/normal-lab-values-nclex-nursing/.