

N432 Postpartum Care Plan
Lakeview College of Nursing
Mallorie Mason

Demographics (3 points)

Date & Time of Admission 9/5/21 at 1:44am	Patient Initials C.R	Age 32 years old	Gender Female
Race/Ethnicity Race: Caucasian Ethnicity: Hispanic	Occupation Teacher at University of Illinois	Marital Status Married	Allergies NKA
Code Status Full	Height 5'3" 160.02 cm	Weight 158 lbs 71.82 kg	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: Patients GTPAL is G1T1P1A1L1. The patient has a history of spontaneous labor.

During the clients deliver the patient had a complication of fetal intolerance.

Past Medical History: The patient has a history of hypothyroidism.

Past Surgical History: The patient has had a tonsillectomy and a septoplasty.

Family History: Patient states that there is “no family history that would put her at a high risk for this pregnancy”.

Social History (tobacco/alcohol/drugs): Patient states she does not use alcohol, drugs, and has never smoked tobacco.

Living Situation: The patient lives at home with her husband.

Education Level: The patient highest level of education she has received is her master.

Admission Assessment

Chief Complaint (2 points): Contraction

Presentation to Labor & Delivery (10 points):

A 32-year-old female was admitted to OSF Hear of Mary to the labor and delivery unit on

9/5/21. The patient explained that the contractions started at home around 1:30 in the morning.

She explained that the contractions lasted around 14-15 hours. Her contractions began to become

regular around five to six minutes apart with a one-minute contraction duration. Once the patient was admitted to the hospital, she was given Oxytocin to help strengthen her contractions and help induce her fast. The patient only got dilated to a six before having to perform a cesarean section.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction of labor

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

The patient is in the fourth stage of labor. The fourth stage approximately begins after the placenta is delivered and lasts about six weeks. The woman's body begins to return to normal or pre-pregnancy (Ricci et al., 2020). Everything should return to normal in those six weeks. During the fourth stage, nurses are to monitor the patient quite frequently. The nurse should monitor vital signs, fundal height and lochia, and the patient's pain.

The patient's vitals should all be in the normal range during the fourth stage of labor. It is essential as a nurse to check vitals because we are looking for signs and symptoms of infection. The patient's pulse rate should be bradycardia up to the first two weeks after the placenta has been delivered. The slowing of the heart rate is normal due to diminished cardiac output, stroke volume, and increases that will flow back into the heart and central circulation and not to the placenta anymore (Ricci et al., 2020). Bradycardia is around 40 to 60 beats per minute. My patient postpartum heart rate was 75, so it was around 60. A tachycardia heart rate is abnormal

and may indicate hemorrhage, dehydration, or hypovolemia. The patient blood pressure will fall in the first two days, increase three to seven days after birth, and return to normal after six weeks (Ricci et al., 2020). Increased blood pressure may indicate preeclampsia, and low blood pressure may indicate an infection or hemorrhage. My patient had increased blood pressure. She was being monitored quite frequently and is even being sent home with a blood pressure cuff to make sure her blood pressure is lowering and not higher.

The patient's reproductive system goes back to normal after childbirth. That is something that the nurse needs to monitor. A daily fundal check should occur. The fundus during the first 12 hours postpartum is located right at the umbilicus. In the first couple of days, the fundus should descend under the umbilicus one centimeter, and by day three, should be two to three fingers under the umbilicus (Ricci et al., 2020). It is abnormal for the fundus to not return down to its normal state. That is why nurses do messages and check to make sure the fundus is regressing. My patient fundus was regressing. I messaged her fundus at two fingers below the umbilicus, and she was two days postpartum. The lochia color is usually deep red after the first three days of childbirth. Then days after that, the lochia color will become pinkish to brown to white. My patient had very little lochia since she had a cesarean section. Assessing the patient's pain is a priority. The patient is going to have afterpains, and afterpains are very typical. The thing about afterpains is that they should reside if analgesics are given (Ricci et al., 2020). Analgesics did help my patient pain.

Risk factors for postpartum include hemorrhage, infection, and depression. A hemorrhage is an excessive amount of blood loss. The patient should not bleed through more than one pad an hour and not pass any blood clots the size (Mayo Clinic, 2018). The patient should not have a fever higher than 100.4 degrees Fahrenheit. The fever is a primary indication of infection. My patient

was having neither of those symptoms, no fever nor excessive bleeding. A postpartum patient may experience mood disorders. The women may feel tired, irritable, or worried (Ricci et al., 2020). The mother may experience the short-term "maternal blues" or up to postpartum psychosis. My patient did not display any signs of postpartum mood disorder.

Postpartum Course References (2) (APA):

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

Mayo Clinic. (2018). *Postpartum depression*.

<https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617>.

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	3.50-5.20	4.25	3.97	3.85	
Hgb	11.0-16.0	12.8	12.4	11.9	
Hct	34-47	39.3	36.5	35.2	
Platelets	140-400	189	110	114	Thrombocytosis, infection, anemia
WBC	4.0-11.0	12.09	11.30	19.90	High levels of WBC can indicate an infection within the body.
Neutrophils	45.3-79.0	N/A	70.4	87.5	High level of neutrophils means infection.
Lymphocytes	11.8-45.9	16.9	21.4	8.2	Low level of lymphocytes means infection.
Monocytes	4.4-12.0	4.8	6.7	4.0	
Eosinophils	0.0-6.3	1.8	1.2	0.1	
Bands	0-700	N/A	N/A	N/A	

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-O Positive or Negative	A positive	N/A	N/A	
Rh Factor	Positive or Negative	Positive	N/A	N/A	
Serology (RPR/VDRL)	Nonreactive	Nonreactive	N/A	N/A	
Rubella Titer	Positive	Positive	N/A	N/A	
HIV	Nonreactive	Nonreactive	N/A	N/A	
HbSAG	Nonreactive	Nonreactive	N/A	N/A	
Group Beta Strep Swab	Negative	Negative	N/A	N/A	
Glucose at 28 Weeks	>140	129	N/A	N/A	
MSAFP (If Applicable)	N/A	N/A	N/A	N/A	

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
Lactate Dehydrogenase	140-271	N/A	158.45	N/A	
Sodium	133-144	N/A	134	N/A	
Potassium	3.5-5.1	N/A	3.8	N/A	
Chloride	98-107	N/A	104	N/A	
Anion gap	8.0-16	N/A	11	N/A	
Glucose	70-99	N/A	74	N/A	

BUN	7-25	N/A	12	N/A	
Creatine Blood	0.50-1.2	N/A	0.68	N/A	
BUN/Creatine	6-20	N/A	18	N/A	
Total Protien	6.4-8.9	N/A	6.2	N/A	Low levels can mean preeclampsia.
Albumin	3.5-5.7	N/A	3.4	N/A	May be decreased slight kidney disease. Albumin may decrease during pregnancy.
A/G ratio	1.0-2.2	N/A	1.2	N/A	
Calcium	8.6-10.3	N/A	9.1	N/A	
T Bili	0.2-0.8	N/A	0.8	N/A	
SGOT (AST)	13-39	N/A	19	N/A	
SGPT (ALT)	7-52	N/A	12	N/A	
Alkaline phospahte	34-104	N/A	141	N/A	Alkaline phosphate increase during late pregnancy
GFR	>=60	N/A	>60	N/A	

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)	52.2 – 91.9	N/A	54.	N/A	

Lab Reference (1) (APA):

Ricci, S. 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
<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>The patient came to the hospital on 9/5/21 because of contractions. The patient was in the third stage of labor for 24 hours. The first and second stages were not noted, and we do not know the specific time in each first or second stage. The patient's labor was spontaneous, but the patient was given Oxytocin. Oxytocin is used to help induce labor or make weak contractions stronger (Frandsen & Pennington, 2020). The patient was dilated to a six during labor when she started to get a fever and had hypertension. The baby was very tachycardic. These signs could have meant infection. The decision was made to perform a cesarean section at that point and time so the baby did not contract the infection. The mother agreed and signed a consent form.</p>
<p>Current stage of labor</p>	<p>The mother is in the fourth state of labor, also know puerperium period. The puerperium period starts after the delivery of the placenta, and the stage lasts about six weeks (Ricci et al., 2020). The patient's body is beginning to return to normal after the delivery of her baby. The fundus should be measured to make sure it is returning into place. The nurse should assess the color of lochia. Three to four days after birth, the lochia color should be</p>

	<p>Rubra. Cesarean births tend to have less lochia due to the removal of uterine debris during the cesarean (Ricci et al., 2020).</p> <p>The nurse should assess the patient’s pain and administer medication due to the labor of the child. Vital signs should be assessed frequently after labor.</p>
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Stage of Labor References (2) (APA):

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

Frandsen, C. & Pennington, S. S. (2020). *Abrams’ clinical drug therapy: Rationales for nursing practice* (12th ed.). Lippincott, Williams, Wilkins.

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

Home Medications (2 required)

Brand/Generic	Prenatal multivitamin	Levothyroxine Synthroid			
Dose	27mg	75mcg			
Frequency	Daily	Daily			
Route	Oral	Oral			
Classification	Vitamin	Thyroid hormone/ Synthetic thyroxine			
Mechanism of Action	Replaces vitamins that the mother does not consume enough of in	Levothyroxine replaces endogenous thyroid hormone. Levothyroxine exerts its physiological			

	her daily diet to support the baby. The vitamin helps with babies function.	effect by controlling DNA transcription (Jones & Bartlett, 2020).			
Reason Client Taking	Patient is not consuming the right amount of vitamins needed for proper baby functioning.	Hypothyroidism			
Contraindications (2)	1)Increased iron storage 2)Hemolytic anemia	1)Acute MI 2)Hypersensitivity to Levothyroxine			
Side Effects/Adverse Reactions (2)	1)Vitamin toxicity 2)Dark stools due to iron.	1)Increased appetite 2)Weight loss			
Nursing Considerations (2)	1)Avoid antacids and dairy products two hours before taking. 2)Take with full glass of water.	1)Monitor for signs and symptoms of over or undertreatment because of drugs therapeutic effect. 2)Administer 30 to 60 minutes before breakfast.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor signs and symptoms for prenatal vitamin toxicity.	Thyroid function test			
Client Teaching needs (2)	1)If stomach becomes upset with taking prenatal vitamin take vitamin with food. 2)Do not take more than the recommended dosage.	1)Inform the patient that the medication therapy will be for life. 2)Instruct client to notify provider immediately if she becomes pregnant. The dose may need to be increased.			

Hospital Medications (5 required)

Brand/Generic	Acetaminophen Tylenol	Oxycodone Oxycontin	Polyethylene glycol MiraLAX	Benzocaine Anacaine	Simethicone
Dose	975mg	5-10mg	17g	1 spray	80mg
Frequency	PRN every 6 hours	PRN every 6 hours	Daily PRN	4 hours PRN	4 times daily
Route	Oral	Oral	Oral	Topical	Oral
Classification	Non salicylate Antipyretic	Opioid Opioid analgesic	Laxative	Local Anesthetics Esters	anti- flatulence
Mechanism of Action	Inhibits the synthesis of prostaglandins production and interferes with the pain impulse (Jones & Bartlett, 2020).	Creates an emotional response to pain at the spinal cord by blocking the release of inhibitory neurotransmitters (Jones & Bartlett).	Irritating the GI mucosa by pulling water into the bowel (Frandsen & Pennington, 2020).	Decreases the influx of sodium into the nerve cell preventing conduction of the nerve impulse (Frandsen & Pennington, 2020).	Changes the surface tension of a gas bubble, which thing makes gas easier to pass. Can relieve bloating.
Reason Client Taking	Pain	Pain form cesarean section	Constipation	Incision	Gas
Contraindications (2)	1)Hypersensitivity to acetaminophen 2)Severe hepatic impairment	1)Hypersensitivity to oxycodone 2)Significant respiratory depression	1)Hypersensitivity 2)Intestinal obstruction or fecal impaction.	1)Hypersensitivity to benzocaine 2)Not use subarachnoid administration	1) Hypersensitive 2) Pregnancy can use if use out ways the risk.
Side Effects/Adverse Reactions (2)	1)Hepatotoxicity 2)Hypotension	1)Bradycardia 2)Seizure	1)Nausea and diarrhea 2)Abdominal Pain	1)Allergic reaction 2)Burning	1)Diarrhea 2)Headache
Nursing Considerations (2)	1)Monitor the end of parental infusion for air embolism. 2)Use caution in people with alcoholism, hepatic disease, and severe renal impairment.	1) Excess use of opioids can lead to abuse, addiction, or even overdose. Monitor intake of dose. 2) Chronic use of oxycodone in pregnancy can result In Nows.	1)The nurse should monitor for bowel elimination patterns. 2)Effects take 2-4 days to take effect.	1)Asses for hypersensitivity reaction 2)Asses lung and respiratory status.	1)Shake suspension before using. 2)Asses abdominal pain and bowel sounds.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Monitor ALT,AST, bilirubin, and creatine. Monitor liver and renal	Asses and monitor client pain. Monitor for respiratory depression.	Monitor electrolytes. Monitor bowel cleansing.	Monitor site for irritation.	Monitor patients gas, see if bloating is getting better.

	function.				
Client Teaching needs (2)	1)Take recommended dosage. 2) Teach client signs and symptoms of hepatotoxicity.	1)Do not take oxycodone longer than prescribe and take only prescribed dosage. 2)Avoid driving when taking oxycodone.	1)Do not take with milk or gastric antacids. 2)Take medication all at once do not safe.	1) Do not ambulate without assistance until told to do so. 2)Report anxiety, rash, hives, or redness.	1) Avoid carbonated beverages 2)Take recommended dose.

Medications Reference (1) (APA):

Frandsen, C. & Pennington, S. S. (2020). *Abrams’ clinical drug therapy: Rationales for nursing practice* (12th ed.). Lippincott, Williams, Wilkins.

Jones & Bartlett Learning. (2019). *2020 Nurse’s drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	The patient is alert, awake, and responsive. The patient is oriented to time, place, person, and situation. The patient did not appear to be in any distress. The patient was dressed appropriately and well groomed.
INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	The patients skin color is usual for ethnicity. Skin character is intact and dry. The temperature of the patients skin is warm to the touch. Turgor is elastic and returned back to a normal state in less than two seconds. The patient has no rashes, bruises, or wounds. The patient did have a cesarean section, so the patient has a low transverse incision. The patient Braden score is 22 No drains are present.
HEENT (1 point): Head/Neck: Ears:	The patients head is symmetrical without any deformities. The patients neck is symmetrical The trachea was aligned with no deviation. The lymph nodes were not palpable.

<p>Eyes: Nose: Teeth:</p>	<p>The patient ears were symmetrical, the tympanic membrane was pearly grey, there was no discharge or redness of the ear. The patient has no hearing problems. The patients sclera of their eyes were white, no conjunctiva, or discharge. The patient does not wear glasses. The patient nose was symmetrical. There were no polyps, deviated septum, discharge, redness, or turbinate's. The patient teeth were all intact there was no sign of poor dental hygiene. The mucous membranes were moist and pink.</p>
<p>CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>The patient's heart rhythm is sinus rhythm. S1 and S2 sounds were detected and heard. No murmurs were heard or detected also S3 and S4 were not heard as well. The patient radial, brachial, dorsalis pedal pulses were 4+ bounding. The patient capillary refill time was less than two seconds. No neck vein distention. No edema.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient respiration rate was 18. The patient respirations were regular and unlabored. The respiratory pattern was regular. The patients breath sounds were clear both anterior and posterior lobes. The lung aerations is equal. No use of accessory muscle.</p>
<p>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:</p>	<p>The patients diet at home and at the hospital is regular. The patient height is 5'3" The patient weight is 158 lbs Bowel sounds were active in all four quadrants Patient has been very constipated when she does go it is very little. No masses when abdomen was palpated. Client did experience some pain upon palpitation, but was not unbearable. The patient has no distention, incisions, scars, drains, or wounds.</p>

<p>GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Patient urine presents to be yellow and clear. Patient urination has been normal for her. No pain with urination. Did not inspect genitals. No catheter.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient does not need any ADL assistance. Patient is a fall risk Fall risk score: 10 Patient is active and mobile, but is very slow with walking due to abdominal pain from cesarean section. Patient is independent when getting up no assistance needed. The patient doesn't need assistance with equipment. The patient does not need support to stand or walk.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>The patient moves all extremities well. The patient pupils were equal, reactive to light and accommodation. Yes patient strength in arms and legs were both equal. The patients strength is a five. The patient is orientated to person, place, time, and situation. The patient has normal cognition. The patient speech is clear The patient is alert, awake, and responsive.</p>
<p>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):</p>	<p>The patient uses her husband as support through a difficult time. The patient highest education level is a masters degree. When asked about religion the patient states, there is no specific religion they identify with or prefer. Patient has a strong home environment and family support/structure.</p>
<p>Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:</p>	<p>The final heigh was one finger below the umbilicus. The fundal was firm. The patient has scant bleeding. The lochia color is rubra. There is no episiotomy or lacerations.</p>
<p>DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount:</p>	<p>The rupture of membrane was artificial. The time of the rupture was at 1537 on 9/5/21 The color was clear. The amount was moderate. There was no order. The delivery date was 9/6</p>

<p>Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>The delivery time was 2211 The type was cesarean The baby is a female. Apgars: 8 Weight: 7lb 5.8 oz Feeding Method: Breastfeeding</p>
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Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	85 beats per minute	121/68 mmHg	18 breaths per minute	98.1 F	95%
Labor/Delivery	105 beats per minute	125/73 mmHg	18 breaths per minute	99.4 F	99%
Postpartum	75 beats per minute	129/87 mmHg	18 breaths per minute	97.9 F	96%

Vital Sign Trends: The vitals signs for prenatal are stable. During labor the patient did strike a fever which then considered the doctor because of infection. It is normal to have a slight elevated heart rate during delivery. Vital signs for postpartum are all stable besides blood pressure is slightly elevated.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	Abdomen	2	Patient states when she is resting it just	Tylenol was given at this time to help with pain.

				feels uncomfortable.	
1100	0-10	Abdomen	2	Patient states the pain gets worse when she gets up and moves around.	Oxycodone was given at this time to help control pain.

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.: IV dressing assessment:	N/A The patient did not have an IV.

Intake and Output (2 points)

Intake	Output (in mL)
Patient drank two cups of orange juice (236 mL). The patient had a water bottle and drank 32 oz (960mL). The patient total intake is 1,196 mL.	Patient voided 600 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.
Fundal Assessment (N)	Daily	Fundal assessment needs to be performed with every patient. It is important that the fundus is returning back to normal state.
Pain Assessment (N)	Every 2 hours	It is common for women to experience after pain. Nurses need to make sure their pain is being assessed and under control. This will also tell if the patient needs more pain medication.

Administer pain medication and stool softeners (M)	Daily	My patient was very constipated she even requested MiraLAX and is on stool softeners. Administering these medications will help with clients constipation. Pain medication should subside after pains.
Measure blood pressure	Every 2 hours	My patient blood pressure was slightly elevated. The nurse needs to monitor to back she the blood pressure is not getting higher. Also to see if the blood pressure is resolving itself.

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 stage takes place one to two days after delivery. My patient is two days postpartum. The patient wanted to talk about her delivery, which I stayed in the patient's room to listen to her deliver. The patient needs rest to gain back physical strength. My patient rested the whole day besides when getting ready to be discharged.

Discharge Planning (2 points)

Discharge location: The patient will be discharged home with her husband

Equipment needs (if applicable): Blood pressure cuff

Follow up plan (include plan for mother AND newborn): The patient will return back to the doctor within one week for a blood pressure check. Then the patient will return in two weeks for an incision check. After that the patient and the baby will return back in 6 weeks with their point of care provider for a routine checkup.

Education needs: The patient is being sent home with a blood pressure cuff. The patient needs educated on how to use her blood pressure cuff and how to check her own blood pressure. The patient was educated on how to properly feed her child. This was very important for this mother because this is her first child. The patient was educated on how to take care of her incision.

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

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>Evaluation (2 pts each)</p> <ul style="list-style-type: none"> How did the patient/family respond to the nurse's actions? Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for infection related to cesarean section as evidence by redness around incision.</p>	<p>Infection is a very common complication in postpartum especially with cesarean section. My patient already had signs of infection during labor.</p>	<p>1.Use proper hand hygiene overtime entering the room. Rationale Hand hygiene is the number one way to prevent infection. 2.Moinitor temperature q 12 hours Rationale Fever is the number one sign of infection.</p>	<p>The patient appreciated that we washed our hands every time and were monitoring if she had a fever. The patient understood that she needs to look for signs of infection herself.</p>
<p>2. Risk for acute pian related to cesarean section as evidenced by "My pain is 5 out of 10 when I walk and 2 out of 10 when I am resting".</p>	<p>It is common for patient to experience pain after a caesarean section.</p>	<p>1. Administer pain medication. Rationale After pains should reside after analgesic administered. 2. Reposition the client Rationale Repositioning the client can help with succeed their pain.</p>	<p>The patient said that the pain medications were working and her pain was decreasing. The patient liked when we repositioned her. She said that it also helped with the pain.</p>
<p>3. Risk for constipation as evidence by</p>	<p>It is not common for women blood</p>	<p>1. Drinking fluids Rationale: Drinking fluids helps liquefy</p>	<p>The patient took drinking fluids very seriously. She had a water bottle filled up</p>

<p>pregnancy related to “Can I have MiraLAX this morning”</p>	<p>pressure to remain elevated after delivery. Blood pressure will be elevated maybe one day. My patient is blood pressure is being consistently elevated.</p>	<p>the stool. 2. Walking around Rationale Helps the patients bowel move</p>	<p>with the amount of ounces on the side. The patient walked around as much as she could.</p>
<p>4. Deficient knowledge related to breastfeeding as evidence by “this is my first child, can you guys watch me breastfeed to make sure I am doing it correctly”.</p>	<p>My patient expressed to the nurse to have her help with breastfeeding. Nurses will watch breastfeeding regardless to make sure everything is going okay.</p>	<p>1. Teach the patient how to latch the newborn. Rationale The latching of the nipple is extremely important in breastfeeding. 2. Make sure the patient is holding the baby correctly while feeding. Rationale Making sure the baby is conformable during breastfeeding.</p>	<p>The patient found our teaching very helpful. The patient found a comfortable breastfeeding position for herself and the baby. The patient demonstrated good proper latching.</p>

Other References (APA)