

N432 Postpartum Care Plan
Lakeview College of Nursing
Janet Song

Demographics (3 points)

Date & Time of Admission 9/12/21	Patient Initials K.D.	Age 27 years old	Gender Female
Race/Ethnicity White or Caucasian	Occupation No work	Marital Status Married	Allergies No known allergy
Code Status Full	Height 5'8''(172.7cm)	Weight 85.7kg(189lb)	Father of Baby Involved Yes. At 16:30 father of the baby arrived at the hospital.

Medical History (5 Points)

Prenatal History: G1 T1 P0 A0 L1, K.D. gives birth to her first child.

Past Medical History: Not available

Past Surgical History: ACI reconstruction arthroscopy (Bilateral, 2012)

Family History: Heart disease (Father), Ovarian cancer (Mother)

Social History (tobacco/alcohol/drugs): Never smoked, denies previous alcohol and drug use,

Previous alcohol use (1-2 bottles of beer in a week)

Living Situation: She is living with her husband.

Education Level: She graduates from college.

Admission Assessment

Chief Complaint (2 points): "clear leakage of fluid occurred"

Presentation to Labor & Delivery (10 points):

At 35 weeks of pregnancy, twenty-seven-year-old came to the hospital via ambulation with spouse on 9/11/21 at 11:15 pm. She states that there was leakage of clear fluid. The patient was not in pain. However, fetal movement felt by the patient's hand. As soon as she found the

clear fluid, she and her husband drove to the hospital. She has confirmed a rupture and dilated 3cm by healthcare professionals and was admitted to the hospital on 9/12/21.

Diagnosis

Primary Diagnosis on Admission (2 points): Premature labor due to membrane rupture.

Secondary Diagnosis (if applicable):.

Postpartum Course (18 points)

The K.D. is in her postpartum period, which is in her 4th stage of labor. She gave birth on 9/12/21 at 1:20 pm, gravida 1, term 1, preterm1, abortion 0, and living 1.

The postpartum period brings lots of changes to a woman's body. The oxytocin will be released from the pituitary gland to contract the uterine (Barlow, 2019). Also, this hormone can be stimulated by breastfeeding. Indeed, the patient's uterus was contracting well, as evidence by the height of the fundus and the stages of lochia. Uterus tends to go back to the prepregnancy stage by contracting themselves. Barlow (2019) states that the level of fundus will decrease within 24 hr after delivery, about 1 to 2 cm. The patient's position and location of the uterus were below the umbilicus with two fingers. This indicates that the client's uterus is contracting well within the normal range. Lochia is a uterine discharge after giving birth (Ricci, 2021). There are three stages of lochia which is lochia rubra, lochia serosa, and lochia alba (Barlow, 2019). The client's lochia was rubra which was a dark red color, and it will last 1 to 3 days after giving birth. The amount was less than 2.5 cm, and no odor. The abnormal lochia shows excessive blood loss, foul

odor, and persistent heavy lochia rubra for more than three days (Barlow, 2019). However, the client's lochia is within the normal range.

After assessing the patient, we found no evidence of postpartum disorders such as deep vein thrombosis and infection. However, the patient might have postpartum mood disorders due to the mood change, staying alone in the room. Thrombus usually occurs in the lower extremities, and postpartum patients are at high risk (Barlow, 2019). It can lead to a pulmonary embolism, so assessing the signs and symptoms is essential. The symptoms can be calf tenderness, swelling, redness, and warmth on the lower extremities. However, the client does not have any signs or symptoms of deep vein thrombosis.

The other important postpartum disorder could be postpartum hemorrhage, which can occur when a patient loses lots of blood during vaginal birth. The signs and symptoms could be perineal pad saturation in 15 min or less, tachycardia, hypotension, pallor of the skin, and oliguria (Barlow, 2019). The information on the amount of blood loss cannot be found in the patient's chart. However, this patient does not have any signs and symptoms of hemorrhage. Also, the laboratory test such as Hgb, Hct, coagulation profile (PT) which can indicate hemorrhage, does not show any hemorrhage on this patient (Ricci, 2019). Moreover, the patient's laceration is healing well without any signs of infection.

Postpartum Course References (2) (APA):

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L., Wilford, K., & Williams, D. (2019). *ATI: RN Maternal newborn nursing* (11th ed.). Assessment Technologies Institute, LLC.

Revised 12/8/20

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). 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 (3/4/21)	Admission Value (9/12/21)	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30	3.67	4.19	Not available	Mild anemia is common in patient with pregnancy (Capriotti, 2020).
Hgb	12.0-15.8	11.6	12.7	Not available	It is lower than normal range because of low number of RBCs (Capriotti, 2020).
Hct	36-47	34.6	37.8	Not available	It means the patient has low percentage of red blood cells. Hct represents the percentage of RBCs found in 100 mL of whole blood (Hinkle, 2018).
Platelets	140-440	213	329	Not available	
WBC	4-12	11.7	7.9	Not available	
Neutrophils	47.0-73.0	73.4	Not available	Not available	
Lymphocytes	18-42	18.6	21	Not available	
Monocytes	4-12	7.1	6.7	Not available	
Eosinophils	0-5.0	1.5	1.8	Not available	
Bands	0-3.0	Not available	Not available	Not available	

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 (3/14/21)	Value on Admission	Today's Value	Reason for Abnormal

Blood Type	A, AB, B, O	AB	AB	Not available	
Rh Factor	Positive, negative	negative	Negative	Not available	
Serology (RPR/VDRL)	Reactive or non-reactive	Not available	Non-reactive	Not available	
Rubella Titer	Immune or not immune	Immune	Immune	Not available	
HIV	Reactive or non-reactive	Non-reactive	Non-reactive	Not available	
HbSAG	Positive, negative	Non-detected	Non-detected	Not available	
Group Beta Strep Swab	Positive, negative	Negative	Not available	Not available	
Glucose at 28 Weeks	<140	96	Not available	Not available	
MSAFP (If Applicable)	0.5 to 2.0	Not available	Not available	Not available	

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
Not available					

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)	Not available	Not available	Not available	Not available	

Lab Reference (1) (APA):

Capriotti, T. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.) F A DAVIS.

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

	Your Assessment
History of labor: Length of labor Induced /spontaneous Time in each stage	14h 9m G1 T1 P0 A0 L1, This is her first labor experience. Spontaneous 13h02m/ 1h03m/ 4m The patient is currently in a postpartum stage which is the fourth stage of labor.
Current stage of labor Stages of Labor #4,	After the baby is born, the uterus gets smaller due to the contractions of the uterus smooth muscle. According to Barlow

<p>Postpartum</p>	<p>(2019), the location of the fundus will be descended about 1-2 cm every 2hr. It will take about two weeks to uterus become not palpable and lie within the pelvis.</p> <p>Indeed, 9/12/21 was one day after the labor of the patient. The patient’s fundus was firm and well contracted. The fundal height was below the umbilicus when placing two fingers. The color of the post-birth uterine discharge was a dark red color, which is lochia rubra. Moreover, the quantity was scant. The patient does not have any pain when she walks or when the nursing student palpates her fundus. It can be a positive sign that her uterus is contracting well. According to Ricci (2021), the mother’s bladder will be hypotonic, and she can barely feel the sensation of a full bladder. However, K.D. said she is urinating well without any pain.</p>
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Stage of Labor References (2) (APA):

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L., Wilford, K., & Williams, D. (2019). *ATI: RN Maternal newborn nursing* (11th ed.). Assessment Technologies Institute, LLC.

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

Home Medications (2 required)

Brand/Generic	Tylenol/ Acetaminophen (Jones, 2020).	Prenatal vitamin (Ricci, 2021).	Not available	Not available	Not available
Dose	650 mg	1 tablet, 0.8mg			
Frequency	2-3 times/day, PRN	Every night			
Route	PO	PO			
Classification	Antipyretic, nonopioid analgesic	Vitamin			
Mechanism of Action	Inhibits the prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Iron and folic acid are needed to form new blood cells for the expanded maternal blood volume and to prevent anemia. Iron is essential for fetal growth and brain development and in the prevention of maternal anemia. An increase in folic acid is essential before pregnancy and in the early weeks of pregnancy to prevent neural tube defects in the fetus.			
Reason Client Taking	To relieve fever and pain.	To supply adequate nutrition. Recommendations for the pregnant women: Vitamin A 770 mcg, Vitamin C 85 mg, Vitamin D 5 mcg, Iron 27mg, Folate 600 mcg			

Contraindications (2)	<ol style="list-style-type: none"> 1. Severe hepatic impairment. 2. Hypersensitivity to acetaminophen. 	<ol style="list-style-type: none"> 1. Decreased kidney function 2. Do not consume alcoholic beverages. 			
Side Effects/Adverse Reactions (2)	<ol style="list-style-type: none"> 1. Hepatotoxicity 2. Atelectasis 	<ol style="list-style-type: none"> 1. Constipation 2. Upset stomach 			
Nursing Considerations (2)	<ol style="list-style-type: none"> 1. Use cautiously in patients with hepatic impairment or active hepatic disease, chronic malnutrition, and severe hypovolemia. 2. Monitor renal function in patient on long term therapy. 	<ol style="list-style-type: none"> 1. Ask the patient if they are allergic to any part of prenatal vitamin. 2. Increase consumption of fruits and vegetables. 			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Reviewing client's liver function test results such as AST, ALT, and bilirubin.	Check client's allergy and diet.			
Client Teaching needs (2)	<ol style="list-style-type: none"> 1. Do not exceed recommended dosage or take other drugs containing acetaminophen at the same time. 2. Teach patient to recognize signs of hepatotoxicity, such as bleeding and bruising. 	<ol style="list-style-type: none"> 1. Take the prenatal vitamin with a full glass of water. 2. Do not take dairy product with prenatal vitamin. 			

Hospital Medications (5 required)

Brand/Generic	Advil/ Ibuprofen (Jones, 2020).	Colace/ Docusate sodium (Jones, 2020).	Tucks/Witch hazel glycerin (University, 2020).	Zofran/ Ondansetron hydrochlorid e (Jones, 2020).	Hydrocortone/ Hydrocortisone (Jones, 2020).
Dose	800 mg	100 mg	1 Each	4 mg	1 Each
Frequency	Q8h	PRN	Q1h PRN	Q6h PRN	PRN
Route	PO	PO	Topical	PO	Topical
Classification	Analgesic	Laxative	Dermatology , herbal	Antiemetic	Adrenocorticoid replacement, anti- inflammatory
Mechanism of Action	Reduces inflammato ry symptoms and relieves pain by inhibiting prostagland ins.	Decreasin g surface tension between oil and water in feces.	The chemical called tannins helps to reduce swelling and inflammatio n.	Decrease nausea and vomiting by preventing serotonin release in the small intestine.	Suppress inflammation response by binding to intracellular glucocorticoid receptors.
Reason Client Taking	To relieve pain.	To treat constipati on.	To relieve itching and irritation for skin.	To prevent nausea and vomiting.	To reduce the inflammation.
Contraindicatio ns (2)	1. Angioedem a 2. Bronchospa sm	1. Fecal impaction 2. Undiagno sed abdomina l pain	1. Hypersensiti vity to witch hazel 2. Avoid oral use	1. Congenital long QT syndrome 2. Hypersensiti vity to ondansetron	1. Hypersensitivity 2. Idiopathic thrombocytopeni c purpura
Side Effects/Adverse Reactions (2)	1. GI bleeding 2. Renal failure(acute)	1. Dizziness 2. Nausea	1. Nausea 2. Vomiting	1. Arrhythmias 2. Hypotension	1. Anaphylaxis 2. Metabolic alkalosis
Nursing Considerations (2)	1. Know the risk of heart failure	1. Long- term use of	1. Use the pad after using the	1. Patients with phenylketon	1. It should not be given to immunocompro

	increases with use of NSAIDs 2. GI tract bleeding, perforation, and ulceration may occur.	docusate can cause dependence on laxatives for bowel movements. 2. Assess for laxative abuse syndrome.	bathroom. 2. Assess the patient and call the doctor if symptoms are not improving or get worse within 7 days.	uria must avoid getting ondansetron. 2. Monitor patient closely for serotonin syndrome.	mised patient. 2. It can worsen the infections, assess the signs and symptoms for any reaction.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzyme and CBC, it may worsen anemia	Assess bowel movement.	Check if the client is allergic to witch hazel.	Electrolyte imbalance should be corrected before ondansetron is administered.	Assess the skin prior to administration.
Client Teaching needs (2)	1. Take the tablets with a full glass of water and ask not to lie down for 15 to 30 minutes to prevent esophageal irritation. 2. Educate patient to avoid alcohol, aspirin, and corticosteroids while taking ibuprofen.	1. Encourage client to increase fiber intake and drink water daily. 2. Notify prescriber when client experiencing rectal bleeding.	1. Use the Witch hazel as prescribed. 2. Stop using when they have an allergic reaction.	1. Advise patient to use calibrated container or oral syringe to measure oral solution. 2. If patient experiences severe or worsening symptom, they should immediately call the hospital.	1. Educate patient to report any signs or symptoms of infection. 2. Gently apply to the affected area of skin.

Medications Reference (1) (APA):

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

University of Michigan Health (2020). *Glycerin and witch hazel topical*. University of Michigan Health. <https://www.uofmhealth.org/health-library/d03764a1>

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Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient is A&O x4, well-groomed, and in no distress.</p>
<p>INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 23 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin color was pink, dry/normal, and warm to touch. There is no turgor, no rashes, no bruises, and no wound noted.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical, normal cephalic. The patient’s ears are normal. Eyes are symmetrical EOM. The nose is symmetrical and has no deviation. Dentures are well-groomed.</p>
<p>CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable):</p>	<p>Hear sounds normal S1 and S2, nor murmurs, no gallops or rubs detected in S3 and S4. Capillary refill is less than 3 seconds. Peripheral pulses are 2+ symmetric.</p>

<p>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>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respirations are regular, nonlabored, symmetrical, and no wheezes or crackles were noted.</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>Client's current diet and diet at home are regular diet. Height: 5'8''(172.7cm) Weight: 85.7kg(189lb) Bowel sounds are active in all 4 quadrants. The patient had the last bowel movement in the morning, but she does not remember the exact time. No abnormalities were found upon inspection for incisions, scars, drains, or wounds. The patient's abdomen was bloated due to postpartum but did not have any pain and mass.</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>The quantity of urine was not on the chart, but the patient states that she is urinating regularly without any pain. She states that she does not have any pain on genitals.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 0 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>The patient does not need any assistance, and she has normal ROM. She has strengths in both the upper and lower extremities.</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:</p>	<p>She is awake, oriented, alert to the time, person, place. Her mental status, speech is normal. The patient is mature and cognitive. The patient has normal muscle stretch reflexes (+2).</p>

Mental Status: Speech: Sensory: LOC: DTRs:	
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):	The patient is a mature adult. She is living with her husband. Her religion is Lutheran. She is going to church with her husband, and her husband is taking care of her and her baby.
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	Fungal height and position were U/2 and firm. The bleeding amount was scant (less than 2.5cm), and no odor. The color was red (Rubra). The patient presented with a laceration.
DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	The client arrived in the hospital due to a rupture of membranes on 9/11/21, 11:13 pm. The leakage of clear fluid and some bloody discharge were found. Delivery Date & time: 9/12/21, 1:20 pm Type: Vaginal Quantitative blood loss: not available Male or Female: Female Apgars: 1 min-8, 5min-9 Weight: 5lb 4oz Feeding Method: Breast milk

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	Not available				
Labor/Delivery	75	150/65	16	36 C	97%
Postpartum	62	122/79	15	36.6 C	98%

Vital Sign Trends:

Vital signs are stable and within the normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0955	0-10		0	No pain	
1650	0-10		0	No pain	

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: The patient does not have IV insertion. Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	The patient does not have IV insertion.

Intake and Output (2 points)

Intake	Output (in mL)
Not available	Urine 1800mL, blood 228mL, output total 2028mL

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.
N: Provide warm blanket and suggest skin-to-skin method. T: To increase the baby’s	Until the baby’s temperature is warm enough, we	The baby’s temperature does not go up when using the warm blanket. The best way to increase the baby’s temperature

temperature.	suggest that the mom hold the baby.	is by attaching it with her mom. It will help not only increasing temperature but also give comfort to the baby.
N: Educate the patient the proper way to breastfeeding. T: The proper breastfeeding technique will lead baby to eat milk under a comfortable position.	Every 4 hours, when mom is feeding her baby.	The patient gave birth yesterday. She does not have a chance to learn some feeding technique that helps the baby stay in a comfortable position.
N: Administer the pain medication. T: Ibuprofen 800mg was given to the patient.	Every 8 hours.	The patient had vaginal delivery a day ago. She might have some pain. Ibuprofen will decrease the pain level and reduce the inflammatory symptoms.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking-in phase

What evidence supports this?

Ricci (2021) states that the taking-in phase occurs during the first 24 to 48 hours after birth. The patient has been 24 hours after giving birth. She sought help when she was breastfeeding her baby and allowing the nurse to educate and be involved in baby care.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to the home with her baby.

Equipment needs (if applicable):

Follow up plan (include plan for mother AND newborn):

A postpartum checkup is needed to check the mother is recovering well and infant caring, newborn growth checkup, and vaccinations for baby.

Education needs: The mom needs breastfeeding education.

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. Ineffective breastfeeding is related to improper positioning, as evidenced by the patient is not used to breastfeeding her baby.	She has a difficult time positioning her baby when breastfeeding.	1. Educate the patient about football hold position. Rationale The mother can see the baby’s mouth and guide the baby’s mouth to the nipple (Ricci, 2021). 2. Burp the baby after the breastfeeding Rationale It helps release the air in the baby’s stomach and can prevent vomiting in the baby (Ricci, 2021).	1. The client followed the nurse’s breastfeeding technique and was able to find a comfortable position for both mom and baby. 2. Once the baby burps several times after feeding, the baby seems to fell asleep.
2. Postpartum pain related to the vaginal delivery, as evidenced by the patient delivered the baby yesterday.	The vaginal delivery causes lots of pain, and the laceration has not been fully recovered yet.	1. Assess the patient’s pain in the urinary system. Rationale Pain while urinating can be caused by perineal laceration (Ricci, 2021) 2. Administer the ibuprofen 800mg every 8 hours. Rationale This medication relieves pain by inhibiting prostaglandins (Jones, 2020).	1. She does not have pain while she is urinating. 2. After re-assess the pain scale after administering the medication, she does not have any pain.
3. Risk for VTE related to prolonged bed rest, as evidenced	Staying in bed long time will increase the	1. Assess the patient closely for the signs and symptoms. Rationale	1. There were no signs or symptoms of VTE when assessing the

<p>by the patient was taking a rest in the bed after she gave birth.</p>	<p>risk of VTE.</p>	<p>While doing physical assessment on the patient, press the lower extremities to find any signs of VTE (Ricci, 2021). 2. Suggest patient to avoid sitting in one position for a long period. Rationale It will promote adequate circulation on the patient's body and can prevent the risk of VTE (Ricci, 2021).</p>	<p>patient. 2. After breastfeeding her baby, she tried to walk the room and go to the bathroom. Moving her body will help her to increase blood circulation.</p>
<p>4. Risk for postpartum blues related to rapid cycling mood symptoms as evidenced by her lack of coping mechanisms.</p>	<p>Her husband was at work in the morning, and she was staying alone in the room.</p>	<p>1. Suggest the patient have an adequate sleep. Rationale Taking adequate sleep will help to reduce stress (Ricci, 2021). 2. Suggest the patient spend more time with her husband to reduce the depression. Rationale The baby's father should involve in the baby's care for her wife to decrease the postpartum blues such as restlessness, hopelessness, moody, and sadness (Ricci, 2021).</p>	<p>1. The patient took a quality of sleep in the morning while her baby was asleep. 2. Adequate assistant from her partner made her smile.</p>

Other References (APA)

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