

N432 Postpartum Care Plan
Lakeview College of Nursing
Tuan Nguyen

Demographics (3 points)

Date & Time of Admission 9/14/2021 at 6:20 AM	Patient Initials C. F. R	Age 31 years old	Gender Female
Race/Ethnicity Caucasian	Occupation Customer service manager	Marital Status Married	Allergies N/A
Code Status Full	Height 5'10" (177.8 cm)	Weight 264 lbs (119.7 kg)	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: The client has had five pregnancies (G5) in the past which only three, including her most recent one, survived (T3, P3, and L3). She has had 0 abortions (A0). The client experienced a spontaneous abortion and an ectopic pregnancy in two of her pregnancies

Past Medical History: The client has a history of abnormal Papanicolaou smear test, depression, and ectopic pregnancy.

Past Surgical History: The client has had a salpingectomy on 6/1/20, cesarean sections on (6/8/2018), and (9/14/21), and a low transverse uterine incision on 9/15/21.

Family History: The client's father has a history of hypertension, anxiety disorder, and depression. The client's maternal grandfather had diabetes. The client's maternal grandmother had non-Hodgkin's lymphoma, and her paternal grandfather had diabetes.

Social History (tobacco/alcohol/drugs): The client stated that she never smoked or used harmful drugs. She states that she did not drink throughout her pregnancy but did drink "occasionally" about one to two drinks per week before her pregnancy.

Living Situation: The client states that she lives at home with her husband and two children in a comfortable, clean home.

Education Level: The client states that she had completed "some" college level but cannot precisely remember.

Admission Assessment

Chief Complaint (2 points): Induction of labor

Presentation to Labor & Delivery (10 points): The client is a 31-year-old female admitted to the labor and delivery unit on 9/14/2021 at 0620 hours. She stated that the onset of her induced labor began at 0930 hours on 9/14/2021. She received misoprostol to stimulate her uterus to contract. Her labor lasted over twelve hours, with the pregnancy reaching station -2 at 2332 hours. After the cesarean section was performed, the client stated that she experienced a burning-like pain at her cesarean incision site, rated at a 6 on the numeric pain scale. Since the end of the delivery, the client states that she experiences bleeding, dependent edema in both of her lower extremities, fatigue, and pain at her incision site. The client states that laying down to rest helps relieve the pain. She also takes 30 mg of ketorolac every six hours to help control her pain.

Diagnosis

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

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

The client is in the fourth stage of labor. Characteristics of this stage include the expulsion of the placenta, which can last from 1-4 hours after birth (Ricci et al., 2020). The mother's body goes through physiologic and psychological changes during this stage. So frequent assessments should occur and include comfort measures to help the mother heal and adapt.

Frequent assessments of the client are essential to promote the health of the mother. Identifying normal and abnormal findings will help provide a glimpse of things to address for the mother to remain healthy.

A head-to-toe approach to assessments should take place in addition to taking frequent vital signs, pain level assessment and examining for complications. Upon assessment, the client should have a firm fundus. The fundus should remain firm to prevent excessive bleeding; otherwise, it may be a sign of hemorrhaging (Ricci et al., 2020). The fundus should also experience changes in the location and should be a centimeter or two below the previous location every 24 hours (Barlow et al., 2019). The lochia should progressively turn from a Rubra-like color into a creamy white appearance (Ricci et al., 2020). A prolonged Rubra coloration of the lochia would mean excess bleeding and hemorrhage. Odors should also not be a finding when assessing the lochia. Lochia with odor usually indicates an infection such as endometritis (Ricci et al., 2020). In addition, multiple large clots should not be findings; otherwise, it would indicate a potential hemorrhage (Barlow et al., 2019). The client, during the clinical rotation, displayed normal assessment findings upon assessment. She had a firm fundus 1 inch below the umbilicus and had Rubra-colored lochia, which is appropriate since she had given birth early in the morning. Lochia should have a Rubra coloration for about 1 to 3 days after delivery (Barlow et al., 2019). The client's lochia also did not have any odor to it.

Vital signs should also be assessed in order to evaluate the health of the mother. Due to decreased blood volume, postpartum clients have a slower heart rate between 60 to 70 bpm (Ricci et al., 2020). Elevated heart rates may indicate blood loss or hemorrhaging (Barlow et al., 2019). Blood pressure should remain relatively unchanged from the client's normal range and should still ideally strive to reach 120/80 mmHg (Barlow et al., 2019). Expected respiratory

values are between 16 and 24 breaths per minute. Deviation outside of the expected respiratory range may indicate preexisting respiratory conditions (Ricci et al., 2020). Finally, temperature readings should also remain below 101 degrees Fahrenheit (Ricci et al., 2020). The client, during clinical, displayed typical vital signs throughout labor with only slight deviations in her heart rate. She had a heart rate of 57 bpm postpartum; however, she stated that she was hungry and dehydrated, which could affect her heart rate (Ricci et al., 2020).

Aside from postpartum hemorrhaging, other complications may arise during the postpartum stage, including infection and postpartum blues, and depression. The client experienced a cesarean birth, which involves creating an incision and cutting through skin barriers, and potentially introducing harmful pathogens into the body. A fever of 100.4 degrees Fahrenheit or higher indicates postpartum infection (Barlow et al., 2019). Risk factors such as cesarean birth, bladder catheterization, and multiple vaginal examinations after rupture of membranes are common for postpartum infections because they involve introducing foreign external objects into the body (Barlow et al., 2019). The client from clinical has all three risk factors, but fortunately, she did not display any abnormal temperature readings.

Postpartum mood disorders such as postpartum blues and depression may occur after a highly emotionally intensive event such as birth. The cause of either condition is unknown, so no definitive risk factors are attributed to postpartum blues and depression (Ricci et al., 2020). Clients with a history of depression do have a higher risk of experiencing postpartum depression (Ricci et al., 2020). Approximately 80% of women who have experienced the birthing process have experienced signs and symptoms, including restlessness, worthlessness, guilt, hopelessness, sadness, low-energy levels, and moodiness (Ricci et al., 2020). Upon assessment, the client from clinical did not seem to exhibit many of the mentioned signs of postpartum blues or depression.

After questioning the client, she only stated that she had low energy because she only had an hour or two of sleep. She did not mention any negative feelings relating to postpartum blues or depression, which means that she is one of the few that did not experience the blues or depression after delivery. The client does have a history of depression, as indicated in her medical history, so she is still at risk for postpartum depression.

Upon a final assessment of the client, she appears to be in the taking-in phase. This phase occurs immediately after birth and is characterized by the reliance on others to meet her needs and dependent behavior from the mother (Ricci et al., 2020). She has stated that she felt hungry, thirsty, and tired and requested help from the nurse and her husband to provide her snacks and water. In this phase, the mother also interacts with her newborn, doing things from holding them to bond to claiming that the newborn possesses traits like the mom's (Ricci et al., 2020). The client held her baby a couple of times and did attempt to breastfeed her baby.

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 (11.0 ed.).

Assessment Technologies Institute, LLC.

Ricci, S., Kyle, T., & Carman, S. (2020). 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	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30x10 ⁶ /mcL	4.28	N/A	N/A	N/A
Hgb	12.0-15.8 g/dL	12.2	N/A	N/A	N/A

Hot	36.0-47.0%	37.1	N/A	N/A	N/A
Platelets	140-440 K/mcL	16.8	N/A	N/A	N/A
WBC	4.0-12.0 K/mcL	10.18	N/A	N/A	N/A
Neutrophils	47.0-73.0%	N/A	N/A	N/A	N/A
Lymphocytes	18.0-42.0%	16.4	N/A	N/A	N/A
Monocytes	4.0-12.0%	4	N/A	N/A	N/A
Eosinophils	0-5%	0.8	N/A	N/A	N/A
Bands	0-5%	N/A	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	N/A	AB+	AB+	N/A	N/A
Rh Factor	A+, A-, B+, B-, O+, O-, AB+, AB-	Positive	Positive	N/A	N/A
Serology (RPR/VDRL)	Nonreactive	Nonreactive	N/A	N/A	N/A
Rubella Titer	> 10: Nonreactive	Nonreactive	N/A	N/A	N/A
HIV	Non-Detected	Nonreactive	Non-Detected	N/A	N/A
HBsAg	Non-reactive	Nonreactive	Non-Detected	N/A	N/A
Group Beta Strep Swab	Negative	Nonreactive	Negative	N/A	N/A
Glucose at 28 Weeks	Less than 140 mg/dL	N/A	88 mg/dL	N/A	N/A
MSAFP (If Applicable)	N/A	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
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	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)	N/A	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (6th ed.). St. Louis, Mo. Mosby

OSF Healthcare (2020). *Reference range (lab values)*. Urbana, IL

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

	Your Assessment
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<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>The client experienced induced labor at 0930 hours on 9/14/2021 to assist the client speed up her delivery process after being in 40 weeks and 4 days in gestation. She was given misoprostol (Cytotec) at 0730 hours as a cervical ripening agent and then 30 mg of oxytocin throughout her labor process to assist with her contractions during her delivery process. Vaginal assessments were done at 1700 with no abnormal findings. Dilation of the cervix reached 2.5 cm at 1820 hours. Rupturing of the membranes occurred at 1855 hours on 9/14/2021. At 2312 hours, effacement was achieved, and the baby reached stage -3 with the baby's head getting close above the pelvis. Labor reached station -2 at 2332 hours. Finally, at 0034 hours, the client was able to deliver her baby on 9/15/2021 successfully.</p> <p>The client did not experience the stages of labor because of her cesarean section and medication-induced medications. Her stages of labor were also undocumented; however, typical times for each stage include 14-20 hours for the first stage, 2-3 hours for the second stage, depending on if it is the mother's first birth or subsequent birth. (Ricci et al., 2020). The third phase involves the expulsion of the placenta and usually takes between 2-30 minutes (Ricci et al., 2020). The fourth stage of labor usually is the first 1-</p>
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	<p>4 hours after birth and involves the mother healing and bonding with her baby (Ricci et al., 2020). The client was only in stage 3 labor for 1 minute.</p>
<p>Current stage of labor</p>	<p>The client is in the fourth stage of labor. In this stage, the placenta is successfully removed from the client, and the mother holds her newborn to bond with it and may even try to breastfeed it (Ricci et al., 2020). The fourth stage may range from at least 2 hours after birth to 4 hours (Barlow et al., 2019). The fundus should be firm and well contracted during this stage, with red lochia mixed with some clots (Ricci et al., 2020). The mother is usually hungry, thirsty, and tired during this stage as well (Ricci et al., 2020). The client from clinical showed consistent signs and symptoms of the fourth stage. For example, she stated that she was hungry and thirsty. She also held her baby and even tried to breastfeed it. The client’s fundus was also firm upon assessment.</p>

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 (11.0 ed.). Assessment Technologies Institute, LLC.

Ricci, S., Kyle, T., & Carman, S. (2020). Maternity and pediatric nursing (4th ed.). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Prenatal multivitamin	Lactobacillus rhamnoses	N/A	N/A	N/A
Dose	1 tablet	1 capsule	N/A	N/A	N/A
Frequency	Nightly	Once a day	N/A	N/A	N/A
Route	Oral	Oral	N/A	N/A	N/A
Classification	Pharmacologic Class: N/A Therapeutic Class: Vitamin	Pharmacologic Class: N/A Therapeutic Class: Antidiarrheals, probiotic	N/A	N/A	N/A
Mechanism of Action	The medication provides the body with multiple vitamins and minerals needed for body function and baby development. (Drugs.com, 2021)	Lactobacillus rhamnosus is a bacteria that prevent the growth of harmful bacteria in the stomach and intestines and helps maintain balanced gut flora. (Drugs.com, 2021)	N/A	N/A	N/A
Reason Client Taking	The client is taking this medication for prenatal health and development. (Drugs.com, 2021)	The client is taking this medication as a prophylaxis treatment to prevent diarrhea. (Drugs.com, 2021)	N/A	N/A	N/A
Contraindications	Contraindications	Contraindications	N/A	N/A	N/A

<p>(2)</p>	<p>include taking other multivitamin products within two hours before or after taking prenatal multivitamins and taking potassium supplements or salt substitutes.</p> <p>(Drugs.com, 2021)</p>	<p>include having short bowel syndrome or having a weak immune system.</p> <p>(Drugs.com, 2021)</p>			
<p>Side Effects/Adverse Reactions (2)</p>	<p>Side effects/adverse reactions include vomiting and constipation.</p> <p>(Drugs.com, 2021)</p>	<p>Side effects/adverse reactions include stomach bloating and gas.</p> <p>(Drugs.com, 2021)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>
<p>Nursing Considerations (2)</p>	<p>1) Educate the importance of ingesting adequate vitamins and nutrients while pregnant.</p> <p>2) Monitor the client's CMP levels to prevent overdose of vitamins.</p> <p>(Drugs.com, 2021)</p>	<p>1) Tell the client to avoid taking lactobacillus rhamnosus within 2 hours before or after taking any other medicine.</p> <p>2) Tell clients that they can open the capsule and sprinkle the medicine into food if the client cannot swallow the capsule whole.</p> <p>(Drugs.com, 2021)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

<p>Key Nursing Assessment(s)/Lab(s) Prior to Administration</p>	<p>Order a CMP to monitor the client’s vitamins to prevent overdose of vitamins.</p> <p>(Drugs.com, 2021)</p>	<p>Complete and monitor a CBC to prevent toxicity.</p> <p>(Drugs.com, 2021)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>
<p>Client Teaching needs (2)</p>	<p>1) Tell your client to make sure they tell their provider all the current medications that they are taking.</p> <p>2) Educate the client on signs and symptoms of allergic reactions, such as hives, difficulty breathing, swelling of the face, lips, tongue, and throat.</p> <p>(Drugs.com, 2021)</p>	<p>1) Tell the client to store lactobacillus rhamnosus at room temperature away from moisture, heat, and sunlight.</p> <p>2) Tell the client not to take different forms of lactobacillus rhamnosus at the same time.</p> <p>(Drugs.com, 2021)</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</p>

Hospital Medications (5 required)

Brand/ Generic	Acetaminophen TYLENOL	Ketorolac TORADOL	Ibuprofen MOTRIN	Metoclopramide REGLAN	Polyethylene glycol GLYCOLIC
Dose	975 mg	30 mg	800 mg	10 mg	17 g
Frequency	Q6H	Q6H	Q8H	Q6H PRN	Daily PRN
Route	Oral	IV	Oral	IV	Oral
Classification	<p>Pharmacologic Class: Nonsalicylate, paraminophenol derivative</p> <p>Therapeutic Class: Antipyretic, nonopioid analgesic</p> <p>(Jones, 2020)</p>	<p>Pharmacologic Class: NSAID</p> <p>Therapeutic Class: Analgesic</p> <p>(Jones, 2020)</p>	<p>Pharmacologic Class: NSAID</p> <p>Therapeutic Class: Analgesic, anti-inflammatory, antipyretic</p> <p>(Jones, 2020)</p>	<p>Pharmacologic Class: Dopamine-2 receptor antagonist</p> <p>Therapeutic Class: Antiemetic, upper GI stimulant</p> <p>(Jones, 2020)</p>	<p>Pharmacologic Class: Osmotic laxative</p> <p>Therapeutic Class: N/A</p> <p>(Jones, 2020)</p>
Mechanism of Action	<p>This medication reduces pain sensation by inhibiting the enzyme cyclooxygenase, blocking prostaglandin production, and hindering pain impulse generation in the peripheral nervous system.</p>	<p>This medication blocks cyclooxygenase and prevents the synthesis of prostaglandins, which reduces the inflammatory response and relieves pain.</p>	<p>This medication blocks the related activity of cyclooxygenase, which is an enzyme needed to synthesize prostaglandins, which reduces inflammatory symptoms.</p>	<p>This medication interferes with the inhibitory effect of dopamine on the GI smooth muscles, causing gastric contraction and promoting gastric emptying and peristalsis. Promoting gastric</p>	<p>This medication causes water retention in stools and softens them.</p>

				emptying and peristalsis helps reduce gastroesophageal reflux. Metoclopramide also blocks dopaminergic receptors in the chemoreceptor trigger zone, preventing nausea and vomiting.	
	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(MedlinePlus, 2021)
Reason Client Taking	The client is taking this medication to relieve moderate pain related to her recent birth.	The client is taking this medication to relieve moderate to severe pain related to her recent birth.	The client is taking this medication to relieve mild to moderate pain related to her recent birth.	The client is taking this medication to prevent gastroesophageal reflux and nausea.	The client is taking this medication as a prophylaxis to prevent constipation.
	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(MedlinePlus, 2021)
Contraindications (2)	Contraindications to this drug include hypersensitivity to acetaminophen and severe hepatic impairment.	Contraindications for this drug include hypersensitivity to ketorolac, aspirin, and other NSAIDs and advance renal impairment.	Contraindications for this drug include angioedema, caused by hypersensitivity to aspirin or other NSAIDs, and hypersensitivity to ibuprofen or its components.	Contraindications for this drug include hypersensitivity to metoclopramide and GI hemorrhage, mechanical obstruction, or perforation.	Contraindications for this medication include hypersensitivity to polyethylene glycol and its component and bowel obstructions.

	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(MedlinePlus, 2021)
Side Effects/ Adverse Reactions (2)	Side effects and adverse reactions include anxiety and hypertension. (Jones, 2020)	Side effects and adverse reactions include edema and hyperkalemia. (Jones, 2020)	Side effects and adverse reactions include renal failure and hypokalemia. (Jones, 2020)	Side effects and adverse reactions include bradycardia and bronchospasms. (Jones, 2020)	Side effects and adverse reactions include hypotension and arrhythmias. (Jones, 2020)
Nursing Considerations (2)	1) Administer cautiously in patients with hepatic impairment or alcoholism. 2) Monitor patient's renal function on long-term therapy of acetaminophen.	1) Inject ketorolac slowly and monitor the injection site for bleeding, bruising, or hematoma. 2) Monitor liver enzymes as ordered and stop administration if liver enzymes become	1) Use ibuprofen cautiously in patients with hypertension, and monitor blood pressure closely throughout therapy. 2) Monitor the client for GI bleeding, perfo	1) Use cautiously in clients with depression because it increases the risk of suicidal ideation. 2) Avoid administering rapid IV delivery as it can cause anxiety, restlessness, and drowsiness.	1) Store this medication at room temperature. 2) Monitor the client for symptoms of overdose such as diarrhea, thirst, confusion, and seizures.

		me elevated to avoid hepatic impairment.	ration, and ulceration since NSAIDs can increase the risk for GI bleeding.		
	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(MedlinePlus, 2021)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor the client's AST, ALT, bilirubin levels and ensure they are within limits to prevent liver damage before administration.	Assess the client for a history of GI bleeding since ketorolac increases the risk of GI bleeding. Also, monitor AST, ALT, and bilirubin to avoid hepatic impairment.	Monitor the client's CBC for decreased hemoglobin, hematocrit, and blood count to prevent GI bleeding.	Assess client for signs of intestinal obstruction, such as abnormal bowel sounds, diarrhea, nausea, and vomiting, before administering metoclopramide.	Monitor the client's electrolyte levels such as sodium and potassium since diarrhea from overdose can waste many electrolytes.
	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(Jones, 2020)	(MedlinePlus, 2021)
Client Teaching needs (2)	1) Tell the client to adhere to the recommended dosage	1) Tell the client to take ketorolac with a meal, snack, or	1) Instruct the client not to lie down for 15 to 30 minutes	1) Inform the client that taking metoclopramide with breastfeeding should	1) Advise the client to avoid milk and dairy prod

	<p>es to prevent overdose.</p> <p>2) Educate the client on the signs and symptoms of liver toxicity, such as bruising, malaise, and bleeding.</p> <p>(Jones, 2020)</p>	<p>antacid to prevent stomach upset.</p> <p>2) Instruct the client to notify the provider if the client experiences blood in urine, easy bruising, itching, rash, swelling, or yellow eyes or skin.</p> <p>(Jones, 2020)</p>	<p>after taking ketorolac to avoid esophageal irritation.</p> <p>2) Advise the client to take ketorolac with food or after meals to reduce GI distress.</p> <p>(Jones, 2020)</p>	<p>be avoided since it may cause adverse effects in the nursing infant.</p> <p>2) Advise the client and the client's family to monitor for abnormal behaviors or thoughts suggesting suicidal ideation. Contact the provider if suicidal ideation occurs.</p> <p>(Jones, 2020)</p>	<p>ucts.</p> <p>2) Avoid alcohol since it can increase the risk of withdrawal seizures, which is also caused by polyethylene glycol.</p> <p>(Drug Bank, 2021)</p>
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Medications Reference (1) (APA):

Drugs.com. (2021). *Lactobacillus rhamnosus GG*. <https://www.drugs.com/mtm/lactobacillus-rhamnosus-gg.html>

Drugs.com. (2021). *Prenatal multivitamins*. <https://www.drugs.com/mtm/prenatal-multivitamins.html>

Jones, D. W. (2020). *Nurse's drug handbook*. (A. Barlett, Ed.) (19th ed.). Jones & Bartlett Learning.

MedlinePlus. (2021). *Polyethylene glycol 3350*.
<https://medlineplus.gov/druginfo/meds/a603032.html>

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>The client is alert and oriented to time, place, person, and situation. She appears well-groomed and is calm and cooperative. She states that she is tired and “only slept for two hours” last night but does not appear to be in any other form of 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>The client’s skin is warm, pink, dry, and intact. Tenting of the skin was absent. There are no rashes, bruises, abrasions, or wounds, but a transverse cesarean incision above the pubic bone is present upon inspection from the client's birth. No drainage or erythema was present around the incision. The client has a Braden score of 23, which means there is a low risk for skin breakdown and impaired skin integrity. There are no drains present upon inspection.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The client’s head is normocephalic and does not appear to have any bruises or lesions. Her head is aligned with her neck, and there is no pain present in either her head or neck. Her nose, eyes, and ears are intact, with no drainage present. Her eyes, nose, and ears are symmetrical. Her pupils</p>

	<p>are equal, round, reactive, and accommodating to light (PERRLA). She has white sclera and bright red conjunctiva. The client's teeth appear to be intact, with none missing. The client wears glasses.</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 checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>The client's S1 and S2 were clear and constant. No murmurs or S3 gallops were heard. Her heart rate was 57 beats per minute with a +3 pulse bilaterally in the radial, carotid, and brachial arteries. The dorsalis pedis and posterior tibialis had a +2 pulse. Her capillary refill was less than three seconds bilaterally. The client did not have neck vein distention but did have edema in her lower extremities. She wears SCDs on both lower extremities.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>The client's breathing sounds were clear and audible upon bilateral auscultation of the region below the clavicle bone anteriorly and six spots posteriorly on the client's back. The client had 16 respirations per minute. Inhalation and exhalations were symmetrical and complete. No accessory muscle use upon inspection or deformity of the chest upon inspection. She states that she has no difficulties breathing.</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 client is on a regular diet at home and during her hospital stay. Her height is 177.8 cm (5'10") Her weight is 119.7 kg (264 lbs) The client's bowel sounds were hypoactive, with approximately 8-10 gurgles per minute in all four quadrants. The client stated that her last bowel movement was "some time" before admission on 9/14/2021. The client experienced 2/10 pain upon light palpation and a 6/10 pain upon deep palpation the closer it got to the incision site. No masses felt upon palpation. Upon inspection, the client's abdomen was not distended and had no rashes, bruises, drainages, or wounds. A transverse cesarean incision was present above the pubic bone with no drainage or erythema.</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 checked="" type="checkbox"/> N <input type="checkbox"/> Type: Indwelling Size: 18 gauge</p>	<p>The client had 600 mL of clear, yellow urine collected from her foley bag. She states that she does not experience pain with urination. Her vulva was slightly swollen and appeared slightly pinkish red with an 18-gauge indwelling catheter, placed on 9/14/2021, inside and secured to her right thigh upon inspection.</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: 30 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The client demonstrated independence in movement as she does not need ADL assistance or help getting up from bed and ambulating. She is a low fall risk and has a fall score of 30. She is independent and does not need equipment to support her if she sits at the side of the bed for about a minute upon sitting up from her bed.</p>
<p>NEUROLOGICAL (2 points): NEW: 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 client has control and moves all extremities well and independently with equal strength in all extremities. She exhibits PERRLA, and her pupils are equal, round, reactive to light, and accommodate to light. Throughout the clinical rotation, the client was alert, conscious, and oriented x4 to person, time, place, and situation. Her mental status is appropriate as she responds to all questions well with audible and clear speech. Sensory was intact in all extremities, and deep tendon reflexes were present in the patella.</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 client lives at home with her husband and two other children. Her husband is her most significant support during her pregnancy and helps take care of her children. He was present with her as she was giving birth and stayed the night. The client is Catholic and stated that she received “some” level of college.</p>
<p>Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:</p>	<p>The client's fundal height was 1 inch below her umbilicus (U1). She had lost around 350 mL of blood and had light consistency with Rubra-colored lochia. She had a cesarean section and did not have an episiotomy or lacerations.</p>
<p>DELIVERY INFO: (1 point) Rupture of Membranes: Time:</p>	<p>The client experienced a rupture of membranes at 1855 hours on 9/14/2021. The observed fluids were clear and odorless.</p>

<p>Color: Amount: Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>The client delivered her 5 lb (12.6 oz) female baby on 9/15/2021 at 0034 hours through a cesarean cut. There was a collected 587 mL of blood loss during the procedure. The client's Apgar scale was 8 at around 1 minute and a 9 at around 5 minutes. The client provided breastfeeding to her newborn.</p>
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Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Respiratory Rate	Temp	Oxygen
Prenatal	77 bpm	121/83 mmHg	18 respirations/minute	96.6 F (35.9 C)	96%
Labor/Delivery	85 bpm	136/74 mmHg	16 respirations/minute	97.9 F (36.6 C)	94%
Postpartum	57 bpm	108/59 mmHg	16 respirations/minute	97 F (36.1 C)	98%

Vital Sign Trends: The client’s vital signs experienced fluctuations throughout labor, most noticeably in blood pressure and pulse, while respiration, temperature, and oxygen remained unchanged and within defined limits. In the prenatal stage, the client's pulse of 77 bpm and blood pressure of 121/83 mmHg were lower than they were during the labor/delivery stage. The increase in blood pressure and heart rate is attributed to the increased pain and anxiety

experienced by the client during the labor/delivery stage (Ricci et al., 2020). The client’s blood pressure of 136/74 and heart rate of 85 bpm both experienced a decrease as the client progressed to the postpartum stage. The client’s blood pressure was 108/59 mmHg during the postpartum stage, with a heart rate of 57 bpm, slightly below the normal range for heart rate. At this point in the process, the client stated that she had little sleep and little to eat and was a little dehydrated, which could help explain the drop in the heart rate and blood pressure (Ricci et al., 2020).

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numeric pain scale	Abdominal incision	2/10	Burning	Administer acetaminophen to help relieve client pain.
0930	Numeric pain scale	Abdominal incision	2/10	Burning	Administer ketorolac to help relieve client 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:	The client has an 18-gauge IV catheter in her right wrist placed on 9/14/2021. The IV was clear, patent, and could easily be flushed. The insertion site was absent of erythema, drainage, and discoloration. The IV dressing was dry, intact, clean, and was saline-locked.

Intake and Output (2 points)

Intake	Output (in mL)
IV = 2,416 mL	Void = 2,950 mL
Total = 2,416 mL	Blood = 587 mL

	Total = 3,537 mL
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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 the client’s pain (N)	Every 2 hours	The client recently had a cesarean section and is experiencing a burning pain rated at a 2/10 on the numeric pain scale. Frequently assessing the pain will monitor and see if pain treatment is effective.
Administer ketorolac to the client (M)	30 mg Q6H	The client recently had a cesarean section and is experiencing pain rated initially at a 4/10. Ketorolac is given once every six hours to help control her pain. Pain has been successfully reduced to a 2/10 by the end of the clinical rotation.
Monitor the client’s vital signs (N)	Every 2 hours	The client gave birth recently and had a cesarean section. She lost about 587 mL of blood during her procedure and is at risk of bleeding due to her recent procedure. Monitoring the client's blood pressure, heart rate, and respirations will provide a glimpse of the amount of blood that may potentially be lost.
Provide the client education on breastfeeding techniques and	Once at 1030 hours	The client expressed concerns about her ability to provide her proper newborn

financial resources (N)		care due to her inability to breastfeed at the time and her limited financial resources. Education was provided on formal, informal resources that the client could look into to reduce the financial burden. She was given education on breastfeeding techniques and the importance of proper nutrition while feeding to help her after she stated that she was dehydrated and hungry.
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Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in?

The client is in the taking-in phase.

What evidence supports this?

In this phase, the mother usually depends on others to help her meet her needs, such as food, water, and sleep (Ricci et al., 2020). She also spends time holding her baby to get to know it more and to identify specific features in the baby (Ricci et al., 2020). The client remained on bed rest for most of the clinical rotation and only stood when asked. She relied on her husband and the nurse to provide her with food and water. She also expressed the desire to sleep since she stated that she was only able to get about an hour or two of sleep following the delivery of her baby. The client also spent time holding her baby and even trying to breastfeed it. Overall, while the client could stand and walk on her own, she still required the assistance of the nurse and her husband for most of her care needs.

Discharge Planning (2 points)

Discharge location: The client states that she will go home with her husband after discharge.

Equipment needs (if applicable): The client expressed concerns regarding her financial status and is worried that it will hinder the quality of care she will give to her newborn. Brochures can be given to the client with details of local support services that can help her financially.

Follow-up plan (include a plan for mother AND newborn): The client should follow up with her provider in two weeks and six weeks. Her baby should follow up in 24-48 hours with the provider to check her health.

Education needs: The client was given education on breastfeeding techniques, informal and formal support services.

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 bleeding related to the cesarean section as evidenced by bloody dressing at the incision site</p>	<p>The client recently had a cesarean section and experienced about 587 mL of blood during the procedure. The dressing located at her incision site was stained with Rubra-</p>	<p>1. Monitor the client's vital signs for manifestations of bleeding as abnormal values. Rationale: Early bleeding compensatory mechanisms alter respiration, pulse, and blood pressure (Phelps, 2020) 2. Educate the client on the adverse effect of increased risk for bleeding in pain relief medications such as ibuprofen, and aspirin</p>	<p>1. Goal met: The client's vital signs were monitored, and she was made aware of any abnormal values. The client and her husband expressed appreciation. The client's blood pressure was slightly below normal limits, and she was made aware of the finding. No modifications are necessary.</p>

	<p>colored blood and is expected to have more blood after birth. Measures should be taken to make sure excessive bleeding can be avoided.</p>	<p>Rationale: This will help the client know which medication to take and avoid to prevent further bleeding (Phelps, 2020).</p>	<p>2. Goal met: The client was educated on the potential increased risk for bleeding associated with aspirin and ibuprofen and acknowledged to avoid them until bleeding stops.</p>
<p>2. Pain-related to birth, as evidenced by the client's statement, "It is not too bad, but I would like the pain to go away."</p>	<p>The client experienced a burning pain-like sensation near her incision. She states that the pain is controlled at a 3 or a 4 but would like to remove the pain altogether.</p>	<p>1. Assess the patient using a numeric pain scale. Rationale: Pain is subjective, so by using a numeric pain scale, the client's perception of pain can be collected to create a baseline (Phelps, 2020). 2. Administer pain medication as prescribed and monitor for medication effectiveness. Rationale: Administering pain medication provides the client with pain relief (Phelps, 2020).</p>	<p>1. Goal met: The client's pain of 3/10 was collected using the numeric pain scale. The client waited to see what was going to happen next. 2. Goal partially met: The client received pain medication. After ten minutes, her pain was reassessed again, and the pain was rated a 2/10. The client expressed that pain is controlled, but she would like for it to go away completely.</p>
<p>3. Ineffective breastfeeding related to the inability to breastfeed, as evidenced by the client's statement, "I have tried breastfeeding, but it did not come out."</p>	<p>The client had trouble breastfeeding her baby. She stated that she tried to breastfeed her baby, but only a small amount came out. She also stated that she was dehydrated and hungry, which could affect her breast milk</p>	<p>1. Educate the client on the importance of adequate nutrition and fluid intake while breastfeeding. Rationale: Proper nutrition and hydration are crucial to breast milk production and essential to meet the infant's demands for breast milk (Phelps, 2020). 2. Educate the client on techniques that will stimulate the letdown reflex, such as taking warm showers, breast massages, and holding the neonate</p>	<p>1. Goal met: The client was given education on the importance of adequate nutrition and hydration while breastfeeding. She acknowledged the importance and was thankful for the information. Client was able to recite what she learned. 2. Goal met: The client was given education on techniques on</p>

	supply.	close to the breasts. Rationale: Proper techniques help reduce the client's anxiety and promote the letdown reflex (Phelps, 2020).	breastfeeding. She acknowledged these techniques and explained back how to perform the techniques.
4. Caregiver role strain related to increasing household size as evidenced by the client's financial concerns.	The client expressed concerns about supporting another child since it may become financially burdening on the family. The client stated that she has had difficulty paying for food and other necessities for her two other children.	1. Educate the client on the importance of the available formal support services, such as hospital social workers, Meals on Wheels, or food pantries. Rationale: Providing the client with resources will help the client cope by having a reliable support structure and will help the client take care of her newborn adequately (Phelps, 2020). 2. Educate the client on the informal support groups, such as family members, friends, and church groups. Rationale: Providing the client with informal resources will help the client better cope and reach out for support when she needs it (Phelps, 2020).	1. Goal met: Education on possible support services was given to the client. The client stated that she would look into the services once she left the hospital for support. 2. Goal met: Education was given to the client about possible informal support services. She stated that she would try to look into her family for financial support once she leaves the hospital.

Other References (APA)

Phelps, L. L. (2020). *Spark's and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.