N432 Postpartum Care Plan

Lakeview College of Nursing

Name: Claire Zumbahlen

Demographics (3 points)

Date & Time of Admission 8/4/21	Patient Initials AB	Age 34	Gender Female
Race/Ethnicity White	Occupation Graphic designer	Marital Status Married	Allergies Penicillin (rash)
Code Status Full code	Height 5'6"	Weight 90.7	Father of Baby Involved *father is sperm doner the patients wife is involved

Medical History (5 Points)

Prenatal History: G: 3 T:2 P:0 A:1 L:2

Past Medical History: ACL rupture

Past Surgical History: Anterior cruciate ligament repair, wisdom teeth extraction

Family History: Unknown due to adoption

Social History (tobacco/alcohol/drugs): None

Living Situation: Home with wife

Education Level: Bachelors

Admission Assessment

Chief Complaint (2 points): Spontaneous rupture of membranes

Presentation to Labor & Delivery (10 points):A 34-year-old female who was 37 & 4 arrived to labor and delivery on 10/5/21. The patient was scheduled for an induction on 10/5/21. She had a spontaneous rupture of membranes overnight before her induction. At the time of admission, the patient was dilated to a two. The patient was started on Pitocin upon arrival.

Diagnosis

Primary Diagnosis on Admission (2 points):Spontaneous rupture of membranes

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

The fourth stage of labor began when the placenta delivery had ended. At this time, the mother enters what is known as the postpartum period. The mother is transitioning to recovery and spending time with her newborn and family. During this phase, often, the mother feels a sense of peace and excitement (Ricci et al., 2020). At times the mother may feel fatigued, irritable, and worried; if any of those symptoms continue, she should seek help from a medical provider (Ricci et al., 2020). The mother starts becoming attached to the newborn by cuddling and breastfeeding (Ricci et al., 2020). My mother was holding and cuddling her baby as well as her partner after birth. She is also breastfeeding her child. During the postpartum period, the mother's fundus should be firm and well contracted at the midline of the umbilicus or below. If the mother's uterus is no longer firm and becomes boggy, it should be massaged to keep firm (Ricci et al., 2020). My patient's fundus was firm at two centimeters below the umbilicus. The mother should be monitored closely after birth to prevent hemorrhage. The interventions would include monitoring the fundus, lochia, and vitals to make sure she remains stable (Ricci et al., 2020). She should have her vital signs taken at least every 15 minutes for the first hour, then every 4 hours. Watching the heart rate and blood pressure can help as a nurse detect that a hemorrhage is occurring (Ricci et al., 2020). My patient had her vitals taken every 4 hours during

her stay. The lochia should be red, mixed with clots, and have a moderate flow (Ricci et al., 2020). My mother had a minimal flow of red lochia, which is a good sign.

Upon discharge, the mother needs to rest whenever she can. She should also limit visitors for the first two weeks so she can start breastfeeding and rest as much as possible. The mother also should not lift heavier than her baby (Cleveland Clinic, 2017). She should wash her hands frequently, especially after using the bathroom, changing diapers, and feeding the baby (Cleveland Clinic, 2017). The mother should continue to do perineal care to promote healing and prevent infection (Cleveland Clinic, 2017). She should also follow up with her obstetrician in six weeks to make sure she is healing and recovering well and contact them if she has concerns before. My patient had an appointment scheduled for after discharge.

Postpartum Course References (2) (APA):

Cleveland Clinic. (2017, May 26). *Post pregnancy care after giving birth*. Cleveland Clinic. Retrieved October 7, 2021, from https://my.clevelandclinic.org/health/articles/9679-caring-for-your-health-after-delivery.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. 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	**3.8-5.3**	**3.81**	**5.2**	**N/A**	
Hgb	**12.0-15.8**	**12.2**	**11.1**	**N/A**	**The patient is anemic due to pregnancy (Ricci et al., 2021).**
Hct	**36-47%**	**32.5**	**33.6**	**N/A**	
Platelets	**140,000-440,000**	**296,000**	**311,00**	**N/A**	
WBC	**4,000-**	**6,400**	**7,200**	**N/A**	

	12,000				
Neutrophils	**47-73**	**72.3**	**55.4**	**N/A**	
Lymphocytes	**18-42**	**18.5**	**18.0**	**N/A**	
Monocytes	**0.2-1.0**	**0.50**	**0.54**	**N/A**	
Eosinophils	**0.0-0.4**	**0.4**	**0.0**	**N/A**	
Bands	**0.0-0.1**	**0.06**	**0.10**	**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, B, O, AB**	**A**	**N/A**	**N/A**	
Rh Factor	**+/-**	**(-)**	**N/A**	**N/A**	
Serology (RPR/VDRL)	**+/-**	**(-)**	**N/A**	**N/A**	
Rubella Titer	Immune or not immune	**Immune**	**N/A**	**N/A**	
HIV	**+/-**	**(-)**	**N/A**	**N/A**	
HbSAG	**+/-**	**(-)**	**N/A**	**N/A**	
Group Beta Strep Swab	**+/-**	**(-)**	**N/A**	**N/A**	
Glucose at 28 Weeks	**Less than 140**	**88**	**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

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)	**< 0.25**	**N/A**	**N/A**	**N/A**	

Lab Reference (1) (APA):

OSF Lab references per epic charting

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. Wolters Kluwer.

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

	Your Assessment
History of labor:	**The patients total time of labor was 12 hours and 18 minutes.**

Length of labor **Induced /spontaneous** **Time in each stage**	**The patient had a spontaneous rupture of membranes which is why she came to the hospital. The patients first stage lasted 1 hour and 12 minutes. The second stage lasted 1 hour and 2 minutes and the third stage lasted four minutes. The length of labor varies for every person, but is typically shorter with the second birth (Ricci et al., 2020).**
Current stage of labor	**My patient is currently in the fourth stage of labor. She is recovering and bonding with her child (Cleveland Clinic, 2017). This stage lasts about six weeks while her body is transitioning back to her prepregnant body. Every woman has different recovery lengths due to the physical and psychological changes she experiences when transition to the role of a mother (Ricci et al., 2020)**

Cleveland Clinic. (2017, May 26). *Post pregnancy care after giving birth*. Cleveland Clinic. Retrieved October 7, 2021, from https://my.clevelandclinic.org/health/articles/9679-caring-for-your-health-after-delivery.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	**Prenatal vitamin w/ calcium**	**Asprin/ Acetylsalicylic acid ASA**			
Dose	27 mg/ 1 mg	81 mg			
Frequency	daily	Daily			
Route	PO	PO			
Classification	Multivitamin	Salicylate/ NSAID			
Mechanism of Action	Unsaturated bonds occur in the fatty acid change to enable the adaptation and growth pathways in the brain.	Blocks the activity of cyclooxygenase , the enzyme needed for prostaglandin synthesis.			
Reason Client Taking	Nutrition of the fetus	Prevent or delay the onset of preeclampsia			
Contraindications (2)	Do not take if you have allergies to any of the ingredients, talk to doctor if you have liver or stomach	Breast feeding, third trimester of pregnancy			

	problems				
Side Effects/Adverse Reactions (2)	Upset stomach, headache	GI bleeding, angioedema			
Nursing Considerations (2)	Monitor patient closely for adverse reaction, watch patient and educate patient on signs of overdose	Ask about tinnitus, make sure patient stops taking in third trimester			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check if patient has pernicious anemia	Assess patient for any bleedings and how many weeks pregnant			
Client Teaching needs (2)	Take with a full glass of water, never take two doses at a time if a dose is missed	Stop taking third trimester and when breast feeding, take with food to prevent GI upset			

Hospital Medications (5 required)

Brand/Generic	**Oxytocin/ Pitocin**	**Motrin/ Ibuprofen**	**Dermoplast/ benzocaine menthol**	**Tucks/ witch hazel glycerin**	**Rho D immune globulin/ RhoGAM**
Dose	30 units/ 500 mL	800mg	1 spray	1 pad	300 mcg
Frequency	Once	Q 8 prn	Q 4hrs PRN	PRN	Once
Route		PO	spray	pad	IM

	IV				
Classification	Oxytocic hormones/ uterine contractions stimulator	Nonsteroidal anti-inflammatory drug	Local anesthetic	Local anesthetic	Immune globulins
Mechanism of Action	Increases the concentration of calcium inside the muscle cells that control the contraction of the uterus	Ibuprofen is a non-selective inhibitor of an enzyme called cyclooxygenase (COX), which is required for the synthesis of prostaglandins via the arachidonic acid pathway. COX is needed to convert arachidonic acid to prostaglandin H2 (PGH2) in the body. PGH2 is then converted to prostaglandins	acts by preventing transmission of impulses along nerve fibers and at nerve endings	Local anesthetic due to inhibition of conduction of nerve impulses from sensory nerves, resulting from an alteration of the cell membrane permeability to ions.	RhoGAM (rho(d) immune globulin (human)) and MICRhoGAM (rho(d) immune globulin (human)) act by suppressing the immune response of Rh-negative individuals to Rh-positive red blood cells.
Reason Client Taking	Control bleeding after childbirth	Pain control	Reduce pain and discomfort	Reduces perineal and hemorrhoidal discomfort	Prevent Rh sensitization from delivery to protect your next fetus
Contraindications (2)	Hypersensitivity to the	Hypersensitivity to the	Methemoglobinemia in the past,	Allergic to any of its	Dehydration, high

	medication, fetal is in distress prior to birth	medication, patients who have had any asthmatic type of reaction to aspirin or other NSAIDs.	heart disease	componen ts, taking vitamin D	amount of triglyceride in the blood
Side Effects/Adverse Reactions (2)	Runny nose, cramping	Nausea, diarrhea	Headache, fast heart beat	Rash, burning	Fever, rapid breathing
Nursing Considerations (2)	Watch for fast, slow, or uneven heart rate; watch for shallow breathing or breathing that stops	Monitor the patient's liver function, and monitor pain meds	Monitor for heart level changes, warn patient it feels cold when sprayed	Teach to apply to laceration s and warn them it feels cold	Monitor heart rate and airway
Key Nursing Assessment(s)/L ab(s) Prior to Administration	Verify vitals and dose before administratio n	Pain assessment	Pain and discomfort of the peritoneal area	Pain and discomfor t of the peritoneal area	Check liver and kidney functions or signs of disfunction
Client Teaching needs (2)	Notify the doctor or nurse if never vomiting, or excessive bleeding after child birth	Take with meals, do not take with aspirin	Use the small amount needed, how to apply to lacerations	Use sparingly and only externally	Allert the nurse if shortness of breath occurs, or difficulty urinating and swelling

Medications Reference (1) (APA):

RxList. (2021). *The internet drug index for prescription drug information, interactions, and side effects*. RxList. Retrieved September 11, 2021, from https://www.rxlist.com/script/main/hp.asp.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to time, date, place, and person. No distress Well groomed
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pink Dry Warm Elastic turgor 2+ No rashes No bruises No incisions 22
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 The patient's head, and neck were symmetrical and she had a normal range of motion of her face, head, and neck. The patient's ears were pink with no discharge present. The nose was symmetrical, with no drainage present. The teeth were intact and in great condition.
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒**	When auscultating the patient, S1 and S2 heart sounds were heard with no murmur, gallops, or rubs present. The patient's carotid, radial, ulnar, brachial, femoral, popliteal, dorsal pedis, and posterior tibial pulses were 2+ bilaterally. The patient's capillary refill was normal. No neck vein distention was present. The patient had edema present in the legs and feet.

Edema Y ☒ N ☐ **Location of Edema: legs and feet**	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient's respirations were unlabored. While auscultating the patient bronchial vesicular sounds were heard in all lobes anteriorly and posteriorly.
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:**	The patient is on a regular diet at home and a regular diet at the hospital. The patient was 5 foot and 6 inches and weighed 90.7 kg on admission. The patient had active bowel sounds that were present in all four quadrants. The patient's last bowel movement was 10/5. On palpation of the abdomen, the patient's fundus was firm and two inches below the umbilicus. The patient had mild distention of the abdomen. The patient had a small scar from an ACL surgery. The patient also had a peritoneal laceration.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Voiding with no issues. Genitals were pink with minimal swelling.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 5** **Activity/Mobility Status:** **Independent (up ad lib) ☐ Yes** **Needs assistance with equipment ☐ No** **Needs support to stand and walk☐ No**	.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:**	The patient has a good mental status. She is alert and oriented, has good hygiene, is calm and cooperative, and maintains good eye contact. Her speech is clear and appropriate to topics. The patient sensory is intact. The patient is alert and oriented. The patient's deep tendon reflexes are present.

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 able to cope with everyday life. The patient does not have any religion practices. The patient lives at home with her wife and feels safe.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal Height is minus 2. Minimal bleeding Rubra Few to no blood clots Stage 2 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:**	2354 Clear Leakage None 10/5 1203 Vaginal 350 mL Female 8 and 8 3555 Kg Breast

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**86**	**120/80**	**18**	**36.9**	**Not documented**
Labor/Delivery	**86**	**106/64**	**20**	**98.6**	**99%**
Postpartum	**91**	**120/72**	**18**	**98.6**	**100%**

Vital Sign Trends: The patients vitals did not change much. The BP decreased which shows the patient was relaxed and tolerating pain.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**0-10**	**Abdomen/ perineal**	**2**	**Dull**	**Medication (Ibuprofen)**
0950	**0-10**	**Abdomen/ perineal**	**2**	**Dull**	**Position Change**

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:**	18 gauge R hand Patent but removed on assessment No drainage or erythema Dressing intact but removed

Intake and Output (2 points)

Intake	Output (in mL)
Eating and drinking regular food	**Up and moving and voiding**

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.
Offering ibuprofen, T	**Every 6 hours**	**This was provided for the patient to help reduce pain.**
Ice Pack, N	**PRN**	**This was provided to the patient to**

		help reduce pain and inflammation in the perineal area.
Assessing fundal height, N	**Every 8 hours**	**This intervention is to determine the height and firmness of the fundus to help with early detection of bleeding.**
Assist with breast feeding, N	**PRN**	**This intervention is due to the patient needing help with breast feeding and a lack of knowledge related to breast feeding.**

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? The taking in phase occurs 24-48 hours after birth. The mother and her partner are interacting with their newborn. The mother is also able to catch up on sleep and adjust to being a new mom. The mother was adjusting to breast feeding and making decisions regarding her and her baby.

Discharge Planning (2 points)

Discharge location: Discharge to home with Wife

Equipment needs (if applicable): Breast pump

Follow up plan (include plan for mother AND newborn): Mother should follow up in 6 weeks with her OB. Newborn should follow up in 1-2 days with the pediatrician.

Education needs: The mother should be educated on signs of infection, breast feeding, and safe sleeping.

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	Rational	Intervention/Rational (2	Evaluation

(2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**(1 pt each)** Explain why the nursing diagnosis was chosen	**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.	**(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. Acute pain related to just giving birth as evidenced by showing signs of pain.	**This diagnosis was chosen due to patient's pain being a high priority and making sure the mother is comfortable.**	**1. apply cold pack Rational: Ice packs help to reduce pain and swelling (Ricci et al., 2021). 2.pain assessment Rationale: Determining and understanding the patients individual acceptable pain level enables the nurse to work with the patient to determine adequate pain relief Ricci et al., 2021).**	**The clients pain stays under a 4 during their stay and they are able to tolerate the pain. The client responded by using cold packs and a frequent pain assessment while I was at clinical.**
2. Risk for bleedi.ng related to vaginal birth as evidence by having minimal vaginal bleeding	**This diagnosis was chosen due to the patient having bleeding after birth.**	**1. Monitor fundal height Rationale: If the fundal height is above the umbilicus this would be an abnormal finding that could be a sign that excessive bleeding may occur (Ricci et al., 2021). 2.Vitals every 4 hours Rational: A drop in blood pressure or an increase in the heart rate could be a sign of bleeding (Ricci et al., 2021).**	**The patient will have minimal bleeding and stable vitals. The patient responded well to fundal height checks and frequent vital signs.**
3. Knowledge deficit of infection related to first degree laceration as evidenced by open wound	**This is due to the patient having a laceration and being highly susceptible to an infection.**	**1. Encourage perineal care Rationale: The practice of good hygiene can reduce the spread of microorganisms into the genital area (Ricci et al., 2021).**	**The patient will remain infection free. The patient was performing perineal care when up and moving to the bathroom and responded well to the**

susceptible for infection.		**2. Inspect peritoneum Rationale: Excessive swelling, redness, discolored discharge or blood could be a sign of an infection that would need to be treated as soon as possible (Ricci et al., 2021).**	**check of the peritoneum.**
4. Knowledge deficit on education of newborn care related to just having a child as evidence by asking questions about breast feeding and the infant.	**This is due to the patient just having a baby and adjusting to the life of a newborn parent.**	**1. Breast feeding Rationale: Breast feeding is a new and important need for the baby to get proper nutrition (Ricci et al., 2021). 2. Safe sleeping Rationale: Safe sleeping is essential to prevent SIDS. The baby should be alone in a crib with nothing else (Ricci et al., 2021).**	**The patient will know how to properly breast feed and know about safe sleeping practices. The patients is doing well with learning about breast feeding and has her infant sleeping alone in the bassinet.**

Other References (APA)

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and Pediatric Nursing*. Wolters Kluwer.