

N432 POSTPARTUM CARE PLAN

N432 Postpartum Care Plan

Lakeview College of Nursing

Sarah Evans

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 10/11/21	<b>Patient Initials</b> D.W.	<b>Age</b> 29 <b>DOB</b> 2/11/92	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Police Officer	<b>Marital Status</b> Married	<b>Allergies</b> No known allergies
<b>Code Status</b> Full	<b>Height</b> 5'3" 160cm	<b>Weight</b> 204 pounds 92.5 kg	<b>Father of Baby Involved</b> yes

**Medical History (5 Points)**

**Prenatal History:**   Gravidity 1

Term 1

Preterm 0

Abortion 0

Living 1

The patient had a fetal pericardial effusion and fetal macrosomia which complicated her pregnancy. She has had no other pregnancies.

**Past Medical History:** The patient stated she had no pertinent past medical history.

**Past Surgical History:** The patient had a cesarean section on 10/11/21.

**Family History:** The patient's mother has a history of diabetes and hypertension. The patient's father has a history of myocardial infarction and hypertension. The patient's maternal grandmother has a history of cancer.

**Social History (tobacco/alcohol/drugs):** The patient claims she has never smoked or used illicit drugs. The patient stated she did not use alcohol during her pregnancy.

**Living Situation:** The patient lives at home with her husband and two large dogs.

**Education Level:** The patient has a bachelors degree in law enforcement.

### **Admission Assessment**

**Chief Complaint (2 points):** The patient came into the hospital to deliver her baby because she was past her due date and measuring large. She decided to have a cesarean section due to the expected size of her baby.

**Presentation to Labor & Delivery (10 points):** The patient, a 29 year old female, was admitted to the labor and delivery unit on 10/11/21 at 1000 (onset) for a scheduled cesarean section. She was 41 weeks and 2 days pregnant at the time of admission and this was her first pregnancy. She stated she was “not feeling (characteristics) any contractions at that time and was not dilating”. She stated she did not have any pain at the time of admission (location, duration). The patient stated she was anxious about the cesarean section (aggravating factors), but speaking with the nurse midwife helper alleviate her anxiety (relieving factors). There were no treatments because the patient was not experiencing discomfort at that time.

### **Diagnosis**

**Primary Diagnosis on Admission (2 points):** Postpartum care following cesarean delivery.

Secondary Diagnosis (if applicable): There is no secondary diagnosis for this patient.

### **Postpartum Course (18 points)**

The patient is in her fourth stage of labor. The postpartum period begins as soon as the uterus expels the placenta after birth. Many physicians include the six weeks following delivery in the postpartum period (Ricci et al., 2020). During the fourth stage of labor, the new mother’s body adjusts to no longer carrying the baby, losing the accumulated extra fluid, and providing nourishment for the newborn in the form of breast milk (Ricci et al., 2020). Many people do not

consider this period a part of labor, but it is essential in forming a bond between the mother, the other family members, and the infant (Ricci et al., 2020). This stage of labor also focuses on the physiological return to many pre-pregnancy norms, including hormonal changes, fluid shifts, and weight loss (Ricci et al., 2020). During this stage of labor, the uterus should become firm and contracted (Mayo Clinic, 2019). The fundus should feel firm, like pushing on the back of one's hand. The lochia should diminish as time goes on, be red, and the client should not soak through a pad in one hour. The mother will progressively become more tired during this period as she learns to care for her newborn and experiences hormonal changes. Offering to help with the care of the newborn, housework, and any other concerns during this time can help the new mother with this overwhelming exhaustion.

During this shift, my patient seemed very pleasant, comfortable, and not distressed. She was not experiencing severe pain and only required ibuprofen for pain management post-cesarean section. Her lochia was red, light, and amounted to less than ten centimeters on a pad in an hour. My patient had a scheduled cesarean section on 10/11/21 because she was forty-one weeks and two days of gestation. She was not dilating or making labor progress. Her baby also measured larger than expected for his gestational age. Her nurse-midwife suggested a cesarean section to lessen the chances of strenuous labor. My patient lost 843 mL of blood during delivery. My patient was ready to go home during this shift, but her infant had low blood sugar readings requiring prolonged nursing care. My patient was also learning to breastfeed and how to soothe her infant. She was in the taking-hold phase (Ricci et al., 2020).

During the fourth stage of labor, the nurse should monitor for postpartum complications, closely monitor the patient's vitals, vaginal discharge, and perform frequent fundal assessments (Mayo Clinic, 2019). Some complications the nurse needs to monitor for include incisional and

uterine infection, heavy blood loss, changes in mental status, depression, stroke, deep vein thrombosis, amniotic fluid embolism, and uterine inversion (Mayo Clinic, 2019). Some common signs and symptoms of infections are redness, swelling, and foul smelling or purulent drainage. A postpartum depression screening should be administered to every patient. Patients with hypertension, previously diagnosed mental health conditions, obesity, and pre-term or post-term deliveries are at a higher risk for postpartum complications (Mayo Clinic, 2019).

### Postpartum Course References (2) (APA):

Mayo Clinic. (2019). *Postpartum complications: What you need to know*. [https://](https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/postpartum-complications/art-20446702)

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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	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30 10 <sup>6</sup> /mc L	4.42	4.44	3.88	n/a
Hgb	12.0-15.8 g/dL	12.9	12.8	11.1	Decreased blood volume following delivery of a baby is seen due to blood loss (Pagana, 2019).

<b>Hct</b>	<b>36.0-47.0%</b>	<b>37.8</b>	<b>37.6</b>	<b>33.0</b>	<b>Decreased hematocrit levels are commonly seen after hemorrhage (Pagana, 2019). This patient lost 843mL during delivery which is likely the reason for this lower hematocrit level.</b>
<b>Platelets</b>	<b>140-440 10<sup>3</sup>/mc L</b>	<b>266</b>	<b>212</b>	<b>194</b>	<b>n/a</b>
<b>WBC</b>	<b>4.00-12.00 10<sup>3</sup>/mc L</b>	<b>10.14</b>	<b>10.40</b>	<b>14.60</b>	<b>Inflammation can cause an increase in white blood cells (Pagana, 2019). This patient recently had a cesarean section which causes a lot of inflammation.</b>
<b>Neutrophils</b>	<b>1.60-7.70 10<sup>3</sup>/mc L</b>	<b>7.85</b>	<b>7.60</b>	<b>12.30</b>	<b>Neutrophils can be decreased due to dietary insufficiencies which the patient could have been experiencing due to the body sending all necessary nutrients to the growing baby, and she could have increase in neutrophils due to inflammation following her cesarean section (Pagana, 2019).</b>
<b>Lymphocytes</b>	<b>1.30-3.20 10<sup>3</sup>/mc L</b>	<b>1.55</b>	<b>1.80</b>	<b>1.30</b>	<b>n/a</b>
<b>Monocytes</b>	<b>0.20-1.00 10<sup>3</sup>/mc L</b>	<b>0.65</b>	<b>0.80</b>	<b>1.00</b>	<b>n/a</b>
<b>Eosinophils</b>	<b>0.00-0.40 %</b>	<b>0.03</b>	<b>0.10</b>	<b>0.3</b>	<b>n/a</b>
<b>Bands</b>	<b>0.0-1.0%</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>n/a</b>

**Other Tests** **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	AB	n/a	AB	n/a
Rh Factor	negative or positive	positive	n/a	positive	n/a
Serology (RPR/VDRL)	non-reactive	non-reactive	non-reactive	n/a	n/a
Rubella Titer	immune	immune	immune	n/a	n/a
HIV	not detected	not detected	not detected	n/a	n/a
HbSAG	not detected	not detected	not detected	n/a	n/a
Group Beta Strep Swab	negative	negative	negative	n/a	n/a
Glucose at 28 Weeks	less than 140 mg/dL	122	n/a	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.

A biophysical profile was completed on 10/11/21. The fetal heart rate at this time averaged 148 beats per minute. The overall score was 8/8. These findings indicate the baby was doing very well and met all requirements. This test was used to determine if there were any expected complications with performing a cesarean section. The patient required no further admission labs.

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


**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. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

\*Normal lab values were acquired from epic charting system.

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

	<b>Your Assessment</b>
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<p><b>History of labor:</b></p> <p><b>Length of labor</b></p> <p><b>Induced /spontaneous</b></p> <p><b>Time in each stage</b></p>	<p>This patient experienced no reported preterm labor. She came to the hospital for a scheduled cesarean section and never was in active labor. From the time of admission until the birth of the baby was two hours and fifteen minutes (admission time was 1000, time of birth was 1215). The membranes were ruptured artificially at 1214. The amniotic fluid was reported to be clear, colorless, and had no odor. The baby was delivered at 1215 via primary scheduled cesarean section. The indication for this cesarean section was macrosomia which means the baby is larger than 8 pounds, 13 ounces (Ricci et al., 2020). The third stage of labor was noted to be 0 hours, 01 minutes. There was not first or second stage of labor noted. The three active stages of labor end after the placenta is expelled (Ricci et al., 2020). In this case the placenta was expressed at 1216 and noted to be intact. The fourth stage of labor lasts up to six weeks following delivery (Mayo Clinic, 2019).</p>
<p><b>Current stage of labor</b></p>	<p>The mother is currently experiencing the fourth stage of labor which is also known as the postpartum period (Ricci et al., 2020). This mother is adjusting well during this stage of labor. Her uterus is contracting well and is firm and measuring two centimeters below the umbilicus. During the postpartum period the uterus should contract and be firm (Ricci et al., 2020). It should begin to descend below the umbilicus and eventually receded into the pelvis behind the pubic bone (Ricci et al., 2020). The patient’s lochia is red and lightening. She reports less than ten centimeters of lochia on a pad in one hour. She is learning to nurse well and hopeful that her milk supply will meet her baby’s needs soon. Her baby is latching easily and drinking colostrum, but is currently experiencing low blood sugar levels. He is requiring glucose and formula supplementation currently until her milk supply is able to meet his needs and his blood glucose level improves.</p>

**Stage of Labor References (2) (APA):**

Mayo Clinic. (2019). *Postpartum complications: What you need to know*. <https://>

[www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/postpartum-complications/art-20446702](http://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/postpartum-complications/art-20446702)

Ricci, S. S., Kyle, T., & Carman, S. (2021). 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)**

<b>Brand/Generic</b>	<b>prenatal vitamin</b>	<b>Tylenol acetaminophen</b>	<b>The patient was taking no other medications at home prior to admission.</b>	<b>n/a</b>	<b>n/a</b>
<b>Dose</b>	<b>0.8 mg</b>	<b>975mg</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Frequency</b>	<b>Daily at night</b>	<b>q6h</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Route</b>	<b>PO</b>	<b>PO</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Classification</b>	<b>Combination of vitamin and mineral</b>	<b>Nonsalicylate/Nonopioid analgesic</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>

<b>Mechanism of Action</b>	<b>Provides the vitamins and minerals necessary for healthy fetal development.</b>	<b>The mechanism of action for acetaminophen is not fully understood but it is thought to inhibit prostaglandin production which interferes with pain impulses (Jones, 2021).</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Reason Client Taking</b>	<b>The patient was taking this to promote the health of her developing child.</b>	<b>The client can take this for pain if needed.</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Contraindications (2)</b>	<b>High iron levels, and hyponatremia.</b>	<b>Hypersensitivity, hepatic impairment</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Constipation and black tarry stool.</b>	<b>Hypokalemia, and wheezing.</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>

<b>Nursing Considerations (2)</b>	<b>Do not give this medication to a patient who is hyponatremic. Consider giving this medication with a stool softener if necessary.</b>	<b>Use this medication cautiously in patients with hepatic impairment. Monitor AST, ALT, bilirubin, and creatinine in patients who use this medication long term.</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	<b>Check the patient's CMP for the sodium level and assess for constipation before administration.</b>	<b>Assess pain before administration and one hour after administration. Monitor liver enzymes.</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>
<b>Client Teaching needs (2)</b>	<b>Teach the client the expected findings of stool will include dark green or black stools. Teach the client to report constipation before it becomes severe.</b>	<b>The dosage should not exceed 4g per day. Make sure to tell the patient about possible liver damage if they exceed the recommended dose.</b>	<b>n/a</b>	<b>n/a</b>	<b>n/a</b>

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	<b>Motrin ibuprophen</b>	<b>Mylicon simethicone</b>	<b>Colace docusate sodium</b>	<b>Norco hydrocodon e- acetominop hen</b>	<b>Lan-O- Soothe Lanolin cream</b>
<b>Dose</b>	<b>800 mg</b>	<b>80 mg</b>	<b>100 mg</b>	<b>5-325 mg</b>	<b>varries</b>
<b>Frequency</b>	<b>q8h PRN</b>	<b>4x daily after meals and nightly</b>	<b>2x daily PRN</b>	<b>q4h PRN</b>	<b>apply to nipples PRN after breast feeding</b>
<b>Route</b>	<b>PO</b>	<b>PO</b>	<b>PO</b>	<b>PO</b>	<b>Topical</b>
<b>Classification</b>	<b>NSAID, analgesic (nonopioid).</b>	<b>Anti- flatulence/ Gastrointest inal agents</b>	<b>Laxative, stool softener</b>	<b>Opioid analgesic controlled substance schedule II</b>	<b>Emollient</b>

<p><b>Mechanism of Action</b></p>	<p>Causes a reduction in prostaglandin synthesis which produces an anti-inflammatory, analgesic, and antipyretic response.</p>	<p>Simethicone reduces pain following cesarean section by reducing gas and relieving abdominal distention (Martingan o, 2020).</p>	<p>Docusate sodium is a surfactant that softens stool by decreasing surface tension between oil and water in feces. This action lets more fluid penetrate stool, forming a softer fecal mass.</p>	<p>Activates opioid receptors to induce pain relief.</p>	<p>Softens and moistens the skin to reduce pain and itching.</p>
<p><b>Reason Client Taking</b></p>	<p>The patient can take this medication for mild to severe pain if needed. She plans to take this at home as needed for pain.</p>	<p>This medication can reduce the pain and length of hospital stay following a cesarean section (Martingan o, 2020).</p>	<p>This medication is available to the patient if she becomes constipated.</p>	<p>This medication is available to the patient for mild to severe pain. The patient filled this prescription just in case but it hopeful she won't need it.</p>	<p>This topical cream is available to the patient for nipple discomfort due to breast feeding.</p>

<b>Contraindications (2)</b>	Patients who have had a previous reaction to an NSAID or who have kidney failure should not take this medication.	Patients should not take this medication if they are pregnant or if they have a hypersensitivity to simethicone .	Contraindications for this medication include fecal impaction, intestinal obstruction.	Patients should not take this if they are in respiratory depression or if they have asthma.	Do not use if signs of skin infection are present or if there is a hypersensitivity to this medication.
<b>Side Effects/Adverse Reactions (2)</b>	Low blood sugar and low potassium can result from taking this medication.	Loose stool, and headaches are common side effects of this medication.	Possible side effects include Dizziness, syncope, palpitations .	This medication can cause respiratory depression and is addictive.	This medication can cause skin burning and irritation.
<b>Nursing Considerations (2)</b>	Use with caution in patients with a history of stomach ulcers or patients who drink alcohol excessively as this can increase the risk for gastrointestinal bleeding.	The patient's bowel sounds should be returning to normal. Monitoring this while giving this medication is necessary. Also this medication can cause a rash.	Long term use of this medication can lead to dependence. This medication can also cause electrolyte imbalances.	The use of this medication increases the risk of misuse or abuse. This medication should not be given to a patient with altered consciousness.	Lanolin does not have any known side effects with other medications. This medication is for external use only.

<p><b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b></p>	<p><b>Check renal function labs and assess for GI bleeding and pain level before giving this medication.</b></p>	<p><b>Continually assess the patient's level of abdominal pain prior to administration. Also assess the patient's bowel sounds.</b></p>	<p><b>Check lab work for electrolyte imbalances and assess patients for laxative use disorder if indicated.</b></p>	<p><b>Assess the patient's respirations and check that resuscitation equipment and antidote is available before use.</b></p>	<p><b>Assess the patient's nipple discomfort and for any signs of infection prior to use.</b></p>
<p><b>Client Teaching needs (2)</b></p>	<p><b>Teach client that NSAIDs can cause damage to the stomach lining if taken in excess or for long periods of time. Teach the client to avoid the use of alcohol while taking NSAIDs.</b></p>	<p><b>Take this medication as prescribed. Take one hour before or two hours after meals.</b></p>	<p><b>Take this medication with a full glass of water. Increase fiber intake to encourage naturally regular bowel movements.</b></p>	<p><b>Take this medication exactly as prescribed and warn the patient of possible addiction before starting this medication.</b></p>	<p><b>Teach patient not to administer near or in the eyes. Teach the patient to discontinue use if irritation arises.</b></p>

**Medications Reference (1) (APA):**

Cunha, J. (2021). *Lanolin*. RxList. [https://www.rxlist.com/consumer\\_lanolin/drugs-condition.htm](https://www.rxlist.com/consumer_lanolin/drugs-condition.htm)

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Martingano, D., Mitrofanova, A., Kim, A. F., Ulfers, A., Hood, K., Stevenson, R., & Singh, S.

(2020). 191: Postoperative management of cesarean deliveries with simethicone and metoclopramide decreases opiate use and postpartum stay. *American Journal of Obstetrics & Gynecology*, 222(1). <https://doi.org/10.1016/j.ajog.2019.11.207>

**Assessment**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>The patient was alert and oriented to person, place, time, and situation. The patient was not in any distress during the time of assessment. The patient appeared neat and clean and changed from a patient gown into regular clothes to go home at about 1000.</p>
<p><b>INTEGUMENTARY (1 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds/Incision:</b> .  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/>      N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>The patient’s skin color is appropriate for her ethnicity. Her skin was warm, and not overly dry. Her skin turgor was elastic and showed no signs of dehydration. The patient had no rashes or bruises. She has an incision from her recent cesarean section. It is a low transverse bilateral incision that appears to be approximated well and shows no signs of infection. The incision shows very little erythema, now swelling, and no drainage were visible.</p> <p>The patient’s braden score is 22 which indicates she is low risk for skin break down. There were no drains present at the time of assessment.</p>

<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>The patient’s head is normocephalic with no visible abnormalities. Her facial features are symmetrical. Her trachea is midline, all lymph nodes are not palpable. Her carotid pulses are 3+ bilaterally. The patient states she has not noticed any recent hearing changes and her ears are non-tender to palpation. There is no drainage or redness visible upon examination. The patient’s eyes show no drainage, PERRLA bilaterally, and the conjunctiva is pink and moist. The patient’s extra-ocular movements are intact and her eyes accommodate well. She does not wear glasses or contacts. The patient states her nose is patent bilaterally and complains of no drainage or soreness. There was no visible septal deviation redness or polyps. The patient’s gums were pink and firm. Her oral mucous membranes were moist. The soft palate rises and falls and there were no abnormalities visible on the patients tonsils. Her teeth appeared to be well cared for and she stated there are none missing.</p>
<p><b>CARDIOVASCULAR (2 point):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Location of Edema:</b></p>	<p>The S1 and S2 heart sounds were clearly heard with no audible S3 or S4 sounds. The patient’s heart rate and rhythm were regular. The peripheral pulses were palpable at 2+ at the radial, and dorsalis pedis pulse sites bilaterally. The patient’s capillary refill in her fingers and toes was less than two-seconds bilaterally. There was trace non-pitting edema on the patients ankles and feet bilaterally.</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Breath Sounds: Location, character</b></p>	<p>The patient's respirations were non labored and had a regular rate and rhythm. She did not use accessory muscles to breath. The breath sounds were vesicular in all five lobes both anteriorly and posteriorly. Chest expansion was even bilaterally.</p>

<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at Home:</b>  <b>Current Diet:</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>              <b>Distention:</b>              <b>Incisions:</b>              <b>Scars:</b>              <b>Drains:</b>              <b>Wounds:</b></p>	<p>The patient has been eating a regular diet at home taking care to consume more iron containing foods like leafy greens. In the hospital the patient is on a regular diet. The patient’s height is 160cm and her weight is 92.5 kg. Normo-active bowel sounds were heard in all four quadrants. The patient states her last bowel movement was on 10/11/21 before she came into the hospital. The patient’s abdomen was soft, not distended, and appropriately tender to palpation. There were no abnormal masses. The patient’s incision from her cesarean section on 10/11/21 was well approximated with no visible signs of infection. There were no other visible scars, drains, or wounds.</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Quantity of urine:</b>  <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Inspection of genitals:</b>  <b>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>              <b>Type:</b>              <b>Size:</b></p>	<p>The patient voided 4 times during this shift. She denies pain with urination. The student nurse did not observe the patient’s genitals. Her catheter was removed on 10/12/21 before this assessment.</p>
<p><b>MUSCULOSKELETAL (1 points):</b>  <b>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b>  <b>Needs assistance with equipment</b>  <b>Needs support to stand and walk</b></p>	<p>The patient needed no assistance with ADLs. Her fall risk score was 0 indicating low risk for falls. The patient has no activity limitations except for not lifting anything heavier than her baby who is roughly ten pounds for the next two weeks. She has also been instructed not to submerge in water for two weeks and should abstain from sexual intercourse for 6-8 weeks. She is up ad liberty in her room. She does not need assistance with any equipment or support to stand or walk.</p>

<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b>  <b>DTRs:</b></p>	<p>The patient moves all extremities well with equal strength and no deficits in all four extremities. Her eyes PERRLA. She is oriented to person, place, time, and situation. Her metal status is appropriate for her situation and development. She is able to express herself well and understands verbal communication well. The patient response to stimulus as expected and is very alert. Her deep tendon reflexes are 2+ with a brisk response.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points)</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The patient is coping well as she has become a new mother. She does not seem too overly concerned with her baby's blood sugar drop and she wants what is best for him. She relies on her family for coping. The patient's developmental level is appropriate for her age. She has a bachelors degree in law enforcement and works as a police officer in Champaign. She states her family belongs to a church, but they don't attend regularly. The patient states her mom and her husbands mother and father all live close by and plan to support them as they adjust to parenthood. The patient lives at home with her husband and two dogs. They hope to bring their new son home today.</p>
<p><b>Reproductive: (2 points)</b>  <b>Fundal Height &amp; Position:</b>  <b>Bleeding amount:</b>  <b>Lochia Color:</b>  <b>Character:</b>  <b>Episiotomy/Lacerations:</b></p>	<p>The patient's fundus is currently 2 centimeters below the umbilicus. She has a light amount of bleeding that is red with no clots. She reports less than 10 centimeters of loch on a pad in one hour. The patient had a cesarean section so she has no vaginal lacerations or episiotomy.</p>

<p><b>DELIVERY INFO: (1 point)</b>  <b>Rupture of Membranes:</b>  <b>Time:</b>  <b>Color:</b>  <b>Amount:</b>  <b>Odor:</b>  <b>Delivery Date:</b>  <b>Time:</b>  <b>Type (vaginal/cesarean):</b>  <b>Quantitative Blood Loss:</b>  <b>Male or Female</b>  <b>Apgars:</b>  <b>Weight:</b>  <b>Feeding Method:</b></p>	<p>The patient's membranes were artificially ruptured just before the birth of her baby at 1214 on 10/11/21. The amniotic fluid was noted to be clear with no color, and had no odor. The amount was moderate. Her newborn son was delivered at 1215 on 10/11/21 via cesarean section. His apgar scores were 8 and 9. He weighed 4695 grams or 10 pounds 5.6 ounces. He is currently breastfeeding. The patient's estimated blood loss was 843 mL.</p>
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**Physical Exam (18 points)**

**Vital Signs, 3 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>Prenatal</b>	<b>82</b>	<b>130/74</b>	<b>18</b>	<b>97.2</b>	<b>97%</b>
<b>Labor/Delivery</b>	<b>82</b>	<b>125/69</b>	<b>16</b>	<b>97.3</b>	<b>97%</b>
<b>Postpartum</b>	<b>69</b>	<b>113/69</b>	<b>16</b>	<b>98.0</b>	<b>98%</b>

**Vital Sign Trends:** The patient's vital signs have remained stable. Her blood pressure decreased after delivery which is likely due to blood and fluid loss.

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
10/13/21 0240	numeric	incisional/ abdomen	1 at rest 2 with activity	dull constant	ibuprofen given
10/13/21 0935	numeric	incisional/ abdomen	2 at rest 3 with activity	dull constant	ibuprofen given

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	The patient had no IV at the time of assessment. Her IV was removed on 10/12/21. It was an 18 gauge located on the top of her right hand. The insertion site appeared to be healing well with no signs of infection.

**Intake and Output (2 points)**

<b>Intake</b>	<b>Output (in mL)</b>
The patient stated she had consumed roughly 200 mL of coffee and water during breakfast and about 400 mL of water during this shift.  Total intake was 600 mL.	The patient voided four time during this shift.  Her last bowel movement was on 10/11/21.

**Nursing Interventions and Medical Treatments During Postpartum (6 points)**

<b>Nursing Interventions and Medical Treatments (Identify)</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a</b>

<b>nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)</b>		<b>short rationale.</b>
Gave ibuprofen at 0935 (T)	every 8 hours	The patient is having mild to moderate pain after her cesarean section. Ibuprofen is an anti-inflammatory analgesic which will reduce her pain and inflammation.
Gave simethicone at 0935 (T)	4 times daily after meals and nightly	Studies show using simethicone after a cesarean section can reduce abdominal distention, pain, and length of stay in the hospital.
Provided education regarding how to swaddle and soothe a newborn baby. (N)	Two times	The patient and her husband are first time parents. They were not swaddling the baby well or soothing him effectively.
Provided education to the patient regarding incision care and signs of infection. (N)	One time	The patient is going home with an open to air incision. There is a chance it could become infected. If she knows what to look for she will know when to notify her doctor of a problem.

### **Phases of Maternal Adaptation to Parenthood (1 point)**

**What phase is the mother in?** The patient is in the taking-hold phase. The taking-hold phase typically begins two to three days after the birth of the baby and can last for several weeks (Ricci et al., 2020). In this phase of maternal adaptation the mother is independently able to take care of herself and her body again. She will become more preoccupied with her infant and her ability to take good care of him. The new mother will want to learn everything about how to best care for her newborn but will seek information and assurance from others (Ricci et al., 2020).

**What evidence supports this?** The patient is in this phase because she no longer needs help with her own bodily care. She has demonstrated this by dressing herself, showering herself, and

meeting her own needs. She is not in a great deal of pain and her concern has turned to her son. She is interested in going home with him soon so she can rest better and begin taking care of him independently.

### **Discharge Planning (2 points)**

**Discharge location:** The patient will discharge to her home where she lives with her husband and two large dogs.

**Equipment needs (if applicable):** There are no anticipated equipment needs at this time.

**Follow up plan (include plan for mother AND newborn):** The baby will need to be seen by his pediatrician within 24-48 hours of discharge. The nurse set an appointment for 1100 on 10/14/21 for him. The mother will need to follow up with Christie Clinic OB in two weeks for an incision check and six weeks for a routine post part exam. She should contact her provider as needed if other concerns arise.

**Education needs:** The patient should be educated about her activity restrictions which include no heavy lifting for two weeks. This includes anything heavier than her baby who is currently about ten pounds. No sexual intercourse for six-eight weeks. Do not submerge in water for two weeks. The patient should also be educated on normal postpartum expectations and signs and symptoms that require medical attention. She will also need to be educated on how to monitor her signs and symptoms of hypoglycemia for her newborn son.

### **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><b>Nursing Diagnosis (2 pt each)</b> Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p><b>Rational (1 pt each)</b> Explain why the nursing diagnosis was chosen</p>	<p><b>Intervention/Rational (2 per dx) (1 pt. each)</b> 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><b>Evaluation (2 pts each)</b></p> <ul style="list-style-type: none"> <li>How did the patient/family respond to the nurse’s actions?</li> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p>1. Risk for insufficient breast milk related to milk not coming in fully as evidenced by low blood glucose level in infant.</p>	<p>The patient is a first time mother and her milk has not fully come in yet. She is concerned with her body’s current ability to meet the needs of her son. He will require supplementation until her milk comes in better. I rated this as the priority because it is what is keeping the family from being discharged and is currently the patient’s highest concern.</p>	<p>1. Encourage the mother to feed the infant on demand as often as every 1.5-3 hours Rationale feeding on demand can help establish breastfeeding and encourage milk production (Ricci et al, 2020). 2. Teach the mother that if the baby has 6-8 wet diapers daily he is getting enough colostrum. Rationale- the less the mother worries and is able to bond with her baby the better her milk supply will come in (Ricci et al, 2020).</p>	<p>1. Goal partially met- the patient was instructed to wait two hours between feedings even though her son showed signs of hunger during this time. This was for the purpose of glucose testing. The mother plans to feed on demand in the future. 2. Goal partially met- this teaching was provided to the mother but her anxiety level was not evaluated post teaching.</p>

<p>2. Risk for infection related to cesarean section as evidenced by slight erythema around incision.</p>	<p>This diagnosis was chosen due to because the patient has a new incision. Her incision is also located in a skin fold and could easily become infected.</p>	<p>1. Teach the patient signs and symptoms of infection in an incision site so she can monitor her own progress in healing and notify the doctor of any concerns. Rationale- the patient will be able to monitor herself for infection and seek medical care in she becomes concerned (Gulanick, 2022). 2. Use standard precaution when assessing the patient's incision site. Rationale- washing hands and wearing gloves will lower the risk of introducing bacteria from the hospital to the patient and is the best method to prevent infection (Gulanick, 2020).</p>	<p>1. Goal met- the patient understood the teaching and said she would notify her provider with any concerns after discharge. 2. Goal met- the nurse washed hands and wore gloves to prevent the spread of germs to the patient's incision.</p>
<p>3. Readiness for enhanced parenting related to learning newborn soothing skills as evidenced by learning to swaddle baby.</p>	<p>This nursing diagnosis was chosen because these are first time parents who have displayed some difficulty soothing their baby.</p>	<p>1. Demonstrate how to swaddle the baby. Rationale- Swaddling the newborns naturally comforts him and prevents startle reflex (Ricci et al, 2020). 2. Demonstrate burping, patting the back, and swaying and rocking to provide comfort to the newborn. Rationale- comforting the newborn relaxes the baby and promotes parental bonding as they meet the baby's needs (Ricci et al, 2020).</p>	<p>1. Goal met- the student nurse demonstrated swaddling to the parents and they received the teaching well because their son immediately was more comfortable after being swaddled. 2. Goal met- the nurse and student nurse casually discussed several methods for soothing the baby with the parents. They later demonstrated a few of these techniques.</p>

<p>4. Risk for bleeding related to delayed postpartum hemorrhage as evidenced by the possibility that this could occur up to twelve weeks after delivery.</p>	<p>All postpartum women are at risk for a postpartum hemorrhage and it is one of the leading causes of maternal death in the United States.</p>	<p>1. Continually assess the amount of lochia and the patient’s fundus Rationale these are two of the best indications for if the uterus is contracting well and if there is excess bleeding (Ricci et al, 2020). 2. The patient is at risk for up to twelve weeks postpartum. Therefore, educating her on the signs and symptoms of irregular hemorrhagic bleeding could save her life. Rationale- the patient will soon be discharged but remains at risk for delayed postpartum hemorrhage (Ricki et al, 2020). Teaching her to assess herself and when to seek medical is extremely important.</p>	<p>1. Goal met- the nurse and student nurse assessed these things at least three times during this shift. 2. Goal met- the nurse discussed the risk and ways to self assess for postpartum hemorrhage. The patient stated she understood this teaching.</p>
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**Other References (APA)**

Gulanick, M., Myers, J. (2022) *Nursing care plans: Diagnoses, interventions, & outcomes* (10th ed.). Elsevier.

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