N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission **10/10/2021**	**Patient Initials** **D D**	**Age** **23 yo**	**Gender** **F**
Race/Ethnicity **African American**	**Occupation** **CNA**	**Marital Status** **Single**	**Allergies** **No know allergies**
Code Status **Full code**	**Height** **5'8"**	**Weight** **219 lbs. (99.3 Kg)**	**Father of Baby Involved** **Yes, the father was present during birth. They leave together.**

Medical History (5 Points)

Prenatal History: Gravida – 3, Term – 1, Preterm – 0, Abortion – 1, Living – 2. (G3T1P0A1L2). The patient already has a son before this newborn that makes her have two living children. She previously had an abortion at nine weeks gestation due to an ectopic pregnancy. For the current pregnancy, the patient has received prenatal care since the beginning of her pregnancy. She regularly follows all the scheduled visits until delivery day.

Past Medical History: Patient has no past medical history in the file

Past Surgical History: patient has no past surgical history in the file, and she states that she did not have any surgery in the past.

Family History: there is no family history in the file.

Social History (tobacco/alcohol/drugs): smoke cigarette (1 packet every 2 weeks), marijuana user, and she drinks alcohol occasionally.

Living Situation: living in 3 bedrooms apartment with her friend, boyfriend, and her son.

Education Level: High school graduate and CNA certificate.

Admission Assessment

Chief Complaint (2 points): Cramping abdominal pain.

Presentation to Labor & Delivery (10 points):.

A patient is a 23-year-old female at 37 weeks two days pregnant who presented to labor and delivery with cramping abdominal pain that started yesterday morning 10/09/2021, lasting throughout the whole day. The patient says that the contractions felt like a "dull ache in the back and lower stomach" that did not stop after a shower or walking. There were no leaking of fluids and no vaginal bleeding observed during admission. Once the nurse evaluated the patient, she determined a cervical dilation of 6 cm 80% effacement with intact fetal membrane. The nurse determined a positive fetal movement.

Diagnosis

Primary Diagnosis on Admission (2 points): laboring pain

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

Postpartum and recovery is the fourth and final stage of labor that begins with the expulsion of the placenta and the physiological adjustment of the mother body because the female reproductive system can constantly remodel itself (Ricci et al., 2020).

Postpartum can including a time of rapid change in the body, such as postpartum hemorrhage, uterine inversion, amniotic fluid embolism, and eclampsia. It is also the time of restoration of muscle tone and connective tissue to the prepregnant state. Functional, during the postpartum phase, the uterus returns to its standard size through the process of involution, the cervix gradually closes back to a regular appearance, the ovarian function returns, and estrogen production resumes. The muscle tone of the perineum turns around

to normal. It is the phase that the nurse can massage the uterus if it is boggy. Besides the uterus, there are many other body functions adjustments after the delivery of the child, including the cardiovascular, urinary, gastrointestinal, muscles, integumentary, respiratory, and endocrine systems. For example, according to Ricci et al. (2020), an increase in cardiac output and stroke volume during pregnancy falls after birth once the placenta is delivered. The client has vaginal discharges called lochia during the postpartum period, which gradually decreases in texture and amount. The lochia has a different name based on its color. For example, the lochia rubra refers to a deep red blood color that occurs for the first three to four days after delivery. *Lochia serosa* is a pinkish brown blood color that occurs for 4 to 10 days after delivery. The lochia alba, or yellowish-white creamy blood color, lasts from the 10th day to 8 weeks postpartum (Ricci et al., 2020).

According to Paladine et al. (2019), the postpartum period, defined as the 12 weeks after delivery. During this phase, the new mother needs many assessments and education about breastfeeding, stress management, urinary incontinence, constipation, sexuality, and contraception. The nurses support their patients to positively accept the change and the transition to parenthood by reporting any change in their health and baby.

The new mother can also experience complications after childbirth includes hemorrhage, infection or sepsis, excessive bleeding after giving birth, chest pain, shortness of breath, seizures, hypertensive, gestational diabetes mellitus, an elevated temperature. Ricci et al. (2020) report that Postpartum hemorrhage is one of many potentially life-threatening complications after childbirth and is the leading cause of maternal death worldwide.

During the postpartum phase, the mother feels excitement to become a mother and peace (Ricci et al., 2020). She also develops independence about self-caring and her responsibility

as a new mother by taking care of her newborn. Further, the postpartum phase is characterizing by bonding between the mother and her baby due to the close emotional attraction to the newborn (Ricci et al., 2020).

Postpartum Course References (2) (APA):

Paladine, H. L., Blenning, C. E., & Strangas, Y. (2019). Postpartum Care: An Approach to the Fourth Trimester. *American Family Physician*, *100*(8), 485–491.

Ricci, S. 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	3.8-5.3	2.95	3.37	N/A	RBC levels are slightly low because of increased maternal iron needs and demands from the growing fetus. It might be due to poor nutrition or malabsorption (Ricci et al., 2020)
Hgb	12-15.8	9.9	11.4	N/A	It is common to see a reduced hemoglobin level during pregnancy because a woman's blood volume provides essential nutrition to the developing baby by increasing by half (Ianni et al., 2021).
Hct	36-47%	30.6	32.7	N/A	Hematocrit is the percentage of red blood. It is decreased because of a low RBC level count during

					pregnancy due to an iron deficiency diet (Ricci et al., 2020).
Platelets	**140-440**	**270**	**296**	**N/A**	
WBC	**4-12**	**10.21**	**9.00**	**N/A**	
Neutrophils	**47-73**	**65.8**	**63.1**	**N/A**	
Lymphocytes	**18-42**	**25.1**	**23,5**	**N/A**	
Monocytes	**4-12**	**7.3**	**9.0**	**N/A**	
Eosinophils	**0-5**	**1.6**	**0.8**	**N/A**	
Bands		**N/A**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	**A, B, O, AB**	**O**	**O**	**N/A**	
Rh Factor	**+ or -**	**+**	**+**	**N/A**	
Serology (RPR/VDRL)	**+ or -**	**Non-reactive**	**Non-reactive**	**N/A**	
Rubella Titer	**immune / not immune**	**immune**	**immune**	**immune**	
HIV	**+ or non-detected**	**Non detected**	**Non detected**	**N/A**	
HbSAG	**+ or -**	**Non-reactive**	**Non-reactive**	**N/A**	
Group Beta Strep Swab	**+ or -**	**Negative**	**Negative**	**N/A**	
Glucose at 28 Weeks	**<140**	**138**	**N/A no prenatal care**	**N/A no prenatal care**	
MSAFP (If Applicable)	**0.5-2.0**	**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
MCV	80-100	103.7	97.0	N/A	Elevated MCV during pregnancy shows enlarged red blood cells. That means that is a possibility of anemia. (Ricci et al., 2020).
Chlamydia DNA	+ or -	-	-	N/A	
Gonorrhea	+ or -	-	-	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)	120-160	N/A	N/A	N/A	

Lab Reference (1) (APA):

Ianni, Colleen, McDowall, Megan, Zuska, & Inez. (2021). Differential Diagnosis of Low Hemoglobin. Dimensions of Critical Care Nursing, 40, 204-209. https://doi.org/10.1097/DCC.0000000000000483

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

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

	Your Assessment

History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**The length of all stages of pregnancy lasted around 4 hour and 53 minutes.** **Spontaneous vaginal delivery** **1st stage = 4hours 53 minutes** **2nd stage = 0h 06 minutes** **3rd stage = 0h 02 minutes**
Current stage of labor	**The patient is currently in the fourth and final stage of labor, postpartum. Also known as the recovery stage, which starts with expulsion of the placenta (Ricci et al., 2020). It is the stage where the uterus contracts and going back to its initial position. The patient experienced abdominal pain due to childbirth that rates 5/10. This new mother is exciting to become a mother, and she is bonding with her baby. She is just taking a shower by herself to acquire independence. Moreover, the patient develops independence in this stage by increasing autonomy in her care and the baby. The new mother is exciting to touch her baby, keeps skin-to-skin contact, and breastfeeds her baby during this phase. In the fourth phase, the patient understands that it is beneficial to feed her baby following birth and the importance of keeping the newborn close to the mother's skin as often as possible**

	(Almutairi et al., 2021).

Stage of Labor References (2) (APA):

Almutairi, W. M., Ludington, S. M., Quinn Griffin, M. T., Burant, C. J., Al-Zahrani, A. E., Alshareef, F. H., & Badr, H. A. (2021). The Role of Skin-to-Skin Contact and Breastfeeding on Atonic Postpartum Hemorrhage. ***Nursing Reports****,* ***11*****(1), 1–11. https://doi.org/10.3390/nursrep11010001**

Ricci, S. S., Kyle, T., & Carman, S. (2020). ***Maternity and pediatric nursing*** **(4th ed.). 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	**Docusate Sodium/Colace (Jones & Bartlett Learning, 2020).**	**Prénatal Vitamine/ Vitafol-OB+DHA (Jones & Bartlett Learning, 2020)**
Dose	**100 mg capsule**	**27 mg tablet**
Frequency	**Take 1 capsule by mouth every day**	**Take 1 tablet by mouth every day**
Route	**oral**	**oral**
Classification	**Laxative/ Anionic surfactant**	**vitamins**
Mechanism of Action	**Increases water, flat penetration in intestine, allows for easier passage**	**vitamins/minerals are absorbed to boost immune system and prevent**

	of stool (Jones & Bartlett Learning, 2019).	**complications and certain congenital diseases or defects (Jones & Bartlett Learning, 2019).**
Reason Client Taking	**The patient is having constipation and hard stool during pregnancy. Colace helps her to have soft stool.**	**The patient was taking prenatal vit during pregnancy to provide the additional vitamins that help for the development of the baby.**
Contraindications (2)	**Fecal impaction** **Nausea/vomiting**	**Stomach ulcers** **Too much iron in the blood**
Side Effects/Adverse Reactions (2)	**Diarrhea** **Throat irritation** **Rash**	**Upset stomach** **headache**
Nursing Considerations (2)	**Instruct patient to report an abdominal pain, muscle cramps, and dizziness when taking the medication.** **Advice the patient that Docusate may take up to 3 days to often the stools.**	**Instruct the client to take the medication daily and with food to avoid stomach irritation.** **Teach the patient to avoid taking other OTC vitamins because it can cause toxicity.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess cramping, rectal bleeding, nausea, and vomiting.** **Monitor patient's electrolytes level.**	**Vitamin b-12 and folate labs to ensure they are within the normal range.** **Assess client for ulceration of the stomach**
Client Teaching needs (2)	**Teach patient that normal bowel movements do not always occur daily.** **Instruct patient to take medication with a full glass of water and to increase fluid intake during the treatment.**	**Instruct the patient to take prenatal vit. With full glass of water.** **Do not take antiacids within 2 hrs. before or 2 hrs. after taking prenatal vitamin.**

Hospital Medications (5 required)

Brand/Generic	**Ibuprofen/ Motrin (Jones & Bartlett Learning, 2020)**	**Lansinoh/ Lanolin (Jones & Bartlett Learning, 2020)**	**Methylergonovine/ Methergine (Jones & Bartlett Learning, 2020)**	**Ondansetron/ Zofran (Jones & Bartlett Learning, 2020)**	**Oxytocin/ Oxytocin (Jones & Bartlett Learning, 2020)**
Dose	**800 mg tablet**	**0.15 g**	**200 mcg injection**	**4 mg tablet**	**30 units/500 mL in NS**
Frequency	**Take 800 mg tablet every 8 hrs. PRN**	**Apply 0.15 g Every 1 hr. PRN**	**200 mcg injection every 2 hrs. PRN**	**Take 4 md every 6 hrs. PRN**	**60-300 milli-units/ hr.**
Route	**0ral**	**topical**	**IM**	**oral**	**IV**
Classification	**NSAID**	**Emollients**	**Oxytocic**	**Antiemetic**	**Oxytocic hormone**
Mechanism of Action	**It works by reducing hormones that cause pain and swelling in the body (Jones & Bartlett Learning, 2019).**	**It softened the skin by forming an occlusive oil film on the stratum corneum layer of the transdermal water loss (Jones & Bartlett Learning, 2019).**	**It acts directly on the smooth muscle of the uterus and increases the tone, rate, and amplitude of rhythmic contractions (Jones & Bartlett Learning, 2019).**	**It blocks the action of serotonin which may cause nausea and or vomiting (Jones & Bartlett Learning, 2019).**	**Oxytocin works by increasing the concentration of calcium inside muscle cells that control contraction of the uterus (Jones & Bartlett Learning, 2019).**
Reason Client Taking	**The patient is taking this medicati**	**The patient is using this medication to prevent dry and itching**	**The patient took this medication to prevent hemorrhage**	**Patient is taking this medication to prevent nausea and**	**The patient had oxytocin to stimulate labor. It**

	on for the relieve of mild pain.	**skin around the breast.**	**postpartum**	**vomiting after delivery**	**was continuous after labor to contract the uterus and to stimulate the breast milk letdown.**
Contraindications (2)	**GI bleeding disorder. Cardiac disorder.**	**Skin blisters Dermatitis**	**Preeclampsia Seizure disorder**	**Torsade's de point QT prolongation**	**Uterine sepsis Active genital herpes**
Side Effects/Adverse Reactions (2)	**Drowsiness Insomnia**	**Burning redness**	**Chest pain Leg cramps**	**Bronchospasm Diarrhea**	**Premature ventricular, contraction Tachycardia.**
Nursing Considerations (2)	**Caution patient to avoid alcohol ingestion during treatment. Assess for any vision changes: blurred vision.**	**Assess the patient breast for any swelling, warmth, and redness. Assess the nipple areas skin irritation, ulcer, and cracked nipples caused by breast feeding.**	**Monitor B/P, pulse for any change that may indicate hemorrhage. Assess fundal tone and assess for severe Abd. cramping.**	**Monitor for any change in patient respiration. Inform the patient the reason that she is taking Zofran.**	**Assess for constipation and I/ O ratio because a decrease output may indicate urinary retention. Monitor CNS changes: dizziness and hallucination.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor liver function tests: AST, ALT, bilirubin**	**Assess respiratory function. Assess for sings of infection.**	**Check Calcium level for hypocalcemia. Assess paresthesia of the extremity,**	**Assess for tremors and rigidity. Monitor QT prolongatio**	**Monitor baseline blood pressure before and after medication**

	, and creatine. Assess any history of peptic ulcer disorder .		**weakness, and muscular pain**	**n**	**is given. Assess character, frequency, and duration of uterine contractions prior to administration**
Client Teaching needs (2)	**Teach patient to report joint pain, edema, and blood in the urine.**	**Teach patient to report allergic reaction: hives, difficulty breathing, and swelling of the lips and face. Instruct patient to stop avoid taking herbal product and OCT with this medication.**	**Teach patient about the side effect of medication such abdominal cramping. Educate the patient to report any headache and chest pain.**	**Teach patient to report diarrhea and rash during treatment. Teach patient to report immediately any sign of respiratory distress**	**Teach patient to report increased blood loss, abdominal cramps, increased temperature, and foul-smelling lochia. Advise patient that contraction will be like menstrual cramps, gradually increasing in intensity.**

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:**	**Patient is alert and oriented to person, place, and time. Patient is well groomed, showing no**

Orientation: **Distress:** **Overall appearance:**	**sign of distress or fatigue, or fever.**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score :** **Drains present: Y☐ N ☒** **Type :**	**Patient skin appears clean and intact. She just has a shower 30 minutes ago. There are no rashes or wound on the skin. Skin is moist and pink with normal elasticity, warm in touch, and normal texture. Skin turgor is normal. Patient has black hair. Capillary refill < 2 sec. Patient does not have any wounds or incision on the skin.** **Braden Score = 20 (Average risk)**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is in midline no deviation. No trachea deviation. No lymph node palpable, thyroid is not palpable. Carotid pulse is regular. No drainage from eye bilaterally, Auricle pink without lesion. Patient uses glasses for lecture. PEERLA present. No drainage from eye bilaterally. Septum is Medline. Oral mucosa is pink and moist. No lesion noted in the mouth. Posterior pharynx and tonsils are moist and pink without exudate noted, tonsils 1+, uvula is midline, soft palate rises and falls symmetrically, hard palate intact. Teethes are slightly white, good dentition without any cavity.** .
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vien Distension : Y ☐ N ☐** **Edema: Y ☒ N ☐** **Location of Edema: Hand and foot bilaterally**	**.Heart sounds are normal, regular rhythm and rate. Clear S1 and S2 without murmurs, gallops or rubs. No gallop or murmur. No carotid bruit noted. Bilateral radial pulse is regular and strong 2+, bilateral pedal pulses are palpable 2+. Capillary refills less than 3 seconds in fingers and toes bilaterally. No neck vein distention, Edema 1+ present in upper and lower extremities bilaterally.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Patient is breathing normally at room temperature. No accessory muscle is using now. Patient denied SOB or distress. Anterior and posterior lung sound are auscultating for a full minute in 6 places in chest and 6 in the**

	back of chest. Sounds are clear, no wheezing, no crackles, and the patient does not have a cough.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height: 5'8"** **Weight: 219 lbs. (99.3 kg)** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**The patient claimed that she eats regular food at home and in the hospital without any restriction.** **Height: 5'8"** **Weight: 219 lbs. (99.3 kg)** **The abdomen is soft, slightly tender to palpation, with mild abdominal pain rates of 5/10 on a scale of 10.** **No organomegaly or masses noted upon palpation of all four quadrants.** **The patient does not have a BM yet since delivery** **Last bowel movement on 10/09/2021** **No distention, incisions, scars, drains, or wounds.**
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Yellow urine color, and clarity is clear.** **The patient voided independently in the bathroom. She states that she voided x4 since this morning. The quantity was not recorded.** **No catheter in place. The patient denied pain during urination. No lesion on female organ.**
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	**Patient is oriented to own ability; she can stand up and go to the bathroom by her own. The upper and lower member are strong 4/4 bilaterally. No support devices used. No risk of fall. She does not use any equipment. She showered by independently today.** **No need of assistance for ADLs.** **Fall score of 0**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	**Patient appears alert and orientee X3. MAEW is normal compared to her age. PERLA is present, she reacts in light and accommodation. Arm and foot strength equally bilaterally. She speaks English well with clear speech. Patient shows no sign of**

Mental Status: **Speech:** **Sensory:** **LOC:** **DTRs:**	**neurological deficit. Negative rhombegrs Deep tendon reflexes in all locations 2+ bilaterally.**
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):**	**Patient is Christian, she trusts Jesus as son of God. She lives in 3-bedroom apartment with her friend, her boyfriend, and her old son. Patient claimed that her fiend and the father of the baby will give her help. Patient has a high school diploma and CAN certificate**
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	**Fundal height -1** **Bleeding of 40mL after birth** **Lochia color: Rubra** **Deep-red blood color** **No lacerations or episiotomy**
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:**	**Spontaneous rupture of membranes in 1908 on 10/10/2021** **Clear** **Amount does not document on file** **No odor** **Delivered in 1944:29 on 10/10/21** **Vaginal delivery** **350 mL of blood loss** **Male** **1 min apgars = 9 total, 5 min apgars = 9 total** **3490 g (7lbs. 1oz)** **Breastfeeding/bottle feeding**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**90**	**116/80**	**16**	**98.1**	**98%**
Labor/Delivery	**96**	**118/67**	**16**	**97.9**	**100%**
Postpartum	**80**	**104/75**	**16**	**98.1**	**96%**

Vital Sign Trends: The resident's vital signs are within average value without any abnormalities of decreased or increased value from prenatal first visit throughout labor and delivery and postpartum.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1230	0/10	N/A	N/A	N/A	Customize the patient.
1600	5/10	Lower Abdomen	mild	dull	Administer Ibuprofen 800 mg tablet PRN

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 resident does not have IV on place.

Intake and Output (2 points)

Intake	Output (in mL)
1200 mL (reported by the patient)	The patient voided X3 inside of the toilet

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "T" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Fundal massage (N)	Massage the	The uterine massage helps to reduce

	uterus every 4-8 hours until discharge.	**bleeding and cramping of the uterus after childbirth.**
Ibuprofen 800 mg (T)	**Take 800 mg tablet by mouth every 8 hours as needed for mild to more severe pain**	**Ibuprofen is a NSAID that can help the patient for mild pain after giving birth and during postpartum.**
Docusate Sodium 100 mg (T)	**Take 1 capsule by mouth every day.**	**A stool softener helps to treat constipation. The patient has been having constipation for two days. Colace will help her to have soft stool.**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? The patient is in a phase of taking-hold phase.

What evidence supports this? The taking-hold phase starts on the second to third day postpartum when the mother regains control over her bodily functions, become independent, and demonstrates increased autonomy. This patient took a shower by herself without any assistance.

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The mother is to return for a six-week postpartum follow-up appointment after discharge. The mother needs to go with the newborn to see the doctor on 10/13/21 and discuss the newborn ‘s circumcision.

Education needs: The patient already has a son that she breastfeeds before. She states that she does not need any help to breastfeed this baby; she knows caring and nursing.

However, the nurse teaches the patient about how to self-massage her uterus because it is boggy. The patient does not know how to contract the uterus. She is learning it from the nurse.

Nursing Diagnosis (30 points)
Must be NANDA approved nursing diagnosis and listed in order of priority
Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client."

2 points for correct priority

Nursing Diagnosis (2 pt each) Identify problems that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational (1 pt each)** Explain why the nursing diagnosis was chosen	**Intervention/Rational (2 per dx) (1 pt. each)** Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours." List a rationale for each intervention and using APA format, cite the source for your rationale.	**Evaluation (2 pts each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to childbirth as evidence by the pain of 5 on a scale of 1-10	**During the assessment, the patient rates her 5/10 on a scale of 0-10. She repots a dull lower abdominal pain**	**1. Assess patient's signs and symptoms of pain behavioral pain cues and administer pain medication as prescribed as needed. (q8 hr.). Rationale: This assessment of pain allows for care plan modifications as needed (Phelps, 2020).** **2.Reassess the patient's pain after 30 t0 1 hour by asking her to rate the pain on a scale 0 to 10. Rationale: This provides baseline for comparison and establishes a trusting-care relationship that encourages accurate communication (Phelps,**	**The patient requests pain medication from the nurse. Ibuprofen 800 mg is giving to the patient.** **The nurse will assess the patient after one hour to check the effectiveness of the medication. If the medication is not adequate, the nurse will administer another 800 mg tablet PO dose after 8 hours.**

		2020).	
2. Deficient knowledge related to lack of exposure to information as evidence by the patient is unfamiliar with uterine massage and orthostatic hypotension.	**Patient states that she does not know how to perform fundal massage.**	**1. Explain and teach the patient the importance of massaging the uterus every 4 to 8 hours. Rational: To avoid uterus atony and prevent hemorrhage (Phelps, 2020).** **2.Advice the client to be seated when holding and feeding the baby. Also, to change the position slowly when lying down to prevent orthostatic hypotension. That could put the patient at risk of falls (Phelps, 2020). Rationale**	**The patient massaged her uterus by herself after the nurse taught her** **The patient slowly changed the position from seating to supine.**
3. Risk of infection related to decreasing hemoglobin and lochia as evidence the patient has a Hgb = 11.4	**Low hemoglobin can put the patient at risk of infection.**	**1.Monitor the amount of lochia discharge and assess for odor every 4 hours. Rationale: Because the uterine infection delays the lengthen flow (Phelps, 2020).** **2. Observe for signs of exaggeration, fatigue, fever, chills, and uterine tenderness every 8 hrs. Rationale: Those can lead to bacteremia (Phelps, 2020).**	**The patient's lochia is red and weighs 40 mL at 1500 without odor. The patient has a shower and replaces a new pad.** **The patient denied signs of fever, malaise, and chills. She verbalized that she would call and report if she is experiencing those signs.**
4. Risk for imbalanced fluid volume related to pregnancy as evidence	**The patient has bilateral edema on her hand and foot. Moreover, she states that she**	**1. Educate the patient about daily fluids restriction. Rationale: This knowledge will help her to enhance a sense of control (Phelps,**	**The patient verbalized that she would decrease her fluids intake to 1800 mL daily to decrease this fluid overload.**

bilateral edema hand and foot.	**gained much weight from pregnancy throughout delivery.**	**2020).** **2. Instruct the patient to self-monitor her weight daily.** **Rationale: This will help detect any alteration that can worsen the patient's condition (Phelps, 2020).**	**The patient agrees to check her weight daily. Furthermore, to report an increase of 1 kg per day.**

Other References (APA)

Phelps, L. (2020). ***Sparks & Taylor's Nursing Diagnosis Reference Manual*****. Lippincott Williams & Wilkins.**