N432 Postpartum Care Plan

Lakeview College of Nursing

Name: Christine Nlandu

Demographics (3 points)

Date & Time of Admission **11/1/21** **At 0525**	**Patient Initials** **SM**	**Age** **37**	**Gender** **F**
Race/Ethnicity **White/caucasian**	**Occupation** **Factory worker**	**Marital Status** **Divorced**	**Allergies** **Latex and wound dressing adhesive, which result in rash and hives.**
Code Status **Full code**	**Height** **5'8.5"**	**Weight** **250 lb**	**Father of Baby Involved** **The father of the baby is involved.**

Medical History (5 Points)

Prenatal History: G4T2P2A0L4. The client had a classical cesarean for the first child, making all other births be scheduled for cesarean section. The client had gestational diabetes during the current pregnancy and advanced maternal age. All kids are alive, but she had two preterm births. Risk of congenital abnormality fetus one.

Past Medical History: Chronic anxiety, depression, anemia, kidney disease, migraine, and mood disorder.

Past Surgical History: 3 cesarean sections, cystoscopy calculus removal right ureter, and gastroschisis.

Family History: Father has a liver issue, mother colon cancer, spine issue, and kidney stones. Paternal grandparents: heart disease, colon cancer, and hypertension. Maternal grandparents: cancer, diabetes, stroke, breast cancer, and hypertension.

Social History (tobacco/alcohol/drugs): The patient uses tobacco during pregnancy, ¼ pack a day, a former smoker for 25 years; 3.75 pack per year and has a history of marijuana use twice a week. The client does use alcohol sparing a couple drinks a moth.

Living Situation: The client lives at home with her boyfriend and a 17-month baby.

Education Level: Some college.

Admission Assessment

Chief Complaint (2 points): Repeat cesarean birth.

Presentation to Labor & Delivery (10 points): A 37-year-old, Caucasian, female presented to the labor and delivery unit on 11/01 at 0525 for a scheduled cesarean section. The patient had a classical cesarean and can no longer have a vaginal birth. The client is a G3T1P2A0L3 and was at 37 weeks of gestation and zero days. The patient last menstrual was 2/15/21, and the estimated delivery date (EDD) is 11/22/21. The patient entered the operating room at 0726, and the procedure started at 0728. The patient was put on general anesthesia, intubated, and a foley catheter with a single lumen French, size 16, was in place. The water broke at 0822, and the baby was born at 0822. The incision was closed at 0941, and the client left the operating room at 1009.

Diagnosis

Primary Diagnosis on Admission (2 points): Repeat cesarean births

Secondary Diagnosis (if applicable):N/A

Postpartum Course (18 points)

Post-partum is the fourth and last stage of labor, also called puerperium, which starts after the delivery of the placenta and ends when reproductive organs return to a nonpregnant state. The postpartum stage is characterized by two adjustments, including physiologic and psychological changes. Even though this stage lasts 6 months, it is not the case for all postpartum women (Ricci et al., 2020). The physiologic adjustment consists of uterus involution; for example, the uterus returns to its prepregnant state. Uterus size decreases about one finger bread each day and reaches the umbilic level 12 hours after birth. The uterus goes to the phase called exfoliation, which allows the healing of the placenta site and may take six weeks (Barlow & al., 2019). Lochia is the flow of the remaining debris after birth through discharge. After delivery, lochia is bright red, then change to dark red called Rubra, which lasts one to two days, followed by serosa, a pinkish-brown color discharge from day 4-10. Alba is the yellowish-white creamy color that starts on day 10th through 8 weeks after delivery and ends with a clear discharge like the color (Ricci et al., 2020). Cervical involution occurs when the cervix returns to the prepregnant state. Other changes during postpartum are a decrease in vaginal distention, alteration of vaginal function, and menstruation. Additionally, the urinary tract, cardiovascular, musculoskeletal system, respiratory, integumentary, endocrine, breast, and gastrointestinal change (Ricci et al., 2020). During pregnancy, the cardiac output and the stroke volume increase; after delivery of the placenta, they decrease. After delivery of the placenta, the intestine, stomach regain the standard placement. The bladder returns to normal because the uterus pressure is released after birth, increasing bladder capacity, reducing bladder tone, swelling, and bruising of tissues (Ricci et al., 2020). The pituitary gland releases

oxytocin, which causes the uterus to contract and stimulate breast milk production (Barlow & al., 2019).

The most common abnormal findings are boggy uterine atony, a failing of the uterus to contract properly, resulting in collections of blood that form clots and rise the fundus. If lochia goes through the normal cycle and returns to bright red, it indicates bleeding or infection. During palpation, the fundus may be located to the side, which means the bladder is full, can result in bleeding. White blood cells may be increased and indicate infection. There are three main risk factors for postpartum complications, including bleeding, a loss of 1000 ml of blood or more after delivery. Uterine atony is the most common cause of bleeding. If bleeding is not treated urgently, it can result in chock. Signs and symptoms of shock are low blood pressure, increased pulse, and respiration rate. Infection occurs when there is a rapid filling of urinary bladder stasis, which increases the chance of urinary tract infection. The condition can result in endometritis, mastitis, urinary tract infection, and wound infection. Signs of infection are edema, ecchymosis, redness, and discharge (Ricci et al., 2020).

The most common complication is postpartum mood disorder is depression. Hormones change after birth, and some women experience baby blues, which is a normal, relatively short time of sadness. However, if sadness persists for more than two weeks, it may be postpartum depression. Signs of postpartum depression are frequent crying, mood swing, irritability, sleep disturbance, fatigue, loss of sexual interest, appetite, difficulty concentrating, negative thoughts, hopelessness, and despair (Ricci et al., 2020).

During clinical, the uterus was 1 cm above umbilic, midline, and firm six hours after delivery. The patient gave birth to her fourth child. Rubra was odorless with scant amounts. The client lost 1000 ml of blood, which indicates postpartum hemorrhage. During clinical, we assessed the client from head to toe, with normal findings. We assisted the client during the ambulation, moved from the delivery room to the postpartum room. Other nursing interventions during postpartum include:

- **Administering pain medication.**
- **Oxytocin.**
- **Checking vital signs continuously for the first 24 hours.**
- **Giving stool softer.**
- **Administering Rhogam if a mother is Rh-negative and the child positive.**

Teach the mother about breastfeeding, using a pillow while coughing, and position. Explain the importance of early ambulation, observe signs of infection, intake, and output, rest, and provide discharge teaching. Clinical data indicates that women who have their first child by cesarean have a 90% chance of having another one in a subsequent pregnancy (Ricci et al., 2020).

Postpartum Course References (2) (APA):

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

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 *10^6	3.65	4.23	4.23	RBC levels are slightly low because of increased maternal iron needs and demands from the growing fetus. Can also be due to poor nutrition or malabsorption. The client has a history of anemia (Ricci et al., 2020)
Hgb	12-15.8	9.3	11.1	11.1	RBC levels are slightly low because of increased maternal iron needs and demands from the growing fetus. Can also be due to poor nutrition or malabsorption. The client has a history of anemia (Ricci et al., 2020)
Hct	36-47%	30.3	34.2	34.2	RBC levels are slightly low because of increased maternal iron needs and demands from the growing fetus. Can also be due to poor nutrition or malabsorption. The client has a history of anemia (Ricci et al., 2020)
Platelets	140-440*10^3	285 10*3 ul	227	227	

WBC	**4-12^3**	**14.83**	**14.20**	**14.20**	**The WBC often increases after delivery. The body prevent infection and aid in healing by increasing WBC called postpartum leukocytosis. The patient has a history of kidney disease, which indicates inflammatory or infection process (Ricci et al., 2020)**
Neutrophils	**47-73 %**	**71.5**	**75.6**	**75.6**	**The Neutrophil often increases after delivery. The body prevent infection and aid in healing by increasing WBC called postpartum leukocytosis (Ricci et al., 2020)**
Lymphocytes	**18-42%**	**21.7**	**17.4**	**17.4**	**Lymphocyte counts decrease due to pregnancy and hormones changes, which impact blood count of the total lymphocytes (Ricci et al., 2020)**
Monocytes	**4-12%**	**4.3**	**4.9**	**4.9**	
Eosinophils	**0-5%**	**1.8**	**1.1**	**1.1**	
Bands	**<10%**	**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**	**A**	**A**	**A**	
Rh Factor	**+ or -**	**positive**	**positive**	**positive**	
Serology (RPR/VDRL)	**+ or -**	**negative**	**negative**	**negative**	
Rubella Titer	**immune / not immune**	**118.60iuml**	**immune**	**immune**	
HIV	**+ or -**	**negative**	**negative**	**negative**	

HbSAG	**+ or -**	**negative**	**negative**	**negative**	
Group Beta Strep Swab	**+ or -**	**negative**	**negative**	**negative**	
Glucose at 28 Weeks	**< 140**	**179**	**73**	**73**	**During pregnancy the placenta builds hormones that cause glucose to build up in bloodstream, but the pancreas fails to produce enough insulin or receptors cells resistance, rising the blood sugar levels and results in gestational diabetes (Ricci et al., 2020)**
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
COVID 19 PCR (19)	**+ or -**	**negative**	**N/A**	**N/A**	
Glucose	**70-100**	**179**	**73**	**73**	**During pregnancy the placenta builds m hormones that cause glucose to build up in bloodstream, but the pancreas fails to produce enough insulin or receptors cells resistance, rising the blood sugar levels and results in gestational diabetes (Ricci et al., 2020)**

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):

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 client was schedule for cesarean birth due to a history of classical cesarean section of the first child. The procedure started at 0726-1009.**

Current stage of labor	**The patient is in her fourth and final stage of labor, postpartum, and recovery. The fourth stage begins with the completion of the expulsion of the placenta and membranes. This stage gives the client a sense of peace and excitement (Ricci et al., 2020). In other words, the fourth stage occurs when the mother's body returns to the nonpregnant state. During recovery, the uterus contracts and pushes out the uterus remaining blood and resting muscle tone. Nursing intervention during postpartum included changing pads, fundus assessment, taking vital signs, early ambulation of the patient to prevent blood clots, and repositioning the client. The client was NPO after the caesarian birth until the gag reflex returns with normative bowel sounds. The client is on a clear liquid diet. The patient experienced hemorrhage and upper extremities shaking. The client has risks of infection and worsening anemia. In addition, it is common to experience discomfort from pain, difficulty urinating, weakness and dizziness when standing up after a cesarean birth. The woman was delighted to have another child. She has pain discomfort when coughing and did well with the ambulation, walking with assistance. The patient was instructed to hold the incision with**

	a pillow while coughing.

Stage of Labor References (2) (APA):

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

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	**Ferrous sulfate/Feosol (Jones & Bartlett, L, 2020, P. 491-494).**	**Prenatal Vitamin/ Fumarate/ ferrous fumarate (Jones & Bartlett, 2020).**			
Dose	**325 mg**	**27.08 Mg tab**			
Frequency	**Twice a day**	**Once a day**			
Route	**Oral**	**Oral**			
Classification	**Antianemic**	**Vitamin and iron supplement**			

Mechanism of Action	**Ferous acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated Ferrin in reticuloendothelial cells of the bone marrow, liver and spleen.**	**Provides pregnant body with necessary vitamins and iron to support fetal and maternal needs.**			
Reason Client Taking	**To treat anemia and nutritional supplement.**	**Prenatal care to prevent nutritional deficiency. It also treats and prevents low blood levels of iron**			
Contraindications (2)	**Hemolytic anemia & Hemochromatosis**	**Stomach ulcers Too much iron in the blood**			
Side Effects/Adverse Reactions (2)	**Hypotension & Anaphylaxis**	**Sore teeth or gums, stomach irritation**			
Nursing Considerations (2)	**Give iron tablet with a full glass of water & Check stool for occult blood per order.**	**Instruct the client to take the medication with food to avoid stomach irritation. Monitor for fast or**			

		uneven heart rhythms			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor iron serum levels and hemoglobin before and during therapy.**	**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)	**Instruct patient to eat food high in vitamin C & avoid food that impaired with iron absorption like dairy product, eggs, and spinach. Avoid drinking coffee or tea one hour before iron intake.**	**Instruct the patient to take their prenatal tablet with a full glass of water. Instruct patient on the importance of taking their prenatal vitamin to treat or prevent vitamin deficiency.**			

Hospital Medications (5 required)

Brand/Generic	**Hydrocodo**	**ondansetro**	**Ibuprofen**	**oxytocin**	**Enoxaparin**

	ne/ Acetaminophen/ Norco (Jones & Bartlett, L, 2020, P. 585-588).	**n (Zofran) (Jones & Bartlett, L, 2020, P. 915-918).**	**(Motrin) (Jones & Bartlett, L, 2020, P. 601-605).**	**(Pitocin) (Jones & Bartlett, L, 2020).**	**Sodium/ Lovenox (Jones & Bartlett, L, 2020, P. 404-407).**
Dose	**325 mg**	**4 mg**	**30 mg**	**60-300ml/hr**	**40 mg**
Frequency	**Every 6 hours PRN**	**Every 6 hours PRN**	**Every 6-hour PRN.**	**300 ml/hr continuous until the 500 ml bag is done.**	**Once daily**
Route	**Oral**	**IV**	**IV**	**IV**	**Subcutaneous.**
Classification	**Opioid analgesic**	**Serotonin receptor antagonist/ antiemetic**	**NSAID**	**Oxytocic agents**	**Anticoagulant**
Mechanism of Action	**Binds to and activates opioid receptors at sites in the periaqueductal and periventricular gray matter, the ventromedial medulla, and the spinal cord to produce pain relief.**	**blocks the action of serotonin which may cause nausea and or vomiting.**	**Ibuprofen blocks the activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation. By inhibiting prostaglandins this NSAID reduces inflammato**	**Oxytocin works by increasing the concentration of calcium inside muscle cells that control contraction of the uterus.**	**Lovenox potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors, which prevent clot formation.**

			ry symptoms and relieves pain.		
Reason Client Taking	**To manage pain.**	**The patient is taking to prevent post operative nausea and vomiting during cesarean section.**	**Patient is taking for mild to more severe pain related to cesarean section.**	**The client is taking to increase uterine contraction to prevent bleeding.**	**To prevent clots formation after cesarean section.**
Contraindications (2)	**Acute or chronic bronchial asthma & respiratory depression**	**Concomitant use of apomorphine Congenital long QT syndrome.**	**High blood pressure & Alcoholism**	**Late deceleration & Active genital herps infections.**	**Active major bleeding & a history of heparin induced thrombocytopenia.**
Side Effects/Adverse Reactions (2)	**Hypotension & coma**	**Headache & weakness.**	**Headache &fatigue**	**Nausea/ vomiting & stomach cramping**	**Hemorrhage & anaphylactic shock.**
Nursing Considerations (2)	**Do not give to patient with impair conscious & use caution in client with COPD.**	**Instruct the patient to avoid over the counter cold medications while taking. Maintain adequate fluid intake**	**Be aware that patient may be at increased risk for cardiovascular event and GI bleeding. Administer drug with food if GI upset occurs.**	**Monitor carefully for uterine tetany. & Report for any coma-like responses or seizure activity.**	**Use extreme caution in client with an increased risk of hemorrhage & closely observe client received spinal anesthesia because they can develop spinal hematoma and report changes in sensory or motor**

					function
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor for respiration depression when initiating therapy.**	**Auscultate lung sounds, labs should be CMP/chemistry panel to assess magnesium, phosphate, potassium**	**Take baseline and periodic evaluations of Hgb, renal and hepatic function. Assess for an allergy to ibuprofen or other NSAIDs.**	**Monitor baseline blood pressure before and after medication is given. Assess frequency, and duration of uterine contractions prior to administration.**	**Assess for bleeding before and during therapy.**
Client Teaching needs (2)	**Take the capsules or tablets as whole & avoid alcohol.**	**Advise patient to immediately report signs of hypersensitivity. Instruct patient that this medicine causes a transient blindness that resolves within a few minutes to 48 hours.**	**Notify physician immediately if passing dark tarry stools, "coffee ground". & Do not take aspirin concurrently with ibuprofen.**	**Provide patient information about how oxytocin will affect their bodies and contractions. Report headache, dizziness, palpitations, or intense pain.**	**Notify the provider if bleeding occurs & Avoid NSAID or aspirin increasing the risk of bleeding. Educate the client how self-administer the medicine.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). ***Nurse's drug handbook*** **(19th ed.). Burlington, MA.1**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The client appears alert and oriented to person, time, and place. The client is well-groomed. She is confident, open, cooperative and speaks English well.**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type: Hemovac wound drainage**	**Braden scale: 20** **The client's skin is warm, pink, and dry. Skin turgor is expected because the client is not dehydrated. She does not have rashes or bruises. She has a cesarean incision with hemovac wound drainage noted.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head normocephalic and neck is symmetrical, the trachea is midline without deviation, normal thyroid, carotid pulse palpable 2+ bilateral. The ear canal is transparent, and the tympanic membrane is pearly grey bilateral. Pupils: PERLA, conjunctive pink bilateral. The client does not wear glasses, the nose is midline, or polyp.** .

CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**The client is not on telemetry. Clear S1 and S2 are noted. Regular rhythm and apical pulse are present. Peripheral pulses palpable 2+ throughout bilateral, capillary refill is less than 3 sec, no cyanosis, murmur, pitting edema bilateral, or neck vein distention.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Normal rhythm, rate, and pattern. Respiration is not labored bilateral anterior and posterior; no crackles, rhonchi, wheezing were noted bilaterally.**
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height: 5'8.5"** **Weight: 250 lbs** **Auscultation Bowel sounds:** **Last BM: 10/30/21** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions: yes** **Scars: N/A** **Drains: yes** **Wounds: N/A**	**The client is on a diabetic diet at home, was NPO at midnight, and now, she is on clear liquid diet. The abdomen is soft, non-tender, or mass noted. She has lower transversal incision with a hemovac wound drainage. Normal bowel sounds for all quadrants. The client rates the pain about 9 on the scale of 0-10.**
GENITOURINARY (2 Points): **Quantity of urine: 225 ml** **Pain with urination: Y ☐ N ☒** **Inspection of genitals: Lochia with scant amount.** **Catheter: Y ☒ N ☐** **Type: Indwelling catheter with single lumen French.** **Size: 16**	**The urine is yellow, clear with average quantity. She has foley catheter.**
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 20** **Activity/Mobility Status:** **Independent (up ad lib) ☐**	**The client is alert and oriented to person, place, and time. She tested negative for the Homan sign. Normal range of motion bilateral, equal strength 5/5, does not use an assistive device. The client has restriction activity of the daily living due to cesarean**

Needs assistance with equipment ☐ **Needs support to stand and walk☐**	**incision. She can only lift 10 lbs. she need support to stand up and supervision during ambulation.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	**The patient is awake, oriented PERLA, equal strength, expected level of conscience, no sensory deficit, and an average pace of speech. Normal tendon reflex 2+ bilateral with full range of motion. Normal balance. Assistance needed during ambulation for safety precautions.**
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 loves good people and religious (Christian) support for coping methods, attempted some colleges, and lives with her boyfriend and a 17 month baby. Normal development level for her age.**
Reproductive: (2 points) **Fundal Height & Position: 1 cm above umbilic** **Bleeding amount: scant** **Lochia Color: Rubra** **Character: No odor.** **Episiotomy/Lacerations: N/A**	
DELIVERY INFO: (1 point) **Rupture of Membranes:** **Time: 0822** **Color: Clear** **Amount: Moderate** **Odor: N/A** **Delivery Date: 11/01/21** **Time: 0822** **Type (vaginal/cesarean): Cesarean.** **Quantitative Blood Loss:1000 ml.** **Male or Female: Male** **Apgars: 1 minute score is 8; 5 minutes score is also 8.** **Weight: 3140 g** **Feeding Method: Both (breastfeeding and bottle).**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**73**	**110/64**	**Not documented in the chart**	**Not documented in the chart**	**Not documented in the chart**
Labor/Delivery	**82**	**118/71**	**18**	**97.7 F oral**	**99 % room air**
Postpartum	**85**	**145/73**	**17**	**97.8 F oral**	**98% room air.**

Vital Sign Trends: All vital signs were within normal range except for postpartum systolic blood pressure. Pain can increase systolic blood pressure. The client rates pain 9/10.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1440	**0-10**	**Lower abdominal**	**7**	**Dull**	**Pain medicine.**
1755	**0-10**	**Lower abdominal**	**9**	**Sharp and cramping**	**Pain medicine & use pillow when coughing.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV: Left metacarpal vein** **Date on IV: 11/1** **Patency of IV: Fluid is running.**	**Dextrose 5%, 125 ml/hr.**

Signs of erythema, drainage, etc.: N/A IV dressing assessment: Dressing is clean, dry, and intact without signs of infiltration.	

Intake and Output (2 points)

Intake	Output (in mL)
1150 ml (IV intake and oral)	**1650 (Urine plus blood lost).**

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 assessment. (N)	**Every 4 hours**	**Assessing the fundus helps identify risk for bleeding. Massage the uterus when the fundus is boggy.**
Assist with bottle feeding (N)	**Every two to three hours.**	**Assisting with feeding will help the client to take some rest.**
Assist with ambulation(N)	**PRN**	**Ambulate the client as tolerated to prevent DVT, pulmonary emboly or stroke.**
Hydrocodone 325 mg every 6 hours PRN (T)	**325 mg tablet by mouth to relieve moderate to severe pain.**	**Opioid alters pain receptors and helps the client to relax after a cesarean.**

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? 1 to 2 days after birth, the mother is passive and somewhat depends on nursing staff; food and sleep are significant needs.

Discharge Planning (2 points)

Discharge location: The client will return home with her baby.

Equipment needs (if applicable): A breast milk pump.

Follow-up plan (include a plan for mother AND newborn): The caregiver will schedule an appointment for the newborn to see a pediatrician 48 hours following discharge. The mother needs to schedule a follow-up appointment with her provider within a few days after discharge for a checkup of the incision.

Education needs: The client needs to be educated about postpartum care and life, especially after a c-section once they return home. Also, parents need education on breastfeeding, or bottle-feeding. Teach them about how to hold, change, and burp the baby. This education should emphasize some points such as sleep, rest, follow-up, lifting restriction, caring of the incision, the baby, and the family. The client should avoid driving for two weeks.

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	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	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.

evidenced by" components		**for each intervention and using APA format, cite the source for your rationale.**	
1. Acute pain related to increasing muscle contractions as evidenced by the pain of 9 on a scale of 1-10	**The patient was asked to rate her pain on a 0-10 scale during the postpartum assessment. The patient stated that her pain was a 9.**	**1. Assess the patient's signs and symptoms of pain and observe for nonverbal cues. Rationale: This pain assessment allows for care plan modifications as needed (Ricci et al., 2020). 2. administer pain medication as prescribed. Then, reassess the effectiveness of the intervention. Rationale: This establishes a trusting-care relationship that encourages accurate communication (Ricci et al., 2020).**	**The patient verbalized that she wants her pain to be manageable to take care of herself and the baby.**
2. Risk for infection related to invasive procedures as evidenced by indwelling catheter.	**This diagnosis is pertinent because using foley catheters and inadequate genital hygiene increases the chance of infection.**	**1. Assess the clients' incision site every 4 hours. Rationale: Monitor the incision site for signs of infection, including redness, fever, foul smell, or drains (Ricci et al., 2020). 2. Monitoring temperature, pulse, and WBC count as indicated. Rationale: Increasing temperature and WBC indicate infection (Ricci et al., 2020).**	**The patient remained negative for signs and symptoms of infection.**
3. Self-care deficit related to perineal care as evidenced by the inability to	**This diagnosis was chosen because teaching is**	**1. Teach the client to avoid baths for 4 to 6 weeks until joints and balance are restored to**	**The client will verbalize taking a shower for the first 6 weeks, changing pads frequently, patting gently from front to**

perform complete bathing.	**essential during postpartum to prevent infection.**	**prevent falls.** **Rationale: During post-operatory, patients are at increased risk of falls due to dizziness and pain. Falling may result in wound dehiscence, which increases the risk of wound infection (Ricci et al., 2020).** **2. Teach the client to watch hands before changing perineal pads, after disposing of soiled pads, and after voiding. Teach the client to frequently change pads, apply them, and remove them from front to back. Use the peri bottle filled with warm water after urination and before applying a new perineal pad.** **Rationale: Doing so will prevent infection (Ricci et al., 2020).**	**back, and washing hands before and after changing pads.**
4 Knowledge deficit related to breastfeeding as evidenced by lack of infant stimulation to continue sucking.	**This diagnosis was chosen because the client's mother failed to stimulate the baby while breastfeeding.**	**1. Assess the mother and the newborn during the initial feeding session to determine the need for assistance and education.** **Rationale: Mother and infant must be comfortable to ensure breastfeeding success (Ricci et al., 2020).** **2. Provide refresher teaching to the mother on proper breastfeeding.** **Rationale: Infants require enough nutrition to grow and have a small stomach capacity, which means they need feedings every**	**The mother verbalizes the importance of regular feedings every2-3 hour. The mother stimulated the baby during breastfeeding.**

		2-3 hours (Ricci et al., 2020).	

Other References (APA)

Ricci, S.S., Kyle, T., & Carman, S. (2017). ***Maternity and pediatric nursing*** **(3rd ed.). Wolters Kluwer.**