N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
12/31/21 at 1625	EK	28	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Divorced but in a relationship	Peanuts Promethazine (Phenergan)
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	172.7 cm (5’ 8”)	82.6 kg (182 lbs)	Yes

Medical History (5 Points)

Prenatal History: Tested positive for marijuana on first prenatal visit. Prenatal and iron supplements were prescribed. Tested negative for hepatitis B and HIV but positive for Group beta strep. The patient is a cystic fibrosis carrier who is G6T5A1L5.

Past Medical History: Cystic fibrosis, labor dystocia, anxiety, anemia, lumbar degenerative disc disease, mild asthma, bipolar disorder, HPV, and depression.

Past Surgical History: Cholecystectomy

Family History: Maternal grandparents who are deceased had diabetes, sister has bipolar 1 disorder, other has seizures, father has lung cancer.

Social History (tobacco/alcohol/drugs): Marijuana use every day, ½ PPD smoker, and denies use of alcohol.

Living Situation: Lives in a house in Georgetown Illinois with her boyfriend who is the baby’s father. They have two dogs and a cat.

Education Level: Associates Degree

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points):

A pregnant 28-year-old female 38 weeks and 5 days gestation presented to the emergency department at 1625 on 12/31/21 complaining of abdominal pain. She reported spotting at home with date of last period being 2/02/21 and an estimated time of delivery of 11/9/21. She denies decreased fetal movement and ROM. She is G6T4A1L4 with no previous cesarian sections. She was admitted to labor and delivery where she had a spontaneous rupture of membranes at 1646 12/31/21.

Diagnosis

Primary Diagnosis on Admission (2 points): Spontaneous Vaginal Birth

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

The patient is in the fourth stage of labor after having a spontaneous vaginal delivery. This stage begins with the completion of the expulsion of the placenta and ends with the initial physical correction and stabilization of the mother (Ricci et al., 2021). This stage initiates the postpartum period. Close monitoring of both the mother and her newborn is done during this stage (Ricci et al., 2021). The postpartum phase lasts longer because childbirth is a long process, and the mother's body is still trying to get back to homeostasis (Ricci et al., 2021). The mother's fundus should be firm and well contracted. It is abnormal to palpate a boggy uterus and indicates a need for fundal massage. The fundus is located at the midline between the umbilicus and the symphysis pubis, and it slowly rises to the level of the umbilicus during the first hour after birth

(Ricci et al., 2021). This patients' fundus was three fingerbreadths below the midline, which is a normal finding. It would be abnormal for it to be above the umbilicus and shifted to the side. The assessment of this stage focuses on monitoring the mother closely to prevent hemorrhage, bladder distention, and venous thrombosis (Ricci et al., 2021).

Vital signs, the amount and consistency of the lochia, and the uterine fundus are monitored every 4 hours upon getting to postpartum unit. This changes to every 8 hours, 24 hours after delivery. The lochia is red, mixed with small clots, and a moderate flow (Ricci et al., 2021). The lochia slowly develops into a lighter discharge. This patients' lochia was scant and rubra, which is a normal finding. Vital signs were within normal limits. The patient's bladder was non-distended upon palpation, and the patient was able to void regularly. Bowel sounds were normoactive in all four quadrants, which is a normal finding. Tachycardia indicates further investigation and can be due to hypovolemia, dehydration, or hemorrhage (Ricci et al., 2021). Blood pressure falls within the first 3 to 7 days after childbirth and returns to pre-pregnancy levels by six weeks (Ricci et al., 2021). A significant increase in blood pressure with a headache may indicate preeclampsia (Ricci et al., 2021).

The client is in the taking-hold phase, which is the time after birth when the patient spends time with her baby, changes them, feeds her them, and gives them ample skin-to-skin time (Ricci et al., 2021). When the mother spends time with the newborn, she identifies the common features of the newborn (Ricci et al., 2021).

Complications that can arise during the postpartum period include preeclampsia, hemorrhage, and mood disorders. Risk factors for postpartum hemorrhage include precipitous labor (less than 3 hours), uterine atony, placenta previa or abruptio placentae, labor induction or augmentation. It can also be due to operative procedures, retained placental fragments, a

prolonged third stage of labor, multiparity (more than 3 births closely spaced), and uterine overdistention (Ricci et al., 2021). This patient is at risk for postpartum hemorrhage and postpartum infection due to it being her fifth spontaneous vaginal birth. Risk factors for postpartum infection include operative procedures such as a c-section, history of diabetes, prolonged labor, catheter use, anemia, multiple vaginal exams during labor, prolonged rupture of membranes, manual extraction of placenta, and compromised immune system (Ricci et al., 2021). Foul-smelling lochia or an unexpected change in color and amount can be a sign of infection along with fever, uterine tenderness, and bleeding (Boushra & Rahman, 2021). A postpartum mood disorder can be assessed by the women's emotional status and how she interacts with her family, her level of independence, energy levels, eye contact with her infant, posture, and comfort level while holding the newborn, and sleep and rest patterns (Ricci et al., 2021). Some other signs that can indicate a mood disorder are mood swings, irritability, or crying episodes (Ricci et al., 2021). Risk factors for experiencing a postpartum mood disorder are exhaustion, pain, absence of support system, baby in the NICU, traumatic birth experience, substance abuse, anesthesia, or unwanted outcomes (Ricci et al., 2021). This patient did not show any signs of a postpartum mood disorder.

Postpartum Course References (2) (APA):

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

Boushra, M., & Rahman, O. (2020, July 15). *Home - Books - NCBI*. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books.

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.8-5.3	3.80	3.66	3.78	Diagnosis of cystic fibrosis, PMH of anemia, and spontaneous vaginal delivery with EBL of 150 Ricci et al., 2021)
Hgb	12-15.4	12.2	11.1	12.1	Diagnosis of cystic fibrosis, PMH of anemia, and spontaneous vaginal delivery with EBL of 150 (Ricci et al., 2021)
Hct	36-47	36.1	31.8	34.2	Diagnosis of cystic fibrosis, PMH of anemia, and spontaneous vaginal delivery with EBL of 150 (Ricci et al., 2021).
Platelets	140-440	212	234	240	WNL
WBC	4-12	8.4	10.9	15.4	Spontaneous vaginal delivery (Ricci et al., 2021)
Neutrophils	47-73	49	65	52	WNL
Lymphocytes	18-42	23	41	32	WNL
Monocytes	**4-12**	10	11	8	WNL
Eosinophils	**0-5**	2.4	1.6	4.2	WNL
Bands	**0-5**	0.0	0.2	0.0	WNL

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, and O	B	B	B	N/A
Rh Factor	Positive or Negative	Positive	Positive	Positive	N/A
Serology (RPR/VDRL)	Positive or	Negative	Negative	Negative	N/A

	Negative				
Rubella Titer	>10 is Immune And <10 is Non-immune	Immune	Immune	Immune	N/A
HIV	Positive or Negative	Negative	Negative	Negative	N/A
HbSAG	Positive or Negative	Negative	Negative	Negative	N/A
Group Beta Strep Swab	Positive or Negative	Positive	Positive	Positive	The mother has Group B strep in her body. This is from normal flora of the skin and puts the child at risk of infection during delivery. The common treatment is prophylactic antibiotics during labor and delivery (Ricci et al., 2021).
Glucose at 28 Weeks	<140	132	Lab not drawn	Lab not drawn	N/A
MSAFP (If Applicable)	0.5-2.0	Lab not drawn	Lab not Drawn	Lab not drawn	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
Trisomy 18	Negative	Negative	Negative	Negative	N/A
Down Syndrome	Negative	Negative	Negative	Negative	N/A
Neural Tube Defects	Negative	Negative	Negative	Negative	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)	28-217	Not Drawn	Not Drawn	Not Drawn	N/A

Lab Reference (1) (APA):

Ricci, S., Kyle, T., & Carman, S. (2021). *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**	Patient is a 28-year-old female at 38 weeks and 5 days gestation. She came complaining of abdominal pain with a spontaneous ROM at 1646 after admission. Prophylactic antibiotics were given during labor and delivery to prevent the transmission of group beta strep to the infant. Labor dystocia was present so oxytocin was given to augment birth. Carboprost was given to reduce post-delivery bleeding and induce contractions to expel

	the placenta. Normal times for the stages as well as the patient's time for each stage are (Ricci et al., 2021): First stage: 14-20 hours Patient time: 6 hours 38 minutes Second stage: 1-2 hours Patient time: 6 minutes Third stage: 15-60 minutes Patient time: 5 minutes
Current stage of labor	The patient is currently in the fourth stage of labor which is the initiation of the postpartum phase (Ricci et al., 2021). In this stage the baby is born as well as the placenta (Greene, 2019). This patient is approximately 24 hours into the postpartum phase. Her vital signs are stable. Her fundus is firm, midline, and three centimeters below the umbilicus. She is bottle feeding the infant every 2-3 hours. She denies pain but has acetaminophen PRN for mild pain.

Stage of Labor References (2) (APA):

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

Greene, J. (2019). *The four stages of labor*. The Four Stages of Labor | Kaiser Permanente Washington. https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2Fpregnancy%2Fbirth%2FlaborStages.html.

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 (Iron)	Buspirone (Bustab)			
Dose	325 mg	10 mg			
Frequency	Daily	BID			
Route	PO	PO			
Classification	Nutritional supplement	Anxiolytic			
Mechanism of Action	This medication replaces and prevents losses of vitamins and minerals that are essential to fetal growth and development (Ricci et al., 2021).	Acts as a partial antagonist at serotonin 5-hydroytryptamin receptors producing antianxiety effects. (Loeble, 2020).			
Reason Client Taking	Deficiency, prophylactic, or replenishment.	Anxiety			
Contraindications (2)	Peptic ulcer disease and iron overload (Loeble, 2020).	Sever renal impairment or severe hepatic impairment (Loeble, 2020).			
Side Effects/Adverse Reactions (2)	Loss of appetite and dark colored stools	Abdominal distress and Urine retentions (Loeble, 2020).			
Nursing	Can increase	Follow closely			

Considerations (2)	liver enzymes. Iron toxicity can be reduced with deferoxamine.	if patient is withdrawn from long term buspirone therapy and food can decreased the clearance of the drug.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess CBC to look at RBC, Hgb, and Hct. Assess iron levels.	AST/ALT and Creatinine			
Client Teaching needs (2)	Store in original container. Take with a full glass of water.	Do not drink grapefruit juice and only take the prescribed amount (Loeble, 2020).			

Hospital Medications (5 required)

Brand/Generic	Benzocaine-menthol (Dermoplast)	Carboprost (Hemabate)	Methylergonovine (Methergine)	Oxytocin (Pitocin)	Acetaminophen (Tylenol)
Dose	1 spray	250 mcg	200 mcg	1-20 milliunits/min	650 mg
Frequency	Q4H PRN	Q15M PRN	Q2H PRN	Continuous	Q4H PRN
Route	Topical	IM	IM	IV	PO
Classification	Local anesthetic	Prostaglandin analog	Ergot Alkaloid	Oxytocic	Antipyretic
Mechanism of Action	Blocks the signals of the nerves in the	Binds to prostaglandin E2	Agonizes the 5-HT serotonin receptor to	Increases calcium concentratio	Inhibits prostaglandin production

	localized area.	receptor causing contractions and reduced bleeding.	increase contraction and reduce blood loss.	n inside muscles to increase uterine contractions.	and interferes with pain impulse generation.
Reason Client Taking	Post-delivery pain	Induction of contractions to expel placenta related to dystocia	Postpartum bleeding	Augment birth related to dystocia.	Pain relief
Contraindications (2)	Hypersensitivity and	Gestational diabetes and preeclampsia or eclampsia	Preeclampsia or eclampsia and coronary artery disease.	Infection at injection site. Inflammation at injection site.	Hepatic impairment and active liver disease
Side Effects/Adverse Reactions (2)	Tremors and blurred or double vision.	Hypertension and shortness of breath	Increased blood pressure and seizures.	Hirsutism and weight gain.	Hepatoxicity and leukopenia
Nursing Considerations (2)	Explain that it will be cold when applied and apply to localized area to relieve pain.	Monitor the frequency, duration, and force of uterine contractions.	Should not be taken for longer than one week and milk pumped within 12 hours of last dose should be discarded.	Monitor the infants heart rate. Check glucose q2H.	Monitor renal function in long term use and use parenteral drug 6 hours once seal has been broken
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess vision and pain	Assess lung sounds and blood pressure of the mother.	Monitor blood pressure and maternal contractions.	Monitor contraction pattern. Monitor electrolytes.	Ensure the patient does not have a liver or kidney disease or dysfunction
Client Teaching needs (2)	Do not use for more than 7 days and do not use more than what is prescribed.	This medication will induce contractions and reduce bleeding.	Do not breast feed until 12 hours after last dose and do not drink grapefruit juice.	Teach the patient the reason she is receiving it. Explain high gravidity increases the likelihood of hemorrhagin	Tablets may be crushed and teach signs of hepatotoxicity

				g after delivery.	

Medications Reference (1) (APA):

Loebl, S. (2020). *2020 Nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** AOx4 **Orientation:** Oriented to person, time, and place **Distress:** No acute distress **Overall appearance:** Clean and well groomed	Patient is alert and responds to verbal stimuli. Oriented to person, place, and time with no acute distress. Appropriately dressed, clean, and well groomed.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is pink, dry, and intact with normal skin turgor. No rashes or bruises to note. No wounds or incisions to note. Braden score of 23 No drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is normocephalic and symmetrical. Neck is midline, no tracheal deviation, no palpable lymph nodes. PERLA bilaterally, white sclera, and pink conjunctiva. Extraocular movements are intact. Nose has bilateral patency, no discharge, no polyps. The teeth are intact, and dentition is good.

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:**	Clear S1 and S2 auscultated with no adventitious sounds. Pulses are 3+ bilaterally throughout. Capillary refill is less than 3 seconds on fingers and toes. No neck vein distention or edema inspected or palpated.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respiratory rate and pattern are regular. Breath sounds are clear anteriorly and posteriorly. Chest rises and falls symmetrically. No accessory muscle use.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	The patient eats a normal diet at home and is on a normal diet in the hospital. I took her and her boyfriend dinner. The patient is 5'8" and 182 lbs. Bowel sounds are normoactive and her last bowel movement was today 11/1/21. There is no distention, incisions, wounds, pain, or masses to note. The patient has scars from previous cholecystectomy.
GENITOURINARY (2 Points): **Quantity of urine:** 200 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** Genitals are clean, dry, and intact without lesions or erythema. **Catheter: Y ☐ N ☒** **Type:** **Size:**	200 mL of urine documented during stay. Patient denies pain with urination. Genitals are clean, dry, and intact without lesions or erythema. No catheter to note.
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** ☐	The patient is independent in ADLs and mobility. Morse fall risk score of 20 which is not considered a fall risk.

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:**	MAEW and PERLA. Strength is equal in both arms and legs bilaterally. The patient is AOx4 with normal mental status. Speech and LOC are considered normal and DTRs are intact.
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 and her family are Christian and she has her associates degree. The family is made up of now 5 children, her boyfriend, two dogs, and a cat. The boyfriend's family is supportive and wants to visit. The patient is close with her own family who provide emotional support.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundus is firm at a -3 position. EBL is 150 mL. Lochia is scant and rubra. No episiotomy or lacerations to note.
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 at 1646. ROM fluid is clear, normal amount, and odorless. Child was delivered on 10/31/21 at 2314 via spontaneous vaginal delivery. Child is male with an Apgars score of 9 and a weight of 2960 g (6 lbs. 8 oz.) The child is bottle fed.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	72	108/68	19	98.2 F	99% RA

Labor/Delivery	88	119/73	20	98.7 F	98% RA
Postpartum	70	100/60	16	98.6 F	99% RA

Vital Sign Trends: The patient's vital signs are stable across time from the prenatal appointments, labor and delivery and postpartum vital check. The pulse, blood pressure, respiratory rate, and temperature all increased during labor and delivery which is normal. The pulse was 88, the BP was 119/73, respiratory rate 20, temperature of 98.7 F, and 98% oxygen saturation on room air.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	Numeric	Abdomen	1	Slight Ache	Acetaminophen 650 mg PRN
1600	Numeric	No pain	No pain	No pain	No pain

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:** 10/31/21 **Patency of IV:** Easily flushable **Signs of erythema, drainage, etc.:** No signs of erythema, drainage, bleeding, or infiltration. **IV dressing assessment:** Clean, Dry, and Intact	Lactated Ringers 125 mL/hr

Intake and Output (2 points)

Intake	Output (in mL)

485 mL	450 mL

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.
Administer prescribed Pitocin (T)	Continuous	Pitocin was provided prophylactically to prevent postpartum hemorrhage (Ricci et al., 2021)
Assess vital signs of mother and baby (N)	Q4H	Patient vital signs need to be checked every four hours after 48 hours of birth. Vital signs are stable (Ricci et al., 2021).
Assess fundus (N)	Q4H	Patient fundus is assessed every 4 hours after birth along with vital signs. At 48 hours it should be 2 cm below the umbilicus, which hers was in less than 24 hours (Ricci et al., 2021).
Assess pain	Q2H	Pain should be assessed every two hours following labor and delivery (Ricci et al., 2021). Patient rated her pain 1/10 on a numeric pain scale located at the abdomen at 1400. Patient denied acetaminophen. At 1600 the patient rated her pain at 0/10.

Phases of Maternal Adaptation to Parenthood (1 point)

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

What evidence supports this? Taking-hold phase is characterized by the mother taking control by doing tasks for the child and being less tired than the previous phase. The mother feeds the baby, gets up and walks around, and is giving the child a lot of skin-to-skin contact.

Discharge Planning (2 points)

Discharge location: Home to house in Georgetown with the baby's father.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The patient should follow up with her provider in 2 weeks, and the babies should follow up with their doctor in 24-48 hours of being discharged**.** Well child visits will be needed for the child as well.

Education needs: Patient already has four other children at home, so she has a general understanding. She was reminded of proper ways to feed and how often the baby needs to be fed. She was educated on how the baby need to be sleeping at night, in their own crib, crib empty, and they need to be lying on their back.

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. Risk for maternal	The patient is at risk for	**1.**Monitor temperature, pulse, and WBC count, as	Client is free of infection. She knows the signs and

infection related to spontaneous rupture of membranes related to spontaneous vaginal birth.	getting a post delivery infection because the birth process opens up exposure to pathogens.	indicated. **Rationale:** Increased temperature or pulse greater than 100 bpm may indicate infection. Elevated WBC can indicate infection (Ricci et al, 2021). **2**.Wash hands and wear gloves when performing assessment of incision. **Rational:** Good hand hygiene and wearing gloves can stop the spread of infection.	symptoms of an infection and agrees to report it.
2. Risk for bleeding related to postpartum hemorrhage evidenced by G6T5A1L5.	The patient just had her 5th child which puts her at higher risk of postpartum hemorrhage.	**1.** Administer prescribed Pitocin, Carboprost, and Methergine. **Rationale:** These drugs induce contractions and reduce bleeding (Ricci et al., 2021). **2.** Massage the fundus **Rationale:** Fundal massage has been proven to firm the fundus and reduce bleeding risk (Ricci et al., 2021).	The patient doesn't have postpartum hemorrhage and has limited vaginal bleeding related to birth.
3. Knowledge deficit related to substance use evidenced by prenatal history of marijuana use every day, ½ ppd smoker, and need for nicotine patch at home to prevent withdrawal.	The patient tested positive for marijuana at her first prenatal visit and reports that she uses the drug every day.	**1.** Provide written and verbal information on cessation of smoking and marijuana use. **Rationale:** Providing the patient with information on smoking and marijuana use can help them open their mind to quitting **2.** Discuss other coping mechanisms for stress. **Rationale:** Providing information on alternative coping mechanisms to smoking can help the patient cope with stress without using substances.	The patient verbalizes the education on substance abuse and is interested in trying healthier coping mechanisms.
4. Knowledge	The mother	**1.** Educate about the	The mother understands the

	deficit related to skin-to-skin contact with the child as evidenced refusing skin to skin and asking for the baby to be swaddled for her.	was asked if she would like skin-to-skin time with the baby after eating and she politely declined and asked for the baby to be swaddled instead in order to keep it warm.	benefits of skin-to-skin contact with the baby. **Rationale:** Babies can never have too much skin-to-skin contact time. Skin-to-skin helps the child form healthy attachment to the mother while increasing oxytocin for the mother can help prevent bleeding (Ricci et al., 2021) **2.** Swaddle the child and lay them back down. **Rationale:** Swaddling the child keeps them warm prevent hypothermia when they are sleeping or not having skin-to-skin contact with the mother (Ricci et al., 2021).	importance of skin-to-skin contact and understands why the baby is to be swaddled if no skin-to-skin.

Other References (APA):

Martin, P. (2021, March 29). *Normal Laboratory Values for Nurses: A Guide for Nurses*. Nurseslabs. https://nurseslabs.com/normal-lab-values-nclex-nursing/.