N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 3/6/22	Patient Initials A.M.	Age 24 years old	Gender Female
Race/Ethnicity White or Caucasian	Occupation Unemployed	Marital Status Single	Allergies No known allergy
Code Status Full	Height 5’2’’(157cm)	Weight 61.7kg(136lb)	Father of Baby Involved Yes. At 10:50 father of the baby arrived at the hospital.

Medical History (5 Points)

Prenatal History: G3 T3 P0 A0 L3,

Past Medical History: anemia; anxiety disorder, bipolar disorder

Past Surgical History: none

Family History: no information provided

Social History (tobacco/alcohol/drugs): the patient smokes every day, use marijuana, drink alcohol socially

Living Situation: She is living with mother.

Education Level: She graduates from college.

Admission Assessment

Chief Complaint (2 points): induction of labor

Presentation to Labor & Delivery (10 points):

At 39 weeks of pregnancy, twenty-four-year-old came to the hospital for induction of labor. She states that the contraction has started. The patient was in pain. However, fetal movement felt by the patient’s hand. As soon as the contraction started, she and her mother

drove to the hospital. She has confirmed a rupture and dilated 3cm by healthcare professionals and was admitted to the hospital on 3/6/22.

Diagnosis

Primary Diagnosis on Admission (2 points): induction of labor

Secondary Diagnosis (if applicable):n/a

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	3.67	3.58	Not available	Mild anemia is common in patient with pregnancy (Capriotti, 2020).
Hgb	12.0-15.8	11.6	10.6	Not available	It is lower than normal range because of low number of RBCs (Capriotti, 2020).
Hct	36-47	34.6	32.1	Not available	It means the patient has low percentage of red blood cells. Hct represents the percentage of RBCs found in 100 mL of whole blood (Hinkle, 2018).
Platelets	140-440	213	216	Not available	
WBC	4-12	11.7	10.6	Not available	
Neutrophils	47.0-73.0	73.4	79.7	Not available	
Lymphocytes	18-42	18.6	19.8	Not available	
Monocytes	4-12	7.1	5.8	Not available	
Eosinophils	0-5.0	1.5	0.8	Not	

				available	
Bands	0-3.0	Not available	Not available	Not available	

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, AB, B, O	A	A	Not available	
Rh Factor	Positive, negative	positive	positive	Not available	
Serology (RPR/VDRL)	Reactive or non-reactive	Not available	Non-reactive	Not available	
Rubella Titer	Immune or not immune	Immune	Immune	Not available	
HIV	Reactive or non-reactive	Non-reactive	Non-reactive	Not available	
HbSAG	Positive, negative	Non-detected	Non-detected	Not available	
Group Beta Strep Swab	Positive, negative	Negative	Not available	Not available	
Glucose at 28 Weeks	<140	96	Not available	Not available	
MSAFP (If Applicable)	0.5 to 2.0	Not available	Not available	Not available	

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
Not available					

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)	Not available	Not available	Not available	Not available	

Lab Reference (1) (APA):

Capriotti, T. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed.)

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

	Your Assessment
History of labor: Length of labor Induced /spontaneous	 23H 14M Spontaneous

Time in each stage	Stage 1: 22H58M Stage 2: 0H13M Stage 3: 0H03M
Current stage of labor Stages of Labor #4, Postpartum	A.M. is in her postpartum period, which is in her 4th stage of labor. She gave birth on 3/6/22, gravida 3, term 3, preterm 0, abortion 0, and living 3. The postpartum period brings lots of changes to a woman's body. The oxytocin will be released from the pituitary gland to contract the uterine (Barlow, 2019). Also, this hormone can be stimulated by breastfeeding. Indeed, the patient's uterus was contracting well, as evidenced by the height of the fundus and the stages of lochia. Uterus tends to go back to the pre-pregnancy stage by contracting themselves. Barlow (2019) states that the level of fundus will decrease within 24 hr after delivery, about 1 to 2 cm. Indeed, 3/7/22 was one day after the labor of the patient. The patient's fundus was firm and well contracted. The fundal height was below the umbilicus when placing two fingers. This indicates that the client's uterus is contracting well within the normal range. Lochia is a uterine discharge after giving birth (Ricci, 2021). There are three stages of lochia which is lochia rubra, lochia serosa, and lochia alba (Barlow, 2019). The client's lochia was

	Rubra, a dark red color, and it will last 1 to 3 days after giving birth. The amount was less than 2.5 cm and no odor. The abnormal lochia shows excessive blood loss, foul odor, and persistent heavy lochia rubra for more than three days (Barlow, 2019). However, the client's lochia is within the normal range. Moreover, the quantity was scant. The patient does not have any pain when she walks or when the nursing student palpates her fundus. It can be a positive sign that her uterus is contracting well. According to Ricci (2021), the mother's bladder will be hypotonic, and she can barely feel the sensation of a full bladder. However, A.M. said she is urinating well without any pain. The other crucial postpartum disorder could be postpartum hemorrhage, which can occur when a patient loses lots of blood during vaginal birth. The signs and symptoms could be perineal pad saturation in 15 min or less, tachycardia, hypotension, pallor of the skin, and oliguria (Barlow, 2019). The information on blood loss cannot be found in the patient's chart. However, this patient does not have any signs and symptoms of hemorrhage. Also, the laboratory test such as Hgb, Hct, coagulation profile (PT) which can indicate hemorrhage, does not show any hemorrhage on this patient (Ricci, 2019). Moreover, the patient's laceration is healing well without any signs of infection.

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. (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)

Brand/Generic	Tylenol/ Acetaminophen (Jones, 2020).	Prenatal vitamin (Ricci, 2021).	Not available	Not available	Not available
Dose	650 mg	1 tablet, 0.8mg			
Frequency	2-3 times/day, PRN	Every night			
Route	PO	PO			
Classification	Antipyretic, nonopioid analgesic	Vitamin			
Mechanism of Action	Inhibits the prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Iron and folic acid are needed to form new blood cells for the expanded maternal blood volume and to prevent anemia. Iron is essential for fetal growth			

		and brain development and in the prevention of maternal anemia. An increase in folic acid is essential before pregnancy and in the early weeks of pregnancy to prevent neural tube defects in the fetus.			
Reason Client Taking	To relieve fever and pain.	To supply adequate nutrition. Recommendations for the pregnant women: Vitamin A 770 mcg, Vitamin C 85 mg, Vitamin D 5 mcg, Iron 27mg, Folate 600 mcg			
Contraindications (2)	1. Severe hepatic impairment. 2. Hypersensitivity to acetaminophen.	1. Decreased kidney function 2. Do not consume alcoholic beverages.			
Side Effects/Adverse Reactions (2)	1. Hepatotoxicity 2. Atelectasis	1. Constipation 2. Upset stomach			
Nursing Considerations (2)	1. Use cautiously in patients with hepatic impairment or active hepatic disease, chronic malnutrition, and severe hypovolemia. 2. Monitor renal function in patient on long term therapy.	1. Ask the patient if they are allergic to any part of prenatal vitamin. 2. Increase consumption of fruits and vegetables.			

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Reviewing client's liver function test results such as AST, ALT, and bilirubin.	Check client's allergy and diet.			
Client Teaching needs (2)	1. Do not exceed recommended dosage or take other drugs containing acetaminophen at the same time. 2. Teach patient to recognize signs of hepatotoxicity, such as bleeding and bruising.	1. Take the prenatal vitamin with a full glass of water. 2. Do not take dairy product with prenatal vitamin.			

Hospital Medications (5 required)

Brand/Generic	Advil/ Ibuprofen (Jones, 2020).	Colace/ Docusate sodium (Jones, 2020).	Tucks/Witch hazel glycerin (University, 2020).	Zofran/ Ondansetron hydrochloride (Jones, 2020).	Hydrocortone/ Hydrocortisone (Jones, 2020).
Dose	800 mg	100 mg	1 Each	4 mg	1 Each
Frequency	Q8h	PRN	Q1h PRN	Q6h PRN	PRN
Route	PO	PO	Topical	PO	Topical
Classification	Analgesic	Laxative	Dermatology, herbal	Antiemetic	Adrenocorticoid replacement, anti-inflammatory
Mechanism of Action	Reduces inflammatory symptoms and relieves pain by	Decreasing surface tension between oil and water in	The chemical called tannins helps to reduce swelling and	Decrease nausea and vomiting by preventing serotonin release in the	Suppress inflammation response by binding to intracellular glucocorticoid

	inhibiting prostaglandins.	feces.	inflammation.	small intestine.	receptors.
Reason Client Taking	To relieve pain.	To treat constipation.	To relieve itching and irritation for skin.	To prevent nausea and vomiting.	To reduce the inflammation.
Contraindications (2)	1. Angioedema 2. Bronchospasm	1. Fecal impaction 2. Undiagnosed abdominal pain	1. Hypersensitivity to witch hazel 2. Avoid oral use	1. Congenital long QT syndrome 2. Hypersensitivity to ondansetron	1. Hypersensitivity 2. Idiopathic thrombocytopenic purpura
Side Effects/Adverse Reactions (2)	1. GI bleeding 2. Renal failure(acute)	1. Dizziness 2. Nausea	1. Nausea 2. Vomiting	1. Arrhythmias 2. Hypotension	1. Anaphylaxis 2. Metabolic alkalosis
Nursing Considerations (2)	1. Know the risk of heart failure increases with use of NSAIDs 2. GI tract bleeding, perforation, and ulceration may occur.	1. Long-term use of docusate can cause dependence on laxatives for bowel movements. 2. Assess for laxative abuse syndrome.	1. Use the pad after using the bathroom. 2. Assess the patient and call the doctor if symptoms are not improving or get worse within 7 days.	1. Patients with phenylketonuria must avoid getting ondansetron. 2. Monitor patient closely for serotonin syndrome.	1. It should not be given to immunocompromised patient. 2. It can worsen the infections, assess the signs and symptoms for any reaction.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzyme and CBC, it may worsen anemia	Assess bowel movement.	Check if the client is allergic to witch hazel.	Electrolyte imbalance should be corrected before ondansetron is administered.	Assess the skin prior to administration.
Client Teaching	1. Take the	1.	1. Use the	1. Advise	1. Educate

needs (2)	tablets with a full glass of water and ask not to lie down for 15 to 30 minutes to prevent esophageal irritation. 2. Educate patient to avoid alcohol, aspirin, and corticosteroids while taking ibuprofen.	Encourage client to increase fiber intake and drink water daily. 2. Notify prescriber when client experiencing rectal bleeding.	Witch hazel as prescribed. 2. Stop using when they have an allergic reaction.	patient to use calibrated container or oral syringe to measure oral solution. 2. If patient experiences severe or worsening symptom, they should immediately call the hospital.	patient to report any signs or symptoms of infection. 2. Gently apply to the affected area of skin.

Medications Reference (1) (APA):

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

University of Michigan Health (2020). *Glycerin and witch hazel topical*. University of Michigan Health. https://www.uofmhealth.org/health-library/d03764a1

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress:	The patient is A&O x4, well-groomed, and in no distress.

Overall appearance:	
INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 23 Drains present: Y☐ N ☒ Type:	Skin color was pink, dry/normal, and warm to touch. There is no turgor, no rashes, no bruises, and no wound noted.
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Head and neck symmetrical, normal cephalic. The patient's ears are normal. Eyes are symmetrical EOM. The nose is symmetrical and has no deviation. Dentures are well-groomed.
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:	Hear sounds normal S1 and S2, nor murmurs, no gallops or rubs detected in S3 and S4. Capillary refill is less than 3 seconds. Peripheral pulses are 2+ symmetric.
RESPIRATORY (1 points): Accessory muscle use: Y☐ N ☒ Breath Sounds: Location, character	Respirations are regular, nonlabored, symmetrical, and no wheezes or crackles were noted.
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:	Client's current diet and diet at home are regular diet. Height: 5'2''(157cm) Weight: 61.7kg(136lb) Bowel sounds are active in all 4 quadrants. The patient had the last bowel movement in the morning. No abnormalities were found upon inspection for incisions, scars, drains, or wounds. The patient's abdomen was bloated due to postpartum but did not have any pain and mass.

GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y ☐ N ☒ Inspection of genitals: Catheter: Y ☐ N ☒ Type: Size:	The quantity of urine was not on the chart, but the patient states that she is urinating regularly without any pain. She states that she does not have any pain on genitals.
MUSCULOSKELETAL (1 points): ADL Assistance: Y☐ N ☒ Fall Risk: Y ☐ N☒ Fall Score: 0 Activity/Mobility Status: Independent (up ad lib) ☐ Needs assistance with equipment ☐ Needs support to stand and walk☐	The patient does not need any assistance, and she has normal ROM. She has strengths in both the upper and lower extremities.
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:	She is awake, oriented, alert to the time, person, place. Her mental status, speech is normal. The patient is mature and cognitive. The patient has normal muscle stretch reflexes (+2).
PSYCHOSOCIAL/CULTURAL (2 points) Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	The patient is a mature adult. She is living with her mother. Her religion is Christian. Her partner visited in the morning. It is unclear if he would provide support to her and the baby.
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	Fungal height and position were U/2 and firm. The bleeding amount was scant (less than 2.5cm), and no odor. The color was red (Rubra). The patient presented with a laceration.
DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount:	The client arrived in the hospital due to a rupture of membranes on 3/6/22. Delivery Date & time: 3/6/22, 22:58 pm Type: Vaginal

Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	Quantitative blood loss: 300ml Male or Female: male Apgars: 1 min-8, 5min-9 Weight: 6lb Feeding Method: Formula

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	81	130/70	18	97.9 F	96
Labor/Delivery	101	150/65	22	97.9 F	85%
Postpartum	70	114/76	18	97.6 F	98%

Vital Sign Trends: Vital signs are stable and within the normal range currently. Her blood pressure, pulse elevated during labor and delivery related to the pain which was expected.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	6/10	back	strong	sharp	relaxation
1050	7/10	Back, stomach	strong	Cramping; sharp	Given Ibuprofen

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 Location of IV: left hand Date on IV: 3/6/2022 Patency of IV: Signs of erythema, drainage, etc.: none	Normal Saline

IV dressing assessment: dry, clean	

Intake and Output (2 points)

Intake	Output (in mL)
120ml	525ml

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.
N: Provide warm blanket and suggest skin-to-skin method. T: To increase the baby's temperature.	Until the baby's temperature is warm enough, we suggest that the mom hold the baby.	The baby's temperature does not go up when using the warm blanket. The best way to increase the baby's temperature is by attaching it with her mom. It will help not only increasing temperature but also give comfort to the baby.
N: Educate the patient the frequency of feeding, and the proper way to use formula. T: The right time and way to feed the baby provides adequate nutrition.	Every 4 hours, when mom is feeding her baby.	The patient gave birth yesterday. This is the first baby out of three that have blood sugar taken. This is also the first baby that uses formula.
N: Administer the pain medication. T: Ibuprofen 800mg was given to the patient.	Every 8 hours.	The patient had vaginal delivery a day ago. She might have some pain. Ibuprofen will decrease the pain level and reduce the inflammatory symptoms.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking-in phase

What evidence supports this?

Ricci (2021) states that the taking-in phase occurs during the first 24 to 48 hours after birth. The patient has been 24 hours after giving birth. She sought help when she was breastfeeding her baby and allowing the nurse to educate and be involved in baby care.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to the home with her baby.

Equipment needs (if applicable):

Follow up plan (include plan for mother AND newborn):

A postpartum checkup is needed to check the mother is recovering well and infant caring, newborn growth checkup, and vaccinations for baby.

Education needs: The mom needs formula feeding education.

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. Postpartum pain related to the vaginal delivery, as evidenced by the patient delivered the baby yesterday.	The vaginal delivery causes lots of pain, and the laceration has not been fully	1. Assess the patient's pain in the urinary system. Rationale Pain while urinating can be caused by perineal laceration (Ricci, 2021)	1. She does not have pain while she is urinating. 2. After re-assess the pain scale after administering the

	recovered yet.	2. Administer the ibuprofen 800mg every 8 hours. Rationale This medication relieves pain by inhibiting prostaglandins (Jones, 2020).	medication, she still has pain but can tolerate it.
2. Knowledge deficit of formula feeding related to improper positioning, as evidenced by the patient is not used to bottle feeding her baby.	She has a difficult time positioning her baby when feeding.	1. Educate the patient about football hold position. Rationale The mother can see the baby's mouth and guide the baby's mouth to the bottle (Ricci, 2021). 2. Burp the baby after the breastfeeding Rationale It helps release the air in the baby's stomach and can prevent vomiting in the baby (Ricci, 2021).	1. The client followed the nurse's feeding technique and was able to find a comfortable position for both mom and baby. 2. Once the baby burps several times after feeding, the baby seems to fell asleep.
3. Risk for VTE related to prolonged bed rest, as evidenced by the patient was taking a rest in the bed after she gave birth.	Staying in bed long time will increase the risk of VTE.	1. Assess the patient closely for the signs and symptoms. Rationale While doing physical assessment on the patient, press the lower extremities to find any signs of VTE (Ricci, 2021). 2. Suggest patient to avoid sitting in one position for a long period. Rationale It will promote adequate circulation on the patient's body and can prevent the risk of VTE (Ricci, 2021).	1. There were no signs or symptoms of VTE when assessing the patient. 2. After breastfeeding her baby, she tried to walk the room and go to the bathroom. Moving her body will help her to increase blood circulation.
4. Risk for postpartum blues related to rapid cycling mood symptoms as evidenced by her lack of coping mechanisms.	Her partner did not visit till late morning, and she was staying alone in the room.	1. Suggest the patient have an adequate sleep. Rationale Taking adequate sleep will help to reduce stress (Ricci, 2021). 2. Suggest the patient spend more time with her husband to reduce the depression.	1. The patient took a quality of sleep in the morning while her baby was asleep. 2. Adequate assistant from her partner made her smile.

		Rationale The baby's father should involve in the baby's care for her wife to decrease the postpartum blues such as restlessness, hopelessness, moody, and sadness (Ricci, 2021).	

Other References (APA)

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