

N432 Postpartum Care Plan  
Lakeview College of Nursing  
Whitney Simlin

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 03/27/2022	<b>Patient Initials</b> F. S.	<b>Age</b> 23 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> African	<b>Occupation</b> Nurse	<b>Marital Status</b> Married	<b>Allergies</b> None
<b>Code Status</b> Full Code	<b>Height</b> 5'3" (160.02 cm)	<b>Weight</b> 173 lb. (78.5 kg)	<b>Father of Baby Involved</b> Involved

**Medical History (5 Points)**

**Prenatal History:** The patient has a GTPAL score of 11001.

**Past Medical History:** The patient has a medical history of a parotid mass, anxiety, depression, carpal tunnel syndrome on left side, and allergic rhinitis.

**Past Surgical History:** The patient has a past surgical history of parotidectomy and a cyst removal.

**Family History:** According to the chart, the patient has no family history.

**Social History (tobacco/alcohol/drugs):** According to the chart, the patient is a former smoker but quit smoking in 2019, she drinks alcohol (unknown amount), and does not use drugs.

**Living Situation:** The patient lives with her husband.

**Education Level:** The patient has a bachelor's degree in nursing from Lakeview College of Nursing.

**Admission Assessment**

**Chief Complaint (2 points):** Induction of labor

**Presentation to Labor & Delivery (10 points):** On March 27, 2022, a 23-year-old, African female presented to the Labor and Delivery unit for labor induction. The induction was

previously scheduled. The patient was G1P0T0A0L0. The patient was 41 weeks and 4 days pregnant. The artificial rupture of membranes was started at 0200. No vacuum or forceps were used for birth. The second stage was prolonged. The delivery of the baby occurred vaginally at 0605. The spontaneous delivery of the placenta occurred at 0635. The placenta appearance was intact, and the placenta was discarded after delivery.

### Diagnosis

**Primary Diagnosis on Admission (2 points):** Induction of labor

**Secondary Diagnosis (if applicable):**

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### 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
<b>RBC</b>	3.75-5.0 million/mm <sup>3</sup>	3.79 million/mm <sup>3</sup>	5.0 million/mm <sup>3</sup>	3.48 million/mm <sup>3</sup>	During the postpartum stage, the patient experienced hemorrhaging (Mayo Clinic, 2019).
<b>Hgb</b>	11.5-14 g/dL	11.9 g/dL	11.1 g/dL	9.8 g/dL	During the postpartum stage, the patient experienced hemorrhaging (Mayo Clinic, 2019).
<b>Hct</b>	32%-42%	37%	43%	35%	The hematocrit level on admission

					may be high because of dehydration (Hematocrit, 2019).
<b>Platelets</b>	150-350 million/mm <sup>3</sup>	170 million/mm <sup>3</sup>	245 million/mm <sup>3</sup>	167 million/mm <sup>3</sup>	
<b>WBC</b>	5.0-15 million/mm <sup>3</sup>	8.14 million/mm <sup>3</sup>	8.10 million/mm <sup>3</sup>	11 million/mm <sup>3</sup>	
<b>Neutrophils</b>	47%-73%	51.1%	74.3%	n/a	Total neutrophils are elevated during pregnancy due to a “left shift.” However, the increased neutrophils are not related to any infection or inflammation (Mayo Clinic, 2019).
<b>Lymphocytes</b>	15%-40%	14.9%	19.8%	n/a	Decreased lymphocytes indicate bone marrow response to increased erythropoiesis during pregnancy (Mayo Clinic, 2019).
<b>Monocytes</b>	4%-12%	5.9%	5.4%	n/a	
<b>Eosinophils</b>	0%-5%	0.7%	0.4%	n/a	
<b>Bands</b>	0%-1%	n/a	n/a	n/a	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text cita

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
<b>Blood Type</b>	A, B, AB, O	O	O	O	
<b>Rh Factor</b>	Negative or Positive	Positive	Positive	Positive	

<b>Serology (RPR/VDRL)</b>	Non-reactive	N/A	Non-reactive	N/A	
<b>Rubella Titer</b>	Immune	Immune	Immune	Immune	
<b>HIV</b>	Negative	N/A	Negative	N/A	
<b>HbSAG</b>	Not detected	N/A	Not detected	N/A	
<b>Group Beta Strep Swab</b>	Negative	Negative	Negative	N/A	
<b>Glucose at 28 Weeks</b>	< 140 mg/dL	136	136	136	
<b>MSAFP (If Applicable)</b>	Negative	N/A	N/A	N/A	

tions in APA format.

**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

**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
<b>Urine Creatinine (if</b>	N/A	N/A	N/A	N/A	<b>Lab work not drawn</b>

applicable)					
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**Lab Reference (1) (APA):**

Corbett, J., & Bank, A. (2019). *Laboratory tests and diagnostic procedures* (9<sup>th</sup> ed.). Pearson Education, Inc. Hematocrit (2019). Retrieved from

[https://www.emedicinehealth.com/hematocrit\\_blood\\_test/topic-guide.htm](https://www.emedicinehealth.com/hematocrit_blood_test/topic-guide.htm)

Laboratory Values (n. d.). Retrieved from

<https://annualmeeting.acponline.org/sites/default/files/shared/documents/for-meeting-attendees/normal-lab-values.pdf>

Mayo Clinic. (2019). *Iron deficiency anemia during pregnancy: Prevention tips.*

<https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/anemia-during-pregnancy/art-20114455>

**Stage of Labor Write Up, APA format (30 points):**

	Your Assessment
<p><b>History of labor:</b></p> <p><b>Length of labor</b></p> <p><b>Induced /spontaneous</b></p> <p><b>Time in each stage</b></p>	<p>The patient was in the first stage of labor for 15 hours. Then, she was in the second stage of labor for 5 hours. Finally, the patient was in the third stage of labor for 30 minutes. Labor started at 1000. Dilation and effacement were complete at 0100, and the patient began to push at 0105. The infant was born at 0605, and</p>

	<p>the placenta was delivered at 0635 The patient was admitted to the Labor and Delivery unit on 03/27/2022 at 0600 for a scheduled induction of labor. The patient was induced with oxytocin. The patient achieved 100% dilation and effacement. The patient pushed effectively and enacted spontaneous vaginal delivery with complications in the third stage of delivery, causing PPH. This was an elective vaginal planned induction.</p>
<p><b>Current stage of labor</b></p>	<p>The postpartum stage, or the fourth stage, of labor, begins right after the placenta is delivered. The postpartum stage ends when the mother becomes physiologically adjusted and stabilized. This stage can happen anywhere from one to four hours after birth (Ricci, Kyle, &amp; Carman, 2021). During the postpartum stage of labor, the mother usually feels relief in anxiety and an overall sense of peace. The mother is also extremely excited, wide awake, and very talkative (Ricci, Kyle, &amp; Carman, 2021). Attachment between the mother and infant begins with skin-to-skin contact. Skin-to-skin contact helps to build trust and a relationship. During the attachment process, the mother will feed the infant for the first time (Ricci, Kyle, &amp; Carman, 2021).</p> <p>During the postpartum stage of labor, the fundus should</p>

	<p>be firm, midline, and just at the level of the umbilicus or lower. The fundus is massaged regularly to maintain its firmness. Massaging the fundus also helps the body get rid of the lochia (Ricci, Kyle, &amp; Carman, 2021). The lochia consists of red blood, small clots, and a moderate amount of flow. The postpartum assessment should also include inspection of any lacerations or episiotomies (Ricci, Kyle, &amp; Carman, 2021).</p> <p>The most crucial focus of the postpartum period is the mother. It is essential to frequently monitor the patient to prevent hemorrhaging (Ricci, Kyle, &amp; Carman, 2021). Often during the postpartum stage, the bladder can become distended. Therefore, it is essential to have the patient empty her bladder if the fundus is not midline (Ricci, Kyle, Carman, 2021). If the patient has had an epidural, it might be vital for her to have a catheter until the bladder wakes up. The mother can request food and drink during this time, but it is essential to monitor for nausea and vomiting (Ricci, Kyle, &amp; Carman, 2021). If the birth is cesarean instead of vaginal, the recovery period may be slightly different, but the main focuses stay the same (Smith, 2020).</p> <p>F.S. is in the 4<sup>th</sup> stage of labor- postpartum stage (Ricci, Kyle, and Carman, 2021) and is experiencing hemorrhaging. Her bladder is distended and we must use a straight catheter to empty it because she is having trouble urinating. Due to injury that</p>
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	<p>occurred during the 3<sup>rd</sup> stage of birth, she has lost 1920 mL of blood and lochia. The patient is given 500 mL of lactated ringers to replenish the fluid loss that caused tachycardia, oxygen saturation of 92%, tenting, and hypotension.</p> <p>F.S. is also rated her pain, located between her stomach and vagina, as a 5 on the 1-10 scale when asked. Ibuprofen was given PO as ordered. Ibuprofen did not relieve her pain, so morphine was administered per order.</p>

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

Ricci, S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4<sup>th</sup> ed.). Philadelphia: Wolters Kluwer.

Smith, L. (2020). *What are the stages of labor?*

<https://www.medicalnewstoday.com/articles/308919>

**Current Medications (7 points, 1 point per completed med)  
\*7 different medications must be completed\***

**Home Medications (2 required)**

<b>Brand/Generic</b>	prenatal vitamin-ferrous fumarate ( <b>Feostat</b> )	Flonase/fluticasone			
<b>Dose</b>	27-1 mg	50 mcg			

<b>Frequency</b>	Daily	1-2 daily			
<b>Route</b>	Oral	nasal			
<b>Classification</b>	Multivitamin	corticosteroid			
<b>Mechanism of Action</b>	Acts to normalize RBC production by binding with hemoglobin	Fluticasone binds and activates glucocorticoid receptor, resulting in the activation of lipocortin.			
<b>Reason Client Taking</b>	To increase RBC production during and after pregnancy.	Seasonal allergies			
<b>Contraindications (2)</b>	Hemolytic anemia, Gastritis	Hypersensitivity to steroids, hypertension			
<b>Side Effects/Adverse Reactions (2)</b>	Metallic taste, abdominal cramps	High blood pressure, upset stomach			
<b>Nursing Considerations (2)</b>	Give with a full glass of orange juice to promote absorption, do not give with antacids	Observe for paradoxal bronchospasm, may reduce fetal growth rate			
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess iron levels before administration . Assess RBC count before administration as well	Assess pulmonary function			
<b>Client Teaching needs (2)</b>	Take with chicken, fish, or lean red meats since they are all high in	Do not blow your nose or tip your head back after using the spray. Use the medicine exactly as			

	Vitamin C to increase absorption, avoid foods that impair absorption such as eggs, spinach, and high-fiber foods.	directed.			
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**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Lactated Ringers/ lactated ringer's injection	Pitocin / Oxytocin	Ibuprofen / Motrin	Hamamelis virginiana / Witch Hazel Tucks Pads	Cortisone 10 / Hydrocortisone
<b>Dose</b>	500 mL	30 units in 500 mL LR	800 mg	1 Pad	1% Cream
<b>Frequency</b>	1-20mU/min	Once	Q8H	Q1H or PRN	Q6H or PRN
<b>Route</b>	IV	IV	PO	Topical	Topical
<b>Classification</b>	Alkalinizing Agents	Oxytocic / stimulates contractions	NSAID	Herbal Remedy	Corticosteroid
<b>Mechanism of Action</b>	Restores fluid and electrolyte balances, produces diuresis, and acts as alkalinizing agent (reduces	Pitocin causes the uterus to contract and induces labor.	Inhibits prostaglandin synthesis	To relieve swelling, itching, minor burning, and pain after birth or to use with hemorrhoids	To relieve inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses

	acidity).				
<b>Reason Client Taking</b>	replace water and electrolyte loss because of low blood volume and low blood pressure	The client is taking to stimulate contractions and strengthen them.	To relieve mild to moderate pain	Laceration in Perineum	Hemorrhoids
<b>Contraindications (2)</b>	High blood pressure, placenta previa	Fetal distress, Hypersensitivity to Pitocin or its components.	asthmatic reaction  CABG surgery	No known contraindications; Avoid allergies to Witch Hazel or any of its components	Diabetes, low thyroid levels
<b>Side Effects/Adverse Reactions (2)</b>	Decreased urine output, <b>Decreased heart rate</b>	Nausea, vomiting, hemorrhaging.	hypotension, bleeding	No side effects when applied directly to the skin. However, for patients who ingest Witch Hazel – be advised of upset stomach and liver problems.	Itching, scaling, burning, blistering of the skin.
<b>Nursing Considerations (2)</b>	Use cautiously in patients with hepatic impairment; monitor renal function in patients on long-term therapy	Pitocin should be inspected for discoloration and cloudiness. The level given to the patient is specific to the contractions and mother.	monitor for bleeding  monitor for signs and symptoms of cardiovascular events	Use as needed. Apply a pad when the patient feels discomfort.	Monitor for signs of skin reactions such as rash, urticaria. Monitor for signs of anaphylaxis, such as tightening of the chest or lungs.
<b>Key Nursing Assessment(s)/L</b>	Monitor AST and	Monitor the fetal heart	Hgb & Hct	No lab tests were noted.	No lab tests were noted.

<b>ab(s) Prior to Administration</b>	ALT levels	rate, monitor the mother's oxygen and fetal distress.	renal function CMC, CMP		
<b>Client Teaching needs (2)</b>	Notify doctor of difficulty breathing, notify doctor of stomach pain	Inform the patient that the strength of the contraction is going to increase. Inform the Patient that Pitocin will stimulate contractions and speed up labor.	the drug may cause fluid retention report signs and symptoms of bleeding promptly	Teach to apply to episiotomy, lacerations, & hemorrhoids to relieve pain and discomfort as needed. Warn patient it feels cold when applied initially.	Apply a small amount of cream to the affected area. Please do not allow the cream to get into one's eyes.

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	The patient is alert and oriented times 4. The patient shows signs of acute distress and is very tired. The patient is well-groomed and is appropriately dressed.
<b>INTEGUMENTARY (1 points):</b> <b>Skin color:</b> <b>Character:</b> <b>Temperature:</b> <b>Turgor:</b> <b>Rashes:</b> <b>Bruises:</b>	The patient's skin color is typical for her race and is warm, dry, and intact. The patient's temperature is 99.0 F. Patient's skin is elastic, and there is tenting (4 seconds). The patient has no rashes or bruises. The patient's Braden score is 23, which places her at no risk. There are no

<p><b>Wounds/Incision:</b> .</p> <p><b>Braden Score:</b></p> <p><b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Type:</b></p>	<p>drains present.</p>
<p><b>HEENT (1 point):</b></p> <p><b>Head/Neck:</b></p> <p><b>Ears:</b></p> <p><b>Eyes:</b></p> <p><b>Nose:</b></p> <p><b>Teeth:</b></p>	<p>The patient's head and neck are symmetrical, normocephalic, supple, and no JVD is present. The patient's tympanic membranes are pearly gray. The patient's eyes are PERRLA. The patient's nose is patent, with no septum deviation. The patient shows no signs of dental caries.</p>
<p><b>CARDIOVASCULAR (2 point):</b></p> <p><b>Heart sounds:</b></p> <p><b>S1, S2, S3, S4, murmur etc.</b></p> <p><b>Cardiac rhythm (if applicable):</b></p> <p><b>Peripheral Pulses:</b></p> <p><b>Capillary refill:</b></p> <p><b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Location of Edema:</b></p>	<p>The patient is in normal sinus rhythm, with S1 and S2 sound present. The patient's pulse is 131. The patient's capillary refill is less than 3 seconds. The patient has no neck vein distention or edema.</p>
<p><b>RESPIRATORY (1 points):</b></p> <p><b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Breath Sounds: Location, character</b></p>	<p>No</p> <p>Regular respiration rate, regular respiratory pattern, bronchial/vesicular breath sounds present in the upper lobes and lower lobes bilaterally</p>
<p><b>GASTROINTESTINAL (2 points):</b></p> <p><b>Diet at Home:</b></p> <p><b>Current Diet:</b></p> <p><b>Height:</b></p> <p><b>Weight:</b></p> <p><b>Auscultation Bowel sounds:</b></p> <p><b>Last BM:</b></p> <p><b>Palpation: Pain, Mass etc.:</b></p> <p><b>Inspection:</b></p> <p><b>Distention:</b></p> <p><b>Incisions:</b></p> <p><b>Scars:</b></p> <p><b>Drains:</b></p> <p><b>Wounds:</b></p>	<p>Normal</p> <p>Regular with snacks- encourage PO fluids</p> <p>5' 3"</p> <p>173 lbs</p> <p>Active/Present in RLQ, RUQ, LUQ, and LLQ</p> <p>Unknown/Before admission</p> <p>Pain not at 0708, no masses</p> <p>No distention</p> <p>No incisions</p> <p>No scars</p> <p>No drains</p> <p>No wounds</p>
<p><b>GENITOURINARY (2 Points):</b></p> <p><b>Quantity of urine:</b></p> <p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Inspection of genitals:</b></p>	<p><b>350 mL</b></p> <p><b>2<sup>nd</sup> degree laceration on perineum</b></p>

<p><b>Catheter:</b> Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p><b>Straight catheter used</b>  <b>No indwelling catheter present</b>                  N/A                  N/A</p>
<p><b>MUSCULOSKELETAL (1 points):</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> X <input type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>5  <b>No fall risk</b>                   Yes                  No                  No</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b>  <b>DTRs:</b></p>	<p>The patient moves all extremities well. The Patient is PERRLA. The patient’s strength is equal bilaterally and is currently weak. The patient is alert and oriented times 4. The patient’s speech is clear. The patient has had no loss of consciousness. The patient’s deep tendon reflexes are 2+.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The patient has a supportive husband. She uses prayer as a coping mechanism. The patient’s level of education is Bachelor’s Degree. She mentions that she is non-religious. She is Muslim.</p>
<p><b>Reproductive: (2 points)</b>  <b>Fundal Height &amp; Position:</b>  <b>Bleeding amount:</b>  <b>Lochia Color:</b>  <b>Character:</b>  <b>Episiotomy/Lacerations:</b></p>	<p>1 cm below umbilicus, no deviation- soft and boggy                  1920 mL                  Rubra                  Normal, bloody                  No episiotomy, 2nd degree laceration</p>
<p><b>DELIVERY INFO: (1 point)</b>  <b>Rupture of Membranes:</b>  <b>Time:</b>  <b>Color:</b>  <b>Amount:</b>  <b>Odor:</b></p>	<p><b>Artificial</b>  <b>0220</b>  <b>Clear</b>  <b>Moderate</b>  <b>No odor</b></p>

<b>Delivery Date:</b>	<b>03/28/2022</b>
<b>Time:</b>	<b>0605</b>
<b>Type (vaginal/cesarean):</b>	<b>Vaginal</b>
<b>Quantitative Blood Loss:</b>	<b>2270 mL</b>
<b>Male or Female</b>	<b>Female</b>
<b>Apgars:</b>	<b>9 and 9</b>
<b>Weight:</b>	<b>9 lb 0 oz</b>
<b>Feeding Method:</b>	<b>breastfeeding</b>

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

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>Prenatal</b>	<b>65</b>	<b>125/65</b>	<b>20</b>	<b>98.6</b>	<b>100</b>
<b>Labor/Delivery</b>	<b>70</b>	<b>120/70</b>	<b>20</b>	<b>99</b>	<b>92</b>
<b>Postpartum</b>	<b>131</b>	<b>87/45</b>	<b>20</b>	<b>99</b>	<b>95</b>

**Vital Sign Trends:** The pulse increases from prenatal, to delivery, and into postpartum where it is very high. The blood pressure begins high and is low during the postpartum stage. Respirations remain normal. Her temperature increases and she has a low-grade fever during labor/ delivery and post-partum. Her oxygen saturations begin normal than drop and we see them go back up during postpartum. The trends we so are consistent with what her body experienced. During the postpartum period, her pulse rate blood pressure and oxygen levels exemplify what we normally see in patient with PPH.

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

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>0708</b>	<b>1-10</b>	<b>Abdomen</b>	<b>5</b>	<b>sharp</b>	<b>Pain medication</b>

<b>1115</b>	<b>1-10</b>	<b>Perineum</b>	<b>6</b>	<b>throbbing</b>	<b>Ice pack</b>
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**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	The patient has an 18 g IV on her Left forearm. The date on the IV states 3/27/2022. There are no signs of erythema or drainage. IV is patent, and dressing is clean

**Intake and Output (2 points)**

<b>Intake</b>	<b>Output (in mL)</b>
500 mg bolus x 2  30 mg Pitocin in 500 mL  =1500 mL	350 mL

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

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<b>Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a short rationale.</b>
Disposable Ice Pack – N	Every 3-4 hours or PRN	Non-Pharmacologic treatment for abdominal pain the patient was experiencing hours after birth. The pain was due to the uterus contracting back to a smaller size after birth.
Motrin – T	Every 8 hours	This medication was a pharmacologic treatment for the abdominal pain the

		patient was experiencing from her uterus contracting after birth.
Witch Hazel Tucks Pads – T	Every 1 hour or PRN	These witch hazel tucks pads were a relief for the laceration the patient experienced during vaginal birth.
Frequent positional changes - N	As much as the mother feels comfortable with	Frequent positioning allows the mother to choose the position which is most comfortable to her and to minimize her pain/discomfort

**Phases of Maternal Adaptation to Parenthood (3 point)**

**What phase is the mother in?** The patient is in the dependent taking-in phase of parenthood. She is within the first 48 hours of birthing her child. She has to focus on meeting personal needs and relies on others for assistance. She is also excited and talkative and has a need to review the birth experience with others (Holman et al., 2019).

**What evidence supports this?** She was meeting her personal needs, which meant that she needed medication for the abdominal pain that she was experiencing. She was given Motrin for the pain as well as multiple disposable ice packs. She was able to position herself freely in her bed to her comfort level.

**Discharge Planning (3 points)**

**Discharge location: Home with husband and baby**

**Equipment needs (if applicable):**

**Follow up plan (include plan for mother AND newborn):** Patient is planning to be discharged today to home with her husband. The patient will need a pump to help with breastfeeding. They have scheduled a follow-up visit with her provider for the mother and newborn. The parents were educated on infant safety, provider-follow up importance, and signs that should be reported to the provider.

**Education needs:**

**Nursing Diagnosis (30 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

**Two of the Nursing Diagnoses must be education related i.e. the interventions must be education for the client.”**

**2 points for correct priority**

<p><b>Nursing Diagnosis (2 pt each)</b> Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p><b>Rational (1 pt each)</b> Explain why the nursing diagnosis was chosen</p>	<p><b>Intervention/Rational (2 per dx) (1 pt. each)</b> Interventions should be specific and individualized for his patient. Be sure to include a time interval such as Assess vital signs q 12 hours.” List a rationale for each intervention and using APA format, cite the source for your rationale.</p>	<p><b>Evaluation (2 pts each)</b></p> <ul style="list-style-type: none"> <li>How did the patient/family respond to the nurse’s actions?</li> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p><b>1.</b> Constipation related to fluid volume deficit as evidenced by a decrease in blood volume.</p>	<p>This was chosen due to the patient not defecating since before she gave birth.</p>	<p><b>1.</b> Assess the patient’s activity level, encourage ambulation <b>Rationale</b> Ambulation can stimulate peristalsis to return, encouraging the client to defecate (Wayne, 2017). <b>2.</b> Encourage a fluid intake of 2000 to 3000 mL <b>Rationale</b> Fluid helps to keep the fecal mass soft and promote elimination (Wayne, 2017).</p>	<p>The patient was excited to be able to walk around and get out of bed. The patient was aware that she should be increasing her fluid intakes to 2000-3000 mL per day and had no problem with it.</p>
<p><b>2.</b> At risk for infection</p>	<p>This diagnosis is to teach the</p>	<p><b>1.</b> Use a peri bottle to promote cleansing.</p>	<p>The patient enjoys using a peri bottle. The patient</p>

<p>related to a vaginal delivery as evidenced by a first-degree laceration.</p>	<p>patient how to prevent infection when caring for her postpartum body.</p>	<p><b>Rationale</b> Pain is typically caused when wiping after birth, so using the peri bottle helps to eliminate that while reducing the risk for infection from sitting urine (Belleza, 2021). 2.Frequent changing of pads when they become heavily saturated <b>Rationale</b> Changing pads once they become saturated decreases the risk of infection because it does not give the bacteria time to grow (Belleza, 2021).</p>	<p>was made aware of the frequent changes of the pads to prevent bacteria from growing and had no problem with it.</p>
<p>3. At risk for depression related to postpartum as evidenced by changes in hormones.</p>	<p>This diagnosis is to teach the patient how to be cautious and aware that they may develop postpartum depression.</p>	<p>1. Give the father and mother a pamphlet on awareness of signs and symptoms of postpartum depression. <b>Rationale</b> Being aware of signs and symptoms can help to diagnose the disease sooner and seek treatment faster (Belleza, 2017). 2.Educate the mother on the reasons for the changes in her mood, such as fluctuating hormonal levels. <b>Rationale</b> The mother knowing that her mood will be compromised prepares her for what is to come (Belleza, 2017).</p>	<p>The patient and her husband were understanding of why they needed the pamphlet on postpartum depression. They acknowledged that even though she may not feel depressed now, she may feel depressed a few weeks down the road. The patient was willing to learn about the disease and what may happen.</p>
<p>4. At risk for knowledge deficit related to breastfeeding as evidenced</p>	<p>This diagnosis was chosen because the patient expressed concern about</p>	<p>1. Give the mother a pamphlet to take home educating her on breastfeeding. <b>Rationale</b> Taking home a pamphlet</p>	<p>The patient was appreciative of the pamphlet so that they could look back on information they may forget when they return</p>

<p>by the need for education pamphlets.</p>	<p>pumping to breastfeed at home.</p>	<p>allows her to be able to look back on information in case she forgets (John Hopkins Medicine, 2021).  <b>2. Encourage frequent feedings</b>  <b>Rationale</b>                  This allows for the mother to have time to bond with her baby and to get used to the pumping patterns (John Hopkins Medicine, 2021).</p>	<p>home. The patient showed a clear understanding of why it is important to breastfeed for as long as the baby wants and whenever the baby wants.</p>
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**Other References (APA)**

Belleza, M. (2021, August 12). *Infection control in nursing*. Nurseslabs.

<https://nurseslabs.com/infection-control-in-nursing/>

Belleza, M. (2017, January 19). *Postpartum depression*. Nurseslabs.

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John Hopkins Medicine. (2021, February 3). *Postpartum discharge instructions*.

[https://www.hopkinsmedicine.org/howard\\_county\\_general\\_hospital/services/mothers\\_and\\_babies/taking\\_baby\\_home/postpartum-discharge-instructions.html](https://www.hopkinsmedicine.org/howard_county_general_hospital/services/mothers_and_babies/taking_baby_home/postpartum-discharge-instructions.html)

Wayne, G. (2017, September 24). *Constipation nursing care plan*. Nurseslabs.

<https://nurseslabs.com/constipation/>