N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 4/18/22	**Patient Initials** KE	**Age** 35 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Stay at home mother	**Marital Status** Single, but dating the father of the baby	**Allergies** Codeine, Haldol
Code Status Full	**Height** 5’ 4” or 162.6 cm	**Weight** 189 lbs or 85.7 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G5T1P2A2L3

The patient has delivered two baby’s prior to this delivery. Her first daughter was born via induced vaginal delivery after a 12 hours long labor. The patients second daughter was breached so after a 12 hours labor she was born via C-section. The patient received prenatal care with this pregnancy.

Past Medical History: The patient has a history of bipolar disorder, depression, personality disorder, Herpes, and UTI’s.

Past Surgical History: The patient has a history of a C-section in 2009.

Family History: The patient has a family history of alcohol abuse in her father and depression in her mother.

Social History (tobacco/alcohol/drugs): The patient currently smokes 1 pack of cigarettes per day for as long as she can remember. It was also mentioned that she has used methamphetamine’s and marijuana. The patient does not drink alcohol.

Living Situation: The patient lives at home with her boyfriend, two daughters, and now her new baby.

Education Level: Some college was noted by the patient.

Admission Assessment

Chief Complaint (2 points): Scheduled C-section

Presentation to Labor & Delivery (10 points):

A 35 year old female was admitted to the hospital on 4/18 for her scheduled C-section.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled C-section

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	3.0-5.30 (10 (6) / mcL)	3.78 (10 (6)/mcL)	3.80 (10 (6)/mcL)	3.80 (10 (6)/mcL)	
Hgb	12.0-15.8 g/dL	11.8 g/dL	11.6 g/dL	11.6 g/dL	Fluid retention and inadequate nutrition can cause low hemoglobin, which is an expected finding during pregnancy (Pagana et al., 2021).
Hct	36.0-47.0%	33.6%	33.2%	33.2%	Fluid retention and inadequate nutrition can cause a low hematocrit which is an expected finding in pregnancy (Pagana et al., 2021).
Platelets	140-440 10 (3)/mcL	232 mcL	245 mcL	245 mcL	

WBC	4.00-12.00 10 (3)/mcL	10.60 mcL	11.30 mcL	11.30 mcL	
Neutrophils	47.0-73.0%	Not drawn	74.4%	74.4%	Bacterial infections and tissue trauma can be the primary causes of increased neutrophils (Pagana et al., 2021). This particular patient has a medical history of UTIs and has undergone a C-section that causes tissue trauma.
Lymphocytes	18.0-42.0%	Not drawn	14.8%	14.8%	Lower lymphocytes could indicate a decrease in immune system function, which prevents the mother from rejecting the fetus, which is common during pregnancy (Ricci et al., 2021).
Monocytes	4.0-12.0%	Not drawn	7.5%	7.5%	
Eosinophils	0.0-5.0%	Not drawn	2.7%	2.7%	
Bands	0-5%	Not drawn	Not drawn	Not drawn	

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, O	O	O	O	
Rh Factor	+,-	+	+	+	
Serology (RPR/VDRL)	Reactive, or non-reactive	Non-reactive	Non-reactive	Non-reactive	
Rubella Titer	Immune/not immune	Not drawn	Lab drawn, results not yet received	Lab drawn, results not yet received	
HIV	Detected/not detected	Not detected	Not detected	Not detected	
HbSAG	Detected/not detected	Not detected	Not detected	Not detected	

Group Beta Strep Swab	Positive/negative	Negative	Negative	Negative	
Glucose at 28 Weeks	65-140 mg/dL	124	124	124	
MSAFP (If Applicable)	N/A	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
N/A					
N/A					
N/A					
N/A					
N/A					
N/A					
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 mg/dL	N/A	N/A	N/A	

Lab Reference (1) (APA):

Pagana, K.D., Pagana, T. J., Pagana, T.N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed). Elsevier

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

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The patient came into the hospital for her cesarean, scheduled for 0800 on 4/18/22. The patient had not yet experienced contractions or ROM. The patient was taken back to the OR, where she received spinal anesthesia to ensure pain relief during the cesarean. The spinal pain management technique involves the injection of an anesthetic "caine" agent with or without opioids into the subarachnoid space, which provides pain relief for a woman during a cesarean or labor (Ricci et al., 2020). The next step involved the insertion of a Foley catheter to help eliminate any urine since the patient could no longer control or feel the need to urinate. The physician then performed the cesarean, which resulted in the birth of a baby boy at 0818, which started the third stage of labor. Once the baby was born, two nurses were in charge of taking care of the baby. According to the physician,

	the placenta was delivered at 0819, which then allowed the patient to enter into the fourth stage of labor. The mother was stitched back up and brought out of the OR to a room where she could rest. She was placed on Oxytocin for 30 units and Lactated Ringer's 125 mL/hr after birth to reduce the risk of bleeding and help the uterus contract. During this time following birth, the patient will feel varying degrees of pain or discomfort as her uterus contracts. The patient also received a sequential compression device on her legs to help prevent the formation of thromboembolism. At the time of assessment, the patient was only two hours post-delivery. **Stage 1:** The patient did not whole experience stage one of labor because it involves dilation from 0-10 centimeters. She did not have any contractions and was not dilated at the time of delivery. From the start time of the cesarean at 0800 to delivery, the first stage would technically be 18 minutes. **Stage 2:** The patient never got to 10 centimeters dilated due to a scheduled cesarean. The neonate was delivered at 0818, which is included in the second stage of labor. **Stage 3:** The patient was in the third stage of labor for one minute when the physician delivered the placenta at 0819. The

	third stage of labor consists of the newborn's birth and ends with the separation and birth of the placenta (Ricci et al., 2020). The stages of labor were not fully complete and happened very fast due to never dilating, contracting, and having a cesarean.
Current stage of labor	The patient is currently in the fourth stage of labor, which initiates the postpartum stage, as evidence by placental expulsion (Ricci et al., 2020). The fourth stage ends with the mother's initial physiologic adjustments and stabilization (Ricci et al., 2020). Lochia following birth should be bright red, mixed with small clots. The patient currently has bright red/Rubra lochia and a moderate flow. If there is a change in lochia color or smell, that could indicate an infection. Therefore, assessing lochia, documenting its color, and noting any smell is critical. Her vital signs are within normal limits, except for her pulse and blood pressure being elevated due to the pain she is experiencing. However, her blood pressure, pulse, and the gastrointestinal system should start returning to their peripartum states. Cardiac output and stroke volume should decrease after delivery for up to 2 weeks, demonstrating bradycardia (Ricci et al., 2020). Her uterus is firm, midline, and at the level of the umbilicus upon inspection. The uterus will slowly go back to its original location. It is critical to monitor vital signs, fundal, and lochia status every 15 minutes and document them (Ricci et al., 2020). The patient is

	currently receiving Q15 fundal checks to ensure no postpartum hemorrhage occurs. The main focus during this stage is to monitor the mother closely to prevent bladder distention, venous thrombosis, and hemorrhage (Ricci et al., 2020). The patient is experiencing some moderate pain in her head which is very common after receiving spinal anesthesia. Adverse reactions from spinal anesthesia include spinal headaches and hypotension (Ricci et al., 2020). Interventions for this are rest, ibuprofen, and a cool cloth on her forehead. Other areas that may be painful following birth involve either the C-section incision or the vagina. Since this patient did not give birth vaginally, she would not have any swollenness or pain in her vaginal area. However, she will experience pain around her incision since she underwent a major procedure. The following changes that the mother will go through involve emotional changes. Currently, the patient is experiencing the taking-in phase, which involves the time immediately following birth. During this phase, the patient needs sleep, relives the birth process, and depends on others to meet her needs (Ricci et al., 2020). This phase only lasts about 24 to 48 hours and is considered a passive phase. The next phase is called the taking-hold phase. This phase consists of dependent and independent maternal behavior (Ricci et al., 2020). This phase typically lasts several weeks and involves the mother's concern

	for her health and her new baby's. The last phase is the letting-go phase when the woman reestablishes relationships with other people (Ricci et al., 2020). This is typically when the mother starts to establish parenthood as a lifestyle. It is essential for the support person, significant other, or husband to have a smooth transition. The nurse's job is to help support the partner's transition to parenthood by keeping them informed (Ricci et al., 2020). A mother goes through many changes, both mentally and physically. Therefore, it is critical for her partner to be aware of her psychological status. Postpartum psychological changes could be baby blues, postpartum depression, or postpartum psychosis. The mother's support person should be educated on potential signs of postpartum depression. Postpartum depression can include a depressed mood, fatigue, anxiety, sleep difficulties, and concentration issues that ultimately interfere with the mother's parenting capacity (Kariuki, 2022). A physical assessment of this patient determined that she had a slightly elevated pulse and blood pressure due to pain. She had moderate bright red lochia. Her incision was doing good at the time of assessment with no drainage. She mentioned that she was hot. Therefore, the cold cloth helped also to bring down her temperature. She is experiencing the taking-in phase due to her concern for her needs and also talking about her birth experience.

Stage of Labor References (2) (APA):

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

Kariuki, E. W., Kuria, M. W., Were, F. N., & Ndetei, D. M. (2022). *Predictors of postnatal depression in the slums Nairobi, Kenya: a cross-sectional study. BMC Psychiatry*, *22* (1), 242. https://doi.org/10.1186/s12888-022-03885-4

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Iron (Ferrous Sulfate)	Pepcid (Famotidine)	N/A	N/A	N/A
Dose	325 mg	20 mg			
Frequency	BID	BID			
Route	Oral	Oral			
Classification	Hematinic	Histamine-2 blocker			
Mechanism of Action	Acts to normalize RBC production by the binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, an spleen.	Reduces HCL formation by preventing histamine from binding with h2 receptors on the surface of parietal cells. By doing so, the drug helps prevent peptic ulcers from forming ad helps heal existing ones.			
Reason Client	Anemia	Acid reflux			

Taking					
Contraindications (2)	Hemochromatosis and hemolytic anemias.	Hypersensitivity famotidine, other h2-receptogpr antagonists, or components. Stomach cancer.			
Side Effects/Adverse Reactions (2)	Dizziness and metallic taste.	Arrhythmias and anxiety.			
Nursing Considerations (2)	Give iron tablets or capsules with a full glass of juice or water. For maximum absorption, iron tablets should be given 1 hour before or 2 hours after meals.	Assess for abdominal pain and occult blood. May cause arrhythmias.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain a complete health history including allergies, drug history, possible drug reactions, history of peptic ulcer disease, or recent blood loss. Assess complete blood count, specifically hematocrit and hemoglobin levels, to establish baseline values.	Assess heart rate and sounds prior to administration. Report any rhythm disturbances.			
Client Teaching needs (2)	Instruct patient not to crush enteric-coated tablets or open capsules. Urge patient to eat chicken, fish, lean red meat, and turkey, as well as foods rich in	Instruct patient who also takes antacids to wait 30-60 minutes after taking famotidine, if possible, before taking antacid. Caution patient			

	vitamin C (such as citrus fruits and fresh vegetables) to improve iron absorption.	to avoid alcohol and smoking during famotidine therapy.			

Hospital Medications (5 required)

Brand/Generic	Toradol (Ketorolac)	Pitocin (Oxytocin)	Zofran (Ondansetron)	Prenatal Vitamin (Ferrous fumarate)	Lactated Ringer's
Dose	30 mg	30 units	4 mg	27-1 mg	125 mL/hr
Frequency	Q6	Continuous	Q6 PRN	1 tab daily	Continuous
Route	IV	IV	IV	PO	IV
Classification	NSAID (pyrrolo-pyrrole)	Oxytocin Agents	Selective serotonin (5-HT3), receptor antagonist. Antiemetic	Multivitamin	Alkalinizing agent
Mechanism of Action	The primary mechanism of action is the inhibition of prostaglandin synthesis by competitive blocking of the enzyme cyclooxygenase (COX)	The two main actions of oxytocin in the body are contraction of the womb (uterus) during childbirth and lactation. Oxytocin	Blocks serotonin receptors centrally at the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces	They help promote the development of the baby's teeth and bones.	It restores fluids and electrolyte balances, produces diuresis, and acts as alkalizing agent (reduces acidity).

		stimulates the uterine muscles to contract and also increases production of prostaglandins, which increase the contractions further.	nausea and vomiting by preventing serotonin release to the small intestine and by blocking signals to the CNS.		
Reason Client Taking	Pain relief	To contract the uterus and prevent excess bleeding post-birth	To prevent nausea and vomiting.	Pregnancy to help prevent potential complications such as neural tube defects.	Fluids post cesarean birth along with Oxytocin. They run at the same time.
Contraindications (2)	Systemic mastocytosis, anemia	Do not administer if a vaginal delivery is not optimal and do no administer is the uterus is already hyperactive.	Concomitant use of apomorphine and congenital long QT syndrome.	Iron metabolism disorder causing increased iron storage. An overload of iron in the blood.	It is contraindicated where the administration of sodium, potassium, calcium, chloride or lactate could be clinically detrimental. Contraindicated in severe metabolic acidosis or alkalosis.
Side Effects/Adverse Reactions (2)	Upset stomach and nausea	Anaphylaxis, and convulsions	Hypotension and serotonin syndrome.	Nausea, and constipation.	Hives, itching.
Nursing Considerations (2)	May cause GI bleeding. Stevens-Johnson Syndrome.	Report seizure or coma-like responses. Closely	If hypokalemia or hypomagnesemia is present,	Avoid taking antacids, dairy products,	May worsen existing hypovolemia and hypotension

		monitor fundal tone, fundal height, and position, vital signs an bleeding.	these electrolyte imbalances should be corrected before mediation is administered. Monitor closely for serotonin syndrome, which may include agitation, chills, confusion, diaphoresis, diarrhea, fever, hyperactive reflexes, etc.	coffee, tea within 2 hours prior to and after taking. Do not lie down for at least 10 minutes after taking medication .	causing cardiovascular collapse. Monitor for signs of fluid volume deficit, such as confusion.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor signs of GI bleeding, including abdominal pain, vomiting blood, blood in stools or black, tarry stools. Correct hypovolemia prior to administration.	Monitor maternal status including blood pressure, and pulse. Monitor fluid balance.	Access dizziness and drowsiness that might affect gait, balance, and other functional activities.	Check iron levels.	Assess blood glucose levels prior to and frequently after administrating.
Client Teaching needs (2)	This medication may make you drowsy or dizzy. Report immediately if blood in	Instruct the patient to pay attention to the fluid restrictions put in place while on	Advise patient to immediately report signs of hypersensitivity, such as rash. Reassure patient with	This is best taken on an empty stomach one hour before or two hours after a	Teach patient on why you are giving them fluids. Teach them to report any changes that

	urine, easy bruising, itching, rash, swelling, or yellow eyes or skin.	oxytocin due to the risks that come along with drinking too much while on the medication. Lastly, as with any medication the patient should always express any details that may be pertinent such as allergies or past medical history.	transient blondness that it will resolve within a few minutes to 48 hours.	meal. Take with a full 8 oz glass of water.	may indicate a change in blood sugar.

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** Alert **Orientation:** Oriented x4 (person, place, time and situation). **Distress:** Mild distress, overall not in serious distress. **Overall appearance:** Appropriately groomed, hair is clean. Overall appropriate appearance.	The patient is in mild distress following her C-section which is expected. Her main concern is her headache which interventions are being done to ease that.
INTEGUMENTARY (1 points): **Skin color:** Appropriate for ethnicity **Character:** Dry, warm, and intact	The patients incision was very fresh at the time of this assessment.

Temperature: Warm **Turgor:** Proper skin turgor, less than 3 second rebound. **Rashes:** None were noticed **Bruises:** None were noticed **Wounds/Incision:** Low-transverse C-section with no erythema or drainage. **Braden Score:** 16 **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck:** Symmetrical, trachea is midline with no deviation. Thyroid is nonpalpable. **Ears:** Intact, symmetrical, no drainage or lesions. **Eyes:** Bilateral PERLLA, intact EOMs bilaterally, sclera is white and conjunctiva is pink. **Nose:** No discharge or lesions present. **Teeth:** Throat is pink, moist, and no lesions present. Tonsils are 1+, and teeth look good.	.
CARDIOVASCULAR (2 point): **Heart sounds:** Clear S1 and S2 sounds **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** No audible murmur, gallops, or rubs noted. **Peripheral Pulses:** Pulses are 2+ bilaterally. **Capillary refill:** Capillary refill less than 3 seconds, no edema palpated or inspected in legs or arms. **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:** Breath sounds are even, nonlabored. There were no crackles, wheezes, or rhonchi noted.	.
GASTROINTESTINAL (2 points): **Diet at Home:** Regular **Current Diet:** Regular	.

Height: 162.6 cm **Weight:** 85.7 kg **Auscultation Bowel sounds:** Active bowel sounds in all four quadrants. **Last BM:** Yesterday evening (4/17) **Palpation: Pain, Mass etc.:** Abdomen is soft and nontender upon palpation. No masses found. **Inspection:** Appropriate upon inspection. **Distention:** None found. **Incisions:** Low transverse C-section incision. **Scars:** Patient had barely noticeable scar from previous C-section, after this C-section it was covered by the new incision. **Drains:** None. **Wounds:** None	
GENITOURINARY (2 Points): **Quantity of urine:** 500 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** No rashes or lesions. **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient did receive a catheter prior to the C-section, but had it removed after.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 45 **Activity/Mobility Status:** Patient is currently in the bed postop. **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patient should no longer be a fall risk once her spinal block is no longer working. Early ambulation and help moving around the first couple of times would be beneficial.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☒** **Orientation:** Oriented to person, place, time, and situation (x4). **Mental Status:** Appropriate and alert. **Speech:** Clear **Sensory:** No deficits were found.	.

LOC: N/A **DTRs:** 2+ reflexes.	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** Patient stated "I just deal with it". **Developmental level:** Appropriate for age, no deficits noted. **Religion & what it means to pt.:** Does not go to church, but believes in God according to the patient. **Personal/Family Data (Think about home environment, family structure, and available family support):** Home environment is good, has support from boyfriend and mother according to the patient.	
Reproductive: (2 points) **Fundal Height & Position:** Firm, midline, at the level of the umbilicus. **Bleeding amount:** Moderate **Lochia Color:** Bright red since the assessment I did was immediately after the birth. **Character:** Normal **Episiotomy/Lacerations:** None, patient had a Cesarean birth.	
DELIVERY INFO: (1 point) **Rupture of Membranes:** The physician announced that she ruptured the amniotic sac at 0817 but did not specify color, amount, or odor. **Time:** 0817 **Color:** N/A **Amount:** N/A **Odor:** N/A **Delivery Date:** 4/18/22 **Time:** 0818 **Type (vaginal/cesarean):** Cesarean **Quantitative Blood Loss:** 600 mL **Male or Female:** Male **Apgars:** 9, 9 **Weight:** 7 lbs, 4 oz **Feeding Method:** Formula (Bottle feeding)	The patient did not go into labor naturally or deliver vaginally. Therefore, the was no opportunity for her membranes to be ruptured independently or artificially.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	93	119/66	18	98 ˚F	98%
Labor/Delivery	85	117/63	16	97.9 ˚F	100%
Postpartum	105	124/89	20	97.6 ˚F	100%

Vital Sign Trends:

The patient's vital signs stayed consistent throughout pregnancy and delivery. However, after delivery, the patient was experiencing pain and nausea. Therefore, her pulse and blood pressure were slightly elevated. Overall, the vital signs were in the normal range minus the slight increase in pulse and blood pressure due to the pain she was experiencing.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0740	Verbal 0/10	None	Did not have any pain to experience this	Denied pain	Non needed at this time
1044	Verbal 5/10	Head due to intense headache	More discomfort than pain. Not too severe.	Dull, persistent headache	Place a cool towel on the patient's head to help her headache and lower her complaint of being too hot. The patient could also request a mild pain reliever.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** metacarpal vein, left **Date on IV:** 4/18/22 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of drainage, erythema, or any irritation. **IV dressing assessment:** Clean, dry, and intact	Lactated Ringer's and Oxytocin

Intake and Output (2 points)

Intake	Output (in mL)
1,000 mL IV	500 mL urine, 600 mL blood

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.
Put a cold towel on patients forehead due to temperature and headache (N)	PRN	The intervention was provided to help ease the patient's discomfort that she was experiencing post-C-section. She mentioned she felt hot, as well as having a headache. Therefore, providing a cool towel would help cool her down and provide slight ease to her headache.
Administer Zofran for nausea (T)	Q6 hours	Nausea and vomiting are both uncomfortable for the patient and put her at risk for pressure on her C-section scar, dehydrating, and not getting enough nutrition due to not keeping food down. Food and hydration are essential in the healing of her incision.
Fundal assessments (N)	Q15 minutes	Fundal assessments are a critical nursing intervention because they can identify potential problems such as postpartum

		hemorrhage. Massaging and assessing the fundus is essential. The fundus should be smooth, firm, and midline.
Administer Oxytocin (T)	Continuous	Oxytocin administration is an essential medication routinely administered because it helps the uterus contract and reduces blood loss.

Phases of Maternal Adaptation to Parenthood (3 point)

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

What evidence supports this? The mother is in the first 24-48 hours following birth. She is exhibiting a reliance on others for assistance and is talkative about her birth experience and her feelings post-delivery.

Discharge Planning (3 points)

Discharge location: Patient will be going home to her house with her boyfriend and now three children.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): Follow up in 24-48 hours, 2 weeks, and 6 weeks with physician.

Education needs: The patient has had previous children as well as a C-section before. However, vital information would be helpful in case the patient forgot since her last child was born in 2009. Explaining the care of her incision and restrictions such as not carrying over 10 pounds. Adequate rest, identifying signs and symptoms of infection, and activity restrictions such as lifting are key teaching points to cover prior to discharge (Ricci et al., 2020). Wound infections tend to manifest once the woman is discharged due to the infection taking time to occur. Signs of postpartum infection to look out for are an elevated temperature, pain, chills, general malaise,

increased pulse, malodorous lochia, or abdominal pain (Ricci et al., 2020). Teaching the patient what to look for and how to care for herself post-cesarean birth is essential for nursing care.

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 each of the rationales.	**Evaluation (2 pt each)** How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to Cesarean section as evidence by patient rating pain 5/10 and complaining of a persistent headache.	The top priority is to manage the patient's pain. Comfortability is essential in the plan of care for patients. Pain can cause an increase in vital signs and can make their situation more challenging. Getting the patient's pain under control is essential.	**1.**Provide a pain reliver such as ibuprofen or another non-opioid analgesic. **Rationale** There are two types of pain a woman experiences during birth, both visceral and somatic (Ricci et al., 2020). It is essential to ask the woman to rate her pain because pain fluctuates and is subjective. Administering analgesics as ordered or other forms of pain relief may be needed to provide comfort. These non-opioid analgesics help treat mild to moderate pain such as headaches (Ricci et al., 2020).	The patient responded well to the interventions to control her discomfort post-C-section. The client stated that she felt cooled down, and most importantly, her headache had subsided. There were no modifications needed. The interventions occurred PRN (every 4-6 hours for ibuprofen) until the patient was comfortable.

		2.Provide a cool towel to the patient's forehead using cold water to dampen it. **Rationale** Nonpharmacological methods are often utilized first to help ease any discomfort. It is vital to monitor comfort measures to ensure their efficacy (Ricci et al., 2020).	
2. Risk for deficit fluid volume related to the patient having nausea as evidence by the patient vomiting multiple times throughout Cesarean.	This nursing diagnosis was chosen due to the potential issues that could come along with nausea and vomiting. The patient needs to keep fluids and food down to promote proper healing and gain her energy back to care for her new baby.	**1.** Administer Zofran to help reduce nausea. **Rationale** Zofran is an antiemetic that can be used postoperative to prevent nausea and vomiting (Hinkle & Cheever, 2018). The nurse should intervene when the patient first reports nausea to control the problem before it progresses to vomiting (Hinkle & Cheever, 2018). **2.**Monitor patients ability to hold down food and fluids. **Rationale** Monitoring a patient's I&O includes the amount of fluid taken orally or parenterally, the volume of urine excreted, and other fluid losses such as vomiting, diarrhea, and diaphoresis (Hinkle & Cheever, 2018). These factors play into the amount of daily fluid allowance and determine fluid excess or deficit	The patient responded very well to the Zofran, which is an antiemetic. The patient's nausea subsided, and she no longer was vomiting. This allowed her to feel more comfortable and allowed her to get some nutrients from food. Since the patient is no longer vomiting, the interventions worked, and she is no longer at risk for deficit fluid volume.

		(Hinkle & Cheever, 2018). Therefore, monitoring the patient's ability to hold down fluids and food without vomiting is critical in the potential interventions needed for fluid deficits if vomiting continues.	
3. Risk for venous thromboembolism related to surgical procedures and immobility as evidence by the patient having a Cesarean birth and spending a lot of time in bed.	The main concern for any surgery is a blood clot. Therefore, since the patient had a Cesarean birth, she is at an increased risk for thromboembolism due to immobility and painful procedure..	**1.** Early ambulation after delivery. **Rationale** Encouraging the patient to ambulate to promote venous return from the extremities is critical (Ricci et al., 2020). Turning side to side in bed can also help to improve circulation (Ricci et al., 2020). Circulation and movement are critical for thromboembolism prevention. **2.** Utilize sequential Compression devices (SCD) in the beginning, and compression stockings throughout the healing process. **Rationale** Sequential compression devices produce passive leg muscle contractions until the woman can ambulate (Ricci et al., 2020). Compression stockings usually are applied once the patient has ambulated and no longer needs the sequential compression device. Apply compression stockings and remove them daily to	The patient was hesitant to get out of bed after her C-section. Once it was explained why it was necessary, the patient could get out of bed with assistance. When the patient was in bed, she utilized sequential compression devices. Overall, the interventions helped prevent the patient from developing any venous thromboembolism. The patient responded well to the interventions after the first attempt to get out of bed. Her boyfriend was also supportive in helping her move around.

		inspect the legs (Ricci et al., 2020). Inspection should always be a factor for both the nurse and the patient. If there is swelling, redness, warmth, erythema, or any other concerning changes, further investigation and proper interventions will be promptly needed.	
4. Knowledge deficit related to post Cesarean care as evidence by the amount of years it has been since her last Cesarean.	Teaching our patients should always be in their plan of care. Since the patient has not had a baby in 13 years, she may need some vital information. This is especially true for her understanding of her limitations and how to care for herself post-Cesarean section once she leaves the hospital.	**1.** Teach the patient about potential restrictions such as lifting anything over 10 pounds. **Rationale** Lifting any weight over 10 pounds can put the patient at risk of compromising their incision. Educating the patient on the weight lifting restrictions is critical (Ricci et al., 2020). **2.** Educate the patient on how to care for her incision. **Rationale** Education on how the patient should care for herself outside of the hospital is essential. A nurse should provide information about postpartum care at home upon discharge (Ricci et al., 2020).	The patient responded well to the information provided regarding her post-Cesarean care. She mentioned that she had forgotten what she could and could not do. The teaching was effective because she was able to repeat what was taught to her and ask questions. The patient's boyfriend also listened to the teaching, which was beneficial for her support.

Other References (APA)

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.