

N432 Postpartum Care Plan  
Lakeview College of Nursing  
Marianna Craighead  
6/10/22

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 06/09/22 & 0700	<b>Patient Initials</b> JW	<b>Age</b> 33	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>occupation</b> NA	<b>Marital Status</b> Married	<b>Allergies</b> KNA
<b>Code Status</b> Full	<b>Height</b> 67 inches	<b>Weight</b> 290lbs	<b>Father of Baby Involved</b> Yes

**Medical History (5 Points)**

**Prenatal History:** G-3, T-3, P-0, A-0, L-3, No previous complications with previous pregnancies, all children of previous pregnancies are alive and healthy

**Past Medical History:** Depression, Gestational Diabetes, Polycystic Ovary Syndrome,

**Past Surgical History:** Previous C-section x2

**Family History:** Maternal grandmother diabetic, Maternal grandfather diabetic, Paternal grandmother cancer, Paternal grandfather MI

**Social History (tobacco/alcohol/drugs):** ½ pack of cigarettes a day since she was 18

**Living Situation:** Lives at home with husband and two other children

**Education Level:** Highschool

**Admission Assessment**

**Chief Complaint (2 points):** Scheduled C-section

**Presentation to Labor & Delivery (10 points):** Scheduled for C-section due to gestational diabetes

**Diagnosis**

**Primary Diagnosis on Admission (2 points):** Pregnancy

**Secondary Diagnosis (if applicable):** .NA

**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	4.45	4.52	NA	NA
Hgb	12.1-15.8	12.3	12.3	NA	NA
Hct	36-47	36.3	36.3	NA	NA
Platelets	140-440	291	291	NA	NA
WBC	4-12	8.90	8.95	NA	NA
Neutrophils	47-73	73	68.4	NA	NA
Lymphocytes	18-42	18.2	22.6	NA	NA
Monocytes	4-12	7.7	7.7	NA	NA
Eosinophils	NA	NA	NA	NA	NA
Bands	NA	NA	NA	NA	NA

**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	NA
Rh Factor	Positive or Negative	Positive	Positive	Positive	NA
Serology (RPR/VDRL)	Negative	Negative	Negative	NA	NA
Rubella Titer	Immunity	Immunity	Immunity	NA	NA
HIV	Negative	Negative	Negative	NA	NA
HbSAG	Negative	Negative	Negative	NA	NA
Group Beta Strep Swab	Negative	Negative	Negative	NA	NA
Glucose at 28 Weeks	70-99	160	115	91	Client is obese and has family history of diabetes
MSAFP (If	NA	NA	NA	NA	NA

Applicable)					
-------------	--	--	--	--	--

**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
Chlamydia	Negative	Positive	Negative	NA	Practiced unsafe sex
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA

**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)	NA	NA	NA	NA	NA

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

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Capriotti, T. (2020). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

	<b>Your Assessment</b>
<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>C-section took approximately 1 hour and 33 minutes</p> <p>NA</p> <p>NA</p>
<p><b>The current stage of labor</b></p>	<p>NA</p>

**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* (11<sup>th</sup> 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)**

<b>Brand/Generic</b>	Zoloft Sertraline	Desyrel Trazodone	Humalog Insulin Lispro	N A	N A
<b>Dose</b>	100 mg	50 mg	10 units	N A	N A
<b>Frequency</b>	Daily	Q hs	BID	N A	N A
<b>Route</b>	PO	PO	Sub-Q	N A	N A
<b>Classification</b>	Antidepressant	Antidepressant	Antidiabetic	N A	N A
<b>Mechanism of Action</b>	SSRI	Serotonin uptake inhibitor	cellular uptake of glucose	N A	N A
<b>Reason Client Taking</b>	Depression	Depression	-Gestational Diabetes	N A	N A
<b>Contraindications (2)</b>	-bipolar disorder -Chronic Kidney disease	-MAO taken in last 14 days -Chronic kidney disease	-Chronic Kidney disease -Hypokalemia	N A	N A
<b>Side Effects/Adverse Reactions (2)</b>	-Nausea -loss of appetite	-Tachycardia -Drowsiness	-Hypoglycemia -Weight gain	N A	N A
<b>Nursing Considerations (2)</b>	-Assess for suicide -Monitor for fluid imbalance	-Monitor pulse -Monitor for signs of bleeding	-Room temperature injection -Rotate sites	N A	N A
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess mood	Assess mood	-Blood Glucose level	N A	N A
<b>Client Teaching needs (2)</b>	-Do not breastfeed while taking -Report any GI	-May take 1 week to affect -Avoid Alcohol	-Rotate injection site -Check Blood	N A	N A

	upsets		sugar before injection		
--	--------	--	------------------------	--	--

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Zithromax Azithromycin	Exparel Bupivacaine	Duramorph Morphine	NA	NA
<b>Dose</b>	500 mg	7.5% 2mL	300 mcg	NA	NA
<b>Frequency</b>	250/mL per hr.	Once	Once	NA	NA
<b>Route</b>	IV	IV	IV	NA	NA
<b>Classification</b>	Antibiotic	Sodium Channel blocker	Opioid	NA	NA
<b>Mechanism of Action</b>	Destruction of bacteria	Local anesthetic	Pain blocker	NA	NA
<b>Reason Client Taking</b>	Chlamydia positive	C-section	C-section	NA	NA
<b>Contraindications (2)</b>	-liver disease -hypokalemia	-Hypersensitivity -Chronic kidney disease	-Bronchial asthma -MAOI use within 14 days	NA	NA
<b>Side Effects/Adverse Reactions (2)</b>	-diarrhea -nausea	-Anginal pain -Bradycardia	-Respiratory depression -Nausea	NA	NA
<b>Nursing Considerations (2)</b>	-Take antacids 2 hrs. before or after -monitor for loose stools	-Monitor for increased BP -Monitor CNS	-Monitor respiratory rate -Monitor level of consciousness	NA	NA
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Liver function	Location of vertebrae disc	LOC	NA	NA
<b>Client Teaching needs (2)</b>	-Do not breast -Report Diarrhea	-May not feel lower extremities for 2-3 hrs. -Ask for assistance when standing	-Ask for assistance if drowsiness occurs -Report pain	NA	NA

**Medications Reference (1) (APA):**

Jones & Bartlett Learning. (2021). *2021 Nurse’s Drug Handbook* (20th ed.). Jones & Bartlett Learning

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b> Alert  <b>Orientation:</b> x4  <b>Distress:</b> No  <b>Overall appearance:</b> Appears to be relaxed</p>	<p>The client is a 33-year-old female. The client is responding to questions asked by the nurse. The client is interacting appropriately with the baby. The client shows no signs of distress.</p>
<p><b>INTEGUMENTARY (1 points):</b>  <b>Skin color:</b> Pink  <b>Character:</b> Dry  <b>Temperature:</b> Warm to touch  <b>Turgor:</b> Less than 3 seconds  <b>Rashes:</b> NA  <b>Bruises:</b> NA  <b>Wounds/Incision:</b> Abdominal Incision.  <b>Braden Score:</b> 22  <b>Drains present:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Type:</b> Prevena</p>	<p>Skin is warm and dry upon palpation. Skin turgor is less than two seconds, normal mobility. Nails are without clubbing. There are no rashes upon inspection. The client’s capillary refill is less than 3 seconds between fingers and toes bilaterally. Client Prevena is covering the abdominal incision. Prevena needs to be reinforced to create a proper seal over the incision.</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b> Skull is normocephalic. Thin hair. Trachea midline.  <b>Ears:</b> WNL  <b>Eyes:</b> WNL  <b>Nose:</b> WNL  <b>Teeth:</b> Dentation is good</p>	<p>The client’s head and neck are symmetrical. The trachea is midline and there are non-palpable lymph nodes and lobes. The uvula is midline and tonsil size 2+. There is acuity to regular voices. There is no visible abnormality of ears or palpable deformities. The sclera is white bilaterally. The client’s cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. The client does not wear glasses. Their EOMs are intact b/l and PERRLA b/l. The client’s septum is midline.</p>
<p><b>CARDIOVASCULAR (2 point):</b>  <b>Heart sounds:</b> S1 and S2 present  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b> Regular  <b>Peripheral Pulses:</b> 2+ bilaterally  <b>Capillary refill:</b> less than 3 seconds  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Location of Edema:</b> Bilateral feet 1+</p>	<p>Upon auscultation, there are clear S1 and S2 without murmurs. The client’s PMI is palpable in the 5th intercostal space at the MCL. There is a normal rate and rhythm. The client’s pulses are 2+ b/l. Their capillary refill is less than 3 seconds between fingers and toes b/l. Edema is located in the feet at a 1+.</p>

<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>The anterior and posterior breath sounds are clear bilaterally throughout. The client states she smokes about a ½ pack of cigarettes a day.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at Home:</b> Regular  <b>Current Diet:</b> Regular  <b>Height:</b> 5’7”  <b>Weight:</b> 290lbs  <b>Auscultation Bowel sounds:</b> active x4  <b>Last BM:</b> 6/9/22  <b>Palpation: Pain, Mass etc.:</b> No abnormalities  <b>Inspection:</b>  <b>Distention:</b> None  <b>Incisions:</b> C-section  <b>Scars:</b> None  <b>Drains:</b> Prevena  <b>Wounds:</b> None</p>	<p>Upon inspection, the client’s abdomen was round. There are active and normal bowel sounds and no tenderness after palpation of all four quadrants.</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Quantity of urine:</b> 574mL  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b> No abnormalities  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p>The client voided straw yellow urine of 574 mL. The client reports no pain with urination and there is no discharge upon inspection. There were no sores located on the genitals.</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> 0  <b>Activity/Mobility Status:</b> Independent  <b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>The client shows no signs of muscular atrophy in The limbs. The client’s arm muscle strength is rated at a 5/5 and their leg muscle strength is rated at a 5/5. Client’s fall risk score is zero and has no complaints about the musculoskeletal system at this time.</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"/> <b>if no -</b>  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b> x4  <b>Mental Status:</b> WNL  <b>Speech:</b> Coherent speech  <b>Sensory:</b> Intact  <b>LOC:</b> None</p>	<p>The patient is alert and relaxed. The client is oriented x4; to person, place, time, and situation. The client presents with coherent speech, and their senses are intact. Upon assessment, PERRLA b/l. The client’s strength is equal throughout. The client performed pedal pushes and hand grips with ease.</p>

<b>DTRs:</b> 2+ b/l throughout	
<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>	The client is alert and oriented x4 (to person, place, time, and situation). Thought processes are coherent and memory is intact. The client is diagnosed with depression. The client currently does not have any issue with depression. The client is compliant with medications.
<b>Reproductive: (2 points)</b> <b>Fundal Height &amp; Position:</b> Midline 1cm below the umbilicus <b>Bleeding amount:</b> scant <b>Lochia Color:</b> ruba <b>Character:</b> Thin <b>Episiotomy/Lacerations:</b> NA	Fundal height and position is midline 1 cm below the umbilicus. The client's bleeding is can't and ruba in color. The client denies passing any clots at this time.
<b>DELIVERY INFO: (1 point)</b> <b>Rupture of Membranes:</b> NA <b>Time:</b> NA <b>Color:</b> NA <b>Amount:</b> NA <b>Odor:</b> NA <b>Delivery Date:</b> 6/9/22 <b>Time:</b> 0903 <b>Type (vaginal/cesarean):</b> Cesarean <b>Quantitative Blood Loss:</b> 750mL <b>Male or Female:</b> Male <b>Apgars:</b> 10 <b>Weight:</b> 6lbs 7.4oz <b>Feeding Method:</b> Bottle	The client had a cesarean and lost approximately 750mL of blood. The client had a baby boy who weighs 6lbs 7.4oz. The baby will be bottle feed due to the medication that the client is currently taking for depression.

**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>	88	138/88	18	97.9	97
<b>Labor/Delivery</b>	85	104/65	26	98.2	95
<b>Postpartum</b>	80	118/66	20	98	98

**Vital Sign Trends:** The client's vital signs are stable

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

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
1100	1-10	NA	0	NA	NA
1300	1-10	NA	0	NA	NA

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> NA <b>Location of IV:</b> NA <b>Date on IV:</b> NA <b>Patency of IV:</b> NA <b>Signs of erythema, drainage, etc.:</b> NA <b>IV dressing assessment:</b> NA	NA

**Intake and Output (2 points)**

<b>Intake</b>	<b>Output (in mL)</b>
550mL	574mL

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

<b>Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them,</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a short rationale.</b>

<b>Identify medical treatments with “T” after you list them.)</b>		
Fundal massage (T)	Ordered to be done q4hrs	This is performed to make sure that the uterus is contracting down. Also done to prevent hemorrhaging of the mother.
Assess the mother’s ability to learn new information (N)	After the information is given about care	This is done to be able to determine if the mother understood the said given information. If the information was not understood the information should be retaught in a way that the mother would understand the information.
Labs such as a CBC and CMP(T)	To be completed before discharge	This is done to make sure that the mother isn’t hemorrhaging any and also to make sure that the electrolytes are stable.
Assess for mastitis (N)	To be done q4hrs when assessing the mother	This is done because the mother is not breastfeeding and is at increased risk for mastitis. As a nurse, if this occurs we will help her be able to elevate some of the pain.

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

**What phase is the mother in?** Taking hold

**What evidence supports this?** Mom is engaging with the baby well. Mom has also talked about how other children will interact with her new baby.

**Discharge Planning (3 points)**

**Discharge location:** Home

**Equipment needs (if applicable):** NA

**Follow up plan (include plan for mother AND newborn):** Follow up with provider as ordered. The patient has not had an appointment set up yet with the provider.

**Education needs:** Healthy eating to reduce the risk of gestational diabetes turning into type 2, weight loss to reduce the risk of gestational diabetes turning into type 2, and smoking around the child.

**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	Rational	Intervention/Rational (2	Evaluation
-------------------	----------	--------------------------	------------

<p><b>(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>(1 pt each)</b> Explain why the nursing diagnosis was chosen</p>	<p><b>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 each of the rationales.</p>	<p><b>(2 pt each)</b> How did the patient/family respond to the nurse’s actions?  <ul style="list-style-type: none"> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul> </p>
<p>At risk for postpartum depression episodes related to mental health as evidenced by the diagnosis of depression</p>	<p>The client is diagnosed with depression</p>	<p><b>1. Zoloft</b> <b>Rationale:</b> Antidepressant (Phelps, L.L. (2020))  <b>2. Trazadone</b> <b>Rationale:</b> Antidepressant (Phelps, L.L. (2020))</p>	<p>The client agrees to continue to take medication as ordered to reduce the risk of postpartum depression. The client also states she will report any signs of depression.</p>
<p>At risk for infection related to decreased invasive procedure as evidenced by c-section</p>	<p>The client had a c-section</p>	<p><b>1. Prevena</b> <b>Rationale</b> to decrease the amount of drainage (Phelps, L.L. (2020))  <b>2..Monitor vital signs</b> <b>Rationale</b> an acute change in vital signs can be a sign of infection (Phelps, L.L. (2020))</p>	<p>The client understands the reasoning behind the doctor ordering Prevena. The client also states that she will report signs of not feeling well.</p>
<p>At risk for acute pain related to tissue damage as evidenced by an invasive procedure.</p>	<p>The client had a c-section.</p>	<p><b>1. Abdominal binder</b> <b>Rationale</b> For muscle support (Phelps, L.L. (2020))  <b>2. Perform pain assessment</b> <b>Rationale</b> Allow for the pain to be managed when it occurs (Phelps, L.L. (2020))</p>	<p>The client understands that if pain occurs report it to the nurse immediately.</p>
<p>At risk for anxiety related to uncertainty as evidenced by a new child into the family.</p>	<p>This was chosen because a new baby can cause stress to a family.</p>	<p><b>1. Encourage the client to recognize feelings of anxiety</b> <b>Rationale</b> This will allow the client to be able to solve the anxiety problems (Phelps, L.L. (2020))  <b>2. Have the patient report signs of restlessness, irritability and tachycardia</b></p>	<p>The client is willing to verbalize if they feel anxious. The client also understands the reason behind reporting symptoms to help prevent anxiety.</p>

		<b>Rationale</b> This may be sign of postpartum hemorrhage (Phelps, L.L. (2020))	
--	--	--	--

**Other References (APA):**

Phelps, L.L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th ed.).

Wolters Kluwer.