N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 06/09/2022	**Patient Initials** G.S.	**Age** 07/16/1990	**Gender** F
Race/Ethnicity Hispanic	**Occupation** Secretary	**Marital Status** Married	**Allergies** Cat dander, dust, and mold
Code Status Full code	**Height** 5'3	**Weight** 63.5 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G- 1 P- 0 T-1 A-0 L-1 The client tested positive for Group Beta strep and did receive ampicillin during labor. The patient gave birth spontaneous through the vaginal canal.

Past Medical History: Asthma, premature born at 28 weeks, and anxiety.

Past Surgical History: N/A

Family History: Father has arthritis and mother has thyroid problems and multiple sclerosis.

Social History (tobacco/alcohol/drugs): The patient denies any history of tobacco, alcohol or drug use.

Living Situation: The patient lives at home with her husband.

Education Level: The patient has a high school degree.

Admission Assessment

Chief Complaint (2 points): The patient presented with strong contractions

Presentation to Labor & Delivery (10 points): The patient is a 31- year- old female who came to the hospital on 06/09/2022 for abdominal contractions. The client made 40 weeks' gestation on 06/10/2022. The client was in the latent phase when arriving at the hospital. The client

membrane was rupture by the physician on 06/09/10 and the fluid was clear, no odor and there was a moderate amount. The patient delivered her baby girl at 0345 on 06/10/2022 and the placental at 0354. The client requested for an epidural before shortly giving birth. The patient tested positive for group beta strep (GBS) and received three doses of ampicillin during labor.

Diagnosis

Primary Diagnosis on Admission (2 points): Spontaneous 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	4.2-5.4	7.24	4.41	3.38	Normal decreases are seen with pregnancy due to normal body fluids increase and a decrease in red blood cells (Pagana et al., 2021). The client also lost 420 ml of blood during delivery.
Hgb	12.0-16	11.9	13.1	9.9	Decreased levels are related to blood volume loss during pregnancy (Pagana et al., 2021).
Hct	36.0-47.0	36.4	39.5	30.2	Hemodilution can cause decreased levels during pregnancy (Pagana et al., 2021).
Platelets	140-440	259	257	216	
WBC	5.00-10.00	7.24	10.54	16.48	Labor can cause an increase in white blood cells (Pagana et al, 2021). The client also

					tested positive for GBS which can increase white blood cells.
Neutrophils	47.0-73.0	n/a	n/a	n/a	n/a
Lymphocytes	18.0-42.0	n/a	20.7	7.0	n/a
Monocytes	4.0-12.0	n/a	7.8	5.8	n/a
Eosinophils	0.0-5.0	n/a	1.3	0.3	n/a
Bands	0.0-10.0	n/a	n/a	n/a	n/a

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, O, AB	A+	A+	A+	n/a
Rh Factor	(+), (-)	-	-	-	n/a
Serology (RPR/VDRL)	Nonreactive	Negative	Negative	Negative	n/a
Rubella Titer	Immune or Non-immune	Immune	Immune	Immune	n/a
HIV	(-), (+)	-	-	-	n/a
HbSAG	(-), (+)	n/a	n/a	n/a	n/a
Group Beta Strep Swab	(-), (+)	+	+	+	GBS is present in the client's body and was given antibiotics during labor. This will prevent infection in the newborn. The patient was given ampicillin.
Glucose at 28 Weeks	< 140	98	98	98	n/a
MSAFP (If Applicable)	0.5-2.0	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
Covid test	Negative or positive	Negative	Negative	Negative	n/a

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	< 0.2	n/a	n/a	n/a	n/a

Lab Reference (1) (APA):

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

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 had a spontaneous vaginal delivery that lasted 13 hours and 46 minutes. I could not find data on how long the first stage of labor lasted, but the second stage lasted 2 hours and 55 minutes. I could not see how long the third or fourth stage of work lasted.
Current stage of labor	The patient is in the fourth stage of labor, the postpartum stage. The patient delivered her baby girl at 03:45 with some major lacerations of the vagina. The patient had lacerations described as "W" that ripped into her muscle of the vaginal wall. The patient had second-degree lacerations. The patient received an epidural while in labor due to the intense pain. The patient had to get straight catheter until she regained sensation in her legs. She eventually voided 300 ml of urine on her own. She seemed slightly fatigued but was very active with her newborn. The patient denied having any pain when the nurse did the assessment. The fundus was 1 cm above the umbilicus until she voided, and it was at the level of the umbilicus. The fundus should be at the level of the umbilicus or below the umbilicus (Ricci et al., 2020). The client's calves were warm to the touch,

	and there were no signs of tenderness, although some slight swelling. During the postpartum stage, women have a high risk of developing deep vein thrombosis (Ricci et al., 2020). The patient's assessment was normal, and her vital signs are stable and within normal limits. Furthermore, the patient quantitative blood loss (QBL) is 420 ml. The standard limit of OBL is less than 500 ml for vaginal delivery (Barlow et al., 2019). The patient blood loss is below the standard limit but should be monitored for postpartum hemorrhage on top of her having major lacerations. Some postpartum signs of hemorrhage are tachycardia, hypotension, boggy fundus, and increased bleeding (Ricci et al., 2020). In addition, the patient is at risk for infection due to her 2nd-degree laceration. Some signs and symptoms of infection include redness, edema, warmth, and irritation (Barlow et al., 2019). Lastly, the patient is experiencing the takin-in phase. The patient relies on her husband and staff to help her with ADLs. The patient seems eager to learn how to take care of her newborn baby girl.

Stage of Labor References (2) (APA):

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

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.

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

Home Medications (2 required)

Brand/Generic	Albuterol/ ProAir HFA	Polyethylene glycol 3350/MiraLAX			
Dose	90mcg	17 g			
Frequency	Three times a day (TID)	Daily			
Route	Oral	Oral			
Classification	Inhaled beta 2 agonist	Osmotic laxatives			
Mechanism of Action	Albuterol acts on beta 2 adrenergic receptors to relax the bronchial smooth muscles (Jones, 2021).	MiraLAX works by drawing water into the colon and soften the stool and may naturally stimulate the colon to contract (Jones,			

		2021).			
Reason Client Taking	The patient has a history of asthma.	The patient has frequent periods of constipation.			
Contraindications (2)	Diabetes, high blood pressure (Jones, 2021).	Severe ulcerative colitis, blockage of the stomach or intestines (Jones, 2021).			
Side Effects/Adverse Reactions (2)	Nervousness, tachycardia (Jones, 2021).	Diarrhea, stomach pain (Jones, 2021).			
Nursing Considerations (2)	The nurse should monitor respiration and oxygen saturation (Jones, 2021).	The nurse should monitor how the patient has been taking the medication and if the constipation has been relieved.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should measure the client blood pressure and heart prior and during the administration of this medication (Jones, 2021).	The nurse should do an assessment of the abdomen to recognize any abnormities such as discomfort, distention, and decreases bowel sounds (Jones, 2021).			
Client Teaching needs (2)	The patient should follow the directions on prescription label carefully and know that the medication can cause tachycardia and jittery feeling so do not be alarmed (Jones,	The patient should not use MiraLAX more than once a day and the patient should not use this medication more than 7 days in a row (Jones, 2021).			

	2021).				

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol	Ondansetron /Zofran	Tucks / Witch hazel glycerin	Ibuprofen / Motrin	Simethicon Alka-Seltz
Dose	650mg	40mg	1 pad	600 mg	100 mg
Frequency	OH6 PRN	QH6 PRN	PRN	Q6h prn	QH4 prn
Route	Oral	IV push	Topical	Oral	Oral
Classification	Analgesics and antipyretics	Selective serotonin Antiemetic	Anorectal preparation / Topical anesthetic	NSAID / Analgesic, Anti-inflammatory, Antipyretic	Gastrointes
Mechanism of Action	Block prostaglandin production and interferes with pain impulse generation in the peripheral nervous system (Jones, 2021).	Blocks serotonin receptors centrally in chemoreceptors trigger zone and peripherally at vagal nerve terminals in the intestine (Jones, 2021).	Tucks inhibits the feeling of pain and itching by numbing the perineal area (*Tucks*, 2022).	Blocks cyclooxygenase to mediate inflammatory response and aids in pain relief (*Nurse's Drug Handbook*, 2021).	Decreases tension of g in GI tract, gas to mov easily (Jon
Reason Client Taking	The patient takes this medication for pain related to her pregnancy.	The patient is only taking this medication for precaution purposes if they ever start to feel nausea.	To help perineal discomfort. Aids in prevention of hemorrhoids and minor bleeding (*Tucks*, 2022).	To manage mild to moderate pain with contraction or perineal discomfort.	The patient of having t passing gas
Contraindications (2)	Severe hepatic impairment,	Concomitant use of	Hypersensitivity to this	Hypersensitivity to aspirin or any	Hypersensi simethicon

	severe active liver disease (Jones, 2021).	apomorphine, hypersensitivity to ondansetron (Jones, 2021).	medication and a large open wound (Jones, 2021).	other components and renal impairment (Jones, 2021).	its compon breastfeedi 2021).
Side Effects/Adverse Reactions (2)	Hypotension, angioedema (Jones, 2021).	Bronchospasms, laryngospasm (Jones, 2021).	Skin irritation and contact dermatitis (Jones, 2021).	GI bleeding and hemorrhage (Jones, 2021).	Nausea and constipatio 2021).
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment and monitor renal impairment (Jones, 2021).	If electrolytes are unbalances it should be fix first and watch for signs of hypersensitivity (Jones, 2021).	Monitor for an allergic reaction such as hives or difficulty breathing. Assess perineal area for sins of irritation (Jones, 2021).	Monitor for therapeutic effectiveness. Monitor for GI distress or GI bleeds (Jones, 2021).	The nurse patient for pain, diste bowel sou and throug treatment (2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The key assessments that are renal and liver labs (Jones, 2021).	The nurse should check serum electrolytes before administration (Jones, 2021).	Assess for signs of infection or an allergic reaction in the perineal area (Jones, 2021).	Monitor heart rate / Monitor renal labs such as BUN/creatinine (Jones, 2021).	The nurse for any alle 2021).
Client Teaching needs (2)	The patient can crush or take whole and learn signs of hepatic toxicity (Jones, 2021).	Patient should report signs of hypertensive and transient blindness fixes itself.	Educate the client if there is excessive irritation or burning to contact provider and discontinue taking. Educate the client that this is a topical use only and should not be put in the mouth (Jones, 2021).	Educate the client to not take more than the maximum daily dose. Educate the client to swallow the tablet whole and to not chew the tablet (Jones, 2021).	The patient always tak medication prescribed be taking o stomach (J

Medications Reference (1) (APA):

Drugs.com. (2022). *Tucks.* https://www.drugs.com/mtm/tucks.html

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to person, place, situation, and time (x4). The patient seemed to slightly be confused when it came to caring for the baby and had lots of questions on breastfeeding. She appears slightly fatigued but is interacting with the baby.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin color was appropriate for ethnicity Dry, smooth, intact Warm Elastic None Slight bruising in the perineum. The patient has a second-degree laceration in the perineum area (Wound). The patient Braden score is 11 which means she is at a high risk of developing pressure ulcers if these conditions were to persist. The conditions will get better as the epidural wears off.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Symmetrical and midline No drainage noted PERLA, sclera is white, no conjunctivitis. No drainage noted in the nose Intact

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:**	.Heart sounds regular with no abnormal beats. Pulses are strong, equal with palpitation at radial, pedal, and post-tibial. Capillary refill is less than 3 seconds. No sign of neck vein distention. Edema noted on the lower legs bilaterally (+2).
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient breath sounds are clear both anteriorly and posteriorly. They are nonlabored. The patient respirations were within the normal ranges in each vital signs taken.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	The patient eats a regular diet at home and currently is on an only liquid diet shortly after birth. The patient is 5’3 in height and 140 lbs. The patient bowls sounds are active in all quadrants and her last bowel movement was 06/08/2022. The stomach seems to be swollen but no mass was present. There is distention in the abdomen but no incisions, scars drains or wounds.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient voided 300 ml of urine, so she did not have to get a catheter which was being considered due to the delay in urination.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 45 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walkx**☐	The patient has a fall score of 45 due to being weak and not understanding her limitations after the epidural. The patient is constantly getting up without the nurse being in the room.
NEUROLOGICAL (2 points):	.

MAEW: Y ☒ N☐ **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: A & O (x4)** **Mental Status:** Alert but slightly tired **Speech:** Verbal and impaired **Sensory:** The patient is not able to feel her legs completely at the beginning due to epidural. **LOC:** Alert but slightly tired **DTRs:** N/A	
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 lives at home with her husband which is eager to help a lot at home. A lot of education should be provided due to her being a new mother. She seems to have a lot of support from extended family due to the constant calls of checking up on her.
Reproductive: (2 points) **Fundal Height & Position:** At umbilicus to the right **Bleeding amount:** Scant less than 2.5 cm on pad per hour **Lochia Color:** Rubra **Character:** Firm **Episiotomy/Lacerations:**	The patient had a second-degree laceration described as a "W". All lacerations were able to be repaired
DELIVERY INFO: (1 point) **Rupture of Membranes:** AROM **Time:** N/A did not say a time. **Color:** Clear **Amount:** N/A did not mention the amount besides moderate **Odor:** no odor was noted **Delivery Date:** 06/10/2022 **Time:** 03:45 **Type (vaginal/cesarean):** Vaginal **Quantitative Blood Loss:** 420 QBL **Male or Female :** Female baby **Apgars:** 1 minute; 9 **Weight:** 6 lb. 2 0z **Feeding Method:** breastfeeding	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	66	115/67	16	97.8 F (36.6 C)	100% Room air
Labor/Delivery	75	128/78	16	97.7 F (36.5 C)	100% Room air
Postpartum	80	108/64	18	97.8 F (36.6 C)	100 Room air %

Vital Sign Trends: Vital signs are stable and within normal ranges**.**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
00830	Numeric 0-10	Lower back	2/10	aching	Reposition
1047	Numeric 0-10	Lower back	3/10	aching	Pain medication

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18G
Location of IV:	Anterior left forearm
Date on IV:	06/09/2022
Patency of IV:	The IV is patient and there is no signs of erythema or drainage.
Signs of erythema, drainage, etc.:	
IV dressing assessment:	The IV dressing is clean, dry and intact.

Intake and Output (2 points)

Intake	**Output (in mL)**
150 ml of water	300 ml of urine

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.**
Education on sudden infant death syndrome – N	As needed	Sudden infant death syndrome can be prevented by not sleeping with the infant, not using a blanket in the crib, no stuffed animals, and sleeping on the infant's back. The infant should only have a fitted sheet and a pacifier which can help as well. SIDS is important to teach the new mother to prevent the suffocation and death of the newborn.
Education on breastfeeding the newborn – N	Frequently	The mother is a new parent so constant education on breastfeeding is needed Proper tools for educating the new mother on breastfeeding are essential in providing adequate nutrition, comfort, and confidence.
Fundal assessment – N	Q4h	A fundal assessment is a tool to measure firmness, uterine size, and where it is. Fundal assessment is done following delivery to monitor for postpartum hemorrhage. The Fundus should be firm and at the level of the umbilicus approximately after delivery.

Phases of Maternal Adaptation to Parenthood (3 point)

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

What evidence supports this? The new mother relies on the nursing staff and her husband for assistance with ADL's. She is focused on personal needs due to fatigue and needs to talk about the experience with others (Barlow et al., 2019).

Discharge Planning (3 points)

Discharge location: The patient will be going home with her husband.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The patient will have a follow up appointment with a physician for her and her baby which was not yet decided.

Education needs: The patient will need some additional education on breastfeeding due to this being her first child and she voiced out that she was not sure if the baby was feeding.

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. Risk for falls related to epidural as evidenced by fall score of 45.	The patient is constantly getting out of bed without assistance although instructed to wait for the	**1.**The nurse should keep call light in reach and prioritizing answering the patients call light within a few minutes if possible. **Rationale** It is important for the nurse to talk about the risk of falling to help patient	The goal is for the patient is to call for assistance when she needs to get up and do anything until epidural wears off. The goals were not met because patient constantly gets

	nurse due to still having numbness from epidural.	understand why she need assistance to hopefully prevent falls (Ricci et al., 2020). **2.**The patient bed should remain in the lowest position to avoid injuries if she falls. **Rationale** The patient bed should be in the lowest position because it helps promote patient safety and prevent falls (Ricci et al., 2020).	up without assistance.
2. Risk for infection related to the tearing of the perineum as evidenced by 2nd degree lacerations.	The patient has 2nd degree laceration that can lead to an infection if not taking care of properly.	**1.** The nurse should continue to assess the laceration for signs of infection. **Rationale:** Infection signs and symptoms include erythema, irritation, edema, and warmth (Barlow et al., 2019). **2.** The nurse should do CBC to monitor the client white blood cell. **Rationale** Increased white blood cells can show infection in the body (Ricci et al., 2020).	The goal was met because the nurse constantly assesses the laceration and request for a CBC and her white blood cell labs were normal.
3. Knowledge deficit related to infant care as evidenced by first time mother	The patient is new to motherhood and asked a lot of questions about breastfeeding and the overall care of the baby. The mother was also constantly falling asleep in the bed with baby.	**1.** Educating should be done on breastfeeding and knowing the signs the baby is feeding. **Rationale** Some successful signs of feeding include baby cheeks stay rounded and not hollow, the baby throat moves with each gulp, and the mother can listen for the swallowing sound (Barlow et al., 2019). **2.** The mother should be educated on SIDS.	The goal to give adequate education on being a new mother was not met due to patient still having questions about breast feeding and sleeping with the baby as well.

		Rationale SIDS is important to teach the new mother to prevent the suffocation and death of the newborn (Barlow et al., 2019).	
4. Knowledge deficit related to proper car seat handling related to the patient being a new mother.	The patient asked numerous questions on how to properly put child in car seat while also being in the car.	**1.** The mother should be educated on how to properly put a child in a car seat by the end of stay at the hospital. **Rationale** The buckle of the car seat should fit snuggly around infant and buckle should be at the shoulder of the infant and fit 2 fingers (Ricci et al., 2020). **2.** The mother should be educated on how to properly install a car seat in a car by the end of her stay. **Rationale** The newborn should be sitting rear faced away from airbags and at a 45-degree angle (Ricci et al., 2020).	The goal was met because the patient was able to teach back what the nurse explained to her.

Other References (APA)

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L.,

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

Kluwer.