

N432 Postpartum Care Plan
Lakeview College of Nursing
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Demographics (3 points)

Date & Time of Admission 6/6 at 1530	Patient Initials E.O	Age 18 years old	Gender Female
Race/Ethnicity Hispanic	Occupation Homemaker	Marital Status Single	Allergies NKA
Code Status Full	Height 157.5 cm	Weight 101.2 kg	Father of Baby Involved Father of the baby involved and present

Medical History (5 Points)**Prenatal History:**

Gravida 1, Term 1, Preterm 0, Abortion 0, Living 1

No serious complications. Patient had gestational hypertension during this pregnancy.

Past Medical History:

Fatty liver, eczema, pes planus, obesity

Past Surgical History:

Pilonidal cyst removal-2018

Cesarean section-2022

Family History:

Mother-Diabetes

Other family members- N/A

Social History (tobacco/alcohol/drugs):

Patient has no history of tobacco, alcohol, or drug use

Living Situation:

The patient currently lives with her parents and two siblings

Revised 12/8/20

Education Level:

Patient graduate high school

Admission Assessment**Chief Complaint (2 points):**

Gestational hypertension

Presentation to Labor & Delivery (10 points):

The patient was admitted to the labor and delivery unit due to gestational hypertension. The patient started exhibiting signs and symptoms of gestational hypertension around 22 weeks gestation and continued throughout her pregnancy. The patient does have a previous history of obesity but not hypertension. Patient did have complaints of headaches, nausea, and pitting edema. The patients provider decided to induce her labor so these symptoms would not continue further.

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

Gestational hypertension

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
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RBC	4.01-5.51	5.0	3.92		Blood loss due to gestational bleeding (Bladh et al., 2021)
Hgb	1 st trimester 11.6-13.9 2 nd & 3 rd trimester 9.5-11	10.0	10.4		
Hct	1 st trimester 35-42 2 nd & 3 rd trimester 28-33	30.0	33.0		
Platelets	150-450	200	285		
WBC	4.5-11.1	8.0	7.94		
Neutrophils	2.7-6.5	3.5	N/A		
Lymphocytes	1.5-3.7	3.0	N/A		
Monocytes	0.2-0.4	0.3	N/A		
Eosinophils	0.05-0.5	0.06	N/A		
Bands	0-0.1	0.1	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	N/A	O	O	N/A	
Rh Factor	N/A	Rh negative	Rh negative	N/A	
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	N/A	
Rubella Titer	Positive	Negative	Negative	N/A	The patient had no received her MMR vaccine (Bladh et al., 2021)
HIV	Negative	Negative	N/A	N/A	
HbSAG	Negative	Negative	N/A	N/A	
Group Beta	Negative	Negative	Negative	N/A	

Strep Swab					
Glucose at 28 Weeks	Less than 100	80	N/A	N/A	
MSAFP (If Applicable)	10-20	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					

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)	97-177	N/A	120	N/A	

Lab Reference (1) (APA):

Bladh, M., & Van Leeuwen, A. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. F.A. Davis.

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

	Your Assessment
<p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>The total length of labor for my patient was approximately 13 hours from start to finish.</p> <p>The patient was induced due to gestational hypertension with the use of Dinoprostone and Oxytocin. The patient had a spontaneous rupture of membranes.</p> <p>Stage one: 10</p> <p>Stage two and three: approximately 45-50 minutes</p> <p>Stage four: 1-2 hours</p>
<p>Current stage of labor</p>	<p>The patient is currently in the fourth stage of labor which begins with the delivery of the placenta and includes at least the first 2 hours of birth (Mayo Clinic, 2022). During this stage, the provider may repair incisions such as an episiotomy, cesarean</p>

	<p>section, and lacerations caused by vaginal delivery. During this time, staff will obtain maternal vital signs, assess the fundus, and check lochia (Ricci et al., 2022). If the patient has a catheter, this will be removed, and the nurse will check the urinary output. The nursing staff will promote baby-friendly activities such as skin-to-skin and assist you in breastfeeding your infant if you choose to do so. After delivery, the fundus rose above the level of the umbilicus, which is a normal finding. Assessment of the lochia showed a dark reddish color that contained small clots, another normal finding of the fourth stage of labor. The only abnormality I assessed was my patient's blood pressure which was 145/62. My patient has gestational hypertension, so elevated blood pressure should be expected, but we will continue to monitor. Pedal pulses and skin turgor all appeared normal with traces of edema. Edema is an abnormal sign, so this is something to be monitored. There was no swelling or redness noted.</p> <p>Several postpartum disorders include deep-vein thrombosis, pulmonary embolus, coagulopathies, postpartum hemorrhage, uterine atony, subinvolution of the uterus, and inversion of the uterus, retained placenta, laceration, and hematomas (Ricci et al., 2022). My patient did not have any complications during her c-section.</p>
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Stage of Labor References (2) (APA):

Mayo Foundation for Medical Education and Research. (2022, January 13). *Stages of labor and birth: Baby, it's time!* Mayo Clinic. Retrieved June 15, 2022, from <https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545>

Ricci, S. S., Kyle, T., & Carman, S. (2022). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Famotidine/Pepcid	N/A	N/A	N/A	N/A
Dose	40 mg				
Frequency	Daily/PRN				
Route	PO				
Classification	Pharmacologic: histamine 2 blocker Therapeutic: antiulcer agent				
Mechanism of Action	Reduces HCl formation by preventing histamine from binding with age to receptors on the surface of parietal cells (Jones & Bartlett, 2022).				
Reason Client Taking	Occasional heart burn				
Contraindications (2)	hypersensitivity to Samantha Dean other H2 receptor antagonist order components				
Side Effects/Adverse Reactions (2)	arrhythmias, abdominal pain				
Nursing Considerations (2)	be aware that Pepcid AC chewable tablets contain aspartame				

	which can be dangerous for patients who have phenylketonuria , if oral suspension is given shake vigorously for five to 10 seconds before administrating				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	make sure the patient does not have an allergy to the medication				
Client Teaching needs (2)	caution patient not to take the mantle Dean with any other acid reducing products, instruct patient, instruct patient carefully Chu chewable tablets thoroughly before falling				

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/Tylenol	Hydrocodone/Vicodin	Ibuprofen/Advil	Docusate/Colace	N/A
Dose	1000 mg	325 mg	600 mg	10 mg	
Frequency	Q6/PRN	Q4/PRN	Q6/PRN	Daily/ PRN	
Route	PO	PO	PO	PO	
Classification	Pharmacological: non salicylate para aminophenol derivative Therapeutic: antipyretic, non opioid analgesic	Pharmacologic: opioid Therapeutic: opioid analgesic	Pharmacologic: NSAID Therapeutic: analgesic, anti-inflammatory, antipyretic	Pharmacologic: surfactant Therapeutic: laxative, stool softener	
Mechanism of Action	Inhibits the enzyme cyclooxygenase blocking prostaglandin production and interfering with the pain and pulse generation and the peripheral nervous system (Jones & Bartlett, 2022).	Binds to and activates opioid receptors at sites in the periaqueductal and periventricular grey matter, the ventromedial medulla, and the spinal cord to produce pain relief (Jones & Bartlett, 2022).	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain swelling and basil dilation (Jones & Bartlett, 2022).	Acts as a surfactant that softens stool by decreasing surface tension between oil and water and feces (Jones & Bartlett, 2022).	
Reason Client Taking	Pain	Pain	Pain	Prevent constipation	
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe hepatic impairment	acute or severe bronchial asthma, hypersensitivity to hydrocodone or any of its components	nasal polyps hypersensitivity to ibuprofen or its components	fecal impaction, hypersensitivity to docusate salts or their component	

Side Effects/Adverse Reactions (2)	Hypertension, hepatotoxicity	CNS depression, respiratory depression	seizures, heart failure	nausea, diarrhea	
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment or active hepatic disease, know that before and during long term therapy including parental therapy liver function test must be ran	be aware that hydrocodone increases the risk of abuse addiction and misuse, be aware that opioids like hydrocodone should not be given to women during pregnancy while in labor or while breastfeeding	be aware that ibuprofen should not be used in pregnant women starting at 30 weeks gestation because premature closure of the ductus arteriosus may occur in the fetus, use ibuprofen with extreme caution in patients with a history of GI bleeding or ulcer disease	excessive use can lead to dependence on laxative for bowel movements, contraindicated in electrolyte imbalances	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	patients liver tests must be evaluated	patients vital signs must be taken prior to administration such as pulse respiration and blood pressure	nurse should check or any signs or symptoms of bleeding prior to administration	Make sure the patient does not have an allergy to the medication	
Client Teaching needs (2)	Caution patient not to exceed recommended dosage or take other drugs containing acetaminophen at the same time, teach patient to recognize signs and symptoms of hepatotoxicity	hydrocodone should not be mixed with cough or cold preparations, urge patient to consume plenty of fluids and high fiber foods to avoid constipation	and shrugged patient to take tablets with a full glass of water, advise patients to take drug with food or after meals to reduce GI distress	Patient should report any sudden unexplained abdominal pain, patient should report bleeding from the rectum	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2022 Nurse’s drug handbook* (19th ed.). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alert and responsive A&O x4 No distress noted at this time Patient looked appropriate for age. Patient was clean and groomed.</p>
<p>INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Usual for ethnicity Dry, intact Warm to the touch Elastic No rashes noted No bruising noted Patient had a transverse c-section incision Braden: 21</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head symmetrical. No lymph nodes were palpable. Normal rise and fall of the trachea noted. Ears symmetrical with the eyes. Hearing intact. Vision intact. Eye placement symmetrical. Sclera white conjunctiva pink. No discharge noted. Nose patent and midline. No sneezing, or discharge noted. No polyps. Septum not deviated. Mucosa moist and pink. No ulcerations noted. Patient has good dental hygiene.</p>
<p>CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>S1 and S2 sounds heard. No S3 or S4 sounds Not applicable Peripheral pulses +3 in all extremities Capillary refill less than 2 seconds</p>

<p>Edema <input checked="" type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema:</p>	<p>No JVD present</p> <p>Trace edema present +1</p> <p>Trace edema noted in patients bilateral lower extremities</p>
<p>RESPIRATORY (1 points):</p> <p>Accessory muscle use: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>No accessory muscle use</p> <p>Respiration rate regular and unlabored</p> <p>Breath sounds clear upon inspiration and expiration in all lobes anterior and posterior</p> <p>Lung aeration equal on both sides</p>
<p>GASTROINTESTINAL (2 points):</p> <p>Diet at Home:</p> <p>Current Diet:</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p> <p> Distention:</p> <p> Incisions:</p> <p> Scars:</p> <p> Drains:</p> <p> Wounds:</p>	<p>Regular</p> <p>Regular</p> <p>157.5 cm</p> <p>101.2 kg</p> <p>Bowel sounds present in all four quadrants 6/10</p> <p>Slight pain on palpation, no masses present</p> <p>No distension</p> <p>Transverse c-section incision. No blood or drainage present. Incision healing nicely.</p> <p>No scars aside from the c-section</p> <p>No drains present</p> <p>No wounds present</p>
<p>GENITOURINARY (2 Points):</p> <p>Quantity of urine:</p> <p>Pain with urination: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p> Type:</p> <p> Size:</p>	<p>Unable to calculation an accurate amount but patient voided x2</p> <p>Urine light yellow and clear with no odor or sediment</p> <p>No pain with urination</p> <p>No catheter present</p> <p>Genitals appear normal</p>
<p>MUSCULOSKELETAL (1 points):</p> <p>ADL Assistance: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient needed no help with ADLs</p> <p>Patient is not a fall risk</p> <p>Fall score: 0</p> <p>Patient has active ROM in all extremities</p> <p>Patient is up independently in room and needs to assistive devices to walk or stand</p>
<p>NEUROLOGICAL (2 points):</p> <p>MAEW: <input type="checkbox"/> <input type="checkbox"/> N <input type="checkbox"/></p>	<p>Patient moves all extremities well</p>

<p>PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>Patients pupils were equal, round, reactive to light and accommodation Patients strength +5 in all extremities Patient is A&O x4 Normal cognition Speech clear Patient had full sensation Patient alert and awake Deep tendon reflexes +2 on all extremities</p>
<p>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):</p>	<p>Coping methods include talking with her boyfriend and mother as well as praying. The patient is religious and prays often Developmental level appropriate for age and education level The patient has a very stable home life with the support of her parents and boyfriend</p>
<p>Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:</p>	<p>Fundal height below the level of the umbilicus Moderate Lochia rubra Small clots present, fleshy smell No episiotomy or lacerations due to c-section</p>
<p>DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>Spontaneous rupture of membranes 0146 Clear Moderate No odor noted 6/8 1445 Cesarean 527 ml Female 1 minute-8 5 minutes-10 3.04 kg Breast/supplementing with formula if needed</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	92 bpm	140/85 mm	18 breaths per	37.0 celcius	100% room

		Hg	minute		air
Labor/Delivery	98 bpm	145/62 mm	16 breaths per	37.2	98% room air
		Hg	minute		
Postpartum	88 bpm	130/85 mm	18 breaths per	36.8	97% room air
		Hg	minute		

Vital Sign Trends:

My patients blood pressure is running slightly on the higher side but that is to be expected with gestational hypertension. Her blood pressure did seem to lower after deliver which is what we were hoping for.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0808	Numerical scale	C-section incision	6/10	Throbbing	Patient was given hydrocodone
0908	Numerical scale	C-section incision	2/10	Slight ache	No interventions were needed at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.:	Patient did not have IV access at the time of my assessment as they were getting ready for discharge

IV dressing assessment:	
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Intake and Output (2 points)

Intake	Output (in mL)
600 ml water and tea	Voided x2, Bowel movement x1

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “T” after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
N:The patient was given ice as needed to apply to her abdominal incision for pain management	This intervention was done on an as needed basis	This intervention was provided as a non-pharmacological pain intervention
T: the patient was given hydrocodone for pain due to her C-section	This intervention was performed Q4 or as needed	This treatment was provided because the patient was in pain
N: Patient was offered help with repositioning in bed	This intervention was performed on an as needed basis	This intervention was provided due to having limited range of motion due to abdominal incision
N: Patients feet were elevated to decrease edema	This intervention was performed on an as needed basis	This intervention was provided due to the patient having trace amounts of edema

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in?

My patient is in the “taking in” phase of maternal adaptation

What evidence supports this?

This stage happens 1 to 2 days after delivery. The patient is very dependent on the staff at this time which is apart of the taking in phase of maternal adaptation.

Discharge Planning (3 points)

Discharge location:

The patient will be discharging back home to her parents house

Equipment needs (if applicable):

Not applicable

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

Mom will follow up with her provider in 2 weeks to check on the incision and see how baby is adapting.

Education needs:

Patient will need for education on breastfeeding and how to use her breast pump

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? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
1. acute pain related to C-section as evidenced by pain	this diagnosis was chosen because my patient rated her	1. Rationale: my intervention was giving the patient hydrocodone and I	when I reassessed my patient an hour of following medication administration she rated her pain

rating at a six out of 10	pain on a scale of 0/10 a	reassessed her an hour after (Swearingen & Wright, 2019). 2. Rationale: the patient was instructed to stay in her bed and rest while the medication took effect (Swearingen & Wright, 2019).	a 2/10 and did not need further interventions at that time
2. risk for infection related to C-section	this diagnosis was chosen because my patient has an abdominal incision which puts her at risk for developing an infection	1. Rationale: Skin assessments will be done every shift and per hospital policy to monitor for signs of infection (Swearingen & Wright, 2019). 2. Rationale: Patients temperature will be taken Q4 or per hospital policy to monitor for signs of infection (Swearingen & Wright, 2019).	The patient was educated on the importance of keeping the incision clean and dry and to report any signs of redness swelling or abnormal discharge
3. deficient knowledge related to unfamiliarity with breastfeeding as evidenced by inaccurate understanding of instructions	this diagnosis was chosen because this is the patient first child and does not have experience with breastfeeding	1. Rationale: The patient will meet with the lactation consultant and demonstrate proper latch (Swearingen & Wright, 2019). 2. Rationale: The patient will be educated on how to use a breast pump and how frequently she should be pumping/feeding (Swearingen & Wright, 2019).	The patient was worried that she did not have enough milk supply but I reassured her that during the first few days postpartum she will only be producing colostrum in small amounts
4. deficient knowledge related to vaccine administration as evidenced by asking questions during administration vaccine	I chose this diagnosis because during administration the patient did not have sufficient knowledge of the vaccine I was administering	1. Rationale: The patient was given a handout provided by the CDC about the MMR vaccination (Swearingen & Wright, 2019). 2. Rationale: I explained verbally to the patient what the vaccine was for and the steps of administration (Swearingen & Wright, 2019).	The patient understood the importance of getting the vaccination and did not have any further questions after giving the hand out and spoken to by the nurse and I

Other References (APA)

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and Psychiatric-Mental Health*. Elsevier.