N432 Postpartum Care Plan

Lakeview College of Nursing

Paiton L. Frerichs

Demographics (3 points)

Date & Time of Admission 6/8/2022 8:30 am	**Patient Initials** B.E.	**Age** 19 years old	**Gender** Female
Race/Ethnicity White	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Sulfa Methoxazole-trimethoprim
Code Status Full code	**Height** 160 cm	**Weight** 78 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G1TPAL0

Past Medical History: This patient past medical history is anemia and a mental disorder.

Past Surgical History: No previous surgery.

Family History: Patients father has a history of hypertension; other family members are healthy.

Social History (tobacco/alcohol/drugs): This patient has no usage of alcohol and drugs, she quit vaping when she got pregnant.

Living Situation: Patient lives with her boyfriend.

Education Level: Patients highest educational level is high school.

Admission Assessment

Chief Complaint (2 points): Scheduled induction.

Presentation to Labor & Delivery (10 points): 19-year-old female, G1TPAL0 patient is 39 weeks pregnant. Presents to labor and delivery with a scheduled induction. Last menstrual period was 8/8/2021. Patient denies having leakage of fluid, vaginal bleeding or decreased fetal movement.

Diagnosis

Primary Diagnosis on Admission (2 points): 39 weeks gestation elected induction.

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	3.80-5.30	N/A	4.54	N/A	Within defined limits
Hgb	12.0-15.8	N/A	12.9	N/A	Within defined limits
Hct	36.0-47.0	N/A	38.0	N/A	Within defined limits
Platelets	140-440	N/A	200	N/A	Within defined limits
WBC	4-12	N/A	7.80	N/A	Within defined limits
Neutrophils	47.0-73.0	N/A	79.6	N/A	Reason for increased value could be due to stress on the body or an infection (Pagana et al., 2019).
Lymphocytes	18.0-42.0	N/A	13.8	N/A	Reason for decreased value could be due to deficiency of vitamins and minerals, leaving the body at low nutritional levels (Pagana et al., 2019).
Monocytes	4.0-12.0	N/A	5.0	N/A	Within defined limits
Eosinophils	0.0-5.0	N/A	1.2	N/A	Within defined limits
Bands	N/A	N/A	N/A	N/A	Not completed on this admission

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	Within defined limits
Rh Factor	N/A	Positive	Positive	N/A	Within defined limits
Serology (RPR/VDRL)	Negative	Negative	Negative	N/A	Within defined limits
Rubella Titer	Immune	Nonimmune	N/A	N/A	Patient is not immune and will have to wait til after having the baby to get the vaccine (Pagana et al., 2019).
HIV	Negative	Not detected	Not detected	N/A	Within defined limits
HbSAG	Negative	Not detected	N/A	N/A	Within defined limits
Group Beta Strep Swab	Negative	Negative	N/A	N/A	Within defined limits
Glucose at 28 Weeks	50-179	150	N/A	N/A	Within defined limits
MSAFP (If Applicable)	No risk/negative	N/A	N/A	N/A	Not completed on this admission

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
MPV	9.7-12.4	N/A	8.1	N/A	Within defined limits
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A

N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	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)	N/A	N/A	N/A	N/A	N/A

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th 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**	Patient came in at 0830 on 6/8/2022 for an induced delivery, she gave birth on 6/9/2022 at 0354 resulting in 19 hours and 24 minutes labor. She had a spontaneous vaginal delivery, with an epidural. Patient had a right mediolateral episiotomy. Patient had no complications and is now in postpartum and stable.
Current stage of labor	N/A

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* (11th 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 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Docusate sodium (Colace)	Prenatal multivitamin (One A Day Women's Prenatal)			
Dose	100 mg	1 tablet			
Frequency	BID	Daily			
Route	Oral	Oral			

Classification	Pharmacologic: Surfactant Therapeutic: Laxative, stool softener	Pharmacologic: Vitamin Therapeutic: Water soluble vitamin			
Mechanism of Action	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces.	Helps prevent neural tube defects, and the growth and development of the baby. It also can help prevent anemia.			
Reason Client Taking	Constipation	Nutritional supplement for use prior to conception, during pregnancy, and postnatal			
Contraindications (2)	Concomitant use with mineral oil. Intestinal obstruction.	Hypersensitivity to any component of the formulation. Those with iron metabolism disorder, liver problems, or stomach/intestinal problems.			
Side Effects/Adverse Reactions (2)	Dizziness and palpitations.	Constipation and upset stomach.			
Nursing Considerations (2)	Expect excessive or long-term use of docusate to cause dependence on laxatives for bowel movements. Capsules should be	Monitor for iron toxicity. Use with caution in patients with kidney stones due to calcium content.			

	swallowed whole not crushed or chewed.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders. Assess color, consistency, and amount of stool produced. Assess bowel sounds, abdominal distention, and usual consistency of bowel patterns.	Labs to monitor could be a liver panel and vitamin B-12. Assess patient pre and post pregnancy.			
Client Teaching needs (2)	Do not let patient use if they have nausea, or vomiting. Instruct patient to notify prescriber about rectal bleeding, or symptoms of electrolyte imbalances.	Administer with food to decrease stomach upset. Limit intake of alcohol while taking.			

Hospital Medications (5 required)

Brand/Generic	Ibuprofen (Advil)	Benzocaine-menthol (Dermoplast)	Ferrous sulfate (Iron)	Ondansetron (Zofran)	Witch hazel-glycon (Tucks)
Dose	600 mg	Ointment 20%, apply small amount to affected area	325 mg	4 mg	1 each
Frequency	Q8hrs PRN	Q4hrs PRN	BID	Q6hrs PRN	Q1hr PRN
Route	Oral	Topical	Oral	IV	Topical
Classification	Pharmacologic: NSAID Therapeutic: Analgesic, anti-inflammatory, antipyretic	Pharmacologic: Keratolytic agent Therapeutic: Local anesthetic	Pharmacologic: Hematinic Therapeutic: Antianemia, nutritional supplement	Pharmacologic: Selective serotonin receptor antagonist Therapeutic: Antiemetic	Pharmacologic: Anti hemorrhoidal agent Therapeutic: Anorectal preparations
Mechanism of Action	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation. By inhibiting prostaglandins, the NSAID reduces	Blocks both the initiation n and conduction of nerve impulses by decreasing the neuronal membranes permeability to sodium ions, which results in inhibition of depolarization with resultant blockade of conduction.	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of bone marrow, liver and spleen.	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine.	Vasoconstrictor that tightens blood vessels to reduce redness and stop bleeding.

	inflammatory symptoms and relieves pain.				
Reason Client Taking	Pain	Hemorrhoids	Anemia	Nausea	Hemorrhoids
Contraindications (2)	Significant renal impairment. Hypersensitivity to ibuprofen or its components.	Hypersensitivity to benzocaine or their components. Do not use if you have allergy to local anesthetics.	Hypersensitivity to iron salts or their components. Hemochromatosis.	Concomitant use of apomorphine. Hypersensitivity to ondansetron or its components.	Hypersensitivity to witch-hazel glycerin or its components. Oral use.
Side Effects/Adverse Reactions (2)	Abdominal cramps and headaches.	Stinging sensation and localized rash.	Dizziness and chest pain.	Agitation and anxiety.	Hives and difficulty breathing.
Nursing Considerations (2)	Know that the risk of heart failure increases with the use of NSAIDs such as ibuprofen. Be aware that ibuprofen should not be used in pregnant women starting at 30 weeks gestation because of premature closure of the ductus arteriosus may occur in the fetus.	Monitor patients for signs and symptoms of methemoglobinemia. Do not administer if patient presents with pallor, tachycardia, fatigue, cyanosis, or muscle weakness.	Don't crush enteric coated tablets or open capsules. Dilute and administer with a straw or place drops in back of patients' throat, because iron solutions may stain teeth.	Place disintegrating tablet or oral soluble film on patients tongue immediately after opening package, it can dissolve in seconds. Use calibrated container or oral syringe to measure dose of oral solution.	Caution with heart disease, hypertension, hyperthyroidism, diabetes, or prostatic hypertrophy. This product should not be placed in the rectum using a mechanical device or fingers.

Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess for ibuprofen allergy. Assess pain level. Assess for bleedings disorders and kidney impairment. GFR tests could be checked to monitor the kidney function.	Assess for internal or external hemorrhoids. Assess for pain level and itching.	A comprehensive anemia panel could be checked. Assess skin color, signs and symptoms of bleeding, weakness, cold hands and feet, and shortness of breath.	Assess for hypokalemia or hypomagnesemia before administration.	Assess for internal or external hemorrhoids. Assess pain level, itching, and burning that can be caused by hemorrhoids.
Client Teaching needs (2)	Instruct patients to take with a full glass of water. Advise patients to take drug with food or after meals to reduce GI distress.	Apply evenly. Cleanse affected area with mild soap and warm water, then thoroughly rinse and dry before applying ointment.	Instruct patient not to chew any solid form of iron expect for chewable tablets. Urge patient to eat chicken, fish, lean read meat, turkey, as well as foods rich in vitamin C to improve iron absorption. Can cause dark stools.	Tell patient that oral disintegrating tablets may contain aspartame, which is metabolized to phenylalanine and must be used cautiously in patients with phenylketonuria. Advise patient to immediately report signs of hypersensitivity, such as a rash.	Discontinue and contact physician if hemorrhoids worsen or do not improve within 7 days. Discontinue is bleeding, allergic reaction, redness, irritation, swelling, pain, or other symptoms develop or increase.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook 2021.* Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Appears alert and oriented with asking person, place, time, and situation. Well groomed, no acute distress.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color is white. Skin is warm and dry upon palpation. No rashes, lesions, and bruising. Normal quantity, distribution, and texture of hair for age. Skin turgor normal mobility. Braden scale was 23 with no risk of skin breakdown. No drains were present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck were symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head and neck is noted. Bilateral auricles no visible deformities, lumps, or lesions. Hearing is good and balanced. Eyes are bilateral sclera is white, bilateral cornea clear, bilateral conjunctiva pink and moist, no visible drainage or discharge noticed. No assistive devices. Nose septum is midline, no bumps, lumps, or lesions visual. Good detention, oral mucosa overall moist and pink without lesions noted. .
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒**	Clear S1 and S2 without murmurs gallops or rubs. Normal rate and rhythm. Capillary refill was less than 3 seconds on fingers and toes bilaterally. No neck vein distention. No edema present. Peripheral pulses were 2+ bilaterally.

Edema Y ☐ N ☒ **Location of Edema:**	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and pattern of respirations, respirations symmetrical and non-labored, lung sounds clear throughout anterior/posterior bilaterally, no wheezes, crackles, or rhonchi noted.
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:**	Current and at home diet is regular. Height is 5'3, weight is 172 lbs. Auscultation and palpation of bowel sounds were normal. Client states that last bowl movement was that morning on 6/10/22. Patient is passing gas. No distention, drains, wounds, or scars. Patient had a right mediolateral episiotomy incision.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient had one void before getting discharged. No pain with urination. No catheter present. Inspection of genitals was not assessed.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) X** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient did not need ADL assistance. Fall risk score was 0, making her not at fall risk. Patient is active and independent on her own. She does not need assistance with equipment or support to stand and walk.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	MAEW and PERRLA are intact. Patient has equal strength in both arms and legs. Patient is alert and oriented to person, place, time, and situation. Patients' mental status is normal. Speech is normal. Sensory is not impaired. No loss of consciousness. Deep tendon reflexes are reactive.

Speech: **Sensory:** **LOC:** **DTRs:**	
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):**	Patients coping methods are being with her significant other, and her family. Developmental level is normal for her age. Patient is not religious. Patient lives in Danville. Family support is present from both her side and her significant others.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal height was 38 cm, midline position. Patient bled 320 mL. Lochia color was rubra. Character presented with no odor, and light. Patient had a right mediolateral episiotomy.
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:**	Patient had an artificial rupture of membranes, time, color, amount, and odor was not noted. Patient delivered on 6/9/2022 at 0324 vaginally to a male that weighed 3720 grams. Quantitative blood loss was 320 mL. Apgars was 8.9. Patients feeding method to the newborn is breastfeeding and bottle.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	90	118/78	14	98.2 degrees Fahrenheit	98% room air
Labor/Delivery	100	127/79	18	98.2 degrees Fahrenheit	98% room air

Postpartum	88	112/82	16	98.1 degrees Fahrenheit	100% room air

Vital Sign Trends: Patients vitals increased while in labor/delivery due to increased stress or activity in the body. They went back down to normal when there was a decrease in stress or activity.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0600	0-10	Abdomen	3	Sore and achy	Pain medication
0800	0-10	N/A	0	N/A	N/A

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.:** **IV dressing assessment:**	Patient got IV removed on 6/10/22 at 0600.

Intake and Output (2 points)

Intake	Output (in mL)
25% 240 mL	1 void in toilet.

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.
Pain management (T)	Q8hrs PRN	To reduce pain stimuli and help the patient get more comfortable.
Prenatal multivitamins at home (T)	Daily	To be a nutritional supplement post pregnancy.
Docusate Sodium at home (T)	BID	To help with constipation and bowel movements that patient has been struggling with.
Taught how to breast feed (N)	Daily	To help teach the proper technique of breastfeeding to patient so she can do it herself when she is at home.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking-hold phase

What evidence supports this? This phase usually is in the first 10 days of being at home, this patient got discharged on 6/10/2022. She has stated concerns about breast feeding and getting the adequate amount for the baby, as this is part of this phase. However, she is engaging with the baby.

Discharge Planning (3 points)

Discharge location: Patient will return home with boyfriend.

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The mother and newborn both will come in the following weeks for checkups. The newborn will also be circumcised at the appointment.

Education needs: Patient got educated on what medications to continue using at home and how often. She got informed on how often to feed and bathe the baby, and instructions on how to breastfeed. Patient got a MMR vaccine on 6/10/22 she got informed on why she was receiving this vaccine.

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 bleeding related to anemia as evidenced by history of abnormal anemia labs.	Patient has been diagnosed with anemia in the past and is on medication for it.	**1.** Administering daily iron supplement throughout pregnancy due to being diagnosed with anemia in the past (Phelps, 2020). **2.**. Monitor for signs and symptoms of bleeding or skin discoloration each shift to keep up on changes that could occur (Phelps, 2020).	Patient is fully aware that she has been diagnosed with anemia in the past, and that she needs to be aware of it. She will be assessed to see if she needs to stay on the iron supplements. Goal is to keep anemia under control.
2. Risk for postpartum depression related to	Patient has been diagnosed with it in the past.	**1.** Postpartum depression screening due to history of mental health disorder before leaving the hospital	Patient and family are aware of her past mental health disorder and how this can put her at risk

disturbed thought process as evidenced by diagnosis of past mental health disorder.		(Phelps, 2020). **2.** Refer to get medication, such as an antidepressant (Phelps, 2020).	for postpartum depression. Patient will report any signs of depression and answer honestly on the depression screening before discharging. Goal is to keep mental health disorder on track and use resources when needed.
3. Acute pain related to hemorrhoids as evidenced by rectal burning.	Patient is on medication for hemorrhoids.	**1.** Assess vital signs for changes in baseline every 4 hours. Vital signs usually increase automatically to painful stimuli (Phelps, 2020). **2.** Provide a restful and quiet environment for patient to relax and reduce stimuli that could cause pain (Phelps, 2020).	Patient is aware that she needs to report her pain level, and the goal is to reduce the pain stimuli. Family understand that the goals are to have a quiet and relaxing environment can help reduce the pain stimuli.
4. Risk for maternal injury related to tissue damage as evidenced by right mediolateral episiotomy.	Patient had a right mediolateral episiotomy.	**1.** Pain assessments Q2hrs due to the tissue damage done. (Phelps, 2020). **2.** Ice packs when needed, to help any pain or swelling. (Phelps, 2020).	Patient and family understand that the goal is to keep the swelling and pain under control and by doing so could be using the option of ice packs.

Other References (APA)

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

Wolters Kluwer.