N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 6/22/2022 (0805)	**Patient Initials** RZ	**Age** 25	**Gender** Female
Race/Ethnicity Asian (Chinese)	**Occupation** Unemployed	**Marital Status** Married	**Allergies** No known allergies
Code Status Full code	**Height** 5'2" (158 cm)	**Weight** 61.2 kg	**Father of Baby Involved** Yes, father in room the whole time

Medical History (5 Points)

Prenatal History: G1P0T1A0L1, umbilical vein varix, HSV-1, poor fetal growth affecting management of mother in 2nd trimester, the patient does not have any previous pregnancies

Past Medical History: No past medical history

Past Surgical History: No past surgical history

Family History: Brain cancer (maternal grandma), GI cancer (mother), liver disease (father), cerebrovascular accident (maternal grandfather)

Social History (tobacco/alcohol/drugs): The patient denies a history of tobacco, alcohol, and drugs.

Living Situation: Lives at home with husband

Education Level: Bachelor's degree

Admission Assessment

Chief Complaint (2 points): "Gush of pinkish fluid"

Presentation to Labor & Delivery (10 points): The patient arrived at the Carle Foundation emergency department after a "gush of pinkish fluid." The patient was admitted to Carle labor and delivery due to a spontaneous rupture of membranes. The gush happened at approximately

0630 and the patient was admitted to labor and delivery at 0805. The patient denies feeling contractions at the time of the gush or after. The patient denies pain.

Diagnosis

Primary Diagnosis on Admission (2 points): Preterm, premature rupture of membranes

Secondary Diagnosis (if applicable): Not applicable

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	3.5-5.2	4.88	4.27	N/A	N/A
Hgb	11-16	14.6	12.7	N/A	N/A
Hct	34-47%	44.0	37.9	N/A	N/A
Platelets	140-400	243	213	N/A	N/A
WBC	4-11	8.97	10.36	N/A	N/A
Neutrophils	1.6-7.7	6.22	7.05	N/A	N/A
Lymphocytes	1-4.9	1.77	2.17	N/A	N/A
Monocytes	0-1.1	0.76	0.89	N/A	N/A
Eosinophils	0-0.5	0.1	0.13	N/A	N/A
Bands	0-0.9	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, AB, O	O	N/A	N/A	N/A

Rh Factor	+/-	+	N/A	N/A	N/A
Serology (RPR/VDRL)	Nonreactive	Nonreactive	N/A	N/A	N/A
Rubella Titer	Positive	Positive	N/A	N/A	N/A
HIV	Nonreactive	Nonreactive	N/A	N/A	N/A
HbSAG	Nonreactive	Nonreactive	N/A	N/A	N/A
Group Beta Strep Swab	Negative	Negative	Negative	N/A	N/A
Glucose at 28 Weeks	<140	120	N/A	N/A	N/A
MSAFP (If Applicable)	10-150	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

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-19	Negative	Negative	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	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)	>/= 20	30.1	N/A	N/A	N/A

Lab Reference (1) (APA):

No abnormal values, no references needed.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The total length of labor was 6 hours and 44 minutes. The labor was spontaneous. The length of the first stage was 5 hours and 56 minutes and the second stage was 48 minutes.
Current stage of labor	The patient is currently in the fourth stage of labor. The fourth stage of labor begins when the placenta is fully expelled from the uterus (Ricci et al., 2022). The fourth stage is over when the mother is stabilized and is psychologically adjusted (Ricci et al., 2022). The fourth stage generally lasts around one to four hours

	(Barlow et al., 2019). The fourth stage initiates the postpartum period (Ricci et al., 2022). During this stage, the most important assessments are looking for hemorrhage, fundal assessments, and vital signs (Barlow et al., 2019). Early detection of hemorrhage is essential for the patient's health. Generally, there will be some bleeding and it should be red, mixed with small clots, and mild to moderate flow (Barlow et al., 2019). The fundus should be firm, well contracted, and midline (Ricci et al., 2022). The vital signs should remain stable throughout this stage. During this time interventions should also be taken to prevent bladder distention and venous thromboembolism (Ricci et al., 2022). If the patient does not have a catheter, they should be encouraged to use the restroom frequently to prevent bladder distention. My patient had a scant amount of lochia, and it was a normal consistency. My patient used the restroom frequently and had on sequential compression devices to avoid venous thromboembolisms. My patient had stable vital signs throughout the shift and was monitored for hemorrhage. Additionally, my patient's mood was stable and there were no signs of infection. The patient had a 2nd-degree perineal tear that did not show any signs or symptoms of infection.

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. (2022). *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	Prenatal Vitamin 27/ Multivitamins with Iron	**ONLY ONE HOME MEDICATOIN**	N/A	N/A	N/A
Dose	27mg-0.8mg	N/A	N/A	N/A	N/A
Frequency	1 Tablet Daily	N/A	N/A	N/A	N/A
Route	PO	N/A	N/A	N/A	N/A
Classification	Pharm: Prenatal vitamin Thera: Prenatal vitamin	N/A	N/A	N/A	N/A
Mechanism of Action	Iron becomes a part of one's hemoglobin and myoglobin which carries oxygen to one's tissues, organs, and muscles.	N/A	N/A	N/A	N/A
Reason Client Taking	Treat or prevent vitamin	N/A	N/A	N/A	N/A

	deficiency due to poor diet or pregnancy				
Contraindications (2)	Hypersensitivity to other vitamin/nutritional supplements, Overload of iron in the blood	N/A	N/A	N/A	N/A
Side Effects/ Adverse Reactions (2)	Constipation, GI upset	N/A	N/A	N/A	N/A
Nursing Considerations (2)	Encourage patient to sit up for 10 minutes after taking prenatal vitamins and assess for sensitivity or reaction to vitamins, administer prenatal vitamins daily as prescribed by provider.	N/A	N/A	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patient's CBC and chemistry labs to determine body's nutritional status	N/A	N/A	N/A	N/A
Client Teaching needs (2)	Take medication on an empty stomach 1 hour before	N/A	N/A	N/A	N/A

	or 2 hours after meals. -Avoid antacids, dairy products, tea, or coffee within 2 hours before and after treatment.				

Hospital Medications (5 required)

Brand/ Generic	Tylenol/ Acetaminophen	Dulcolax/ bisacodyl	Benadryl/ diphenhydramine	Zofran ODT/ ondansetron	Advil/ ibuprofen
Dose	1000 mg	10 mg	50 mg	4 mg	600 mg
Frequency	Q6hrs	Daily	Q4hrs	Daily	Q6hrs prn for pain
Route	PO	Rectal	PO	PO	PO
Classification	Nonsalicylate, para-aminophenol derivative, antipyretic, nonopioid analgesic	Laxative, stool softener	Antihistamine, antianaphylaxis adjunct	Antiemetic, antivertigo	NSAID, Analgesic, anti-inflammatory
Mechanism of Action	inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering	Surfactant that softens stool by decreasing surface tension between oil and water in	Binds to central and peripheral H1 receptors, competing with histamine for these sites	Blocks serotonin receptors in the chemoreceptor or trigger zone and peripherally	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandin

	with pain impulse generation in the peripheral nervous system	feces. More fluid penetrate stool, forming a softer fecal mass.	and preventing it from reaching its site of action	at vagal nerve terminals in the intestines. This reduces nausea and vomiting by preventing serotonin release in the intestine.	s, which mediate inflammatory response and cause local pain, swelling, and vasodilation
Reason Client Taking	Pain	To prevent post-birth constipation	Itching	Nausea and vomiting	Mild to moderate pain
Contraindications (2)	Liver impairment, hypersensitivity to acetaminophen	Fecal impaction, intestinal obstruction	Breastfeeding, hypersensitivity to Benadryl	Concomitant use of apomorphine, long QT syndrome	Hypersensitivity to ibuprofen, kidney disease
Side Effects/ Adverse Reactions (2)	Hepatotoxicity, atelectasis	Palpitations, abdominal cramps	Arrythmias, hemolytic anemia	Headache, abdominal pain	Hypertension, peripheral edema
Nursing Considerations (2)	Use cautiously in patients with a history of alcohol abuse, assess liver function tests	Expect excessive or long-term use of treatment cause dependence on laxative for bowel movements, assess for laxative abuse syndrome	Be aware Benadryl will make the patient tired, ensure patient is not breastfeeding	Monitor patient for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions like anaphylaxis and bronchospasm, monitor patient’s electrocardiogram because treatment can prolong QT intervals resulting in	Review BUN and creatinine, ensure the patient does not go over max daily dose

				life-threatening arrhythmias	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess ALT, AST, bilirubin, and creatinine	Assess cause for constipation, assess skin turgor for dehydration	Heart rate, I&Os	Monitor patient's heart rhythm	Assess patient's heart rate and pulse.
Client Teaching needs (2)	Do not exceed to max daily dose, teach signs and symptoms of liver impairment	Encourage patient drink 6-8 glasses of water daily to prevent constipation. Instruct patient to notify prescriber about symptoms of electrolyte imbalance, dizziness, and light-headedness	Take with food, this drug will make you tired	Advise patients to report signs of hypersensitivity like rash to provider, advise patients to seek medical attention if patient experiences persistent, severe symptoms	Instruct patient to take tablets with full glass of water and caution them not to lie down for 15-30 minutes to prevent esophageal irritation. Advise patient to take drug with food or after meals to reduce GI distress

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert and oriented to person, place, time, and situation. (x4) Patient was relaxed and in good spirits during assessment. Patient showed no signs of distress. Overall appearance was clean and well groomed.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient's skin color was appropriate for ethnicity. Skin was warm, dry, and intact. Skin turgor was loose. Patient had no rashes or bruises. The patient had a 2^{nd} degree perineal tear. The patient's Braden score was 22. Patient had no drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head appears normocephalic. Neck appeared symmetrical with trachea at midline. Patient claims no hearing loss or pain in the ears. Eyes exhibited PERRLA. Extraocular movements were intact. Eyes appeared symmetrical with no drainage present, conjunctiva was pink and not inflamed. Patient's nose was symmetrical and deviated septum was not detected. Patient has good oral hygiene, tongue appeared pink and midline with no sores. No dental carries were present. Buccal mucosa was pink and moist.
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:**	S1 and S2 heard. S3 and S4 not heard. Normal rate and rhythm were heard upon auscultation. Upper and lower peripheral pulses were palpable at 3+. No jugular vein distention was noted. Capillary refill was less than 3 seconds. No edema present.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds were clear and equal bilaterally. Patient has no chest deformities. Respirations were observed to be even, calm, and regular. No accessory muscles were used.

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 in the hospital. The patient's height is 158 cm, and weight is 61.2 kg. Bowel sounds were hyperactive in all four quadrants. The patients last bowel movement was 6/24/2022. Patient denies pain upon palpation. No masses present. No presence of distention, incisions, scars, wounds, or drains.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient states there was no pain, urgency, or frequency upon urination. During shift, urine was clear, with no odor. Patient is not on dialysis and did not have a catheter. Inspection of genitals was not performed during shift.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The patient ambulated well without assistance. Patient did not use any supportive devices. Upper extremity strength is 5/5 on right side and 5/5 on the left side. Lower extremity strength is 5/5 on right side and 5/5 on the left side. Patient exhibited equal strength in both arms and legs. Patient exhibited full ROM in both arms and legs. Fall risk score was 0.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	Patient is alert and oriented x4. Eyes exhibit PERRLA signs. Patient's speech is well articulated and clear. Patient moves all extremities well and displays no signs of paralysis. Patient displayed equal strength in all extremities. Patient senses touch in both arms and legs. Patient's reflexes were present.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	Patient talks to husband for support. Patient's developmental level was appropriate for age. Patient was alert and oriented x4. The patient is not religious. Patient depends on husband for support of the newborn.

Personal/Family Data (Think about home environment, family structure, and available family support):	
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fundal height and position: 1 cm below the umbilicus, midline Bleeding amount: Scant (less than 2.5 cm on pad/hr.) Lochia color: Rubra, normal consistency No episiotomy or lacerations
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:**	Spontaneous rupture of membranes on 6/22/2022 at 0630. The patient stated it was pinkish and she did not know the amount and said there was not an odor. The patient gave birth on 6/22/2022 at 1659. The patient had a vaginal delivery with approximately 345 mL of blood loss. The patient gave birth to a female whose APGAR scores were 8 (1 minute) and 9 (5 minutes). The patient will feed the newborn with formula.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	87	108/70	18	36.9°C	98% on room air
Labor/ Delivery	90	97/61	18	36.9°C	99% on room air
Postpartum	82	100/64	16	36.7°C	97% on room air

Vital Sign Trends: Vital signs remained stable throughout the shift and stages of delivery.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0706	0-10	Perineum	1	Aching, cramping	Pain medication offered but refused
0941	0-10	Perineum	2	Aching, cramping	Pain medication offered but refused

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:**	The patients IV was discontinued due to her hemoglobin being over 8.

Intake and Output (2 points)

Intake	Output (in mL)
300 mL	431 mL

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.
Vital signs q8hrs until discharge (N)	Q8hrs	This is important because it can help detect a worsening in the patient's condition.
Notify physician for significant maternal hemorrhage	Until discharge	This is important because if the physician is notified early, we can minimize blood loss for the patient.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in?

My patient was in the taking-in phase.

What evidence supports this?

The evidence for this revolves around the patient trying to care for herself. The patient primarily let her husband and the healthcare team care for her child while she recovered and tried to sleep and eat. The mother felt that if she rested, she could support and take better care of the baby. dw

Discharge Planning (3 points)

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

Equipment needs (if applicable): The patient does not have any equipment needs.

Follow up plan (include plan for mother AND newborn): The patient will follow up with her pediatrician as suggested. The patient will also follow up with OB/GYN to assess the healing of the 2nd-degree perineal tears.

Education needs: The patient needs further education on the best feeding practices for premature babies.

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 hemorrhage	This was chosen because hemorrhage	**1.** Assess for bleeding	The patient understood and

related to 2^{nd}-degree perineal tear as evidenced by perineal muscle tearing (Phelps, 2020).	could be detrimental to the mother.	**Rationale:** This should be done for early detection of hemorrhage (Ricci et al., 2021). **2.** Monitor vitals frequently **Rationale:** Vital signs can be a good detector of internal bleeding (Ricci et al., 2021).	welcomed these interventions. The patient did not hemorrhage but if she did it would have been noticed early. The plan does not require modification.
2 Risk for acute pain related to 2^{nd}-degree perineal tear as evidenced by perineal muscle tearing (Phelps, 2020).	This was chosen because acute pain will interfere with the patient's ability to care for herself.	**1.** Assess the patient's pain levels **Rationale:** This should be done to catch the pain early so early intervention can be made (Ricci et al., 2021). **2** Offer pain medication as ordered **Rationale:** This should be done to prophylactically control the patient's pain (Ricci et al., 2021).	The patient understood and welcomed the interventions. The patient's pain never exceeded a 2/10 with her acceptable pain level being 3/10. The patient denied pain medication. The plan does not require modification.
3. Knowledge deficit related to best feeding practices as evidence by insisting on bottle feeding (Phelps, 2020).	This was chosen due to the lactation consultant advising the patient to breastfeed due to her premature child.	**1.** Ask the lactation consultant to talk to her again **Rationale:** This was chosen because the lactation consultants are the most knowledgeable people regarding breastfeeding (Ricci et al., 2021). **2.** Communicate with the patient to assess barriers to breast feeding. **Rationale:** This was chosen because finding out the patient's barriers can	These interventions could not be assessed due to the lactation consultant not being available during the shift and the nurse feeling it would be best to talk to her after she has had longer postpartum time.

		help overcome issues they may be having (Ricci et al., 2021).	
4. Knowledge deficit related to infection as evidence by not knowing how to care for her perineal tear (Phelps, 2020).	This was chosen because the patient needs to know how to properly care for her wound on an outpatient basis.	**1.** Educate the patient and husband on infection prevention **Rationale:** This was chosen because the patient and her husband will be the primary people caring for the patient's wound (Ricci et al., 2021). **2.** Educate the patient on signs and symptoms of infection. **Rationale:** This will ensure that any infection that occurs will be caught early so treatment can be started early (Ricci et al., 2021).	The patient understood and welcomed the interventions. The patient received and understood the education provided. The plan does not need further intervention at this time.

Other References (APA)

Phelps, L.L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed.). Wolters Kluwer.