

N432 Postpartum Care Plan
Lakeview College of Nursing
Haley Shaw

Demographics (3 points)

Date & Time of Admission 9/1/22 at 0125	Patient Initials A.Q.	Age 29	Gender Female
Race/Ethnicity white	Occupation Starbucks barista	Marital Status single	Allergies none
Code Status Full code	Height 5'5	Weight 260lbs	Father of Baby Involved yes

Medical History (5 Points)

Prenatal History: G2T2P0A0L2, IVF, hypertension

Past Medical History: previous c section, depression, PCOS, MRSA, preeclampsia in previous pregnancy

Past Surgical History: transfer of embryo; intrauterine, c-section (4/25/19), carpel tunnel release

Family History: diabetes in maternal grandfather, hypertension in mother

Social History (tobacco/alcohol/drugs): none

Living Situation: patient lives with partner

Education Level: 12th grade & some college

Admission Assessment

Chief Complaint (2 points): water leaking

Presentation to Labor & Delivery (10 points): This patient is a 29-year-old female that came into the ED G2T1P0A0L1 at 39 weeks 0 days with ruptures membranes. Patient was at home. At 12:45am patients' membranes ruptured. She was in L&D with the complaint of "water leaking." Patients LMP was 12/2/21. Patients EDD is 9/8/22.

Diagnosis

Primary Diagnosis on Admission (2 points): rupture of membranes, secondary c-section

Secondary Diagnosis (if applicable): Patient had preeclampsia and gestational diabetes in previous pregnancy. Patient also has obesity.

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	4.21	4.37	4.37	Within normal limits
Hgb	12-15.8	13.0	13.7	13.7	Within normal limits
Hct	36-47	37.7	40.2	40.2	Within normal limits
Platelets	140-440	316	278	278	Within normal limits
WBC	4-12	9.90	11	11	Within normal limits
Neutrophils	47-73	68.0	63.8	63.8	Within normal limits
Lymphocytes	18-42	20.4	26.7	26.7	Within normal limits
Monocytes	4-12	9.9	8.4	8.4	Within normal limits
Eosinophils	0-5	1.0	0.5	0.5	Within normal limits

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	A	A	A	Within normal limits
Rh Factor	+/-	+	+	+	Within normal limits
Serology (RPR/VDRL)	+/-	-	-	-	Within normal limits
Rubella Titer	Immune/not immune	Immune	Immune	immune	Within normal limits
HIV	+/-	-	-	-	Within normal limits

HbSAG	+/-	-	-	-	Within normal limits
Group Beta Strep Swab	+/-	-	-	-	Within normal limits
Glucose at 28 Weeks	<140	1hour-180/3hr-139	139	139	Within normal limits
MSAFP (If Applicable)	No risk/negative	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
Drug screen	+/-	-	-	-	Within normal limits

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
<p>History of labor:</p> <p style="padding-left: 40px;">Length of labor</p> <p style="padding-left: 40px;">Induced /spontaneous</p> <p style="padding-left: 40px;">Time in each stage</p>	<p>Patient presented to the ED at 0100 on 9/1/22. Her membranes had ruptured at home at 0045 with clear fluid and no odor. Patient was not able to obtain an amount of fluid as she was at her home. Patient had a spontaneous cesarean section. Patients' newborn was delivered at 0350. Patient was in the 3rd stage of labor for 3 minutes. From the time the patients water broke at 0045 until the baby was born was a total of 3 hours and 5 minutes.</p>
<p>Current stage of labor</p>	<p>This patient is currently in the 4th stage of labor as she is still in the first hours after surgery. The patient has a low transverse laceration from the cesarean section. The patient will make a follow up appointment with the doctor to make sure everything is healing properly. Vital indicators such as the patient's temperature, pulse, and blood pressure will be recorded. Additionally, the state of the patient's fundus and</p>

	<p>the amount of bleeding are regularly monitored (Ricci et al, 2021).</p>
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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 different medications must be completed***

Home Medications (2 required)

Brand/Generic	Aspirin/ acetylsalicylic acid	Prenatal/ one a day women’s prenatal			
Dose	81mg	1 tablet			
Frequency	Daily	Daily			
Route	Oral	Oral			
Classification	Pharmacologic: salicylic Therapeutic: NSAID	Pharmacologic: Vitamin Therapeutic: Water soluble vitamin			

Mechanism of Action	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.	helps prevent major birth defects of the fetus' brain and spine			
Reason Client Taking	Prevent preeclampsia	Nutritional supplement for pregnant women while pregnant and after pregnancy			
Contraindications (2)	Hypersensitivity to aspirin, active bleeding, or coagulation disorders	-iron metabolism disorder causing increased iron storage -a type of blood disorder where the red blood cells burst called hemolytic anemia			
Side Effects/Adverse Reactions (2)	Nausea, decreased blood iron level	Nausea, constipation			
Nursing Considerations (2)	Assess pain and pyrexia one hour before or after medication. In long-term therapy monitor renal and liver function and ototoxicity	Assess her gastrointestinal system; ask about her pre-pregnancy weight, any discomforts such as vomiting, diarrhea or constipation, hemorrhoids, and changes in bowel habits			
Key Nursing Assessment(s)/Lab(s)	Routinely check for signs of	Liver panel and vitamin B12.			

) Prior to Administration	bleeding. Assess any known allergy's to NSAID's	Assess pre and post pregnancy weight.			
Client Teaching needs (2)	Take with food because it could cause an upset stomach. Breastfeeding mothers should always check with prescriber before taking.	Take prenatal with food to prevent nausea. Patient could also take at night to prevent nausea.			

Hospital Medications (5 required)

Brand/Generic	Lactated ringers	Oxytocin/ Pitocin	Reglan/ metoclopramide	Ketorolac/ Toradol	Lansinoh lanolin cream
Dose	125mL/hr	30units/500mL	10mg	30mg	Every hour PRN
Frequency	Continuous	Daily	Every 6 hours PRN	Every 6 hours	Every hour PRN
Route	Intravenous	Intravenous	Intravenous	Intravenous	topical
Classification	Alkalinizing Agents	oxytocic hormones	Pharmacologic: dopamine 2 receptor antagonist Therapeutic: antiemetic, upper GI stimulant	Pharmacologic: NSAID Therapeutic: analgesic	emollient
Mechanism of Action	restores fluid and electrolyte balances, produces diuresis,	reduce overall blood loss, by functioning as a uterotonic. Contracts uterus	Antagonizes the inhibitory effect of dopamine on GI smooth	Blocks cyclooxygenase, an enzyme needed to synthesize	soften the skin by forming an occlusive oil film on

	and acts as alkalizing agent		muscle.	prostaglandins.	the stratum corneum layer of the epithelium , thus decreasing the trans epidermal water loss
Reason Client Taking	To stay hydrated	To reduce blood loss/ contract uterus	To prevent postoperative nausea and vomiting	For pain	Nipple discomfort
Contraindications (2)	Hypercalcemia, hypokalemia	Hypersensitivity to components of Pitocin and hyperactive/hypertonic c uterus	Epilepsy, hypersensitivity to metoclopramide or its components	Advanced renal impairment Active peptic ulcer disease	Skin irritation, poisonous when ingested
Side Effects/Adverse Reactions (2)	Itching, hypersensitivity leading to anaphylaxis	Confusion, difficulty breathing	Patient should check with prescriber before breastfeeding, anxiety	CVA, seizures	Skin burning, stinging, redness, or irritation
Nursing Considerations (2)	May worsen existing hypovolemia and hypotension causing cardiovascular collapse. Monitor for signs of fluid volume deficit.	Assess IV site. Check bleeding routinely.	Use cautiously in patients with hypertension as it may increase catecholamine levels. Notify prescriber if patient shows signs of toxicity.	Know that risk of heart failure increases. Monitor liver enzymes.	Use sparingly on dry nipples after breastfeeding sessions. If lanolin poisoning suspected, discontinue use & seek medical care.

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Calculate IV rate, assess IV site	Check other medications that patient is using and check for allergies. Monitor patient's bleeding.	Assess for extrapyramidal symptoms and tardive dyskinesia. Assess for gastrointestinal complaints	Assess hgb or hct labs. Assess liver panel.	Check for cracked nipples. Ask if any allergies to this.
Client Teaching needs (2)	Check with your doctor right away if you have stomach pain, confusion, irregular heartbeat, numbness or tingling in the hands, feet, or lips. Check with doctor if you have trouble with breathing, or weakness or heaviness of the legs.	Explain to patient the use of this medication. Patient should report any adverse reactions.	Instruct patient on how to take form prescribed, advise against activities that require alertness.	Alert patient not to take aspirin or other NSAID's without consulting doctor. Urge patient to avoid alcohol while taking this.	Apply a pea sized amount. No need to wipe off before breastfeeding.

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point):	Appears alert and oriented to person, place, time,
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<p>Alertness: Orientation: Distress: Overall appearance:</p>	<p>and situation. Overall appearance well groomed, no acute distress.</p>
<p>INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 17 Drains present: Y<input checked="" type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Skin color is white, warm, and dry upon palpation. No rashes, lesions, and bruising. Normal distribution, and texture of hair. Skin turgor normal. Patient has a urethral catheter. Patient has a low transverse incision from c-section. Patients Braden score is a 17.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical. Trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable (2+). No lymphadenopathy in the head/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 noted. No assistive devices. Nose septum is midline, no bumps, lumps, or lesions visual. Good detention, oral mucosa overall moist and pink without lesions noted.</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 checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear S1 and S2 without murmurs gallops or rubs. Normal rate and rhythm. Capillary refill was less than 3 seconds on fingers/toes bilaterally. No neck vein distention. No edema present. Peripheral pulses are 2+ bilaterally. .</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Normal rate and pattern of respirations, respirations symmetrical and non-labored, lung sounds clear throughout anterior/posterior bilaterally, no wheezes, crackles, or rhonchi noted.</p>
<p>GASTROINTESTINAL (2 points):</p>	<p>Patient has a regular diet at home. Patients'</p>

<p>Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:</p>	<p>height is 5'5 and weight is 260lbs. Auscultation and palpation of bowel sounds are normal. Patient's last bowel movement was 8/31/22. No distension or scars. Patient has low transverse laceration and a urethral catheter.</p>
<p>GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>Patient voided 250mL of urine. No pain with urination. Patient has a 10mL urethral catheter.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 2 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient has a fall risk score of 2. She is independent with no need for assistance with equipment.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" 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>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. Patient's mental status is within normal limits. Speech and sensory are not impaired and is normal. No loss of consciousness. Deep tendon reflexes are reactive.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.:</p>	<p>Patient copes by cleaning or doing self-care. Patients developmental level is normal as she completed high school and some college. Patient is not religious. Patients has tons of support including her partner, family, and friends.</p>

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 & position is firm & even with umbilicus. Moderate to light bleeding amount. Lochia color is rubra and trickle noted with fundal assessment. Patient has a low transverse incision.
DELIVERY INFO: (1 point) Rupture of Membranes: Time: 9/1/22 at 0045 Color: clear Amount: not measured Odor: none Delivery Date: 9/1/22 Time: 0350 Type (vaginal/cesarean): cesarean Quantitative Blood Loss: 585mL Male or Female: female Apgars: 8, 9 Weight: 7lbs 15oz Feeding Method: breastfeeding	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	Not documented	109/74	Not documented	Not documented	Not documented
Labor/Delivery	87	124/76	16	98.4	Not documented
Postpartum	81	113/56	16	98.1	96/ room air

Vital Sign Trends: Patients vitals were slightly increased in labor & delivery due to the stress.

While patient is in postpartum care her vitals are normal and lower than before.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0826	0-10	Incision on abdomen	2	Tender	Relaxation techniques
1130	0-10	Incision on abdomen	3	Tender	Pain medication

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g Location of IV: right hand Date on IV: 9/1/22 Patency of IV: clean, intact, and dry Signs of erythema, drainage, etc.: none IV dressing assessment: clean, dry, and intact	

Intake and Output (2 points)

Intake	Output (in mL)
Clear liquids; ice chips 625mL lactated ringers	250mL urine

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

“N” after you list them, identify medical treatments with “M” after you list them.)		
Offer pain meds (T)	PRN	Offering pain medication will keep the patient comfortable since the patient had a cesarean section.
Fundal assessment (N)	Every 15 mins for the first hour, every 30 mins for the next hour, every 4 hours after that	Fundal assessment helps to assess the consistency shape and location of the uterus. It helps to keep the uterus to contract and prevent hemorrhage.
Using a binder (N)	continuous	This intervention will help keep the patient comfortable and help with pain from having a c section.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? This patient is in the taking in phase.

What evidence supports this? The patient was asking questions about breastfeeding and why it’s important to not bathe her baby in the first 24 hours after birth.

Discharge Planning (3 points)

Discharge location: Patient will go to her home with her partner.

Equipment needs (if applicable): Patient is being provided a breast pump.

Follow up plan (include plan for mother AND newborn): The patient will come in 2 weeks for a check-up then 6 weeks. The newborn will be seen within 24 hours.

Education needs: Patient needs educated on breastfeeding and proper car seat safety.

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

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>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. </p>
<p>1. Risk for infection related to low transverse incision as evidenced by c section</p>	<p>Patient has a risk for infection due to having a laceration from the c section.</p>	<p>1.Maintain standard precautions (Phelps, 2020). Rationale This will decrease the spread of microorganisms. 2.Minimize patients’ risk for infection by: wearing gloves and washing hands before and after providing care (Phelps, 2020). Rationale This is the best way to avoid the spread of pathogens.</p>	<p>Patient will remain free form signs and symptoms of infection. Patient will identify signs a symptom of infection.</p>
<p>2. Risk for hemorrhage related to c section as evidenced by client taking aspirin</p>	<p>Patient is taking aspirin which makes her have a higher risk for hemorrhage.</p>	<p>1. Save all perineal pads used during bleeding and weigh (Phelps, 2020). Rationale This determines the amount of blood loss. 2.Assess lochia frequently (Phelps, 2020). Rationale This determines if the amount discharged is within normal limits.</p>	<p>Patient heart rate, rhythm, blood pressure, and perfusion will remain within expected ranges. The patient will have a balanced 24-hour intake and output.</p>
<p>3. Knowledge</p>	<p>Patient was</p>	<p>1. Assess the mother’s</p>	<p>Mother will breastfeed</p>

<p>deficit of breastfeeding related to lack of access to resources as evidenced by newborn not latching</p>	<p>asking questions about breastfeeding.</p>	<p>knowledge and experience of breastfeeding (Phelps, 2020) Rationale This will help focus the teaching on specific learning needs. 2. Provide a quiet environment and privacy (Phelps, 2020). Rationale This enhances development of breastfeeding skills.</p>	<p>neonate successfully and will experience satisfaction with breastfeeding process.</p> <p>Mother will continue breastfeeding neonate after early postpartum period.</p>
<p>4. Knowledge deficit of preeclampsia related to chance of preeclampsia after birth as evidenced by history of preeclampsia</p>	<p>Patient had preeclampsia in previous pregnancy and can still develop this up to 12 months after giving birth.</p>	<p>1. find a quiet private environment for teaching patient and support person (Phelps, 2020). Rationale This frees patient from distractions. 2. Assess patient’s level of knowledge (Phelps, 2020). Rationale This will determine what level of knowledge the patient needs.</p>	<p>Patient will state intention to make needed changes in lifestyle.</p> <p>Patient will be motivated to learn.</p>

Other References (APA):

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

Wolters Kluwer.