N432 Postpartum Care Plan

Lakeview College of Nursing

Kelsey Bierman

Demographics (3 points)

Date & Time of Admission 09/13/2022	**Patient Initials** BH	**Age** 25	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Receptionist	**Marital Status** Married	**Allergies** Sulfa Drugs
Code Status Full	**Height** 165 cm	**Weight** 130 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: Chronic hypertension, uncomplicated normal vaginal delivery, negative abuse screen.

Past Medical History: Hypothyroidism, Chronic hypertension

Past Surgical History: Low back disc surgery (10/02/2019), Delivery of products of conception, external approach (02/11/2021), Repair perineal skin (02/11/2021), Repair vulva (02/11/2021), Dilation and evacuation (03/24/2020), Microdiscectomy lumbar-thoracic (left)(10,02,2019) and tonsillectomy and adenoidectomy**.**

Family History:

Father: Chronic back pain, Myocardial Infarction, Hypertension

Mother: Arthritis

Paternal Grandfather: Congestive heart failure, Diabetes Mellitus

Paternal Grandmother: Cervical cancer

Maternal Grandfather: Congestive heart failure

Social History (tobacco/alcohol/drugs): Former tobacco smoker of a pack-a-day patient has quit 30 days ago. Denies alcohol and drug use.

Living Situation: Lives with their spouse at their home**.**

Education Level: High School Degree some college

Admission Assessment

Chief Complaint (2 points): Elective Induction

Presentation to Labor & Delivery (10 points): Presented to Labor and Delivery accompanied by significant others. Patients answered admission questions per self and domestic violence was screened for. Patient was G3P1 at 39.3 weeks gestation age. Elective induction process was discussed with patient and patient verbalized understanding.

Diagnosis

Primary Diagnosis on Admission (2 points): G3P1 39.3 weeks elective 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	3.8-5.41	N/A	4.41	4.04	N/A
Hgb	11.3-15.2	N/A	12.5	11.4	N/A
Hct	33.2-45.3	N/A	37.4	33.9	N/A
Platelets	149-393	N/A	194	189	N/A
WBC	4-11.7	N/A	10.7	18.5	WBC count is usually elevated in pregnancy due to the stress of carrying a fetus (Dockree et al., 2021).
Neutrophils	45.3-79	N/A	7.5	N/A	N/A
Lymphocytes	11.8-45.9	N/A	2.4	N/A	N/A

Monocytes	4.4-12	N/A	0.6	N/A	N/A
Eosinophils	0-6.3	N/A	0.7	N/A	N/A
Bands	0.2-1.6	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	O	O	N/A
Rh Factor	Positive or Negative	Positive	Positive	Positive	N/A
Serology (RPR/VDRL)	Non-reactive	N/A	N/A	Non-reactive	N/A
Rubella Titer	Negative	N/A	N/A	N/A	N/A
HIV	Negative	N/A	N/A	Negative	N/A
HbSAG	Negative	N/A	N/A	N/A	N/A
Group Beta Strep Swab	Negative	N/A	N/A	Negative	N/A
Glucose at 28 Weeks	95 mg/dL or less	N/A	N/A	N/A	N/A
MSAFP (If Applicable)	0.5-2.0	N/A	N/A	N/A	N/A

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
PT	11-13.5	N/A	N/A	14.1	N/A

INR	1.1 or less	N/A	N/A	1.06	N/A
PTT	25-35	N/A	N/A	26.7	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)	56-76	N/A	N/A	75	N/A

Lab Reference (1) (APA):

Anjum, S. (2021). *CBC Test during Pregnancy: Importance & Tests Results*. Parenting.firstcry.com. https://parenting.firstcry.com/articles/cbc-complete-blood-count-test-in-pregnancy-why-you-need-it/

Dockree, S., Shine, B., Pavord, S., Impey, L., & Vatish, M. (2021). White blood cells in pregnancy: Reference intervals for before and after delivery. *EBioMedicine, 74*, 103715. https://doi.org/10.1016/j.ebiom.2021.103715

NHS. (2019). *Hyperglycaemia (high blood sugar)*. Nhsinform. https://www.nhsinform.scot/illnesses-and-conditions/blood-and-lymph/hyperglycaemia-high-blood-sugar

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The patient was in labor for 729 minutes, or 12 hours and 15 minutes. The patient had an elective induction of labor. The first stage of labor lasted 700 minutes, the second stage of labor lasted 11 minutes, and the third stage of labor for 18 minutes. The patient did have manual removal of the placenta, and PP Hemorrhage did occur.
Current stage of labor	The patient is currently in the fourth stage of labor Recovery during this stage mother's v/s and fundus are checked every 15 minutes times 4 and then every 30 minutes times 2 and because of the hemorrhage recovery time may be expanded to 4 hours allowing for more frequent checks. After recovery patient will be move postpartum status.

Stage of Labor References (2) (APA):

Mayo Clinic Staff. (2019). *Stages of labor and birth: Baby, it's time!* Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545

Ricci, 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	**Aspirin/ acetylsalicylic acid**	**Levothyroxine/Eltroxin**	**Labetalol**	**Hydrochlorothiazide/Microzide**	**Ibuprofen/ Advil**
Dose	325 mg	3.25 mg	100 mg	25 mg	350 mg
Frequency	Once daily	Once daily	Twice daily	Once daily	Every 4-6 hours PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic class: Salicylate Therapeutic class: NSAID	Pharmacological class: Synthetic thyroxine (T4) Therapeutic class: Thyroid hormone replacement	Pharmacological class: Noncardioselective beta-blocker/alpha blocker Therapeutic class: Antihypertensive	Pharmacological class: Thiazide diuretic Therapeutic class: Diuretic	Pharmacological class: NSAID Therapeutic class: Analgesic, anti-inflammatory, antipyretic
Mechanism of Action	Blocks the activity of cyclooxygenase, the enzyme	Replaces endogenous thyroid hormone, which may	Selectively blocks alpha and beta receptors in	A thiazide diuretic promotes the movement of sodium. Chloride and water from the	Blocks activity of cyclooxygenase, the enzyme

	needed for prostaglandins synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain.	exert its physiologic effects by controlling DNA transcription and protein synthesis. Levothyroxine has all the following actions of endogenous thyroid hormone.	vascular smooth muscle and beta receptors in the heart to reduce blood pressure and peripheral vascular resistance.	blood in peritubular capillaries into the nephron's distal convoluted tubule. Initially, it may decrease cardiac output, extracellular fluid, or plasma volume, which helps explain blood pressure reduction. It also may reduce blood pressure by direct arterial dilation.	needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilative.
Reason Client Taking	To relieve mild pain	To treat hypothyroidism	To manage hypertension	To manage hypertension	To relieve mild pain
Contraindications (2)	1. Active bleeding or coagulation disorders 2. Breastfeeding	1. Hypersensitivity to levothyroxine or its components. 2. Uncorrected adrenal insufficiency.	1. Bronchial asthma 2. Cardiogenic shock	1. Anuria 2. Hypersensitivity to hydrochlorothiazide	1. Angioedema 2. Asthma
Side Effects/Adverse Reactions (2)	1. CNS depression 2. GI bleeding	1. Pseudotumor cerebri 2. Seizures	1. Bradycardia 2. Heart Block	1. Hypotension 2. Pancreatitis	1. Aseptic meningitis 2. CVA
Nursing	1. Moni	1. Be	1. Be	1. Assess	1. Be

Considerations (2)	tor salicylate levels in patients receiving long-term therapy. 2. Expect aspirin therapy to be temporarily halted 5 to 7 days before elective surgery to reduce risk of bleeding.	aware that levothyroxine therapy is not to be used to treat obesity or for weight loss. 2. Monitor PT of patients who are receiving anticoagulants, as a dosage adjustment may be required.	aware that labetalol masks common signs of shock. 2. Be aware that stopping labetalol tablets abruptly after long-term therapy could result in angina, MI, or ventricular arrhythmias.	evidence of hypokalemia, such as muscle spasms and weakness. 2. Monitor patient for decreased visual acuity or ocular pain, especially within hours to weeks of beginning drug therapy and in patients with a history of penicillin or sulfonamide allergy.	aware that ibuprofen should not be used in pregnant women starting at 30 weeks gestation. 2. Know that the risk of heart failure increases with use of NSAIDs.

Key Nursing Assessment (s)/Lab(s) Prior to Administration	1. Assess pain one hour before and after administering aspirin. 2. In long-term therapy, monitor renal and liver function and ototoxicity.	1. Assess heart rate, ECG, and heart sounds 2. Assess episodes of angina pectoris at rest and during exercise.	1. Assess heart rate, ECG, and heart sounds 2. Assess BP periodically and compare to normal values.	1. Monitor blood pressure, daily weights, fluid intake and output, and serum levels of electrolytes. 2. Monitor BUN and serum creatinine levels as ordered.	1. Ask the patient to rate their pain on a numerical scale.
Client Teaching needs (2)	1. Instruct patient to take aspirin with food or after meals because it may cause GI	1. Inform the patient that levothyroxine replaces a hormone that is normally produced by the	1. Advise patient to report confusion, difficulty breathing, rash, slow puls	1. Advise patient to take hydrochlorothiazide in morning and early evening to avoid awakening during the night to urinate. 2. Instruct patient to take drug with food	1. Instruct patient to take tablets with a full glass of water, and caut

	upset if taken on an empty stomach. 2. Advise patients to avoid alcohol while taking aspirin to decrease risk of ulcers.	thyroid gland and that she'll probably need to take the drug for life. 2. Instruct the patient to take the drug at least 30 minutes before breakfast because drug absorption is increased on an empty stomach and evening doses may cause insom	e, and swelling in arms or legs. 2. Caution patient not to stop the drug abruptly because doing so could cause angina and rebound hypertension.	or milk of adverse GI reactions occur.	ion him to not lie down for 15-30 minutes. 2. Advise patient to take drug with food or after meals to reduce GI distress.

		nia.			

Hospital Medications (5 required)

Brand/Generic	Tranexamic acid/cyklokapron	Oxytocin/Pitocin	Labetalol/ Trandate	N/A	N/A
Dose	1,300 mg	1 mU/min	100 mg	N/A	N/A
Frequency	Twice daily for five days	Every 60 min	Twice daily	N/A	N/A
Route	Oral	I.V.	Oral	N/A	N/A
Classification	Pharmacological class: Antifibrinolytic Agents Therapeutic class: Hemostatic inhibitors	Pharmacological class: Oxytocic agent Therapeutic class: Labor inducer	Pharmacological class: Beta blocker Therapeutic class: Antihypertensive	N/A	N/A
Mechanism of Action	TXA is a synthetic reversible competitive inhibitor to the lysine receptor found on plasminogen. The binding of this receptor prevents plasmin (activated form of plasminogen) from binding to and ultimately stabilizes the fibrin matrix.	Oxytocin increases the sodium permeability of uterine myofibrils, indirectly stimulating contraction of the uterine smooth muscle. The uterus responds to oxytocin more readily in the presence of high estrogen concentrations	Selectively blocks alpha and beta receptors in vascular smooth muscle and beta receptors in the heart to reduce blood pressure and peripheral vascular resistance.	N/A	N/A

		and with the increased duration of pregnancy.			
Reason Client Taking	To treat heavy bleeding.	To improve uterine contractions in situations where there are fetal or maternal concerns.	To manage hypertension	N/A	N/A
Contraindications (2)	1. Known allergy to TXA 2. Intracranial bleeding	1. High blood pressure 2. Placenta previa	1. Bronchial asthma 2. Cardiogenic shock	N/A	N/A
Side Effects/Adverse Reactions (2)	1. Seizures 2. Headaches	1. Uterine rupture 2. Cervical laceration	1. Bradycardia 2. Hepatitis	N/A	N/A
Nursing Considerations (2)	1. Monitor for hemodynamics and watch for thromboembolic events. 2. The half-life of TXA is 2 to 11 hours.	1. Start flow charts to record maternal blood pressure and other vital signs, I&O ratio, weight strength, duration, and frequency of contractions. 2. Monitor fetal heart rate and maternal blood pressure	1. Check blood pressure before administering. If the blood pressure is low do not give. 2. Be aware that lacosamide	N/A	N/A

		and pulse at least every 15 minutes during infusion periods.	therapy should be discontinued gradually over at least 1 week to minimize seizure frequency.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. Monitor blood pressure, pulse, and respiratory status as indicated by severity of bleeding. 2. Monitor for overt bleeding every 15-30 minutes.	1. Closely monitor fundal tone, fundal height, and position. 2. Monitor vital signs, pain, and bleeding.	1. Check the patients blood pressure prior to administering	N/A	N/A
Client Teaching needs (2)	1. Instruct the patient to notify the nurse immediat	1. Provide education about how oxytocin will affect their	1. Encourage the patient to carry	N/A	N/A

	ely if bleeding reoccurs or it thromboembolic symptoms develop. 2. Caution patients to make position changes slowly to avoid orthostatic hypotension.	contractions. 2. Instruct patient to report headache, dizziness, palpitations, or intense pain.	medical identification that indicates her diagnosis and drug therapy. 2. Caution patient to avoid hazardous activities until drug's CNS effects her diagnosis and drug therapy.		

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2022 Nurse's drug handbook.* Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert and oriented to time, person, place, and situation. The patient was not in acute distress and was well-groomed. Appears stated age.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient's color was normal for ethnicity and was warm to the touch. Her skin was dry and intact, with no lesions, rashes, or bruising. The patient had a first-degree laceration. Nailbeds were pink with no cyanosis or clubbing. Skin turgor is elastic. No wounds or incisions were noted. The patient's Braden score is 22.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed. Conjunctivae are clear without exudates. Sclera is non-icteric. EOMs are intact. PERRLA is intact. Eyelids are normal without swelling or lesions. The external ear and ear canal are non-tender and without swelling. The canal is clear without discharge. Nasal mucosa is pink and moist. The nasal septum is midline. Nares are patent bilaterally. Oral mucosa is pink and moist with good dentition. Tongue is normal with no lesions. The neck is supple without adenopathy. Trachea is midline. Carotid

	pulses are 2+ bilaterally with no JVD.
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:**	The external chest is normal in appearance. PMI is palpated at the 5th intercostal space at the midclavicular line. Heart rate and rhythm are normal. No murmurs, gallops, or rubs auscultated. Clear S1 and S. +1 pitting edema in the feet and ankles.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The chest wall is symmetrical and without deformity. No signs of trauma. The chest wall is non-tender. No signs of respiratory distress. Lung sounds are clear in all lobes bilaterally without rales, rhonchi, or wheezing.
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 abdomen is soft, symmetric, and nontender without distension. No visible lesions or scars. The aorta is midline. The umbilicus is midline with no herniation. Bowel sounds are present but sluggish in all four quadrants. No masses, hepatomegaly, or splenomegaly were noted. The last bowel movement was on 09/14/2022 at 0000. The patient is on a regular diet at home and at the hospital. The patient is 165 cm tall and weighs 130 kg. The patient has no drains present and no wounds.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Moderate perineal edema. Ice pack applied to perineum. The patient had a partial laceration and this was approximated and sutured. The patient has a small amount of lochia Rubra at this time.
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 upper and lower extremities are atraumatic in appearance, without tenderness or deformity. No swelling or erythema. A full range of motion is noted in all joints. Muscle strength is 5/5 bilaterally. Capillary refill is less than 3 seconds in all extremities. All pulses +2 bilaterally. Steady gait noted. The patient's fall risk score was 35.

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:**	The patient is awake, alert, and oriented to person, place, time, and situation with normal speech. Motor function is normal, with muscle strength 5/5 bilaterally. The sensation is intact bilaterally. Reflexes 2+ bilaterally. The thought process is intact. Steady gait noted.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient is Christian. She had her husband and family for support. Stated that she was closer to her husband's family. She destresses by listening to music and watching TV. Her developmental stage is intimacy versus isolation and is appropriate for her age. The patient has access to a single-family home that has all utilities necessary.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	Fondus Firm at Umbilicus and in midline position. Small amount of Lochia Rubra no clots present. Laceration approximated moderate perineal edema present and ice pack applied.
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:**	ROM 9/13/22 at 1500 Moderate amount of clear fluid that was non odorous. Day of Delivery 9/13/22 at 2345 Normal Spontaneous vaginal delivery of Neonate. The patient had 1800 CC Quantitative Blood loss after delivery due to retained placental parts. Female Apgar's 8/9 3430 grams. Mother is breast-feeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Prenatal	78 beats per minute	144/78 mm Hg	17 breaths per minute	36.6℃ (Tympanic)	98% on room air
Labor/Delivery	N/A	N/A	N/a	N/A	N/A
Postpartum	89 beats per minute	134/62 mm Hg	16 breaths per minute	36.8℃ (Oral)	98% on room air

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric Scale	Back	5 on a scale of 1 to 10	Achy and stabbing	Heating pad Aspirin
0900	Numeric Scale	Back	2 on a scale of 1 to 10	Achy and stabbing	Heating pad.

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:**	18 gauge IV located on the left hand, date on the IV is 09/13/2022. The IV was patent and flushed well. There were no signs of erythema or drainage. The IV dressing was dry and intact.

Intake and Output (2 points)

Intake	Output (in mL)
2,000 mL of water 240 mL of apple juice Total: 2,240 mL	The patient urinated into the hat four times for a total of 1,200 mL of urine.

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "M" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Nursing Intervention: Fundus checks	15 min times 4 30 min times 2 every 4 hours times 24 hours	Fundal checks are important to prevent postpartum hemorrhages. You want to access to make sure that your patient is not having uterine atony.
Nursing Intervention: Record intake and output	every shift	monitor adequate intake and output after hemorrhage to ensure balance.
Nursing Intervention: Perineal Care	Every time patient goes to the bathroom.	Prevent infections.
Medical Intervention: Blood Transfusion	Once	Patient required blood replacement after 1800 cc Quantitative blood loss and decrease in Hemoglobin and hematocrit.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? The mother is in the bonding phase.

What evidence supports this? Breastfeeding, skin to skin, holding her baby and maintaining eye contact.

Discharge Planning (3 points)

Discharge location: Home to husband

Equipment needs (if applicable): Automatic B/P machine to monitor blood pressure.

Follow up plan (include plan for mother AND newborn): Mother at 1-week post-discharge and neonate at 2 days post-discharge

Education needs: Education with bowel and bladder habits, breastfeeding, infant care, and postpartum care to include postpartum depression signs and symptoms. Education on prevention of SIDS and car seat education.

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 infection related to break in skin integrity as evidenced by perineal laceration	I chose this nursing diagnosis because my patient is at an increased risk of infection because of manual extraction of placenta	1. Educate the client and visitors about proper hand hygiene and self-care techniques. Rationale: Proper hand hygiene is the primary method to stop the spread of infection. 2. Educate the client on how to perform proper perineal care Rationale: Patient must know to wipe front to back to prevent bacteria such as E.coli from spreading to the	Goal: Patient will remain free of infection throughout her duration of stay at the hospital. Outcomes: Patient is discharged without an infection. Modification: Educate patient on the signs and symptoms of infection.

		vaginal canal.	
2. Impaired skin integrity related to breastfeeding as evidenced by cracked nipples	I chose this nursing diagnosis because my patient's skin integrity is compromised and can result in impaired breastfeeding.	1. Apply a small amount of purified lanolin such as Lansinoh to nipples after feeding Rationale: The lanolin cream will help provide protection to the nipple and prevent further impaired skin integrity. 2. Advise the patient to wear breast shells in between feedings. Rationale: Breast shells can prevent any painful friction between your nipples and your bra while your fissures are healing.	Goal: The patient will use lanolin cream to help her nipples heal. The healing process will be completed in three days. Outcome: In three days after using lanolin cream the patient will have healed nipples and will better understand how to get her neonate to properly latch. Modification: Educate the patient on proper latch of neonate while feeding
3. Risk for impaired fluid volume related to postpartum hemorrhage as evidenced by 1800 cc quantitative blood loss	This is an important nursing diagnosis because the patient had a significant postpartum hemorrhage and has only urinated 200 cc.	1. Assess neurologic status and observe any behavioral changes and increasing irritability episodes. Rationale: Change in neurological status can be an early sign of cerebral edema caused by fluid retention. 2. Monitor for signs of hypertension, tachycardia, and jugular vein distention. Rationale: Elevated blood pressure can be seen in hypovolemia.	Goal: The patient will obtain hemodynamic stability prior to discharge. Evaluation: Patient hemoglobin and hematocrit will increase to WNL and electrolytes will stabilize prior to discharge. Modification: Blood transfusion was administered postpartum.
4. Risk for impaired bonding related to fatigue as evidenced by postpartum hemorrhage.	I chose this nursing diagnosis because my patient has physical barriers that is preventing	1. Discuss the client's view of infant care responsibilities and parenting roles. Rationale: To provide information about how a client perceives these role changes that will help	Goal: Patient will bond with newborn by holding, maintaining eye contact, and breastfeeding her newborn prior to discharge Evaluation: Patient

	bonding with her newborn such as fatigue.	identify areas of learning need. 2. Explain the factors that lead to the separation of mother and infant brought about by the postpartum hemorrhage. Rationale: Providing information helps minimize anxiety and feelings of helplessness related to the mother's inability to assume the role expected of her.	successfully bonding with her newborn before discharge Modification: Ensure significant other is bonding with the newborn as well.

Other References (APA)

Cleveland Clinic. (2018). *Nipple fissure: Causes, symptoms, diagnosis & treatment*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/22605-nipple-fissure

Martin, P. (2018). *8 Postpartum hemorrhage nursing care plans*. Nurseslabs. https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/