N432 Postpartum Care Plan

Lakeview College of Nursing

Alfonso Crane

Demographics (3 points)

Date & Time of Admission 10/25/2022 @ 2330	**Patient Initials** K.K.	**Age** 20 years old	**Gender** Female
Race/Ethnicity African American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** No known allergies
Code Status Full Code	**Height** 160 cm	**Weight** 59.9 kg	**Father of Baby Involved** Yes

Medical History (5 Points)

Prenatal History: G1 T0 P1 A0 L1. Prenatal care started 06/2022.

Past Medical History: Asthma

Past Surgical History: No past surgical history

Family History: Mother – healthy | Father – healthy | Sister – healthy | Maternal grandmother – stroke | Maternal grandfather – healthy | Paternal grandparents – healthy

Social History (tobacco/alcohol/drugs): No history of alcohol use or tobacco use. Former smoker – Marijuana daily.

Living Situation: The patient lives with their boyfriend.

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points): The patient is a 20-year-old female with a prenatal history of G1T0P0A0L0. The expected delivery date for this patient is 11/29/2022. The patient presents to the emergency department with abdominal pain. Ms. K is positive for contractions and fetal movement. There is no vaginal bleeding or fluid leakage at the time of the ED assessment. The patient reports having abdominal pain and contractions after dinner, at

around 2100 on 10/25/2022. The patient denies headaches, SOB, RUQ pain, and denies any visual changes.

Diagnosis

Primary Diagnosis on Admission (2 points): Abdominal pain

Secondary Diagnosis (if applicable): Bleeding

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 (OSF Database, 2022)	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC (x 10^6)	3.5-5.2	3.86	3.83	3.29	A low value of RBCs is a significant finding to blood loss (Pagana et al., 2019). The patient presented to the OB unit with bleeding.
Hgb (g/dL)	11-16.8	11.5	11.2	9.6	A low Hgb value is a significant finding to blood loss (Pagana et al., 2019). The patient presented to the OB unit with bleeding.
Hct	34%-47%	33.8%	33.1%	28.8%	A low Hct value is a significant finding to blood loss (Pagana et al., 2019). The patient presented to the OB unit with bleeding.
Platelets	140,000-400,000	100,000	112,000	110,000	A low platelet value is a significant finding to blood loss (Pagana et al., 2019). The patient presented to the OB unit with bleeding.
WBC (cells/ mcL)	4,000-11,000	7,200	8,600	12,500	An elevated WBC level can indicate an infection (Pagana et al., 2019). The cesarean birth puts the patient at an increased risk for infection.
Neutrophils	40%-80%	61.1%	51.7%	78.8%	This value is within normal

					limits.
Lymphocytes	18%-40%	25.8%	34%	18%	This value is within normal limits.
Monocytes	2%-10%	11.3%	11.4%	3%	This value is within normal limits.
Eosinophils	0%-8%	1.3%	2.1%	0%	This value is within normal limits.
~~**Bands**~~	~~0%-10%~~	~~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 (OSF Database, 2022)	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O	A	A	A	The mother's blood type is A.
Rh Factor	(+) or (-)	(+)	(+)	(+)	The mother's Rh factor is (+).
Serology (RPR/VDRL)	Reactive or Nonreactive	Nonreactive	Nonreactive	Nonreactive	This value is within normal limits.
Rubella Titer	Immune or Nonimmune	Immune	Immune	Immune	This value is within normal limits.
HIV	Reactive or Nonreactive	Nonreactive	Nonreactive	Nonreactive	This value is within normal limits.
HbSAG	Reactive or Nonreactive	Nonreactive	Nonreactive	Nonreactive	This value is within normal limits.
Group Beta Strep Swab	(+) or (-)	Not performed	Not performed	Not performed	There was no lab value on the date of assessment: 10/26/2022.
Glucose at 28 Weeks	>140	Not performed	Not performed	Not performed	There was no lab value on the date of assessment: 10/26/2022.
~~**MSAFP (If Applicable)**~~	~~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	Prenatal	Value on	Today's	Reason for Abnormal

	Range (OSF Database, 2022)	**Value**	**Admission**	**Value**	
Urine Drug	Not Detected	Detected: Cannabinoid	Detected: Cannabinoid	Detected: Cannabinoid	The patient was positive for cannabinoid, and upon assessment, the patient's social history indicates marijuana use.
INR (ratio)	0.8-1.2	1.0	No value	No value	There was no lab value on the date of assessment: 10/26/2022.
aPTT (sec)	21-35 sec	10.9	No value	No value	There was no lab value on the date of assessment: 10/26/2022.
PT (sec)	11-13 sec	28	No value	No value	There was no lab value on the date of assessment: 10/26/2022.
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 (µmol/L) (if applicable)	45-90 (Pagana et al., 2019)	0	84	0	There was no lab value on the date of assessment: 10/26/2022.

Lab Reference (1) (APA):

OSF Database. (2022).

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**	The length of labor for the patient was a total of 0h1min in the 3rd stage (OSF Database, 2022). There was "no labor", as the patient needed an emergency cesarean birth. The patient had an induced, emergency cesarean birth.
Current stage of labor	The patient is currently in the fourth stage of labor. The fourth stage of labor begins with the completion of the placental expulsion and membranes (Ricci et al., 2021). This stage starts the postpartum period that the mother experiences. The mother may also experience feelings of peace and excitement. The fundus should be firm and well contracted at this stage, typically located at the midline between the umbilicus and symphysis (Ricci et al., 2021). The lochia is red, mixed with small clots, and of moderate flow (Ricci et al., 2021). The focus during this stage is to monitor the mother to prevent hemorrhage, bladder distention, and venous thrombosis -- all complications and risk factors associated with post-birth (Ricci et al., 2021). Vital

	sounds, the amount and consistency of the lochia, and the uterine fundus are monitored every 15 minutes for the first hour during this stage (Ricci et al., 2021). The patient is at OSF in Urbana during this clinical rotation. The patient presented with abdominal pain and bleeding in the triage room of the Obstetrics unit (OSF Database, 2022). Additional abnormal findings include low RBC levels, Hgb, Hct, platelets, and elevated WBC levels (OSF Database, 2022). The cause of the decreased levels may have been the bleeding that the patient presented. Decreased levels of RBCs, Hgb, Hct, and platelets are significant findings related to blood loss (Pagana et al., 2019). Normal findings for this patient include a nonreactive HIV, HBsAg, and Serology result (OSF, 2022). The phase at which the patient is experiencing during the assessment is the “taking-in” phase, which occurs up to 48 hours postpartum (Ricci et al., 2021). Postpartum complications include postpartum hemorrhage, infection, and postpartum mood disorders (Ricci et al., 2021). Signs and symptoms of infection include redness, fever, and tenderness (Ricci et al., 2021). Risk factors related to postpartum hemorrhage include induced labor and hypertension (Ricci et al., 2021). Because of the patient’s cesarean birth and the incision, they are at an increased risk for infection. Risk factors for postpartum mood disorders include a medical history of

	depression, anxiety, or other mood disorders before pregnancy (Ricci et al., 2021).

Stage of Labor References (2) (APA):

OSF Database. (2022).

Pagana, K. D., Pagana, T.J., & Pagana T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th ed.). Elsevier.

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) (OSF Database, 2022) (Jones & Bartlett Learning, 2021)

Brand/Generic	**G:** docusate calcium **B:** Colace	**G:** calcium carbonate **B:** Apo-Cal, Calci-Mix, Calsan, Liqui-Cal, Titralac	N/A	N/A	N/A
Dose	100 mg	1,000 mg	N/A	N/A	N/A
Frequency	BID	Q8 hours PRN	N/A	N/A	N/A
Route	PO	PO	N/A	N/A	N/A
Classification	**Pharm:** Surfactant **Therapeutic:** Laxative, stool softener	**Pharm:** Calcium salts **Therapeutic:** Antacid	N/A	N/A	N/A
Mechanism of Action	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces.	Neutralizes or buffers the stomach acid to relieve discomfort caused by hyperacidity.	N/A	N/A	N/A
Reason Client Taking	To treat constipation.	To treat heartburn or indigestion.	N/A	N/A	N/A
Contraindications (2)	1. Concomitant use with mineral oil 2. Fecal impaction	1. Concurrent use with calcium supplements. 2. Hypercalcemia	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	1. CNS: Dizziness 2. GI: Abdominal cramps	1. CV: Hypotension 2. OTHER: Hypercalcemia	N/A	N/A	N/A
Nursing Considerations (2)	1. Expect excessive or long-term use of docusate to cause dependence on laxatives for	1. Store at room temperature, and protect from heat, moisture, and direct light.	N/A	N/A	N/A

	bowel movements, electrolyte imbalances, osteomalacia, steatorrhea, and vitamin and mineral deficiencies. 2. Assess for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders.	Do not freeze. 2. Monitor serum calcium level, as ordered, and evaluate therapeutic response.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Auscultate for bowel sounds, percuss for dullness, and palpate for masses.	Assess heart, ECG, and heart sounds before the medication administration.	N/A	N/A	N/A
Client Teaching needs (2)	1. Tell the patient not to use docusate when she has abdominal pain, nausea, or vomiting. 2. Advise the patient to take docusate with a full glass of milk or water.	1. Instruct the patient to avoid taking calcium within 2 hours of another oral drug because of the risk of interactions. 2. Urge the patient to ask the prescriber before taking OTC drugs because of risk of interactions.	N/A	N/A	N/A

Hospital Medications (5 required) (OSF Database, 2022) (Jones & Bartlett Learning, 2021)

Brand/Generic	**G:** fentanyl-ropivacaine **B:** Naropin	**G:** ondansetron **B:** Zofran	**G:** acetaminophen **B:** Tylenol	**G:** oxytocin **B:** Pitocin	**G:** cefazolin **B:** Ancef
Dose	10 mL/hour	4 mg	650 mg	2 mL/hour	2 grams
Frequency	Continuous	Q6 hours PRN	Q4 hours PRN	Continuous	Once
Route	IV	PO	PO	IV	IV
Classification	**Pharm:** **Therapeutic:**	**Pharm:** SSRA **Therapeutic:** Antiemetic	**Pharm:** Nonsalicylate, para-aminophenol derivative. **Therapeutic:** Antipyretic, nonopioid analgesic	**Pharm:** Oxytocic **Therapeutic:** Uterine stimulant	**Pharm:** First generation cephalosporin **Therapeutic:** Antibiotic
Mechanism of Action	Binds to the opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathways.	Blocks serotonin receptors in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine.	Inhibits enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Oxytocin increases the sodium permeability of uterine myofibrils, indirectly stimulating contraction of the uterine smooth muscle.	Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross-linking of peptidoglycan strands.
Reason Client Taking	Local anesthetic for epidural analgesia.	To treat nausea and/ or vomiting.	To treat pain.	To stimulate uterine contractions.	To treat infections.

Contraindications (2)	1. Hypersensitivity to fentanyl or its component. 2. Significant respiratory depression.	1. Contraindicated in those with serotonin syndrome. 2. Contraindicated in those with a hypersensitivity to glucocorticoids.	1. Severe hepatic impairment 2. Hypersensitivity to acetaminophen or its components.	1. Hypersensitivity to oxytocin or its components. 2. Obstetric emergencies that favor surgery.	1. Hypersensitivity to cefazolin. 2. Severe renal impairment
Side Effects/Adverse Reactions (2)	1. CNS: seizures 2. CV: hypotension	1. RESP: bronchospasm 2. RESP: pulmonary embolism	1. GI: hepatotoxicity 2. RESP: pulmonary edema	1. CV: bradycardia 2. CNS: permanent CNS damage	1. CNS: seizures 2. GI: hepatic failure
Nursing Considerations (2)	1. Use with extreme caution patience with chronic obstructive pulmonary disease, and in patients with respiratory depression. 2. Know that to achieve optimum pain control with the lowest possible fentanyl dose, also plan to give a non-opioid analgesic, such as acetaminophen, as prescribed.	1. Monitor the patient's electrocardiogram, as ordered, because ondansetron therapy can prolong the T interval. 2. Monitor the patient closely for signs and symptoms of serotonin syndrome.	1. Use medication cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, or severe malnutrition. 2. Monitor renal function in patients on long-term therapy.	1. Monitor for frequency, duration, and force of contractions. 2. Monitor for signs and symptoms of water intoxication, which include headache, irritability, confusion, nausea.	1. Obtain culture and sensitivity test results, if possible and as ordered, before giving this medication. 2. Assess bowel pattern daily; severe diarrhea may indicate colitis.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Assess for pain by having the patient rate on a scale of 0-10.	Assess dizziness and drowsiness that might affect gait, balance, and other functional activities prior to administration.	Assess for pain by having the patient rate on a scale of 0-10.	Assess a 20-minute electronic fetal monitoring strip prior to medication administration.	Assess for PCN allergy prior to medication administration.
Client Teaching needs (2)	1. tell the patient to increase fiber and fluid intake, unless	1. Advise the patient to immediately report signs of hypersensitivity, such as a rash.	1. Tell the patient that the tablets may be crushed or swallowed whole. 2. Teach patient to	1. Provide the patient with education about how oxytocin will affect their	1. Instruct the patient to complete the prescribed course of therapy.

	contraindicated, because drug may cause severe constipation. 2. Caution the patient to avoid hazardous activities until the medication's CNS effects are known.	2. Reassure patient with transient blindness that it resolves within a few minutes to 48 hours.	recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise.	contractions. 2. Advise the patient to report headache, dizziness, palpitations, or intense pain.	2. Tell the patient to report watery, bloody stools to the prescriber immediately, even up to 2 months after medication therapy has ended.

Medications Reference (1) (APA):

OSF Database. (2022).

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** Alert **Orientation:** Oriented x4 **Distress:** Appears to be in acute distress **Overall appearance:** Groomed and awake.	Ms. K is a 20-year-old female. The patient is groomed and awake. Height 160 cm, Weight 59.9 kg, BMI 23.38 kg/m^2, T 36.4°C oral, P 50 bpm 2+ b/l, RR 18, BP 135/71 L arm sitting, 100% O_2. The patient appears to be in acute distress – exhibiting emesis episodes.
INTEGUMENTARY (1 points): **Skin color:** Normal in appearance **Character:** Warm and dry **Temperature:** Warm **Turgor:** Less than 2 seconds **Rashes:** None **Bruises:** None **Wounds/Incision:** Abdominal incision **Braden Score:** 22 **Drains present: Y☐ N ☐** **Type:** None	The skin is warm and dry upon palpation. The skin is elastic, intact, and without discoloration. The skin turgor is less than two seconds with normal mobility. The nails are without clubbing. There are no rashes or bruises upon inspection. The patient has an abdominal incision from cesarean birth. The patient's capillary refill is less than 3 seconds between fingers and toes bilaterally. Braden score of 22, indicating there is no risk. Based on assessment DOS: 10/26/2022.
HEENT (1 point): **Head/Neck:** Skull is normocephalic **Ears:** WNL **Eyes:** WNL	The patient's head and neck are symmetrical. There are non-palpable lymph nodes. There is acuity to regular voices. There is no visible abnormality of ears or palpable deformities.

Nose: WNL **Teeth:** No dentures; good dentition.	There is no edema or redness present. The sclera is white bilaterally. The patient's cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. There is no external drainage. The patient does not wear glasses. Their EOMs are intact b/l and PERRLA b/l. The patient's septum is midline. The patient's lips/oral mucosa are pink; there is good dentition, and the patient does not have dentures. The patient swallows without difficulty.
CARDIOVASCULAR (2 point): **Heart sounds:** Clear S1 and S2 without murmurs **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** None **Peripheral Pulses:** Pulses 2+ b/l **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:** None	Upon auscultation, there are clear S1 and S2, regular rate and rhythm, and without murmurs. The patient's PMI is palpable at the 5th intercostal space at the MCL. There is a normal rate and rhythm. Ms. K's extremities are warm and dry. There is no edema, palpated in all extremities. The epitrochlear lymph nodes are nonpalpable b/l. The patient's pulses are 2+ b/l. Their capillary refill is less than 3 seconds between fingers and toes b/l. There are no reports of chest pain.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Upon auscultation, the patient's lungs are resonant. Their respirations are unlabored and there is no wheezing noted, or shortness of breath reported. The patient has a former history of marijuana use. There is no use of accessory muscles. The patient's nailbeds show no discoloration.
GASTROINTESTINAL (2 points): **Diet at Home:** Regular **Current Diet:** Regular **Height:** 160 cm **Weight:** 59.9 kg **Auscultation Bowel sounds:** Active in all four quadrants **Last BM:** 10/25/2022 **Palpation: Pain, Mass etc.:** No palpable mass or pain. **Inspection:** **Distention:** Non-distended **Incisions:** Abdominal **Scars:** None **Drains:** None **Wounds:** None	Upon inspection, the patient's abdomen is rounded and nondistended. There are active and normal bowel sounds and no tenderness after palpation of all four quadrants. The patient's BMI is 23.38 kg/m^2. The last BM was noted on 10/25/2022. The patient is on a regular diet while at the hospital; presents with nausea and vomiting. The patient is being treated with an antiemetic. There is no pain with defecation. There is no distention, scars, or wounds visible on the abdomen. The patient has an abdominal incision from their cesarean birth. There is no ostomy, NG tube, or PEG tube in place for this patient.

GENITOURINARY (2 Points): **Quantity of urine:** 1,135 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Urethral catheter **Size:** 14Fr	The patient expelled 1,135 mL of urine during the time of assessment. The patient reports no pain or discharge with urination. There is a urethral catheter in place for the patient.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N ☒** **Fall Score:** 2 **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☒**	There is no observed or reported muscle weakness and joint swelling or tenderness from the patient. All of the patient's extremities are with symmetrical movement bilaterally.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** Oriented x4 **Mental Status:** Alert and oriented x4 **Speech:** Coherent **Sensory:** Intact **LOC:** WNL **DTRs:** Reactive	The patient is alert and relaxed. Ms. K is oriented x4, to person, place, time, and situation. The patient's speech is coherent, and their senses are intact. Upon assessment, PERRLA b/l. The patient's strength is equal throughout. The patient performed pedal pushes and hand grips with ease. The patient follows commands, and their motor responses are good. The patient's deep tendon reflexes and within normal limits and reactive.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** Medication therapy **Developmental level:** Appropriate for age. **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient is taking acetaminophen pain. The patient is taking calcium carbonate and ondansetron to treat their nausea, vomiting, and constipation. The patient is alert and oriented x4 (to person, place, time, and situation). Thought processes are coherent and memory is intact. Developmental level is appropriate for age. The patient is not religious. The patient has a support system that includes their boyfriend and grandmother.
Reproductive: (2 points) **Fundal Height & Position:** 1 cm below the umbilicus **Bleeding amount:** Light **Lochia Color:** Rubra **Character:** Red, dark **Episiotomy/Lacerations:** Cesarean birth	The patient's fundus is firm without massage. The fundal height and position of the patient is 1 cm below the umbilicus and midline.
DELIVERY INFO: (1 point) **Rupture of Membranes:** Artificial	the patient had an artificial rupture of membranes on 10/26/2022 at 0626. The color appeared

Time: 10/26/2022 @ 0626 **Color:** clear, blood-tinged **Amount:** 957 mL **Odor:** None **Delivery Date:** 10/26/2022 **Time:** 0643 **Type (vaginal/cesarean):** cesarean **Quantitative Blood Loss:** 189 mL **Male or Female:** Male **Apgars:** 1 min = 7 | 5 min = 9 **Weight:** 1985 g **Feeding Method:** Bottle	clearer and slightly blood tinged. There was no odor and quantitative blood loss measured to 189 mL. The male baby was delivered on 10/26/2022 via a cesarean birth. The baby weighs 1985 grams and is currently in the NICU.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	91	108/71	14	98.6˚F (oral)	100% on room air
Labor/Delivery	59	114/69	16	96.4˚F (oral)	100% on room air
Postpartum	50	134/84	18	97.6˚F (oral)	100% on room air

Vital Sign Trends: The patient's vital signs are trending normal through their pregnancy.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0823	Numerical	Bilateral lower abdomen	6 on a 0-10 scale	Constant	Pain management
0920	Numerical	Bilateral lower abdomen	5 on a 0-10 scale	Constant	Cold pack applied

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 G **Location of IV:** right hand **Date on IV:** 10/26/2022 @ 0143 **Patency of IV:** Patent, dry, intact. **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Clean and dry.	Peripheral IV – Infusing medications. The dressing appeared clean, dry, and intact.

Intake and Output (2 points)

Intake	Output (in mL)
PO: 240 mL of water IV: 1600 mL of IV fluids and medication **Total:** 1,840 mL	Catheter: 1,135 mL of urine Emesis: 500 mL Blood: 768 mL **Total:** 2,402 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 "M" after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Pain medications (N)	Q4 hours PRN	This intervention will help treat and reduce the symptom of pain that the patient is experiencing.
Antiemetic medications (N)	Q8 hours PRN	This intervention will help treat and reduce the nausea and emesis symptoms that the patient is experiencing.
Ambulation (N)	Q2 hours – as often as possible	This intervention will help reduce the risk for blood clots.
Heat pack (N)	PRN	This intervention may help relieve pain through a non-medicinal way for the patient.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? The mother is in the "taking-in" phase.

What evidence supports this? The mother is in her first 48 hours of giving birth.

Discharge Planning (3 points)

Discharge location: The patient will discharge back home with their boyfriend.

Equipment needs (if applicable): No equipment needed for this patient.

Follow up plan (include plan for mother AND newborn): The mother will be seen in 2 weeks and then 6 weeks following their cesarean birth. The newborn has an appointment to be seen on 11/03/2022.

Education needs: Newborn education | Infection prevention | Drug cessation

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 inadequate skin integrity as evidenced by cesarean birth incision.	The patient is at an increased risk for infection because of their incision from their cesarean birth.	**1.** Encourage a semi-fowler's position. **Rationale:** This position will allow for drainage to fall by gravity and prevent pooling of infectious secretions (Ricci et al., 2021). **2.** Maintaining proper and strict hand hygiene for both the nurse and patient/family. **Rationale:** Proper hand hygiene is the primary	The patient will achieve timely healing, free of any complications related to infection.

		method of preventing the spread of infection (Hinkle & Cheever, 2022).	
2. Impaired skin integrity related to wound infection as evidenced by disruption of skin surface from pregnancy.	Women are suspectable to abdominal wound infections due to compromised skin integrity from cesarean births.	**1.** Apply cold and warm compresses to the abdominal area as appropriate. **Rationale:** A cold pack applied for the first 12-24 hours will help reduce any edema and bruising around the abdominal area. After 24 hours, the heat pack will increase circulation, allowing for the area to heal (Hinkle & Cheever, 2022). **2.** Educate the patient on how to recognize and report signs of complications and to schedule/attend follow up appointments. **Rationale:** This will promote early identification of possible complications. Attending scheduled follow up appointments will effectively aid in the wound's healing process and care in the chance of a complication (Ricci et al., 2019).	The patient will regain skin integrity without complications. The patient will allow for proper wound healing and the absences of skin integrity pressure or breakdown.
3. Knowledge deficient related to feeding as evidenced by first-time mother.	The new mother has not expressed whether they were going to be breastfeeding or bottle-feeding during time of assessment.	**1.** Educate the new mother in feeding techniques. **Rationale:** This promotes proper nutrition for the neonate (Ricci et al., 2019). **2.** Allow for the patient to demonstrate the skills learned. **Rationale:** This promotes readiness to feed, proper feedback, and any questions that the new mother might have (Phelps, 2020).	The new mother will feel comfortable in their decision on nutrition and providing feeding to their newborn.
4. Knowledge	It is crucial for	**1.** Assist new parents in	The new parents

deficient related to "newborn cues" as evidenced by first-time parent.	the new mother to learn for their newborn's needs. This promotes a healthy neonate.	exploring coping methods for stress and ways to improve the health of their child. **Rationale:** This promotes healthy coping skills for the new parents (Phelps, 2020). **2.** Have a discussion with the new parents about how their actions can help improve their child's health and behavior. **Rationale:** This can help decrease the pressure that the new parents put on themselves and answer any questions that concern them (Phelps, 2020).	understand and can spot the "newborn cues" and how to respond to these cues with ease and less stress.

Other References (APA):

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