N432 Postpartum Care Plan

Lakeview College of Nursing

Jamal Drea

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
10/26/22 @ 0408	K.K.	20	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black / African American	Unemployed	Single	NKA
Code Status	**Height**	**Weight**	**Father of Baby Involved**
FULL	5'3" (160 cm)	132 lbs (59.9 kg)	Yes

Medical History (5 Points)

Prenatal History: G1-P1-T0-A0-L1, Anemia, late prenatal care, acute cystitis, preterm labor at 35 weeks 1 day gestation

Past Medical History: Asthma

Past Surgical History: C-section

Family History: Stroke (maternal grandmother)

Social History (tobacco/alcohol/drugs): Never used tobacco or consumed alcohol. Uses marijuana daily.

Living Situation: Lives with sister

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points): The patient, K.K., was admitted to the labor and delivery department after having a chief complaint of abdominal pain at 0408 on 10/26/22. The patient had been feeling this pain along with contractions and fetal movement after eating dinner the day before at 2100. K.K says that they do not have

vaginal bleeding or abnormal discharge. After assessment, it was found that the patient's vitals were 104/66 bp, pulse was 60 bpm, temperature was 35.8 degrees celsius, respirations were 16 per minute, and oxygen saturation was 100%. FHM showed 130 bpm, moderate variability, and no decelerations. The patient is scheduled for artificial rupture of membranes and a C-section.

Diagnosis

Primary Diagnosis on Admission (2 points): Preterm labor

Secondary Diagnosis (if applicable): Placental abruption

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	4.2-5.4	3.52	3.29	2.51	Decreases in red blood cell count is normally seen in pregnancy because body fluid increases and leads to dilution of RBCs (Pagana, 2018). The RBC value for this patient is even lower for today's value because they underwent a procedure that resulted in blood loss.
Hgb	>11	11.5	9.6	7.4	Slight hemoglobin decreases normally occur during pregnancy because of expanded blood volume. Blood loss contributed to a greater decrease in Hgb (Pagana, 2018).
Hct	>33	33.8	28.8	21.7	Hematocrit is affected by

					hemodilution during pregnancy, which explains the slight decrease in the Hct value. Blood loss contributed to a greater decrease found in today's value (Pagana, 2018).
Platelets	**150-400**	**110**	**110**	**100**	**Platelets are decreased as a result of hemodilution and blood loss (Pagana, 2018).**
WBC	**5-10**	**6.7**	**12.5**	**16.7**	**The final month of pregnancy and labor caused increased WBC levels because of physical stress on the body (Pagana, 2018).**
Neutrophils	**55-70**	**58.5**	**78.8**	**74.9**	**Neutrophilia is present due to physical stress on the patient and trauma (Pagana, 2018).**
Lymphocytes	**20-40**	**27**	**17.9**	**15.9**	**Elevated levels of estrogen during pregnancy have been found to cause lymphocytopenia (Abu-Raya et al., 2020).**
Monocytes	**2-8**	**11**	**9**	**3**	**Monocytes are increased during pregnancy, especially in the first trimester, because of elevations in IL-12 and TNFa cytokines by the immune system (Abu-Raya et al., 2020).**
Eosinophils	**1-4**	**2.7**	**0**	**0**	**Eosinophils are increased from infection, allergic reactions, or autoimmune disease so a value of 0 is not significant (Pagana, 2018).**
Bands	**0**	**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,**	**A**	**A**	**N/A**	

	or O				
Rh Factor	**+ or -**	**+**	**+**	**N/A**	
Serology (RPR/VDRL)	**Negative**	**Negative**	**N/A**	**N/A**	
Rubella Titer	**Immune**	**Immune**	**N/A**	**N/A**	
HIV	**Negative**	**Negative**	**N/A**	**N/A**	
HbSAG	**Negative**	**Negative**	**N/A**	**N/A**	
Group Beta Strep Swab	**Negative**	**N/A**	**Negative**	**N/A**	
Glucose at 28 Weeks	**<95 fasting and <180 after an hour**	**WDL (no specified value)**	**N/A**	**N/A**	
MSAFP (If Applicable)	**10-150**	**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
Urine drug screen	**Negative**	**N/A**	**Positive for cannabinoids.**	**N/A**	**A urine drug screen checks for use of marijuana, opiates, cocaine, and other abused substances (Pagana, 2018). The patient reported they use marijuana daily which aligns with their result.**
X-ray (pelvis)	**No abnormal findings**	**N/A**	**No foreign bodies, lesions, or fractures. Tissues appear normal.**	**N/A**	
Urine culture	**Negative**	**N/A**	**Positive (few bacteria)**	**N/A**	**A urine culture determines the presence of bacteria and the result is positive (Pagana, 2018). This result coincides with the results of the patient's urinalysis.**
Urinalysis	**Leukocyte**	**N/A**	**WDL except**	**N/A**	**The patient's urine was found to be**

	esterase (negative), clear		**for cloudy and positive with leukocyte esterase**		**cloudy and positive for leukocyte esterase, which is indicative of a UTI (Pagana, 2018).**
CMP	**BUN (10-20), creatinine (0.5-1.1), albumin (3.5-5)**	**N/A**	**WDL except for BUN, creatinine, and albumin which are decreased**	**N/A**	**BUN and creatinine can be decreased as a result of pregnancy. They could also be decreased because of poor nutrition as well as albumin (Pagana, 2018). This could be due to the patient's trouble with nausea and vomiting leading up to delivery.**
PTT	**25-40**	**N/A**	**28**	**N/A**	
Uric acid	**2.7-7.3**	**N/A**	**4.7**	**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)	**87-107**	**N/A**	**N/A**	**N/A**	

Lab Reference (1) (APA):

Abu-Raya, B., Michalski, C., Sadarangani, M., & Lavoie, P. M. (2020). Maternal immunological adaptation during normal pregnancy. *Frontiers in Immunology, 11*, 575197. https://doi.org/10.3389/fimmu.2020.575197

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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

	Your Assessment

History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	**This patient was admitted for spontaneous preterm labor and was later diagnosed by the provider with placental abruption. Placental abruption happens when tearing occurs between the placenta and the uterine lining, leading to blood loss. This can be caused by smoking, cocaine, older maternal age, hypertension, and trauma. The patient could be asymptomatic or have signs like tachycardia, changes in blood pressure, and fetal distress (Schmidt et al., 2022). The patient's social history shows a use of marijuana that could have contributed to the risk for this condition. Hypotension was present upon assessment with a blood pressure of 104/66. The first stage of labor was almost 3 hours (0400-0655). Artificial rupture of membranes was done at this time. The second stage of labor was about an hour as it was shortened due to a scheduled C-section because of the risk from placental abruption. The procedure was about an hour (0655-0755). The third stage of labor is about the delivery of the placenta, which was removed during the procedure, so the total length of labor was approximately 4 hours.**
Current stage of labor	**The patient is currently in the fourth stage of labor, which starts after the placenta is delivered and is typically the process in which the condition of the mother stabilizes 1-4**

	hours after birth. During this phase, the mother is alert, peaceful, excited, and talkative. They are also ready to start the attachment process with their baby (Ricci et al., 2020). The patient is alert and excited to see their newborn in the nursery soon after their Foley catheter was removed and they could walk to the nursery. The fundus should be firm and contracted during this stage because atony could cause problems with hemorrhage. The uterus also undergoes a process called involution in which it will return to normal size and move 1 cm below the umbilicus every day (Ricci et al., 2021). It is important to assess the fundus and monitor closely for bleeding, especially because the patient had the birth complication of placental abruption, which was diagnosed by the doctor, and had a blood loss of 957 mL. Upon assessment, the fundus of the patient was firm and two centimeters below the umbilicus one day after delivery of the newborn. If it were to be weak and boggy, then the nurse would have to massage the area until it was contracted to reduce the risk for hemorrhage. A part of assessment during the postpartum period is lochia, the vaginal discharge after birth that can last up to eight weeks. For the first three or four days after delivery, lochia is termed "rubra" and is dark red in a mixture of mucus, tissue, and blood. Cardiac output is

	decreased and can lead to bradycardia for 2 weeks after childbirth (Ricci et al., 2021). The patient's vitals today showed slight bradycardia with a heart rate of 59 bpm. Postpartum diuresis could occurs due to IV fluids during labor, decline in oxytocin, and retention during pregnancy. Retention could lead to uterine atony (Ricci et al., 2021). This applied to this patient since their urine output was 1500 mL in the last 24 hours. Postpartum complications that could occur with this patient include infection since they have an incision after their C-section. Signs and symptoms of infection present as edema, erythema, fever, tenderness, and elevated WBC (Ricci et al., 2021). The patient does not have any of these signs or symptoms but will be educated so they can report them. Postpartum depression is another complication that can be shown with lack of energy or motivation, feeling of isolation, or constant crying (Ricci et al., 2021). These signs are not shown in the patient as they appear content. They reportedly have a good support system and were visited by multiple family members.

Stage of Labor References (2) (APA):

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

Schmidt, P., Skelly, C.L., Raines, D.A. (2022). Placental abruption. *StatPearls*. Treasure Island StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK482335/

Current Medications (7 points, 1 point per completed med)
7 different medications must be completed

Home Medications (2 required)

Brand/Generic	**Ventolin (albuterol)**	**Colace (docusate sodium)**			
Dose	**2 puffs**	**100 mg**			
Frequency	**Q6H prn for wheezing**	**BID prn for constipation**			
Route	**Oral**	**Oral**			
Classification	**Pharmacologic class:Adrenergic** **Therapeutic class: Bronchodilator**	**Pharmacologic class: Surfactant** **Therapeutic class: Laxative, stool softener**			
Mechanism of Action	**Stimulates beta2-adrenergic receptors in lungs, resulting in relaxation of bronchial smooth muscle with little effect on heart rate.**	**Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces. This action lets more fluid penetrate stool, forming a softer fecal mass.**			
Reason Client Taking	**The patient takes this medication to treat their asthma.**	**The patient is taking this medication to treat constipation.**			
Contraindications (2)	**Hypersensitivity to albuterol or its components. Caution with**	**Nausea or vomiting, undiagnosed abdominal pain**			

	hypertension, hypokalemia, and arrhythmia.				
Side Effects/Adverse Reactions (2)	**Arrhythmia, tachycardia**	**Dizziness, diarrhea**			
Nursing Considerations (2)	**The patient should increase fluid intake with the use of this medication. The patient should hold their breath after administration to promote contact with the lungs.**	**This drug should be taken with a glass of water or milk. Excessive use of this drug can cause a dependence on laxatives for bowel movements.**			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Lung sounds, blood pressure, and heart rate. Assess rate, rhythm, and depth of respirations.**	**Assess bowel movements and electrolytes for imbalances.**			
Client Teaching needs (2)	**Educate the patient on rinsing their mouth after using this medication to avoid dryness and infection. Tell the patient to avoid excessive caffeine because of the potential for tachycardia as a side effect.**	**Tell the patient to not take this drug if they have abdominal pain, nausea, or vomiting. Encourage the patient to increase fiber intake and drink 6-8 glasses of water daily to prevent constipation.**			

Hospital Medications (5 required)

Brand/Generic	**Tylenol (acetaminophen)**	**Mylicon (simethicone)**	**Roxicodone (oxycodone)**	**Feosol (ferrous sulfate)**	**Zofran (ondansetron)**

Dose	**650 mg**	**80 mg**	**5 mg**	**650 mg**	**4 mg**
Frequency	**Q4H prn for mild pain**	**4 times daily (after meals and nightly)**	**Q4H prn for severe pain**	**BID**	**Q6H prn for nausea**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic class: Nonsalicylate, para-aminphenol derivative** **Therapeutic class: Antipyretic, nonopioid analgesic**	**Pharmacologic class: Gastrointestinal agent** **Therapeutic class: Antiflatulent**	**Pharmacologic class: Opioid** **Therapeutic class: Opioid analgesic**	**Pharmacologic class: Hematinic** **Therapeutic class: Antianemic, nutritional supplement**	**Pharmacologic class: Selective serotonin receptor antagonist** **Therapeutic class: Antiemetic**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.**	**Simethicone is a silicone compound that functions as a non-systemic surfactant, decreasing the surface tension of gas bubbles in the GI tract. This action results in coalescence and dispersion of the gas bubbles allowing their removal from the GI tract as flatulence or belching. Simethicone causes the gas bubbles to accumulate and therefore pass more easily either through the upper GI or lower GI opening.**	**Alters perception of and emotional response to pain at spinal cord and higher levels of CNS by blocking release of inhibitory neurotransmitters, such as acetylcholine and gamma-aminobutyric acid.**	**Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen. Iron is an essential component of hemoglobin, myoglobin, and several enzymes, including catalase, cytochromes, and peroxidase. Iron is needed for catecholamine metabolism and normal neutrophil function.**	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine (probable cause of chemotherapy- and radiation-induced nausea and vomiting) and by blocking signals to the CNS. Ondansetron may also bind to other**

					serotonin receptors and to mu-opioid receptors.
Reason Client Taking	**The patient is taking this drug to relieve mild to moderate pain.**	**The patient is taking this drug to treat their GI symptoms like nausea.**	**The patient is taking this drug for moderate to severe pain (was last administered @ 0600).**	**The patient is taking this supplement to treat their anemia after their delivery through C-section.**	**The patient is taking this medication to treat their nausea and vomiting.**
Contraindications (2)	**Hypersensitivity to acetaminophen or hepatic impairment**	**Hypersensitivity to simethicone or a component of the drug. Intestinal obstruction.**	**Acute or severe asthma, GI obstruction, or hypersensitivity to oxycodone**	**Hemolytic anemia or hypersensitivity to components of the medication**	**Hypersensitivity to ondansetron or hypokalemia**
Side Effects/Adverse Reactions (2)	**Hypotension, hepatotoxicity**	**Diarrhea, hypertension**	**Bradycardia, respiratory depression**	**Hypotension, angioedema**	**Arrhythmia, hypotension**
Nursing Considerations (2)	**Ensure that the daily dose of acetaminophen is not exceeded by the patient. Know that components of a liver function test like AST, ALT, bilirubin, and creatinine levels could be elevated due to potential hepatotoxicity of this drug.**	**The maximum daily dose for this medication is 500 mg. This drug has no significant interactions with other medications.**	**Use with caution in patients with asthma. Monitor blood pressure and respirations closely.**	**Administer 1 hour before or 2 hours after a meal for better absorption. Take the medication with water or juice to avoid GI discomfort.**	**Electrolyte imbalances like hypokalemia and hypomagnesemia should be corrected before administration. Assess for dehydration.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess for pain level to compare after administration to see if there is improvement in the patient's pain. Assess liver function tests.**	**Assess GI pain and symptoms like nausea and vomiting.**	**Pain level for reassessment after administration. Assess respiratory status due to side effect risk with respiratory depression. Obtain vital signs.**	**Assess nutritional status and blood pressure. Ask about the history of hemolytic anemia or use of antacids and calcium supplements.**	**Assess for nausea and vomiting. Assess mental status. Assess bowel activity and bowel sounds for peristalsis.**
Client Teaching needs (2)	**Inform the patient about the daily recommended dose for this drug in order to avoid hepatotoxicity. Educate on side**	**Inform the patient on chewing the medication thoroughly. Tell the patient to drink this medication with a glass of**	**Instruct the patient to avoid actions that require alertness or motor skills. Educate the patient on side effects like**	**Educate the patient tha they should not take this supplement within 2 hours of other medications. Warn the**	**Inform that patient that the medication will relieve GI symptoms shortly after administrati**

	effects and signs of hepatotoxicity.	**water.**	**respiratory depression and drowsiness.**	**patient about the use of antacids or calcium supplements.**	**on. Tell the patient to drowsiness and dizziness could be side effects and they should avoid certain activities until their response to the drug is known.**

Medications Reference (1) (APA):

Ingold, C.J., Akhondi H. (2022). Simethicone. *StatPearls*. Treasure Island StatPearls Publishing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK555997/

Jones and Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Kizior, R. J. (2021). *Saunders Nursing Drug Handbook 2021*. Elsevier.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **Alert and oriented x4** **No acute distress** **Overall calm, clean appearance**
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 **Skin color normal with no cyanosis** **Skin is clear** **Warm on palpation** **Normal skin turgor, no tenting noted** **No rashes** **No bruising** **Incision in lower abdominal region** **Braden score: 21** **No drainage present**
HEENT (1 point):	

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic and without abnormal findings. Trachea is midline.** **External ears have normal structure and no lesions.** **Sclera is white and conjunctiva is pink. PERRL.** **Nasal mucosa is pink, moist, and without lesions.** **Oral mucosa is pink and moist. Dentition is good.**
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:**	**Normal S1 and S2 heart sounds.** **Normal heart rate and rhythm.** **Peripheral pulses are 2+ and symmetric.** **Capillary refill is <2 seconds.** **No neck vein distention.** **No edema is present.**
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Unlabored breathing with no accessory muscle use.** **Clear breath sounds with no crackles or wheezing.** **Normal respiratory rate and pattern.**
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:**	**Normal diet at home.** **No restrictions on diet but is nauseous and not tolerating food well yet.** **160 cm (5'3")** **59.9 kg (132 lbs)** **Last BM: yesterday** **Light palpation causes pain. No masses present.** **No distention in the abdomen.** **Incision in lower abdomen from C-section.** **No scars present in abdomen.** **No drainage.** **No wounds other than incision in abdominal region.**

GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	 **1500 mL** **No pain reported with urination.** **No abnormal findings.** **Catheter was removed prior to assessment.**
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☐**	 **No ADL assistance needed but partner is helping the patient conserve energy.** **Fall risk ✓** **Morse fall score: 25** **Activity/Mobility status: Independent**
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:**	 **MAEW ✓** **PERLA ✓** **Strength is equal in extremities bilaterally** **Oriented x4** **Alert, no acute distress** **Normal, calm speech pattern** **Sensory function is normal with no paresthesias.** **LOC: Conscious and alert (15 on GCS)** **DTRs: 2+**
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):**	 **Coping methods: Visited by family, television** **Developmental level: Adult** **No specific religion but believes in God** **Patient currently lives with sister but will move into her own home soon with the father of the newborn. Patient says that both their family and the father's family are really supportive.**
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:** **Character:** **Episiotomy/Lacerations:**	 **Fundus is positioned 2 cm below the umbilicus** **Moderate** **Rubra** **Dark red, thick** **No episiotomy/lacerations**
DELIVERY INFO: (1 point) **Rupture of Membranes:**	 **Artificial rupture of membranes**

Time:	**10/26/22 @ 0626**
Color:	**Color is clear and bloody.**
Amount:	**Not documented.**
Odor:	**No odor.**
Delivery Date:	**10/26/22**
Time:	**0755**
Type (vaginal/cesarean):	**Cesarean**
Quantitative Blood Loss:	**957 mL**
Male or Female	**Male**
Apgars:	**A1 (7) & A5 (9)**
Weight:	**1985 g**
Feeding Method:	**Formula**

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**64**	**134/83**	**16**	**98° F**	**99%**
Labor/Delivery	**99**	**116/70**	**18**	**97.3° F**	**97%**
Postpartum	**59**	**120/72**	**16**	**98.7° F**	**100%**

Vital Sign Trends: Pulse is elevated during labor and delivery but returns back to prenatal values in the postpartum period. Blood pressure is slightly elevated in the prenatal period but decreases during labor and in the postpartum period. Temperature, oxygen saturation, and respiratory rate are constant and stable throughout.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	**4 on Numeric scale (0-10)**	**Abdomen at the incision**	**Mild**	**Feeling of pressure**	**650 mg acetaminophen**
1010	**4 on Numeric**	**Abdomen at the incision**	**Mild, patient reportedly**	**Less pressured feeling**	**None (patient says they are**

	scale (0-10)		**feels better**		**okay at this time)**

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 G** **Right hand** **10/26** **IV is patent** **No signs of erythema, drainage, or infiltration** **IV dressing is secure**

Intake and Output (2 points)

Intake	**Output (in mL)**
240 mL oral fluid intake	**1500 mL urinary output**

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.**
Remove urethral catheter (N)	**Once**	**The patient had a foley catheter in place because they were given an epidural. It was discontinued a day after their procedure and the urine output was recorded.**
Administer 650 mg acetaminophen and 80 mg simethicone (M)	**Prn**	**The patient reported pain and GI symptoms such as nausea and vomiting so acetaminophen and simethicone were administered to provide relief. Pain level was assessed at a later time.**

Assess incision from lower transverse C-section and readjust abdominal binder (N)	**During head to toe assessment**	**The incision is inspected during assessment to check for abnormal findings. The abdominal binder is readjusted to support the affected muscles and provide relief after the C-section procedure.**
Provide water and ice chips (N)	**Prn**	**Water and ice chips were provided at the request of the patient. It is important to avoid maintain hydration, especially since the patient is nauseous and reports vomiting.**

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? This phase of adaptation during parenthood happens within the first 24-48 hours after birth. The patient demonstrates this phase by focusing on recovery and basic needs. They are resting while the partner helps to reduce work for the patient. They are also beginning to tolerate food and fluids after dealing with nausea and vomiting.

Discharge Planning (3 points)

Discharge location: Home

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The mother will have their incision reassessed in 7 days. The newborn will be assessed after 24 hours of age.

Education needs: Signs and symptoms of infection, risks associated with blood clots, limits from procedure, preterm infant care

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 C-section procedure as evidenced by lower abdominal incision	**This diagnosis was chosen because the patient had a lower transverse C-section and the incision could be the site of infection if necessary precautions are not established for the patient.**	**1. Perform hand hygiene before providing care and wear gloves to maintain aseptic technique.** **Rationale: Hand hygiene and gloves protect the patient from the spread of pathogens to avoid infection (Phelps, 2020).** **2. Monitor temperature Q4H and WBC count as ordered.** **Rationale: Increased temperature and WBC count could indicate infection so they should be closely monitored (Phelps, 2020).**	**The patient will understand risk factors that are associated with infection and precautions to avoid the spread of pathogens. The patient will show no signs of infection and vitals will remain in the desired limits.**
2. Acute pain related to surgical incision as evidenced by pain level of 4 on numeric scale	**This diagnosis was chosen because the patient was given oxycodone earlier in the day for severe pain and was given Tylenol hours later after a reported pain level of 4. It is important to provide pain relief to reduce**	**1. Use a numeric pain scale to assess the patient's pain Q4H.** **Rationale: This intervention would be done to compare the patient's pain level after interventions have been performed to evaluate their effectiveness (Phelps, 2020).** **2. Administer prescribed**	**The patient will understand interventions that could be made to manage pain. The goal will be to perform interventions in order to relieve pain and reduce stress for the patient.**

	stress for the patient after they had a surgical incision made.	**analgesics when alternative methods of pain control are not enough for the patient.** **Rationale: Allowing the patient to control their pain management promotes trust in the nurse-patient relationship and reduces stress for the patient (Phelps, 2020).**	
3. Deficient knowledge related to infection as evidenced by first surgical procedure	**This diagnosis is chosen because the patient needs to know about signs of infection so they can report significant findings to prevent further complications.**	**1. Educate the patient on signs and symptoms of infection such as elevated temperature and edema or erythema at the incision site.** **Rationale: Instructing the patient on assessments related to infection allows the patient to participate in care and helps the patient to maintain health by reporting abnormal findings (Phelps, 2020).** **2. Educate the patient on good hygiene techniques and cleaning around the incision site.** **Rationale: The patient will keep the area clean from contamination by pathogens (Phelps, 2020).**	**The patient and family will show a readiness to learn. The patient will verbalize an understanding of how to keep their incision free from infection and how to report signs of infection.**
4. Deficient knowledge related to preterm infant care as evidenced by questions asked by the patient	**This diagnosis was chosen because the patient just had their first child at 35 weeks of gestation and should be educated on care for a prematurely born infant.**	**1.** **Rationale:** **2. Provide written information about the induction of labor with methods and reasonings.** **Rationale: Printed information will reinforce teachings to a patient and will prevent information overload (Phelps, 2020).**	**The patient and family will show a readiness to learn. They will understand more about caring for a preterm infant and plans for care and follow-ups.**

Other References (APA)

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