

N432 Postpartum Care Plan  
Lakeview College of Nursing  
Abraham Eugenio

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 11/1/2022 @ 747am	<b>Patient Initials</b> DC	<b>Age</b> 22	<b>Gender</b> Female
<b>Race/Ethnicity</b> Black and Caucasian American	<b>Occupation</b> Lee's Famous Recipe Chicken Staff	<b>Marital Status</b> single	<b>Allergies</b> Peanuts, cat hair
<b>Code Status</b> Full	<b>Height</b> 152.cm	<b>Weight</b> 81.6kg	<b>Father of Baby Involved</b> yes

**Medical History (5 Points)**

**Prenatal History:** anemia during pregnancy in 3<sup>rd</sup> trimester, high-risk pregnancy in 3<sup>rd</sup> trimester, postpartum thromboembolism, the patient is G3 P1 T0 A1 L1

**Past Medical History:** pulmonary embolism and infarct, depression, miscarriage, asthma

**Past Surgical History:** no significant surgical history

**Family History:** no significant family history

**Social History (tobacco/alcohol/drugs):** patient denies use of tobacco, alcohol or drugs

**Living Situation:** The patient lives with her mother and Clay, the father's baby in a single-family home.

**Education Level:** 10<sup>th</sup> grade

**Admission Assessment**

**Chief Complaint (2 points):** contractions/abdominal cramping in 3<sup>rd</sup> trimester

**Presentation to Labor & Delivery (10 points):**

The patient presented to the hospital for complaints of abdominal pain that started on 10/29/2022. She arrived at 39 weeks of gestation. The patient stated that the pain felt sharp and tight in the lower abdominal and vaginal areas. She describes the eventual contractions to be 4

minutes apart and lasting 2-3 minutes. She stated that sleep helped with the pain. The pain was aggravated by active contractions and time during abdominal cramping. She states the severity of her abdominal pain was a 5 out of 10 on a numerical scale. She was eventually induced on 11/01/2022, and was in labor for more than 4 hours. He delivered a male child, with no complications. She did not develop any lacerations or episiotomies during labor and delivery.

### Diagnosis

**Primary Diagnosis on Admission (2 points):** induction of labor

**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 – 5.30 10(6)/mcL	4.06	4.02	3.82	
Hgb	12.0 – 15.8 g/dL	10.9	10.5	10.4	Low hemoglobin levels can be caused by a recent injury or insufficient nutrition (Cleveland Clinic Staff, 2022). In this case, the recent delivery of the baby is the cause of blood loss.
Hct	36.0 – 47.0 %	33.1	32.0	31.1	A recent blood loss such as that from birth can cause low hematocrit levels (Mayo Foundation for Medical Education and Research, 2021).
Platelets	140 – 440 10(3)/mcL	254	262	215	
WBC	4.00 – 12.00	8.8	9.2	14.4	Increased white blood cells can indicate inflammation or

	10(3)/mcL				infection (Capriotti & Frizzell, 2020).
<b>Neutrophils</b>	47.0 – 73.0 %	62.3	52.7	74.6	Elevated neutrophils are a result of response to inflammation or infection (Capriotti & Frizzell, 2020).
<b>Lymphocytes</b>	18.0 – 42.0 %	21.9	31.1	14.5	
<b>Monocytes</b>	4.0 – 12.0 %	9.7	11.0	9.6	
<b>Eosinophils</b>	0.0 – 5.0 %	5.6	3.9	1.0	High numbers of eosinophils is associated with an allergic reaction, which is also associated with asthma (Capriotti & Frizzell, 2020).
<b>Bands</b>	0.0	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
<b>Blood Type</b>	A, B, AB, O	B	B	N/A	
<b>Rh Factor</b>	(-) or (+)	+	+	N/A	
<b>Serology (RPR/VDRL)</b>	Nonreactive	Nonreactive 10/21/2022	N/A	N/A	
<b>Rubella Titer</b>	> or = 1.1	3.6 as of 5/25/2022	N/A	N/A	
<b>HIV</b>	Not detected	Not detected as of 5/25/2022	N/A	N/A	
<b>HbSAG</b>	Not detected	Not detected	N/A	N/A	
<b>Group Beta Strep Swab</b>	Negative	Negative as of 10/11/2022	N/A	N/A	
<b>Glucose at 28 Weeks</b>	70 – 99 mg/dL	102mg/dL	N/A	N/A	Normally, after a meal, blood sugar can reach up to 200mg/dL (Capriotti & Frizzell, 2020). This is not necessarily a sign of Diabetes Mellitus

<b>MSAFP (If Applicable)</b>	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
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
<b>Urine Creatinine (if applicable)</b>	no range given in the EMR other than “mg/dL”	<b>265.9 mg/dL as of 10/30/2022</b>	N/A	N/A	This urine creatinine is very high, and may be due to faulty testing.

**Lab Reference (1) (APA):**

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. (2<sup>nd</sup> ed.). F.A. Davis Company.

Cleveland Clinic Staff (2022). *Low hemoglobin: Causes, signs & treatment*. Retrieved November 7, 2022, from <https://my.clevelandclinic.org/health/symptoms/17705-low-hemoglobin>

Mayo Foundation for Medical Education and Research. (2021). *Hematocrit Test*. Mayo Clinic. Retrieved November 7, 2022, from <https://www.mayoclinic.org/tests-procedures/hematocrit/about/pac-20384728#:~:text=A%20lower%20than%20normal%20hematocrit,or%20long%2Dterm%20blood%20loss>

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

	<b>Your Assessment</b>
<p><b>History of labor:</b></p> <p><b>Length of labor</b></p> <p><b>Induced /spontaneous</b></p> <p><b>Time in each stage</b></p>	<p>Length of labor is 4 hours and 24 minutes; the patient was induced; the patient was in the 1<sup>st</sup> stage of labor for 4 hours and 3 minutes, 19 minutes in the second stage, and 2 minutes in the 3<sup>rd</sup> stage</p>
<p><b>Current stage of labor</b></p>	<p>The fourth stage of labor is also called the postpartum period. It is a period that lasts 12 weeks after delivery (Paladine et al., 2019). Physiologically, the mother’s blood pressure return to baseline, or can be increased due to excitement (Chauhan &amp; Tadi, 2021). The patient’s uterus will descend over the course of the postpartum period, and the endometrium will be fully restored in 2 to 3 weeks (Chauhan &amp; Tadi, 2021). Right after delivery, uterine</p>

	<p>contractions occur in order to prevent blood loss, and expel any remaining gestational material (Chauhan &amp; Tadi, 2021). These contractions can result in abdominal cramping and pain within the first 24 hours of post-delivery stage. The patient verbalizes a moderate amount of abdominal pain during assessment. She rates the pain at a 4 out of 10 on a numerical scale. As part of involution, the patient expelled a scant amount of lochia rubra. Her fundus is 1 finger below her umbilicus, which shows that her reproductive organs are going back to their original locations. As part of postpartum complication, the patients may present with hypertension, infection and thromboembolic events (Paladine et al., 2019). The patient's blood pressure is within normal range at 113/63. However, her lymphocytes, neutrophils and WBCs are elevated, which may suggest possible infection. However, her temperature does not reflect the presence of infection. She is, however, at a greater risk of developing thromboembolism because of her history of developing pulmonary embolism after the birth of her first child. Currently, the patient is not showing signs of postpartum hemorrhage as evidenced by her firm fundus, and scant lochia rubra. She is also in the taking-hold phase of parental adaptation, as she is less concerned about her personal needs and she is more involved with the care of her newborn.</p>
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**Stage of Labor References (2) (APA):**

Chauhan, G., & Tadi, P. (2021). Physiology, postpartum changes. *StatPearls Publishing*

Paladine, H. L., Blenning, C. E., & Strangas, Y. (2019). Postpartum Care: An approach to the fourth trimester. *American Family Physician, 100*(8), 485–491.

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

**Home Medications (2 required)**

<b>Brand/Generic</b>	<b>Acetaminophen/Tylenol</b>	<b>Calcium carbonate</b>			
<b>Dose</b>	650mg	1 pill			
<b>Frequency</b>	PRN Q4hrs	Q8hr, PRN			
<b>Route</b>	oral	oral			
<b>Classification</b>	Nonsalicylate, antipyretic, analgesic	Calcium salts, calcium replacement			
<b>Mechanism of Action</b>	Acetaminophen blocks the production of prostaglandin by inhibiting the action of cyclooxygenase (Jones & Bartlett Learning, LLC, 2021).	Calcium plays a major role in musculoskeletal and cellular functions. Calcium carbonate intake increases extracellular and intracellular levels of calcium (Jones & Bartlett Learning, LLC, 2021).			
<b>Reason Client Taking</b>	Management of mild to moderate pain	Calcium supplementation			
<b>Contraindications (2)</b>	<ol style="list-style-type: none"> <li>1. Severe hepatic impairment</li> <li>2. Use of other drugs containing acetaminophen</li> </ol>	<ol style="list-style-type: none"> <li>1. History or current kidney stones</li> <li>2. Hypercalcemia or hyperphosphatemia</li> </ol>			
<b>Side Effects/Adverse Reactions (2)</b>	Anxiety, pulmonary edema	Hypotension, paresthesia			
<b>Nursing</b>	<ol style="list-style-type: none"> <li>1. Double check the</li> </ol>	<ol style="list-style-type: none"> <li>1. Assess the patient</li> </ol>			

<p><b>Considerations (2)</b></p>	<p>order is in milligrams vs milliliters</p> <p>2. Determine all sources of acetaminophen intake to prevent overdosing</p>	<p>for Chvostek’s sign and Trousseau’s sign.</p> <p>2. Ensure the patient knows to store calcium properly and to protect it from heat, moisture or frigid temperatures. (Jones &amp; Bartlett Learning, LLC, 2021)</p>			
<p><b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b></p>	<p>1. AST, ALT and liver function should be determined prior to administration of acetaminophen (Jones &amp; Bartlett Learning, LLC, 2021).</p>	<p>1. Assess the patient for hyperexcitability of muscles and check calcium levels when possible.</p>			
<p><b>Client Teaching needs (2)</b></p>	<p>1. Educate the patient that Tylenol can be crushed if needed.</p> <p>2. Ensure that the patient knows not to take more than the prescribed dosage. (Jones &amp; Bartlett Learning, LLC, 2021)</p>	<p>1. Ensure that the client is aware to take calcium carbonate 1 to 2 hours after meals.</p> <p>2. Educate the patient not to take other drugs with calcium for at least 2 hours to prevent interactions. (Jones &amp; Bartlett Learning, LLC, 2021)</p>			

**Hospital Medications (5 required)**

<b>Brand/ Generic</b>	Buspirone/ Buspar	Lovenox/ enoxaparin	Ferrous sulfate tablet	Singulair/ montelukast tablet	Ondansetron /Zofran
<b>Dose</b>	10mg	60mg	325mg	4mg	4mg
<b>Frequency</b>	2x daily	once	2x daily	Every evening	Q6hrs, PRN
<b>Route</b>	oral	SQ	oral	oral	oral
<b>Classification</b>	Azaspiron, anxiolytic	anticoagulant	Hematinic, antianemic	Leukotriene receptor antagonist, antiasthmatic	
<b>Mechanism of Action</b>	Buspirone may act on serotonin receptors in the brain, which can induce antianxiety effects (Jones & Bartlett Learning, LLC, 2021).	Heparin prevents the formation of clots by inactivating the action of coagulation enzymes (Jones & Bartlett Learning, LLC, 2021).	Iron is an important component of blood components such as RBCs and hemoglobin. It is needed to produce RBCs and hemoglobin.	Prevents bronchial inflammation and edema by binding to leukotriene receptors (Jones & Bartlett Learning, LLC, 2021).	
<b>Reason Client Taking</b>	Anxiety symptoms	Prevention of venous thromboembolism	Low hemoglobin and hematocrit	History of asthma	
<b>Contraindications (2)</b>	1. Hypersensitivity to buspirone 2. Nursing women	1. Bleeding 2. Breastfeeding infants	1. Hypersensitivity to iron salts 2. Other anemic conditions	1. Hypersensitivity to montelukast 2. Concurrent use of phenobarbitals	
<b>Side Effects/ Adverse Reactions (2)</b>	Restlessness and constipation	Excessive bleeding, ovarian hemorrhage,	Syncope, hypotension, dyspnea	Chest pain, asthma aggravation	

		dizziness			
<b>Nursing Considerations (2)</b>	<ol style="list-style-type: none"> <li>1. Safety precautions should be done because of possible CNS effects of buspirone.</li> <li>2. If the patient has any signs of renal or hepatic impairment, buspirone must be stopped immediately.</li> </ol>	<ol style="list-style-type: none"> <li>1. The nurse must remember that Heparin should not be given IM because it can cause a hematoma.</li> <li>2. Alternate injection sites to prevent local tissue wasting. (Jones &amp; Bartlett Learning, LLC, 2021)</li> </ol>	<ol style="list-style-type: none"> <li>1. Always give iron with a full glass of fluid such as water or juice.</li> <li>2. Encourage the patient to eat foods rich in Vitamin C to promote iron absorption (Jones &amp; Bartlett Learning, LLC, 2021).</li> </ol>	<ol style="list-style-type: none"> <li>1. The nurse should know that singular is not used to treat acute asthma attacks.</li> <li>2. Monitor the patient for signs of suicidal ideation. (Jones &amp; Bartlett Learning, LLC, 2021)</li> </ol>	
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	BUN, creatinine, and liver enzymes should be considered prior to administration of buspirone.	Coagulation studies should be done and taken into consideration prior to administration of Heparin.	Check the patient's blood pressure and pulse before, during and after iron supplementation.	The patient's respiratory status should be assessed, and other medications used concurrently with singular should be reconciled.	
<b>Client Teaching needs (2)</b>	<ol style="list-style-type: none"> <li>1. Educate the patient about the possible effects of taking Buspirone</li> </ol>	<ol style="list-style-type: none"> <li>1. Educate the patient about the importance of preventing injuries</li> </ol>	<ol style="list-style-type: none"> <li>1. Educate the patient that her stool will become darker due to</li> </ol>	<ol style="list-style-type: none"> <li>1. Educate the patient that singular cannot treat acute asthma attacks and that she</li> </ol>	

	<p>e with grapefruit juice.</p> <p>2. The patient should be made aware that the effects of buspirone may not show up until 1-2 weeks after initiation of therapy. (Jones &amp; Bartlett Learning, LLC, 2021)</p>	<p>because she will be at risk for bleeding (Jones &amp; Bartlett Learning, LLC, 2021).</p> <p>2. Educate the patient to look for signs of bleeding such as black stool, bright red stool, vaginal bleeding, cuts, or bruising (Jones &amp; Bartlett Learning, LLC, 2021).</p>	<p>iron intake.</p> <p>2. Warn patient not to take antacids or iron within 1 to hours after taking iron. (Jones &amp; Bartlett Learning, LLC, 2021)</p>	<p>needs to notify the provider if she needs rescue inhalers.</p> <p>2. Educate the patient's family about monitoring the patient's behavior and to notify the nurse or the provider about depressive symptoms. (Jones &amp; Bartlett Learning, LLC, 2021)</p>	
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**Medications Reference (1) (APA):**

Jones & Bartlett Learning, LLC. (2021). *Nurse's drug handbook* (20<sup>th</sup> ed). Jones & Bartlett Learning, LLC.

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>The patient does not appear to be in distress; she is well groomed, clean and pleasant; she is alert and oriented to person, place, time and situation x4</p>
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<p><b>INTEGUMENTARY (1 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds/Incision: .</b>  <b>Braden Score: 23</b>  <b>Drains present: Y</b><input type="checkbox"/> <b>N</b><input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>No rashes, bruises, wounds or incisions noted; skin turgor quickly recoils; skin color is light brown, appropriate for race and ethnicity; temperature is cool; skin is dry and soft</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>the patient’s head is normocephalic and atraumatic; nose and ears are clear with no purulent discharge noted; oral mucosa is intact; oral, and nasal mucosa are pink; teeth are complete with no significant tartar noted</p>
<p><b>CARDIOVASCULAR (2 point):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention: Y</b><input type="checkbox"/> <b>N</b><input checked="" type="checkbox"/>  <b>Edema Y</b><input type="checkbox"/> <b>N</b><input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>S1 and S2 sounds are present; no S3, S4, murmur, gallops, bruits or rubs auscultated; heart rate normal rate, rhythm unable to be assessed; peripheral pulses are strong +2 in both lower and upper extremities bilaterally; capillary refill are brisk and less than 3 seconds in all extremities; no edema or neck vein distention noted or palpated</p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use: Y</b><input type="checkbox"/> <b>N</b><input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Breath sounds are clear; respirations are normal in rate and rhythm, no respiratory distress noted at this time; chest depresses and rises equally; no wheezing, stridor, rhonchi or crackles auscultated; lung sounds present and clear in all lobes</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at Home: regular</b>  <b>Current Diet: regular</b>  <b>Height: 152.4cm</b>  <b>Weight: 81.6kg</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM: 10/31/2022</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>  <b>Distention:</b>  <b>Incisions:</b>  <b>Scars:</b></p>	<p>Upon inspection, the patient’s abdomen does not have any rashes, cuts, wounds, bruises or bleeding; upon fundal examination and palpation, patient grimaces and verbalizes presence of moderate pain; bowel sounds are present and normoactive in all quadrants upon auscultation; no drains, incisions, scars, distention, or wounds noted; no organomegaly noted</p>

<p><b>Drains:</b> <b>Wounds:</b></p>	
<p><b>GENITOURINARY (2 Points):</b>  <b>Quantity of urine: small</b>  <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Inspection of genitals:</b> no lacerations or cuts, per patient, no significant vaginal bleeding noted  <b>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Type:</b>  <b>Size:</b></p>	
<p><b>MUSCULOSKELETAL (1 points):</b>  <b>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Fall Score: 20, due to Heparin</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib) <input type="checkbox"/></b>  <b>Needs assistance with equipment <input type="checkbox"/></b>  <b>Needs support to stand and walk <input type="checkbox"/></b></p>	<p>the patient shows normal range of motion in all limbs; she can walk and move independently; she does not need support to stand or use equipment</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</b>  <b>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></b>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b>  <b>DTRs:</b></p>	<p>The patient is alert and oriented to person, place, time, situation x4; no sensory deficit noted; and mentation is intact; patient’s speech is clear and nongarbled; she is fully conscious and is able to converse with student and instructor with no impairment or difficulty; DTRs are present</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The patient is an adult female who acts appropriately for her age and level of development. She is accompanied by the father’s baby who actively interacts with the student nurse and shows attentiveness to the patient’s and the baby’s needs.</p>
<p><b>Reproductive: (2 points)</b>  <b>Fundal Height &amp; Position: 1 under umbilicus</b>  <b>Bleeding amount: scant</b>  <b>Lochia Color: red</b>  <b>Character: moist to dry</b></p>	

<p><b>Episiotomy/Lacerations: none</b></p> <p><b>DELIVERY INFO: (1 point)</b></p> <p><b>Rupture of Membranes: artificial</b></p> <p><b>Time: 1005 am</b></p> <p><b>Color: clear</b></p> <p><b>Amount: UTA, and not recorded in chart</b></p> <p><b>Odor: none</b></p> <p><b>Delivery Date: 11/1/2022</b></p> <p><b>Time: 19:39</b></p> <p><b>Type (vaginal/cesarean): vaginal, induced</b></p> <p><b>Quantitative Blood Loss: 150mL</b></p> <p><b>Male or Female: male</b></p> <p><b>Apgars: 8 at 1 minute, 9 at 5 minutes</b></p> <p><b>Weight: 7lbs and 0.5 ounces</b></p> <p><b>Feeding Method: breastfeeding</b></p>	
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**Vital Signs, 3 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>Prenatal</b>	N/A, not recorded in chart	N/A, not recorded in chart	16	N/A, not recorded in chart	99%
<b>Labor/Delivery</b>	N/A, not recorded in chart	122/66	N/A, not recorded in chart	N/A, not recorded in chart	98%
<b>Postpartum</b>	81	113/63	20	98.2F	98%

**Vital Sign Trends:** UTA trend of pulse because it was not assessed, the patient’s blood pressure has gone down since the last one, her oxygen saturation has stayed similar, and respirations have increased since the last one recorded

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
1450	Numeric	Abdomen, lateral	6/10	Sore, cramping	Quiet environment, single medication modality, pillow support
1615	Numeric	Abdomen	4/10	cramping	Quiet environment, single medication modality, pillow support

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV: 18G</b> <b>Location of IV: posterior right hand</b> <b>Date on IV: 11/01/2022</b> <b>Patency of IV: patent</b> <b>Signs of erythema, drainage, etc.: no drainage, erythema or pain</b> <b>IV dressing assessment: the IV dressing is dry, clean and intact</b>	No fluids being administered upon assessment

**Intake and Output (2 points)**

<b>Intake</b>	<b>Output (in mL)</b>
300mL, PO	14.8 mL of urine, last recorded

**Nursing Interventions and Medical Treatments During Postpartum (6 points)**

<b>Nursing Interventions and Medical Treatments (Identify nursing interventions with “N” after you list them, identify medical treatments with “M” after you list them.)</b>	<b>Frequency</b>	<b>Why was this intervention/ treatment provided to this patient? Please give a short rationale.</b>
Prophylactic Lovenox (M)	Once	The patient has a history of pulmonary

		embolism post-partum, so she was given Heparin to prevent the development of PE.
Quiet environment (N)	Continuous	As part of pain management and post-partum recovery, a quiet environment is setup for the patient to promote healing and relief of pain.
Assess vital signs (N)	Q4 hours	The patient's health status should still be monitored, especially postpartum. Complications may arise hours and days after delivery.
Fundal Assessment (N)	Every shift	The fundus continues to descend up to 2 weeks after delivery. The abdomen and fundus should be assessed to monitor for postpartum complications.

### Phases of Maternal Adaptation to Parenthood (3 point)

**What phase is the mother in?** taking-hold phase

**What evidence supports this?** The mother is very involved in taking care of her child. She is very independent and does not need a lot of help from others. She is also a second-time mother, which can make adjustment to parenthood a lot faster.

### Discharge Planning (3 points)

**Discharge location:** The patient will be discharged home with her mother and her partner Clay.

**Equipment needs (if applicable):** no needs at this time

**Follow up plan (include plan for mother AND newborn):** The patient needs to follow up with her primary care provider and establish care for her newborn. Postpartum evaluation with primary care is crucial for her overall health maintenance. Additionally, newborn preventative care can only be done with a primary care provider.

**Education needs:** The patient needs education on the medications she will be taking and postpartum complications.

**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><b>Nursing Diagnosis (2 pt each)</b> Identify problems that are specific to this patient. Include full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p><b>Rational (1 pt each)</b> Explain why the nursing diagnosis was chosen</p>	<p><b>Intervention/Rational (2 per dx) (1 pt each)</b> 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><b>Evaluation (2 pt each)</b> How did the patient/family respond to the nurse’s actions?  <ul style="list-style-type: none"> <li>Client response, status of goals and outcomes, modifications to plan.</li> </ul> </p>
<p>1. Risk for venous thromboembolism related to postpartum complication as evidenced by a history of pulmonary embolism after first birth.</p>	<p>Thromboembolisms can be life-threatening if it travels into the lungs. It can cause severe damage to the pulmonary system, and can even cause death if not addressed or prevented.</p>	<p>1. Administer prescribed anticoagulant. Rationale Administration of the anticoagulant as prescribed will maintain prophylactic levels of anticoagulant therapy (Phelps, 2020). 2. Assess the patient’s circulation every 4 hours. Rationale Consistent assessment of the patient’s circulation and vital signs can help identify the signs and symptoms of a developing thromboembolism (Phelps, 2020).</p>	<p>The patient’s anticoagulant therapy serum levels should remain within therapeutic range. Any signs and symptoms of a thromboembolism will be reported to the provider and proper nursing interventions will be performed to promote the best outcome for the patient.</p>
<p>1. Risk for bleeding related to postpartum complication as evidenced by Heparin administration</p>	<p>The patient is already naturally at risk for postpartum hemorrhage, but the administration of Heparin prophylactically</p>	<p>1. Monitor the patient’s vital signs, level of consciousness and oxygen saturation every 4 hours. Rationale Vital signs change to</p>	<p>The patient’s vital signs remain stable, and the patient and her family members should verbalize understanding of the situation. Any</p>

<p>subcutaneously.</p>	<p>increases bleeding risk even more. Patients can die from postpartum bleeding.</p>	<p>compensate for bleeding. Early signs of bleeding can be detected through the identification of changes in vital sign trends (Phelps, 2020).                  2. Instruct and teach the patient about modifications in daily activities.                  Rationale                  Opting for more gentle versions of daily activities can protect the patient from trauma and prevent bleeding (Phelps, 2020).</p>	<p>changes in the patient’s vital signs will be followed up on, and if warranted, will be relayed to the provider.</p>
<p>1. Risk for impaired parenting related to low educational level and bipolar disorder as evidenced by 10<sup>th</sup> grade education and history of depression.</p>	<p>It is important for the patient to be aware of the child’s needs and how mental health issues may prevent her from taking care of her children properly. It is vital that the patient is able to take care of her children for the sake of their health status.</p>	<p>1. Encourage the patient to ask questions regarding child care.                  Rationale                  The patient may not know what to ask in regard to effective parenting due to lack of personal experience or lack of role models (Phelps, 2020). Encouraging them to ask questions can help the patient think about what she might lack in parenting knowledge.                  2. Educate the patient on the importance of regular visits to the doctor for the child.                  Rationale                  Regular visits to the physician can help identify and detect any delays in the child’s development and promote preventative care (Phelps, 2020).</p>	<p>The patient will ask questions regarding effective parenting. Any important questions may be asked by the nurse to help the patient see important aspects of effective parenting. She will also express desire and intention to bring her child for routine visits to maintain his health.</p>
<p>1. Deficient</p>	<p>Mastitis is a type of</p>	<p>1. Give the patient a</p>	<p>The patient will</p>

<p>knowledge related to Mastitis as evidenced by the patient stating that she will be nursing her newborn.</p>	<p>infection related to breastfeeding that can be very painful and cause a lot of stress for the mother and her family members. Proper education on this matter is important to promote the best breastfeeding experience.</p>	<p>handout with information regarding Mastitis.                  Rationale                  Visual material such as pictures and words can help reinforce the patient’s learning (Phelps, 2020).                  2. Ask the patient to demonstrate and apply teaching regarding the prevention of Mastitis.                  Rationale                  The patient can show her understanding and proficiency in preventing Mastitis through demonstration and application (Phelps, 2020). The nurse then can correct any misunderstanding and help the patient learn.</p>	<p>understand that Mastitis can involve symptoms such as fever, pain and feeling of fullness in the affected breast. The patient will know that if she were to develop Mastitis, she can still feed the baby, unless cysts and other complications develop.</p>
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**Other References (APA)**

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

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