

N432 Postpartum Care Plan  
Lakeview College of Nursing  
Samantha Christison

N432 POSTPARTUM CARE PLAN

**Demographics (3 points)**

<b>Date &amp; Time of Admission</b> 10-31-2022 1148	<b>Patient Initials</b> G.N.	<b>Age</b> 33 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> African American	<b>Occupation</b> CNA	<b>Marital Status</b> single	<b>Allergies</b> No known allergies
<b>Code Status</b> full	<b>Height</b> 4'11" (149.9cm)	<b>Weight</b> 170 lbs (77.1 kg)	<b>Father of Baby Involved</b> No

**Medical History (5 Points)**

**Prenatal History:** before birth: G3T1P1A1L1 after birth: G3T2P1A1L2

Mother started receiving prenatal care on 4-5-2022 in the first trimester. Patient had first pregnancy at 12 years old. The baby was born preterm at 27 weeks via vaginal delivery. The baby was born with trisomy 13 and died a few hours after birth. Patients second birth was 12 years ago patient had no complication with that pregnancy. Baby was born at 40 weeks via vaginal birth spontaneously. Patient had no complication with this pregnancy. Patient was induced due to baby's large size.

**Past Medical History:** no past medical problems

**Past Surgical History:** patient has a c-section on 10-31-2022 no other surgeries noted.

**Family History:** history of trisomy 13. Maternal grandmother has MS, maternal grandfather is healthy and unknow about father or paternal side of family.

**Social History (tobacco/alcohol/drugs):**

Tobacco: Smoked and half pack a day for many years but stopped smoking on 6-2-2022. Patient also vaped 1-2 times a day but stopped on 6-2-2022 as well.

Alcohol: None

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Drugs: None

**Living Situation:** Patient lives in a single room apartment by herself

**Education Level:** Patient graduated high school and earned her CNA licenses as well.

### Admission Assessment

**Chief Complaint (2 points):** Induction

**Presentation to Labor & Delivery (10 points):** Patient presented to the labor and delivery department for a scheduled induction of labor. Patient denies any contraction or fluid loss/discharge. Patient states she has had a few Braxton hicks within the last week but no other signs of labor. Patient states she had one Braxton hick on 10-30-2022 when she woke up around 0630 but nothing else sense.

### Diagnosis

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

**Secondary Diagnosis (if applicable):** NA

### 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	4-5.5	4.81	4.61	Na	Within normal limits
Hgb	11.5-14	13.5	12.2	Na	Within normal range
Hct	32-42	40.6	36.6	Na	Within normal limits
Platelets	150,000-350,000	273,000	285,000	Na	Within normal limits
WBC	5,000-15,000	7,200	5,500	Na	Within normal range
Neutrophils	55-70%	56.7%	55.2%	Na	Within normal range

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<b>Lymphocytes</b>	15-40%	32.7%	34.3%	Na	Within normal range
<b>Monocytes</b>	2-8	7.8	7.9	Na	Within normal range
<b>Eosinophils</b>	1-4	2.2	1.4	Na	Within normal range
<b>Bands</b>	50-65%	Na	Na	Na	Not completed on this admission

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Prenatal Value</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Blood Type</b>	A, B, AB, O	O	O	O	Within normal range
<b>Rh Factor</b>	Negative or positive	Positive	Positive	Positive	Within normal range
<b>Serology (RPR/VDRL)</b>	Negative or positive	Negative	negative	Negative	Within normal range
<b>Rubella Titer</b>	Immune or not immune	Immune	Immune	Immune	Within normal range
<b>HIV</b>	Negative or positive	negative	negative	negative	Within normal range
<b>HbSAG</b>	Negative or positive	negative	negative	negative	Within normal range
<b>Group Beta Strep Swab</b>	Negative or positive	negative	negative	negative	Within normal range
<b>Glucose at 28 Weeks</b>	<140	104	NA	NA	Within normal range
<b>MSAFP (If Applicable)</b>	Na	Na	Na	Na	Not completed on this admission

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**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
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA
NA	NA	NA	NA	NA	NA

**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)	79- 107	Na	Na	Na	Not completed on this admission

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

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

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

	<b>Your Assessment</b>
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<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>The patient presented to the OB unit for induction of labor on 10/31/2022 at 1148. The patient is a 33v year old African American female who has had one preterm pregnancy and loss the fetus at 27 weeks. The fetus had trisomy 15 and didn't survive long after birth. Patient has had no other complications with her second birth. Patient came in to be induced during induction the baby noted to have significant decelerations in heart rate the patient was noted to have a placental abruption. The patient was rushed to the OR. The patient has stage 3 documented at 1 minute. Patient did not experience stage 2. Patient experienced stage 1 for approximately 8 hours before going to the OR.</p>
<p><b>Current stage of labor</b></p>	<p>The mother is currently experiencing stage four of labor. The fourth stage of labor occurs directly after the delivery of the placenta and can last up to 12 weeks after the neonate is born (Ricci et al., 2021). The patient is eager to go home today as she has been at the hospital since 1-31-2022. The patient is currently 60 hours postpartum and is doing well. The patient is voiding well and states she is passing gas often. Patient noted to have scant dark red vaginal bleeding. The patients' vitals have remained stable. The patient states the pain has started to become controlled by the pain medication. The patient's fundal height is 1 cm below the umbilicus and is firm. The patient is at risk for</p>

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	<p>postpartum hemorrhage due to placental abruption. Signs and symptoms of post-partum hemorrhage include clots, dizziness and trouble breathing (Ricci et al., 2021). The patient is also at risk for infection due to surgery. Signs and symptoms of infection include a fever of 100.4 °F along with swelling and pain at the incision site. Being a single mom puts this patient at an even greater risk for post-partum mood disorders. Signs and symptoms of mood disorders include trouble sleeping, anxiety, depression, irritability, loss of appetite, and fatigue (Ricci et al., 2021). This mother is in the taking- hold phase (Barlow et al., 2019).</p>
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**Stage of Labor References (2) (APA):**

Barlow, M., Holman, H., Johnson, J., McMichael, M, Sommer, S., Wheless, L., Wilford, K., & Williams, D. (2019). ATI: RN *Maternal newborn nursing* (11<sup>th</sup> ed.). Assessment Technologies Institute, LLC.

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

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

**Home Medications (2 required)**

<b>Brand/Generic</b>	Docusate sodium	Prenatal vitamin			
	Colace				

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<b>Dose</b>	100 mg	0.8 mg			
<b>Frequency</b>	BID	Once daily			
<b>Route</b>	PO	PO			
<b>Classification</b>	Pharm: surfactant Therapeutic: laxative	Pharm: iron product and mineral combination therapeutic: vitamin supplement			
<b>Mechanism of Action</b>	“Acts as a surfactant that softens stool by decreasing surface tension between oil and water feces.” (Jones and Bartlett, 2021)	Treat or prevents vitamin deficiency during pregnancy (Ricci et al., 2021).			
<b>Reason Client Taking</b>	For constipation	Supplement during the patient’s pregnancy			
<b>Contraindications (2)</b>	“Concomitant use with mineral oil” “Fecal impaction” (Jones and Bartlett, 2021)	Hypersensitivity to vitamins or its components			
<b>Side Effects/Adverse Reactions (2)</b>	Dizziness, palpitations	Headache, nausea			
<b>Nursing Considerations (2)</b>	Long term use can cause dependence on laxatives. Long term	May cause nausea Can decrease the effectiveness of			

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	use can cause electrolyte imbalance.	antibiotics			
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assess stool and how often patient is having a BM	Assess CBC and CMP			
<b>Client Teaching needs (2)</b>	“Take with a full glass of water.” “Encourage patient to increase fiber intake.” (Jones and Bartlett, 2021)	If experiencing nausea trying to take it at night. Notify provider of any adverse side effects such as constipation			

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	ferrous sulfate Feosol	Gabapentin Gralise	Acetaminophen/ Tylenol	Tums Calcium Carbonate	Magnesium hydroxide Philips Chewable Tablets
<b>Dose</b>	325 mg	300 mg	650 mg	1,000 mg	30 ml
<b>Frequency</b>	BID	TID	Q 4hrs. PRN	Q 8hrs. PRN	PRN
<b>Route</b>	PO	PO	PO	PO	PO
<b>Classification</b>	Pharm: hematinic Therapeutic: antianemia, nutritional supplement	Pharm: 1- amino- methyl cyclohexaneace tic acid Therapeutic: anticonvulsant	Pharmacologic al: nonsalicylate Therapeutic: Antipyretic	Pharmacological : Calcium slats Therapeutic: Antacid	Pharm: mineral Therapeutic: electrolyte replacement
<b>Mechanism of Action</b>	“Acts to normalize RBC production by binding with	“GABA inhibits rapid firing of neurons	“Inhibits the enzyme cyclooxygenase, blocking	“Increase levels of intracellular and extracellular calcium, which	“Magnesium exerts a hyperosmotic effect in the

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	hemoglobin or by being oxidized and stored as hemosiderin and aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen” (Jones and Bartlett, 2021).	associated with seizures. It also may prevent exaggerated responses to painful stimuli.” (Jones and Bartlett, 2021)	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” (Jones and Bartlett, 2021).	is needed to maintain hemostasis, especially in the nervous and musculoskeletal systems. Also plays a role in normal cardiac and renal function, respiration, coagulation, and cell membrane and capillary permeability helps regulate the release and storage of neurotransmitters and hormones. Oral forms also neutralize or buffer stomach acid to relieve discomfort caused by hyperacidity” (Jones and Bartlett, 2021).	small intestines. It causes water retention that distends the bowel and causes the duodenum to secrete cholecystokinin . This substance stimulates fluid secretion and intestinal motility” (Jones and Bartlett, 2021).
<b>Reason Client Taking</b>	To provide iron supplement	Pain	pain	Heart burn	constipation
<b>Contraindications (2)</b>	Hemolytic anemias Hemosiderosis	Hypersensitivity to gabapentin or its components	Sever hepatic impairment  Severe active liver disease	Hypercalcemia  Hypophosphatemia	Diverticulitis Ulcerative colitis
<b>Side Effects/Adverse Reactions (2)</b>	Dizziness, hypotension	Hypotension, hyponatremia	Hepatotoxicity Hypotension	Nausea  Irregular heartbeat	Hypotension hypermagnesium
<b>Nursing Considerations (2)</b>	“Give with a full glass of water.” “Don’t give antacids, coffee, dairy products, eggs, tea or whole grain breads and cereals within 1 hour before or 3 hours after iron.” (Jones and Bartlett,	“don’t give drug within 2 hours of an antacid.” “Capsules may be opened and mixed with applesauce.” (Jones and Bartlett, 2021).	“Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypocalcemia, or severe renal	“Store at room temperature, and protect from heat, moisture, and direct light” (Jones and Bartlett, 2021). “Drug is present in breast milk” (Jones and Bartlett, 2021).	“Avoid giving any other oral drugs within 2 hours of the drugs.” “Give medication with large glass of water” (Jones and Bartlett, 2021).

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	2021).		impairment” (Jones and Bartlett, 2021). “Use parenteral drug within 6 hours once vacuum seal of glass vial has been penetrated or contents transferred to another container” (Jones and Bartlett, 2021).		
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Asses what time patient has ate the hour before	Obtain blood work for renal function before administering	Assess pain	Assess indigestion	Monitor serum electrolytes
<b>Client Teaching needs (2)</b>	“Do not chew tablet.” “Encourage patients to eat food rich in vitamin C to improve iron absorption.” (Jones and Bartlett, 2021).	“Cation to not stop taking the drug abruptly.” “Educate patient to not take within 2 hours of antacid.” (Jones and bartlett, 2021).	“Tell patient that tablets may be crushed or swallowed whole” (Jones and Bartlett, 2021). “Caution patient to not exceed recommended dose or take other drugs containing acetaminophen at the same time because of risk of liver damage” (Jones and Bartlett, 2021).	“Urge patient to chew chewable tables thoroughly before swallowing and to drink a glass of water afterward” (Jones and Bartlett, 2021). “Instruct patient to take calcium carbonate tablets 1 to 2 hours after meals and other forms with meals” (Jones and Bartlett, 2021).	“Teach patient to increase fiber and fluid intake. ““caution patient about risk of dependence with long term laxative use” (Jones and Bartlett, 2021).

**Medications Reference (1) (APA):**

Jones & Bartlett Learning, LLC. (2021). *2021 Nurse’s Drug Handbook* (20th ed.).

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

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**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness: A&amp;O x 4</b>  <b>Orientation: Person, Place, Time, and Event</b>  <b>Distress: Patient is in no distress</b>  <b>Overall appearance: patient is well groomed laying supine in bed with head of bed elevated</b></p>	<p>Patient is alert and oriented times 4. Patient appears to be in no apparent distress at this time. Patient is laying supine in bed well-groomed with head of bed elevated. Patient answers all question appropriately.</p>
<p><b>INTEGUMENTARY (1 points):</b>  <b>Skin color: dark, appropriate for ethnicity</b>  <b>Character: moist</b>  <b>Temperature: warm</b>  <b>Turgor: rapid recoil</b>  <b>Rashes: no rashes</b>  <b>Bruises: no bruising</b>  <b>Wounds/Incision: transverse incision on lower abdomen</b>  <b>Braden Score: 23</b>  <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Type:</b></p>	<p>Patient has dark skin that is moist, warm to touch and appropriate for ethnicity. Patient had rapid recoil when completing a turgor test. Patient has no rashes or bruising noted. Patient does have a transverse incision approximately 4 inches in length on her lower abdomen from her c- section. Patient incision is clean free of drainage and covered with skin adhesive. Patient has no drains present and has a Braden score of 23.</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck: normal cephalic, head and neck are symmetrical, trachea is midline without deviation. Thyroid is not palpable. Carotid pulses +2.</b>  <b>Ears: auricle is moist, and pink noted to have no cerebrum build up.</b>  <b>Eyes: PERRLA, pupils size 3</b>  <b>Nose: sinuses are nontender upon palpation, patient noted to have no drainage from both nostrils.</b>  <b>Teeth: uvula is midline soft palate rises and falls symmetrically. Patient noted to have all teeth, oral mucosa is moist, pink and no lesions noted. Teeth are clean and well maintained.</b></p>	<p>Patients head is normal shape and size, head and neck are symmetrical, trachea is midline with no deviation. Thyroid is non palpable. Carotid pulses are +2 bilaterally. Ears are symmetrical, auricle is moist and pink, no cerebrum build up or drainage noted. Eyes are PERRLA, pupils are a size 4, sclera is white, conjunctiva is clear and free from drainage. Patients' sinuses are nontender upon palpation, patient noted to have no drainage from either nostril. Patient noted to have all teeth that are well maintained. Patient mouth is pink and moist, uvula is midline, soft palate rises and falls symmetrically. No lesions noted.</p>
<p><b>CARDIOVASCULAR (2 point):</b>  <b>Heart sounds: s1 and s2 audible is all fields.</b></p>	<p>Patient heart sound are clear and audible in all fields upon auscultation, s1 and s2 heard. No murmurs heard peripheral pulses are present,</p>

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<p>S1, S2, S3, S4, murmur etc.  <b>Cardiac rhythm (if applicable): NA</b>  <b>Peripheral Pulses: peripheral pules are present and +2 in all fields</b>  <b>Capillary refill: less than 3 seconds</b>  <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Location of Edema: +1 bilaterally in lower legs</b></p>	<p>strong and +2. Capillary refill is less than 3 seconds in fingers and toes. Patient noted to have no neck vein distention. <b>Patient noted to have +1 edema in bilateral lower legs.</b></p>
<p><b>RESPIRATORY (1 points):</b>  <b>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Breath Sounds: Location, character clear in all fields</b></p>	<p>Patient has no accessory muscle use. Lung sounds are clear in all fields upon auscultation.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at Home: Normal</b>  <b>Current Diet: Normal</b>  <b>Height: 4'11" (149.9 cm)</b>  <b>Weight: 170lbs (77.1kg)</b>  <b>Auscultation Bowel sounds: active in all four quadrants</b>  <b>Last BM: 10-30-2022</b>  <b>Palpation: Pain, Mass etc.: tender upon palpation</b>  <b>Inspection: incision is clean and well intact</b>              <b>Distention: no distention noted</b>              <b>Incisions: transverse incision on lower abdomen</b>              <b>Scars: no scars noted</b>              <b>Drains: no drains noted</b>              <b>Wounds: no wounds noted</b></p>	<p>Patient is on a regular diet at home and a regular diet currently. Patient is 4 foot eleven inches and 170 pounds. Patients' bowel sounds are active in all four quadrants. Patient states her last bowel movement was on 10-30-2022 but states she has been passing a lot of gas. Patient noted to have some tenderness in her lower abdomen upon palpation. Patient has no distention, no scars, no drains, no wounds but does have a transverse incision on her lower abdomen.</p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Quantity of urine: 2 voids while on shift</b>  <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Inspection of genitals: NA</b>  <b>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>              <b>Type:</b>              <b>Size:</b></p>	<p>Patient voided 2 times while on shift. Urine is pale yellow. Patient has no pain with urination. Inspection of genitals is not needed at this time due to c-section. Patient does not have a catheter.</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 type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Fall Score: 0</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib) <input checked="" type="checkbox"/></b></p>	<p>Patient is up and doing all ADLs on her own. Patient is not a fall risk. Patient has a fall score of 0. Patient is independent.</p>

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<p>Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b> A&amp;O 4  <b>Mental Status:</b> alert and oriented  <b>Speech:</b> clear  <b>Sensory:</b> no sensory deficits  <b>LOC:</b> alert  <b>DTRs:</b> +2</p>	<p>Patient moves all extremities well. Eyes are PERRLA. Patient has equal strengths in upper and lower extremities. Patient is alert and oriented to person, place time and event. Speech is clear and audible. Patient has no sensory deficits. Patient is alert with no altered LOC. Patient DTRs are +2.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b> watching TV  <b>Developmental level:</b> average  <b>Religion &amp; what it means to pt.:</b> not religious  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b> has a good friend to help with baby</p>	<p>Patient states she enjoys watching tv while in the hospital. Patient is average developmental level. When asked about religion patient states she is not religious. Patient she has a few good friends that are her support system.</p>
<p><b>Reproductive: (2 points)</b>  <b>Fundal Height &amp; Position:</b> 1 below umbilicus  <b>Bleeding amount:</b> scant  <b>Lochia Color:</b> rubra  <b>Character:</b> dark red  <b>Episiotomy/Lacerations:</b> none</p>	<p>Patients' fundal height and position is midline at 1 below the umbilicus. Patient has scant dark red blood. Patient has no episiotomy and lacerations.</p>
<p><b>DELIVERY INFO: (1 point)</b>  <b>Rupture of Membranes:</b> artificial  <b>Time:</b> 2053  <b>Color:</b> yellow  <b>Amount:</b> large  <b>Odor:</b> normal  <b>Delivery Date:</b> 10-31-2022  <b>Time:</b> 2204  <b>Type (vaginal/cesarean):</b> cesarean  <b>Quantitative Blood Loss:</b> 2139 ml  <b>Male or Female</b>  <b>Apgars:</b> 8, 9  <b>Weight:</b> 3995 g  <b>Feeding Method:</b> bottle and breast</p>	<p>Patient delivered via cesarean on 10-31-2022 at 2204. Patient membranes were artificially ruptured at 2053. Meconium was thin yellow with no odor and a large amount. The neonate is a female who weighed 3995 g. The neonate Apgar scores of 8 and 9. The neonate is both breast fed and bottle fed.</p>

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**Vital Signs, 3 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
<b>Prenatal</b>	83	118/74	20	Not completed	100% ra
<b>Labor/Delivery</b>	119	113/81	20	96.7°F	100% ra
<b>Postpartum</b>	90	109/71	18	97.8°F	100% ra

**Vital Sign Trends:** patient vital signs remained stable.

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

Time	Scale	Location	Severity	Characteristics	Interventions
0910	1-10	Abdomen	6	Sore, achy	Administer pain medications
1000	1-10	Abdomen	2	Achy	Repositioned patients pillows

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> NA <b>Location of IV:</b> NA <b>Date on IV:</b> NA <b>Patency of IV:</b> NA <b>Signs of erythema, drainage, etc.:</b> NA <b>IV dressing assessment:</b> NA	Patient does not have an IV. Patient site looks clean, no drainage or swelling. No dressing at this time.

**Intake and Output (2 points)**

Intake	Output (in mL)
300 ML of water	2 urine voids, unable to measure.

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50% of breakfast	
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**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>
Administration of pain medication (M)	every 6 hours	The treatment will give the patient relief of pain following a c- section
Head to toe assessment (N)	Once a shift	This is completed to assess the patient complete and be able to care for her the way she needs.
Give extra pillows and reposition (N)	As needed	Repositioning the patient and getting her extra pillows provides comfort to the patient.
Put her socks on her feet (N)	As needed	Helping the mother put her socks on gives her comfort and prevents her from experiencing pain at the incision site.

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

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

**What evidence supports this?** The mother wants to learn and care for the baby. The mother wants to improve competency when caring for her new born.

**Discharge Planning (3 points)**

**Discharge location:** This patient will be discharged home later today.

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**Equipment needs (if applicable):** This patient will need a breast pump to take home to help with breast feeding and increasing her milk supply.

**Follow up plan (include plan for mother AND newborn):** The mother will follow up with her PCP in 6 weeks and the baby will be seen at the pediatrician’s office on 11-07-2022.

**Education needs:** The patient was given education on signs of infection and newborn care as this is her first child to care for. The patient was also taught how to swaddle the baby and how to get the baby to latch better. The patient needs education on the use of a breast pump once they get her one to take home.

**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><b>1.</b> Pain related to c-section as evidence by 6 out of 10 pain scale rating.</p>	<p>Patient will experience more pain after having a major surgery.</p>	<p><b>1.</b>Assess patients’ pain every hour and administer pain medications every 4-6 hours.  <b>Rationale</b> assessment allows for the nurse to give the right medication to control the pain (Phelps, 2020).  <b>2.</b>Help the patient into a comfortable position and use pillows to splint or support incision.  <b>Rationale</b> reducing muscle</p>	<p>The patient understood the importance of performing an assessment and was very appreciative when we help reposition her and give her extra pillows.</p>

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		tension and redistributing pressures reduces pain (Phelps, 2020).	
2. Risk for infection related to c-section as evidence by surgical incision	Patient is at increased risk for infection due to having a surgery.	<p>1. Monitor patients' temperature every 6 hours.  <b>Rationale</b> "Temperature elevation is an early sign of infection" (Phelps, 2020).                  2. Provide education on hand hygiene.  <b>Rationale</b> "Hand hygiene is the single best way to prevent pathogens" (Phelps, 2020).</p>	The patient understood the importance of hand hygiene and the reason we are monitoring her temperature.
3. Deficient knowledge related to formula feeding as evidence by first time mom.	Patient has deficient knowledge on formula feeding due to this being her first baby at home.	<p>1. Provide handouts to the patient.  <b>Rationale</b> "Having a handout allows them to look back at the information provided." (Phelps, 2020).                  2. Have the patient demonstrate preparing a formula bottle.  <b>Rationale</b> "Having the patient perform the skill builds confidence" (Phelps, 2020).</p>	The patient was able to demonstrate preparing formula bottle properly.
4. Deficient knowledge related to newborn care as evidence to first baby at home.	Patient has deficient knowledge of in caring for a newborn as this is her first child, she is taking home.	<p>1. Assess patients' level of knowledge.  <b>Rationale</b> Assessing the patient knowledge allows the nurse to have a better understanding of the education the patient needs (Phelps, 2020).                  2. Provide phone numbers of support services.  <b>Rationale</b> this helps the mother understand the supportive services single mothers can receive (Ricci et al., 2021).</p>	The patient had lots of knowledge about newborn care and was very appreciative of the supportive service information provided.

**Other References (APA)**

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

Phelps, L.L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (11<sup>th</sup> Ed.). Wolters Kluwer.