N432 Postpartum Care Plan

Lakeview College of Nursing

Name: Christina Oakley

11/03/2022

Demographics (3 points)

Date & Time of Admission 11/02/2022	**Patient Initials** A.P	**Age** 18 years old	**Gender** Female
Race/Ethnicity Hispanic or Latino	**Occupation** Student	**Marital Status** Single	**Allergies** No known allergies
Code Status Full Code	**Height** 5'1"	**Weight** 53.1 kg (117 lbs)	**Father of Baby Involved** Father is involved with the care of baby

Medical History (5 Points)

Prenatal History:

GTPAL: G1T1P0A0L1

No complications during the current pregnancy.

Prenatal care started 04/02/2022.

Past Medical History: No past medical history.

Past Surgical History: No past surgical history.

Family History: No significant family history.

Social History (tobacco/alcohol/drugs): None

Living Situation: Currently living with parents.

Education Level: High school graduate.

Admission Assessment

Chief Complaint (2 points): Contractions

Presentation to Labor & Delivery (10 points):

Patient is an 18 year old female who presented for active labor. Patient was GBS negative. She labored on her own without augmentation. She progressed to complete dilation and started pushing at the appropriate time. Patient states that she is here for contractions that started at

0300. The contractions started suddenly. The contractions caused discomfort in the patient's lower abdomen and radiated to the back. The pain from contractions has gotten worse since the contractions have begun. The patient states the contractions come and go. The patient describes the contractions as feeling dull and achy. Patient states the contractions feel better after rhythmic breathing and lying down on the left side. Patient states the contractions feel worse when moving or when the bladder is full. The patient states that they are also experiencing nausea that comes and goes along with the contractions. The patient tried easing the pain from contractions by taking a warm shower and relaxing.

Diagnosis

Primary Diagnosis on Admission (2 points): Term pregnancy, active 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	3.80-5.30 10(6)/ mgL	4.28 10(6)/mgL	3.68 10(6)/mgL	3.19 10(6)/mgL	The development of anemia during pregnancy can explain a low amount of red blood cells. Prepartum iron deficiency can explain low levels of red blood cells during postpartum (Pagana & Pagana, 2018).
Hgb	12.0-15.8 g/dL	11.2 g/dL	7.8 g/dL	6.6 g/dL	Iron deficiency anemia can explain low levels of hemoglobin (Pagana & Pagana, 2018).
Hct	36.0-47.0%	34.3%	25.4%	22.0%	Iron deficiency anemia can explain low levels of

					hematocrit (Pagana & Pagana, 2018).
Platelets	140-440 10(3)/mcL	309 10(3)/mcL	255 10(3)/mcL	225 10(3)/mcL	
WBC	4.00-12.00 10(3)/ mcL	5.60 10(3)/mcL	9.80 10(3)/mcL	14.40 10(3)/ mcL	After delivery, there is a significant increase in white blood cells which can be due to the rupture of membranes occurring before labor (Pagana & Pagana, 2018).
Neutrophils	47.0-73.0%	71.2%	87.1%	83.8%	Neutrophils in the blood can be increased due to extra stress from pregnancy and labor (Pagana & Pagana, 2018).
Lymphocytes	18.0-42.0%	19.0%	8.8%	9.2%	Low levels of lymphocytes may be due to a low iron or folic acid (Pagana & Pagana, 2018).
Monocytes	4.0-12.0%	9.0%	4.3%	6.8%	
Eosinophils	0.0-5.0%	0.2%	0.0%	0.0%	
Bands	N/a	N/a	N/a	N/a	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A+, O+, B+, AB+, A-, O-, B-, AB-	O+	O+	O+	
Rh Factor	Positive or Negative	Positive	Positive	Positive	
Serology (RPR/VDRL)	Non Reactive	Non Reactive	Non Reactive	Non Reactive	
Rubella Titer	Immune	Immune	Immune	Immune	
HIV	Non detected	Non detected	Non detected	Non detected	
HbSAG	Non detected	Non detected	Non detected	Non detected	
Group Beta	Negative	Negative	Negative	Negative	

Strep Swab					
Glucose at 28 Weeks	65-140 mg/dL	104 mg/dL	104 mg/dL	104 mg/dL	
MSAFP (If Applicable)	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	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	N/a	N/a	N/a	N/a	N/a

Lab Reference (1) (APA):

Pagana, K. D. & Pagana, T. J. (2018). *Mosby's diagnostic and laboratory test reference* (6th 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**	The total length of labor was 95 minutes. The first stage was 2 hours and 30 minutes long, the second stage was 36 minutes long, and the third stage was 9 minutes long. The birth was spontaneous.
Current stage of labor	During clinicals, I only observed the patient's fourth stage of labor. The fourth stage of labor is considered postpartum. The postpartum period begins after the delivery of the placenta and last approximately 6 weeks (Ricci et al., 2021). There are many changes to a woman's body after pregnancy. The mother's breast has grown to prepare for lactation and do not return to their prepregnant size (Ricci et al., 2021). The uterus returns to its normal size through a gradual process of involution (Ricci et al., 2021). During the first 12 hours postpartum, the fundus of the uterus is located at the level of the umbilicus (Ricci et al., 2021). During clinicals, I was able to palpate the patient's fundus and feel how firm it was, as well as the positioning of the fundus. The positioning was midline and leveled with the umbilicus, which was anticipated and is considered a normal finding. Lochia is the vaginal discharge that occurs after birth and continues for approximately 4 to 8 weeks (Barlow et al., 2019). Immediately after childbirth, lochia is bright red and consists mainly of blood, fibrinous

	products decidual cells, and red and white blood cells (Barlow et al., 2019). During clinical, I observed the patient's pad and assessed the color and quantitative amount of vaginal bleeding that was on the pad. The color was rubria and the amount was scant. These are normal findings for the first postpartum day. The greatest risk during the postpartum period are hemorrhage, shock, and infection (Barlow et al., 2019). Postpartum hemorrhage is a life-threatening complication that can occur from pregnancy. Postpartum hemorrhage is defined as a cumulative blood loss greater than 1000 mL with signs and symptoms of hypovolemia within 24 hours of the birthing process (Ricci et al., 2021). Risk factors of postpartum hemorrhage include uterine atony, lacerations of the genital tract, episiotomy, and retained placental fragments (Ricci et al., 2021). The patient did not demonstrate any signs of postpartum hemorrhage. Her heart rate was not considered tachycardic and her blood volume loss was 275 mL. During postpartum, infections can occur. Signs and symptoms of infection include a fever of 100.4 F (38 C) or higher after the first 24 hours after childbirth, occurring on at least 2 of the first 10 days after birth, exclusive of the first 24 hours (Ricci et al., 2021). Risk factors include surgical birth, prolonged rupture of membranes, long labor with multiple vaginal examinations, inadequate hand hygiene, and internal fetal instrumental birth. The patient did not demonstrate any signs of infection and her most recent temperature was documented as 97.9 F. Many postpartum women experience mood disorders and present emotions such as sadness, guilt, worthlessness, and hopelessness. The different types are classified based of their severity. Baby blues, postpartum depression, and postpartum psychosis are all the postpartum mood disorders. Drastic falls of hormones such as estrogen and progesterone immediately after birth can contribute to mood disorders, as well as limited social support, and many more risk factors (Ricci et al., 2021). The patient did not exhibit any

	signs of a postpartum mood disorder. The only observed abnormal finding during clinicals was the patient's labs. She had low hemoglobin and hematocrit, along with other abnormal labs. The patient most likely has iron-deficiency anemia and is being treated with iron infusions during hospitalization. The patient also reported mild pain with a rating of a 2 (1-10 scale). No other abnormal findings were observed.

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* (11th 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 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Ferrous sulfate tablets	Prenatal vitamin + Iron Carbonyl-FA (Prenatal Plus Iron) tablets			
Dose	325 (65 Fe) mg	29-1 mg			
Frequency	1 tablet daily	1 tablet daily			
Route	Oral	Oral			
Classification	Pharmacologic class: Hematinic Therapeutic class:	Pharmacologic class: Prenatal multivitamin/mine			

	Nutritional supplement	ral tablet Therapeutic class: Nutritional supplement			
Mechanism of Action	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.	Necessary for the production of hemoglobin. In an iron-deficient state, hemoglobin cannot be synthesized, with resultant microcytic anemia due to the formation of small erythrocytes. This supplement encourages erythropoiesis and oxygen transportation throughout the body.			
Reason Client Taking	Client is taking to replace iron in deficiency status.	Client is taking to treat or prevent vitamin deficiency during pregnancy.			
Contraindications (2)	Contraindicated in patients with hypersensitivity to iron salts or their components and in patients with hemolytic anemia.	Contraindicated in patients with liver problems. Contraindicated in patients with hemochromatosis.			
Side Effects/Adverse Reactions (2)	Dizziness and fever.	Diarrhea and stomach upset.			
Nursing Considerations (2)	Give iron tablet and capsules with a full glass of juice or water. Should be given 1 hour before or 2 hours after meals to maximize	If stomach upset happens, take medication with food. Give medication with a full glass of water.			

	absorption.				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess for vitamin B12 deficiency before taking.	Assess if the patient is taking any other medications that could interact with this medication. Assess allergies to fish or soy/peanuts.			
Client Teaching needs (2)	Instruct patient not to chew any solid forms of iron except chewable tablets. Instruct patient to eat foods high in vitamin C such as fresh vegetables.	Instruct patient not to taking this medication the same time as antacids or some antibiotics. Take medication regularly in order to get the most benefits from it.			

Hospital Medications (5 required)

Brand/Generic	iBuprofen (Motrin) tablets	Iron sucrose (Venofer) 300 mg in sodium chloride 0.9% 250 mL	Docusate sodium (Colace) capsules	Oxytocin (Pitocin) in normal saline premix 30 units/500 mL	Methylergonovine (Methergine) injection
Dose	600 mg	300 mg	100 mg	30 units	200 mg
Frequency	1 tablet every 6 hours as needed	Infused over 90 minutes; 2 times daily	1 capsules daily	60/300mL/hr	Every 2 hours; PRN
Route	Oral	IVPB	Oral	IV	IM
Classification	Pharmacologic class: NSAID Therapeutic class: Analgesic	Pharmacologic class: Iron mineral Therapeutic	Pharmacologic class: Surfactant Therapeutic class: Laxative	Pharmacologic class: Exogenous hormones	Pharmacologic class: Ergot alkaloids Therapeutic

		class: Hematinic		Therapeutic class: Oxytocics	class: Oxytocics
Mechanism of Action	Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation. By inhibiting prostaglandins, this NSAID reduces inflammatory symptoms and relieves pain.	Acts to replenish iron because of increased erythropoiesis and insufficient absorption of iron from GI tract. Iron is an essential component of hemoglobin, myoglobin, and several enzymes, including catalase, cytochromes, and peroxidase, and is needed for catecholamine metabolism and normal neutrophil function.	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.	Acts directly on myofibrils, therby producing uterine contractions; stimulating milk ejection by breast; vasoactive antidiuretic effect.	Acts directly on smooth muscle of the uterus and increases the tone, rate, and amplitude of rhythmic contractions through binding and the resultant antagonism for the dopamine D1 receptor. Thus, it induces a rapid and sustained tetanic uterotonic effect which shortens the third stage of labor and reduces blood loss.
Reason Client Taking	Client is taking to relieve pain from childbirth.	Client is taking to treat iron deficiency anemia.	Client is taking to treat constipation.	Client is taking for initiation or improvement of uterine contractions.	Client is taking to prevent and control bleeding from the uterus.
Contraindications (2)	Contraindicated in patients with angioedema. Contraindicated in patients with hypersensitivity to aspirin or other NSAIDs.	Contraindicated in patients with other forms of anemia than iron deficiency. Hypersensitivity to iron components, iron	Contraindicated in patients with hypersensitivity to docusate salts or their components. Contraindicated in patients with	Contraindicated to a pregnant patient with hypersensitivity to oxytocin and its components. Contraindicate	Contraindicated in patients with hypersensitivity to methylergonovine or its components.

		overload.	undiagnosed abdominal pain.	d in pregnant patients with a cephalopelvic disproportion, and when the delivery requires conversion as in transverse.	Contraindicated in patients with hypertension and pre-eclampsia.
Side Effects/Adverse Reactions (2)	Fluid retention and tachycardia.	Bradycardia and heart failure.	Dizziness and syncope.	Tachycardia and vomiting.	Nausea and chest pain.
Nursing Considerations (2)	Be aware that ibuprofen should not be used in pregnancy women starting at 30 weeks. Know that the risks of heart failure increase with the use of NSAIDs.	Watch for evidence of iron overload such as bleeding in GI tract and lungs, decreased activity, pale eyes, and sedation. Monitor patient closely for evidence of anaphylaxis, such as collapse, dyspnea, loss of consciousness, and seizures.	Expect excessive or long-term use of docusate to cause dependence of laxatives for bowel movements. Assess for laxative abuse syndrome.	Assess and accurately record maternal vital signs. Monitor patient closely during first and second stage of labor.	Mothers should not breast-feed during treatment and at least 12 hours after administration of last dose. Milk secreted during this period should be discarded.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for hypertension before administration.	Monitor hematocrit, hemoglobin, serum ferritin, and transferrin saturation before, during, and after iron sucrose.	Assess for history of laxative abuse before administration.	Assess cervical status prior to administering oxytocin.	Assess blood pressure, heart rate, and respirations prior to administration.
Client Teaching needs (2)	Instruct patient to take ibuprofen with a full glass of water. Advise patient to take drug with food or after meals to reduce GI	Tell patient to inform prescriber if she has a prior history of reactions to parenteral iron products before drug is given.	Tell patient not to use docusate when she has abdominal pain, nausea, or vomiting. Encourage patient to	Explain use and provide client education about how oxytocin will affect their contractions.	Instruct the client to limit physical activity to conserve strength. Increase iron and protein

	distress.	Tell mothers who are breastfeeding while receiving iron sucrose to monitor their infant for constipation or diarrhea.	increase fiber intake, exercise regularly, and drink 6-8 glasses of water to help decrease constipation.	Teach client to report side effects such as headache, dizziness, palpitation, or intense pain.	intake to promote the rebuilding of RBC volume.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). 2022 *Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** A&O x4 **Orientation:** A&O x4 **Distress:** No distress **Overall appearance:** Patient had overall relaxed facial expressions	Patient was alert and oriented x4. No distress appeared to be present. Patient knew the person, place, and time. Patient opens eyes spontaneously and has relaxed facial expressions.
INTEGUMENTARY (1 points): **Skin color:** Brown **Character:** Warm, dry, and intact **Temperature:** 97.9 F **Turgor:** Normal **Rashes:** None **Bruises:** None **Wounds/Incision:** None **Braden Score:** 23 **Drains present: Y☐ N X** **Type:**	Skin is brown, warm, dry, intact, and is dry upon touch. Skin is without discoloration and pressure points without redness. Temperature was taken orally and was 97.9 F. Skin turgor was normal. No rashes, bruises or wounds present on body. Branden score was 23. No drains present on the body.

HEENT (1 point): **Head/Neck:** Symmetrical **Ears:** Symmetrical with head **Eyes:** PERRLA noted with normal EOM **Nose:** No abnormal drainage or erythem**a** **Teeth:** Intact and white in color	Head is normocephalic with symmetrical facial features. Oral cavity normal. No edema, redness, or discoloration. No external drainage; nares patent; lips/oral mucosa pink; moist and intact. The neck and trachea is midline with no deviations. PERRLA is noted with normal EOM. No visual and hearing impairment. Teeth intact and white.
CARDIOVASCULAR (2 point): **Heart sounds:** Normal sinus rhythm **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** N/a **Peripheral Pulses:** Normal **Capillary refill:** Normal **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:** N/a	S1 and S2 sounds are noted. Rhythm is normal sinus rhythm. No murmurs noted. Peripheral pulses are present (+2) and equal bilaterally. Capillary refill is within 2 seconds in all extremities. No observed neck vein distention or edema. Patient doesn't report chest pain.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	Regular depth and pattern; unlabored; expansion symmetrical. Breath sounds are clear in all lobes bilaterally. No adventitious breath sounds are noted.
GASTROINTESTINAL (2 points): **Diet at Home:** Normal **Current Diet:** Normal **Height:** 5'1" **Weight:** 53.1 kg (117 lbs) **Auscultation Bowel sounds:** Equal/Normoactive **Last BM:** 11/02/22 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** None **Incisions:** None **Scars:** None **Drains:** None **Wounds:** None	Regular diet at home and is currently eating a regular diet at the hospital. No dietary restrictions, and no known food allergies. Patient is 5'1" tall and weighs 53.1 kg (117 lbs). Bowel sounds are audible and normoactive in all four quadrants. Last bowel movement was 11/02/22. No reported or observed nausea, vomiting, diarrhea, or constipation. No pain was noted upon palpation of the abdomen. Abdomen is flat and not distended, no scars, or drains are noted upon inspection of the abdomen.
GENITOURINARY (2 Points): **Quantity of urine:** Light yellow **Pain with urination: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:**	No reported or observed difficulties with voiding; urine reported or observed as clear, yellow and without foul odor. Patient reports no pain while urinating. Patient does not have a foley catheter. Patient voided 2000 mL during my clinical rotation. No genital abnormalities noted.

Size:	
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N X** **Fall Risk: Y ☐ N X** **Fall Score:** 1 **Activity/Mobility Status:** Inability **Independent (up ad lib)** X **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient currently denies pain/discomfort. No noticeable pulselessness or pallor. No assistive devices are used. No muscle weakness, joint swelling, or tenderness in all extremities. No edema noted. Symmetrical movement of extremities bilaterally. Patient is a low fall risk with a score of 1. Patient does not need support during ambulation and the patient is independent.
NEUROLOGICAL (2 points): **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** Normal **Mental Status:** Normal **Speech:** Normal **Sensory:** Normal **LOC:** Alert and oriented **DTRs:**Present	Patient moves all extremities well and has no neurological abnormalities related to motion or vision. Equal strength in all extremities. Normal PERLA. Patient was alert and knew the person, place, and time. Level of consciousness is alert and oriented. Patient shows age-appropriate mental development and speech patterns. No sensory abnormalities noted. Deep tendon reflexes are present.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** Goes to church **Developmental level:** Identity vs. Confusion **Religion & what it means to pt.:** Catholic faith and uses religion for her problems and as a way to connect with the world. **Personal/Family Data (Think about home environment, family structure, and available family support):** Lives with family who are both very supportive	Patient states they are religious and uses religion for coping. Patient states they go to church. Patient is in the identity vs. confusion stage. Patient is Catholic and uses religion to help solve problems and as a way to connect with the world. Patient lives with family. Family was very supportive of the pregnancy.
Reproductive: (2 points) **Fundal Height & Position:** 2 below/midline **Bleeding amount:** Scamp midline **Lochia Color:** Rubria **Character:** Light amount (Less than 10 cm on pad/hr) **Episiotomy/Lacerations:** Right periurethral laceration	The fundal height and position was 2 below and midline. Bleeding is scamp and the color of the lochia ais rubria. The amount is light and less than 10 cm on pad/hr. There is a right periurethral laceration.
DELIVERY INFO: (1 point) **Rupture of Membranes:** 11/02/2022 **Time:** 1738	The date of the rupture of membranes was 11/02/22 and the time was 1738. The color was odorless and clear. The amount was large but not

Color: Clear **Amount:** Large **Odor:** None **Delivery Date:** 11/02/2022 **Time:** 0856 **Type (vaginal/cesarean):** Vaginal **Quantitative Blood Loss:** 275 mL **Male or Female:** Male **Apgars:**1 min- 9 5 min-9 **Weight:** 6 lbs 11.4 oz **Feeding Method:** Breastfeeding	measured. The newborn was delivered on 11/02/2022 at 0856 vaginally. The quantitative blood loss was 275 mL. The newborn was a male with an apgars score of 9 at one minute and remained at a 9 at 5 minutes. The newborn weighed 6 lbs and 11.4 oz. Patient is currently breastfeeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal 1423	106	124/84	18	97.5 F (36.4 C)	98% on room air
Labor/Delivery 0845	84	118/82	18	97.5 F (36.4 C)	98% on room air
Postpartum 0900	89	112/68	18	97.9 F (36.6 C)	98% on room air

Vital Sign Trends:

The patient's pulse decreased from prenatal to labor/delivery and then increased during postpartum. The patient's blood pressure steadily decreased prenatal to postpartum. The patient's

temperature stayed the same prenatal to labor/delivery and increased slightly during postpartum. The patient's oxygen has stayed the same prenatal to postpartum.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0400	0-10	Abdomen	2	Cramping	Given iBuprofen.
1109	0-10	Denies pain/Discomfort	N/a	N/a	N/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 G **Location of IV: Posterior left hand** **Date on IV: 11/02/2022** **Patency of IV: Open/not blocked** **Signs of erythema, drainage, etc.: None** **IV dressing assessment: Clean, dry, and intact.**	Peripheral IV on 11/02/22. The size of the IV is an 18 gauge. The location of the IV is on the posterior left hand. IV is open, clean, dry, intact. Transparent dressing is in place. Saline lock.

Intake and Output (2 points)

Intake	Output (in mL)
2000 mL	Voided twice (unable to measure)

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them,	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.

identify medical treatments with "M" after you list them.)		
Monitor vital signs (N).	Every 8 hours; PRN.	Monitoring vital signs is essential in monitoring a patient's general physical health. During postpartum monitoring vital signs will help in early detection of a potential life-threatening complication.
Head to toe assessment (N).	Once per shift.	Doing a head to toe assessment is crucial in gaining a complete understanding of a patient's curreent state. The head-to-toe physical assesses the woman's physiological responses to the birthing process.
Give ibuprofen (M).	Every 6 hours; PRN.	Administration of iBupforen was done to help with pain that the patient was experiencing. The patient reported a pain level of 2 and requested a pain reliever.
Adjusted pillows and reposition (N).	As needed.	The pillows were adjusted and repositioned to help provide comfort for the patient.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in?

The mother is currently in the first stage, which is the "taking-in" phase.

What evidence supports this?

The mother displays the "taking-in" during this time. She is very happy and enjoys sharing her labor and delivery experience with family and others. She is also very eager to learn how to take

care of her baby. She is also dependent and providing care for herself. She displays this by eating, resting, and meeting her comfort needs.

Discharge Planning (3 points)

Discharge location: Mother will be discharged home tomorrow 11/04.

Equipment needs (if applicable): N/a

Follow up plan (include plan for mother AND newborn): The follow up plan for the mother is to continue taking iron supplements. Newborn will need to be evaluated during a checkup in 3-5 days.

Education needs: Mother needs education regarding breastfeeding and different techniques and positioning. Patient also needs education regarding maintaining a well-balanced diet, just like she did during pregnancy.

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. Pain related to delivery as evidenced by mother's verbalization and pain scale showing 2/10.	This nursing diagnosis was chosen because pain is a priority when providing patient care. Evaluating and	**1.** Assess the pain level of the patient and factors relieving or aggravating the pain. **Rationale:** Enables to facilitate nursing care (Jones & Bartlett, 2022). **2.** Administer analgesics	The patient and family responded in a positive matter to the nursing interventions. The patient answered all questions adequately while assessing her pain. Ibuprofen was ordered

	assessing the pain is necessary to provide adequate interventions.	with the physician's orders. **Rationale:** Reduces pain by blocking the pain pathway (Jones & Bartlett, 2022).	as an analgesic to help with the pain and the patient reported improvement afterwards. No modifications were made to the plan.
2. Fatigue related to decreased hemoglobin as evidenced by increased rest requirements.	This nursing diagnosis was chosen because the patient was on medication for iron deficiency and displayed low levels of hemoglobin and hematocrit. The patient also was resting in bed every time I checked on her.	**1.** Teach patient the importance of supplements. **Rationale:** Oral supplements of iron and vitamin B-12 should be administered if patient cannot get enough from their diet to help with fatigue (Jones & Bartlett, 2022). **2.** Advise to take frequent rest periods, especially before more challenging activities. **Rationale:** Frequent rest periods provide a balance that allows the patient to complete desired tasks without getting any more tired (Jones & Bartlett, 2022).	The patient and family were very eager to learn about the importance of supplements such as iron and vitamin B-12. The patient agreed to take these supplements once discharged. The patient was taught to take frequent rest periods and agreed. She agreed that taking frequent rest periods was essential to help treat fatigue and become less tired. No modifications were made to the plan.
3. Knowledge deficit related to breastfeeding as evidenced by failure to latch.	This nursing diagnosis was chosen because this was the patient's first pregnancy and showed a knowledge deficit because I observed her showing difficulty breastfeeding and she also needed assistance from the nurse.	**1.** Educate the mother about the proper storage of milk. **Rationale:** It is critical to preserve milk correctly to remain fresh and retain its nutritional and anti-infective properties (Jones & Bartlett, 2022). **2.** Teach the mother on proper positioning and help to position the baby as needed **Rationale:** To make mother aware that effective breast feeding depends on proper	The mother and family responded very appropriately to the nursing interventions. The patient was very eager to learn and gained a good understanding of how to store the breast milk. Demonstrating and teaching the mother on proper positioning during breast feeding helped the infant with latching on and helped make the experience more relaxing for the

		techniques.	mother. No modifications were made to the plan.
4. Knowledge deficit related to newborn care related to lack of previous experience as evidenced by frequent questioning.	This nursing diagnosis was chosen because this is the patient's first pregnancy and had frequent questions for the nurse regarding bathing, breastfeeding, and burping the baby.	**1.** Teach the patient the importance of newborn care, including follow-up visits to the provider, feeding methods, and noting stools and voiding. **Rationale:** To make mother aware of the importance of chek ups with the provider. This also allows for child's well-being and allows for timely interventions (Jones & Bartlett, 2022). **2.** Teach the patient how to perform infant bathing, diapering, and cord care. **Rationale:** Teach the patient infant care and determine the need for additional teaching and demonstrate to perform at home (Jones & Bartlett, 2022).	The patient and family responded to the interventions very well. The mother and family were both very eager to learn. Newborn care was taught to the mother and family. The mother demonstrated understanding of the teaching by demonstrating how to perform infant care. She also successfully changed the baby and took the baby a bath. The goals were met and no modifications were made to the plan.

Other References (APA):

Jones & Bartlett Learning. (2022). *2022 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning