N432 Postpartum Care Plan

Lakeview College of Nursing

Name

Shivani Patel

Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
11/6/22	K.M.P.	23 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	Unemployed	Single	Latex
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full code	157.5 cm	70.9 kg	No

Medical History (5 Points)

Prenatal History:

GTPAL: G5T5P0A0L5

No complications during the current pregnancy.

Prenatal care started on 4/7/2022

Past Medical History: Chlamydia, contact dermatitis, depression, iron deficiency anemia, oppositional defiant disorder, psychotic disorder, suicide attempt

Past Surgical History: Tonsillectomy

Family History:

Mother- anxiety and depression

Father- anxiety and depression

Two siblings- anxiety and depression

Paternal grandfather- hypertension, diabetes, heart disease

Paternal grandmother- heart disease

Maternal grandmother- thyroid disease

Social History (tobacco/alcohol/drugs):

Former smoker- 0.50 packs per day for 3 years

Drug use- Marijuana daily

No alcohol use

Living Situation: Lives at home with 2 sisters

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Abdominal pain

Presentation to Labor & Delivery (10 points): The patient is a 23-year-old female with a prenatal history of G5T5P0A0L5. The expected delivery date for the patient is 11/1/2022. The patient presents in the emergency department with abdominal pain. The patient is positive for contractions every 5-10 minutes and fetal movement. Patient states that she is here for contractions that started 11/6/22 and came via ambulance by self. The time was not specified. There is no vaginal bleeding or fluid leakage at the time of assessment. The contractions had started suddenly. The contractions caused pain in the lower abdomen and radiated to the back. The pain had gotten worse ever since admission to the emergency department. The contractions come and go. The patient describes the pain as “dull and achey”. The patient states that moving around makes the pain worse. They also stated that they felt better after turned to the left side and focused on deep breathing. The patient is also experiencing nausea with the contractions. The patient denies headache, SOB, or any visual changes. The patient focused on relaxing during the labor process.

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	3.47	3.68	3.57	Low levels of RBC can be due to anemia during pregnancy. Low levels are caused by blood loss that occurs during pregnancy. This is common because women don't have enough iron and other vitamins during pregnancy (Pagana et al., 2019)
Hgb	12.0-15.8	8.2	7.7	7.6	Iron deficiency anemia causes low levels of hemoglobin (Pagana et al., 2019)
Hct	36.0-47.0%	25.4	24.7	24.0	Iron deficiency anemia causes low levels of hematocrit (Pagana et al., 2019)
Platelets	140-440	214	200	175	
WBC	4.00-12.00	10.50	10.80	14.60	High WBC can be caused by stress during pregnancy or a possible infection that may have occurred during the delivery process. An increase in WBC can also be caused by rupture of membranes (Pagana et al., 2019)
Neutrophils	47.0-73.0%	77.2	76.8	83.1	High levels of neutrophils are caused by increased stress from pregnancy and labor (Pagana et al., 2019)
Lymphocytes	18.0-42.0%	16.4	15.6	9.1	Low iron or folic acid in pregnancy can cause low levels of lymphocytes (Pagana et al., 2019)
Monocytes	4.0-12.0%	4.2	6.4	7.3	
Eosinophils	0.0-5.0%	1.6	0.9	0.3	
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, B, AB, O	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	Nonimmune	Nonimmune	Nonimmune	Not being immune increases, the risk acquiring rubella in pregnancy and the baby having congenital rubella syndrome (Pagana et al., 2019). The patient has not been immunized to the rubella titer
HIV	Non detected	Non detected	Non detected	Non detected	
HbSAG	Non detected	Non detected	Non detected	Non detected	
Group Beta Strep Swab	Negative	Negative	Negative	Negative	
Glucose at 28 Weeks	65-140 mg/dL	101 mg/dL	N/A	N/A	
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
Urine drug	Not	Not	Detected:	N/A	The patient was positive for

	detected	detected	Cannabinoid		cannabinoid, and upon assessment, the patient's social history indicates marijuana use.
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)	45-90	N/A	N/A	N/A	

Lab Reference (1) (APA):

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

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

	Your Assessment
History of labor: **Length of labor**	The total length of labor was 2 minutes. There was no

Induced /spontaneous **Time in each stage**	information on the patient's 1st and 2nd stage of labor because the total length of labor was 2 minutes. Thus, the time in each stage was not listed. The patient delivered immediately after admission to the hospital. The patient had an induced, vaginal birth.
Current stage of labor	The patient is currently in the fourth stage of labor. The patient is currently in the "taking-in" phase, which occurs up to 48 hours postpartum. The fourth stage of labor begins with the completion of the placental expulsion and membranes (Ricci et al., 2021). The stage marks the beginning of the postpartum period. The postpartum period lasts about 6 weeks. The mother tends to experience feelings of peace and excitement. The mother experiences many changes to her body after giving birth. The mother's breast prepares for lactation (Ricci et al., 2021). The uterus returns to its normal size. The fundus should be firm and well contracted at this stage. This is typically located at the midline between the umbilicus and symphysis (Ricci et al., 2021). When palpated, the patient's fundus appeared to be midline at level with the umbilicus and firm. The lochia is the vaginal discharge that occurs after birth and continues for about 4-8 weeks. The lochia is red, mixed with small clots, and of moderate flow (Ricci et al., 2021). I observed the patient's pad and assessed the color and quantity of the vaginal bleeding. The color was rubra and the amount was scant. Also, the patient's

	vital sounds, amount and consistency of lochia, and the uterine fundus are monitored every 15 minutes for the first hour during this stage. The patient is currently at OSF in Urbana. The patient presented with abdominal pain and contractions between 5-10 minutes. Abnormal lab findings include low levels of RBC, Hgb, Hct, and lymphocytes. The patient's WBC and neutrophil levels were high. Decreased levels of RBC, Hgb, Hct, and lymphocytes are related to blood loss and anemia (Pagana et al., 2019). High levels of WBC and neutrophils can be caused by increased stress or possible infection during the labor process. The patient had normal levels of platelets, monocytes, and eosinophils. A normal finding also included a non-detected HIV result. The focus during this stage is to monitor the patient to prevent hemorrhage, bladder distention, thrombosis, and other complications associated with post-birth (Ricci et al., 2021). Postpartum complications include postpartum hemorrhage, infection, and postpartum mood disorders. Postpartum hemorrhage is a life-threatening complication that that consists of a cumulative blood loss of 1000 mL The risk factors for post-partum hemorrhage are uterine atony, episiotomy, retained placental fragments, and induced labor (Ricci et al., 2021). The patient did not experience any symptoms of postpartum hemorrhage. The signs and symptoms of infection are redness, fever, and tenderness (Ricci et

	al., 2021). The risk factors for infection include prolonged rupture of membranes, multiple vaginal examinations, surgical birth, and poor hand hygiene. The patient did not experience any signs of infection and her most recent temperature was documented as 97.9 F. Postpartum depression is something that many women experience after giving birth. Some risk factors for postpartum mood disorders include a drastic decrease in estrogen and progesterone levels (Ricci et al., 2021). The patient also tested positive for a drug test. The patient is currently not immunized to rubella. Currently, the patient rates their pain a 5 on a 1-10 scale. No other abnormal findings were observed.

Stage of Labor References (2) (APA):

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

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

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

Home Medications (2 required)

Brand/Generic	Ferrous sulfate/Iron	Docusate sodium/Colace	Buspirone/Bustab	N/A	N/A
Dose	325 mg	100 mg	10 mg	N/A	N/A
Frequency	BID	BID	BID	N/A	N/A
Route	Oral	Oral	Oral	N/A	N/A
Classification	Pharmacologic class: Hematinic Therapeutic class: Nutritional supplement	Pharmacologic class: Surfactant Therapeutic class: Laxative, stool softener	Pharmacologic class: Azapirone Therapeutic class: Anxiolytic	N/A	N/A
Mechanism of Action	Ferrous sulfate helps 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	It acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces	May act as a partial agonist at serotonin 5-hydroxytryptamine1A receptors in the brain, producing antianxiety effects	N/A	N/A
Reason Client Taking	Replace iron due to iron deficiency anemia	It helps to treat constipation	Helps to relieve anxiety	N/A	N/A

Contraindications (2)	-Contraindicated in patients with hypersensitivity to iron salts or their components -Contraindicated in patients with hemolytic anemia	- Concomitant use with mineral oil -Fecal impaction	- Hypersensitivity to buspirone or its components -Severe hepatic or renal impairment	N/A	N/A
Side Effects/Adverse Reactions (2)	-Fever -Dizziness	-Dizziness -Abdominal cramps	-Chest pain -Blurred vision	N/A	N/A
Nursing Considerations (2)	-Give iron tablets with a full glass of water or juice -The tablet should be given 1 before or 2 hours after meals for better absorption	-Expect excessive or long-term use of docusate to cause dependence on laxatives for bowel movements, electrolyte imbalances, osteomalacia, steatorrhea, and vitamin and mineral deficiencies. -Assess for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders.	-Use buspirone cautiously in patients with hepatic or renal impairment. -Institute safety precautions because of possible adverse CNS reactions	N/A	N/A
Key Nursing Assessment(s)/Lab(	-Assess for B12 deficiency before	- Auscultate for bowel sounds,	-Assess the patient's blood pressure	N/A	N/A

s) Prior to Administration	giving medication	percuss for dullness, and palpate for masses			
Client Teaching needs (2)	-Instruct patient to eat foods high in vitamin C such as fruits and vegetables -Instruct patient not to shew any solid form of iron except chewable tables	-Tell the patient not to use docusate when she has abdominal pain, nausea, or vomiting. -Advise the patient to take docusate with a full glass of milk or water.	-Advise patient to take buspirone consistently, either always with or always without food -Caution patient to avoid drinking large amounts of grapefruit juice	N/A	N/A

Hospital Medications (5 required)

Brand/ Generic	Acetaminophen/Tylenol	N/A	Ibuprofen/ Motrin	Ondansetron/ Zofran	Methylergonovine/
Dose	650 mg	N/A	800 mg	4 mg	200 mcg
Frequency	Q4 PRN	N/A	Q8 PRN	Q6 PRN	Q2 PRN
Route	Oral	N/A	Oral	Oral	IM
Classification	Pharmacologic class: Nonsalicylate, para-	N/A	Pharmacologic class: NSAID Therapeutic class: Analgesic	Pharmacologic class: Selective serotonin (5-HT3) receptor	Pharmacologic class: Ergot alkaloids Therapeutic

	aminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic			antagonist Therapeutic class: Antiemetic	class: Oxytocics
Mechanism of Action	It inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus.	N/A	It blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation. It reduces inflammatory symptoms and relieves pain.	It blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine.	It acts directly on smooth muscle of the uterus and increases the tone, rate, and amplitude of rhythmic contractions through binding. It induces a rapid and sustained tenanic uterotonic effect which shortens the third stage of labor and reduces blood loss.
Reason Client Taking	Relieves mild to moderate pain	N/A	Helps to relieve pain from childbirth	It prevents nausea and vomiting	It prevents and controls bleeding from the uterus
Contraindications (2)	- Hypersensitivity to acetaminophen or its components -Severe hepatic impairment	N/A	-Contraindicated in patients with hypersensitivity to aspirin or other NSAIDs -Contraindicated in patients with angioedema	-Concomitant use of apomorphine - Hypersensitivity to ondansetron or its components	- Contraindicated in patients with hypersensitivity to methylergonovine or its components - Contraindicated in patients with

					hypertension and pre-eclampsia
Side Effects/ Adverse Reactions (2)	-Hypotension -Fatigue	N/A	-Tachycardia -Fluid retention	-Constipation -Bronchospasms	-Nausea -Vomiting
Nursing Considerations (2)	- Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment - Monitor renal function in patient on long-term therapy. Keep in mind that blood or albumin in urine may indicate nephritis	N/A	- Know that the risks of heart failure increases with the use of NSAIDs -Be aware that ibuprofen should not be used in pregnancy women starting at 30 weeks.	- Place disintegrating tablet or oral soluble film on patient's tongue immediately after opening package. It dissolves in seconds - Monitor patient closely for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions	- The milk secreted during this period should be discarded -Mothers should not breast-feed during treatment and at least 12 hours after administration of last dose
Key Nursing Assessment(s) /Lab(s) Prior to Administration	-Assess for any allergies to acetaminophen	N/A	-Monitor for hypertension before administration	-Assess dizziness or drowsiness	-Assess blood pressure, heart rate, and respirations before giving medication
Client Teaching needs (2)	- Tell patient that tablets may be crushed or swallowed whole - Inform	N/A	- Advise to take drug with food or after meals to reduce GI distress -Instruct patient to take ibuprofen	- Advise patient to use calibrated container or oral syringe to measure oral solution - Advise patient	- Increase iron and protein intake to promote the rebuilding of RBC -Instruct the

	patient that acetaminophen may cause reduced fertility in both females and males		with a full glass of water	to immediately report signs of hypersensitivity, such as rash	client to limit physical activity to conserve strength.

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert** **Orientation: Oriented x4** **Distress: No visible acute or distress**	The patient is a 23-year-old-female. The patient is alert and oriented to person, place, and time. The patient is in no visible acute distress. Pt well dressed in clean gown. Pt's skin, hair, nails clean

Overall appearance: Well-groomed and awake	and well maintained.
INTEGUMENTARY (1 points): **Skin color: White** **Character: Warm, dry, and intact** **Temperature: 97.9F** **Turgor: Normal** **Rashes: None** **Bruises: None** **Wounds/Incision: None** **Braden Score: 15** **Drains present: Y☐ N ☒** **Type:**	Skin color: White Character: Skin is warm and dry upon palpation Temperature: Taken orally and was 97.9 F Turgor: Skin has normal turgor No rashes, bruises, or wounds Normal quantity, distribution, and texture of hair Braden score: 15 There are no drains present
HEENT (1 point): **Head/Neck: Symmetrical** **Ears: Symmetrical with head** **Eyes: PERRLA noted with normal EOM** **Nose: No abnormal drainage or erythema** **Teeth: Intact and white in color**	Head/Neck: Head and neck are symmetrical. Normocephalic and atraumatic. No cervical lymphadenopathy, normal range of motion, no rigidity. The neck and trachea are midline with no deviations Ears: Left/right external ear normal. No hearing impairment Eyes: No visible drainage from eyes, the bilateral sclera white, the bilateral cornea is clear, bilateral conjunctiva is pink. Extraocular movements: extraocular movements are intact Conjunctiva/sclera: conjunctivae/sclera are normal Pupils: pupils are equal, round, and are reactive to light Nose: Septum is midline and no visible bleeding from nose Teeth: Did not notice plaque or tartar. Teeth are white and aligned with gums. The mucous membrane is moist
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 ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	S1 and S2 sounds are noted. Normal heart rate and 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

RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **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. No accessory muscle use.
GASTROINTESTINAL (2 points): **Diet at Home: Normal** **Current Diet: Normal** **Height: 157.5 cm** **Weight: 70.9 kg** **Auscultation Bowel sounds:** **Equal/normoactive** **Last BM: 11/10/22** **Palpation: Pain, Mass etc.:** **No palpable mass or pain** **Inspection:** **Distention: None** **Incisions: None** **Scars: None** **Drains: None** **Wounds: None**	Diet at home: regular Current diet: regular Height: 157.5 cm Weight: 70.9 kg Bowel sounds: normoactive Last BM: 11/10/22 Upon palpation there is no pain and no abdominal mass present. The abdomen is soft Tenderness: There is no abdominal tenderness. Abdomen is flat and not distended. There is no guarding or rebound Distention: none Incisions: none Scars: none Drains: none Wounds: none No ostomy, nasogastric, or feeding tubes No reported or observed nausea, vomiting, diarrhea, or constipation
GENITOURINARY (2 Points): **Quantity of urine: 1300 mL** **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient's urine output was about 1300 mL of urine during the time of assessment. The patient reports no pain with urination. There is no catheter in place. The patient's urine reported or observed as clear, yellow and without foul odor. No genital abnormalities noted.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 1** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Neurovascular status: normal Normal range of motion. No edema noted Cervical back: normal range of motion Strength: Patient noticeably strong Supportive devices: none ADL assistance: no Fall risk: no Fall risk score: 1 The patient is independent. Does not need assistance with equipment. Does not assistance when standing or walking. There is no observed or reported muscle weakness and joint swelling or tenderness from the patient. All the patient's extremities are with symmetrical movement bilaterally.

NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: Normal** **Mental Status: Normal** **Speech: Normal** **Sensory: Normal** **LOC: Alert and oriented** **DTRs: Present**	MAEW: yes PERRLA: yes, normal pupil accommodation Strength is equal in all extremities. Patient is alert and oriented x4. Orientation, mental status, speech, sensory are all within normal limits. Cranial nerves grossly intact Patient shows age-appropriate mental development and speech patterns. Deep tendon reflexes are present.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Medication therapy and rest** **Developmental level: Appropriate for age** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient will be taking acetaminophen tablets for pain. The patient is also getting as much rest as possible. The patient's developmental level is appropriate for age. The patient is not religious. They have a support system that includes her two sisters. The patient is currently living with her two sisters.
Reproductive: (2 points) **Fundal Height & Position: 1 cm above the umbilicus and midline** **Bleeding amount: Scamp** **Lochia Color: Rubra** **Character: Red, dark with some small clots** **Episiotomy/Lacerations: None**	The patient's fundus is positioned 1 cm above the umbilicus and midline. The bleeding is scamp, and the color is lochia rubra. The patient has no episiotomy or lacerations.
DELIVERY INFO: (1 point) **Rupture of Membranes: Artificial** **Time: 1308** **Color: Clear** **Amount: Moderate** **Odor: None** **Delivery Date: 11/7/22** **Time: 1310** **Type (vaginal/cesarean): Vaginal** **Quantitative Blood Loss: 250 mL** **Male or Female: Male** **Apgars: 1 min=8 and 5 min=9** **Weight: 4070 g** **Feeding Method: Bottle**	There was an artificial rupture of membranes on 11/7/22 at 1308. It was clear and odorless. The amount was moderate and not measured. The newborn was delivered on 11/7/22 at 1310 through vaginal birth. The quantitative blood loss was 250 mL. The newborn was a male with apgar score of 8 at 1 minute and 9 at 5 minutes. The newborn weighs 4070 grams and is currently bottle-feeding.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	112	121/57	18	98.0F (oral)	99%
Labor/Delivery	119	113/56	20	98.7F (oral)	98%
Postpartum	92	112/54	16	97.9F (oral)	100%

Vital Sign Trends:

The patient's pulse increased from prenatal to labor/delivery and decreased from labor/delivery to postpartum. The patient's blood pressure decreased from prenatal to postpartum. The patient's temperature and oxygen levels have remained normal throughout the labor process. The patient's respirations increased from prenatal to labor/delivery and decreased from labor/delivery to postpartum. Though, the patient's respirations remained normal.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1515	Numerical	Abdomen/perineum	5	Cramping-constant	Acetaminophen
1715	Numerical	Denies pain/discomfort	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: N/A **Location of IV: N/A** **Date on IV: N/A** **Patency of IV: N/A** **Signs of erythema, drainage, etc.: N/A**	The patient has no IV

IV dressing assessment: N/A	

Intake and Output (2 points)

Intake	**Output (in mL)**
0 mL	1300 mL (urine)

Nursing Interventions and Medical Treatments During Postpartum (6 points)

Nursing Interventions and Medical Treatments (Identify nursing interventions with "N" after you list them, identify medical treatments with "M" after you list them.)	**Frequency**	**Why was this intervention/ treatment provided to this patient? Please give a short rationale.**
Pain medications (N)	As needed (PRN)	The patient was experiencing pain on their abdomen and perineum area. They described it as "cramping" pain. The patient reported the pain as a 5 on a 1-10 scale.
Ambulation (N)	Q2 hours or as often as possible	It is important to ambulate as soon as possible after delivery to prevent thrombosis. It can also help to improve bladder function and blood circulation.
Monitor vital signs (N)	Every 8 hours or PRN	Monitoring the patient's vital signs helps to assess for any improvements in the patient's health after delivery. If the patient's vital signs are abnormal, it may indicate a potential life-threatening complication.
Head to toe assessment (N)	Once per shift	It is important to do a head-to-toe assessment to assess the patient's physical state. The head-to-toe assessment allows to examine any abnormalities.

Phases of Maternal Adaptation to Parenthood (3 point)

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

What evidence supports this? The mother is in her first 48 hours of giving birth. The mother seems visibly happy and shared her experience with the staff members.

Discharge Planning (3 points)

Discharge location: The patient will discharge back home with her two sisters

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): The newborn will remain in the NICU and will be referred to DCFS. Currently, the mother has no custody of the newborn. No appointments will be made until further notice.

Education needs: The patient needs more education regarding breastfeeding. She will also need to maintain a well-balanced diet and inform the doctor if any postpartum complications occur.

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	**Rational (1 pt each)** Explain why	**Intervention/Rational (2 per dx) (1 pt each)** Interventions should be	**Evaluation (2 pt each)** How did the patient/family respond

that are specific to this patient. Include full nursing diagnosis with "related to" and "as evidenced by" components	the nursing diagnosis was chosen	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.	to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Pain related to vaginal delivery as evidenced by a pain level of 5.	The mother states that she has cramping pain on her abdomen and perineum area. She rates the pain as 5 on a scale of 1-10.	1. Frequently assess the patient's pain level. It is also important to assess aggravating factors. Rationale: Knowing the patient's pain level helps implement ways to reduce the pain. For instance, the patient may be told to maintain bedrest or will be given acetaminophen to decrease the pain (Ricci et al., 2021) 2.Use non-pharmacological methods like ice packs. Apply a cold ice pack for 20 to 30 minutes, several times a day. Rationale: Ice packs help to reduce pain by numbing the affected area. The cold ice pack can also reduce swelling and tenderness (Ricci et al., 2021)	The patient did well with understanding that they will need to inform their pain level to the nurse. She was also aware that she needed to maintain bed rest and take acetaminophen when in pain. The patient was given acetaminophen whenever she reported a high pain level. The patient was instructed that they can also use ice packs to help with their pain.
2. Risk for infection related to vaginal delivery as evidenced by high WBC levels.	The patient's WBC count was 14.60 during the postpartum stage. Vaginal birth can cause infection due to the spreading of bacteria.	1. Encourage the patient to remain in a semi-fowlers position Rationale: The position will allow drainage to fall and prevent pooling of infectious secretions (Ricci et al., 2021) 2.Maintain proper hand hygiene. Ensure that the patient is washing their hands before and after using the washroom Rationale: Proper hand	The patient made sure to wash their hands before and after using the washroom. Before touching the newborn, they were encouraged to wash their hands. The patient will be able to prevent any infections and obtain a faster healing process.

		hygiene is the primary method of preventing the spread of infection (Hinkle & Cheever, 2022)	
3. Fatigue related to decreased hemoglobin as evidenced by recent vaginal delivery.	Iron deficiency anemia can be caused an increased loss of blood during delivery. The patient's hemoglobin level was 7.6.	1. Teach the patient that it is important to take iron supplements like ferrous sulfate Rationale: It is important to take ferrous sulfate if the patient does not get any iron from the foods the patient eats. This can significantly help with their fatigue (Hinkle & Cheever, 2022) 2. Advise the patient to take frequent rest periods and drink plenty of fluids Rationale: Getting enough rest and fluids helps to reduce fatigue. Fluids help to replenish the water the body loses throughout the day and helps to maintain energy (Hinkle & Cheever, 2022)	The patient was given iron supplements as scheduled. They were also aware that they will need to increase their intake. The patient ate well shortly before discharge. The patient's fluid intake was increased. The patient also took several rest periods before her discharge.
4. Knowledge deficit related to lack of previous childcare as evidenced by not having custody of her children	The newborn is referred to DCFS because the mother has no custody over the newborn. Along with that, the mother has no custody over her other children. Thus, she lacks knowledge on how to properly care for her children.	1. Educate the patient on how to properly care for a newborn. Explain the importance of breastfeeding. Rationale: It is important to educate the importance of breastfeeding. Breastfeeding helps to keep the newborn healthy. It supplies all the essential nutrients to the newborn (Ricci et al., 2021) 2. Have a discussion with the parent on why the newborn is being held by DCFS. The newborn will not be able to go home with the parent. Rationale: This can help the parent be more aware of the plan. Communication can	The parent understood that the newborn will not be able to go home with her. She was also aware that the child will be taken by DCFS. The mother was currently accepting of it.

		also help to answer any questions or concerns they may have (Phelps, 2020)	

Other References (APA)

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

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