N432 Postpartum Care Plan

Lakeview College of Nursing

Berich Mpoy

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
2/21/23	Ek	27	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Unemployed	Married	N/A
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full code	158cm	78.400Kg	Yes

Medical History (5 Points)

Prenatal History: G1,T1,P0,A0,L1. Current pregnancy had no complications.

Past Medical History: N/A

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs): Marijuana use

Living Situation: the patient lives with the partner. There was no alcohol abuse, physical abuse, or financial concern, and family and friends were there to support the patient.

Education Level: high school

Admission Assessment

Chief Complaint (2 points): Membrane rupture with cervical ripening for gestational hypertension.

Presentation to Labor & Delivery (10 points):

The patient presented at the hospital complaining of continues abdominal contraction pain. Pain began suddenly, so she called 911 and was brought by ambulance. There are no aggravating or reliving factors. The patient felt like intense cramps. The patient had no treatment before arriving

at the hospital. An examination at the hospital revealed the patient was dilated 2.5cm and 70% effaced and -2 station in mid position.

Diagnosis

Primary Diagnosis on Admission (2 points): 37-week gestational hypertension.

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	3.80-5.41*10^6	N/A	3.82	N/A	
Hgb	11.3-15.2g/dl	N/A	11.3	11.5	
Hct	33.2-45.3	N/A	31.8	33.5	The slight decrease in hematocrit is due to hemodilution. (Jones, 2020).
Platelets	149-393k/mcl	N/A	278	N/A	
WBC	4.0-11.7k/mcl	N/A	13.5	N/A	White blood count elevation due to irritation of labor. (Jones, 2020).
Neutrophils	45.3-79.0%	N/A	71.3	N/A	
Lymphocytes	11.8-45.9	N/A	20.8	N/A	
Monocytes	4.4-12.0	N/A	5.9	N/A	
Eosinophils	0.0-6.3	N/A	0.8	N/A	
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	Oneg	O neg	N/A	N/A	N/A
Rh Factor	Neg	N/A	N/A	N/A	N/A
Serology (RPR/VDRL)	Neg	N/A	N/A	N/A	N/A
Rubella Titer	Neg	N/A	N/A	N/A	N/A
HIV	Neg	Neg	N/A	N/A	N/A
HbSAG	Neg	N/A	N/A	N/A	N/A
Group Beta Strep Swab	Neg	Neg	N/A	N/A	N/A
Glucose at 28 Weeks	Neg	N/A	N/A	N/A	N/A
MSAFP (If Applicable)	Neg	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)	71-151	84	N/A	N/A	N/A

Lab Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook.* (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	N/A Spontaneous N/A
Current stage of labor	When I arrived at my clinical rotation, my patient had already given birth to a six-pound baby boy. My patient is currently in postpartum at the hospital. No abnormal findings were present during my assessment of the patient in postpartum. When palpating the patient's abdomen, the uterus was below the

	umbilicus, which is normal in postpartum. Other normal findings were that the patients bowel sounds were active. The patient was urinating completely but complained of mild burning while urinating. The patient's vital signs, lung and heart sounds were within normal range at the time of the assessment. The patient is in the taking in phase of the adaptation phases of postpartum. The taking in phase of the adaptation phases of postpartum takes place immediately after birth. During this phase the mother needs others to meet her needs, relieves the birth process, retells birth experience, and asks many questions about the baby (Ricci et al., (2017). In addition, the mother faces many risk factors for postpartum complications, such as postpartum hemorrhaging, infections, and mood disorders. Postpartum hemorrhage is the blood loss of more than 1000 milliliters with both routes of delivery within 24 hours. Risk factors for early and late postpartum hemorrhaging include inversion, lacerations, incomplete separation of the placenta, placenta previa, placenta abruption, prolonged oxytocin induced labor, and uterine atony according to Holman et al. (2019). Signs and symptoms of postpartum hemorrhage include saturation of one or more pads during first hour, passage of large clots, rising pulse, decreased blood pressure, clammy and pale skin, and decreased urine

	output. My patient did not present with any signs and symptoms of postpartum hemorrhaging. Bilateral periureteral lacerations also put the patient at risk for infections. The patient wasn't showing sign and symptoms of infection during clinical. Signs of infections include flu like symptoms such as body aches, chills, fever and malaise. According to Holman et al. (2019), postpartum mood disorder occurs in approximately 50 to 85% of women during the first few days after birth and continues up to 10 days. Postpartum disorders are characterized by tearfulness, insomnia, lack of appetite, and feeling of loneliness. Postpartum disorder usually resolves in ten days without intervention. My patient showed no signs of postpartum mood disorder at the assessment time.

Stage of Labor References (2) (APA):

Holman, H.C., William, D., Johnson, J., Sommer, S., Ball, B.S., Morris, C., Leehy, P., Hertel, R., & Assessment Technologies Institute (Contributors). (2019). Maternal newborn nursing: review module (11th ed.). Assessment Technologies Institute.

Ricci, S. S., Carman, S., & Kyle, T. (2017). Maternity and pediatric nursing (3rd ed.). Wolters Kluwer.

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

Brand/Generic	Acetaminop	Naloxone/	Phenylephrin	Ibuprofen/	Calcium carbonate/

	hen/ Tylenol	Narcan	e/ Sudafed	Advil	Tums
Dose	1000mg	0.1mg	100mcg	400mg	1000mg
Frequency	PRN	PRN	PRN	PRN	PRN
Route	Oral	IV Push	IV Push	Oral	Oral
Classification	Antipyretic, nonopioid analgesic. (Jones 2020)	Opioid antagonist, antidote (Jones, 2020).	Alpha 1 androgenic receptor agonist, nasal decongestant (Jones, 2020).	NSAID, analgesic, anti-inflammatory, and antipyretic (Jones, 2020).	Calcium salts, antiacid, hypermagnesemic, hypophosphatemic, hypocalcemic, calcium replacement, and cardiotonic.
Mechanism of Action	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on the temperature-regulating center in the hypothalamus by inhibiting the synthesis of prostaglandin E2"	"Briefly and competitively antagonizes MU, Kappa, and Sigma receptors in the CNS, dance reversing analgesia, hypertension, respiratory depression, and sedation caused by most opioids. MU receptors are responsible for analgesia, euphoria, miosis, and respiratory depression. Kappa receptors are responsible for analgesia and sedation. Sigma receptors control is phoria and other delusional states" (Jones,	"Phenylephrine is alpha-1 adrenergic agonist used in the management of hypertension, generally in the surgical setting associated with the use of anesthetics" (Jones, 2020).	"Blocks cyclooxygenase activity, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation. By inhibiting prostaglandins and reduces inflammatory symptoms and relieves pain. ibuprofen antipyretic action probably stems from its effect on the	"Increases intracellular. and extracellular calcium levels, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems" (Jones, 2020). "Also plays a role in normal cardiac and renal function, respiration, coagulation, cell membrane and capillary permeability (Jones, 2020). "It helps regulate the release and storage of neurotransmitters and hormones" (Jones, 2020). "Oral forms also neutralize or buffer. stomach acid to relieve discomfort caused by hyperacidity"(Jones, 2020).

	(Jones, 2020).	2020).		hypothalamus, which increases peripheral blood flow, causing vasodilation and encouraging heat dissipation" (Jones, 2020).	
Reason Client Taking	Pain	Respiratory depression	Hypotension systolic pressure less than 90	Pain	Taken to relieve discomfort caused by hyperacidity.
Contraindications (2)	Hypersensitivity to acetaminophen or its members, severe hepatic impairment, severe active liver disease. (Jones, 2020)	"Hypersensitivity to naloxone or its components" (Jones, 2020).	Hypersensitivity to phenylephrine or its components. Use with caution in pregnancy.	Angioedema, rhinitis, and bronchospasm (Jones, 2020). Hypersensitivity to ibuprofen or its components and known or suspected infection (Jones, 2020).	Ventricular fibrillation, hyperphosphatemia, renal calculi" (Jones, 2020). Hypersensitivity to calcium carbonate or it's component
Side Effects/Adverse Reactions (2)	Agitation, hypertension, stridor, abdominal pain, hypoglycemic coma, and peripheral edema.	Seizures, cardiac arrest, nasal congestion, headache, edema, and diaphoresis.	Headache, dizziness, tachycardia, and insomnia.	Aseptic meningitis, heart failure, dizziness, and headache.	Paresthesia, irregular heartbeat, nausea and vomiting, and diaphoresis.
Nursing Considerations (2)	"Use acetaminophen cautiously in patients	"Keep resuscitation equipment readily available	Monitor the patient's vital signs (Jones,	Be aware that ibuprofen should not be	"Be aware that. pregnancy may alter dosage needs for mother" (Jones, 2020).

	with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment" (Jones, 2020). Drug may be present in breast milk, and patient should check with prescriber before breastfeeding (Jones, 2020).	during naloxone administration" (Jones, 2020). Monitor patients in post operative setting who have received naloxone because abrupt postoperative reversal of opioid depression after using the naloxone may cause serious adverse effects (Jones, 2020).	2020). Observe for bradycardia and monitor oxygenation (Jones, 2020).	used in pregnant women starting at 30 weeks gestation because premature closure of the ductus arteriosus may occur in fetus (Jones, 2020). Use ibuprofen with extreme caution in patients with the history of GI bleeding or also disease because ibuprofen increases the risk of GI bleeding and ulceration (Jones, 2020).	"Patient should check with prescriber before breastfeeding. Dosage needs for mother may change if breastfeeding" (Jones, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Use the rights of medication before administering. Identify if patient is allergic to acetaminophen. Educate	Before the administration of naloxone all patients should receive the appropriate medical treatment to provide support of their airway, breathing, and circulation. Before the	Instruct the patient to blow nose gently to clear nasal passage before administration of medication. Ensure use of medication	Assess the patient's level of pain using in a numerical pain scale. Assess cardiorespiratory and GI status because they profit may cause hepatic	Store at room temperature, and protect from heat, moisture, and direct light. Do not freeze. Warm solution to room temperature before Parenteral administration (Jones, 2020).

	patient about the adverse effects of acetaminophen.	administration of naloxone all patients should be assessed for other causes of altered mental status and or respiratory depression, such as hypoxia, hypoglycemia, head injury, shock, and stroke.	rights.	and renal impairment and may cause bleeding.	
Client Teaching needs (2)	Educate patient to check with provider because medication appears in breast milk. "Caution patient not to exceed recommended dosage or take other drugs containing acetaminophen simultaneously because of the risk of liver damage" (Jones, 2020).	"Inform patient your family that naloxone will reverse opioid induced adverse reactions" (Jones, 2020). "Urge opioid dependent patient to seek drug rehabilitation" (Jones, 2020).	Educate patient not to exceed dosage. Educate patient not to breastfeed while taking this drug.	Caution pregnant patient not to take ibuprofen during last trimester because this may cause premature closure of the ductus arteriosus(Jones, 2020). Explain that ibuprofen may increase risk of serious adverse cardiovascular reactions, urge patient to seek immediate medical attention if signs or symptoms arise, such as chest pain,	Urge patient to chew chewable tablets thoroughly before swallowing and to drink a glass of water afterward (Jones, 2020). Educate the patient to avoid excessive use of tobacco and excessive consumption of alcohol beverages, caffeine-containing products, and high fiber foods because these substances may decrease calcium absorption (Jones, 2020).

				edema, shortness of breath, slurring of speech, swelling in legs, unexplained weight gain, or weakness (Jones, 2020).	

Home Medications (2 required)

Brand/Generic	Metronidazole/Flagyl	Multivitamins/ Folgard	N/A	N/A	N/A
Dose	500mg	N/A	N/A	N/A	N/A
Frequency	BID	Daily	N/A	N/A	N/A
Route	Oral	Oral	N/A	N/A	N/A
Classification	Nitroimidazole and Antiprotozoal.	Vitamin and mineral combinations.	N/A	N/A	N/A
Mechanism of Action	"Intracellular chemical reduction occurs during anaerobic metabolism. After reduced metronidazole damages DNA helical structure and breaks its strands, inhibiting bacterial nucleic acid synthesis and causes cell death" (Jones, 2020).	Multivitamins are active in the form of enzymes, which, together with enzyme's facilitate essential metabolic processes in the body.	N/A	N/A	N/A
Reason Client Taking	Taken to treat GBS.	Taken to prevent and treat vitamin and nutritional deficiencies.	N/A	N/A	N/A
Contraindications (2)	"Alcohol use ,including products containing	Use with caution in patients with anemia.	N/A	N/A	N/A

	propylene glycol during and for at least three days after medication therapy, first trimester of pregnancy, hypersensitivity to other nitroimidazole derivatives all their components, use of disulfiram within past two week" (Jones, 2020).				
Side Effects/Adverse Reactions (2)	"Chest pain, palpitations, dry mouth, nasal congestion, abdominal cramps, anorexia, and diarrhea" (Jones, 2020).	Yellow discoloration of urine. Side effects and adverse effects rare with this medication.	N/A	N/A	N/A
Nursing Considerations (2)	" Use cautiously in patients with CNS diseases" (Jones, 2020). "Use cautiously in patients with blood dyscrasias or history of such because metronidazole therapy has caused some patients' agranulocytosis, leukopenia, and neutropenia (Jones, 2020).	Avoid giving more than one multivitamin medication because taking more than one can result in vitamin overdose and serious side effects. Do not give multivitamins with milk, other dairy products, calcium supplements, or anti acids that contain calcium.	N/A	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Culture and sensitivity test must be done before 1st dose is given. Assess CBC and vital signs.	Educate the patient to take the correct medication dosage because large doses can harm an unborn baby.	N/A	N/A	N/A

Client Teaching needs (2)	"Urge the patient to take the medication at evenly spaced intervals during the day and with food to minimize adverse GI reactions" (Jones, 2020). "Advise patient to avoid hazardous activities until drug's CNS effects are known and put any abnormal neurologic signs or symptoms, such as numbness, seizure, weakness, or vision changes" (Jones, 2020).	"Advise the patient to avoid taking oil with vitamins because fat soluble vitamins will not be adequately absorbed (Jones, 2020)". Inform the patient that riboflavin (B2) will cause harmless yellow urine discoloration.	N/A	N/A	N/A

Hospital Medications (5 required)

Medications Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook.* (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O X4 is oriented to person, place, situation, and time. The patient shows no sign of distress now. The patient is appropriately dressed for the current situation.
INTEGUMENTARY (1 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	The patient skin color is usual for ethnicity. No sign of cyanosis, rash, lesions, bruises, or wounds. The skin is dry, warm, and intact. The patient skin turgor is less than three seconds. Braden's score is 22. The patient skin was warm with no sign of edema. The patient had no drains present upon assessment.

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normal cephalic. The neck is symmetrical with the trachea at the midline. The carotid pulse is +2 bilaterally. There are no scarring, depressions, or palpable masses around the neck. The patient's hair has a normal texture and is evenly distributed. The patient's eyes are symmetrical, with no sign of exudates or hemorrhage. The eyes are perrla, and extraocular movements are intact. The eyes have no sign of nystagmus. The ears are symmetrical with no sign of discharge and no tenderness. Hearing is intact. The nasal mucosa is pink and moist. The nasal septum is midline, and the nares are patent bilaterally. The patient's oral mucosa is pink and moist. The pharynx is normal in appearance without tonsillar swelling or exudates.
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	 S1 and S2 Normal sinus rhythm Peripheral pulses 3+ Less than two seconds no neck vein distention no edema present
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient has normal lung sounds. The diaphragm rises and falls symmetrically bilaterally. Normal lung sounds anteriorly and posteriorly. Respirations are intact. Respirations 18 per min. The patient did not use accessory muscles when breathing.
GASTROINTESTINAL (2 points): **Diet at Home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:**	 The patients home diet and current diet are regular. 158cm 78.400kg The patient's last bowel movement was around 6:00 on 2/22/23. The abdomen did not appear distended, and no masses or wounds were present. The patient's abdomen had no scars, incisions or lesions upon

Incisions: **Scars:** **Drains:** **Wounds:**	observation. The patient has no ostomy or nasogastric, or feeding tubes present.
GENITOURINARY (2 Points): **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	The patient's urine was yellow and clear, with no abnormal odor. Patient voiced burning with urination. Genitals were not inspected. No catheter was in place at the time of assessment.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	No ADL assistance needed. The patient has both active and passive range of motion in all extremities. Upper and lower extremity strength is 5/5 bilaterally. The patient is a fall risk. Fall score 35. The patient does not need assistance with equipment and does not need support with standing up and walking.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	The patient has 5/5 strength in the upper left extremity and 5/5 in the right lower extremity. The patient's pupils are equally reactive to light and accommodation. The patient is oriented to time, person, place, and situation. The patient has normal cognition and is alert and communicating frequently. The patient's speech is clear and intact. The patient is awake, answering questions appropriately. Deep tendon reflexes not assed.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient stated that she has no coping method, and her highest level of education is high school. she also stated that she is not religious and means nothing to her. She stated that her support system would be her husband and her family, who lives nearby. She lives with her husband and has no pets. She is a bartender, and her husband works as a server at Buffalo Wild Wings. Her husband said he would take a few days off work to help around the house.
Reproductive: (2 points) **Fundal Height & Position:** **Bleeding amount:** **Lochia Color:**	Fundal (fundus) is at the umbilicus (- 1u), and position is midline. 100ml Rubra

Character:	N/A
Episiotomy/Lacerations:	Well approximated
DELIVERY INFO: (1 point)	
Rupture of Membranes:	
Time:	07:39
Color:	Clear
Amount:	Moderate
Odor:	None
Delivery Date:	02/21/23
Time:	14:10
Type (vaginal/cesarean):	Vaginal
Quantitative Blood Loss:	100ml
Male or Female	Male
Apgars:	N/A
Weight:	2,720 grams
Feeding Method:	Breast feeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	65	153/77	14	37.2C	99
Labor/Delivery	114	157/58	N/A	37.6C	94
Postpartum	84	136/81	16	37.6C	97

Vital Sign Trends: The mother's heart rate and blood pressure increased during labor and delivery. Increased heart rate and blood pressure were caused by increased pain during labor and delivery. The mother's heart rate and blood pressure returned to normal postpartum.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:15	numerical scale	N/A	N/A	N/A	N/A

11:25	numerical scale	N/A	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge left peripheral arm IV 02/20/23 Patent No sign of erythema, drainage, phlebitis, infiltration. IV dressing is dry, clean, and intact

Intake and Output (2 points)

Intake	Output (in mL)
200ml	175ml

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.
Monitor for evidence of infection and excessive bleeding at the laceration site. (N) Rhogam ordered (M)	Monitor every 15 minutes for the first two hours after birth and every 30 minutes for the third hour.	Laceration site is monitored for signs of infection and excessive bleeding. What laceration? Bilateral periurethral lacerations Rhogam ordered because the baby has rh positive blood. And mom is Rh positive.
Provide pain relief and antiemetics as needed. (N) Prescribing pain relief and antiemetic medication. (M)	PRN	Pain medication is provided for pain relief to reduce pain level to the ideal level of zero and two on the pain scale. Antiemetic medication is provided for nausea.

Monitor vital signs per protocol. (N) Ordered urinary catheter placement. (M)	Monitor vital signs every 15 minutes for the first hour, then every 30 minutes for the second hour, then every first 24 hours, and after 24 hours every eight hours.	Vital signs are monitored per protocol to detect and prevent any complications and ensure the patient is recovering well. Urinary catheter order ~~to prevent straining and aid in complete bladder emptying.~~ to aid in subinvolution and assist in bladder emptying if patient unable to void.
Assess the uterine fundus for firmness or tenderness. (N)	Check the mother's uterus every 15 minutes for the first two hours after birth and every 30 minutes for the third hour. If possible, check every hour for the following three hours.	The uterine fundus is assessed to ensure there is no hemorrhaging and normal subinvolution of the uterus.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? The mother is in the taking hold phase of maternal adaptation to parenthood.

What evidence supports this? The mother is in her second postpartum day. The mother is independent and ready to make decisions regarding herself care and the infant care activities. She also shows that she is ready for teaching.

Discharge Planning (3 points)

Discharge location: the parents and baby will be discharged home.

Equipment needs (if applicable): The patient will need peri care pads, pain relieving spray, nursing pads, breast pump, diaper wipes, baby clothes, bottles, and pacifiers. Does she have any

of this at home or does someone need to assist her with getting these items? The nurse will assist her with getting some of these items before discharge.

Follow-up plan (include plan for mother AND newborn): call or visit 24 hours after discharge to evaluate whether the family can grasp all instructions and integrate the newborn into the family. Who will make this visit? The nurse The mother will go to her provider once the baby reaches two to four weeks old for a check-up and her return check-up at four to six weeks after birth. These appointments are usually made prior to discharge.

Education needs: educate the mother about health maintenance visit for the newborn once he has reached two to four weeks old and her return checkup four to six weeks after birth. Instruct the mother to avoid lifting heavy weights for the first three weeks after birth. Advise the mother to rest and sleep while her newborn is asleep so she can regain her strength.

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. Acute pain related to trauma sustained during birth as evidenced by bilateral. periurethral	The patient stated she feels pain while urinating.	1. "Using a pain flow chart, record the time of medication administration and results of pain assessment every hour until the next dose to monitor the therapy's effectiveness" (Phelps, L. 2020).	"Patient identifies most effective pain relief measures" (Phelps, L. 2020). "Patient reports achieving pain relief with analgesia or other

lacerations Very good		Rationale. "It allows for assessing whether the medication effectively relieves the patient's pain and time for the medication to begin working" (Phelps, L. 2020). 2. "Ask the patient to help establish goals and develop plan for pain control" (Phelps, L. 2020). 1. Rationale "This gives the patient a sense of control" (Phelps, L. 2020).	measures" (Phelps, L. 2020).
2. Risk imbalanced nutrition: less than body requirements Related to insufficient dietary intake, as evidenced by the patient stating that food makes her nauseous.	The mother did not want to order food because food makes her nauseous.	1. "Provide a pleasant environment at mealtime and keep snacks at the bedside" (Phelps, L. 2020). We might have to begin with nutritious liquids and produce solid foods. Rationale It enhances the appetite and give the patient some control over eating time. 2.Adminster prescribed antiemetic medication. Rationale Provides relief from nausea.	"Patient consumes specified number of calories daily" (Phelps, L. 2020). Patient expresses relief from nausea.
3. Risk for infection related to alteration in skin integrity as evidenced by bilateral periurethral lacerations of the first degree.	The patient has bilateral periurethral lacerations of the first degree.	2. "Monitor temperature at least every four hours, and record on graph paper. Report elevations immediately" (Phelps, L. 2020). Rationle "Sustained temperature elevation after surgery may signal onset of pulmonary complications, infections or the heathens, urinary tract	"Patient will remain free from signs and symptoms of infection" (Phelps, L. 2020). "The patients incisions or wounds will remain clear, and free from purulent drainage"(Phelps, L. 2020). The patient's

		infection, or thrombophlebitis" (Phelps, L. 2020). 2. "Educate patient about: good hand washing technique. Factors that increase infection risk. Signs and symptoms of infection"(Phelps, L. 2020). Rationale "These measures allow patient to participate in care and help patient modify lifestyle to maintain optimum health" (Phelps, L. 2020).	temperature will remain within normal range. "The patient would identify signs and symptoms of infection" (Phelps, L. 2020).
1. Readiness for enhanced postpartum education related to knowledge deficit as evidenced by request for more information	The patient requested for more information about postpartum care.	1. "Assess baseline knowledge of prenatal care, labor and delivery process, and newborn care" (Phelps, L. 2020). Rationale "Helps identify and resolve knowledge deficits" (Phelps, L. 2020). 2. "Provide written literature on prenatal Wellness, labor and delivery expectations, and newborn care" (Phelps, L. 2020). Rationale "Providing written materials allows adequate time to synthesize and understand new information" (Phelps, L. 2020).	"The mother conveys confidence related to newborn care" (Phelps, L. 2020). The mother is satisfied with interventions put in place. "Newborns physical, social, and nutritional needs are met" (Phelps, L. 2020).

Other References (APA)

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.