N432 Postpartum Care Plan

Rancey Rouse

Lakeview College of Nursing

N432: Maternal-Newborn Care

Clinical Instructor Zoe Due

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Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
06/12/23- 1226	SM	31yrs old	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian/ non-Hispanic or Latino	Counselor/Team member at Substance abuse center	Single	Hydrocodone-High- n/v Morphine- high- n/v Fentanyl- high-n/v
Code Status	**Height**	**Weight**	**Father of Baby**
Full	5'5" 165.1 cm	174 lbs 2.6 oz 79 kg	Birth-Unknown, Baby adopted Father Brandon (cousin of birth mother)

Medical History (5 Points)

Prenatal History: G2P2002, no complications, outcomes:2 living children

Past Medical History: Anxiety, depression, migraines, pulmonic stenosis, tetralogy of Fallot, wide QRS,

Past Surgical History: Cardiac surgery- 10 months of age, Pulmonary valve replacement- age 23

Family History: Paternal Grandmother-Breast cancer

Social History (tobacco/alcohol/drugs): Smoker ½ pack/day for 13 yrs, occasional use of marijuana and positive for marijuana urine drug screen

Living Situation: Lives at home with son

Education Level: Highschool degree, no learning barriers or deficits

Admission Assessment

Chief Complaint (2 points): Scheduled on 06/10/23 admission for cardiac evaluation prior to induced labor

Presentation to Labor & Delivery (10 points): On 06/10/2023 the patient was scheduled for a cardiac evaluation prior to induced labor. Upon assessment, the fetus was found to be IUGR therefore an early term delivery and induction was recommended to the patient. The patient gave consent and planned for the new admission to be 06/12/23 at 37 weeks 2 days compared to the original induction date at 39 weeks on 06/24/23. The patient has a cardiac history but no prior complications in pregnancy.

Diagnosis

Primary Diagnosis on Admission (2 points): Singleton Pregnancy

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	3.50-5.20 mcL	3.78	3.43	N/A	Pregnancy causes a decrease in red blood cells. The patient delivering vaginally with some blood loss also can cause this slight decrease (Pagana et al., 2020).
Hgb	11-16 g/dL	12.4 g/dL	11.2 g/dL	N/A	WNL
Hct	34-47%	36.0%	32.3%	N/A	Hematocrit is similar to red blood cells. Both are decreased due to pregnancy and blood loss in a vaginal delivery. This level is slightly decreased and nothing to be concerned about (Pagana et al., 2020).
Platelets	140-400 mcL	206 mcL	250 mcL	N/A	WNL

WBC	4-11 mcL	14.75 mcL	9.00 mcL	N/A	White blood cell count increases with stress. This patient could have been under increased stress during their prenatal lab draw causing this to be increased. Dehydration can also cause an increase in white blood cells which is an increased risk during pregnancy (Pagana et al., 2020).
Neutrophils	1.6-7.70 10^3 uL	4.3% 13.36	N/A	N/A	The patient had pyelonephritis at 23 weeks gestion age, the neutrophils are elevated due to inflammation and stress (Pagana et al., 2020).
Lymphocytes	1.00-4.90 10^3 uL	4.3% 0.63	N/A	N/A	The patient had pyelonephritis at 23 weeks gestion age, the lymphocytes are elevated due to inflammation and stress (Pagana et al., 2020).
Monocytes	0.00-1.10 10^3 uL	4.4% 0.65	N/A	N/A	WNL
Eosinophils	0.00-0.50 10^3 uL	0.1% 0.02	N/A	N/A	WNL
Bands	0-5	N/A	N/A	N/A	Not performed

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+, A-, B+, B-, AB+, AB-, O+, O-	A positive	A positive	N/A	Individual basis, no abnormal

					s
Rh Factor	Rh+ or Rh-	Rh-positive Antibody-negative	Rh-positive Antibody-negative	N/A	N/A
Serology (RPR/VDRL)	nonreactive	nonreactive	N/A	N/A	WNL
Rubella Titer	>10.00 IU/mL=positive/immune	03/0823-41.00=Immune	06/09/23-49.00=Immune	N/A	WNL
HIV	nonreactive	Not detected	Not detected	N/A	WNL
HbSAG	negative	negative	N/A	N/A	WNL
Group Beta Strep Swab	negative	negative	negative	N/A	WNL
Glucose at 28 Weeks	<140 mg/dL	109 mg/dL	N/A	N/A	WNL
MSAFP (If Applicable)	0.5-2.0 MoM	N/A	N/A	N/A	Not performed

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
UA- color	yellow	Yellow	N/A	N/A	WNL
UA- appearance	Clear	Clear	N/A	N/A	WNL
UA- specific gravity	0.000-0.030	0.015	N/A	N/A	WNL
UA- urobilinogen	0.2-1.0 mg/dL	0.2	N/A	N/A	WNL
UA-RBC	0-20 U/L	4	N/A	N/A	WNL
UA-WBC	0-25 U/L	1	N/A	N/A	WNL
UA- protein, ketone, glucose, blood	negative	Negative	N/A	N/A	WNL
Urine drug screen	Cut off value= 50 mg/dL	N/A	>50 mg/dL=positive for cannabis cannabinoids	N/A	The mother stated she smoked marijuana her pregnancy, this is a positive drug screen for cannabis (Pagana et al.,

					2020).

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 (protein/creatinine ratio)	0.021-0.127		N/A	<0.2	N/A	This test will help diagnose pre-eclampsia and is a normal test done in pregnancy, especially for those at higher risk.

Lab Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th 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**	This student nurse assisted a nurse in caring for a mother in the postpartum unit. The patient has a history of two pregnancies, two-term births, and two living children. The first pregnancy had no complications, and the patient has a two-year-old house at home. The mother's prenatal care started on 11/15/22 at seven weeks and three days. The patient was not at risk for complications other than smoking cigarettes and marijuana during pregnancy. The patient had no complications during pregnancy leading up to the induction besides pyelonephritis at

	twenty-three weeks. The patient presented to a prenatal appointment for a cardiac evaluation before induction on 06/10/23. The assessment identified fetal growth restriction, and the provider suggested an earlier induction date. After consent, the original induction date was moved from 06/24/23 to 06/12/23 at thirty-seven weeks and three days gestational age. The delivery was eight hours and sixteen minutes long, with 21 minutes in the second stage and 6 minutes in the third. On 06/13/23 at 0423, membranes were ruptured artificially. The amniotic fluid was clear, odorless, and a moderate amount. Shortly after, at 0528, a baby boy was born vaginally, weighing five pounds, fifteen ounces, and forty-seven centimeters long. The placenta was delivered six minutes after the birth of the newborn. The mother had no complications during delivery and only 241 millimeters of blood loss. Risk factors for postpartum hemorrhage include lacerations of the genital tract, episiotomy, retained placental fragments, uterine inversion, coagulation disorders, large-for-gestational-age newborn, induction of labor with oxytocin, and placenta accreta (Ricci et al., 2020). Risks for infections during labor include a history of cesarean delivery, premature rupture of membranes, diabetes, obesity, and frequent cervical monitoring (Barlow et al.,

	2019). The patient was induced with oxytocin which increased the risks of hemorrhage. The patient does have an increased risk for postpartum depression due to having a history of depression and anxiety, an unwanted pregnancy, and an adoption process.
Current stage of labor	The patient is in the recovery stage (stage 4) after giving birth in the postpartum unit. The patient's vital signs remained stable, and no reports of pain. The fundal height was one centimeter under the umbilicus, and the patient had a scant and light amount of lochia with a rubra color. The patient had no abnormal assessments during this time. The patient did express reports of increased anxiety and wanting to take her previous medications for depression/anxiety; the nurse administered sertraline and buspirone per the provider's orders. The plan is for the newborn to go home with the cousins of the mother, who are the adoptive parents. The family will need some slight education on bottle feeding and knowing when to report signs and symptoms.

Stage of Labor References (2) (APA): need one

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)- Did not include pregnancy considerations because both Sertraline and Buspirone were ordered/prescribed after delivery.

No other home meds!! Prescribed these two before leaving hospital!

Brand/Generic	Sertraline (Zoloft)	Buspirone			
Dose	50 mg	5mg			
Frequency	Daily	BID			
Route	oral	Oral			
Classification	Pharmacologic: selective serotonin reuptake inhibitor Therapeutic: antianxiety, antidepressant	Pharmacologic: Azaspirone Therapeutic: Anxiolytic			
Mechanism of Action	"Inhibits reuptake of neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses" (Jones & Bartlett Learning, 2022).	"May act as a partial agonist at serotonin 5-hydroxytryptamine receptors in the brain, producing antianxiety effects" (Jones & Bartlett Learning, 2022).			
Reason Client Taking	For anxiety/depression	For anxiety/depression			
Contraindications (2)	Use with disulfiram or pimozide, use within 14 days of MAO inhibitor	Severe hepatic or renal impairment, use of MAO inhibitor in last 14 days			

Side Effects/Adverse Reactions (2)	Pulmonary hypertension, atrial arrhythmias	Mood swings, angioedema, restlessness			
Nursing Considerations (2)	Monitor for adverse effects, Monitor mood changes in patient	Monitor for serotonin syndrome, assess for dizziness			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Perform a depression and anxiety screening to establish baseline for monitoring progress. Assess for any history of seizure disorders.	Initiate safety precautions due to possible adverse CNS reactions. Perform depression and anxiety screening prior to administration.			
Client Teaching needs (2)	Educate patient to not stop taking this medication abruptly. Teach patient how to recognize signs of serotonin syndrome.	Caution patient to avoid drinking grapefruit juice, it may take up to 2 weeks of therapy to notice effect of this medication.			

Hospital Medications (5 required)

Brand/ Generic	Ibuprofen (Motrin, Advil)	Acetaminophen	Ondansetron (Zofran)	Bisacodyl (Dulcolax)	Oxytocin in 0.9% sodium chloride
Dose	600 mg	1,000 mg	4mg	10 mg	30 units/500 mL at 125ml/her
Frequency	Every 6 hrs PRN	Every 6 hrs PRN	Daily as needed	Daily as needed	One time dose with a duration over about 4 hours
Route	oral	Oral	IV push	Suppository rectal	IV continuous
Classification	Pharmacologic: NSAID Therapeutic: analgesic,	Pharmacological: nonsalicylate, para-aminophenol derivative Therapeutic: antipyretic,	Pharmacologic: selective serotonin receptor antagonist Therapeutic:	Pharmacologic: Stimulant Laxative Therapeutic: laxatives	Uterotonic agents

	anti-inflammatory, antipyretic	nonopioid analgesic	antiemetic		
Mechanism of Action	"Blocks activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation" (Jones & Bartlett Learning, 2022).	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system" (Jones & Bartlett Learning, 2022).	"Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. Reduces nausea and vomiting by preventing serotonin release in the small intestine" (Jones & Bartlett Learning, 2022).	"Stimulates parasympathetic nerves in the colon directly to increase motility and secretions" (Jones & Bartlett Learning, 2022).	"Oxytocin increases the sodium permeability of uterine myofibrils, indirectly stimulating contraction of the uterine smooth muscle. The uterus responds to oxytocin more readily in the presence of high estrogen concentrations and with the increased duration of pregnancy" (Jones & Bartlett Learning, 2022).
Reason Client Taking	For pain/swelling	For pain	Nausea/ vomiting	constipation	To help the uterine contract
Contraindications (2)	Congenital heart disease, coagulation defects	Hepatic disease, liver disease	Concomitant use of apomorphine, constipation	Rectal bleeding, vomiting, fecal impaction	Transverse lies in pregnancy, if adequate uterine activity fails to achieve satisfactory progress
Side Effects/Adverse Reactions (2)	Hemorrhage, heart failure	Atelectasis, hypokalemia	Hypotension, tachycardia	Abdominal cramping, rectal burning,	Muscle cramps, high blood pressure
Nursing	Monitor	Calculate total	Monitor	Monitor for	Be cautious

Considerations (2)	patient for thrombotic events such as MI, stroke due to increased risk. Monitor CBC for decreased hemoglobin and hematocrit.	daily intake so maximum daily dose is not exceeded. Monitor signs of hepatotoxicity.	patient closely for serotonin syndrome, monitor for decreased bowel activity	abdominal distention, frequently assessing bowel sounds, encourage patient to ambulate	using this in patient with maternal heart disease, assess heart rate and blood pressure frequently.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check when last dose was administered. Give will full glass of water. Obtain vitals to assess heart rate and blood pressure (Jones & Bartlett Learning, 2022).	Check when the last dose was given, check total intake of acetaminophen for the day (Jones & Bartlett Learning, 2022).	Assess IV patency before administering via IV push, know push time is 2-3 minutes (Jones & Bartlett Learning, 2022).	Auscultate bowel sounds, ask patient when their last bowel movement was (Jones & Bartlett Learning, 2022).	Double check prescribed rate, assess fundal height (Jones & Bartlett Learning, 2022).
Client Teaching needs (2)	Educate patient to avoid alcohol while using this medication. Educate patient to be aware of cardiovascular reactions with this	Educate patient to read labels on all over the counter drugs, to ensure not exceeding daily dose limit. Educate patient the signs of hepatotoxicity and the medications effect on liver with long term use (Jones &	Immediately seek medical attention if persistent, severe, unusual or worsening symptoms occur. Place disintegrating tablet under the tongue and let it dissolve	Overuse of this medication can cause laxative dependency. Educate patient to increase foods containing fibers (Jones & Bartlett Learning,	Educate patient the need for se of this drug. Also educate the risks that come with the administration of oxytocin and potential side effects (Jones & Bartlett Learning, 2022).

	drug and if they occur to contact prescriber (Jones & Bartlett Learning, 2022).	Bartlett Learning, 2022).	before swallowing (Jones & Bartlett Learning, 2022).	2022).	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). 2021 *Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented to the time, person, place and situation. No acute distress and well groomed.
INTEGUMENTARY (1 points): **Skin color:** white/pink **Character:** dry **Temperature:** warm **Turgor:** normal mobility **Rashes:** N/A **Bruises:** **Wounds/Incision:** **Braden Score: 16** **Drains present: Y☐ N ☒** **Type:**	Skin is pink, warm and dry upon palpitation. Turgor demonstrated normal elasticity. No rashes, wounds, or drains observed. Bruise/cut under left knee bandage, patient stated due to falling at the pool. Braden score=16.
HEENT (1 point): **Head/Neck:** symmetrical **Ears:** in line with ears **Eyes:** no visible deformities **Nose:** symmetrical **Teeth:** normal dentition	Head and neck are symmetrical. Ears are symmetrical without any lesions, lumps, or visible deformities bilaterally. Ears are symmetrical without any lesions or discharge bilaterally. Nose is symmetrical with face, no visible discharge or bleeding. Normal dentition.
CARDIOVASCULAR (2 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** +3	Murmur present with a continuous swooshing sound. Normal rate and rhythm. Capillary refill is less than 3 seconds. Pulses are +3 bilaterally. No neck vein distention or edema present bilaterally.

Capillary refill: <3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Clear, equal, unlabored breath sounds auscultated anterior/posterior and bilaterally. Regular depth and pattern. No accessory muscle use.
GASTROINTESTINAL (2 points): **Diet at Home:** Regular **Current Diet:** Regular **Height:** 5'5" or 165.1 cm **Weight:** 174 lbs. or 79 kg **Auscultation Bowel sounds:** **Last BM:** 06/11/23 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	Patient is on a regular diet at home and as an inpatient. Abdomen is soft and nondistended. Fundus height is 1 cm below the umbilicus. Normoactive bowel sounds auscultated in all 4 quadrants. No reports of nausea, diarrhea constipation, or vomiting. Last bowel movement was 06/11/23. No abdominal wounds, scars, drains, distention, or incisions observed.
GENITOURINARY (2 Points): **Quantity of urine:** 720 mL **Pain with urination: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient has had 2 urine occurrences. 720 ml of urine output total noted. No abnormal pain with urination, patient stated it is uncomfortable to urinate due to swelling; however, this is normal after vaginal delivery. Urine had dark, red, clots which are also a normal documentation for this situation. Swelling in perineum with slight bruising.
MUSCULOSKELETAL (1 points): **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** Moderate risk **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patient is a moderate fall risk due to having an epidural. Patient has recovered full sensation in legs. Patient was assisted to the first bathroom trip out of bed post epidural. Currently does not need assistance to stand or walk or use of equipment and is up independently. Active range of motion with normal strength. Homans sign negative bilaterally.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** to person, place, time, situation	Alert and oriented x4. Speech is clear at a normal rate, answering questions appropriately. Patellar DTR's demonstrate a +2 bilaterally. Patient has a history of depression and anxiety and stated a desire to take medication again due to increase in emotions.

Mental Status: reports of anxiety and depression **Speech:** normal rate and rhythm **Sensory:** intact **LOC:** alert and responsive **DTRs:** normal reflexes	
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):**	Patient stated talking to friends and family are coping mechanisms. Verbalized a great support system from family, especially mother and grandmother. Patie stated to be religious but does not practice religion every Sunday. Eriksons psychosocial developmental level is generativity vs stagnation, patient does contribute to society and apart of a family.
Reproductive: (2 points) **Fundal Height & Position:** 1 cm below umbilicus **Bleeding amount:** 241 ml **Lochia Color: rubra** **Character:** scant and light **Episiotomy/Lacerations:** N/A	Fundal is firm and 1 cm below umbilicus. Total blood loss during delivery was 241 ml. Bleeding color is rubra or dark red and scant to light bleeding. No episiotomy or lacerations.
DELIVERY INFO: (1 point) **Rupture of Membranes:** AROM **Time:** 0423 **Color:** clear **Amount:** moderate **Odor:** normal **Delivery Date:** 6/13/23 **Time:** 0528 **Type (vaginal/cesarean):** vaginal **Quantitative Blood Loss:** 241 ml **Male or Female:** Male **Apgars:**8,9 **Weight:** 2710 g **Feeding Method:** bottle/formula	Artificial rupture of membranes at 0423, amniotic fluid was clear with no abnormal odor and a moderate amount. Delivery date-06/13/23 at 0528 vaginally with blood loss of 241 ml to a baby boy with Apgar score of 8,9. Baby boy weighed 2710 grams or 5 lb 15.6 oz. Birth mother is formula feeding. Baby is adopted by cousins of birth mother.

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	76 bpm	122/56	18 breaths/min	98° F 36.7 C	98% room air
Labor/Delivery	62 bpm	86/46 (Not abnormal	14 breaths/min	98.4F 36.9 C	99% room air

		mother was laying on arm at time)			
Postpartum	68 bpm	127/83	16 breaths/min	97.7°F 36.5 C	100% room air

Vital Sign Trends: Vital signs remained stable throughout observation. The nurse and student nurse had concerns with a slight elevation in trends of blood pressure and preeclampsia, but shortly after the blood pressure decreased.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0347	Numeric	N/A	0/denied pain	N/A	N/A
1012	Numeric	N/A	0/denied pain	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:18 gauge **Location of IV:** left posterior wrist **Date on IV:** 06/12/23 **Patency of IV:** patent, infusion **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** transparent	Patient has an 18 gauge in left; posterior wrist that was placed on 06/12/23 at 1411. Clean, dry, intact IV site. Patient reports pain or warmth at site. No signs of erythema, drainage, or infiltration observed. Transparent dressing used. Oxytocin in 0.9% sodium chloride 30 unit/500ml infusing over 4 hours. Started at 06/13/23 ended 1320.

Intake and Output (2 points)

Intake	Output (in mL)
50% (water) All that was recorded, student did not assess/record.	720mL

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.
Intake/Output-N (Order is medical however is a nursing assessment)	q4hourx12 hours then qshift x24 hours	The patient is on a strict intake and output assessment due to history of heart conditions. This is a normal assessment in all patients to be sure they are excreting as much as they intake, especially after delivery and using a catheter.
Fundal assessment- N	Each hour for 2 hours, then q4 for first 12 hours	Fundal assessments are done to palpate the uterus and be sure it is hard and returning to normal size and location. If the uterus were to be soft, the patient could be at risk for a hemorrhage. This assessment is critical in postpartum patients.
Vital Signs- N	Each hour for 2 hours, then q4 for first 12 hours	Vital signs need to be assessed during postpartum because mothers are at an increased risk for the first 24 hours. The patient's cardiac history also requires monitoring of the heart rhythm.
Sertraline 50 mg- M	Daily, oral	Postpartum mothers are at increased risk for postpartum depression with a history of depression like the patient had. Also, the patient verbalized wanting to be bac on medications for her depression and anxiety.

Phases of Maternal Adaptation to Parenthood (3 point)

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

What evidence supports this? This is the time immediately after birth, the mother requires rest, fluids, and food. This was supported by the patient allowing the nurse to make decisions on activities and care. The nurse planned when we would help her to the bathroom and talked to the mother about a shower eventually and focusing on rest at that time.

Discharge Planning (3 points)

Discharge location: Home

Equipment needs (if applicable): None

Follow up plan (include plan for mother AND newborn):

The mother will go to her house, where she has another two-year-old son to provide care for. The baby will go home with the adoptive parents.

Education needs: The adoptive parents require education of concerning signs and when to contact a doctor, follow up appointments, and general care for a newborn for first time parents.

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. Risk for Decreased cardiac output related to altered contractility as evidence by auscultated heart murmur.	Cardiac output is how effective the heart is pumping blood through the body. Decreased cardiac output overtime can cause heart failure.	1. Teach patient reportable symptoms of possible cardiac problems. **Rationale-** Knowing the symptoms of decreased cardiac functioning will give the patient a sense of control and will encourage compliance with treatment (Phelps, 2020). 2. Teach patient to stress-reduction techniques and reduce stressful elements.	The patient verbalized what signs and symptoms need to be reported to the provider. Stress-reduction techniques were practiced, the patient stated to try to use the techniques at home. The patients heart rate and blood pressure remained within normal limits.

		Rationale- Reducing stress will also decrease anxiety and restlessness which can lead to arrythmias (Phelps, 2020).	
1. Impaired mood regulation related to anxiety evidenced by patient verbalized concerns.	The mother has a history of depression and anxiety, increasing her risk for postpartum depression. The mother also stated an interest in taking her previous medication due to increased emotions after giving birth.	**1.** Allow for extra visiting periods with family if this seems to allay patient's anxiety. **Rationale-** This allows anxious the patient and family to support each other according to their abilities at their own pace (Phelps, 2020). 2. Give the patient a chance to ventilate own feelings. **Rationale-** This reduces patient's tendency to suppress or repress bottled-up feelings, which may continue to affect behavior even though patient may be unaware of them (Phelps, 2020).	The patient responded to interventions well and communicated with the nurse to gain reassurance, information, and emotional support. The nurse allowed the patient to have extra visitors to help comfort the patient and adoptive parents during this time. The patient also verbalized the increased need and want for previous anxiety and depression medications.
3. Risk for impaired attachment related to physical barrier as evidence by adoptive parents.	The adoptive parents are the newborns' biological parents; therefore, they did not gain the emotional capacity the pregnant woman gains during pregnancy.	**1.** Teach parents to provide for physical care for the child **Rationale-**This will increase the parent's sense of confidence and competence. The infant is in a trust vs mis trust stage using Erikson's theory of psychosocial development, so this will help the newborn trust the adoptive parents. (Phelps, 2020). **2.** Educate parents to make eye contact with the newborn, caress and talk in a soothing tone, call by name, and make positive remarks. **Rationale-** This will help	The parents demonstrated positive interactions with the child. They responded appropriately to behavioral cues and gained confidence in their ability to meet the baby's needs. The parent's cared for the baby in their room on the postpartum unit for a few hours alone which showed their increased confidence.

		foster a healthy parent-newborn attachment to ensure the newborns well-being (Phelps, 2020).	
4. Risk for deficient knowledge deficit related to lack of exposure as evidence by adoptive parents seek additional information	The adoptive parents are first time parents. All parents are nervous, anxious, and need to be educated prior to leaving with their newborn child. This family did not know if they would get to keep the baby or not, which can lead to not being prepared.	**1.** Determine the priority of learning needs by considering what's important to the patient **Rationale-**Discussing the background information the parents know and what they need to be educated on will help to focus on what's needed rather than re-educating (Phelps, 2020). **2.** Have parents incorporate learned skills into daily routine during hospitalization. **Rationale-** This allows the parents to practice caring for the infant and the nurse providing feedback to further educate them for discharge. (Phelps, 2020).	The parents determined their priority in learning was to be able to recognize feeding cues and the appropriate amount to feed the newborn. This was discussed between the parents and nurse; the parents verbally stated an understanding after the teaching. The parents provided for the infant in their room so they could see if they would develop further questions. The parents are observed to be more confident in their parenting after the teaching.

Other References (APA):

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