

N432 Postpartum Care Plan

Tirae Littles

Lakeview College of Nursing

N432: Maternal-Newborn Care

Professor Kumbrat

7/6/23

Demographics (3 points)

Date & Time of Admission 6-24-23 8:00pm	Patient Initials K. P	Age 29	Gender Female
Race/Ethnicity White/Caucasian	Occupation Nurse	Marital Status Married	Allergies Nickel
Code Status Full	Height 5'6	Weight 286lb (130.1kg)	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G1T1P1A0L1

Past Medical History: Allergic rhinitis, Eczema

Past Surgical History: Ankle surgery, & Tooth extraction

Family History: Mother (hypothyroidism)

Social History (tobacco/alcohol/drugs): N/A

Living Situation: Patient & husband live together

Education Level: patient is a nurse

Admission Assessment

Chief Complaint (2 points): Patient had complaints regarding strong contractions.

Presentation to Labor & Delivery (10 points): Patient presented to L&D with contractions, Patient is 40w 2d. Cook's catheter was placed was placed into patient with no complaints until a nurse attempted to insert an indwelling catheter. Nurses realized the cook's catheter was placed in the urethra for 8 hours. Patient did not have any complaints regarding pain but is now experiencing incontinence. Patient received acetaminophen and 2 units. Patient is in L&D in stable condition.

Diagnosis

Primary Diagnosis on Admission (2 points): IOL

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	3.5-5.2	4.14	4.62	N/A	Result within normal limits.
Hgb	12.0-16.0	12.2	12.1	N/A	Result within normal limits.
Hct	34.0-47	32.8(low)	34.5	N/A	Due to being anemic (Ricci et al., 2021).
Platelets	140-400	135(low)	93(low)	N/A	Patients' blood is not clotting properly (Ricci et al., 2021).
WBC	4.0-11.0	9.97	13.85(high)	N/A	This is due to possible infection (Ricci et al., 2021).
Neutrophils	1.60-7.7	5.42	9.38(high)	N/A	This is due to possible infection (Ricci et al., 2021).
Lymphocytes	1.0-4.90	2.51	3.40	N/A	Result within normal limits.
Monocytes	0.00-1.10	0.43	0.82	N/A	Result within normal limits.
Eosinophils	0.00	0.18	0.16	N/A	Result within normal limits.
Bands	0	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	Prenatal	Value on	Today's	Reason for
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	Range	Value	Admission	Value	Abnormal
Blood Type	A, B, AB, O	O	O	O	N/A
Rh Factor	Positive	Positive	Positive	Positive	Result within normal limits.
Serology (RPR/VDRL)	Nonreactive	Nonreactive	Nonreactive	Nonreactive	Result within normal limits.
Rubella Titer	Greater than 10	19	Not drawn	Not drawn	Result within normal limits.
HIV	Negative	Negative	Negative	Negative	Result within normal limits.
HbSAG	Nonreactive	Nonreactive	Nonreactive	Nonreactive	Result within normal limits.
Group Beta Strep Swab	Negative	Negative	Negative	Negative	Result within normal limits.
Glucose at 28 Weeks	Less than 140	139	Not drawn	Not drawn	Result within normal limits.
MSAFP (If Applicable)	N/A	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
LDH	112-278	168	145	Not drawn	Result within normal limits.
Uric Acid	2.6-6	5.0	5.5	Not drawn	Result within normal limits.

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	47.00-110.00	74.78	Not drawn	Not drawn	Low due to thrombocytopenia affecting pregnancy

applicable)					
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Lab Reference (1) (APA):

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

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

	Your Assessment
History of labor: Length of labor Induced /spontaneous Time in each stage	Patient did not experience stages of labor
Current stage of labor	

Stage of Labor References (2) (APA):

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

Home Medications (2 required)

Brand/Generic	Prenatal	Ferrous Sulfate		
Dose	1mg	325mg		

Frequency	Daily	PRN		
Route	oral	Oral		
Classification	Pharmacologic class: Iron product	Iron products		
Mechanism of Action	<u>A variety of vitamins and minerals that helps get babies the nutrients that are needed during development</u>	Synthetic iron supplement used to treat iron deficiency and iron deficiency anemia.		
Reason Client Taking	To get enough vitamins during pregnancy.	Patient is anemic		
Contraindications (2)	1.Hypersensitivity 2. Vitamin B12 deficiency	Take this drug at least 6 hours before an antacid Herbal medications interfere with this drug.		
Side Effects/Adverse Reactions (2)	Dry skin Puritis	Severe Stomach Bloody or tarry stools		
Nursing Considerations (2)	Monitor patient for any bodily changes Check patients known allergies before admin	Monitor patient for iron overload syndrome s/s		
Key Nursing Assessment(s)/Lab(s) Prior to	Monitor vitals & Assess pain	Monitor patients iron level		

Administration		Monitor Patient H&H & Platelets		
Client Teaching needs (2)	1. Take your prenatal multivitamin with a full glass of water 2. Take prenatal in the morning	Take on an empty stomach 1 hr. after a meal Swallow the tablet whole		

Hospital Medications (5 required)

Brand/Generic	Toradol (Ketorolac tromethamine)	Prochlorperazine (compro)	Black Draught (senna)	Tylenol (Acetaminophen)
Dose	15mg	10mg	15mg	650mg
Frequency	Every 6 hours	Every 6 hours	PRN	Q8
Route	IV Push	Oral	Oral	Oral
Classification	Pharmacologic class: NSAID Therapeutic class: Analgesic	Pharmacologic class: Piperazine phenothiazine Therapeutic class: Antiemetic	Pharmacologic class: Laxative Therapeutic class: Laxative	Pharmacologic class: No salicylate, para-aminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic
Mechanism of Action	Blocks cyclooxygenase, an enzyme needed to synthesize prostaglandins.	Alleviates nausea and vomiting by centrally blocking dopamine receptors in the medullary chemoreceptor trigger zone and by peripherally	Works by irritating luminal sensory nerve endings, thereby stimulating colonic motility and reducing colonic water	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen

		blocking the vague nerve in the GI tract.	absorption.	also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E.
Reason Client Taking	To treat moderate to severe pain that requires analgesia at the opioid level.	To control nausea and vomiting related to surgery.	To help relieve constipation	To relieve mild to moderate pain
Contraindications (2)	<ol style="list-style-type: none"> 1. High risk of bleeding 2. Labor and delivery 	<ol style="list-style-type: none"> 1. Hypersensitivity to prochlorperazine 2. Severe CNS depression 	<ol style="list-style-type: none"> 1. Fecal impaction 2. Acute surgical abdomen 	<ol style="list-style-type: none"> 1. Use of drug at any time during pregnancy may increase risk attention deficit hyperactivity disorder (ADHD) after birth 2. Drug may reduce fertility in females and males.
Side Effects/Adverse Reactions (2)	<ol style="list-style-type: none"> 1. Urine retention 2. Coma 	<ol style="list-style-type: none"> 1. Hypotension 2. Tachycardia 	<ol style="list-style-type: none"> 1. Stomach pain 2. Black, tarry stools 	<ol style="list-style-type: none"> 1. Hypertension and headache are common side effects
Nursing Considerations (2)	<ol style="list-style-type: none"> 1. Know that the risk of heart failure increases with ketorolac use because drug is a NSAID. 	<ol style="list-style-type: none"> 1. Patient should check with provider before breastfeeding. 2. Drug may cause fetal harm. 	<ol style="list-style-type: none"> 1. Although small amounts of senna cross into breast milk, it doesn't seem to be a problem for nursing babies. If the mother uses 	<ol style="list-style-type: none"> 1. Use this drug cautiously if patient has hepatic impairment 2. Calculate total daily intake of acetaminophen including other products that may

	2. Notify prescriber if pain relief is inadequate or if breakthrough pain occurs between doses because supplemental doses of an opioid analgesic may be required.		senna in recommended amounts, senna does not cause changes in the frequency or consistency of babies' stools. 2. Electrolyte disturbance and potassium deficiency can make conditions worse with Senna overuse.	contain acetaminophen so maximum daily dosage is not exceeded.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor AST & ALT	Monitor CMP and CBC	Urine culture and HGB	Monitor CBC and CMP
Client Teaching needs (2)	1.This drug may affect FHR 2.This drug is a contraindication during labor and delivery	1. Drug may cause fetal harm. 2. Use with caution only if benefit to mother outweighs potential risk to fetus.	1. Stop Senna if you experience rectal bleeding, no bowel movement within 12 hours of using Senna or if you experience constipation. 2. Get emergency help if signs of allergic reaction are experienced to include hives and difficulty breathing.	1. Inform patient that tablets may be crushed or swallowed whole, but that extended-release forms should not be broken, chewed, crushed, or split. 2. Teach patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.

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Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2021 Nurse's Drug Handbook (19th ed.). Jones & Bartlett Learning.

Assessment**Physical Exam (18 points)**

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	Alert Person, Place, Time, Location Pt in some distress due to Pain around cesarean incision Clean, well groomed.
INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: Braden Score: Drains present: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Wound vac	White, Clean, and dry Warm to touch Elasticity intact No rashes or bruises upon assessment Patient has c-section incision Patient Braden score is 22, wound vac present
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Symmetrical with skull and face Ears appear normal no noted nodules or drainage Sclera is white EOMs intact Nose is midline without bleeding. Teeth are in good condition
CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc.	S1 and S2 heard throughout no murmurs. Cardiac rhythm is normal, pulses are 3+ bilaterally, cap refills less than 3 secs, no

Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:	neck vein distention noted. Patient does have edema throughout her lower extremities.
RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Lungs are clear, no crackles or wheezes noted.
GASTROINTESTINAL (2 points): Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:	Patient follows a regular diet at home and the hospital. Patient is 5'6 and weighs 286lbs. Patients bowel sounds are normal in all four quadrants. Patients last Bm was last night. Patient did not report any gastrointestinal pain. No distention, patient has a low left transverse incision. No scars or wounds noted, wound vac in place.
GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	Patient urinates quite often, pt had 226 outputs of urine. No pain with urination, genitals appear normal, no catheter in use.
MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 10 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	Activity as tolerated. Patient is a bit weak but maintains independency. Patient does not need equipment or assistance to stand and walk.
NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation:	

Mental Status: Speech: Sensory: LOC: DTRs:	Person, Place, Time, Location Normal Cognition Clear, No language barrier Normal Alert 2 bilaterally normal DTRs WNL LOC WNL Sensory WNL
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):	Social Support, Religious Coping Intimacy vs. Isolation Patient developmental level is WNL Patients' sister, husband and mom have been of great assistance during the pregnancy.
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	1 Below, Midline Moderate Red Normal Left Transverse Incision
DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor: Delivery Date: Patient had c-section on Time: 8:00 Type (vaginal/cesarean): Cesarean Quantitative Blood Loss: 226 Male or Female: Female Apgars: 9/9 Weight: 7lb 3oz Feeding Method: Breastfeeding	C-SECTION 8:00am Not documented Not documented Patient did not have odor throughout c-section

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Prenatal	62	103/68	20	98.0f	99
Labor/Delivery	70	133/72	20	98.2f	99
Postpartum	68	162/77	20	98.0f	99

Vital Sign Trends: Patients vitals remained stable throughout the morning. There was a slight increase in the patients' blood pressure each time, a cesarean can provoke anxiety which can increase blood pressure. Patients' oxygen, temp, and RR all remained WNL.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:00am	1-10	Lower back	5	Achy pain	Patient received a hot pack and ibuprofen
11:00am	1-10	N/A	0	N/A	Patient did not experience any pain around this time.

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:	Patient has an 18G in her left antecubital, IV was inserted on 6-28-23. Patency of iv is good. NS was flushed to ensure this. No signs of erythema or drainage. IV dressing is in good condition,

Intake and Output (2 points)

Intake	Output (in mL)
Intake not recorded	277

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.
Abdominal Binder (N)	Early postpartum, wear the abdominal binder 4-6 hours per day, and as the binder becomes more comfortable, increase the wear time to 8-12 hours per day.	After your procedure, a binder will offer some comfort, light compression, and perhaps even some pain relief, all of which may aid in the healing process.
Ambulating (N)	As early as six to eight hours post-surgery.	Early ambulation benefits patients by lowering the risk of deep vein thrombosis, increasing the rate of breastfeeding, encouraging better food and nutrition, and increasing patient satisfaction.
Pain assessment (N)	Every 4 hours	Pain assessment was provided to treat pain or discomfort.

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Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking hold phase

What evidence supports this? Patient gained confidence and started making more decisions for herself without relying on the needs of others.

Discharge Planning (3 points)

Discharge location: Patient will be returning home with her husband

Equipment needs (if applicable): Breast pump

Follow up plan (include plan for mother AND newborn): For the next four weeks, the patient should gradually increase his or her daily activities, with no heavy lifting or intense exertion. Consume plenty of water. To maintain regular bowel movements, eat high-fiber foods and shower instead of bathing. Only soap and water should be used to clean the perineal area. Change peri pads on a regular basis; bleeding may last up to six weeks; and refrain from sexual activity for the first six weeks after delivery. Two weeks after the post-cesarean section, the patient should return for a post-partum exam with your OB physician to inspect the incision. The patient will return to the OB physician six weeks later to be cleared to resume normal activities and to discuss birth control choices. The newborn baby boy is to follow up within twenty-four hours with a pediatrician to discuss infant health.

Education needs: Co-sleeping, SIDS, postpartum warning signs, wound care, infection prevention, heaving heavy bleeding, and oral temperature monitoring are all things to consider.

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.	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	Evaluation (2 pt each) How did the patient/family respond to the nurse's actions? • Client response,
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<p>Include full nursing diagnosis with “related to” and “as evidenced by” components</p>		<p>include a time interval such as Assess vital signs q 12 hours.” List a rationale for each intervention and using APA format, cite the source for each of the rationales.</p>	<p>status of goals and outcomes, modifications to plan.</p>
<p>1. Risk for infection related to cesarean section incision as evidenced by alteration to skin integrity</p>	<p>The patient's cesarean section has been recognized as a risk factor that predisposes the patient to infection.</p>	<p>1.Instruct patient to clean perineum area with peri bottle after each void to help control the possibility of infection (Phelps, 2020). Rationale: This helps the patient prevent infection 2.Maintain standard precautions. Wear gloves if you might encounter the patient’s blood and body secretions (Phelps, 2020). Rationale: This prevents the spread of germs.</p>	<p>The patient reacted with a nod of agreement. After changing the babys diaper, the patient did hand hygiene.</p>
<p>1. Risk for unstable blood pressure, related to hormonal change, as evidenced by continuous high blood pressure during pregnancy.</p>	<p>Due to the fluctuation of the patients BP during pregnancy.</p>	<p>1.Assess hemodynamic status, including blood pressure, heart rate, oxygen saturation, and respiratory rate for abnormalities. Rationale: May be early indicators of high or low blood pressure (Phelps, 2020). 2.Encourage patient and family to share concerns regarding outcomes of tests. Rationale: To reduce anxiety (Phelps, 2020).</p>	<p>Patients’ blood pressure is maintained within normal limits. Patient remains hemodynamically stable.</p>
<p>1. Knowledge deficit related to safe sleep education as</p>	<p>The patient was co-sleeping with the infant after</p>	<p>1. Communication open and honestly with patient (Phelps, 2020).</p>	<p>The patient exhibited a desire to learn. The patient wondered whether the newborn</p>

<p>evidenced by patient sleeping with infant in hospital bed.</p>	<p>the infant breastfed. The patient was asleep, and the infant was sleeping under the breast.</p>	<p>Rationale: This ensures an understanding between the patient and nurse so there isn't any confusion.</p> <p>2. Educate patient on SIDS (Phelps, 2020).</p> <p>Rationale: Sids is sudden infant death syndrome and sleeping with your infant is a contraindication</p>	<p>should sleep on his on his side or back. (On the back), this was informed and demonstrated with the infant.</p>
<p>1. Knowledge deficit related to infant care as evidence by no previous pregnancies.</p>	<p>Due to patient stating she never took care of a baby.</p>	<p>1. Encourage patient to ask questions and use therapeutic communication (Phelps, 2020).</p> <p>Rationale: This helps ensure the patient is receiving adequate information regarding postpartum.</p> <p>2. Establish priorities and include family as requested (Phelps, 2020).</p> <p>Rationale: This ensures that patient has an input regarding the care of her and her baby.</p>	<p>Patient practice skills. Patient expresses desire to overcome lack of knowledge.</p>

Other References (APA)

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

Wolters Kluwer.