

N432 Postpartum Care Plan

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N432: Maternal-Newborn Care

Professor Bohlen

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Demographics (3 points)

Date & Time of Admission 2/14/24 at 1800	Patient Initials D.A	Age 24	Gender Female
Race/Ethnicity White/Caucasian	Occupation Not employed	Marital Status Single	Allergies No Known Allergies
Code Status Full Code	Height 5'11 (180.3cm)	Weight 167lb (75.8kg)	Father of Baby Involved Father was present for babies' birth.

Medical History (5 Points)

Prenatal History: G5T4P0A1L3 (Gravida 5 Para 3). Patient did not experience any complications with her current pregnancy. Patient states she did not have any complications with her previous pregnancies which were vaginal births. The outcomes of the previous pregnancies are not on file.

Past Medical History: Heart disease, Kidney disease, Postpartum anemia (2/9/22), Potts disease, and Postpartum Hemorrhage (2015).

Past Surgical History: Tonsillectomy

Family History: Family history is not on file. The patient did state her mom has heart problems.

Social History (tobacco/alcohol/drugs): Patient denies tobacco, drug and alcohol use. Patient was positive for amphetamines on February 2, 2024.

Living Situation: Patient states she lives with her significant other and her children.

Education Level: Patient did not complete high-school, she received her GED.

Admission Assessment

Chief Complaint (2 points): Patients presented to ED with complaints of strong contractions.

Presentation to Labor & Delivery (10 points): Client is G5Para3 at 37w6d gestation.

Client presented to labor and delivery with painful contractions on 2/14/24, stating

“contractions grew stronger throughout my ultrasound which is why I came into the

hospital”, the patient has had 3 previous full-term births without problems. The Patient

was positive for amphetamines on 2-2, however, pregnancy has been uncomplicated.

The Patient continued to contract upon arrival and cervix changed from 3 to 4cm. The

patient was admitted to the labor and delivery unit for nurses to rupture membranes and

augment if needed.

Diagnosis

Primary Diagnosis on Admission (2 points): Labor

Secondary Diagnosis (if applicable): Secondary diagnosis not applicable.

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	3.80-5.30u/L	3.56uL	3.56uL	3.56uL	Patient experienced postpartum anemia in the past which means the clients iron is not within normal limits, due to the continuing decrease in RBCs which alters H&H as well. “Untreated postpartum anemia affects the wellbeing of both the mother and

					child. Maternal ID or anemia related complications may impair physical capacity and performance and negatively impact health-related quality of life” (Moya et al., 2022).
Hgb	12.0-15.8 g/dL	9.7 g/dL	9.7 g/dL	9.7 g/dL	Previous postpartum anemia can cause hemoglobin levels to decrease (Moya et al., 2022).
Hct	36.0-47.0%	30.1%	30.1%	30.1%	Hematocrit levels are decreased due to lack of healthy red blood cells this can result from the patients’ previous postpartum anemia incident (Moya et al., 2022).
Platelets	140-440uL	266uL	266uL	266uL	Results are WNL
WBC	4.00-12.00uL	11.40uL	11.40uL	11.40uL	Results are WNL
Neutrophils	47.0-73.0uL	70.0uL	70.0uL	70.0uL	Results are WNL
Lymphocytes	18.0-42.0%	21.5%	21.5%	21.5%	Results are WNL
Monocytes	4.0-12.0%	6.3%	6.3%	6.3%	Results are WNL
Eosinophils	0.0-5.0%	1.6%	1.6%	1.6%	Results are WNL
Bands	0%-3%	Results not uploaded in chart.			

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
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Blood Type	A,B,AB,O	A	A	A	Patient results are WNL
Rh Factor	Positive or Negative	Positive	Positive	Positive	Patient results are WNL
Serology (RPR/VDRL)	Non-reactive	Non-reactive	Non-reactive	Non-reactive	Patient results are WNL
Rubella Titer	Non-immune or immune	Non-immune	Non-immune	Non-immune	Patient results are WNL
HIV	Negative	Negative	Negative	Negative	Patient results are WNL
HbSAG	Negative	Not detected	Not detected	Not detected	Patient results are WNL
Group Beta Strep Swab	Negative	Negative	Negative	Negative	Patient results are WNL
Glucose at 28 Weeks	Below 140	Test was ordered but not completed			
MSAFP (If Applicable)	Varies depending on gestation	Not applicable	Not applicable	Not applicable	Not applicable

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

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

Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Explanation of Findings
Urine Creatinine (if applicable)	N/A				Lab was not done

Lab Reference (1) (APA):

Moya, E., Phiri, N., Choko, A. T., Mwangi, M. N., & Phiri, K. S. (2022). Effect of postpartum anemia on maternal health-related quality of life: a systematic review and meta-analysis. *BMC Public Health*, 22(1). <https://doi.org/10.1186/s12889-022-12710-2>

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

	Your Assessment
History of labor: Length of labor Induced /spontaneous Time in each stage	5 hours Spontaneous First and second stage not recorded, 3 rd stage lasted for 2 minutes.
Current stage of labor	Client is currently in her fourth stage of labor. The fourth stage of labor known as the “recovery stage”. The fourth stage of labor consisted of this nursing

	<p>student monitoring the client's vitals, monitoring for signs of bleeding, making the client comfortable, assessment of fundus (fundus is 2cm below umbilicus & positioned midline), perineal area and overall physical appearance. Additionally, the healthcare team should assist with feedings and educating the client on ways to bond with her newborn. The mother is in the "taking in phase", which involves bonding between the mother and newborn. "The fourth stage of labor is the first hour or two after you deliver. During this time, your provider may have to repair an incision (episiotomy) or tears (lacerations) made during the delivery" (Beth Israel Deaconess Medical Center, 2024). "During the fourth stage, your primary nurse will monitor your blood pressure, pulse, and temperature" (Beth Israel Deaconess Medical Center, 2024). "She or he will also check to see how well contracted the top of your uterus (fundus) is and the amount of bleeding (lochia) you are having from your vagina" (Beth Israel Deaconess Medical Center, 2024). "Most often, right after delivery, your baby will be placed on your abdomen, your primary nurse will dry and wrap</p>
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	<p>the baby in a blanket for warmth” (Beth Israel Deaconess Medical Center, 2024). “Your nurse will also suction any secretions from your baby's mouth (Beth Israel Deaconess Medical Center, 2024). “The nurse will weigh your baby, check the vital signs (temperature, heart rate, and breathing), and perform an initial examination” (Beth Israel Deaconess Medical Center, 2024). “Your primary nurse will also help you to initiate breast-feeding, if that is your intention” (Beth Israel Deaconess Medical Center, 2024). “Within about two hours after delivery, your baby will be transferred to the newborn nursery, and you will be transferred to a postpartum (after childbirth) room, where you will spend the remainder of your hospital stay” (Beth Israel Deaconess Medical Center, 2024). During the fourth stage of labor and delivery it is normal to notice “tremors, chills, discomfort from pain, dizziness especially while standing up, difficulty urinating due to swelling in the genital area” (Radhakrishnan, 2021). Abnormal findings during the fourth stage of labor include: excessive bleeding, intense or increasing abdominal pain, and s/s of</p>
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	<p>infection. There are many risk factors for postpartum hemorrhage such as “retained placental tissue: This is when the entire placenta doesn't separate from your uterine wall. It's usually caused by conditions of the placenta that affect your uterus's ability to contract after delivery” (Cleveland Clinic, 2022).</p> <p>Another risk factor for PPH is “Blood clotting condition (thrombin): If you have a coagulation disorder or pregnancy condition like eclampsia, it can interfere with your body's clotting ability, this can make even a tiny bleed uncontrollable” (Cleveland Clinic, 2022). Signs and symptoms of a postpartum infection include: A temperature of 100.4, redness, warmth, (especially near an incision site) tachycardia, vaginal odor, green discharge, and painful urination are signs that can indicate infection.</p> <p>“Postpartum mood disorders pose significant challenges to women's mental health and well-being during the postpartum period” (Garapati et al., 2023).</p> <p>Risk factors for postpartum mood disorders include: hormonal changes, client previously diagnosed with depression, family history of depression or anxiety, lack of family support, and financial difficulties.</p>
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Stage of Labor References (2) (APA):

Beth Israel Deaconess Medical Center. (2024). *Stages of Labor*. Wwww.bidmc.org.

<https://www.bidmc.org/centers-and-departments/obstetrics-and-gynecology/programs-and-services/pregnancy/labor-and-delivery/stages-of-labor#:~:text=The%20fourth%20stage%20of%20labor%20is%20the%20first%20hour%20or>

Cleveland Clinic. (2022, January 3). *Postpartum Hemorrhage: Causes, Risks, Diagnosis & Treatment*. Cleveland Clinic. <https://my.clevelandclinic.org/health/diseases/22228-postpartum-hemorrhage>

Garapati, J., Jajoo, S., Aradhya, D., Reddy, L. S., Dahiphale, S. M., & Patel, D. J. (2023). Postpartum Mood Disorders: Insights into Diagnosis, Prevention, and Treatment. *Cures*, 15(7). <https://doi.org/10.7759/cureus.42107>

Radhakrishnan, R. (2021). *What Are the 4 Stages of Labor?* *Childbirth*. MedicineNet. https://www.medicinenet.com/what_are_the_4_stages_of_labor/article.htm

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

Home Medications (2 required)

Brand/Generic	Acetaminophen/Tylenol	Prenatal vitamin/prenatal multivitamin			
Dose	975mg	1mg			

Frequency	Q6 PRN	Once a day			
Route	Oral	Oral			
Classification	“Antipyretic, nonopioid analgesic” (Jones & Bartlett Learning, 2023).	Dietary supplements.			
Mechanism of Action	“Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system” (Jones & Bartlett Learning, 2023).	“This medication is a multivitamin and iron product used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy Vitamins and iron are important building blocks of the body and help keep you in good health” (WebMD, 2024).			
Reason Client Taking	Client takes this when she is experiencing mild to moderate pain.	Taking prenatal with iron allows the clients body to replenish blood supply.			
Contraindications (2)	Hepatic impairment Hypersensitivity to acetaminophen & its components (Jones & Bartlett Learning, 2023).	Contraindicated in patients experiencing Alcohol abuse and patients with liver problems (WebMD, 2024).			
Side Effects/Adverse Reactions (2)	Hypotension Headache (Jones & Bartlett Learning, 2023).	Stomach upset Constipation N/V Headache			

		(WebMD, 2024).			
Nursing Considerations (2)	“Monitor renal function in patients on long term therapy” (Jones & Bartlett Learning, 2023). Ensure you are giving the correct dosage before administration.	Monitor client for swelling Monitor clients’ overall well-being & monitor vitals (WebMD, 2024).			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor AST, ALT, Bili, and Creatinine levels.	Monitor CBC.			
Client Teaching needs (2)	Teach client that tablets may be crushed, “teach client to recognize signs of hepatotoxicity; such as bleeding, easy bruising and malaise” (Jones & Bartlett Learning, 2023).	Teach the client to take the prenatal vitamin along with a well-balanced diet. This medication is best taken on an empty stomach 1 hour before or 2 hours after meals (WebMD, 2024).			

Hospital Medications (5 required)

Brand/ Generic	Benzocaine menthol/Desmoplast	Hydrocortison e/Cortaid	Lansinoh/ Lanolin cream	Ibuprofen/ Motrin	Pitocin/ Oxytocin
Dose	1 spray	1% cream apply small amount to area	Apply pea size amount	600mg	30 units/500 ml admin dose 0.06-0.3units
Frequency	PRN Q4	PRN Q6	Q1 PRN	Q6 PRN	Continuou s
Route	Topical	Topical	Topical	Oral	IV

Classification	Topical anesthetics	Topical corticosteroid	Topical emollients	NSAID	Uterotonic agent
Mechanism of Action	“Benzocaine is a local anesthetic (numbing medication). It works by blocking nerve signals in your body” (Multum, 2023).	“hydrocortisone is a topical (for the skin) a steroid medicine that is used to treat inflammation and itching caused by skin conditions that respond to steroid medication” (Multum, 2023).	“Lansinoh for Breast Feeding Mothers (for the skin) is used to treat or prevent dry skin, itching or other skin irritation caused by conditions such as diaper rash, radiation therapy skin burns, and others” (Multum, 2023).	“Blocks activity of cyclooxygenase the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling and vasodilation” (Jones & Bartlett Learning, 2023).	“Pitocin is a hormone that is used to induce labor or strengthen uterine contractions, or to control bleeding after childbirth” (Multum, 2022). “Pitocin is also used to stimulate uterine contractions in a woman with an incomplete or threatened miscarriage” (Multum, 2022).
Reason Client Taking	Peri pain	Hemorrhoids	Dry skin	To relieve cramping	To reduce bleeding and help prevent PPH.
Contraindications (2)	This drug is contraindicated	Contraindicated in patients	Contraindicated in	Contraindicated in	Contraindicated in

	ed in patients with methemoglobinemia, and clients who have heart disease (Multum, 2023).	with hypersensitivity to hydrocortisone, and patients with fungal infections (Multum, 2023).	patients with deep wounds, and patients showing signs of infection (Multum, 2023).	patients with asthma, and patients that experience bronchospasms (Jones & Bartlett Learning, 2023).	clients with cervical cancer and heart problems (Multum, 2022).
Side Effects/Adverse Reactions (2)	Itching, and redness (Multum, 2023).	Dryness, and numbness (Multum, 2023).	Hives, & bleeding (Multum, 2023).	Dizziness, & Epistaxis (Jones & Bartlett Learning, 2023).	Excessive bleeding, severe headache (Multum, 2022).
Nursing Considerations (2)	Monitor client for confusion and assess clients' temperature for signs of infection (Multum, 2023).	Monitor clients blood sugar and assess clients LOC (Multum, 2023).	Monitor client for signs of allergic reaction (Multum, 2023). View patients' current medication list, and check to see if the drug is contraindicated with the patients' other medication	"This drug increases the risk of premature closure of the fetal ductus arteriosus if given at 30 weeks or later during pregnancy" (Jones & Bartlett Learning, 2023). "This drug should be avoided in patients with recent MI"	Document and assess the clients' response to the medication, Consider that the clients blood pressure can decrease or increase while taking this medication (Multum,

			(Multum, 2023).	(Jones & Bartlett Learning, 2023).	2022).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess clients O2, assess skin (Multum, 2023).	Assess clients' skin prior to giving this medication (Multum, 2023).	Assess clients' vitals (Multum, 2023).	Monitor clients H&H	Monitor patients bleeding, and blood pressure (Multum, 2022).
Client Teaching needs (2)	"Avoid using the medicine on skin that is raw or blistered, such as a severe burn or abrasion" (Multum, 2023). "Avoid getting this medication in your eyes" (Multum, 2023).	"Teach client to wash their hands before and after applying" (Multum, 2023). Teach client to shake this spray well before using (Multum, 2023).	Teach client to notify provider if bradypnea occurs, Teach the client to assess their body for any open wounds prior to taking this medication (Multum, 2023).	Client should take this medication with water. Patient should follow the prescription on the medication do not exceed the dosage (Jones & Bartlett Learning, 2023).	Teach client to notify the provider if severe headache persists. Inform client to check with provider before taking OTC meds and vitamins (Multum, 2022).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2023). *2023 Nurse's Drug Handbook*. (21st ed.). Jones & Bartlett Learning.

Multum, C. (2023, December 21). *Benzocaine topical Uses, Side Effects & Warnings*.

Drugs.com. <https://www.drugs.com/mtm/benzocaine-topical.html>

Multum, C. (2023, December 21). *Hydrocortisone topical Uses, Side Effects & Warnings*.

Drugs.com. <https://www.drugs.com/mtm/hydrocortisone-topical.html>

Multum, C. (2023, March 6). *Lansinoh for Breast Feeding Mothers Uses, Side Effects & Warnings*. Drugs.com. <https://www.drugs.com/mtm/lansinoh-for-breast-feeding-mothers.html>

Multum, C. (2022, November 13). *Pitocin Uses, Side Effects & Warnings*. Drugs.com. <https://www.drugs.com/mtm/pitocin.html>

WebMD. (2024). *Drugs & Medications*. www.webmd.com.
<https://www.webmd.com/drugs/2/drug-19981-280/prenatal-vitamin-oral/multivitamins-w-iron-includes-prenatal-vitamins-oral/details>

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	Patient alert and oriented X4 Patient does not appear to be in distress overall the patient does appear to be tired, patient does not appear to be well groomed.
INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: 22 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Patients skin is white warm and intact. Patient skin turgor is normal, skin does not remain tinted. Patient does not have any rashes or bruises. Patient does not have any wounds but does have a small laceration on her left labia. Patients Braden score is 22 No drains present
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Head and neck appear midline, no nodules noted in neck. Head is symmetrical no lumps or abnormalities noted. Patients' eyes are clear of drainage, sclera is white, conjunctiva pink and moist. PERLA noted. Nose is midline, teeth are white.
CARDIOVASCULAR (2 point):	Patients heart sounds are normal, S1 and

<p>Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>S2 heard no murmur or gallops heard. Peripheral pulses are 2+. Cap refill<3secs, no NVD, or edema noted.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Lung sounds were heard anteriorly and posteriorly, lung sounds clear bilaterally no crackles or wheezing noted.</p>
<p>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:</p>	<p>While pregnant the patient stated she ate mostly fruits and vegetables because she couldn't keep down heavier foods. Patient states she can currently eat anything she wants, such as pizza, chicken and burgers. Patient is 5'11 and weighs 167lb.</p> <p>Patients' bowel sounds were listened to in all four quadrants and were active. Patients last BM was 2/12/24. Upon palpitation there were no masses patient did not experience any pain upon palpation.</p> <p>There are no incisions, abdominal distention, scars, drains or wounds noted throughout observation.</p>
<p>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:</p>	<p>Patient urinates 30cc or more an hour, Urine is yellow no smell noted, patient does not experience pain with urination. Genitals appear normal. Patient does not have a catheter.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input 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"/></p>	<p>Patient does not need ADL assistance, patient is a fall risk, fall score is 10. Patients' activity level is as tolerated. Patient does not need assistance with equipment and is able to walk on her own (independently).</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>Patient MAEW, PERLA intact, strength is equal bilaterally on both her arms and legs. Patients is</p>

<p>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:</p>	<p>oriented x4 Mental status appears normal no emotional distress noted. Patients' speech and sensory level is normal. Patient LOC is normal and appears to be alert at all times. no concerns noted. Patients DTR are 2+ bilaterally.</p>
<p>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):</p>	<p>Patient states she copes by spending time with family Intimacy vs isolation Patient does not have a religion she follows Patient states she receives support from her mother and significant other. Patient lives at home with her significant other.</p>
<p>Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:</p>	<p>Patients' fundus is 2cm below umbilicus, fundus is midline. 440 mL Lochia color is rubra No odor noted Laceration located on left labia</p>
<p>DELIVERY INFO: (1 point) Rupture of Membranes: Time: Color: Amount: Odor: Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>Artificial rupture of membranes 18:55 Clear Not documented None 02/24/24 2355 Vaginal 440 mL Male 8/9 6 lbs. 11oz (3033 g) Bottle fed</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	94	115/59	Respirations not recorded in chart.	97.9F	100
Labor/Delivery	102	94/52	Respirations not recorded in chart.	97.8F	100
Postpartum	72	102/51	20	97.7F	98

Vital Sign Trends: Vitals were in normal limits for prenatal

and postpartum period. During labor and deliver Patients Pulse was elevated along with a decreased BP. Pulse elevation is usually elevated in the labor/delivery process.

Patient stated she experiences hypotension after giving birth.

Pain Assessment, 2 sets (2 points)

2 hours After the ibuprofen was give the patient stated she is not currently experiencing pain.

Time	Scale	Location	Severity	Characteristics	Interventions
9:00am	1-10	Abdomen	5	Dull cramping pain	Ibuprofen given
12:00pm	1-10	Abdomen	6	Dull cramping pain	Tylenol give

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:	20G Left posterior hand 2/14/24 Patent/Saline locked No signs or erythema, drainage, or infiltration. IV dressing is clean, dry and intact

Intake and Output (2 points)

Intake	Output (in mL)
Intake not documented but client did eat 100% of her breakfast and drank 24oz.	440 blood output
IV fluid not documented.	530 cc of 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.
Monitor how much the client is bleeding.	The client should be checked every few hours for vaginal bleeding, and every 15-30 minutes if at risk for PPH.	The client has a decreased H&H. Bleeding should be monitored to ensure the patient isn't losing too much blood, which can lead to decreased LOC.
Client should increase activity as tolerated.	Activity should be increased as tolerated. Client should be moving at least Q2.	Increasing activity can help prevent blood clots and improve the clients blood circulation.

Clients BP should be monitored to prevent hypotension.	Clients BP should be assessed every 2-4 hours.	This intervention was provided for the client because the clients blood pressure has been low. Low blood pressure in postpartum patients can cause dizziness, and confusion.
Assess clients' labial laceration.	Regularly, & if client states she is experiencing irritation near the laceration site.	This intervention is pertinent to the client as an incision site can become infected. The laceration should be monitored for redness, warmth and drainage.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking in phase

What evidence supports this? The mother is spending time resting and recovering, the patients' family stopped by to feed the baby while mom relaxed and ate her lunch.

"This phase, taking-in phase, may last for a day or two" (Brookside Associates, 2020).

"The nurse should plan activities so that the patient can rest as much as possible because failure to allow the patient to receive the necessary and earned rest may yield a "sleep hunger" which may be manifested by irritability, fatigue, and general interference with the normal restorative process" (Brookside Associates, 2020). "The father's role is primarily being supportive of his wife and his family" (Brookside Associates, 2020).

Discharge Planning (3 points)

Discharge location: Home with significant other

Equipment needs (if applicable): None

Follow up plan (include plan for mother AND newborn): Newborn is to go to the pediatrician within the next 24-48 hours. The mothers follow up plan is to visit her healthcare provider within 4-6 weeks to assess moms physical, mental and emotional status.

Education needs: Client should be reminded to drink adequate amounts of water, abstain from inserting anything in the vagina for 6 weeks, Notify the provider if laceration site begins to burn or swell, client should be urinating at least 30cc an hour, client should be maintaining a healthy nutritious diet, client should increase activity levels as tolerated.

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

<p>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</p>	<p>Rational (1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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.</p>	<p>Evaluation (2 pt each) How did the patient/family respond to the nurse’s actions? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan. </p>
<p>1. Decreased H&H related to prior postpartum anemia as evidenced by</p>	<p>This nursing diagnosis was chosen because decreased blood cells</p>	<p>1.Screen client for bleeding risk factors. Rationale “Some individuals know risk factors for bleeding, others do not” (Phelps,</p>	<p>The client understands that her H&H is not within normal limits, the client is interested in improving her CBC</p>

<p>hemoglobin being 9.7g/dl and hematocrit being 30.1%.</p>	<p>can lead to fatigue and decreased energy levels. Client had previous postpartum anemia and this could possibly still be affecting the clients' CBC.</p>	<p>2020). It is important to prevent and correct decreased blood levels. 2."Monitor physiological responses such as; vitals, O2 levels, and LOC" (Phelps, 2020). Rationale "Early bleeding compensatory mechanisms alter respirations, pulse, blood pressure, and subtle changes" (Phelps, 2020), signs of bleeding can be detected by completing the previously stated assessments.</p>	<p>values. Outcome: clients H&H will be WNL. No modifications added to clients' plan.</p>
<p>2. Risk for postpartum depression related to clients' children being turned over to DCFS as evidenced by client being sad when her newborn was taken away.</p>	<p>This nursing diagnosis was chosen because many mothers experience PPD and this client is at risk because she is unable to bond with her newborn.</p>	<p>1. Refer client to a psychiatrist or a therapist Rationale Referring the client to a therapist will assist the client with developing coping strategies while promoting the clients healing process. "It may help to talk through your concerns with a psychiatrist, psychologist or other mental health professional" (Mayo Clinic, 2022). "Through therapy, you can find better ways to cope with your feelings, solve problems, set realistic goals and respond to situations in a positive way" (Mayo Clinic, 2022). 2. Assess the clients' mental status and behavior. Rationale "PPD may lead to poor</p>	<p>Client is aware of the situation and appears to be upset, family did leave the clients room when asked by the nurse. Patient did not seem like she was ready to change her ways. Outcome: clients' drug test will be negative. No modifications were added to the clients' plan.</p>

		maternal-infant bond, failure of breastfeeding, negative parenting practices, marital discord, as well as worse outcomes concerning child physical and psychological development” (Mughal et al., 2021). Due to this, assessing the clients’ mental status can assist the healthcare team with understanding the clients’ symptoms and identifying an appropriate treatment plan before the clients’ depression worsens.	
<p>3. Knowledge deficit related to bottle feeding as evidenced by the client not knowing how much to feed newborn.</p>	<p>This nursing diagnosis was chosen due to the patients lack of understanding on how much the baby should be getting fed. It is important for newborns to receive an adequate feeding which promotes grown and effective output.</p>	<p>1. “Monitor the baby’s weight” (Wagner, 2023). Rationale “Weight gain is the main factor when evaluating an infant’s development” (Wagner, 2023). Monitoring the newborns weight allows the healthcare team to figure out if the newborn is receiving an adequate amount of nutrition. 2. “Ask the patient to verbalize the signs of hunger in babies” (Wagner, 2023). Rationale “Babies give signs that they are hungry. Initially, the baby may display the following to signal that they are ready to be fed:</p> <ul style="list-style-type: none"> • Rooting • Sticking out their tongue • Licking their lips • Placing hands in 	<p>Client seemed to be interested in learning how much the newborn should eat and asked questions about over feeding her baby. Outcome: newborn will maintain a healthy weight.</p>

		<p>their mouth</p> <ul style="list-style-type: none"> • Sucking on things • Fussiness • Crying (late sign)” (Wagner, 2023). <p>Noticing these signs will ensure that the newborn is being fed in a timely manner.</p>	
<p>4. Knowledge deficit related to laceration as evidenced by lack of knowledge about signs of infection.</p>	<p>This nursing diagnosis was chosen because it is important for the client to be able to recognize signs of infection. Early detection of infection is important to prevent further complications.</p>	<p>1. Teach the client how to perform Kegel exercises (Wayne, 2023). Kegels help with building the pelvic floor muscle. (Wayne, 2023). Rationale “These exercises improve pelvic floor muscle tone and ureterovesical junction sphincter tone, thereby reducing or eliminating episodes of incontinence” (Wayne, 2023). 2. “Encourage water intake” (Wagner, 2021). Rationale Proper hydration promotes wound healing. “Optimal hydration helps to reduce inflammation and swelling after an injury, brings increased blood flow and delivery of nutrients to the injured area, and aids in the removal of waste products” (Reiner, 2023).</p>	<p>Client stated that she understands the importance of recognizing signs of infection. Outcome: patient will not experience signs of infection.</p>

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