

N432 Postpartum Care Plan

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Lakeview College of Nursing

N432: Maternal-Newborn Care

Professor Bohlen

2/15/2024

Demographics (3 points)

Date & Time of Admission 2/13/2024 1457	Patient Initials D. D. P.	Age 33	Gender Female
Race/Ethnicity African American	Occupation “ I run my own business”	Marital Status Single	Allergies NKA
Code Status Full	Height 5’ 7” (170.2 cm)	Weight 186 lbs (84.5 kg)	Father of Baby Involved Father not involved but support partner is involved

Medical History (5 Points)

Prenatal History: No prenatal issues with previous pregnancies. This pregnancy, the doctor was concerned with a fetal abnormality noted in an ultrasound so opted to induce at 38 weeks and 3 days. **Gravida**= 6, **Term**= 3, **Preterm**= 3, **Abortion**3, **Living**= 3-**these numbers don’t add up correctly.**

Past Medical History: Asthma, Genital Herpes, Anemia, Anxiety

Past Surgical History: Patient states she has had no past surgical history. Nothing noted in her chart about past surgeries.

Family History: Patient states she doesn’t know of a family history of illness. Patient states she wasn’t raised by her family.

Social History (tobacco/alcohol/drugs): Patient states she quit smoking in 2016 and only uses nicotine patches, doesn’t do recreational drugs or consume alcohol.

Living Situation: Patient states she lives in Danville, in a house she shares with her boyfriend.

Education Level: High school diploma

Admission Assessment

1/2/2024

Chief Complaint (2 points): Induction

Presentation to Labor & Delivery (10 points): Patient states: “I was at my prenatal appointment yesterday and I was getting an ultra sound. I was 38 weeks and so that’s why I was getting an ultra sound done. There wasn’t anything wrong that I could sense. The doctor looked at my ultrasound and was concerned about a possible fetal abnormality seen in the ultrasound. My doctor wanted to admit me and induce me to make sure the baby was ok”.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction

Secondary Diagnosis (if applicable): No other concerns were complicating the pregnancy other than possible fetal abnormality noted in ultrasound.

Laboratory Data (15 points)

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

Lab	Normal Range	Prenatal Value	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30 10(6)/uL	3.76	3.6	3.43	Patient has a diagnosis of Anemia (Pagana et al., 2022).
Hgb	11.0-16.0 g/dL	11.3	10	9.8	Patient has a diagnosis of Anemia (Pagana et al., 2022).
Hct	34-47%	34.3	31.9	30.0	Patient has a diagnosis of Anemia (Pagana et al., 2022).
Platelets	140-440 10(3)/uL	377	370	344	
WBC	4.0-11.0 10(3)/uL	10.7	11.3	10.7	Patient has a diagnosis of Genital Herpes and takes Valtrex (Pagana et al., 2022). Is this patient having an outbreak or is she experiencing a severe

					reaction to medication?
Neutrophils	47.0-73.0%	75.1	76.4	70.7	
Lymphocytes	18.0-42.0%	16.0	14.2	19.7	Patient has a diagnosis of Genital Herpes and takes Valtrex (Pagana et al., 2022). Is this patient having an outbreak or is she experiencing a severe reaction to medication?
Monocytes	4.0-12.0%	6.6	7.5	6.9	
Eosinophils	0.0-5.0%	2	1.7	2.5	
Bands	N/A	N/A	N/A	N/A	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
Blood Type	A, B, AB, O,	O	O	O	
Rh Factor	+, -	+	+	+	
Serology (RPR/VDRL)	Positive/Negative	10/13/23 Positive	12/8/23 Negative	Waiting on results	Labs were drawn on 2/14/24 related to possible false positive lab on 10/13/23. What could have caused the result to be positive?
Rubella Titer	Immune Not Immune	Immune	Not drawn	Not drawn	
HIV	Positive/Negative	Negative	Negative	Negative	
HbSAG	Positive/Negative	Not detected	Not drawn	Not drawn	
Group Beta Strep Swab	Positive/Negative	Negative	Not drawn	Not drawn	
Glucose at 28 Weeks	<140	No value noted	No value noted	No value noted	Due to change in prenatal provider this lab was missed.
MSAFP (If Applicable)	N/A	N/A	N/A	N/A	

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

Lab Test	Normal Range	Prenatal Value	Value on Admission	Today's Value	Reason for Abnormal
					No other abnormal test noted for this patient

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)					Urine Creatinine was not done for this patient

Lab Reference (1) (APA):

Pagana, K.D., Pagana T.J., & Pagana, T. P. (2022) *Mosby's Diagnostic and Laboratory Test Reference* (16th 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	Length of labor was 53 minutes total. Patient was induced and spent 25 minutes in the first stage of labor, 25 minutes in the second stage of labor, and 3 minutes in the third stage of labor.

Current stage of labor	Post 4 th stage

In the F first stage of labor, the mother's body starts to prepare for delivery of her baby (Ricci et al., 2021). The mother's cervix will start to dilate and will be complete when the mom reaches 10 cm and 100% effacement (Ricci et al., 2021). Spacing This mother was induced due to a possible fetal abnormality noted on her 38 week ~~ultra-sound~~ ultrasound. Possible fetal abnormalities noted at 35-37 weeks gestation could include but are not limited to: ~~-don't need-~~ hydronephrosis, mild ventriculomegaly, ventricular septal defect, and duplex kidney (Ficara et al., 2020). Nothing was noted in the mother's chart about what possible ~~abnormality was~~ abnormalities were seen, and no abnormalities were documented on the baby after delivery. This mother had her membrane ruptured on 2/13/2024 there were no noted abnormalities with the amniotic fluid. The Fluid was clear, and no odor was noted. This mother also received an epidural during her first stage of labor. According to the documentation, this mother spent 25 minutes in the first stage of labor.

The second stage of labor is ~~when where~~ the baby ~~has crowned~~ begins to crown and the mom is ready to push. The second stage of labor ends after the baby is delivered (Ricci et al., 2021). This mother spent 25 minutes in the second stage of labor. The third stage of labor starts after the baby has been delivered to the delivery of the placenta (Ricci et al., 2021). This mother spent 3 minutes in this stage of labor.

The fourth stage of labor lasts 1 to 4 hours post-delivery of the baby and placenta (Ricci et al., 2021). I started to care for mom at 30.33 hours post-delivery. Documentation did not note anything remarkable during the delivery process. Mom is taking care of herself and is very attentive to her baby. Though she had an uncomplicated delivery, mom is still at risk for ~~postpartum~~ postpartum hemorrhage, and infection and she is also at risk for postpartum mood disorders (Ricci et al., 2021). The mom's weight puts her at an increased risk for hemorrhage and DVT. Mom also has a diagnosis of anemia, which she is being treated for. Mom's postpartum vitals were in the normal range: BP 117/76, P 74, R 18, T 98.5 oral, O2 98% on room air. As of the date of clinical, mom did not show signs or symptoms of hemorrhage. Mom is on an antiviral for genital herpes, which further increases her risk for infection related to a depressed immune system. As of date of clinical, mom did not have signs or symptoms of infection. Mom's mood was upbeat and euphoric, though this can change as hormone levels change. Mom's mood and demeanor did change when her significant other showed up to spend the day with her at the hospital. Mom's fundal assessment was noted to be two finger widths below the umbilicus, midline, and firm. Mom was passing scant, rubra, lochia without clots. Mom did have some complaints of abdominal cramping and was provided Tylenol, which provided her relief. This student nurse provided hydration for mom, obtained assessment information on mom, provided requested supplies for baby, and encouraged mom to make sure she kept up on her nutrition intake since she only ate 25% of her breakfast.

The Taking-In Phase "is the time immediately after birth when the mom needs sleep and depends on others to help her make decisions and helps with care" (Ricci et al., 2021, p 529). This phase can last 1 to 2 days postpartum. This is also the time where when the mom identifies herself in with her baby like claiming the baby has her dark eyes and the baby has her nose

(Ricci et al., 2021). This patient doted over her baby but also depended on the help of her significant other as soon as he arrived and allowed staff to assist her with her care and care of the baby. This patient did express how much her son had her nose and dark eyes.

Stage of Labor References (2) (APA):

Ficara, A., Syngelaki, A., Hammami, A., Akolekar, R., & Nicolaides, K. H. (2020). Value of routine ultrasound examination at 35–37 weeks' gestation in diagnosis of fetal abnormalities. *Ultrasound in Obstetrics & Gynecology*, 55(1), 75-80.

<https://doi.org/10.1002/uog.20857>

Ricci, S. S., Kyle, T., & Carman, S. (2021). *Maternity and pediatric nursing* (4th ed., pp. 529). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Ferrous Sulfate	Valacyclovir (Valtrex)			
Dose	324mg Extended Release	1gm			
Frequency	Daily	Daily			
Route	PO	PO			
Classification	Antianemic (Jones & Bartlett Learning, 2022).	Antiviral (Pope, 2023).			

Mechanism of Action	“Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored” (Jones & Bartlett Learning, 2022).	“Inhibits DNA synthesis and viral replication by competing with deoxyguanosine triphosphate for viral DNA polymerase and being incorporated into viral DNA” (Pope, 2023)			
Reason Client Taking	Anemia	Genital Herpes			
Contraindications (2)	Hemolytic anemias or other anemic conditions	Taking NSAIDs with this medication can reduce the effectiveness of this medication. Hypersensitive reactions to this drug or its components			
Side Effects/Adverse Reactions (2)	GI upset Dyspnea/wheezing	GI upset Headache disorder			
Nursing Considerations (2)	Instruct patient to take on an empty stomach unless GI reaction occurs. Instruct to take with orange juice.	Instruct patient to drink plenty of fluid while taking this medication so it doesn't build up in the kidneys. Instruct patient to take the medication exactly as directed and at the exact time it is prescribed for even if they are showing improvement in symptoms.			

Key Nursing Assessment(s)/Lab(s) Prior to Administration	CBC, serum iron and ferritin	Monitor kidney function and liver function before and while on the medication.			
Client Teaching needs (2)	<p>“Educate patient to avoid foods like dairy products, eggs, spinach, and high fiber foods that impair iron absorption” (Jones & Bartlett Learning, 2022).</p> <p>“Educate patient to eat chicken, fish, lean red meat, and turkey, as well as foods rich in vitamin C to improve iron absorption” (Jones & Bartlett Learning, 2022).</p>	<p>“Those with genital herpes or cold sores should avoid sexual contact until the course of treatment is finished during active outbreaks. When not in an active outbreak a condom should be utilized because herpes can be spread in absence of symptoms” (Pope, 2023)</p>			

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Albuterol (Proventil, Ventolin)	Oxytocin (Pitocin)	Nicotine (Nicoderm CQ)	Ibuprofen (Motrin)
Dose	975 mg	2.5mg	30units/500 ml	21mg	600mg
Frequency	Every 6 hours PRN	Every 6 hours PRN	continuous	Change every 24 hours	Every 6 hours PRN
Route	PO	Nebulization	IV	Topical Patch	PO
Classification	Analgesic	bronchodilator	Oxytocic or uterotonic agents	Smoking cessation agent	NSAID
Mechanism of		“To relax	“Oxytocin	“Nicotine, a	“NSAID

Action	“Analgesic that blocks COX enzymes in the brain/ used to treat pain and fever” (Jones & Bartlett Learning, 2022).	bronchial smooth muscle cells and inhibit histamine release” (Jones & Bartlett Learning, 2022).	stimulates uterine contraction by activating G-protein-coupled receptors that trigger increases in intracellular calcium levels in uterine myofibrils. Oxytocin also increases local prostaglandin production, further stimulating uterine contraction” (Medicine.com, 2020)	naturally occurring alkaloid, binds stereoselectively to nicotinic-cholinergic receptors at the autonomic ganglia, in the adrenal medulla, at neuromuscular junctions, and in the brain” (Medicine.com, 2020).	that blocks COX enzymes/ used to treat pain and fever and reduce inflammation” (Jones & Bartlett Learning, 2022).
Reason Client Taking	Pain relief	Asthma	Hemorrhage prevention	Nicotine dependence	Pain relief
Contraindications (2)	“Taking other medications that contain Tylenol. Those who have a hypersensitivity to ibuprofen” (Jones & Bartlett Learning, 2022).	“No adequate studies have been done determining infant risk during breastfeeding. Hypersensitivity to albuterol or its components” (Jones & Bartlett Learning, 2022).	“Receiving this medication for over 24 hours. Hypersensitivity to Oxytocin oxytocin or its components” (Medicine.com, 2020).	“Hypersensitivity to nicotine or any component of the formulation. Contraindicated if you are allergic to soya” (Medicine.com, 2020).	Those who have asthma and those who have a hypersensitivity to ibuprofen (Jones & Bartlett Learning, 2022).
Side	GI upset and	May make	Nausea/	GI upset and	GI upset

Effects/Adverse Reactions (2)	decreased urination	the patient feel jittery, may cause an increase in heart rate	Vomiting Severe headache	abnormal dreams	and dizziness
Nursing Considerations (2)	Monitor pain levels before and after administration. Monitor for bleeding in stools.	Monitor lung sounds prior to administration, monitor for tolerance build up with prolonged use.	“Monitor for excessive bleeding and vital signs. Educate the patient on the importance of reporting if they feel dizziness, SOB, weakness on one side, or vision changes as these could indicate a serious reaction” (Medicine.com, 2020).	Make sure previous patch has been removed before new one applied. Monitor for s/sx s/s-spell out of nicotine toxicity.	Monitor pain levels before and after administration. Monitor for bleeding in stools.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Renal and hepatic labs	Monitor serum potassium levels with this medication	I&O during administration and maternal vital signs (Medicine.com, 2020)	Monitor that patient is not smoking while using the patch in order to prevent nicotine toxicity.	Renal labs and cardiac function
Client Teaching needs (2)	Educate to take with food and plenty of water. Educate to report black tarry stools as this could be a sign of bleeding.	Educate to wash mouth mouthpiece weekly. Educate to take all of the nebulizer treatment until no	Educate that the medication is given to stop or treat bleeding after birth. Educate to notify nursing staff if they are	Educate to change the patch every 24 hours. Educate to not smoke while also wearing a patch due to possible nicotine	Educate to take with food and plenty of water. Educate to report black tarry stools as this could be a sign of bleeding.

		more medication can be seen.	soaking through one pad an hour.	toxicity.	
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Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2022 Nurse's drug handbook* (19th ed. Pp 77-80, 622-624, 1469). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:	Patient is A&Ox4 with no apparent distress noted. Overall appearance is well groomed.
INTEGUMENTARY (1 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:	Skin color is usual for ethnicity, moist, warm to touch with turgor less than 3 seconds. No rashes, bruises or wounds/incisions noted. Braden score is 23 which is low risk for skin break down. No drains present.
HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Patient declined an in depth assessment of her head and neck. I observed symmetry of her head and face. Eyes were without drainage and redness. Ears were without drainage and patient stated she can "hear just fine". Nose was without drainage and septum appears midline. Patient stated she has her own teeth and doesn't have any problems with them. Teeth appeared white and clean when patient was speaking with this student. No halitosis noted.
CARDIOVASCULAR (2 point): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses:	Heart sound normal with S1 and S2 heard. Rhythm was normal. Peripheral pulses 3+ and normal. Capillary refill less than 3 seconds. Absent of edema and neck vein distention.

<p>Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respirations regular and unlabored. Lung sounds clear inspiratory and expiratory. No accessory muscles used.</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>Current diet and diet at home is a regular diet with thin liquids. Patient is 170.2 cm and 84.5 kg. Bowel sounds active in all four quadrants. Last BM was 2/13/2024. No complaints of pain upon palpation or deep palpation. No abnormal findings upon inspection. No drains used.</p>
<p>GENITOURINARY (2 Points): Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>Patient takes herself to the bathroom. No complaints of pain, burning, or frequency/urgency with urinating. Patient did not allow me to physically examine her genitals. Patient doesn't have a catheter at this time.</p>
<p>MUSCULOSKELETAL (1 points): ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: 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 doesn't require ADL assistance at this time. Fall risk is low with a fall score of 15. Up ad lib and doesn't require equipment or support to stand and walk.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech:</p>	<p>Patient did not allow me to perform MAEW, PERLA, or strength test. Patient is A&Ox4 with no apparent distress noted. Speech is clear and patient is alert answering questions appropriately.</p>

Sensory: LOC: DTRs:	
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>Patient states she has her boyfriend she can “lean on” if she needs to. She is at Intimacy vs. Isolation stage of development. She is able to read and write as well as form full structured sentences and makes informed decisions. Patient stated that when she was younger she went to church and believed in God but she doesn’t really practice anything religious as an adult. Patient states she does have contact with her sisters if she needs help her boyfriend cannot support her with emotionally but over all she relies on him because he is truly there for her. Patient states she feels safe at home and isn’t being abused by anyone.</p> <p>This student observed a noticeable mood change from when the patient was alone to when her boyfriend came for the day. Patient became closed off and short when prior to his presence she was open and talkative.</p>
Reproductive: (2 points) Fundal Height & Position: Bleeding amount: Lochia Color: Character: Episiotomy/Lacerations:	<p>Fundal height is two fingers width below the umbilicus and midline. Scant rubra lochia noted. Patient states she is not passing clots. Patient states she did not have an episiotomy and doesn’t have any lacerations.</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>Membrane was ruptured at 1630 on 2/13/2024. Color of fluid was clear with no odor. No amount was noted. Baby boy was delivered vaginally on 2/14/2024 at 0040. Quantitative blood loss was 330 ml. Apgar score at 1 minute was an 8 and at 5 minutes were 9. Baby weighed 5 pounds 14.9 ounces. Baby is breast feeding and also formula feeding using Similac Sensitive formula.</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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1/2/2024

Prenatal	75	118/78	Nothing Charted	Nothing Charted	Nothing Charted
Labor/Delivery	83	127/80	20	98.5 Oral (36.9)	93% on room air
Postpartum	74	117/76	18	98.5 Oral (36.9)	98% on room air

Vital Sign Trends:

Patient runs a normal blood pressure at baseline, and elevated slightly during labor. No significant changes or abnormal values noted over all for pulse and blood pressure. Not able to assess trend with respiratory rate, temp, or O2 in regards to prenatal verses labor/delivery or postpartum. Labor/delivery and postpartum respiratory rate, temp and oxygen are within normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0755	Number	Abdomen	6/10	Achy and cramping	Tylenol provided
1000	Number		0/10		

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV:	Patient had an 18 G to posterior right hand. No date noted on dressing. No s/s of

Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	infection or infiltration noted. Dressing was C/D/I. IV was removed by this student at 1000 on 2/15/2023. No fluids were running at time of IV assessment.
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Intake and Output (2 points)

Intake	Output (in mL)
250 ml noted intake from breakfast	Voided 2x while I was there at clinical

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.
Tylenol provided M	PRN	Pain to the abdomen rated 6/10,
Removed IV N	1 time	Patient no longer needed IV access
Gave water N	PRN	Encouraged patient to maintain hydration to help with her overall health.
Encouraged Eating all of her breakfast N	PRN	Encouraged food intake to help with breast milk production, healing post partum, and to maintain energy to care for herself and her baby. Patient only consumed 25% of her breakfast.

Phases of Maternal Adaptation to Parenthood (3 point)

What phase is the mother in? Taking-In Phase

What evidence supports this?

Taking-In Phase “is the time immediately after birth when the mom needs sleep and depends on others to help her make decisions and helps with care” (Ricci et al., 2021, p 529).

This phase can last 1 to 2 days postpartum. This is also the time where mom identifies herself ~~in~~ **with** her baby like claiming the baby has her dark eyes and the baby has her nose (Ricci et al., 2021). This patient doted over her baby but also depended on the help of her significant other as soon as he arrived and allowed staff to assist her with her care and care of the baby. This patient did express how much her son had her nose and dark eyes.

Discharge Planning (3 points)

Discharge location: Home in Danville with her boyfriend

Equipment needs (if applicable): Not applicable

Follow up plan (include plan for mother AND newborn): Mom will follow up in 6 weeks with her PCP and baby will follow up in 24 to 48 hours after discharge.

Education needs: Breast feeding, maternal nutrition intake, birth control.

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? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
1. Risk for hemorrhage related to BMI as evidenced by weight of 186lbs.	Mother's weight puts her at risk for hemorrhaging postpartum.	1. "Monitor patient's vital signs per protocol, especially HR for early detection of hemorrhage. Rationale- E arly detection of subtle changes can reduce the risk of a bleeding event" (Phelps, 2023, p 51-	Mother's post partum vital signs were within normal ranges for this patient. Mother's post partum pain regimen includes an NSAID. Mother has only used the NSAID once without

		54). 2. “Review medications such as anticoagulants, ASA, NSAIDS, or cancer drugs that can affect homeostasis. Rationale- Drugs that interfere with clotting mechanisms or platelet activity increase the risk for bleeding” (Phelps, 2023, p 51-54).	adverse events noted.
2. Increased risk for DVT related to weight and postpartum bleeding as evidenced by weight of 186 lbs.	Mother’s weight puts her at risk for DVT.	1. “Assess peripheral circulation and pulses. Rationale- Weak pulses, swelling, or elevated skin temperature could indicate DVT” (Phelps, 2023, p 693-696). 2.” Encourage frequent changes in position and ambulation frequently. Rationale- Ffrequent movement and ambulation helps to keep blood circulating and decreases the risk of stasis” (Phelps, 2023, p 51-54).	No signs or symptoms of DVT noted. Patient was up ad lib without difficulty.
3. Knowledge deficit of family dynamics related to new baby as evidenced by mom stating there is an eight year difference between youngest child and infant.	There is an eight year gap between the youngest child and the infant.	1. “Encourage infants two other siblings to be part of the care of the infant. Rationale- Enhances family rolls and family bonds” (Phelps, 2023, p 245-248). 2. “Provide family with resources on social support and community resources. Rationale- Rreinforces family strength and assists when families are experiencing stress” (Phelps, 2023, p 245-248).	Not able to assess due to none of the other family members came into the hospital during my time there other than her boyfriend. The boyfriend did hold and feed the infant while mom slept.
4. Knowledge	Boyfriend is in	1. “Assess measures taken	Not able to assess.

deficit of family dynamics related to father not a part of the child's life as evidenced by mom stating the dad is not involved but her boyfriend is.	the picture but he is not the father of the baby. Mom's demeanor changed from outgoing and happy to quiet and reserved when her boyfriend came for the day.	to maintain open and positive communications. Rationale- Healthy communications bridge the gap between members of the family" (Phelps, 2023, p 245-248). 2. "Assess measures taken to maintain safety in the home environment. Rationale- Environments that are free from environmental hazards assure a sense of security" (Phelps, 2023, p 245-248).	Mom did state she was aware of community support programs she could access if she needed it. She already planned to go to the health department for assistance with WICC. Unable to evaluate if she has a safety plan should she need one.
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Phelps, L.L. (2023). *Nursing Diagnosis Reference Manual* (12th ed., pp 51-54, 245-248, 693-696). Wolters Kluwer.

Other References (APA)

Medicine.com (2020, February 10). *Nicotine*.

<https://www.medicine.com/drug/nicotine/hcp> -put under medication section

Medicine.com (2020, February 10). *Oxytocin*.

<https://www.medicine.com/drug/oxytocin/hcp#pharmacology> -put under medication section

Pope, C. (2023, April 5). *Valacyclovir: 7 things you should know*.

<https://www.drugs.com/tips/valacyclovir-patient-tips#how-it-works> -put under medication section

N432 Postpartum Care Plan Grading Rubric

Student Name:

Demographics	3 points	1.5 points	0 points	Points
Demographics <ul style="list-style-type: none"> Date of admission 	Includes complete	1-2 of the key components are	3 or more of the key	

<ul style="list-style-type: none"> • Patient initials • Age • Gender • Race/Ethnicity • Occupation • Marital Status • Allergies • Code Status • Height • Weight • Father of Baby Involvement 	<p>information regarding the patient. Each section is filled out appropriately with correct labeling.</p> <p style="text-align: center;">3 pts</p>	not filled in correctly.	components are not filled in correctly and therefore no points were awarded for this section	
Medical History	5 points	2.5points	0 points	Point s
<p>Prenatal History</p> <ul style="list-style-type: none"> • GTPAL • Complications in previous/current pregnancies • Outcomes of previous pregnancies <p>Past Medical History</p> <ul style="list-style-type: none"> • All previous medical diagnosis should be listed <p>Past Surgical History</p> <ul style="list-style-type: none"> • All previous surgeries should be listed <p>Family History</p> <ul style="list-style-type: none"> • Considering paternal and maternal <p>Social History</p> <ul style="list-style-type: none"> • Smoking (packs per day, for how may year) • Alcohol (how much alcohol consumed and for how many years) • Drugs (how often and drug of choice) <p>Living situation</p> <p>Education level</p> <ul style="list-style-type: none"> • If applicable to learning barriers 	<p>Includes each section completed correctly with a detailed list of pertinent medical history, surgical history, family history and social history. If patient is unable to give a detailed history, look in the EMR and chart.</p> <p style="text-align: center;">5 pts</p>	1-2 of the key components is missing detailed information.	3 or more of the key components are not filled in correctly	
Admission Assessment-Chief	2 points	1 point	0 points	Point

Complaint				s
Chief Complaint <ul style="list-style-type: none"> Identifiable with a couple words of what the patient came in complaining of 	Chief complaint is correctly identified. 2 pts	Chief complaint not completely understood.	No chief complaint listed.	
Admission Assessment-Presentation to Labor & Delivery	10 points	5 points	0 points	Point s
Presentation to Labor & Delivery <ul style="list-style-type: none"> Information is identified in regards to why the patient came to the hospital Utilization of OLD CARTS as appropriate Written in a paragraph form with no less than 5 sentences Information was not copied directly from the chart and no evidence of plagiarism Information specifically stated by the patient using their own words is in quotations Plagiarism will receive a 0 	Every key component of the HPI is filled in correctly with information such as those identified with (OLD CARTS). It is written in a paragraph form, in the student's own words. There is no evidence of plagiarism identified. This is developed in a paragraph format with no less than 5 sentences. 10 pts	1-2 of the key components are missing in the HPI. The HPI is lacking important information to help determine what has happened to the patient.	3 or more components are missing in the HPI. Paragraph is not well developed, and it is difficult to understand what the patient is seeking care for. There is evidence of plagiarism noted in the HPI.	
Primary Diagnosis	2 points	1 points	0 points	Point s
Primary Diagnosis <ul style="list-style-type: none"> The main reason the patient was admitted Secondary Diagnosis <ul style="list-style-type: none"> If the patient has more than one reason they are being admitted 	All key components are filled in correctly. The student was able to identify the correct	One of the key components is missing or not understood correctly.	Student did not complete this section and there is concern for lack of understanding the	

	primary diagnosis and listed the appropriate secondary diagnosis if applicable. 2 pts		diagnosis.	
Laboratory Data	15 points	7.5 points	0 points	Points
<p>Normal Values</p> <ul style="list-style-type: none"> Should be obtained from the chart when possible as labs vary some. If not possible use laboratory guide. Normal values should be listed for all laboratory data. <p>Laboratory Data</p> <ul style="list-style-type: none"> Prenatal Values Admission Values Most recent Values (the day you saw the patient) <p>Rational for abnormal values</p> <ul style="list-style-type: none"> Written in complete sentences with APA citations Explanation of the laboratory abnormality in this patient For example, elevated WBC in patient with pneumonia is on antibiotics. Minimum of 1 APA reference, no reference will result in zero points for this section <ul style="list-style-type: none"> Source(s) should be 5 or less years old Source(s) greater than 5 years old 	<p>All key components have been addressed and the student shows an understanding of the laboratory norms and abnormalities.</p> <p>Student had 1 reference listed with in text citations and is able to correlate abnormal laboratory findings to the patient's particular disease process. 15 pts</p>	<p>1-2 of the patient's labs were not reported completely with normal values or patient results. Lab correlation did not completely demonstrate student's understanding of correlation. Student had 1 reference listed with in text citations</p>	<p>Student did not have an understanding of laboratory values and the abnormalities.</p> <p>3 or more labs were excluded. Student did not discuss the abnormal findings in APA format with a minimum of 1 reference or no with in text citations. Source(s) utilized were greater than 5 years old.</p>	

will not be accepted				
Stage of Labor	30 points	15 points	0 points	Points
<p>Stage of Labor Write Up:</p> <ul style="list-style-type: none"> • History of labor <ul style="list-style-type: none"> ○ Length of labor ○ Induced vs. spontaneous ○ Time in each stage of labor • Current stage of labor • Professionally written essay in correct APA format outlined all aspects of the stage of labor the client is in during the student's care • Information is well written and no less than 1 page • Location of client in postpartum course • Normal findings during client's location in the postpartum course • Abnormal findings during client's location in the postpartum course • Stage of adapting client is in • Risk factors for postpartum complications <ul style="list-style-type: none"> ○ Postpartum hemorrhage ○ Infection (include S/S) ○ Postpartum mood disorder • Listed clinical data that correlates to this particular client • Plagiarism results in a 	<p>All key components have been addressed and the student shows an understanding of the norms and abnormalities .</p> <p>Disease process was thorough with a direct correlation of how this related to the patient and their diagnostic testing that was performed. Student had 1 reference listed and is able to correlate abnormal findings to the patient's particular disease process.</p> <p style="text-align: center;">30 pts</p>	<p>1-3 key components were missing such as signs and symptoms, expected findings, correlation and treatment. Student was able to describe the pathophysiology of the disease process and understanding of the stage(s) of labor.</p>	<p>4 or more of the key components is missing. Student did not have an understanding of the stage(s) of labor or the disease process and how to correlate it to the patient. Section was not in APA format with minimum of 2 references (0 points will be given. Source(s) utilized were greater than 5 years old</p>	

<p>zero in this section</p> <ul style="list-style-type: none"> • Minimum of 2 APA reference, no reference will result in zero points for this section <ul style="list-style-type: none"> o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted 				
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Current Medications	7 points	6-1 points
<p>Current Medications</p> <ul style="list-style-type: none"> • Requirements of 5 inpatient hospital medications and 2 home medications—these must be 7 DIFFERENT medications • Each medication must have brand/generic name • Dosage, frequency, route given, class of drug and the action of the drug • Reason client taking • 2 contraindications must be listed <ul style="list-style-type: none"> o Must be pertinent to your patient • 2 side effects or adverse effects • 2 nursing considerations • Key nursing assessment(s)/lab(s) prior to administration <ul style="list-style-type: none"> o Example: Assessing client's HR prior to administering a beta-blocker o Example: Reviewing client's PLT count prior to administering a low-molecular weight heparin • 2 client teaching needs • Minimum of 1 APA citation, no citation will result in loss of all points in the section <ul style="list-style-type: none"> o Source(s) should be 5 or less years old o Source(s) greater than 5 years old will not be accepted 	<p>All key components were listed for each of the 7 medications, along with the most common side effects, contraindications and client teachings. Student had 1 APA citation listed.</p> <p style="color: red; text-align: center;">7 pts</p>	<p>1 point will be lost for each medication with incomplete information.</p>
Physical Exam	18 points possible	1-17 points
<ul style="list-style-type: none"> • Completion of a head-to-toe assessment according to Physical assessment criteria on care 	<p>All key components are met including a</p>	<p>1-3 of the key components is missing</p>

<p>plan done on the students own and not copied from the patient's chart</p> <ul style="list-style-type: none"> • Fall risk assessment • Braden skin assessment • No fall risk or Braden scale will result in a zero for the section • Incomplete Reproductive assessment will result in a zero for the section 	<p>complete head to toe assessment, fall risk and Braden score.</p> <p style="text-align: center;">18 pts</p>	<p>from a given section.</p>	
Vital Signs	5 points	2.5 points	
<p>Vital Signs</p> <ul style="list-style-type: none"> • 3 sets of vital signs are recorded with the appropriate labels attached • Includes a prenatal set, labor/delivery set, and postpartum set • <i>If client has not delivered for a postpartum set, student is to list TWO vitals from labor and delivery</i> • Student highlighted the abnormal vital signs • Student wrote a summary of the vital sign trends 	<p>All the key components were met for this section (with 2 sets of vital signs) and student has a good understanding of abnormal vital signs.</p> <p style="text-align: center;">5 pts</p>	<p>Only 1 set of vital signs were completely recorded and/or 1 of the key components were missing.</p>	
Pain Assessment	2 points	1 point	
<p>Pain assessment</p> <ul style="list-style-type: none"> • Pain assessment was addressed and recorded twice throughout the care of this patient • It was recorded appropriately and stated what pain scale was used 	<p>All the key components were met (2 pain assessments) for this section and student has a good understanding of the pain assessment.</p> <p style="text-align: center;">2 pts</p>	<p>Only 1 pain assessment was completely recorded and/or 1 of the key components is missing.</p>	
IV Assessment	2points	1 point	
<p>IV assessment</p> <ul style="list-style-type: none"> • IV assessment performed and it is charted including what size of IV and location of the IV • Noted when the IV was placed • Noting any signs of erythema or drainage • Patency is verified and recorded • Fluid type and rate is recorded or Saline lock is noted. • IV dressing assessment is recorded (clean, dry and intact) 	<p>All of the key components were addressed. Student demonstrates an understanding of an IV assessment.</p> <p style="text-align: center;">2 pts</p>	<p>One of the key components is missing.</p>	
Intake and Output	2 points	1 point	
Intake	All of the key	1 of the key	

<ul style="list-style-type: none"> Measured and recorded appropriately—what the patient takes IN Includes: oral intake, IV fluid intake, etc. <p>Output</p> <ul style="list-style-type: none"> Measured and recorded appropriately—what the patient puts OUT Includes: urine, stool, drains/tubes, emesis, etc. 	<p>components of the intake and output were addressed.</p> <p>Student demonstrates an understanding of intake and output.</p> <p style="text-align: center;">2 pts</p>	<p>components of the intake and output is missing.</p> <p>Difficult to determine if the student has a thorough understanding of the intake and output.</p>	
Nursing Care/Interventions	6 points	3 points	
<p>Nursing Interventions</p> <ul style="list-style-type: none"> List the nursing interventions and medical treatments utilized with your client Includes a rationale as to why the intervention is carried out or should be carried out for the client Differentiates between nursing interventions (N) and medical interventions (M) Include the frequency that the intervention is being performed 	<p>All the key components of the nursing care were addressed. Student demonstrated an understanding of the nursing care.</p> <p style="text-align: center;">6 pts</p>	<p>1 of the key components of the nursing care was missing, therefore it was difficult to determine if the student had a thorough understanding of the nursing care.</p>	
Phases of Maternal Adaption to Parenthood	3 points	1.5 point	
<p>Phases of Maternal Adaption to Parenthood</p> <ul style="list-style-type: none"> What phase is the mother in? What evidence supports this? 	<p>All key components were addressed.</p> <p>The student demonstrated an appropriate understanding of the phases of maternal adaption to parenthood.</p> <p style="text-align: center;">3 pts</p>	<p>1 of the key components is missing or incomplete.</p> <p>Student demonstrated somewhat of an understanding of the phases of maternal adaption to parenthood.</p>	
Discharge Planning	3 points pts	1.5 points	
<p>Discharge Planning</p> <ul style="list-style-type: none"> Discharge location Equipment needs (if applicable) Follow up plan <ul style="list-style-type: none"> o Include plan for mother AND newborn Education needs 	<p>All key components were addressed.</p> <p>The student demonstrated an appropriate understanding of the discharge plan.</p>	<p>1 of the key components is missing or incomplete.</p> <p>Student demonstrated somewhat of an understanding of the discharge plan.</p>	

	3 pts		
Nursing Diagnosis	30 points	29-10 points	
<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • List 4 nursing diagnosis <ul style="list-style-type: none"> ○ Include full nursing diagnosis with “related to” and “as evidenced by” components ○ These should be specific to the patient • Two Nursing diagnoses are related to needed teaching topics <ul style="list-style-type: none"> ○ List 2 priority teaching items ○ Includes 1 expected outcome for each teaching topic ○ Includes how the information would be taught ○ Includes an expected outcome • Appropriate nursing diagnosis • Appropriate rationale for each diagnosis <ul style="list-style-type: none"> ○ Explain why the nursing diagnosis was chosen • Minimum of 2 interventions for each diagnosis <ul style="list-style-type: none"> ○ Include a rationale for each intervention. ○ Include a source for each rationale. • Correct priority of the nursing diagnosis • Appropriate evaluation 	<p>All key components were addressed. The student demonstrated an appropriate understanding of nursing diagnoses, rationales, interventions and listed diagnosis in correct priority.</p> <p style="text-align: center;">30 pts</p>	<p>1-2 of the nursing diagnosis/rational/intervention/evaluation sections was incomplete or not appropriate to the patient. Prioritization was not appropriate.</p>	
Overall APA format	5 Points	2.5 Points	
<p>APA Format</p> <ul style="list-style-type: none"> • The student used appropriate APA in text citations and listed all appropriate references in APA format. • Source(s) utilized should be 5 or less years old. <ul style="list-style-type: none"> ○ Source(s) greater than 5 years old will not be accepted. • Professional writing style, grammar, and spelling was used in all narrative sections. 	<p>APA format was completed and appropriate. Grammar and spelling were professional and without errors</p>	<p>APA format was used but not correct with 1-2 errors noted. 1-2 grammar, spelling errors or overall poor writing style was used. Content was difficult to understand.</p>	
<p>Instructor Comments:</p>			
<p>There is no need to double space at the beginning of a sentence. Please make sure to check for grammar and spelling errors. Don't forget to utilize draft coach.</p>			

Try to make interventions in your own words not direct quotes from your source.

Total Points Awarded

145/150=96.6%