

N432 Postpartum Care Plan
Lakeview College of Nursing
Ta'Shayla Mitchell

Demographics (3 points)

Date & Time of Admission 1-22-20/ 0618	Patient Initials KG	Age 38	Gender F
Race/Ethnicity White	Occupation Stay at Home	Marital Status Married	Allergies NKDA
Code Status Full Code	Height 5'10in	Weight 210 lbs	Father of Baby Involved Yes

Medical History (5 Points)

Prenatal History: G4 P3 T2 L4

Past Medical History: Asthma

Past Surgical History: C-Section

Family History: Hypertension

Social History (tobacco/alcohol/drugs): Previous alcohol use. Denies smoking and drug use.

Living Situation: Home with husband and three children

Education Level: Some college

Admission Assessment

Chief Complaint (2 points): Pregnancy

Presentation to Labor & Delivery (10 points): Patient arrived to the hospital by car with husband for scheduled induction of labor on January 22, 2020 at 0618. The mother is a G4 P3 T2 L4. Patient reports having contractions the night before her scheduled IOL.

Diagnosis

Primary Diagnosis on Admission (2 points): Scheduled IOL

Secondary Diagnosis (if applicable):

Postpartum Course (18 points)

Postpartum Course References (2) (APA): (Medical Chart, January 22, 2020)

Henry, N. J. E., McMichael, M., & Johnson, J. (2016). *Rn adult medical surgical nursing: review module*. Leawood, KS: Assessment Technologies Institute.

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	4.2-5.4	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Hgb	12-16	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Hct	37-47%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Platelets	150,000-400,000	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
WBC	5,000-10,000	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Neutrophils	55-70%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Lymphocytes	20-40%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Monocytes	2-8%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Eosinophils	1-4%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day
Bands	0.5-1%	n/a	n/a	n/a	Will draw on 1-23-2020 during post-op day

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	n/a	A	A	A	n/a
Rh Factor	n/a	-	-	-	n/a
Serology (RPR/VDRL)	Negative	Non-Reactive	n/a	Non-Reactive	Within normal limits
Rubella Titer	Negative	Immune 7-29-19	n/a	Immune	Within normal limits
HIV	Negative	Negative 11-6-19	n/a	Negative	Within normal limits
HbSAG	Negative	Non-Detected	n/a	Non-Detected	Within normal limits
Group Beta Strep Swab	Negative	Negative	n/a	Negative	Within normal limits
Glucose at 28 Weeks	Negative	n/a	n/a	n/a	Not documented
MSAFP (If Applicable)	Negative	n/a	n/a	n/a	Not documented

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
HCT	37-47%	31.3%	n/a	n/a	Not documented
HGB	12-16	10.5	n/a	n/a	Not documented
GBS	Negative	Negative	n/a	n/a	Not documented

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)	Negative	n/a	n/a	n/a	Not applicable Test not performed

Lab Reference (APA): (Medical Chart, January 22, 2020)

Henry, N. J. E., McMichael, M., & Johnson, J. (2016). *Rn adult medical surgical nursing: review module*. Leawood, KS: Assessment Technologies Institute.

Stage of Labor Write Up, APA format (15 points):

	Your Assessment
History of labor:	Arrived at hospital at 0618 and delivered at 1251.
Length of labor	Length of labor: 6 hours and 33 minutes.
Induced /spontaneous	Induced
Time in each stage	N/A
Current stage of labor	Postpartum and delivered

	<p>First stage</p> <ul style="list-style-type: none"> • 0-10 cm dilation • Consist of three phases: latent, active, and transition <p>Second stage</p> <ul style="list-style-type: none"> • From complete dilation to birth of the newborn; may last up to 3 hours <p>Third stage</p> <ul style="list-style-type: none"> • Separation and delivery of placenta; usually takes 5-10 minutes but may take up to 30 minutes <p>Fourth stage</p> <ul style="list-style-type: none"> • 1-4 hours after the birth of newborn; time of maternal physiologic adjustment
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Stage of Labor References (2) (APA): (Medical Chart, January 22, 2020)

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and Pediatric Nursing*. Philadelphia: Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Albuterol/ Proventil	Aspirin			
Dose	1 puff	81mg			
Frequency	PRN	Daily			
Route	PO	PO			
Classification	Beta 2 Agonists	Antiplatelet			
Mechanism of	Relaxes bronchial	Inhibits			

Action	smooth muscles	prostaglandins, platelet aggregation, analgesic activity and antipyretic			
Reason Client Taking	Asthma	Mild pain			
Contraindications (2)	Hypersensitivity to milk or albuterol	Hypersensitivity Allergy to tartrazine dye			
Side Effects/Adverse Reactions (2)	Tremors Nausea	Angioedema bronchospasms			
Nursing Considerations (2)	Educate client on use of inhaler Educate client to keep device clean and dry	Assess pain one hour before and after medication Assess other medication interactions			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	None noted. Personal need for use.	Assess pain prior to administration			
Client Teaching needs (2)	Educate client this is for oral inhalation only Shake well before each use	Drug enters breastmilk Avoid chronic or high dose during pregnancy			

Hospital Medications (5 required):

Brand/Generic	Ibuprofen/Motrin	Prenatal Vitamin	Oxytocin/Pitocin	Colace/docusate	Tylenol/Acetaminophen
Dose	800mg	27-0.8mg	30u/500ml	100mg	975mg
Frequency	Q8hr	Nightly	Continuous	BID	Q6hr PRN
Route	PO	PO	IV	PO	PO
Classification	NSAID	multivitamin	Oxytocic Agent	Laxative	Antipyretic

Mechanism of Action	Inhibits synthesis of prostaglandins in body tissues	Contains iron products used to prevent vitamin deficiencies during pregnancy	Uterine stimulant	Reduces tension of oil-water interface of stool	Acts on hypothalamus to produce antipyresis
Reason Client Taking	pain	Prevent vitamin deficiency	Induction of labor	Soften stools during pregnancy	Mild pain
Contraindications (2)	Hypersensitivity GI events	Hypersensitivity Liver disease	Cephalopelvic disproportion Unfavorable fetal positions or presentations	Hypersensitivity Intestinal obstruction	Severe active liver disease Hypersensitivity
Side Effects/Adverse Reactions (2)	Dizziness Epigastric pain	Constipation Diarrhea	Sinus bradycardia Neonatal seizure	Abdominal cramping Diarrhea	Angioedema Disorientation
Nursing Considerations (2)	Assess client pain prior to administration	Educate patient to avoid taking antacids, dairy products, tea, or coffee within two hours before or after medication as it may decrease effectiveness	Administer via IV	Do not administer within one hour of milk Do not administer within one hour of antacids	Do not exceed 4g/day May increase risk for bleeding
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess client pain score prior to administration	None noted	Monitor fetal movement and vital signs of mother and baby	Monitor for therapeutic response	Assess client pain score prior to administration
Client Teaching needs (2)	Take with food or water to avoid GI effects Should not take during pregnancy	This medication passes into breastmilk Best if taken on empty stomach	Educate client that this medication may lower their heart rate	Educate client not to bear-down during bowel movements as it puts increased pressure on uterus	Educate client that Tylenol is excreted in breast milk

Medications Reference (APA): (Medical Chart, January 22, 2020)

Assessment

Physical Exam (18 points)

<p>GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Mother was alert, cooperative, and appeared stated age. She appeared fatigued while lying in bed. She did not have any signs of distress. Mother received epidural and was attempting to regain control over lower body.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p>	<p>Skin is pink, warm, and dry. Temperature is within normal limits during all vital sign assessments. Turgor is good and present in less than 3 seconds. No rashes or bruises. Mother has a 2nd degree laceration from vaginal delivery of babe. Braden score not noted. No drains present.</p>
<p>HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head/neck are normocephalic. PERLA present. No signs of abnormalities for HEENT during assessment. No dentures.</p>
<p>CARDIOVASCULAR (1 point): 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 checked="" type="checkbox"/> N<input type="checkbox"/> Location of Edema:</p>	<p>Heart sounds present with regular rate and rhythm. No murmurs, gallops, or rubs present. Peripheral pulses noted 2+ bilaterally. Capillary refill noted less than 3 seconds. Some edema and varicose veins noted on right foot.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breath sounds clear on auscultation bilaterally. No labored breathing. No adventitious breath sounds.</p>

<p>GASTROINTESTINAL (5 points): Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Fundal Height & Position:</p>	<p>Regular diet at home. Regular diet inpatient. Height: 5'10in Weight: 210 lbs Bowel sounds active and present upon auscultation in all four quadrants. Last bowel movement not known. No distention, incisions, or drains. Mother has second degree laceration following vaginal delivery. Fundal height and position: U/3</p>
<p>GENITOURINARY (5 Points): Bleeding: Color: Character: 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: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p>	<p>Bleeding was bright pink after delivery. Output was measured at 288 mL during assessment. Urine was present on pad and towels during assessment and changing. Rupture of membranes not assessed at this time. 2nd degree laceration.</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" 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>Mother received epidural and did not have full independence with walking or standing during assessment. Needed assistance to stand and pivot in chair.</p>
<p>NEUROLOGICAL (1 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:</p>	<p>Mother was able to lift legs about 3 inches during assessment. Alert and oriented to person, place, time, and situation. No altered mental status. No noted speech, LOC or sensory deficits.</p>

Mental Status: Speech: Sensory: LOC: DTRs:	DTRs present bilaterally, lower extremities.
PSYCHOSOCIAL/CULTURAL (1 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):	Mother has support from spouse, other children, and parents. Religion was not noted. Father was present and helpful entire shift.
DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	Delivered on 1-22-2020 at 1251. Vaginal delivery. 288 ml of blood loss. Female Baby birth weight: 7lb 11oz, 50.8cm. Breast feeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	112	116/61	16	98.4F	97%
Labor/ Delivery	88	123/60	20	98.6F	100%
Postpartum	88	116/65	16	99.1F	100%

Vital Sign Trends: Stable

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1551	Numeric Pain Scale	n/a	0	n/a	Patient reports no pain during

					this time
1700	Numeric Pain Scale	n/a	0	n/a	Patient reports no pain during 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:	18 gauge Left Metacarpal Vein 1-22-2020 Patent No signs of erythema, drainage, or swelling Transparent dressing

Intake and Output (2 points)

Intake	Output (in mL)
1,996.3 mL	1,350 mL

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 “T” after you list them.)	Frequency	Why was this intervention/ treatment provided to this patient? Please give a short rationale.
Vital signs (N)	Every 15 minutes during first hour Every 30 minutes during second hour	Obtaining vital signs frequently to compare to previous. Vital sign changes may be an indicator of complications.
Fundus Checks (N)	Every 15 minutes during first hour Every 30 minutes during second hour	Fundus checks are to determine the degree of uterine involution. The fundus should be midline and feel firm. Normally the fundus progresses downward 1cm per day
Breastfeeding (N)	8-12 times/day	Ensure the mother and baby are bonding and that mother is producing milk and baby is developing “sucking” reflexes

Pain (N)	Every 15 minutes during first hour Every 30 minutes during second hour	Discomfort and pain may come from a variety of sources. Relieving the underlying problem is the first step in pain management.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? Taking in phase

What evidence supports this? The mother just delivered 2 hours before my start of care for her. She expressed that she was tired and just wanted to rest. The mother also expressed her excitement for finally having a girl. Her and her husband have three sons currently. Mother was pleasant to care for, cooperated and contributed to her and baby’s care.

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): n/a

Follow up plan (include plan for mother AND newborn): Educate as needed

Education needs: Infant safety education, breastfeeding education, and hemorrhage prevention education

Nursing Diagnosis (30 points)

Must be NANDA approved nursing diagnosis and listed in order of priority
Two of them must be education related i.e. the interventions must be education for the client.”

Nursing Diagnosis (2 pt each)	Rational (1 pt each)	Intervention/Rational (2 per dx) (1 pt each)	Evaluation (1 pt each)
Identify problems that are specific to this patient. Include	Explain why the nursing diagnosis was	Interventions should be specific and individualized for his patient. Be sure to	<ul style="list-style-type: none"> How did the patient/ family respond to the nurse’s actions?

<p>full nursing diagnosis with “related to” and “as evidenced by” components</p>	<p>chosen</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 your rationale.</p>	<ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for hemorrhage related to postpartum AEB blood loss after birth</p>	<p>Hemorrhaging is always a risk after postpartum. Monitoring the mother closely is essential.</p>	<p>1. Assess fundus every 15 the first hour postpartum and every 30 minutes the second hour Rationale Placement of the fundus gives an indication of whether bleeding is occurring 2. Assess vital signs every 15 minutes the first hour and every 30 minutes the second hour Rationale A change in vital signs can be indicative of hemorrhage</p>	<p>Mother was very cooperative during fundus checks. Fundus was u/3 which is a good indicator that hemorrhage was not occurring at time of care.</p>
<p>2. Risk for ineffective breastfeeding r/t poor infant sucking reflexes AEB infant not feeding 8-12 times per day</p>	<p>Ensure the mother and baby are bonding and that mother is producing milk and baby is developing “sucking” reflexes</p>	<p>1. Assess the mother’s knowledge regarding the process of lactation and breastfeeding Rationale This will determine the level of awareness the mother has on the importance of breastfeeding 2. Assess the structure of the mother’s breast and nipples Rationale Determine the presence of any breast anomalies which may not permit breastfeeding</p>	<p>Mother was very cooperative during breastfeeding. Mom never denied breast to baby.</p>
<p>3. Risk for impaired infant/mother bonding related to postpartum AEB infant</p>	<p>Skin to skin contact directly after birth is enforced to ensure the infant will bond with</p>	<p>1. Assess mother perception of situation and infant care responsibilities Rationale This allows nurses to identify any areas of learning need</p>	<p>Mother and baby had skin-to-skin contact during all times that assessments were not happening or baby was not sleeping in crib.</p>

and mother not bonding	mother and vice versa	<p>2. Encourage contact with infant</p> <p>Rationale Reassure the mother of the proper care associated with a newborn</p>	
<p>4. Risk for pain related to tissue damage AEB 2nd degree laceration</p>	<p>2nd degree lacerations are common after vaginal deliveries. Managing the mother's pain after birth is a priority.</p>	<p>1. Assess pain every 15 minutes during first hour and every 30 minutes after</p> <p>Rationale This will help with choosing a treatment for pain and catching any pain early</p> <p>2. Provide comfort measures such as ice pack</p> <p>Rationale Ice packs decrease edema and pain sensation</p>	<p>Mother reported no pain during entire shift. She did ask for ibuprofen towards end of shift but not for pain management.</p>

Other References (APA)

Ricci, S. S., Carman, S., & Kyle, T. (2017). *Maternity and Pediatric Nursing*. Philadelphia: Wolters Kluwer.