

N432 Postpartum Care Plan
Lakeview College of Nursing
Lindsey Platt

Demographics (3 points)

Date & Time of Admission 1/27/2019 11:28	Patient Initials OO	Age 31	Gender F
Race/Ethnicity African American	Occupation Student	Marital Status Married	Allergies NKA
Code Status Full	Height 5'3"	Weight 184 lbs	Father of Baby Involved yes

Medical History (5 Points)**Prenatal History:****Past Medical History:** anemia**Past Surgical History:** no significant history**Family History:** hypertension in mother and father**Social History (tobacco/alcohol/drugs):** denies**Living Situation:** at home with her spouse and 2-year-old daughter**Education Level:** some college**Admission Assessment****Chief Complaint (2 points):** contractions

Presentation to Labor & Delivery (10 points): Patient is a 31 year-old female with IVP at 39w0d. She was 2-3 cm dilated when she arrived. Contractions were irregular however she was admitted for labor. Fetus is small for gestational age.

Diagnosis**Primary Diagnosis on Admission (2 points):** Labor and delivery

Secondary Diagnosis (if applicable):NA

Postpartum Course (18 points)

Patient is a 31-year-old female presented as a G2P2 at 39w1d. She did not utilize an epidural for pain management. She presented with contractions and was kept for augmentation of labor which was performed with oxytocin infusion and AROM for clear fluid. The fetal vertex was identified in LOA position. She pushed effectively and delivered without difficulty. The infant was placed to maternal chest for skin to skin contact. Patient and her infant were left to recover in stable condition. In assessing mother-infant bonding, the patient holds the baby face-to-face, responds to the infant crying, smiles and talks to her. She does not show any signs of complications of postpartum depression.

Postpartum Course References (2) (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Elkins, C. B., Holman, H. C., ...

Barlow, M. S. (2016). *RN nursing care of children review module* (10th ed.). Assessment Technologies Institute, LLC.

Postpartum depression. (2018, September 1). Retrieved from

<https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617>

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	4.0-5.2	No labs obtained	4.13	3.53	She lost blood during labor
Hgb	F:12-15	No labs	12.3	10.3	She lost blood during labor

	M: 14-16	obtained			
Hct	F:42-52 M:35-47	No labs obtained	37.3	31.5	She lost blood during labor
Platelets	140-440	No labs obtained	303	262	
WBC	4.0-11.0	No labs obtained	9.00	13.20	Stress from delivery
Neutrophils	45-75%	No labs obtained	63.3	74.8	
Lymphocytes	20-40%	No labs obtained	22.8	15.3	Stress from delivery
Monocytes	4-6%	No labs obtained	11.4	8.6	Stress from delivery
Eosinophils	<7%	No labs obtained	2.2	1.0	
Bands	<3%	No labs obtained	0.3	0.3	

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	NA	No labs obtained	No labs obtained	O	
Rh Factor	NA	No labs obtained	No labs obtained	+	
Serology (RPR/VDRL)	negative	No labs obtained	negative	No labs obtained	
Rubella Titer	negative	No labs obtained	immune	No labs obtained	

HIV	negative	No labs obtained	Negative	No labs obtained	
HbSAG	negative	No labs obtained	negative	No labs obtained	
Group Beta Strep Swab	negative	negative	No labs obtained	No labs obtained	
Glucose at 28 Weeks	71.9 + or - 5.7	No labs obtained	No labs obtained	No labs obtained	
MSAFP (If Applicable)	0.5-2.0	No labs obtained	No labs obtained	No labs obtained	

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
Chlamydia	negative	negative			

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)	NA				

Lab Reference (APA):

Kee, J. L. F. (2018). *Laboratory and diagnostic tests with nursing implications*. NY, NY: Pearson.

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

	Your Assessment
<p>History of labor:</p> <p style="padding-left: 40px;">Length of labor</p> <p style="padding-left: 40px;">Induced /spontaneous</p> <p style="padding-left: 40px;">Time in each stage</p>	<p>Length of labor was 12 hours. She was induced. The average time in the first stage is 12 hours, the second stage 30 min- 2 hours, third stage 5-30 min, and the fourth stage 1-4 hours</p>
<p>Current stage of labor</p>	<p>postpartum</p>

Stage of Labor References (2) (APA):

Ricci, S., Kyle, T. & Carmen, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Lippincott, Williams & Wilkins. ISBN: 978-1-60913-747-2

Henry, N., McMichael, M, Johnson, J., DiStasi, A., Roland, P., Wilford, K., and Barlow, M.

(2016). ATI: RN *Maternal newborn nursing*. (10th Ed.). Assessment Technologies Institute, LLC.

Current Medications (7 points, 1 point per completed med)

7 different medications must be completed

Home Medications (2 required)

Brand/Generic	Prenatal vitamin	No other at home meds
Dose	0.8 mg	
Frequency	daily	
Route	PO	
Classification	vitamin	
Mechanism of Action	Treats or prevents vitamin deficiency	
Reason Client Taking	Prevent illnesses during pregnancy	
Contraindications (2)	Iron metabolism disorder, stomach ulcers	
Side Effects/Adverse Reactions (2)	Constipation, nausea	
Nursing Considerations (2)	Give regularly, this passes into breast milk,	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Vital signs, CBC	
Client Teaching needs (2)	do not take more than prescribed dose, take on empty stomach with full glass of water	

Hospital Medications (5 required)

Brand/Generic	Docusate sodium (331)	acetaminophen (Tylenol) (8)	Ondansetron (Zofran)	Ibuprofen (Motrin)	Tetanus-diphtheria-acellular
Dose	100 mg	650 mg	4 mg	800 mg	0.5 ml
Frequency	daily	Q4H PRN	Q12H PRN	Q8H	once
Route	PO	PO	IV	PO	injection
Classification	Stool softener	analgesic	Antiemetic	analgesic	vaccine
Mechanism of Action	Decreases surface tension between oil and water in feces	Inhibits prostaglandin synthesis in CNS and PNS (blocks pain impulse)	Blocks serotonin receptors	Reduces inflammatory symptoms by vasodilation	Convey active immune response
Reason Client Taking	Constipation	pain	Nausea	Pain	immunity
Contraindications (2)	Fecal impaction, hypersensitivity	PUD, GI bleeds	Long QT syndrome, hypersensitivity	Asthma, nasal polyps	Encephalopathy, seizures
Side Effects/Adverse Reactions (2)	Abdominal cramping, throat irritation	Abdominal pain Heartburn	Headache, diarrhea	Dizziness, epigastric pain	Pain, headache
Nursing Considerations (2)	Watch for electrolyte imbalance, long term use can lead to constipation	Risk for stroke increases the longer ibuprofen is used, if IV ensure infusion pumps are programmed properly	Monitor for serotonin syndrome, may mask symptoms of gastric distention	Risk for serious thrombotic events such as stroke for MI increases the longer ibuprofen is used, monitor for chest pain, slurring of speech, or SOB; and watch for signs of infection	Shake well before use, withdraw 0.5 ml dose from vial using a sterile needle and syringe
Key Nursing Assessment(s)/Lab(s)	Vital signs, electrolytes,	Vital signs, renal function	Vital signs, LOC	Vital signs, WBC	Vital signs

) Prior to Administration	I+O				
Client Teaching needs (2)	Do not use if they are vomiting or have nausea, increase fiber intake	Do not exceed recommended dose, recognize the signs of overdose: bleeding, fever, sore throat	Seek medical attention if symptoms worsen, place on tongue immediately after opening and let it dissolve	Take with food or after meals; avoid alcohol, aspirin, and corticosteroids	IM injection, moving the arm will help with soreness

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:	A+Ox4 Patient does not show emotional or respiratory distress Appears well-nourished. She was sitting on the bed most of the shift.
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:	Skin appeared pink, warm and dry Varicose veins on lower extremities Temperature was 37.6 degrees No rashes, bruises, or wounds Skin turgor was normal, capillary refill less than 3 seconds Braden score of 4 No drains present
HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:	Head appeared normocephalic TMs are clear bilaterally Nasal passages are clear and moist Eyes and teeth showed no abnormalities
CARDIOVASCULAR (1 point):	Heart sounds appeared normal. No murmurs.

<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>Peripheral pulses were normal 3+. Capillary refill less than 3 seconds. Lower extremities showed edema. No neck vein distention.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Lungs were clear in all 5 lobes. No accessory muscle use needed. Respiratory rate was 16.</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 5'3" 184 lbs Bowel sounds active in all four quadrants pain upon palpation No distention, incisions, scars, drains, or wounds Last BM was this morning No ostomy, NG, or feeding tubes Fundus was firm</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>Color of urine was dark amber No output while we were there No pain with urination No dialysis No catheter Normal uranalysis Rupture of membranes occurred at 12:09 AROM. It was clear and had no odor</p>
<p>MUSCULOSKELETAL (2 points): ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Has assistance from her husband to help with the needs of the newborn Active ROM</p>

<p>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>Fall risk of 0 She can get up and ambulate independently Did not need ADL assistance but general weakness and fatigue</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 type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: DTRs:</p>	<p>A+Ox4 Moves all extremities Pupils equal, round, and reactive to light Strength was equal in all extremities bilaterally No lightheadedness or focal weakness No slurred speech or sensory deficits No LOC DTRs intact</p>
<p>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):</p>	<p>Has support from husband. States she goes to church. Highest level of education completed is some college. She appeared accepting, calm, and was actively listening</p>
<p>DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p>	<p>She delivered a baby girl on 1/28 at 14:31 She delivered vaginally and lost 1% of blood Apgars was 8 and 8 She is currently breastfeeding</p>

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	68	126/69	18	96.8	99
Labor/ Delivery	60	127/76	16	97.0	97
Postpartum	64	122/70	16	97.7	99

Vital Sign Trends: during labor, her oxygen saturation decreased slightly, her blood pressure increased, and her pulse decreased.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1600	Numeric	Abdomen	3	Cramping	Ibuprofen
1700	Numeric	Abdomen	1	Cramping	none

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:	No IV site

Intake and Output (2 points)

Intake	Output (in mL)
No intake recorded	733

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.
24 hour newborn screen	once	Sent to the state to check for diseases with no signs or symptoms

24 hour hearing test	Once	To check the baby’s hearing function
Administer ibuprophen	Once	Pain management. She was experiencing cramping
Changed the baby’s diaper	once	To prevent skin breakdown

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? taking hold stage

What evidence supports this? She is independent, focusing on self-care and sleeping when she can, breastfeeding when the baby is hungry.

Discharge Planning (2 points)

Discharge location: home

Equipment needs (if applicable): NA

Follow up plan (include plan for mother AND newborn): follow up with PCP within a day of discharge

Education needs: discharge packet including how to care for a newborn, signs and symptoms of postpartum depression, when to call the physician, and the number to the floor in case she has any questions

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	Rational	Intervention/Rational (2	Evaluation
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<p>(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>(1 pt each) Explain why the nursing diagnosis was chosen</p>	<p>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 your rationale.</p>	<p>(1 pt each)</p> <ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
<p>1. Pain related to breastfeeding as evidenced by a rating of 3</p>	<p>She was cramping during breastfeeding</p>	<p>1. Administered ibuprofen Rationale: for pain 2. Reassessed her pain after administering Rationale: To ensure the effectiveness of the drug</p>	<p>The ibuprofen relived her pain</p>
<p>2. DVT prevention related to immobility as evidenced by new mothers wanting to stay in bed</p>	<p>She was laying in bed most of the shift</p>	<p>1. Encourage ambulation Rationale: prevents pooling of blood 2. Provide anti-embolic stockings Rationale: increases blood flow back to the heart</p>	<p>She got up frequently to go to the bathroom and wore anti-embolic stockings</p>
<p>3. Readiness for transition related to discharge as evidenced by being in postpartum for over 24 hours</p>	<p>She is getting ready to be discharged</p>	<p>1. abdominal binder Rationale: A binder provides support and decreases stretching/tension on muscles or the surrounding tissue of the wound to promote healing 2. explain to the patient and her partner that intercourse is not recommended during the process of wound healing Rationale: intercourse is not recommended for 6 weeks after delivery</p>	<p>She wore the abdominal binder and understands waiting for intercourse</p>
<p>4. Optimal comfort and wellbeing related to postpartum as evidenced by</p>	<p>She appeared tired</p>	<p>1. Assess for signs of complications with parenting (e.g., being unable to take on the role of daily infant care and feeding; lack of interest in caring for and</p>	<p>She had her husband there to help with comfort measures and to help with their other child. She was not having any problems</p>

<p>her stating she was tired</p>		<p>feeding the newborn; lack of consistent and ongoing support from family members, friends, church group support, and neighbors; reference to self or newborn as ugly or problematic; difficulty with sleep; and loss of appetite). Rationale: Parents usually attach without ambivalence to their newborn, want to parent their newborn, and have the energy and motivation to do so, but they also may need to develop infant care and decision-making skills as new parents and learn to balance individual needs with infant needs on a daily basis 2. Help the patient and family identify and develop a daily pattern to meet individual needs, incorporate the newborn into the family, continue with lactation preferences (pumping, breastfeeding, or bottle feeding) Rationale: The patient may need assistance with personal care, newborn care/feeding, or parenting her other children</p>	<p>latching but was worried if the baby was not getting enough to eat since she is wanting to eat often. I assured her that it was normal, a newborn stomach cannot hold that much at a time.</p>
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Other References (APA)

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Place of publication not identified: MOSBY.