

N432 Postpartum Care Plan
Lakeview College of Nursing
Shannon O'Malley

Demographics (3 points)

| | | | |
|---|---------------------------------|-------------------------------------|--|
| Date & Time of Admission 03/03/2020 | Patient Initials C.D | Age 32 | Gender Female |
| Race/Ethnicity White | Occupation Banker | Marital Status Married | Allergies Amoxicillin, ceclor, codeine |
| Code Status Full | Height 5'6 (167.6 cm) | Weight 252 lbs (114.3 kg) | Father of Baby Involved Yes |

Medical History (5 Points)

Prenatal History: The patient is G4T2P0A2L2. She has no history of issues with her first pregnancy and delivery.

Past Medical History: Alcoholism in remission, bipolar disorder, genital herpes, hypothyroidism, polycystic ovarian syndrome, and thyroid disease

Past Surgical History: Mandible surgery, ovarian cyst removal, dilation and curettage of the uterus, and hysteroscopy

Family History: Mom and dad: diabetes, hypertension

Social History (tobacco/alcohol/drugs): Not a former smoker, alcohol use in remission, and not a former drug user

Living Situation: At home with spouse and daughter

Education Level: Masters degree

Admission Assessment

Chief Complaint (2 points): Scheduled induction

Presentation to Labor & Delivery (10 points): The husband brought the patient to the hospital via car and they were able to walk onto the unit.

Diagnosis

Primary Diagnosis on Admission (2 points): Induction of labor

Secondary Diagnosis (if applicable): Polyhydramines

Postpartum Course (18 points)

This patient delivered her baby at 0959, so when the shift started she was in the fourth phase of labor. This is considered postpartum, although the fourth phase ends around 4 hours after delivery of the placenta. This time is for recovery and acceptance. The mom is placed into a postpartum room and frequent assessments are made to ensure everything is working the way it should. At this time in the labor phase, nurses should monitor for signs of hemorrhage, provide comfort, and support family connection (Ricci, Kyle, & Carman, 2017).

“Assessments during the fourth stage center on the woman’s vital signs, status of the uterine fundus and perineal area, comfort level, lochia amount, and bladder status” (Ricci, Kyle, & Carman, 2017, p. 523). Her blood pressure should stay stable during birth and after, but a low blood pressure reading can indicate signs of post partum hemorrhage. Her heart rate should remain similar to her baseline, but might be a little slower. This is a result of the body adjusting to the high volume of blood lost during birth. A high temperature indicates dehydration or infection (Ricci, Kyle, & Carman, 2017). Her respiratory rate should remain normal at 16-24 breaths per minute.

Vital signs are not the only important assessment after birth. Nurses must also assess fundal height, position, and firmness every 15 minutes during the first hour following birth (Ricci, Kyle, & Carman, 2017). This is to ensure that the fundus becomes firm enough to stop the bleeding and prevent post partum hemorrhage. The fundus should be midline under the umbilicus and it should be firm upon palpation. It is important to then assess the perineal area for

swelling or hematoma formation (Ricci, Kyle, & Carman, 2017). Monitor for pain and discomfort in the mother. This patient specifically asked for Tylenol due to abdominal cramping and discomfort.

It is critical in this phase to provide support and information. Prioritizing non-pharmalogical interventions over pharmalogical interventions is key. Things like applying ice, using numbing spray, and repositioning are all ways to promote comfort. The mother is our main concern during this stage, so as nurses it is vital to tend to her needs, educate the family, and make her as comfortable as possible during this exciting time.

Postpartum Course References (2) (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing*. Wolters Kluwer.

Henry, N. J., McMichael, M., Johnson, J., DiStasi, A., Elkins, C., Holman, H., Roland, P.,

Hertel, R., Wilford, K., Barlow, M. (n.d.). *RN Adult Medical Surgical Nursing* (10.0 ed.).

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 | 4.28-5.56 | N/A | 3.45 | N/A | The patients RBC's are low due to bleeding from a vaginal delivery |
| Hgb | 12-17 | N/A | 11.8 | N/A | The patients hemoglobin is low due to bleeding from a vaginal delivery |
| Hct | 33.2-45.3 | N/A | 33.1 | N/A | N/A |
| Platelets | 150-400 | N/A | 189 | N/A | N/A |

| | | | | | |
|--------------------|-------------|-----|-------|-----|-----|
| WBC | 4.5-11 | N/A | 10.00 | N/A | N/A |
| Neutrophils | 45.3%-79.0% | N/A | 75.1 | N/A | N/A |
| Lymphocytes | 11.8%-45.9% | N/A | 17.3 | N/A | N/A |
| Monocytes | 4.4%-12.0% | N/A | 6.4 | N/A | N/A |
| Eosinophils | 0-6.3 | N/A | 0.5 | N/A | N/A |
| Bands | <10% | 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 | N/A | A | N/A | N/A |
| Rh Factor | +/- | N/A | + | N/A | N/A |
| Serology (RPR/VDRL) | Non reactive | N/A | Non reactive | N/A | N/A |
| Rubella Titer | Immune | N/A | Immune | N/A | N/A |
| HIV | Non detected | N/A | Not detected | N/A | N/A |
| HbSAG | Non detected | N/A | Not detected | N/A | N/A |
| Group Beta Strep Swab | +/- | N/A | Negative | N/A | N/A |
| Glucose at 28 Weeks | 70-110 | N/A | N/A | N/A | N/A |
| MSAFP (If Applicable) | 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) | Negative | N/A | N/A | N/A | N/A |

Lab Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 th ed.). F.A. Davis Company

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

| | Your Assessment |
|---|--|
| <p>History of labor:</p> <p>Length of labor</p> <p>Induced /spontaneous</p> <p>Time in each stage</p> | <p>8h 26m</p> <p>Induced</p> <ol style="list-style-type: none"> 1. 8h 10m 2. 0h 10m 3. 0h 6m |
| <p>Current stage of labor</p> | <p>First stage of labor: The first stage of labor begins with regular contractions, effacement, and dilation, and finishes with a full dilation of 10 cm. The first stage is divided into a latent and active phase. The latent phase is characterized by mild, irregular contractions that continually soften the cervix. The active phase consists of a 3-4 cm dilation and descent of the fetal presenting part.</p> |

| | |
|--|--|
| | <p>Second stage of labor: The second stage begins with the mother being 10 cm dilated and ends with the fetus being born.</p> <p>Third stage of labor: The third stage of labor consists of the delivery of the placenta after the fetus is born. This typically happens within 30 minutes after delivery of the baby.</p> |
|--|--|

Stage of Labor References (2) (APA):

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

Normal Labor and Delivery: Practice Essentials, Definition, Stages of Labor and Epidemiology. (2019, November 11). Retrieved from <https://emedicine.medscape.com/article/260036-overview>

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

Home Medications (2 required)

| | | | | | |
|----------------------------|---|--|--|--|--|
| Brand/Generic | Acyclovir (Zovirax) | Levothyroxine (Synthroid) | | | |
| Dose | 400 mg | 137 mcg | | | |
| Frequency | TID | Once daily | | | |
| Route | Oral | Oral | | | |
| Classification | Antiviral | Thyroid products | | | |
| Mechanism of Action | Interferes with DNA polymerase to inhibit DNA replication via | Thyroid hormone increased basal metabolic rate and increases | | | |

| | | | | | |
|---|--|---|--|--|--|
| | chain termination | utilization of glycogen stores | | | |
| Reason Client Taking | Treatment of genital herpes | Treatment of hypothyroid disease | | | |
| Contraindications (2) | Hypersensitivity Renal failure | Hypersensitivity Treatment of obesity | | | |
| Side Effects/Adverse Reactions (2) | Fatigue Rash | Angina Flushing | | | |
| Nursing Considerations (2) | Monitor kidney labs Maintain adequate hydration | Avoid overdose Monitor with patients who have hypertension | | | |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | Check vitals and compare them to baseline | Monitor for increased HR before administering | | | |
| Client Teaching needs (2) | Report to PCP if you experience adverse effects | Call PCP if you experience food reactions with levothyroxine | | | |

Hospital Medications (5 required)

| Brand/Generic | acetaminophen (Tylenol) | benzocaine menthol (Permoplast) | Docusate sodium (Colace) | Ibuprofen (Motrin) | oxytocin (Pitocin) |
|-----------------------|--------------------------------|--|---------------------------------|---------------------------|---------------------------|
| Dose | 650 mg | 1 spray | 100 mg | 800 mg | 60-300 milli units/min |
| Frequency | Q4 hr PRN | Q4 hr PRN | Daily/PRN | Q8 hr | Continuous |
| Route | Oral | Topical | Oral | Oral | IV |
| Classification | Analgesic | Anesthetics | Laxative | NSAID | Oxytocic |
| Mechanism of | Acts on | Prevent | Reduces | Inhibits | Stimulates |

| | | | | | |
|---|--|--|--|---|---|
| Action | hypothalamus to produce antipyresis | conduction of nerve impulses by reducing sodium permeability | tension of oil-water interface of the stool | synthesis of prostaglandins in body tissues | the uterus with vasopressive and antidiuretic effects |
| Reason Client Taking | Treatment of pain | Treatment of discomfort | Treatment of constipation | Treatment of pain | Induction of labor |
| Contraindications (2) | Hypersensitivity Liver disease | Hypersensitivity Bacterial infection | Hypersensitivity Nausea | Hypersensitivity Renal impairment | Unfavorable fetal positions Hypersensitivity |
| Side Effects/Adverse Reactions (2) | Dizziness Rash | Burning Edema | Nausea and vomiting | Dizziness Abdominal discomfort | Bradycardia Neonatal seizure |
| Nursing Considerations (2) | Monitor patients with hepatic impairment | No not let patient use for a prolonged period of time | Monitor for abdominal and stomach pains | Monitor for GI upset Monitor for rash | Monitor for hyperstimulation of the uterus |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | Asses pain level before and after administration | Monitor skin where medication is applied | Monitor patients electrolytes and hydration | Ensure the patients kidney labs are WNL | Monitor for fetal distress on FHR strips |
| Client Teaching needs (2) | Do not exceed the recommended does in one day | The patient can administer medication on her own | Drink an adequate amount of fluids to help the process | Report to provider if there are any adverse reactions | Report bleeding and other adverse effects |

Medications Reference (APA):

2018 Nurses drug handbook (17th ed.). (2018). Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

| | |
|--|---|
| GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance: | The patient is A+Ox4. She is not in any distress. She appears happy and tired at the same time. Her husband is by her side holding the new born. |
| INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds/Incision: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type: | The patient's skin is pink warm and dry. There are no rashes, bruises, wounds or incisions present. The patient does not have a Braden score. There are no drains present. |
| HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth: | The patient's head is normocephalic. Her eyes meet PERLA. The patient's ears were not assessed. The patient's nares are patent. The patient's teeth are straight and clean. |
| 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 type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema: | The patients S1 and S2 are present upon auscultation. The patients peripheral pulses are +2. No neck vein distention is noted. Edema is present bilaterally on both feet and ankles. |
| RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character | The patient's lung sounds are clear bilaterally. There is no accessory muscle use. |
| GASTROINTESTINAL (5 points): Diet at Home: Current Diet: Height: Weight: Auscultation Bowel sounds: | The patients diet at home is regular. She is 167.6 cm in height and weighs 114.3 kg. Auscultation of bowel sounds was not assessed. The patient's last bowel movement was 03/03/2020. Upon palpation there were no abnormal pains or masses. Upon inspection there was no distention, |

| | |
|--|---|
| <p>Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Fundal Height & Position:</p> | <p>incisions, scars, drains, or wounds noted. Fundal height is U1 midline.</p> |
| <p>GENITOURINARY (5 Points): Bleeding: Color: Character: 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: Rupture of Membranes: Time: Color: Amount: Odor: Episiotomy/Lacerations:</p> | <p>The patient is not bleeding currently. The patient urine is clear and yellow with no odor. The patient's genitals were not assessed. There is no catheter present. The patients membranes were ruptured artificially at 0145 AM. The fluid was clear with no odor. The fluid measured to be about ¾ of a gallon. There are no lacerations.</p> |
| <p>MUSCULOSKELETAL (2 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>She does not need ADL assistance. She is not a fall risk. She is active and up and independently walking.</p> |
| <p>NEUROLOGICAL (1 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: Sensory: LOC: DTRs:</p> | <p>The patient can move all extremities well. PERLA is met. The patient's strength is equal bilaterally in all extremities. The patient is A+Ox4. Her mental status is intact. Her speech is clear and concise.</p> |
| <p>PSYCHOSOCIAL/CULTURAL (1</p> | <p>The patient's coping mechanisms include</p> |

| | |
|--|---|
| <p>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>therapy, good family support, and watching television. She has a master’s degree. She is Lutheran. She stated that she feels safe at home with her family.</p> |
| <p>DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:</p> | <p>The patient delivered a baby girl at 0959 AM on 01/04/2020. The baby was delivered vaginally. The mother lost 304 mL of blood. The babies APGAR scores were 7 after 1 minute and 9 after 5 minutes. The baby weighed 3907 g. The mother is breast feeding.</p> |

Vital Signs, 3 sets (5 points)

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|----------------------------|-------|--------|-----------|------|--------|
| Prenatal | N/A | N/A | N/A | N/A | N/A |
| Labor/ Delivery | 82 | 132/64 | 20 | 98.2 | 99 |
| Postpartum | 77 | 137/71 | 20 | 97.7 | 100 |

Vital Sign Trends: The patients vitals remained stable throughout labor and the shift.

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|------|-------|----------|----------|-----------------|------------------|
| 1518 | 0-10 | Abdomen | 4 | Cramping | Tylenol |
| 1601 | 0-10 | Abdomen | 4 | Cramping | Stopping Pitocin |

IV Assessment (2 Points)

| | |
|-------------------------|---------------------------------------|
| IV Assessment | Fluid Type/Rate or Saline Lock |
| Size of IV: 20 G | Saline lock |

| | |
|--|--|
| <p>Location of IV: Metacarpal vein Date on IV: 03/03/2020 Patency of IV: Patent, flushing without difficulty Signs of erythema, drainage, etc.: No signs of drainage IV dressing assessment: The IV is dry and intact</p> | |
|--|--|

Intake and Output (2 points)

| | |
|---------------|-----------------------|
| Intake | Output (in mL) |
| 490.7 | 404 |

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. |
|--|--------------------|--|
| N+T: Administered pain medication | Q4 hrs | To manage pain |
| N+T: Check babies glucose | Twice during shift | To ensure adequate glucose levels |

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in?

- Taking it in phase

What evidence supports this?

- She is feeding the child, speaking too it lovingly, talking about taking her home, and speaking to her husband with anticipation about having the big sister meet the new baby.

Discharge Planning (2 points)

Discharge location: Home with husband and daughter

Equipment needs (if applicable): N/A

Follow up plan (include plan for mother AND newborn): Visit pediatrician within the first week, call PCP if there are any signs of bleeding or unusual pain

Education needs: Breast-feeding consult

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.”**

| <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 your rationale.</p> | <p>Evaluation (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. Impaired comfort related to postpartum delivery as evidence by a 4/10 pain rating</p> | <p>This was chosen because the patient is in consistent pain from vaginal delivery</p> | <p>1. The patient was given Tylenol 2. She was repositioned to a more comfortable position to rest</p> | <p>The patient was able to take Tylenol and relax in her hospital room while the baby slept.</p> |
| <p>2. Risk for activity intolerance related to postpartum</p> | <p>This was chosen because the patient needs to limit her activity</p> | <p>1. The patient was given pillows to help maximize her comfort 2. The patient has a list of things she can and cannot</p> | <p>The patient understands her limitations and asks questions when necessary</p> |

| vaginal birth | while she is recovering | do in the next couple of weeks | |
|--|--|--|--|
| 3. Risk for constipation as evidence by trouble having bowel movements after delivery | This was chosen because the patient was having trouble having a bowel movement | 1. Colace was prescribed to help with a bowel movement 2. Fluids are administered to help the process | The patient has yet to have a bowel movement |
| 4. Labor pain related to vaginal delivery as evidence by cramping and pain score of 4/10 | This was chosen because the patient is experiencing abdominal cramping related to giving birth | 1. Tylenol was administered 2. The patient was repositioned for comfort | The patient is more comfortable and is open about her pain |

Other References (APA)

Ladwig, G. B., Ackley, B. J., Makic, M. B. F., Martinez-Kratz, M. R., & Zanotti, M. (2020). *Mosbys guide to nursing diagnosis*(5th ed.). Elsevier.