N432 Postpartum Care Plan

Lakeview College of Nursing

Lindsey Davis

Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
3/11/20	AW	20	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	N/A	Single	Norco (rash), Xanax (hallucination)
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	152.4 cm	80.3 kg	yes

Medical History (5 Points)

Prenatal History: Patient is negative for RPR, HbSAG, GBS, beta strep swab. Rubella immune and taking amg folic acid daily. Patient has be attending prenatals regularly. She is G1P1.

Past Medical History: PTSD, depression, anxiety, Spinabifida, epilepsy-(none since 7yrs)

Past Surgical History: Meningocelectomy at birth, lymphadenectomy

Family History: Mother-cancer

Social History (tobacco/alcohol/drugs): Former smoker 0.75 pack years, quit when mom found out she was pregnant 6/19.

Living Situation: Home with significant other.

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Spontaneous rupture of membranes

Presentation to Labor & Delivery (10 points): Patient is 39 weeks, woke up in a puddle of fluids at 1:45. Patient came in to labor and delivery was triaged for contractions. Now 3cm with no bleeding and still feeling fetal movement.

Diagnosis

Primary Diagnosis on Admission (2 points): Spontaneous rupture of membranes

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points):

The patient was brought in to labor and delivery on 3/11 around 02:30. Patient states that she woke up in a medium size puddle of fluid around 01:45. Patient is now 3cm with no bleeding and still feeling fetal movement. Patient delivered baby at 09:56. At the start of this shift, I received report on my patient and was able to use the computer to collect some information. At this time patient was still in labor and delivery recovering. I witnessed a nurse assessment of both mother and baby. During mother's assessment, vitals were taken which were stable, we assessed for fundal location which was to the left of the umbilicus due to a full bladder and firm. Then we also assessed neuro status everything was normal except patient did present with 4 beats clonus. When reflexes were checked at the knees, flexes were not hyperactive. At this time the nurse educated the patient on what clonus was and what they were looking for. She was very therapeutic and reassuring to the patient that they would be monitoring her closely, she explained the symptoms and instructed the patient to call out immediately if she noticed any of them. For baby assessment, vitals were taken I was able to listen to heart and lungs. The baby had also passed her first meconium stool, I was able to change the diaper because mom and dad wished to watch the process. Patient also requested to watch me swaddle the baby as well. Before leaving patient we placed everything in her reach including baby in basinet. Patient was told after she was doing eating, we would assist her up to the bathroom and then to her new room on post-

partum. Around 17:00 patient and baby were moved to their new rooms via two nurses, two students and dad. Patient was stable and comfortable when we left the room.

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	4-6 mcl	4.24	4.24		
Hgb	11.3-15.2 g/dL	11.1	11.1		Due to the small decrease in Hgb, this could just be this patient's normal level.
Hct	33.2-45.3%	33.9	33.8		
Platelets	149-393 k/mcl	278	279		
WBC	4.0-11.7 k/mcl	13.7	18.5		Due to ROM this could increase the patients WBC because there is a portal of entry to the body.
Neutrophils	45.3-79.0%	76.3	80.7		With the increase in WBC neutrophils would also increase on admission to help fight off any infection.
Lymphocytes	11.8-45.9%	14.0	11.5		
Monocytes	4.4-12.0%	9.0	7.4		
Eosinophils	0-6.3%	0.3	0.2		
Bands		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+	A		

Rh Factor		Positive	Positive		
Serology (RPR/VDRL)	non reactive	Negative	Negative		
Rubella Titer	non detected	Immune	Immune		
HIV	non detected	Negative	Negative		
HbSAG	Negative	Negative	Negative		
Group Beta Strep Swab	Negative	Negative	Negative		
Glucose at 28 Weeks	Negative	n/a	n/a		
MSAFP (If Applicable)		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
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)		137.7			

Lab Reference (APA):

Henry, N.J.E., Mcmicheal, M., Johnson, J., DiStasi, Ball, B.S., Holman, C., Lemon, T. (2016).

*Rn adult medical surgical nursing: review module.*Assessment Technologies Institute.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	• Stage 1/latent phase=1hour 0100-Spontaneous rupture of membranes • Stage 1/active phase=3hours 0200-Dilated 3cm, 80% effaced, station 0 • Stage 1/transition=2hours 15 minutes 0420-5.5cm, 90% effaced, station 0 • 0600-8cm 100%, station 0 • Stage 2=2hours 41minutes 0715-10cm 0800 baby girl born at 0956 • Stage 3=14 minutes 0956-1010 placenta
Current stage of labor	Currently in stage 4 since 1010 am to 12:10. The fourth stages begins with the delivery of the placenta and includes at least the first 2 hours after. During this stage it is important to assess fundus and lochia every 15 minutes for the first hour. Encourage bonding. Assess laceration. Promote bonding between the mother and baby. Most new mothers are ready for a nap or a resting period.

Stage of Labor References (2) (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Roland, P., Wilford, K. L., & Barlow, M. S. (2016). *Rn maternal newborn nursing: review module*. Assessment Technologies Institute

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

Current Medications (7 points, 1 point per completed med)
7 <u>different</u> medications must be completed

Home Medications (2 required)

Brand/Generic	Calcium carbonate/ TUMS	Prenatal vitamin			
Dose	1,000 mg	27-0.8mg			
Frequency	PRN every 8 hours	Daily			
Route	Oral	Oral			
Classification	antacid	Vitamin			
Mechanism of Action	Essential component and participant in physiologic systems and reactions	Multivitamin and iron product used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, during pregnancy.			
Reason Client Taking	heartburn indigestion	supplement			
Contraindications (2)	Hypercalcemia, and dehydration	Iron metabolism disorder causing increased iron storage. An overload of iron in the blood.			
Side Effects/Adverse Reactions (2)	hypercalcemia, nephrolithiasis	Constipation Diarrhea			

Nursing Considerations (2)	caution if renal impairment or hyperparathyroidism	n/a			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor kidney function test.	Iron labs			
Client Teaching needs (2)	Take by mouth, with water.	Take with full glass of water. Do not break, chew crush or open capsule-take whole.			

Hospital Medications (5 required)

Brand/Generic	Ondansetron/ Zofran- ODT	fentaNYL/ ropiv.	Acetaminophen/ Tylenol	Carboprost/ Hemabate	Cytotec/Misoprostol	
Dose	4 mg	50 mcg	975 mg	250 mcg	1000mcg	
Frequency	PRN every 6 hours	PRN every 2 hours	PRN every 4 hours	PRN every 15 mins	Once	
Route	Oral	Subcutaneous	Oral	Intramuscular	rectally	
Classification		anesthesia	analgesics	gynecologic bleeding	Prostaglandins	
Mechanism of Action	selectively antagonizes serotonin 5-HT3 receptors	Binds to various opioid receptors, producing analgesia and sedation	antipyretic effect via direct action on the hypothalamic heat-regulating center.	stimulates smooth muscle and uterine contractions	Inhibits gastric acid secretions and protects GI mucosa; produces uterine contractions.	
Reason Client Taking	nause	severe pain	Mild pain	bleeding	hemorrhage	
Contraindications (2)	congenital long QT syndrome, bradycardia	caution if seizure disorder, or hypovolemia	Hepatic impairment, hypovolemia	symptomatic CAD, caution if anemia	Prior cesarean section. Caution if cardiovascular disease.	
Side	bradyarrhyth	Monitor for	renal tubular	uterine rupture,	Uterine rupture	

Effects/Adverse Reactions (2)	mias, ECG if electrolyte abnormalities	respiratory depression, hypotension	necrosis, headache	hemorrhage	bronchospasm	
Nursing Considerations (2)	Monitor vitals	Vital signs continuously and ECG	caution if malnutrition or renal impairment	No routine tests, monitor vitals and signs for excess bleeding.	Serum pregnancy test <2wk before treatment starts	
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Cardiac rhythm at baseline	Cardiac rhythm at baseline	Monitor liver function	Monitor vitals.	Serum pregnancy test <2wk before treatment starts. Monitor GI symptoms.	
Client Teaching needs (2)	Fine to take while driving.	Not to drive or drink while taking this medication.	Don't take with alcohol	If patients feels light headed or notices signs of excessive bleeding notify the nurse.	Teach about side effects of GI and GU effects.	

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient appeared tired and no signs of pain. Patient knew where he was, who he was, the year and the president. A&O x4. Patient had not complaints and no requests at this time.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The Patient's skin is pink, dry, and warm. Patients' stomach and back appear well moisturized, and no rashes detected. Skin integrity was intact. Lower extremities have +2 pitting edema, and varicose veins present, nurse and patient state this has been normal through the pregnancy. Nails normal for ethnicity. Cap normal less than 3 seconds. Skin turgor was normal, 1 second of tenting. No wounds or bruises were noted on the assessment. The Patient's Braden score was 23.

HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Pupils are symmetrical, with no sclera. Head and Neck appear in normal limits. No jugular vein distention, no carotid bruit, no lymphadenopathy. Trachea midline, no thyroid tenderness. The ear is within normal limits and hearing intact. Patient denies the use of glasses. The nose appears normal, with no deviation. Patient has no dentures, and no cavities noted at this time. .
CARDIOVASCULAR (1 point): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	Regular rate and rhythm, S1 and S2 are normal, no murmurs/rubs/or gallops, point of maximal intensity non displaced. The capillary refill was normal within 3 seconds. Nail beds normal for ethnicity. +2 edema on the ankle, pedal bilaterally. Pulses normal 3+ radial and dorsal bilaterally. Pulses intact and symmetrical in all extremities.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient does sound clear in upper and lower lungs bilaterally both anterior and posterior upon auscultation. No rales/rhonchi/wheezes. Patient has regular unlabored breathing—patient on room air. No cough noted
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:**	Patient does not follow any special diets at home and is on a normal diet in the hospital. Weight is 80.3 kg, and height is 152.4cm, making the BMI 34.6, placing this patient in the obese category for his height and weight. Normal bowel sounds normal in all four quadrants (sounds heard within 1 minute). Resonant to percussion, soft, non-distended and tender on the right side both upper and lower quadrants, no rebound and no hepatomegaly. No palpable masses. Stretch marks noted on lower abdomen. Last bowel movement was 3/10/2020. Fundus to the left of umbilicus (due to full bladder), hard.
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:**	Patients bleeding is light rubra color. Patient had spontaneous rupture of membranes at home around 0100, patient states it was clear, a large amount on the bed with no odor. Patient has a 1st degree laceration.

Pain with urination: Y ☐ N ☒ **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☒ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patients fall risk in the computer was a 0. However, patient had an epidural so she is a fall risk for the first 12 hours. She does need assistance, up with 2 for the first time.
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:** **DTRs:**	Patients' pupils were equal, round, and reactive to light when assessing with a penlight. Patient was orientated to person, place, time, and situation. The Patient's level of consciousness was within normal limits. The patient was easily arousable. The Patient's speech was clear and easy to understand. Judgment is intact. No LOC. Patient is positive for 4 beat clonus with normal patellar DTRs.
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):**	Patient completed the 12th grade. Patient is a Christian and believes in God. Patient lives at home independently with significant other.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:**	Patient had a vaginal delivery today 3/11 at 0956. Patient lost approximately 165mL. Patient delivered a baby girl weight was 3.29kg, apgar 8 at 1, 9 at 5. Patient is currently breastfeeding, baby.

Weight: **Feeding Method:**	

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	99	112/65	18	36.5	95
Labor/ **Delivery**	112	146/88	20	37.9	95
Postpartum	86	125/74	20	37.3	97

Vital Sign Trends: Vitals all fall in within normal limits, except for pulse and blood pressure during labor. However, these vitals are normal and expected due to pain and distress during delivery.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
01:56	Numeric	Abdomen	10/10	Intermittent cramp ache	None
13:04	Numeric	abdomen	4/10	Intermittent cramp ache	Tylenol given

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 Right top of hand. 3/11/20 10:30am IV has line not attached and saline locked, clean and intact. Dressing was allusive, no phlebitis or infiltration present, catheter patent.

Intake and Output (2 points)

Intake	Output (in mL)

1432- Lactic Ringers	380 urine, 165 blood

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.
Monitor neuros by checking for clonus	Hourly	Clonus is a sign of preeclampsia that can be life threating to the mother.
Monitor fundal height and position.	With every assessment	To prevent blood loss.
Monitor laceration for signs and symptoms of infection.	With every assessment	Infection prevention
Encourage ambulation	frequently	To promote circulation in lower extremities.

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? This mother seems to be in the dependent phase of maternal adaptation.

What evidence supports this? Evidence to support this is mother wanting to watch the first diaper change, wanting watch the nursing student swaddle the baby. Mother is relaying on the assistance of nursing staff and father, which is approaches for this time period.

Discharge Planning (2 points)

Discharge location: Home with significant other.

Equipment needs (if applicable): Breastfeeding supplies such as a breast pump.

Follow up plan (include plan for mother AND newborn): Both mother and baby should have follow up visits. Baby should be seen by their pediatrician within 24-48 hours of leaving the hospital. Mother should be seen by OB physician within one week of discharge.

Education needs: The mother should be educated on signs of post-partum hemorrhage and when to be seen or taken into a doctor's office. She should also be reminded of the side effects of clonus so she can watch for those symptoms as well.

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) 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 your rationale.	**Evaluation (1 pt each)** • How did the patient/ family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Complication of pregnancy-associate hypertension related to blood pressure as evidence by 4 beat clonus.	Preeclampsia is a huge risk for post-partum mothers and can be life threating if not treated properly.	**1.** Assess BP regularly **Rationale-**high bp is a symptom of preeclampsia. **2. Assess neuro status Rationale-**looking for hyperactive reflexes, clonus, loc, etc.	Patient was very willing to participate in the plan of care and willing to be compliant.
2. At risk for imbalanced fluid volume related to fluid loss	Patient lost 160 mL of blood during delivery.	**1.** Assessing BP regularly **Rationale-** Low blood pressure is a sign of dehydration. **2.** Administering fluids	Patient was very willing to participate in the plan of care and willing to be compliant.

during labor.		**Rationale-**Help replace the fluid loss.	
3. At risk for infection related to first degree laceration.	Laceration in the patient's perineum puts patient at risk for infection if not cleaned properly.	**1.** Watch for signs of infection, tachy, fever. **Rationale** these are early signs to detect infection. **2.** Educate on how to clean the wound. **Rationale** Educating the patient is the best way to get them to be complaint.	Patient was very willing to participate in the plan of care and willing to be compliant.
1. At risk for anxiety related to fear of the unknown.	Patient already has a history of anxiety and has been without her medication during pregnancy.	**1.** Assess patient for mental status. **Rationale-**To make sure she is not overly anxious. **2.** Watch Heart rate. **Rationale-**When elevated can indicate anxiety or fear.	Patient was very willing to participate in the plan of care and willing to be compliant.

Other References (APA):

Ladwig, G. B., & Ackley, B. J. (2011). *Mosbys Guide to Nursing Diagnosis.* Elsevier Health Sciences.