N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	Patient Initials	Age	Gender
0430 this morning	**N/a**	**37 years old**	**Female**
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black	**Work from home**	**married**	**NKA**
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full	**5'3"**	**196lbs**	**yes**

Medical History (5 Points)

Prenatal History: G7T7P0A0L7. Client was diagnosed with significant for gestational diabetes controlled with diet and dental caries. Glucose on admission is 135.

Past Medical History: significant only for a strong family history of diabetes mellitus

Past Surgical History: Patient denies past surgeries

Family History: significant only for a strong family history of diabetes mellitus

Social History (tobacco/alcohol/drugs): Patient reports that she has quit smoking. Her smoking use included cigarettes. She has never used smokeless tobacco. She reports that she drank alcohol. She reports that she does not use drugs

Living Situation: She lives with her husband

Education Level: Patient has a college degree

Admission Assessment

Chief Complaint (2 points): high blood glucose

Presentation to Labor & Delivery (10 points): She arrived in early labor at 0430 this morning. Her prenatal course was significant for gestational diabetes controlled with diet and dental

carries. Glucose on admission is 135. The patient's past obstetrical history was significant for a progressive increase in the size of her children at birth, with her last child weighing 9# 3 oz.

Diagnosis

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

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

The client is 28 years old and has just delivered her 7th child, who was large for gestational age. On the first evaluation, the client had heavy bleeding with quarter size clots and a boggy, flaccid uterus, and a blood loss of 1420 ml which is indicative of bleeding. The initial interventions to stop the bleeding performed for this client were fundal massage, administration of misoprostol, methylergonovine. However, the client's uterus was still atonic. The second intervention made to stop the bleeding was administering Carboprost, and after administration, the client's womb began to firm, and the bleeding decreased until there was no further bleeding. The client's vital signs were done three different times, and initially, the client's blood pressure was hypertensive at 141/79, but by the third vital sign measurements, her blood pressure lowered to 134/72.

The most common cause of postpartum hemorrhage is uterine atony, which us what the client experienced after delivering her first son **(Web MD, 2019)**. Some reasons that could have happened can be due to the infant being large for gestational age, which causes the uterus to stretch further than with a fetus that is average for gestational age. Also, the fact that she has had six other children before this pregnancy could contribute to the decreased contractility of the uterus over time. In a regular postpartum client, the uterus would return to its standard size by

gradually going through involution usually over 9-10 days (Ricci, Kyle, Carman, 2017, p.536). The uterus should perform "contraction of muscle fibers to reduce those previously stretched during pregnancy" however, in this client, the uterus was overstretched, causing the womb to be unable to contract, which caused the hemorrhage (Ricci, Kyle, Carman, 2017, p.536). The client is currently in the recovery stage of the postpartum hemorrhage and has been on the postpartum unit a few hours after the delivery of her baby boy.

Postpartum Course References (2) (APA):

Wed MD. (2019, December 6). *Vaginal Bleeding After Birth: When to Call a Doctor*. Retrieved May 4, 2020, from https://www.webmd.com/women/vaginal-bleeding-after-birth-when-to-call-doctor#2

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

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	**3.8 – 5.3**	**4.40**	**4.08**	**4.08**	
Hgb	**12 – 15.8**	**12.8**	**14.08**	**9.2**	**Blood loss can cause this abnormal value**
Hct	**36 – 47**	**37.7**	**37**	**33.9**	**Blood loss can cause this abnormal value**
Platelets	**140 - 440**	**259**	**212**	**189**	
WBC	**4 – 12**	**10.80**	**6.7**	**6.7**	
Neutrophils	**47.0 – 73.0%**	**77.4**	**65.4%**	**65.4%**	
Lymphocytes	**18.0 – 42.0%**	**16.4**	**25.9%**	**25.9%**	**Could have been due to infection**
Monocytes	**4.0 –**	**5.7**	**7.8%**	**7.8%**	

	12.0%				
Eosinophils	**0.0 – 5.0%**	**0.2**	**0.4%**	**0.4%**	
Bands	**0.0 – 0.4%**	**0%**	**0.4%**	**0.4%**	

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	**O**	**N/a**	**N/a**	**N/a**	**important to know in case of blood loss and needs for blood transfusions**
Rh Factor	**Negative**	**N/a**	**N/a**	**N/a**	**If negative and baby is positive may need RhoGAM injection after delivery**
Serology (RPR/VDRL)	**Non-reactive**	**N/a**	**N/a**	**N/a**	
Rubella Titer	**Immune**	**N/a**	**N/a**	**N/a**	**If not immune will be given injection after delivery**
HIV	**Not detected**	**N/a**	**N/a**	**N/a**	**If positive the infant will be treated accordingly based on type of delivery**
HbSAG	**Non-reactive**	**N/a**	**N/a**	**N/a**	
Group Beta Strep Swab	**Positive**	**N/a**	**N/a**	**N/a**	
Glucose at 28 Weeks	**60 - 99**	**N/a**	**N/a**	**N/a**	
MSAFP (If Applicable)	**N/a**	**N/a**	**N/a**	**N/a**	
		N/a	**N/a**	**N/a**	
		N/a	**N/a**	**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
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	N/a	N/a	N/a	N/a	N/a
N/a	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)	<0.2	N/a	N/a	N/a	To determine kidney function

Lab Reference (APA):

Capriotti, T., Frizzell, J., (2016), *Pathophysiology Introductory concepts and clinical perspectives*. Philadelphia, PA, F.A. Davis Company

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

	Your Assessment
History of labor:	

Length of labor **Induced /spontaneous** **Time in each stage**	Stage 1-0430-1105 Stage 2- 1105 Stage 3- 1105-1119 Induced
Current stage of labor	Currently stage 3 of labor. Placenta is delivered vaginally. If the client has a c-section the placenta will be removed during the procedure. The provider will check to see if the placenta is intact. The third stage typically lasts 5-30 minutes but could be if an hour. The client should relax and possibly try breastfeeding to stimulate oxytocin that promotes contractions to expel the placenta. After delivery the nurse will massage the fundus to assess for firmness because if it feels boggy the nurse will implement interventions to prevent or stop hemorrhaging.

Stage of Labor References (2) (APA):

Mayo Clinic. (2020, February 6). *Labor anddelivery, postpartum care*. Retrieved May 2, 2020, from https://www.mayoclinic.org/healthy-lifestyle/labor-and-delivery/in-depth/stages-of-labor/art-20046545

Mayo Clinic. (2020, March 25). *Pregnancy week by week*. Retrieved May 2, 2020, from https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/placenta/art-20044425

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

Home Medications (2 required)

Brand/Generic	Aspirin (Bayer aspirin)	Amoxicillin (Novamoxin)	(VITRON) Vitamin c & Iron	N/a	N/a
Dose	81 mg	875 mg	1 mg tablet (proprietary blend)	N/a	N/a
Frequency	Daily	BID	1 tablet/day	N/a	N/a
Route	Oral	Oral	Oral	N/a	N/a
Classification	Anticoagulant	penicillin's	Vitamin C and iron supplement	N/a	N/a
Mechanism of Action	Non selectively and irreversibly inhibits cyclooxygenase, reducing prostaglandin and thromboxane A2 synthesis, producing analgesic, anti-inflammatory, and antipyretic effects and reducing platelet aggregation	Bactericidal; inhibits cell wall mucopeptide synthesis	Vitamin C helps the iron get absorbed better in the GI tract	N/a	N/a
Reason Client Taking	Thin the blood during pregnancy	Treat infection	Iron absorption	N/a	N/a
Contraindications (2)	Hypersensitivity Aspirin triad	Hypersensitivity Mononucleosis	Hypersensitivity Iron metabolism	N/a	N/a

			disorder		
Side Effects/Adverse Reactions (2)	Dyspepsia nausea	Nausea Vomiting	Constipation Stomach pain	N/a	N/a
Nursing Considerations (2)	Monitor PT and INR Use vitamin K as antidote	Monitor CBC Ask about med compliance	CBC Monitor dietary intake	N/a	N/a
Key Nursing Assessment(s)/Lab(s) Prior to Administration	PT and INR	Cr at baseline CBC	CBC	N/a	N/a
Client Teaching needs (2)	Avoid leafy green foods Hold pressure longer for cuts that bleed.	Take as prescribed Finish the bottle even when feeling better	Will cause dark stools Should be taken on an empty stomach	N/a	N/a

Hospital Medications (5 required)

Brand/Generic	Oxytocin (Pitocin)	Hydrocodone (hysingla ER)	(Tylenol) Acetaminophen	Carboprost (Hemabate)	Mistoprostal (cytotec)
Dose	30 mg in 500 ml bag	1 tablet	650 mg	0.25mg	800mcg
Frequency	334ml/hr	Q6h PRN	Q4h PRN	once	Once
Route	IV	PO	PO	IM	Rectal
Classification	Gynecologic bleeding	Opioid	Analgesic	Gynecology bleeding	Cytoprotectants
Mechanism of Action	Binds to oxytocin receptors in myometrium, increasing	Binds to various opioid receptors, producing	Analgesic mechanism of action unknown; antipyretic	Stimulates smooth muscle and uterine contractions	Inhibits gastric acid secretion and protects GI mucosa;

	intracellular Ca and stimulating uterine contractions	analgesia and sedation	effect via direct action on the hypothalamic heat-regulating center	(synthetic prostaglandin)	produces uterine contractions
Reason Client Taking	Contacting the uterus	Pain	Pain	Stop bleeding	Contract the uterus
Contraindications (2)	Hypersensitivity Vasa previa	Hypersensitivity MAO inhibitor use w/in 14 days	Hypersensitivity Caution hepatic impairment	Hypersensitivity Pregnancy in third trimester	Hypersensitivity Prior c-section
Side Effects/Adverse Reactions (2)	Nausea Vomiting	Nausea Constipation	Nausea Rash	Vomiting diarrhea	Diarrhea Abdominal pain
Nursing Considerations (2)	Electronic fetal monitoring Assess uterus contractions	BP after treatment Monitor ECG	As pain scale rating prior to admin. Ask pain scale 30-60 mins after administration	Monitor effectiveness to stopping the bleeding Maximum dose is 12g	Monitor contractions Assess firmness of the uterus while massaging
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Electronic fetal monitoring	Cr at baseline s/s respiratory depression	Cr. at baseline	No routine test recommended	Assess uterus for firmness
Client Teaching needs (2)	Hormone can be stimulated by breast feeding This will aid in contracting the uterus after birth.	Report any decrease in breathing from baseline Medicine could cause dizziness so to ask for assistance when ambulating post administration	Do not take more than 4g within a day Do not wait for pain to be intolerable before asking for pain medications	Notify provider t o renal or liver impairment prior to administration Notify the provider and staff of history of asthma	This is used to prevent NSAID associated gastric ulcers but is has other uses such as treating postpartum hemorrhage May experience nausea and abdominal

					cramps

Medications Reference (APA):

Jones & Bartlett Learning. (2019) *2019 Nurse's Drug Handbook, eighth edition.* Burlington, MA, Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x4 Distressed Clothes damp from sweat Dressed in a hospital gown
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	No rashes, bruises, wounds, or drains present Braden Score: 10 skin warm, moist, and pink
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERLA Ears: moist and pink Teeth: white, clean, no significant odor Nose: moist and pink Head and neck midline

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:**	3+ pitting edema to both feet, clear S1 and S2, normal sinus rhythm, cap refill < 3secs, no neck vein distention, Peripheral pulses +2, no neck vein distention, no murmurs
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Lung clear in all quadrants No accessory muscle use
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:**	Normoactive bowel sounds in all quadrants Regular diet Weight: 196lbs Height: 5'3" Last BM unknown No pain during palpations No distention, incisions, scars, drains, or wounds No ostomy, NG, or feeding tubes/PEG tube
GENITOURINARY (5 Points): **Bleeding:** **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **Rupture of Membranes:** **Time:** **Color:** **Amount:** **Odor:** **Episiotomy/Lacerations:**	No pain or burning when voiding No dialysis No Catheter Urine yellow and clear Membranes are ruptured because newborn is delivered; color-clear, odor- odorless, amount- Quantifiable blood loss 1420 ml. Foley catheter removed (output 605ml) at initiation of pushing Left mediolateral episiotomy
MUSCULOSKELETAL (2 points): **ADL Assistance: Y☐ N ☐**	Full ROM No supportive devices

Fall Risk: Y ☐ N☐ **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Independent – Stand by assist with ADL No numbness or tingling Strength equal bilaterally in arms and legs Skin pink, warm, pulses +2, full sensation and motor function. Fall Score:10
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:**	Orientation X4 Yes MAEW Yes, PERLA Yes, strength equal Alert Clear speech no slurred speech Felt sensation in extremities Full level of consciousness; no loss of consciousness
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 is thrilled to finally have a boy after 6 girls! Uses deep breathing exercises to help with pain and changes positions frequently
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	Boy At 1105, she delivered a 10lbs 2 oz baby boy mediolateral episiotomy Quantifiable blood loss 1420 ml. Vaginal birth Breast feeding APGAR: 9

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	**102**	**141/72**	**16**	**98.2**	**97% room air**
Labor/	**100**	**139/70**	**16**	**97.8**	**97% room**

Delivery					**air**
Postpartum	**102**	**134/72**	**16**	**98.2**	**97% room air**

Vital Sign Trends: on admission, viral signs are stable, report of good fetal movements**.**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**numeric**	**Abdominal cramping**	**6**	**cramping**	has hydrocodone I tablet Q 6 hours prn
1200	**Numeric**	**Perineal discomfort**	**6**	**Discomfort**	Tylenol 650mg Q 4 hours prn and position change

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:**	IV left wrist 20 g oxytocin 500ml to run over 4 hours following 2-hour acute recovery period Patency good, no signs of erythema, drainage and dressing intact, clean, and dry

Intake and Output (2 points)

Intake	Output (in mL)
1000ml IV	Quantifiable blood loss 1420 ml. Foley catheter removed (output 605ml) at initiation of pushing

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- massage the fundus M- Misoprostol 800 mcg rectal, IM methylergonovine 0.25mg	N- every assessment preformed fundal massage M- once	Client is experiencing a post-partum hemorrhage due to quarter size clots and boggy, flaccid uterus and blood loss of 1420ml. The uterus was massaged until firm and misoprostol and methylergonovine were administered to decrease the bleeding.
N- fundus massage T- carboprost	N- every assessment preformed fundal massage M- once inhibit	Postpartum fundal massage continued, and the medication stopped the bleeding.
N/a	**N/a**	**N/a**
N/a	**N/a**	**N/a**

Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in?

Taking-in phase

What evidence supports this?

Talkative about finally having a boy, dependent, and within 24-48 hours post birth.

Discharge Planning (2 points)

Discharge location: home with family

Equipment needs (if applicable): none needed

Follow up plan (include plan for mother AND newborn): none currently

Education needs: Teach the client about signs and symptoms of hemorrhaging so she knowns when to seek medical attention.

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. A risk for severe fluid volume deficit related to potentially life-threatening consequences as evidence by the 1420ml blood loss.	Blood loss greater than 500 ml is an indication of hemorrhage and interventions were done but the loss of fluids will cause dehydration post birth.	1. Monitor hydration status Rationale Normal specific gravity is 1.005-1.030 and greater than 1.030 is an indication of dehydration 2.Assess temperature every 2-4 hours per facility policy Rationale Elevated temperature is associated with dehydration	Client asks why it is necessary to take her temperature so often since she not sick. The nurse response by saying that elevated temperature can indicated dehydration because of the blood loss you are at higher risk for dehydration. Goal: client to consume at least 2 liters of water for 24 hours.
2. Acute pain related to vaginal birth as evidence by pain level of a 6 on a scale of 0-10.	Client complains of abdominal cramping and perineal discomfort post-delivery with a pain rating of 6.	1 encourage the client to verbalize her level of pain using a valid pain scale Rationale This goes towards documentation and understanding of the client's pain. 2. assess for verbal and nonverbal cues indicating pain Rationale	The client tells the nurse her pain is a 6 and she's feeling abdominal cramping. She presents with facial grimacing. The nurse documents the verbal pain rating and the nonverbal pain indications prior to moving on to address the pain and alleviate it.

		Nonverbal cues include facial grimacing, moaning, and muscle tension.	
3. Risk for infection related to episiotomy as evidence by being a wound near the rectum which increases chances of contamination.	Unclear if client has ever cared for an episiotomy wound before so teaching proper care will prevent infection.	1. Educate to the client why they are receiving a stool softener, increase fluid intake and fiber. Rationales This will prevent constipation and reduce the need for striating with can irritate the episiotomy. 2. Instruct the client to pat the area dry after a stiz bath. Also after voiding or having a BM the client should spray the area with warm water and pat dry with clean towel or wet wipe but do not use toilet paper. Rationales Using a patting motion will decrease the chances of contaminating the wound with bacteria. Also, it will decrease the chances of the sutures being pulled causing pain.	The client demonstrated understanding while being assisted to the bathroom by patting herself dry after voiding. The nurse administers the stool softener to the client, and she asks why, and the nurse tells the client it will prevent constipation. The nurse also gets the client a fresh glass of water and suggests she eats foods high in fiber because that will also decrease constipation.
4. Potential for shock related to hemorrhage as evidence by 1420ml blood loss.	The fast shift in fluid volume could cause shock in the client and should be monitored.	1. Position the client in a side lying position for optimal perfusion and change positions every 30 mins. Rationales This ensures adequate circulation. 2. Keep record of I/O's of the client Rationales Monitoring I/O's will	Within 2-3 hours of appropriate interventions, the patient returns to a functional level of blood volume/body fluids as measured by return to urinary output greater than 30 ml/hr.

		contribute to monitoring if the client is taking in enough fluids to reduce the chances of shock.	

Other References (APA)

Swearingen, P., (2019) *All-in-One Nursing Care Planning Resource*. Fifth edition. St. Louis, MI, Elsevier