

N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission 02/23/2020	Patient Initials AK	Age 23	Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Married	Allergies No known allergies
Code Status full	Height 5'4''/162.2cm	Weight 221lb/100.2kg	Father of Baby Involved yes

Medical History (5 Points)

Prenatal History: Patience followed appropriate care and went to every single appointment as well as have taken prenatals to improve baby's likelihood for success. Patient had nausea and depression with this pregnancy and those symptoms were being controlled with medication as well as follow up appointments with a psychiatric Department.

Past Medical History: ADHD, anxiety, GERD

Past Surgical History: cyst removal, EGD

Family History: chart was lacking this information patient was not forthcoming with this information

Social History (tobacco/alcohol/drugs): no tobacco use or drug use, some alcohol use.

Living Situation: Patient lives with her husband and son in a home with their two dogs and one cat.

Education Level: patient finished high school and has some college education.

Admission Assessment

Chief Complaint (2 points): induction of labor due to mental status

Presentation to Labor & Delivery (10 points):

The patient presented during the end of the latent phase which in this case the patient was at 3cm of dilation and 70% effaced. During this phase contraction duration can last from 30 to 45 seconds and the intensity can be mild to palpation. Contractions frequency are becoming to be 2 to 5 minutes and the duration of 45 to 60 seconds and can be intensity of moderate to palpation. This patient was in the first stage of Labor from when she presented of 3 cm until the 10 centimeters mark for 5 hours. During the second stage of Labor there is consistent active pushing that can last up to an hour, contractions are in a 2 to 3 minute consistency or less contractions intensity are strong and the mothers have strong urges to push during this phase. For this patient the perineal phase ended at 12:54 p.m. The placenta separated from the uterine wall and comes out from the vaginal opening 1:00 pm. The patient hemorrhaged after the delivery of the placenta and received 2 mg of methergine, 1000 mg of cytotec and 1000 mg TXA. The fourth stage of Labor is not charted or documented in the chart. The Patients current stage of Labor is postpartum.

Diagnosis

Primary Diagnosis on Admission (2 points): Social induction

Secondary Diagnosis (if applicable):.

Postpartum Course (18 points)

During the postpartum phase the body is trying to get back to normal previous to the fetus.

The uterus contracts and goes down to the normal size it was previous to baby by day 9.

Lochia starts with a rubra color which is deep red mixture of mucous, tissue debris and

blood that occurs from the first three to four days after birth(Ricci, Kyle, & Carman, 2017). After that the color of the Lochia will reduce in color and eventually disappear. Some patients my experience afterpains where does the involvement involution process involves uterine contractions. Shortly after birth the vaginal mucosa is red and thin with fewer gey. The mucosa thickens an regenerates then approximately 3 weeks. The perineum is also red and bruised for the first day or two after the birth. If the birth involved an episiotomy or laceration they complete healing takes about four to six months in the case of no complications at the site. Muscle tone may or may not return to normal, depending on the extent of injury to muscle, nerve, in connecting tissues(Ricci, Kyle, & Carman, 2017). The patient I was assigned to drink clinical did not have episiotomy or a laceration during the vaginal delivery. Though there was some swelling and bruising in the perennial area during the first 24 hours after delivery. Blood pressure in pools go back to normal previous two pregnancy. The stroke volume goes back down and blood pressure stabilizes. The patient should be encouraged to avoid every three hour's to assure the uterus is allowed to contract appropriately. The phases of maternal adaptation start with the taking in phase which is the time immediately after birth when the patient needs sleep, depends on others to meet her needs, in reliefs the events surrounding the birth process(Ricci, Kyle, & Carman, 2017). This is the face that my patient is in while I was doing her assessment. There will be talk about the baby Ann revisiting the birth process. The second phase is the taking hold phase where it is characterized by dependent and independent maternal behavior. This face typically starts the second or third day postpartum and may last several weeks. This is the phase where the patient regains control over her bodily functions and is taking hold and becoming preoccupied with the present. The next phase is the letting

go phase . The third phase of maternal adaptation where the woman establishes relationships with other people. Is adapting to Parenthood through the new role as a mother and assuming responsibilities of the care of the newborn with a bit more confidence(Ricci, Kyle, & Carman, 2017).

Postpartum Course References (2) (APA):

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

Henry, Norma Jean E., et al. *RN Maternal Newborn Nursing: Review Module*. Assessment Technologies Institute, 2016.

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	4.84	4.33	4.56	Hemorrhage and with active bleeding the number of red blood cells decreased.
Hgb	12 - 15.8	14.8	11.7	9.5	With active bleeding the number of red blood cells increase and the hemoglobin increases. It takes time for the hemoglobin to fall only if blood volume is finished with fluids of the hemoglobin diminish.
Hct	36 - 47	42.6	35.1	29	With active bleeding, the number of red blood cells decrease and therefore their hematic rate decreases.
Platelets	140 - 440	202	222	191	
WBC	4 - 12	9.3	8.3	12.5	
Neutrophils	47 - 73	70.5	64.5	66.9	

Lymphocytes	18 - 42	4.5	26.5	25.2	
Monocytes	4-12	6.3	7.3	6.8	
Eosinophils	0-5	1.2	1.4	0.3	
Bands	1-5	not documented	not documented	not documented	

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	O	O	O	
Rh Factor	+/-	+	+	+	
Serology (RPR/VDRL)	negative	negative	negative	negative	
Rubella Titer	negative	negative	negative	negative	
HIV	Non-reactive	Non-reactive	Non-reactive	Non-reactive	
HbSAG	Negative	Negative	Negative	Negative	
Group Beta Strep Swab	negative	negative	negative	negative	
Glucose at 28 Weeks	60-180	142			
MSAFP (If Applicable)					

Additional Admission Labs **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal	Prenatal	Value on	Today's	Reason for Abnormal
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	Range	Value	Admission	Value	
No other labs					

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)	Not charted				

Lab Reference (APA):

Pagana, K. D., & Pagana, T. J. (2014). *Mosbys manual of diagnostic and laboratory tests*. St. Louis, MO: Elsevier Mosby.

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

	Your Assessment
History of labor:	
Length of labor	First stage: 5 hours 3-10

<p>Induced /spontaneous</p> <p>Time in each stage</p>	<p>second stage 1254 hemorrhage 2mg methergine 1000mg</p> <p>Cytotec, 1000 mg TxA</p> <p>third stage: not complete charting and was not able to get much information</p> <p>Induced labor</p>
<p>Current stage of labor</p>	<p>Post partum</p>

Stage of Labor References (2) (APA):

Henry, Norma Jean E., et al. *RN Maternal Newborn Nursing: Review Module*. Assessment Technologies Institute, 2016.

Ricci, S. S., Kyle, T., & Carman, S. (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	Bupropion HCL PO	Celexa	prenatal			
Dose	150mg	20mg	0.4-32.5mg			
Frequency	Daily	Daily	Daily			
Route	Orally	Orally	Orally			
Classification	Antidepressant	Antidepressant	vitamin			
Mechanism of Action	Inhibits norepinephrine, dopamine, and serotonin reuptake.	Probably linked to potentiation of serotonergic activity in the CNS resulting from inhibition of neuronal reuptake of serotonin.				
Reason Client Taking	Depression	Depression	aid the diet needs before, during, and after pregnancy			
Contraindications (2)	Use of SSRI's, renal and hepatic impairment	Hypersensitivity, hypokalemia	hypersensitivity			
Side Effects/Adverse Reactions (2)	abnormal dreams, seizures	nausea, hypotension	Abdominal pain, constipation			
Nursing Considerations (2)	increased restlessness	correct electrolyte	constipation, stool			

	, minimize risk of seizures	imbalance before starting drug	discoloration			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	May increase LFT values.	non reported	none			
Client Teaching needs (2)	monitor for increased suicidal thoughts, consult provider before taking OTC drugs.	MAO inhibitors should not be taken at the same time, not to stop taking drug abruptly.	Signs of a significant reaction like wheezing; chest tightness need to be reported			

Hospital Medications (5 required)

Brand/Generic	Tylenol	Celexa				
Dose	650mg	20mg				
Frequency	Q4 PRN	Daily				
Route	Orally	Orally				
Classification	analgesic	Antidepressant				
Mechanism of Action	due to activation of descending serotonergic inhibitory pathways in the CNS	Probably linked to potentiation of serotonergic activity in the CNS resulting				

		from inhibition of neuronal reuptake of serotonin.				
Reason Client Taking	pain relief	Depression				
Contraindications (2)	renal and hepatic insufficiency	Hypersensitivity, hypokalemia				
Side Effects/Adverse Reactions (2)	Skin rash, Anemia	nausea, hypotension				
Nursing Considerations (2)	do not use with other drug products containing acetaminophen or if allergic to acetaminophen or any of the inactive ingredients	correct electrolyte imbalance before starting drug				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	liver panel	non reported				
Client Teaching needs (2)	Liver problems like dark urine, fatigue, lack of appetite need to be reported	MAO inhibitors should not be taken at the same time, not to stop taking drug abruptly.				

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

<p>GENERAL (0.5 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>AOx3 No acute distress and appears stated age, well groomed an relaxed laying on the bed with the infant.</p>
<p>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:</p>	<p>pink, warm and dry skin turgor is elastic, capillary refill is less than 3 seconds. No noted lesions or rash.</p> <p>Braden scale of 20</p> <p>No drains or ports present on the patient.</p>
<p>HEENT (0.5 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Had is normal cephalic, PERRLA, extraocular movements intact. No noted deviated septum, polyps. Moist mucous membranes, no noted exudate, lesions or erythema. Trachea midline, good dentition.</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 type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>Regular rate and rhythm, no noted murmurs, galops or rubs. No noted neck vein distention or edema. Cap refill less than 3 seconds , peripheral pulses palpable.</p>
<p>RESPIRATORY (1 points): Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Lungs clear to auscultation bilaterally, no noted wheezes, bronchi or crackles. No accessory muscle use</p>
<p>GASTROINTESTINAL (5 points): Diet at Home: Current Diet: Height:</p>	<p>Died at home in current is normal diet with no restrictions.</p> <p>5'4''/162.2 cm</p>

<p>Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Fundal Height & Position:</p>	<p>221 lb/100.2 kg</p> <p>Bowel sounds present in all four quadrants, no pain or tenderness upon palpation, no abnormal masses felt.</p> <p>fundus is midline 2 centimeters below the umbilicus.</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>Minimal light colored bleeding with no clots or smell noted</p> <p>patient expresses no pain, burning urgency or frequency</p> <p>Inspection of genitals was not performed due to patient refusal</p> <p>No catheter in place</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>ROM intact in the upper and lower extremities</p> <p>no ADL assistance</p> <p>patient is a fall risk</p> <p>5/5 strength in upper and lower extremities independent and does not need assistance with equipment</p> <p>does not need support to stand or walk</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:</p>	<p>MAEW</p> <p>PERLA</p> <p>Strength is equal in both arms and legs</p> <p>mental status x 3</p> <p>no sensory loss noted</p> <p>DTR's intact</p>

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):	married with extended family involved. The patient has a 3 year old son at home. Patient has finished high school and has had some college level classes. Husband at bedside and seems to be attentive to the patient's needs.
DELIVERY INFO: (1 point) Delivery Date: Time: Type (vaginal/cesarean): Quantitative Blood Loss: Male or Female Apgars: Weight: Feeding Method:	02/23/2020 12:54 pm Vaginal 1000 ml Female APGAR score of 8 and 9 3902g Breast feeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	104	129/63	18	98.0 F	98%
Labor/ Delivery	11	114/56	18	98.5 F	97%
Postpartum	96	103/63	17	98.0 F	99%

Vital Sign Trends: Normal

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1410	Numerical	NA	0/10	NA	None
1500	Numerical	NA	0/10	NA	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 in place, some bruising at the location of the IV insertion site no further complications.

Intake and Output (2 points)

Intake	Output (in mL)
240 ml of juice	150 ml voided
130 ml water	50 ml voided

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.
Tylenol 650 mg M	every 4 hour's as needed	to reduce the pain after vaginal delivery
ice diapers N	as needed	to help with swelling and pain in the peroneal area

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Phases of Maternal Adaptation to Parenthood (1 point)

What phase is the mother in? taking in phase

What evidence supports this? patient is coping with the new infant and adaptation to a new routine as well as getting assistance from family.

Discharge Planning (2 points)

Discharge location: Home

Equipment needs (if applicable): breast pump

Follow up plan (include plan for mother AND newborn): primary care visit as well as establishment of a pediatric care for the infant

Education needs: coping mechanism as well as proper latching technique

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) <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>
<p>1. risk for a deficient fluid volume due to blood loss as evidenced by hemorrhage</p>	<p>the patient lost a significant amount of blood and could be deficient in</p>	<p>1. Assess and record the type , amount, inside of bleeding . Count amount perineal pads and if possible save blood clots to be evaluated by physician. Rationale: The amount of</p>	<p>Patient will have a lochia flow of less than one saturated perineal pad per hour. Patient will demonstrate improvement in the</p>

<p>during birth</p>	<p>fluid volume</p>	<p>blood loss and the presence of blood clots will help to determine the appropriate replacement need of the patient. 2. Assess the location of the uterus and degree of the contractility of the uterus/ Massage boggy uterus using one hand and place the second hand above the symphysis pubis. Rationale: The degree of the contractility of the uterus will measure the status of the blood loss. Placing one hand just above the symphysis pubis will prevent possible uterine inversion during a massage</p>	<p>fluid balance as evidenced by a good capillary refill, adequate urine output, and skin turgor.</p>
<p>2. Risk for infection due to decreased hemoglobin as evidenced by blood work</p>	<p>patients body just lost a lot of blood and had a traumatic event</p>	<p>1. Monitor rate of uterine involution and nature and the amount of lochial discharge. Rationale: Infection of the uterus delays involution and lengthen the flow of the lochia. 2. Observe for signs of fever, chills, body malaise, anorexia, pelvic pain or uterine tenderness. Rationale: These symptoms reflect systemic involvement, possibly leading to bacteremia, shock or even death if left untreated.</p>	<p>Patient will display white blood cell count and vital signs within expected ranges.</p>
<p>3. Risk for altered parent infant attachment related to anxiety</p>	<p>patient had counseling regarding this baby</p>	<p>1. discuss clients view of infant care responsibilities and parenting role Rationale: to provide information about how a client perceived these rule</p>	<p>patient will express comfort with the parenting role</p>

<p>associated with the parent role as evidenced by verbal expression</p>		<p>changes that will help in identifying areas of learning need 2. explain the factors that lead to the separation of mother and infant brought about by the postpartum hemorrhage Rationale: to minimize anxiety and feeling of helplessness related to the mother's inability to assume the role expected to her</p>	
<p>4. anxiety related to interpersonal transmission as evidenced by express concerns due to the changes in the life events</p>	<p>patient had a hard time accepting the new baby due to financial status</p>	<p>1. encourage the client and the family to identify feelings of anxiety Rationale: verbalization of anxiety provides an opportunity to clarify information, correct misconceptions and gain perspective, facilitating the problem solving process 2. stay with the client by providing a calm, empathetic and supportive attitude Rationale: to help in maintaining emotional control in response to that changing physiological status. Helps in lessening interpersonal transmission of feelings.</p>	<p>patient will verbalize awareness of feeling of anxiety</p>

Other References (APA)

Martin, P., Martin, P., & Martin, P. (2019, June 1). 8 Postpartum Hemorrhage Nursing Care Plans. Retrieved March 1, 2020, from <https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/#Deficient-Fluid-Volume-isotonic>

Martin, P., Martin, P., & Martin, P. (2019, June 1). 8 Postpartum Hemorrhage Nursing Care Plans. Retrieved from <https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/#Risk-For-Infection>