N432 Postpartum Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date & Time of Admission	**Patient Initials**	**Age**	**Gender**
6/10/2020	K.J.	23	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	No Occupation	Single	Orange juice & Tomato
Code Status	**Height**	**Weight**	**Father of Baby Involved**
Full Code	5'1"/154.9cm	147 lb/66.7kg	Yes

Medical History (5 Points)

Prenatal History: Patient followed appropriate care and wen tot every single appointment as well as have taken prenatal to improve baby's likelihood for success. Patient had nausea with this pregnancy and the symptom was controlled with Zofran.

Past Medical History: Autistic disorder, Epistaxis, and recurrent mood disorders

Past Surgical History: 3 c-sections

Family History: Father – asthma. Maternal grandmother – breast cancer, cervical cancer, and diabetes. Paternal grandfather – diabetes and hypertension.

Social History (tobacco/alcohol/drugs): Current everyday smoker, no alcohol, and marijuana use before pregnancy

Living Situation: Living with boyfriend and two children.

Education Level: Patient finished high school.

Admission Assessment

Chief Complaint (2 points): Term pregnancy at 39 (planned c-section)

Presentation to Labor & Delivery (10 points): The patient is a 23-year-old and at 39 weeks presented to labor and delivery for a repeat cesarean secondary to her history of cesarean

delivery x2. Patient claimed that she did not have any pain and came to labor and delivery for a scheduled c-section. She has not taken any medications before she came to the hospital. The patient was given Zofran for nausea. The patient's current stage of labor is postpartum.

Diagnosis

Primary Diagnosis on Admission (2 points): Planned c-section

Secondary Diagnosis (if applicable): N/A

Postpartum Course (18 points)

During the postpartum period, the woman's body starts to go back to its prepregnant state, and these changes generally resolve by the sixth week after giving birth (Ricci et al., 2017). The uterus restores to its standard size through a slow process of involution, and which includes changes that return it to its usual condition (Ricci et al., 2017). Shrinkage involves three processes: contraction of muscle fibers to reduce those previously stretched during pregnancy (Ricci et al., 2017). Catabolism, of which shrinks enlarged, individual myometrial cells (Ricci et al., 2017). The healing of uterine epithelium from the lower layer of the decidua after the upper layers have been sloughed off and shed during lochia discharge (Ricci et al., 2017).

Women who have had a cesarean birth tend to have less blood flow because the uterine debris is removed manually along with the delivery of the placenta (Ricci et al., 2017). Lochia is present in most women for at least three weeks after childbirth, but it persists in some women for as long as six weeks (Ricci et al., 2017). The cervix typically returns to its prepregnant state by week six of the postpartum period, but the patient had c-section, so her uterus was intact (Ricci et al., 2017).

The center of gravity has drastically changed after a c-section. The body is still adjusting to that as well as healing from surgery (Smith, 2017). One of the most significant risks of c-section is developing a blood clot in the leg (Smith, 2017). The patient was encouraged to walk and ambulate her legs to prevent blood clots from happening. She walked around her room and took a shower independently.

Risk factors for postpartum infection include anemia, multiple vaginal examinations during labor, and manual extraction of the placenta (Ricci et al., 2017). The patient was at risk of getting anemia due to low levels of hemoglobin and hematocrit. The nurse examined for bleeding from her vagina, hence the multiple examinations during labor. The patient had a c-section, so the OB/GYN removed her placenta manually.

Risk factors for postpartum hemorrhage involve labor induction, operative procedures, and prolonged third stage of labor (Ricci et al., 2017). The patient was at risk for bleeding because she had a c-section but did not need to induce labor or experience a prolonged third stage.

Risk factors for postpartum mood disorders include financial problems, have bipolar disorder, a history of depression, and difficulty breast-feeding (Mayo Clinic, 2018). The patient is currently no working, has a history of recurrent mood disorders, and is bottle feeding the newborn.

Postpartum Course References (2) (APA):

Mayo Clinic. (2018). *Postpartum depression*.

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

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

Smith, A. (2017). *Cesarean birth postpartum recovery*. The Birth Hour. https://thebirthhour.com/cesarean-birth-postpartum-recovery/

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	N/A	N/A	N/A	
Hgb	12-15.8	N/A	N/A	10.1	With active bleeding the number of red blood cells decrease and the hemoglobin decreases. It takes time for the hemoglobin to fall only if blood volume is finished with fluids of the hemoglobin diminish (Ricci et al., 2017).
Hct	36-47	N/A	N/A	30.2	With active bleeding, the number of red blood cells decrease and therefore the hematocrit rate decreases (Ricci et al., 2017).
Platelets	140-440	N/A	N/A	331	
WBC	4-12	N/A	N/A	16.10	WBCs are increased because of patient tested positive with chlamydia (Ricci et al., 2017).
Neutrophils	47-73	N/A	N/A	N/A	
Lymphocytes	18-42	N/A	N/A	N/A	
Monocytes	4-12	N/A	N/A	N/A	
Eosinophils	0-5	N/A	N/A	N/A	
Bands	1-5	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	N/A	A	
Rh Factor	+/-	N/A	N/A	+	
Serology (RPR/VDRL)	negative	N/A	N/A	N/A	
Rubella Titer	negative	N/A	N/A	N/A	
HIV	Non-reactive	N/A	N/A	N/A	
HbSAG	negative	N/A	N/A	N/A	
Group Beta Strep Swab	negative	N/A	N/A	N/A	
Glucose at 28 Weeks	60-180	N/A	N/A	N/A	
MSAFP (If Applicable)	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
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)	N/A	N/A	N/A	N/A	N/A

Lab Reference (APA):

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

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

	Your Assessment
History of labor: **Length of labor** **Induced /spontaneous** **Time in each stage**	The patient presents to labor and delivery a scheduled cesarean. She was given spinal anesthesia. Spinal anesthesia is when a needle that is inserted into the lower back and the anesthetic is injected through the needle into the fluid that surrounds the spinal cord and numbs the nerves (Hares, 2017). Once the nerves are numb, one will not be able to feel any pain (Hares, 2017). The patient has passed stage four.
Current stage of labor	The patient has passed the fourth stage of labor. Stage four is one hour after delivery (Ricci et al., 2017). The woman's body is

	beginning to undergo the physiologic and psychological changes that occur after birth (Ricci et al., 2017). The fundus was assessed, and it was firm and is 1cm below the umbilicus. Patient still has lochia. She was given Norco for cesarean incision pain.

Stage of Labor References (2) (APA):

Hares, J. (2017). Spinal anesthetic. https://patient.info/treatment-medication/anaesthesia/spinal-anaesthetic

Ricci, S. S., Kyle, T., & Carman, S. (2017). *Maternity and pediatric nursing* (3rd ed.). Wolters Kluwer.

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

Home Medications (2 required)

Brand/Generic	Acetaminophen (Tylenol)	Ibuprofen (Advil)			
Dose	325 mg	600 mg			
Frequency	Q6h PRN	Q6h PRN			
Route	Oral	Oral			
Classification	Antipyretic	Antipyretic			
Mechanism of Action	Inhibits enzyme cyclooxygenase	Blocks activity of			

	.	cyclooxygenase .			
Reason Client Taking	To relieve mild to moderate pain.	To relieve mild to moderate pain.			
Contraindications (2)	Severe hepatic impairment. Severe active liver disease.	Asthma. Bronchospasm. Nasal Polyps.			
Side Effects/Adverse Reactions (2)	Agitation. Peripheral edema.	Fluid retention. Tachycardia.			
Nursing Considerations (2)	Monitor renal function in patient on long term therapy. Monitor end of a parenteral infusion to prevent air embolism.	Serious GI tract bleeding may occur without warning symptoms. Assess patient's skin regularly for signs of rash.			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver panel	CBC, Liver panel, BUN & creatinine			
Client Teaching needs (2)	Tell patient that may be crushed or swallowed whole. Teach patient to recognize signs of hepatoxicity.	Advise patient to report flu-like symptoms. Explain that medication may increase risk of adverse cardiovascular reactions.			

Hospital Medications (5 required)

Brand/Generic	Azithromycin (Zmax)	Cefazolin (Ancef)	Ondansetron (Zofran)	Oxytocin (Pitocin)	Sodium citrate (Bicitra)
Dose	500 mg	2g/20mL	4mg	30u/500mL	500mg/ 5mL
Frequency	Once	Once	Q6h PRN	Once	Once
Route	IV	IV	IV	IV	Oral
Classification	Antibiotic	Antibiotic	Antiemetic	Hormones	Antiurolithics

Mechanism of Action	Blocking peptide translocation and inhibit RNA dependent protein synthesis.	Interferes with bacterial cell wall synthesis.	Blocks serotonin receptors.	Increase concentration of calcium inside muscle cells.	Prevent aspiration pneumonitis during surgical procedures.
Reason Client Taking	To treat Chlamydia.	To prevent infections.	To prevent nausea and vomiting.	Control postpartum bleeding.	To make urine less acidic.
Contraindications (2)	Hepatic dysfunction. Hypersensitivity.	Hypersensitivity. Renal failure.	Hypersensitivity. Congenital long QT syndrome.	Hypersensitivity. Anticipated nonvaginal delivery.	HF. Edema. Hypertension.
Side Effects/Adverse Reactions (2)	Agitation. Chest pain.	Hearing loss. Abdominal cramps.	Arrhythmias. Bronchospasms.	Jaundice. Arrhythmias.	Numbness in hands or feet. Rapid & Shallow breathing.
Nursing Considerations (2)	Monitor bowel elimination. Assess for bacterial or fungal infection.	Monitor IV site for irritation, phlebitis, and extravasation. Assess bowel pattern daily; severe diarrhea may indicate p. colitis.	Monitor for s/s hypersensitivity. Monitor EKG as ordered.	Monitor maternal BP and pulse frequently. Monitor for drowsiness, confusion, H/A, and anuria.	Monitor for alkalosis. Monitor for fluid overload.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver enzymes.	BUN & serum creatinine.	Non reported.	Electrolyte panel.	Hct, Hb, electrolytes, pH, urinalysis
Client Teaching needs (2)	Take medication 1hr before or 2-3 hrs. after food. Report signs and symptoms of allergic reaction.	Instruct to complete the prescribed course of therapy. Tell pt. to report water, bloody stools, to prescriber immediately.	Educate pt. to seek immediate medical attention if she experiences persistent, severe, unusual, or worsening symptoms. Advise to report signs of hypersensitivity.	Drinking too much liquid can be unsafe while receiving this medication. Tell provider for fast, slow, or uneven heart rate.	Instruct pt. to take as directed. Advise pt. to avoid salty foods.

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (0.5 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	AOx3 No acute distress and appears stated age, well-groomed and relaxed laying on the bed with the infant.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds/Incision:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	pink, warm, and dry skin turgor is elastic, capillary refill is less than 3 seconds. No noted lesions or rash. **Braden score of 20** No drains or ports present on the patient.
HEENT (0.5 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	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.
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, no noted murmurs, galops or rubs. No noted neck vein distention or edema. Cap refill less than 3 seconds, peripheral pulses palpable. No edema.
RESPIRATORY (1 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lungs clear to auscultation bilaterally, no noted wheezes, bronchi, or crackles. No accessory muscle use
GASTROINTESTINAL (5 points): **Diet at Home:** **Current Diet:** **Height:**	Diet at home in current is normal diet with no restrictions. 5’1’’/154.9 cm

Weight: **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Fundal Height & Position:**	147 lb/66.7 kg Bowel sounds present in all four quadrants, no pain or tenderness upon palpation, no abnormal masses felt. fundus is midline 1 centimeters below the umbilicus.
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:**	Minimal light-colored bleeding with no clots or smell noted patient expresses no pain, burning urgency or frequency Inspection of genitals was not performed due to patient refusal No catheter in place
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 ☐**	ROM intact in the upper and lower extremities no ADL assistance patient is not at fall risk **Fall score of 0** 5/5 strength in upper and lower extremities independent and does not need assistance with equipment does not need support to stand or walk
NEUROLOGICAL (1 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW PERLA Strength is equal in both arms and legs mental status x 3 no sensory loss noted DTR's intact

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):**	Has a boyfriend who is involved. The patient has two other children at home. Patient has finished high school. Boyfriend is at bedside and seems to be attentive to patient's needs.
DELIVERY INFO: (1 point) **Delivery Date:** **Time:** **Type (vaginal/cesarean):** **Quantitative Blood Loss:** **Male or Female** **Apgars:** **Weight:** **Feeding Method:**	 6/10/2020 0806 Cesarean 1,000 mL Female APGAR score of 8 and 9 2990g Bottle feeding

Vital Signs, 3 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
Prenatal	95	119/77	16	97.8°F	97
Labor/ Delivery	76	106/62	16	97.6°F	98
Postpartum	86	108/78	18	98.7°F	97

Vital Sign Trends: The patient's vital signs during prenatal, labor/deliver, and postpartum are within the normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1425	Numeric	Abdominal Incision	8	sharp	Gave Norco
1830	Numeric	N/A	0	N/A	N/A

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

Intake and Output (2 points)

Intake	Output (in mL)
1000 mL of water	2300 mL voided 100 mL lochia

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 325 mg "M"	Q6h	To reduce pain.
Zofran 4 mg "M"	Q6h	To relieve nausea.
Shower "N"	As needed	For relaxation after c-section.
Deep breathing "N"	Q2h	To help prevent lung congestion from sitting in bed.

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 her boyfriend.

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 of infant in one week as well as mom to check c-section incision.

Education needs: C-section care.

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. Risk for a deficient fluid volume due to blood loss as evidenced by hemorrhage during birth.	The patient lost a significant amount of blood and could be deficient in fluid volume.	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 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	Patient will have a lochia flow of less than one saturated perineal pad per hour. Patient will demonstrate improvement in the fluid balance as evidenced by a good capillary refill, adequate urine output, and skin turgor.

		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.	
2. Risk for infection due to decreased hemoglobin as evidenced by blood work	patients body just lost a lot of blood and had a traumatic event	1. Monitor rate of uterine involution and nature and the amount of lochia 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.	Patient will display white blood cell count and vital signs within expected ranges.
3. Risk for altered parent infant attachment related to anxiety associated with the parent role as evidenced by verbal expression	patient had counseling regarding this baby	1. discuss clients view of infant care responsibilities and parenting role Rationale: to provide information about how a client perceived these rule 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	patient will express comfort with the parenting role

		anxiety and feeling of helplessness related to the mother's inability to assume the role expected to her	
4. Anxiety related to interpersonal transmission as evidenced by express concerns due to the changes in the life events	patient had a hard time accepting the new baby due to financial status	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.	patient will verbalize awareness of feeling of anxiety

Other References (APA):

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