# N432 Postpartum Care Plan

Lakeview College of Nursing

Rece Doggett

07/15/2020

## Demographics (3 points)

| Date & Time of Admission | Patient Initials | Age | Gender |
|---|---|---|---|
| 07/06/2020 | R.G. | 32 | F |
| **Race/Ethnicity** | **Occupation** | **Marital Status** | **Allergies** |
| White/Hispanic | Full-time @ Carle | Single/Boyfriend | Phenergan |
| **Code Status** | **Height** | **Weight** | **Father of Baby Involved** |
| Full | 5ft 3in | 180lb | Yes |

## Medical History (5 Points)

**Prenatal History:** Routine Checkups on 04/20, 6/16, 06/23, and 07/01. Patient attended her checkups as scheduled. This likely had a positive impact on the baby's health. Patient stated that this pregnancy was much smoother than previous pregnancies. The previous pregnancy was a spontaneous miscarriage.

There was a visit on 12/10/2019 for absent fetal heart tones.

**Past Medical History:** Abnormal pap smear of cervix, Anemia, GERD, HEP B, Herniated disk, HSV-1

**Past Surgical History:** Appendectomy, Upper endoscopy, Breast enhancement surgery

**Family History:** Paternal – Arthritis, cancer, HTN; Maternal – Arthritis, diabetes, heart, HTN

**Social History (tobacco/alcohol/drugs):** Client has no social history other than social drinking before pregnancy. No notes of binge drinking or alcoholism.

**Living Situation:** Lives with boyfriend in their own home.

**Education Level:** College Graduate

## Admission Assessment

**Chief Complaint (2 points):** Induction of labor

**Presentation to Labor & Delivery (10 points):** Client is gravida 5 para 2022 with intrauterine pregnancy. She is 39 and 5/7th weeks by 1st trimester ultrasound. Prenatal care with Dr. Burns at 3 weeks and expressed the only complications with pregnancy is GERD. she arrived for scheduled induction on 07/06/2020. She denies any leaking of any fluids or vaginal bleeding. Reporting good fetal movement and verbalized about being nervous for the process and feeling of pain. Methods of pain control were discussed with patient. Client arrived at 1 cm dilated and 30% upon admission. There was no note about when patient entered or left the stages of pregnancy.

## Diagnosis

**Primary Diagnosis on Admission (2 points):**Normal vaginal delivery

**Secondary Diagnosis (if applicable):** Induction of labor

## Postpartum Course (18 points)

The postpartum phase takes place after the process of childbirth is complete. This stage is the mothers body trying to return to normal. Contractions continue to prevent postpartum hemorrhage. The uterus returns to its normal size before pregnancy by the end of the 9th day. Lochia, tissue debris, and blood continue to show for a few days after birth, but it should not be excessive. After a few days this should stop. Vaginal mucosa will be red for a few days after birth but will thicken and regenerate in a few weeks. The perineum is usually red and bruised for a couple days after birth and will return to normal. The client assigned during clinical meets the all normal standards excluding one complication. The first stage laceration the mother

experienced should heal in four to six months with no complications at the site. This is a risk for infection due to the open wound in the perineal area. This laceration was sutured immediately after birth to prevent bleeding. Muscles and nerves should return to normal if no extensive damage is taken. In this case they should return to normal with no issue as well as muscle tone. Client had stable vitals during all stages of labor which should not change now. The client has been encouraged to walk and urinate often. The mother has not experienced any other stages now.

The next stage the mother would be in is the taking hold phase. In this phase the mother is having a sense of independence and experiencing normal maternal behavior in caring for the child. This stage may last several weeks. The client should regain control over bodily functions and become more aware of events occurring. The following stage is the letting go phase. This stage occurs when the mother establishes relationships with others and is adapting to parenthood. Her new role as a mother and taking responsibility for the care of her newborn with confidence is the primary function of this final stage.

**Postpartum Course References (2) (APA):**

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

## 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 | | 3.9 | | |
| Hgb | 12-15.8 | | 11.8 | | **Most likely due to blood loss during labor. Client did not lose much blood during labor.** |

| | | | | | |
|---|---|---|---|---|---|
| Hct | 36-47 | | 34.4 | | |
| Platelets | 140-440 | | 217 | | |
| WBC | 4-12 | | 9.8 | | |
| Neutrophils | | | | | |
| Lymphocytes | | | | | |
| Monocytes | | | | | |
| Eosinophils | | | | | |
| Bands | | | | | |

**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 | Nonreactive | Negative | |
| Rubella Titer | Immune | Immune | Immune | Immune | |
| HIV | Non-detected | Non-detected | Non-detected. | Non-detected | |
| HbSAG | N/A | N/A | N/A | N/A | |
| Group Beta Strep Swab | Negative | Negative | Negative | Negative | |
| Glucose at 28 Weeks | N/A | N/A | N/A | N/A | |
| MSAFP (If Applicable) | Negative | Negative | Negative | Negative | |
| | | | | | |
| | | | | | |
| | | | | | |

**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 |
|---|---|---|---|---|---|
| Ur drug screen | Neg | Neg | Neg | Neg | N/A |
| Hep B surface antigen | Positive | Neg | Neg | Neg | 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) | Urine culture in progress | | | | |

**Lab Reference (APA):**

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

Capriotti, T., & Frizzell, J. P. (2016). *Human pathophysiology: Introductory concepts and clinical perspectives*.

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

| | **Your Assessment** |
|---|---|
| **History of labor:**<br>**Length of labor**<br>**Induced /spontaneous**<br>**Time in each stage** | Patient was scheduled for induction of labor on 07/06/2020 @ 1800.<br>ROM occurred at 0348<br>Child birthed at 0518 with a total blood loss of 100 mL<br>Placenta spontaneous and intact @ 0640<br>Chart does not specify when first, second, or third stages of labor. |
| **Current stage of labor** | No longer in labor. Postpartum recovery is the current stage of pregnancy. Resting comfortably in bed with child and boyfriend at bedside.<br>The client is currently in the "taking in" phase meaning that she is reliant on healthcare workers and family for needs and support. She is very excited about being with her child and sharing her experiences. The mother still feels some discomfort upon palpation of the fundus which is to be expected. |

**Stage of Labor References (2) (APA):**

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

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

**Home Medications (2 required)**

| **Brand/Generic** | Ferrous Sulfate Iron 325mg | Acetaminophen Tylenol | | | |
|---|---|---|---|---|---|
| **Dose** | 1 tablet | 2 tablets | | | |
| **Frequency** | Daily | PRN | | | |
| **Route** | PO | PO | | | |
| **Classification** | Trace element, mineral | Nonopioid Analgesic | | | |
| **Mechanism of Action** | Normalizes RBC production | Blocks Prostaglandin production | | | |
| **Reason Client Taking** | Provide adequate RBC production | Headaches | | | |
| **Contraindications (2)** | Hemochromatosis, hemolytic anemias | Hypersensitivity , Hepatic impairment | | | |
| **Side Effects/Adverse Reactions (2)** | Fever, dyspnea | Anxiety, Abdominal pain | | | |
| **Nursing Considerations (2)** | Give supplement with full glass of water or juice, do not crush or open capsules, should be given 1 to 2 hours after meal | Monitor renal function, use cautiously with hepatic impairment | | | |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | Check Fe Labs | Potassium and Calcium | | | |
| **Client Teaching needs (2)** | This will help maintain RBC | Tablets may be crushed or | | | |

| | | | | | |
|---|---|---|---|---|---|
| | production.<br>Take as instructed by doctor. | swallowed whole<br>Instruct client to keep out of reach of children. | | | |

**Hospital Medications (5 required)**

| **Brand/Generic** | Carboprost Hemabate | Benzocaine -menthol Dermoplast | Oxytocin Pitocin | Fentanyl Ropivacaine | Lidocaine PF 1% |
|---|---|---|---|---|---|
| **Dose** | 1 tablet 250mg | 1 spray | 30Units/ 500mL | 2-0.2mcg/ mL | 20mL |
| **Frequency** | Q15 | TID | Cont. | Cont. | Once |
| **Route** | IM | Aerosol | IV | Epidural | IM |
| **Classification** | Oxytocic | Local anesthetic | Oxytocic | Opioid | Local anesthetic |
| **Mechanism of Action** | Enhances uterine response for contractions | Causes temporary numbness/loss of feeling to skin | Increases Ca inside muscle cells to increase uterine contraction | Binds to opioid receptor sites | Causes temporary numbness/loss of feeling to skin |
| **Reason Client Taking** | Prevent Bleeding | Discomfort | Prevent hemorrhage, contractions | Pain | Procedure |
| **Contraindications (2)** | Hypersensitivity to drug<br>Placental previa | Allergies to benzocaine<br>Certain blood disorders | Elective labor induction<br>Placental previa | Asthma, hypersensitivity, or intolerance | Adams stokes syndrome, hypersensitivity |
| **Side Effects/Adverse Reactions (2)** | N/V/D<br>Dyspnea | Seizures<br>tachycardia | Uterine Hypertonicity<br>N/V | Amnesia, confusion | Agitation, anxiety |

| | | | | | |
|---|---|---|---|---|---|
| **Nursing Considerations (2)** | Monitor uterine contractions<br>Observe and report excessive vaginal bleeding | Observe for respiratory depression<br>Watch for compromised myocardial function because of risk of electrolyte imbalances | Electronic fetal heart monitor<br>Do not confuse with oxycodone. | Should not be given to women pregnant or in labor d/t neonatal opioid withdrawal syndrome….<br>They done messed up.<br>Use with caution in pts w/ copd | Observe for respiratory depression<br>Watch for compromised myocardial function because of risk of electrolyte imbalances |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | FHR<br>Uterine assessment for rupture | Check electrolytes<br>Determine if needed before giving | FHR<br>Uterine assessment for rupture | RR<br>What to do if respiratory failure occurs | Check electrolytes<br>Determine if needed before giving |
| **Client Teaching needs (2)** | One-time medication<br>Medication is used to prevent hemorrhage. | Instruct they will feel numbness<br>Tell patient that they may have difficulty speaking, or experience dizziness | One-time medication<br>Medication is used to prevent hemorrhage. | Don’t take more than prescribed.<br>Can seriously effect consciousness and judgement. | Instruct they will feel numbness<br>Tell patient that they may have difficulty speaking, or experience dizziness |

**Medications Reference (APA):**

Learning, J. &. (2018). *2019 nurse's drug handbook*. Jones & Bartlett Learning.

## Assessment

**Physical Exam (18 points)**

| | |
|---|---|
| **GENERAL (0.5 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | Patient is AO x 4 name date place +<br>Appears to be in no acute distress.<br>Client is dressed in hospital gown – appropriate for setting |
| **INTEGUMENTARY (2 points):**<br>**Skin color:** Pink<br>**Character:** Dry<br>**Temperature:** Warm<br>**Turgor:** Rapid<br>**Rashes:** None<br>Bruises: None<br>**Wounds/Incision:** None are visible<br>**Braden Score:** 21<br>**Drains present: Y☐ N ☒**<br>**Type:** | See left |
| **HEENT (0.5 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | Normocephalic<br>No drainage from eyes ears or nose.<br>Proper dental hygiene is visible.<br>Client has her ears pierced. |
| **CARDIOVASCULAR (1 point):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:** 2 + throughout<br>**Capillary refill**: <3 seconds<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☐ N ☒**<br>**Location of Edema: None** | Normal heart sounds and normal rhythm<br>S1 and S2 sounds noted. No S3 or S4 sounds were heard. |
| **RESPIRATORY (1 points):** | Lung sounds normal with normal pulmonary |

| | |
|---|---|
| **Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character** | effect. |
| **GASTROINTESTINAL (5 points):**<br>**Diet at Home:** Normal<br>**Current Diet:** Normal<br>**Height:** 5ft 3in<br>**Weight**: 180 lb.<br>**Auscultation Bowel sounds:** Normoactive<br>**Last BM:** Not specified<br>**Palpation: Pain, Mass etc.:** see right<br>**Inspection:** None<br>**Distention:** None<br>**Incisions:** None<br>**Scars:** None<br>**Drains:** None<br>**Wounds:** None<br>**Fundal Height & Position:** See right | Palpation of abdomen to assess fundus. Fundus was midline and hard @ the level of the umbilicus. |
| **GENITOURINARY (5 Points):**<br>**Bleeding:** Rarely<br>**Color:** Yellow<br>**Character:** Clear<br>**Quantity of urine:** voided 5 times today<br>**Pain with urination: Y ☐ N ☒**<br>**Inspection of genitals**: As needed<br>**Catheter: Y ☐ N ☒**<br>**Type:**<br>**Size:**<br>**Rupture of Membranes:** Yes<br>**Time:** 0348<br>**Color:** Clear<br>**Amount:** 100 mL<br>**Odor:** none<br>**Episiotomy/Lacerations:** First degree laceration | |
| **MUSCULOSKELETAL (2 points):**<br>**ADL Assistance: Y☐ N ☒**<br>**Fall Risk: Y ☐ N☒**<br>**Fall Score: 0**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib) ☒**<br>**Needs assistance with equipment ☐**<br>**Needs support to stand and walk☐** | Client has some pain when doing physical activity but is independent and able to move to the bathroom by self. |
| **NEUROLOGICAL (1 points):**<br>**MAEW: Y ☒ N☐**<br>**PERLA: Y ☒ N☐** | . |

| | |
|---|---|
| **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐**<br>**Orientation:** Understanding and oriented<br>**Mental Status:** Follows commands as asked.<br>**Speech:** Clear<br>**Sensory:** Normal<br>**LOC:** None<br>**DTRs:** +1 | |
| **PSYCHOSOCIAL/CULTURAL (1 points):**<br>**Coping method(s):**<br>**Developmental level:**<br>**Religion & what it means to pt.: Catholic**<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | Client states she has a normal home life and works full time at Carle. Seeing her child is something that makes her happy and is what she is looking forward to doing for the time she has off. Her boyfriend offers moral and physical support as needed. Pt attends church as often as she can which means a lot to her. |
| **DELIVERY INFO: (1 point)**<br>**Delivery Date:** 07/09/2020<br>**Time:** 0518<br>**Type (vaginal/cesarean):** Vaginal<br>**Quantitative Blood Loss:** 100mL<br>**Male or Female:** Female<br>**Apgars: See right**<br>**Weight:** 3900g<br>**Feeding Method:** Bottle | Apgar<br>1 Min: 8<br>5 Min: 9 |

**Vital Signs, 3 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| Prenatal | 76 | 112/72 | 18 | 97.7 | 100 |
| Labor/Delivery | 74 | 136/66 | 18 | 97.7 | 100 |
| Postpartum | 60 | 130/74 | 18 | 98.0 | 98 |

**Vital Sign Trends: All vitals seemed to be stable throughout labor with no complications.**

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 0655 | Numerical | Head | 4/10 | Aching | Medications |
| 1400 | Numerical | Abdomen | 5/10 | Aching cramping | Medications |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV:** 20G<br>**Location of IV:** Left AC<br>**Date on IV:** 07/08/2020<br>**Patency of IV:** Functional<br>**Signs of erythema, drainage, etc.:** None<br>**IV dressing assessment:** Secured | |

**Intake and Output (2 points)**

| Intake | Output (in mL) |
|---|---|
| Total of 360 IV fluids and medications | 100 mL blood and ROM |

**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. |
|---|---|---|
| Suture of Lac 1st degree (T) | Once | Prevent bleeding |
| Encourage walking (N) | PRN | Improve circulation and Prevent DVT |
| Administering pain medications (T) | PRN | Control pain and comfort. |
| Fundal Assessment (N) | Q4 | Check and prevent postpartum hemorrhage |

**Phases of Maternal Adaptation to Parenthood (1 point)**

**What phase is the mother in?** Taking in phase

**What evidence supports this?** She had just given birth a day prior and there was visible excitement shown by mother.

**Discharge Planning (2 points)**

**Discharge location:** Home

Equipment needs (if applicable): None

**Follow up plan (include plan for mother AND newborn):** Client will plan a visit with a primary care physician for herself and pediatric care for her child.

**Education needs:** Newborn care after discharge**.**

**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)**<br>• How did the patient/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |
|---|---|---|---|
| 1. Acute pain related to recent birth as evidence by facial grimacing and guarding of abdomen | Client shows grimacing and guarding of the abdomen. | 1.Assess pain frequently Rationale – Documentation and understanding of individuals acceptable pain allows you to provide adequate pain relief<br>2.Teach and encourage relaxation and breathing | The client responded positively to information given and attempted relaxation techniques as instructed. |

| | | | |
|---|---|---|---|
| | | techniques<br>Rationale – these techniques promote adequate oxygenation to tissues and decrease physiologic responses to pain | |
| 2. Knowledge deficit r/t feeding patterns as evidenced by verbal concern. | Client questioned the nurse about feeding because her child was not taking the bottle. | 1. Follow schedule for neonates feeding times<br>Rationale – Having an organized schedule helps maintain proper feeding times.<br>2. Teach techniques to help neonate feed<br>Rationale – trying different methods of getting the neonate to feed can increase the amount of milk they take in. | Client verbalized understanding and attempted to try a new method of feeding that the nurse had shown her. She appreciated the information given and thanked her for her time. |
| 3. Knowledge on nonpharmaceutical pain treatment r/t unfamiliarity to treatment as evidenced by verbal questioning | Client given warm blanket to help with comfort. She was unsure how it would effect pain. | 1. Assess knowledge client has on subject<br>Rationale – Knowing what the client already knows can determine what they need to learn<br>2. Provide education to client<br>Rationale – if the client is taught how to reduce pain without medication it may improve pain and reduce the needs for medication. | Client was accepting of information and put the heated blanket over her body. She made no statement if it helped with pain or not. |
| 4. Decreased skin or tissue integrity r/t childbirth as evidenced by first degree laceration | Client experienced a first-degree laceration which has a chance for infection | 1. Assess pain every 2H<br>Rationale – pain relief increases movement and heat which improves circulation and promotes healing<br>2. Assess site of wound<br>Rationale – early identification of infections can result in medical intervention helping heal the wound before it gets bad. | Client had a neutral response to the interventions taken. She verbalized understanding of the importance of keeping the perineal area clean and free from infection. |

## Other References (APA)

Swearingen, P. L., & Wright, J. (2018). *All-in-One nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Mosby.

References

Capriotti, T., & Frizzell, J. P. (2016). *Human pathophysiology: Introductory concepts and clinical perspectives*.

Learning, J. &. (2018). *2019 nurse's drug handbook*. Jones & Bartlett Learning.

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

Swearingen, P. L., & Wright, J. (2018). *All-in-One nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Mosby.