**MIRACOSTA COLLEGE**
**DATA COLLECTION TOOL - Postpartum**
**ADN Program**

Student: Kendra Koenig Date: 9/8/11

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| Date of Delivery: 9/6/ 11 @ 13:19 Age: 22 Length of Stay: 3 days | Post-Op Day : NA |
| Code Status: (Circle or Highlight the status)<br>Full Code<br>Full Care/Do Not Resuscitate | Allergies: List medication/herbs/food and the reaction they cause:<br>Latex-urticaria and pruritus<br>Prednisone- anaphylactic rxn |
| Admitting diagnosis:<br>SVD and Pre-eclampsia<br>Spontaneous Vaginal Delivery or ____ Cesarean Section | Give a brief description of the pathophysiological changes that occur in the postpartum patient:<br><br>Pre- eclampsia: "Normally in pregnancy the spiral arteries in the uterus widen from thick-walled muscular vessels to thinner, saclike vessels with much larger diameters. This change increases the capacity of the vessels, allowing them to handle the increased blood volume of the pregnancy." These changes don't occur in women with pre-eclampsia or they only occur slightly which results in decreased placental perfusion and hypoxia. When the placenta becomes ischemic, a substance is released that is toxic to endothelial cells. "This anomaly causes generalized vasospasm, which results in poor tissue perfusion in all organ systems, increased peripheral resistance and BP, and increased endothelial cell permeability, leading to intravascular protein and fluid loss and ultimately to less plasma volume. The main pathogenic factor is not an increase in BP but poor perfusion as a result of vasospasm and reduced plasma volume."<br><br>-Involution: the uterus returns to its nonpregnant state after birth (by 2 weeks the uterus shouldn't be palpable and by 6 weeks after birth it should resume its pre-pregnancy position)<br>-Lochia (rubra, serosa, and alba)<br>-Decrease in size of hemorrhoids within 6 weeks of child birth<br>-Breast tenderness/ engorgement<br>-Postpartal diuresis: excessive sweating at night especially 2-3 days after birth<br>-Restoration of bladder tone within 5-7 days<br>-PP transient anemia<br>-Polyuria |
| Estimated Gestational Age at Delivery:<br>39+2<br>Surgery/procedures done and when: NA | |
| Clinical signs and symptoms **expected** for this postpartum patient: (from your textbook):<br>-Fundus should be @ U (within 12 hours of birth)<br>-Mild uterine cramping<br>-Lochia rubra (may contain small clots)<br>-Internal hemorrhoids may evert while the woman is pushing during birth causing S/Sx's of: itching, discomfort, and bright red bleeding<br>-Fatigue<br>-Colostrum expelled from breasts<br>-PP diuresis<br>-Elevated BP<br>-Proteinuria<br>-Generalized edema (face/ hands)<br>-HA<br>-Blurred vision<br>-Pyrosis (heart burn) | Clinical signs and symptoms your patient demonstrates:<br>-Fatigued<br>-Small amount of lochia rubra<br>-Tender breasts/ nipples<br>-Polyuria<br>-Mild uterine cramping<br>-Fundus @ U<br>-Irritating hemorrhoids<br>-Colostrum expelled from the breasts<br>-Elevated BP @ 0800 144/73 and @ 1200 137/86<br>-1+ bilateral pitting edema |
| **Pertinent Medical / Obstetrical Health History (Gavida and Para, Labor & Delivery Complications, Anesthesia):**<br>G2P1: 8/2010 Pt had a SAB @ 12 weeks of gestation. Pt had an AROM and a SVD. Pt received a Fentanyl epidural at about 4 cm dilation. Pt had unstable BP throughout pregnancy. On 8/18/11, the Pt had a 24 hour urine collection done and she had 284 mg of protein in her urine. Pt was being treated with magnesium via IV for preeclampsia. | |
| **Physical: information obtained and documented that reflects what has occurred with the patient prior to your arrival. This information is found in the H&P in the chart or computer and the nursing assessment documentation in the computer.** | **Student Assessment: this is information you observe during clinical:**<br>**After obtaining shift report what is the most important nursing intervention for you to carry out this shift?** |

**Cognitive/Perceptual:**

General Mood (Happy, Crying, Depressed): Excited

Support System (Significant Other): Mom was down from Redding, CA for a week and a half to help with the baby. Her husband/ FOB will return from a 7 month deployment 9/17/11.

Sensory impairment and correction: Dyslexia- Pt is supposed to wear glasses and do eye exercises but she doesn't. She reports that her eyesight has improved with age

PERRLA: PERRL Size of Pupils: 4mm

Level of Consciousness: Alert

Orientation: X3

Affect: (calm, cooperative, agitated, combative) Kind

Headache/Blurred Vision: denied

DTRs/Clonus: not present

**Oxygenation/Perfusion:**

Lung Sounds: Clr bilaterally

Heart Sounds: Normal S1 and S2

Apical Pulse Rate and regular vs. irregular)

Pulses (strength/symmetry):
Radial: 2+
Dorsalis Pedis: 2+
Posterior Tibial: 2+

**Pulse Quality Scale**
0 -Absent
1+ - Palpable but weak
2+ - Normal
3+ - Increased
4+ - Bounding

Capillary Refill: <3 seconds

Skin Color: Rosy pink

Skin temperature: Warm

Risk for Venous Thromboembolic Event (VTE): Yes, pregnancy increases the risk for VTE's

SCD: -

Heparin or LMWH: -

Edema (Amount and Location): Bilateral pedal edema with 1+ pitting

**Edema Scale**
1+ Mild pitting, slight indentation, no perceptible swelling of the leg
2+ Moderate pitting, indentation subsides rapidly
3+ Deep pitting, indentation remains for a short time, leg looks swollen
4+ Very deep pitting, indentation lasts a long time, leg is very swollen

Oxygen type and amount: NA

Telemetry Rhythm: NA

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| **Nutrition/Hydration**<br>Nausea/Vomiting: Denied<br>Bowel Sounds: Hypo-Normo active<br>Abdomen tender vs. non tender<br>Abdomen distended? No<br>Epigastric pain? No<br><br>Previous 24 hours intake and output<br><br>Diet: Regular diet (Pt stated that she was started right away on a regular diet). include % taken for previous 24 hours: Pt ate 80% of her breakfast<br><br>Tube Feeding: Type: NA Rate/hour: NA<br><br>Height/weight: 165.1 cm/ 87.8 Kg<br><br>Vascular Access: (Peripheral or Central)<br><br>IV gauge : 18g IV Site (use phlebitis scale) : 0 Phlebitis, 0 infiltration<br><br>IV solution: NA- saline locked @ rate : NA<br><br>Dates : (IV site and tubing to be changed)<br>**L wrist inserted 9/6/11** | **Phlebitis Scale**<br>Grade Clinical Criteria<br>0 no symptoms<br>1 erythema at access site with or without pain<br>2 pain at access site with erythema and or edema<br>3 pain at access site with erythema and or edema, streak formation, palpable venous cord<br>4 pain at access site with erythema and or edema, streak formation, palpable venous cord > 1" length, purulent drainage |
| **Elimination :**<br><br>Voiding Difficulties/Bladder Distention: NA-- Pt had voided 3x by 8 AM.<br><br>Color, odor, clarity, amount of urine: Pt reports passing red/ bloody urine with no odor. She also stated that she is "peeing the amount that she normally does" .<br><br>Presence of urinary catheter (type/size): NA<br><br>BM pattern (prior to hospital): Regular--daily<br><br>Date of Last BM: 9/5/11 (normal BM)<br><br>Possible Causes of Diarrhea or Constipation in this patient: Epidural anesthesia, reduced mobility, reduced fluid intake, and fear of pain associated with BM<br><br>Hemorrhoids: Present Flatus: Pt reports passing flatus | |
| **Mobility/Activity and Rest:**<br><br>Activity ordered: Ambulate Ad Lib<br><br>Muscle Strength/ROM: 4+ muscle strength and great ROM<br><br>Fall Risk: No-Witnessed Pt ambulating without distress. Pt reported no feelings of dizziness or lightheadness upon standing. | |
| **Comfort (N/V/D/C/fatigue/lack of appetite)/Pain:**<br>**Pain: 4/10**<br>Location: Lower ABD and vaginal+perineum areas<br><br>Quality: Crampy/ pressure<br><br>Alleviating factors: Rest, peri care, ice packs, ibuprofen<br><br>Aggravating factors: Movement and walking<br><br>**Other Comfort Issues: (e.g. N/V, constipation):** No BM since 9/5/11. Pt also reports a back ache from the epidural.<br><br>Interventions Ordered/Performed: Pt denied any pain medication until 1300. She was able to tolerate pain 4-5/ 10 on the pain scale. Once the pain escalated to a 6/10 she requested medication. Colace ordered BID. | Pain level before treatment:<br>6/10 @ 1300<br><br>Treatment (include meds, non pharmacological treatments):<br>-Ibuprofen @ 1300; by 1400 the Pt's pain was down to a 3/10 from a 6/10<br>-ice packs<br>-tucks pads<br>-rest<br>-extra pillows for her back and repositioning |

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| Encouraged frequent PO hydration with water and increasing ambulation. | |
| **Regulation:** evidence of immune compromise, any endocrine/hormonal disorder: NA<br>Bedside glucose readings: NA | Blood glucose readings and coverage: NA |
| **Integumentary: note location and description**<br>Wound surgical (Episiotomy) or Lacerations include degree: Second degree perineal laceration<br><br>Wound: NA<br><br>Abrasions/bruises/rash: Pt had a rash on her R upper arm- medial aspect. Pt reports that this is r/t the continuous BP monitoring during labor and delivery.<br><br>Interventions: Peri care, ice packs, ibuprofen PRN for pain and inflammation | Treatment |
| **Laboratory Results: Please record all labs results, whether they are high or low and why you think they are abnormal.**<br>**-Urine blood: Large :**<br>**-WBC 20. 5 H Pt just had a SVD which places stress upon the body (along with trauma to the body), triggering an immune response, raising the WBC**<br>**-Lymphocytes 13 L Antibiotic Tx?**<br>**-Monocytes 1.5 H Possible bacterial infection?**<br>**-Granulocytes 16.9 H Physical and emotional stress, trauma**<br>**-CBC "segs" 79 H Stress and trauma**<br>**-Chloride 109 H Eclampsia**<br>**-Co2 18 L Pain, pregnancy, anxiety**<br>**-Albumin 3.0 L Stress**<br>**-Urine RBC 11-20 H Labor process**<br>**-Lactate dehydrogenase 199 H Skeletal muscle injury r/t birth**<br>**-Alkaline phosphatase 209 H Recent ingestion of meal? Antibiotic Tx?** | |
| **Reproductive / Sexuality:**<br><br>**STD's: No Hx of STD's**<br><br>**Breasts (Soft, Filling, Engorged/ Nipples – dry, cracked, bruised, intact/shape): Pt reports breast/ nipple tenderness**<br><br>**Fundal Tone & Location (e.g. U+1, U-1, or @U): @U boggy; massaged until firm**<br><br>**Lochia (Amt & Color): Lochia rubra, small amount** | |
| **Safety/Security Needs:**<br>Fall Risk Assessment: I wouldn't classify this Pt as a fall risk. She does have a saline lock but it's not disrupting her ADL's. She is alert and oriented x3. She is s/p Mag but has no S/Sx's of preeclampsia other than the elevated BP.<br><br>Interventions to prevent injury: Non skid slippers, side rails up x 2, call light within reach<br><br>**Infant ID bracelet on mother: # 66651; accu tech # 43** | |
| **Love and Belonging Needs:**<br>Occupation (current or prior to retirement): Dental Assistant student at Kaplan. Pt has 6 week internship to finish once she goes back to school and then she'll be done!<br>Support System: Husband and many friends. Both her and her husband's families reside in Redding, CA.<br>Community: Murrieta<br>Spirituality: None (religion, etc)<br>Culture: America<br>Language: English<br>Interpreter needed: yes no<br>Bonding: Excellent- even though my Pt was a first time mother, it seemed like she had the whole "new mom role" down pact! She seemed like such a natural! She and her baby boy were so relaxed. It was beautiful watching them bond and mom adoring her new baby boy. | |
| **Body Image/Self Esteem Needs** | |

Potential changes in patient's body that may result in negative feelings: weight gain/ stretch marks
Patient's Perception of Health and Illness: Pt feels great….just a little bit tired from the labor process! She is up and active ambulating around her room and interacting with her visitors! She is thrilled that her son has arrived!

**Patient/Family Education:**

**1. S/Sx's to notify the HCP (i.e. pre-eclampsia: HA, blurred vision, and heart burn; or hemorrhage)**
**2. How to care for second degree perineal laceration**
**3. Tips to preventing constipation: increased activity, increased fluids, increased fiber, stool softeners**

**Answer this question: If the physician came in at this moment to discharge the patient, what are at least 3 priority teaching instructions for this patient?**

Barriers to learning:
Slight dyslexia

Preferred Method of Learning: (reading, doing, hearing)

**Discharge Planning (does patient need HH, Rehab, OT/PT, medical equipment):**

**Pt will be discharged home after 3 days of hospitalization on 9/8/11.**

Health Promotion: What does the patient do to maintain their health?

Pt states that she enjoys eating healthy (no cola, etc.) and exercising. She doesn't smoke tobacco and drinks socially maybe 1x per month.

**Nursing Diagnoses: Prioritize patient problems in order with 1 being the highest priority (must have a minimum of 3 complete nursing diagnoses with 1 of the diagnoses being a psychosocial issue):**

**1. Acute pain r/t birthing process**
**2. Effective breast feeding r/t knowledge**
**3. Risk for situational low self esteem r/t social role changes**

**Interventions for each nursing diagnosis in order of priority**

**1. Keep Pts pain below a 4/10 on the pain scale with the use of pain med's and nonpharmacological measures such as massage and distraction with music**
**2.Monitor the BF process and identify opportunities to enhance knowledge and experience regarding BF.**
**3. Help the Pt to identify the resources and social support network available at this time.**

**MD Orders (Chart/Kardex)**
**-ambulate ad lib when stable**
**-cool/ warm sitz bath**
**-ice pack to perineum x 20 min Q6x24hrs**
**-shaken baby syndrome education**
**-VS Q4x24hrs; then Q8hrs if Pt is stable**

| Medications: Name/Dose/Frequency/Route: | Mechanism of Action: | Why is your patient on this medication? | What does the nurse need to know/do before giving this med |
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| Tucks pads/ 1 pad/ Q6 PRN/ Topical | "Helps relieve irritation and burning do to hemorrhoids." | Pt has hemorrhoids | Assess perineum and hemorrhoids. Can be safely disposed of down the toilet. |
| Colace/ 100 mg/ BID/ PO | Prevents constipation by promoting incorporation of water into stool-softer fecal mass | Pt is constipated | *Hold for loose stools. Assess pt for abdominal distention, presence of bowel sounds, bowel function; assess color, consistency, and amount of stool produced. Also ask Pt if they are passing flatus, when their last BM was, and to describe their stools. |
| Lanolin/ 1 tube/ PRN/ Topical | "Soothes, heals, and protects sore cracked nipples" | PRN for nipple pain/ discomfort | Assess nipples. Safe and natural for mom and baby. Does NOT need to be removed prior to breast feedings. |
| Ibuprofen/ 800 mg/ Q8 PRN/ PO | Inhibits prostaglandin synthesis | Tx of mild to moderate pain and inflammation | Assess for S/Sx of GI bleeding, renal dysfunction, and hepatic impairment. Assess pain prior to and 1-2 hours after administration .Take ibuprofen with milk or food to prevent stomach upset. |

**Please answer the following questions:**

1. What are you on alert for today with this patient? S/Sx's of pre-eclampsia: increased BP, blurred vision, heart burn, HA; S/Sx's of hemorrhage: anxiety, pallor, decreased BP, increased HR and RR, increased lochia rubra, soft/ boggy fundus
2. What are the important assessments to make on this patient? PP assessment: BUBBLE HE (breasts/ nipples/ uterus-fundus/ bladder/ BM/ lochia/ laceration/ hemorrhoids/ emotional status), bowel sounds, VS Q4hrs, monitor lab values, assess for S/Sx of PIH and pre-eclampsia, and pain assessments. Most important would be: assessing for S/Sx's of pre-eclampsia, VS Q4hrs with special attention to BP (must notify MD if SBP is >160), fundal checks, perineal laceration inspection, monitoring amount of lochia
3. What complications may occur? What could go wrong? Pt could seize r/t pre-eclampsia (have suction set up and crash cart near). Pt could have PP hemorrhage
4. What interventions will prevent these complications? Careful monitoring of the Pt for S/Sx's of pre-eclampsia and encouraging the Pt to report: blurred vision, heart burn, and HA immediately; massaging the fundus until firm; monitoring the amount and characteristics of lochia

**After determining the highest priority nursing diagnosis or patient problem, please complete a concept map which will include the problem, the signs and symptoms, the interventions to deal with the problem and evaluation required to determine if the interventions worked.**

Key Problem/ND
Acute pain r/t birthing process

Supporting Data:
-Pt reports tender nipples/ breasts
-Pt has a second degree perineal lac
-Pt reported Hx of hemorrhoids throughout pregnancy; she is using Tuck's pads for relief
-Pt's pain ranged from a 3/10 to a 6/10 throughout the day
-Pt reports a back ache r/t epidural
-Pt used ice packs for pain relief
-800 mg ibuprofen given at 1400

#1

Key Problem/ND
Constipation r/t labor and delivery

Supporting Data:
-Pt's last BM was 9/5/11
-100 mg colace ordered BID
-Pt reports crampy ABD pain and passing flatus
-Constipation is a side effect of epidural analgesia
-Pt reports fear of straining with defecation

#2

Key Problem/ND
Effective breast feeding r/t knowledge

Supporting Data:
-Pt was able to demonstrate and verbalize all 4 BF positions
-Baby was BF Q2-3 hours for 15-20 min each time
-Pt was keeping a very accurate feeing and diaper record (I+O's)
-1 BF witnessed at 08:15; excellent latch technique and suckling noted

#4

Key Problem/ND
Fatigue r/t child birth

Supporting Data:
-Pt reports feeling fatigued after labor
-Pt's mother braided her hair because she was too tired
-7 ibs, 10 oz baby born 9/6/11 at 13:19
-Pt's mom came down to help with the baby for 2 weeks (so the Pt could get extra rest and have an extra hand)

#3

Reason For Needing Health Care
(Medical Dx/Surgery)
SVD and Pre-eclampsia

Key Assessments: Monitor for S/Sx's of pre-eclampsia: HA, blurred vision, heart burn; monitor for S/Sx's of PP hemorrhage: bleeding, anxiety, decreased BP, increased HR and RR, pallor; VS (especially BP), BUBBLE HE (breasts/ nipples, fundus checks, bladder distention, bowel sounds, lochia, perineal laceration, hemorrhoids, and emotional status)

Key Problem/ND
Risk for injury r/t vasospasm and high blood pressure

Supporting Data:
-Pt was Dx with pre-eclampsia
-Pt was s/p MAG (side effects of MAG include: hypotension, CNS depression, lethargy, depressed reflexes, and confusion)
-MAG takes 24 hours to exit the body
-Pt's BP was 144/73 at 0800 and 137/86 at 1200

#5

Key Problem/ND
Risk for infection r/t tissue trauma and blood loss

Supporting Data:
-Elevated WBC 20.5
-EBL during SVD was 344 mL
-Pt has a second degree perineal lac
-Low albumin 3.0 (impaired wound healing)

#6

Key Problem/ND
Risk for sleep deprivation r/t care of infant

Supporting Data:
-Pt's husband doesn't return from deployment until 9/17/11
-Pt will be a stay at home mom (infant's primary care giver)
-Pt will be BF the infant Q2-3 hours throughout the night

#7

Key Problem/ND
Risk for situational low self esteem r/t social role changes

Supporting Data:
-Pt is a 1st time mom
-Pt will be a stay at home mom while the dad works
-Pt will finish her last 6 weeks of Dental Assisting school when the baby is "older"

#8

**Processed Nursing Problems**

Student: Kendra Koenig Patient initials: CM

**Problem #3: Problem Statement (Nursing Diagnosis, R/T):**

**Constipation r/t labor and delivery amb: the Pt reporting that her last BM was on 9/5/11, she has 100 mg of colace ordered BID, she reports crampy ABD pain and passing flatus, she reports having a fear of straining with defecation, and constipation is a common side effect of epidural analgesia.**

**Outcome: The patient will....( include time frame):**

**The Pt will have a BM by 9/9/11. The Pt had the baby 9/6/11 and it usually takes 2-3 days after the delivery to spontaneously pass a BM.**

| Nursing Interventions: | Rationale (Evidence-Based Practice Trend): |
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| 1. Assess the Pt's usual patterns of defecation, including time of day, amount and frequency of stool, and consistency of stool. Palpate for ABD distention, percuss for dullness, and auscultate bowel sounds. | 1. There often are multiple reasons for constipation; the first step is assessment of the usual patterns of bowel elimination. In Pt's with constipation the ABD is often distended and tender, and stool in the colon produces a dull percussion sound. Bowel sounds will be present. |
| 2. Encourage the Pt to consume 1.5 to 2L of water per day. | 2. When dehydrated, the body absorbs additional water from stools resulting in dry, hard stools that are difficult to pass. |
| 3. Encourage the Pt to ambulate around the PP halls. The Pt was moving all around her room so I encouraged her to go a little father and ambulate around the halls later in the evening (once her company left). | 3. When Pt has diminished mobility, even minimal activity increases peristalsis, which is necessary to prevent constipation. |
| 4. Administer 100mg of colace BID as ordered. | 4. Colace helps to soften the stool. |
| 5. Document that the Pt hasn't passed a BM under G/I assessment. Include NI's that were implemented to help the Pt pass a BM. | 5. Proper documentation is of the nurse's most important tasks and is vital to accurate nursing care. It allows a baseline for further evaluations. |

Evaluation: met unmet

What nursing interventions contributed to success or failure to meet outcomes?

Unable to assess due to time restrictions. The Pt was to be discharged home 9/8/11. I hope the the Pt was able to pass a BM by the time she was discharged home or within 24 hours of her discharge. She was receiving colace BID so hopefully that helped her pass a BM.

**Problem # 5: Problem Statement (Nursing Diagnosis, R/T):**

**Effective breastfeeding r/t knowledge amb: the Pt verbalizing and demonstrating all 4 breastfeeding positions, the Pt breastfeeding the baby Q2-3 hours for 15-20 minutes each time and alternating between L and R breasts, the Pt was also keeping a very accurate feeding and diaper record to monitor intake and output, and I witnessed one breastfeeding at 08:15 and noted excellent latch technique and suckling.**

| Outcome: The patient will....( include time frame):<br><br>The Pt will maintain effective breastfeeding for at least 6 months (the Pt's goal was to breastfeed for at least 6 months). | |
|---|---|
| **Nursing Interventions:** | **Rationale (Evidence-Based Practice Trend):** |
| 1. Monitor the breast feeding process. Monitor for S/Sx's of nipple pain or trauma.<br><br>2. Encourage and facilitate early skin-to skin contact.<br><br>3. Give encouragement/ positive feedback related to breastfeeding mother- infant interactions.<br><br>4. Identify current support- person network and opportunities for continued breastfeeding support.<br><br>5. Encourage the mother to keep accurate intake and output including: breast feedings (L or R breast and amount of time), spit ups, pee diapers, and poopy diapers.<br><br>6. Document one witnessed breastfeeding Q shift along with the number of breastfeedings, the duration of the feedings, and which breast was used for the feeding. | 1. Breastfeeding should be observed by nurses and lactation consultants while the woman is in the hospital to identify ineffective breastfeeding patterns prior to discharge. These factors (nipple pain/ trauma) have been identified as impacting the continuation of breastfeeding in the first few weeks of motherhood.<br><br>2. Benefits of skin-to-skin contact (i.e. early initiation of breast feeding, increased ability of newborn's to distinguish their mother's milk, increased breastfeeding duration and success) have been supported in literature .<br><br>3. Effective breastfeeding is influenced by maternal state and the mother's knowledge of breastfeeding.<br><br>4. Education and support to breastfeeding mothers increases the length of breastfeeding and helps to promote exclusive breastfeeding.<br><br>5. It is important to keep accurate intake and output to ensure adequate nutrition and functioning of body systems.<br><br>6.Proper documentation is of the nurse's most important tasks and is vital to accurate nursing care. It allows a baseline for further evaluations. |
| Evaluation: met unmet<br><br>Unable to evaluate due to time restrictions. I hope that my Pt was able to meet her breastfeeding goal of 6 months or longer! Hopefully she has a good support system behind her encouraging her to do so. | |