

NURSE EDUCATION PROGRAM
MATERNAL-INFANT HEALTH NURSING
POSTPARTUM CARE PLAN

Student name _____

Date(s) of care _____

GENERAL INFORMATION DATA BASE:

Age: _____ Marital Status: _____

G _____ T _____ P _____ A _____ L _____

Date of delivery _____

Type of delivery _____

Allergies _____

Blood type: _____

GBS status _____ Rubella Status _____

Estimated due date _____

Type of feeding: Breast _____ Bottle _____ Both _____

Alternative feeding method(s) (cup, finger,) _____

Primary language/culture _____

Infant gender _____

Infant weight _____

Infant length _____

Apgar scores: 1 minute _____ 5 minutes _____

MATERNAL HEALTH HISTORY:

A. Please list any **pre-existing medical or psychiatric conditions**, Briefly define each condition, include signs and symptoms using your course texts as reference. State the potential significance for pregnancy and postpartum.. Describe the potential effects of these conditions on pregnancy and the postpartum period. Please cite references.

B. Briefly outline the patient's **labor history**. Include information regarding length of labor, time membranes were ruptured, other risks of infection, condition of infant at birth, infant's need for oxygen at birth or resuscitation, and the presence of congenital abnormalities and/or infection.

C. Provide a brief overview of the patient's social history. This should include information about whom the patient is living with, and whether there are siblings of the infant living at home. If so, include ages, whether the mother is currently working or in school, and what are her plans for working in the future. Economic and social stressors should be identified.

5. DEVELOPMENTAL ASSESSMENT

Mother/Infant

Be sure to address each of these for both mother AND infant.

A Identify the developmental stage (according to Erikson) for this client's age group. Explain the behaviors that relate that relate to the tasks of this stage. Include **general** (not necessarily specific to the client) indicators of both positive and negative resolution to this developmental stage. **Cite your source for this material here.**

Mother: stage:

Positive indicators

Negative indicators

Infant: stage:

Positive indicators

Negative indicators

B State whether you think that your client is moving successfully through this stage or not and substantiate your answer. Consider whether there is a risk that the task of mothering may conflict with successful resolution of the mother's current developmental task. State, based on the information that you have available, whether you think that your client can adequately meet the development needs of her infant based on what you know about her current developmental demands. Explain your answer.

MATERNAL PHYSICAL ASSESSMENT

<p><u>VITAL SIGNS:</u></p> <p>T: _____ P: _____ R: _____ B/P: _____</p> <p>PAIN:(type, location, degree, medications ordered)</p> <p>BREASTS: _____ UTERUS: _____ BLADDER: _____ BOWEL: _____ LOCHIA: _____ Episiotomy/laceration: _____ HOMAN’S : _____ EMOTIONAL: _____ TAKING-IN TAKING_HOLD</p> <p>APPETITE: _____</p> <p>ACTIVITY _____</p> <p>If Cesarean delivered:</p> <p>INCISION: _____ (use REEDA assessment above)</p> <p>LUNG SOUNDS</p> <p>BOWEL SOUNDS</p> <p>LABS:</p>	<p align="center"><u>OVERALL ASSESSMENT NOTE FOR THE MOTHER:</u></p> <p>Assume you are writing a comprehensive assessment note for the mother on the day you cared your patient. Assessment should include information about her mental status and psychological status. Include information about whether she is in the <i>taking-in</i> or <i>taking-hold</i> phase. Emotional (describe maternal child interaction, state of bonding). State your evidence.</p> <p>Breasts (engorged, non-engorged, soft, filling, condition of the nipples), Uterus/fundus (size, location, firm or boggy, displaced), Elimination, (voiding, catheterization, last bowel movement, need for stool softeners) Lochia: state amount and type (rubra, serosa, alba). Perineal area: (lacerations, edema, hematomas, hemorrhoids; REEDA assessment includes information about treatments being used such as ice, Tucks pads), Homan’s sign (left and right), Incision: staples/steri strips intact, REEDA assessment Lung sounds; Bowel sounds.</p> <p>Pain: beside type, location, degree, be sure to state what pain medication patient is written for and what medications she is currently taking. Is this medication regimen currently working? Why or why not?</p>
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OVERALL INFANT
PHYSICAL ASSESSMENT

<p><u>VITAL SIGNS:</u></p> <p>Birth weight: _____</p> <p>Today's weight: _____</p> <p>T: _____</p> <p>P: _____</p> <p>R: _____</p> <p>PAIN ASSESSMENT:</p> <p>STATE: (alert, quiet, agitated, sleeping)</p> <p>INTEGUMENTARY:</p> <p>JAUNDICE:</p> <p>FEEDING PATTERN:</p> <p>VOIDING: pattern of voids since birth</p> <p>STOOLING: pattern of stools since Birth.</p> <p>FEEDING PATTERN:</p> <p>LABS:</p> <p>PROCEDURES:</p>	<p>Assume you are writing a comprehensive assessment note for the infant you have cared for today. Your assessment should include an overall assessment of the infant's state (was the infant mostly sleepy, alert, agitated). If vital signs were not within normal limits, provide rationales for why and interventions that were made. Infant's pain assessment should include scores during procedures and while at rest. Integumentary assessment should include color (pink, ruddy, cyanotic, acrocyanosis, jaundice), if jaundiced describe how far into the trunk area jaundice is noted. Assess cord (REEDA, clamp on, off), assess mucus membranes.</p> <p>Neuro: note whether infant appears jittery; normal reflexes including Moro, sucking, Babinsky, palmar, plantar).</p> <p>Feeding: describe type of feeding and pattern. If bottle feeding, review and state type, amount, and frequency of feeding since birth, with emphasis on feeding during your shift. If breastfeeding, review and record frequency of feeding and time at breast each feeding since birth with emphasis on today's feeding. Assess for effective positioning and latch (include information about whether mother's nipples are sore during feedings). Voiding: review and state voiding pattern since birth with emphasis on number of voids during your shift. Stooling: review and record frequency of stooling since birth with emphasis on today's stooling pattern. Identify type of stools infant is currently passing (meconium, transitional, yellow).</p>
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8. ORDERED PATIENT MEDICATIONS

+DO NOT INCLUDE THE COMMON INPATIENT MATERNITY MEDICATIONS.

Please list all medications ordered by the physician that your patient is currently receiving. Please state the method being used to administer the medication, i.e.: crushed in fruit, taken with food, etc.

MEDICATION ORDER	WHAT IS A SAFE DOSE?	SPECIFIC CLASS	INDICATION SPECIFIC TO YOUR PATIENT

FUNCTIONAL HEALTH PATTERNS
MOTHER/INFANT

Select one priority functional health pattern for *mother* and one functional priority health pattern for the *infant* for each day of care. The functional health patterns are designed to assist you in assessing your patient's **discharge teaching needs**. Much of this teaching plan will be framed in the context of **health promotion** needs rather than **critical care needs**. Your goal is to assess your patient and family needs to determine what teaching and information will be most helpful. Many of the families you will be working with will be relatively healthy, but will nevertheless have teaching needs based on potential risks that are related to their postpartum and newborn status. Therefore, many of your diagnoses will be **potential for** rather than **actual** manifestations.

Below are the requisites to choose From.

UNIVERSAL REQUISITES:

- A. Promotion of Normalcy.
- B. Maintenance of Sufficient Intake of Air, Water, and Food.
- C. Provision of Care Associated with Bowel/Bladder Elimination and Issues Related to Skin Integrity.
- D. Maintenance of a Balance between Activity and Rest.
- E. Maintenance of a Balance between Solitude and Social Interaction.
- F. Prevention of Hazards to life function and well being

From these requisites identify 5 diagnosis for the mother and 5diagnosis for the infant.

Functional Health Patterns – Mother

Assessment: (**Must be comprehensive enough to support your diagnosis**)

Please include here the **specific assessment findings** that relate only to your diagnosis. From this assessment finding you will identify a nursing diagnosis, desired outcomes, and interventions which support your desired outcome.

	Discharge Planning/Interventions	Rationales	Evaluation (did your interventions help you to meet your desired outcomes?)
Nursing Diagnosis:			
Goals			
Desired outcome (realistic, measurable, time frame)			

