Post partum hesi case study

Business

Piton Is a hormone used to stimulate uterine contractions and prevent hemorrhage from the placental site.

Prior to discontinuing the IV, it is most important to ensure that the uterus is contracting by assessing fungal firmness. D) Oral intake. Assessment of oral fluid Intake Is Important when determining If dilation IV fluids are Indicated. But it is not the first priority. Points Earned: Correct Answer(s): c 2.

What is the priority nursing diagnosis for Marie, who is experiencing residual effects of epidural anesthesia?

A) Risk for infection. The lack of sensation below the waist caused by the residual effects of epidural anesthesia does not pose any real threat of infection, because epidural side effects are unrelated to the mechanisms of infection transmission or development. B) Risk for injury. Epidural anesthesia causes temporary loss of voluntary movement and muscle strength In ten lower extremities. Serious Injury could De Incurred IT Merle attempts to get out of bed on her own, because her legs will be unable to sustain her weight.

The nursing priority is to ensure her safety by implementing use of all four side-rails and instructing her to not get out of bed for the first time without assistance.

C) Impaired physical mobility. Maria’s impaired physical mobility is temporary and is not likely to cause complications resulting in long-term immobility. D) Altered urinary elimination. While the epidural anesthesia may temporarily inhibit Maria’s ability to void voluntarily, this is usually resolved within six hours. Marie should be monitored for bladder fullness during the

period that she is unable to sense the need to void, but this concern is secondary to client safety.

. What is the priority nursing action to address Maria's needs related to the repair of her 4th degree perinea laceration? A) Provide prescribed oral pain medication and stool softener. Feedback: INCORRECT Marie has no sensation below her waist because of the residual effects of the epidural anesthesia. She does not need pain medication at this time. A stool softener is usually administered within 24 hours of delivery, but it is not a priority at this time. B) Teach proper and frequent use of the pert-bottle.

It is important for the nurse to instruct Marie in measures to prevent infection, such as frequent and proper perinea hygiene techniques during the postpartum period. However, this teaching is not a priority at this time. Marie is exhausted (therefore not receptive to teaching), and she is unable to get up to the bathroom to void (epidural anesthesia). The more appropriate time to teach use of a pert-bottle is while assisting Marie after she is able to get up and void in the bathroom. C) Apply perinea ice packs consistently for the first 24 to 48 hours.

Feedback: CORRECT Topical perinea ice packs cause local vasoconstriction, resulting in decreased swelling and tissue congestion, as well as promoting comfort.

The application of ice packs Is ten portly nursing Acton Tort ten TLS 24 to B mourn, wanly Is ten pergola hat the tissue is most vulnerable to swelling resulting from the trauma. D) Encourage warm sits baths 2 to 3 times daily. Soothing, warm sits baths should be encouraged, because they increase

circulation to the site and promote healing. However, sits baths are not encouraged until the 2nd or 3rd postpartum day, after the swelling has decreased.

Promotion of increased circulation prior to this time will result in increased amounts of swelling, tissue congestion, and pain.

Early detection of, and intervention for, postpartum complications promotes positive client outcomes. Postpartum protocol requires that the nurse assess Maria's vital signs, funds, perineum, vaginal bleeding, pain, leg movement, and IV every 1 5 minutes for the first hour and then every hour for the next three hours. 4. Considering Maria's history, which postpartum complication is she most at risk for? A) Deep vein thrombosis.

Venous thrombosis forms in response to inflammation in the vein wall as a result of venous stasis.

Factors contributing to the development of deep vein thrombosis in the postpartum client include increased amounts of certain blood clotting factors, obesity, increased maternal age, high parity, prolonged inactivity, anemia, heart asses, and varieties. Maria's history does not indicate any risk factors for deep vein thrombosis. B) Substitution. Substitution occurs when the uterus fails to follow the normal pattern of involution, but instead remains enlarged.

It is caused by placental fragments or infection. The labor and delivery nurse stated that Marie delivered the entire placenta, I.

E. , no fragments were retained in the uterus. Maria's history does not indicate any risk factors for substitution. C) Endometriosis. Endometriosis is a uterine infection, one of four types of puerperal (of or pertaining to toddlers) Intentions.

Marble's nelsons does not Include any AT ten Doctors Tanat contribute to increased risk for puerperal infection which are: poor nutritional status, anemia, vaginal infection with group B streptococcus, and diabetes.

D) Hemorrhage. Postpartum hemorrhage indicates loss of greater than 500 ml of blood after the end of the third stage of labor. Causes of early postpartum hemorrhage include uterine atone (relaxation of the uterus), laceration of the genital tract, and retained placental fragments. Factors in Maria's history that contribute to the potential for hemorrhage include: overprotection of the uterus due to a large infant, the trauma of a forceps delivery, a prolonged labor, and the use of extinction.

Postpartum Crisis Fifteen minutes after the initial assessment, the nurse finds Marie disoriented and lying on her back in a pool of vaginal blood, with the sheets beneath her saturated with blood.

5. What is the priority nursing action? A) Take vital signs. If the nurse takes the vital signs first, time will be lost while the client continues hemorrhaging. B) Check the bladder. Several interventions should be implemented simultaneously.

Bladder distention is a moon problem that can impede uterine contraction and predispose the client to bleeding, but another action should be implemented immediately. C) Massage the funds.

Since a boggy funds is the most likely reason for this client's hemorrhaging, massaging the funds is the most important intervention. The nurse should also call for assistance due to the amount of blood that has pooled under the client. D) Increase ten IV rate.

This is an important action since the client is hemorrhaging and is probably humiliatingly unstable. 6. What is the best method for the nurse to use to obtain immediate assistance? A) Call or help from the doorway of the client's room. Although staying with the client is important during a crisis, it is not appropriate to shout in the hallway.

This could alarm other clients, and it is not the best way to summon help.

B) Go to the nurse's station to notify the charge nurse. The nurse should never leave a critical client's bedside for any reason. The first rule during a crisis is to stay with the client. C) Activate the priority call light from the bedside. The priority call light signals to the entire nursing unit that a client is in crisis.

All personnel available will respond to the distress signal. D) Telephone the healthcare provider from the client's room.

Feedback: INCORRECT The healthcare provider needs to be notified as soon as possible, but not without collecting data first. The healthcare provider will have questions regarding the client's status. Anticipating and collecting the

necessary data will facilitate effective communication with the healthcare provider. The nurse has requested assistance and personnel are on their way.

While waiting for help to arrive, what is the next priority action? A) Apply oxygen. Applying oxygen is important to improve the client's oxygenation, but it is of less rarity than addressing the cause of the hemorrhage.

B) Increase the IV infusion rate. Greater fluid volume administered intravenously is an important lifesaving action, but this is of less priority than addressing the cause of the hemorrhage. C) Obtain vital signs.

It is important to assess vital signs, but this is of less priority than addressing the cause of the hemorrhage. D) Assess for bladder distention. The client is two hours post delivery with an IV infusing at 125 ml/hour, which can contribute to dieresis. A distended bladder impedes uterine contraction and contributes to excessive bleeding. After the funds is massaged, the bladder should be checked for distention.

The charge nurse, two staff nurses, and an unlicensed assisted personnel (PAP) rush in to assist the nurse with Marie.

8. Which task is best delegated to the PAP during this crisis? A) Obtain the vital signs and 02 saturation. Obtaining vital signs and pulse geometry are within the scope of practice for the PAP, and the nurse should interpret these findings as indications of hypoglycemia due to blood loss, and should also report the findings to the healthcare provider. B) Change the bed linens and bathe the client. The client is lying in a pool of blood.

A firm funds indicates uterine contraction during the postpartum period, which is important to prevent further hemorrhage. D) Heart rate 94. A decrease in the heart rate indicates that the fluids being administered are helping maintain fluid volume, but this is not the best indicator of the medication's effectiveness. Postpartum hemorrhage is designated as blood loss in excess of 500 ml within the first 24 hours of delivery. 12. Considering the client's history, what etiology is most likely? A) Uterine atone.

The client's history revealed a prolonged labor (muscle fatigue) and a large baby (uterine overprotection).

These are both frequent causes of uterine atone. B) Retailer placental parts The initial report received from the labor and delivery nurse was that the full placenta was delivered. C) Perinea laceration. The laceration edges were well approximated and intact.

D) Coagulation. Acquired coagulation may be secondary to upperclassman, sepsis, or significant hemorrhage during delivery. The client's history did not include these problems. Marie is pale, weak, and anxious, but no longer disoriented. Her funds is firm and is 1 CM above the umbilicus. She is receiving 02 per nasal canal at 4 liters/minute and has an 02 saturation of 88%.

Her vital signs are: BP 74/44, pulse 116 and respirations 26. Her bleeding has slowed considerably. The nurse asks the ASAP to bathe Marie and change the bed linens. Marie tells the nurse that her husband went home to pick up their three children and bring them to the hospital. She states that she doesn't want her children to see her this way and asks the nurse to tell Mr.

. Wilson what has happened. 13. What intervention should the nurse implement to communicate the situation to Maria's husband? A) Dial the telephone number for Marie and hold the phone for her, allowing her to talk to her husband and explain what happened.

Feedback: INCORRECT Since Marie is still weak and unable to communicate effectively, it is not appropriate to have her try to explain the situation to her husband on the telephone. In addition, the client expressed a desire for someone else to contact her husband.

B) Wait until Mr.. Wilson arrives at the hospital with the children, and talk to him before he goes in to see his wife. Feedback: INCORRECT It is best if contact with Mr..

Wilson is attempted prior to his arrival at the hospital with the children. C) Ask the unit clerk to notify Mr.. Wilson about Maria's change in condition, but let