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Postpartum uterine infection Initial assessment

Midwifery & O.G. Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

29-year-old woman with postpartum fever. Care stage: At the first supervised assessment.

Medical history: Fictional obstetric history: G2P2 during the first postpartum week. Fever, uterine pain and abnormal lochia developed after the current birth. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The woman requests respectful explanation and involvement of her chosen support person with consent. Assess access to maternity follow-up, nutrition, transport and infant-care support.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Lower abdominal pain, feeling unwell and abnormal-smelling lochia.

Objective findings and required checks: Fever and uterine tenderness need urgent maternity assessment and sepsis screening.

Physical examination and investigations: Review observations, blood tests, cultures when indicated and assessment for retained tissue or other sources.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Postpartum uterine infection: Ascending or procedure-associated infection can inflame postpartum uterine tissues and progress systemically.

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Medical / surgical management

Escalate promptly, monitor perfusion and provide prescribed antimicrobial and source-directed care.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed broad-spectrum antimicrobial	Treat the assessed postpartum infection	Check allergy, timing and response
prescribed analgesic	Relieve discomfort	Reassess pain and clinical progression.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Lower abdominal pain, feeling unwell and abnormal-smelling lochia. Fever and uterine tenderness need urgent maternity assessment and sepsis screening. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize vulnerability to infection or worsening infection; raised temperature increasing discomfort and fluid needs; pain interfering with rest or activity; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Escalate promptly, monitor perfusion and provide prescribed antimicrobial and source-directed care. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends.	Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan.	1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm. 4. Escalate promptly, monitor perfusion and provide prescribed antimicrobial and source-directed care. Rationale: Ascending or procedure-associated infection can inflame postpartum uterine tissues and progress systemically. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about chills, headache, intake and illness onset. Assess: Record temperature site, trend, hydration and other observations.	Raised temperature increasing discomfort and fluid needs. Possible factors: an inflammatory or infectious process. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Temperature-related discomfort improves and clinical deterioration is detected promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Explains monitoring, hydration instructions and warning signs for review.	1. Trend temperature together with circulation, breathing and mental state. Rationale: Temperature alone does not describe illness severity. 2. Provide comfortable clothing and fluids when permitted; avoid extreme cooling. Rationale: Supportive care reduces discomfort without provoking unnecessary stress. 3. Administer prescribed treatment and obtain ordered specimens using correct technique. Rationale: Cause-directed management and reliable samples support recovery.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain hygiene, prescribed treatment, feeding-related medicine advice and follow-up warning signs. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain hygiene, prescribed treatment, feeding-related medicine advice and follow-up warning signs.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Shock, confusion, severe abdominal pain, heavy bleeding or respiratory deterioration needs emergency review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Ascending or procedure-associated infection can inflame postpartum uterine tissues and progress systemically.

- Priority concerns: Vulnerability to infection or worsening infection; Raised temperature increasing discomfort and fluid needs; Pain interfering with rest or activity; Learning needs about the condition and care plan.

- Shock, confusion, severe abdominal pain, heavy bleeding or respiratory deterioration needs emergency review.

- Explain hygiene, prescribed treatment, feeding-related medicine advice and follow-up warning signs.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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