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Insufficient fluid replacement for current losses Postpartum hemorrhage

Midwifery & O.G. Nursing | Focused diagnosis-based template

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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.

Clinical assessment

Subjective: Feels faint and weak; bleeding is heavier than expected.

Objective findings and required checks: Blood loss and circulatory changes require an immediate obstetric emergency response.

Physical examination and investigations: Quantify loss, assess uterine tone and circulation, and obtain ordered blood count/coagulation and compatibility tests.

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

Clinical focus and pathophysiology

Postpartum hemorrhage: Uterine atony, retained tissue, trauma or coagulation problems can cause serious postpartum blood loss.

Medical / surgical management

Activate the hemorrhage protocol, assess causes and perform authorized emergency measures while preparing prescribed treatment.

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Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed uterotonic	Treat uterine atony when indicated	Check contraindications and response
prescribed tranexamic acid/blood products	Support indicated hemorrhage treatment	Verify timing, indication and reaction monitoring under protocol.

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

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Focused nursing-problem template

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 thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition. 4. Activate the hemorrhage protocol, assess causes and perform authorized emergency measures while preparing prescribed treatment. Rationale: Uterine atony, retained tissue, trauma or coagulation problems can cause serious postpartum blood loss. 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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Health education and continuing care

After stabilization explain anemia/recovery care, recurrent bleeding warning signs and follow-up.

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

Ongoing heavy loss, shock, collapse or reduced consciousness requires immediate senior emergency care.

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

- Uterine atony, retained tissue, trauma or coagulation problems can cause serious postpartum blood loss.
- Priority concerns: Insufficient fluid replacement for current losses.
- Ongoing heavy loss, shock, collapse or reduced consciousness requires immediate senior emergency care.
- After stabilization explain anemia/recovery care, recurrent bleeding warning signs and follow-up.

Exam / viva: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Maternal-Newborn Nursing: external further reading - OpenStax / Rice University
https://openstax.org/books/maternal-newborn-nursing/pages/preface

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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