Basic Nursing Procedure Manual
Maternal Health Nursing/Clinical

Postpartum Performance
Lippincott Checklist

Grades shall be assigned to individual students on the basis of the instructor's judgment of the student's scholastic achievement using the grading system below

Excellent – Exceptional Achievement	4	A
Very Good – Extensive Achievement	3	B
Good – Acceptable Achievement	2	C
Fair– Minimal Achievement	1	D
Poor – Inadequate Achievement (*To secure credit, course must be repeated.)*	0	F

Postpartum Performance Checklist

Student Name: …….. Date: ……..

Instructor: …… Clinical Area: ……..

1.**Preparations**	0	1	2	3	4
• Prepare the client care area, necessary supplies, and equipment.					
• Use an antiseptic hand rub or wash hands thoroughly with soap and water and dry with clean, dry cloth or allow to air dry.					
• Greet the woman and her companion respectfully and with kindness, introduce yourself,					
• Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
• Provide continual emotional support and reassurance					
• Provide Privacy and Confidentiality.					
2. Obtains history					
• Obtains menstrual history (LMP, EDD). • Obtains obstetrical history(G, P, Abortion) • Obtains history of the current labor (time, type, outcome of labor, weight of baby).					
3.Assesses the general health status of a woman					
• Observe gait and movements, and behavior and facial expressions. • Observe general hygiene, noting visible dirt and odor. • Check conjunctive for pallor. • Ask the woman to empty her bladder. • Check Vital signs.					
4. **Postpartum Assessment Guide (BUBBLE–EE)**					
BREASTS: • Palpate each breast for firmness, fullness, tenderness, and contour.					

• Encourage all moms to wear a support bra whether nursing or non-nursing. • Provide information on collection and storage of breast milk and feeding technique. • Encourage all moms to breast care and feeding. • Assess the mom complain of sore nipples, are the nipples red, cracked. • Assess for signs of mastitis: fever, erythema of breasts and flu-like symptoms.					
Uterus: • Ask the woman to empty her bladder if she has not voided recently. (A full bladder contributes to uterine relaxation and sub involution.) • Have the woman assume supine position with knees slightly flexed (relaxes abdominal muscles). • Apply a lower perineal pad, and observe Lochia as fundus is palpated. • Cup one hand above the symphysis pubis to support the lower uterine segment; with the other hand, palpate abdomen until top of fundus is located. • Measure height of top of fundus in fingerbreadths above, below, or at umbilicus (Involution: 1 cm =about one fingerbreadth). • Determine whether fundus is in midline (deviation typically indicates full bladder). • Observe for firmness of fundus(boggy, soft, deviated to one side (due to retained products, distended bladder, uterine atony, bleeding) • Massage the fundus in a circular motion with the flat surface of the fingers of the dominant hand. • Assess **after pain** "Intermittent uterine contractions, which represent relaxation and contraction of the muscle fibers occur for the first 2 or 3 days' postpartum". • Document the consistency and location of fundus.					

Bladder: • Encourage mother to pass urine within four hours of birth to assess ability to empty her bladder. • Recommend Kegel exercise (stopping the flow of urine mid-stream help strengthen pelvic muscles). • Assess mother if experience any of the following symptoms (Lower abdominal discomfort. Burning. Reduced sensation. A feeling of incomplete emptying after passing urine). **Bowel:** • Ask the mother if she has had a bowel movement. • Auscultate bowel sounds • Prevent or treat constipation to reduce perineal pain • Encourage increase in fluid and juices along with increasing intake of fruits and vegetables. • Encourage Ambulation. • Observe hemorrhoids for extent of edema (can interfere with bowel elimination). **Lochia (**Vaginal discharge in first 4-6 weeks**):** • Assess lochia (type, amount, odor and consistency). • Instruct mother on use of sitz bath to promote healing, hygiene and comfort. • Encourage frequent perineal care and peripad changes to prevent infection • Avoid sexual contact to avoid spread of bacteria. • Educate mother to observe for (unpleasant smell, fever with chills, and pain in the lower abdomen). **Episiotomy, Perineal Incision:** • Inspect perineum for edema, bruising, and hematoma. • Monitor episiotomy or laceration for REEDA (*R*edness, *E*dema, *Ec*chymosis, *D*ischarge, and *A*pproximation). • Instruct mother on positioning to relieve pressure on perineal area.					

• Instruct mother on use of sitz bath to promote healing, hygiene and comfort. **Lower Extremities:** • Aske mother to lie in the supine position, the knee of the examined leg should be flexed. • Inspect edema, varicose vein, and pedal pulses in both legs. • Assess legs for (Tenderness, Redness, Hotness and Swelling). • As examiner should abruptly dorsiflex the patient's ankle • As examiner observes whether or not the patient reports pain in this calf and popliteal region. Pain indicates a positive sign. **Emotions:** • Assess the mother Psychological changes (Taking-In Phase, Taking-Hold Phase, and Letting Go Phase). • Encourage mother to express love & attachment toward new baby. • Use empathetic communication, and encourage client/family to verbalize fears, express emotions. • Avoid false reassurance; give honest answers and provide only the information requested. • Teach mother relaxation techniques (Breathing Exercises). **Document findings. Report abnormal findings.**					