Postpartum Nursing Assessment

Maternal Health Nursing\Clinical

❖ Postpartum Period

- Is the period during which the woman readjusts, physically

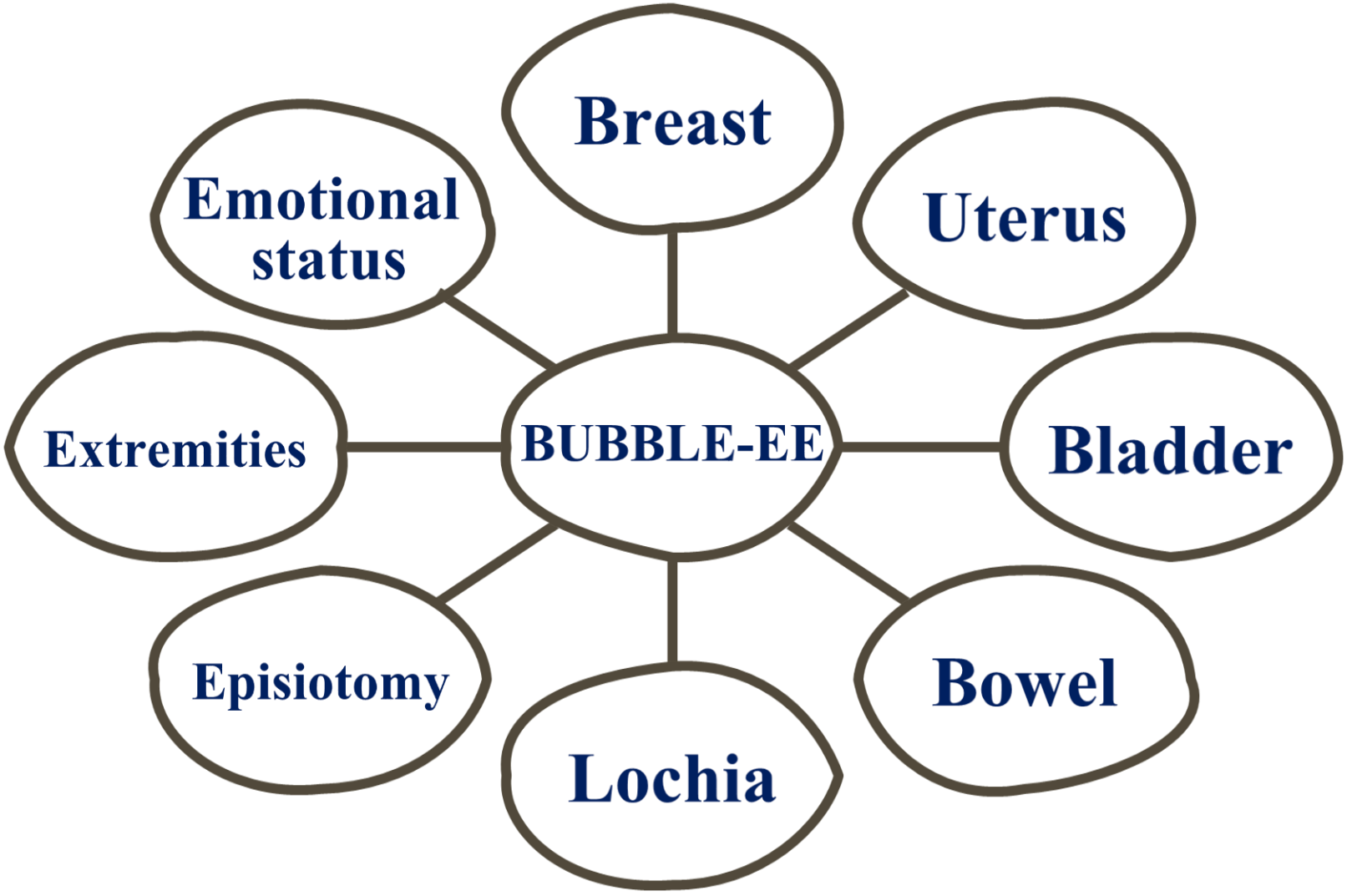
and psychologically, from pregnancy and birth.

- It begins immediately after birth and

continues for about **6 weeks** or until the body

has **returned to a near to nonpregnant state**.

❖ Postpartum Assessment



❖ Nursing assessment during post partum period

Post partum assessment typically is performed as follows:

→ During the first hour: every 15 minutes

→ During the second hour: every 30 minutes

→ During the first 24 hours: every 4 hours

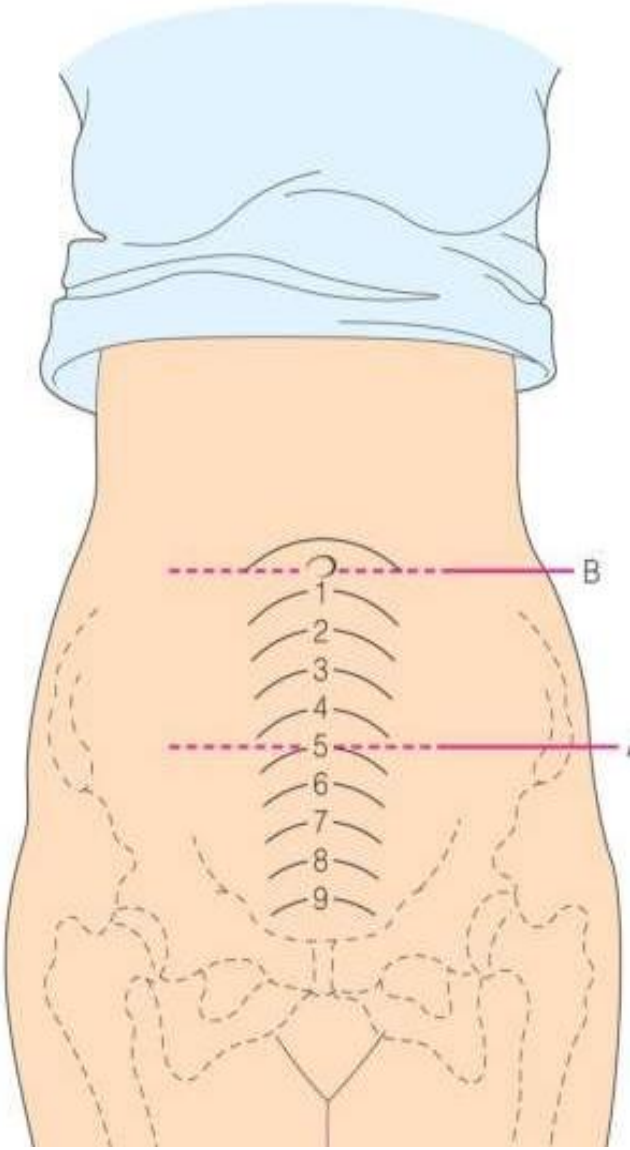
→ After 24 hours: every 8 hours

Assessment of Uterus

❖ Involution Of the Uterus

- Involution → The rapid reduction in size of the uterus and its return to a condition similar to its non-pregnant state, although it remains slightly larger than it was before the first pregnancy.

- **Sub involution** → failure of the uterus to return to non-pregnant state.



-The uterus with the assistance of the uterine muscles, contracts the blood vessels at the site of placental attachment to control bleeding.

- The uterus continues to contract after delivery, and its size decreases rapidly as estrogen and progesterone levels diminish

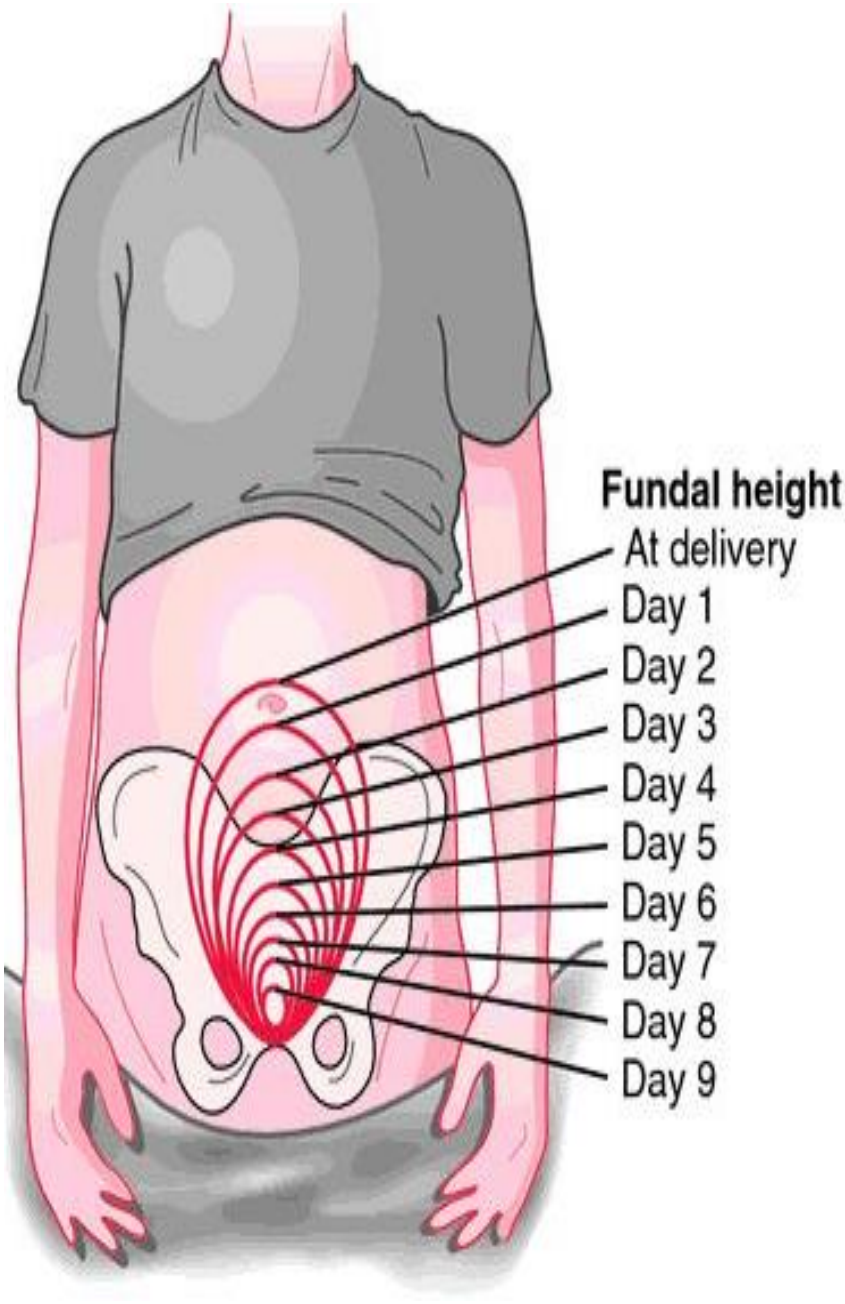
-The fundus continues to descend into the pelvis at the rate of approximately 1 cm (finger-breadth) per day and should be non palpable by 10 days postpartum

Involution of the uterus

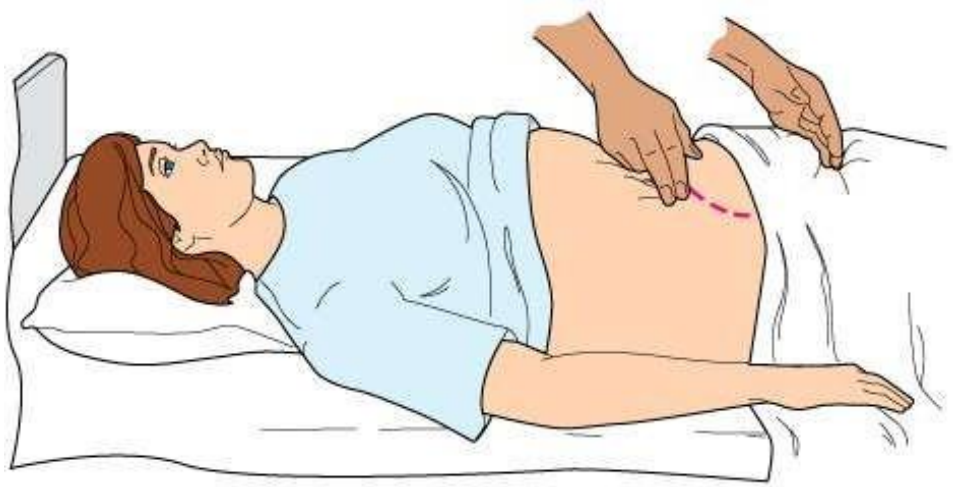
-At the end of third stage of labor, the uterus in midline, about 2 cm below the level of umbilicus.

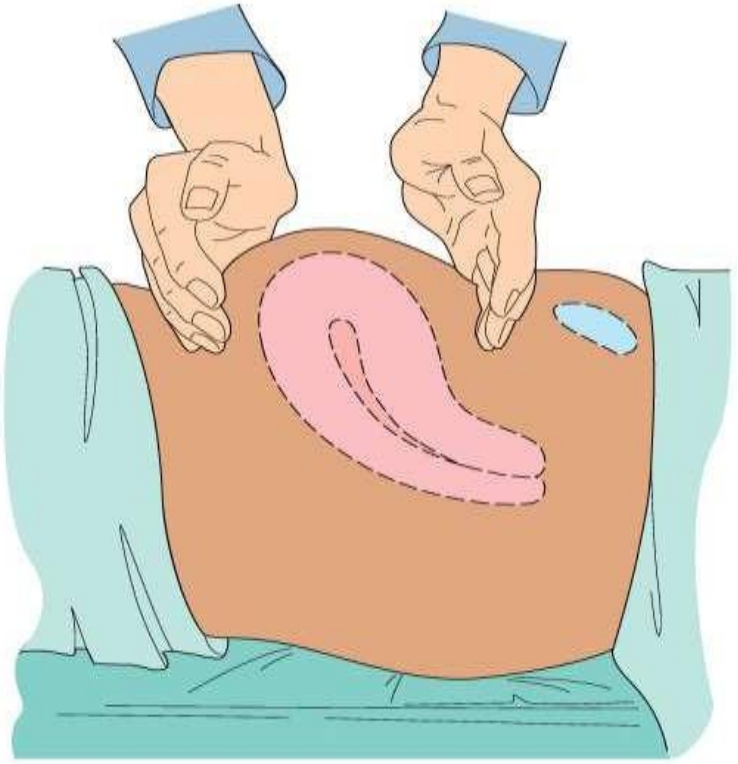
-Within 12 hrs fundus maybe approximately 1 cm above the umbilicus, or at umbilicus level.

-The fundus descends about 1cm every 24 hrs.



Uterus Assessment





- ✓ The women should void before her abdomen is examined
- ✓ Always support the bottom of the uterus during any assessment of the fundus.

❖ The nurse determines :

- The Relationship of the fundus to the umbilicus.
- The firmness of the fundus.
- The fundal Position (whether the fundus is in the midline or displaced to either side of the abdomen)

Normal Finding → Firm, Contracted and in the Midline

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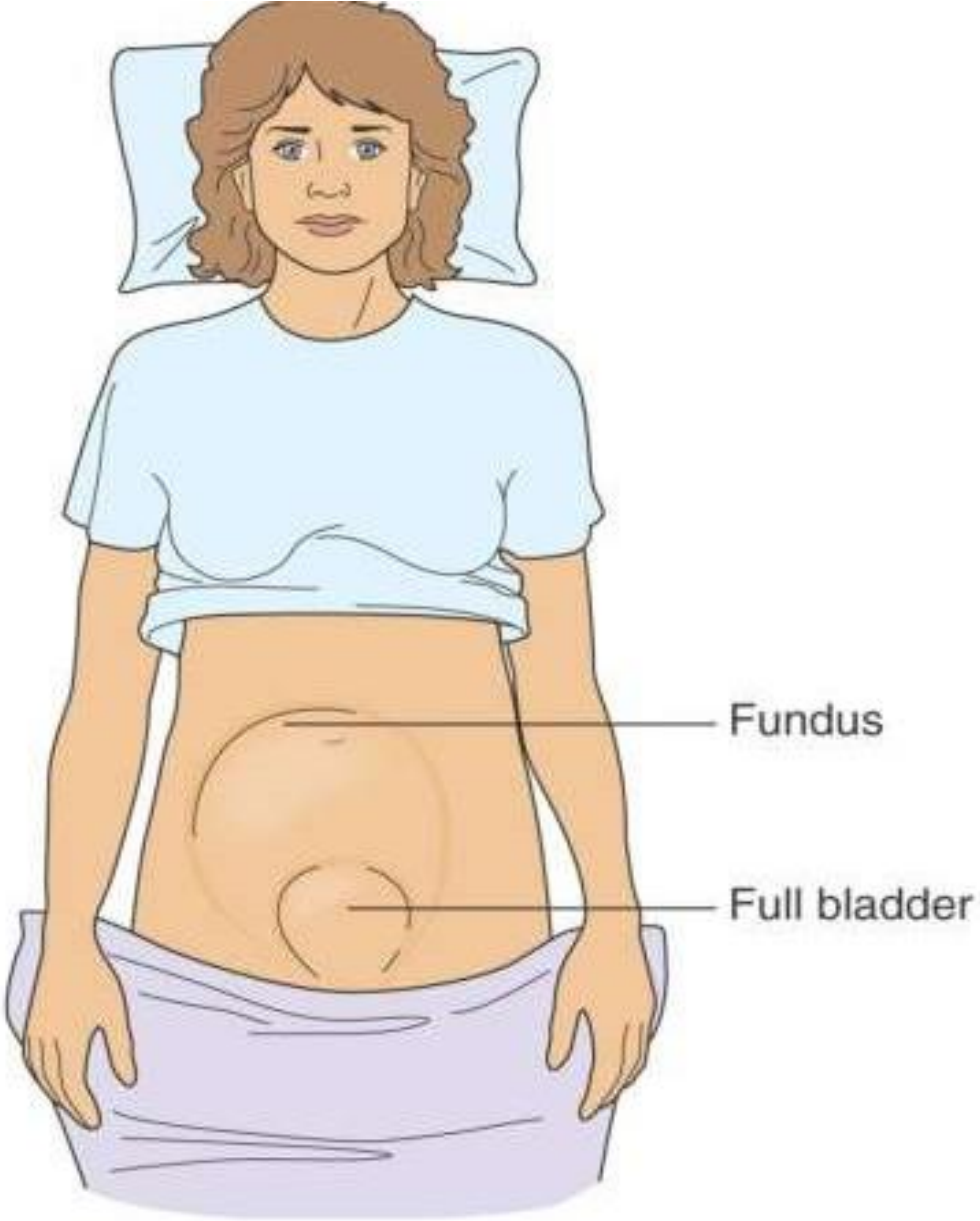


The uterus becomes displaced and deviated to the right when the bladder is full.

Uterine atony: relaxation of the uterus in the postpartum period.

Boggy uterus: a term used to describe the uterine fundus when it is not firmly contracted after the birth of baby early in the postpartum period.

Postnatal hemorrhage: loss of blood greater than 500 ml following vaginal birth this classified as early or immediate if it occurs within the first 24 hours.

❖ Postpartum Hemorrhage (PPH)

- **Early (immediate or primary) PPH:** Occurs in the first 24 hours after childbirth
- World Health organization (WHO) definition of PPH
  - **Blood loss ≥ 500 ml within 24 hours after birth.**
  - **Sever PPH: blood loss ≥ 1000 ml within the same time frame**

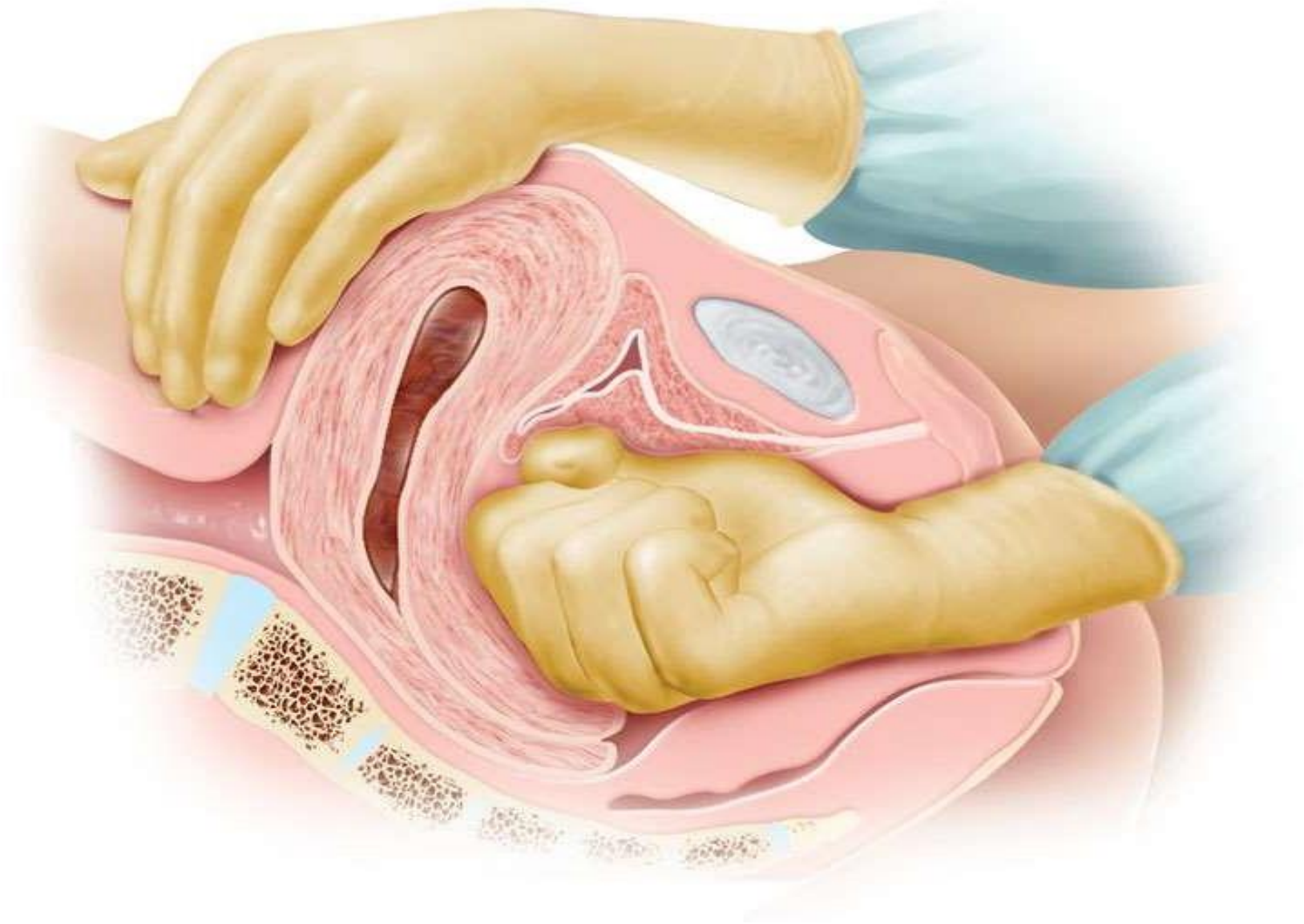
❖ Uterine Atony \Boggy Uterus - contributing factors

- **Overdistention of the uterus due to multiple gestation, polyhydramnios, or a large infant (macrosomia)**
- **Prolonged labor**
- **Oxytocin augmentation or induction of labor**
- **Grandmultiparity**
- **Prolonged third stage of labor—more than 30 minutes**
- **Operative birth**
- **Retained placental fragments**
- **Placenta previa**

❖ Clinical Therapy

- **Monitor patients vital signs** to observe hemodynamic stability.
- **Venous access with large bore catheters** (18 gauge), sometimes using two concurrent access sites, will be established to administer crystalloid solutions such as normal saline or Lactated Ringer's.
- **Empty bladder**
- **External uterine massage**
- **Bimanual massage**
- **Uterine stimulants** (uterotonic agents) Oxytocin, ergotamine, and prostaglandin. Misoprostol, after attempts to control bleeding with oxytocics

External uterine massage



Bimanual Massage

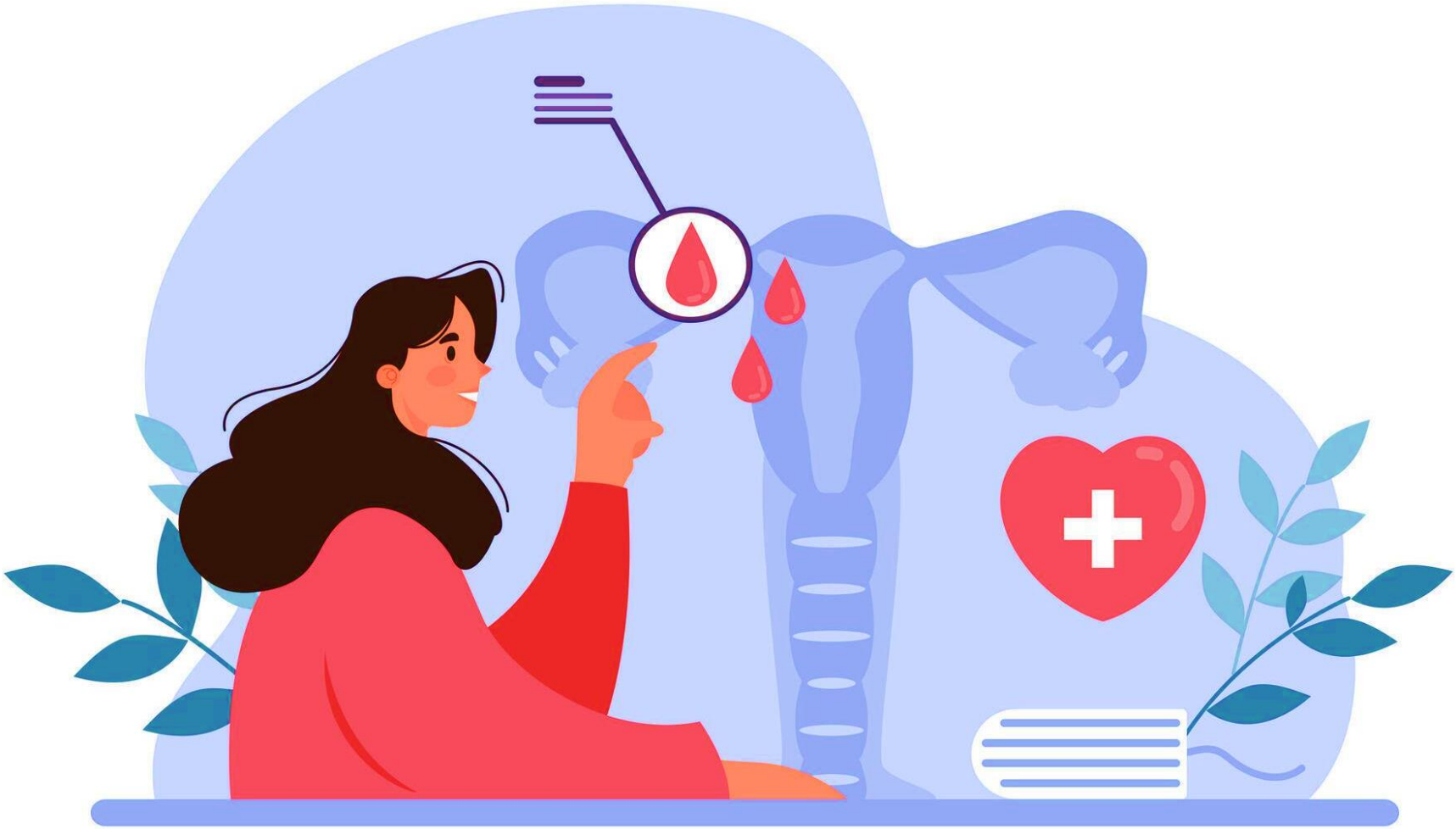
❖ Afterpain

Intermittent uterine contractions, are a normal occurrence during the postpartum period. Afterpains are caused by the release of the hormone oxytocin and the subsequent relaxation and contraction of the uterine muscles.

Relief of after pain:

1. Positioning (prone position)
2. Analgesia administered an hour before breastfeeding
3. Encourage early ambulation – monitor for dizziness and weakness

Assessment of Lochia



After delivery, the endometrial surface of the uterus is shed via the vagina. The shedding endometrium is known as lochia. Lochia occurs in three successive stages that include lochia rubra, lochia serosa, and lochia alba.

❖ Lochia: Rubra, Serosa, Alba

Rubra: dark red in color, present the first 1-3 days postpartum, should not contain clots, a few small clots are considered normal.

Serosa: pinkish to brownish in color, from the 3ed to the 10th day post delivery.

Alba: creamy or yellowish in color, persists until 6weeks

Characteristics of Lochia			
Type of lochia	color	Postpartal day	Composition
Lochia Rubra	red	1-3	Blood, fragment of decidua, and mucus
Lochia Serosa	Pink	3-10	Blood, mucus, and invading leukocytes
Lochia alba	White	10-14 (may last 6 weeks)	Largely mucus; leukocyte count high

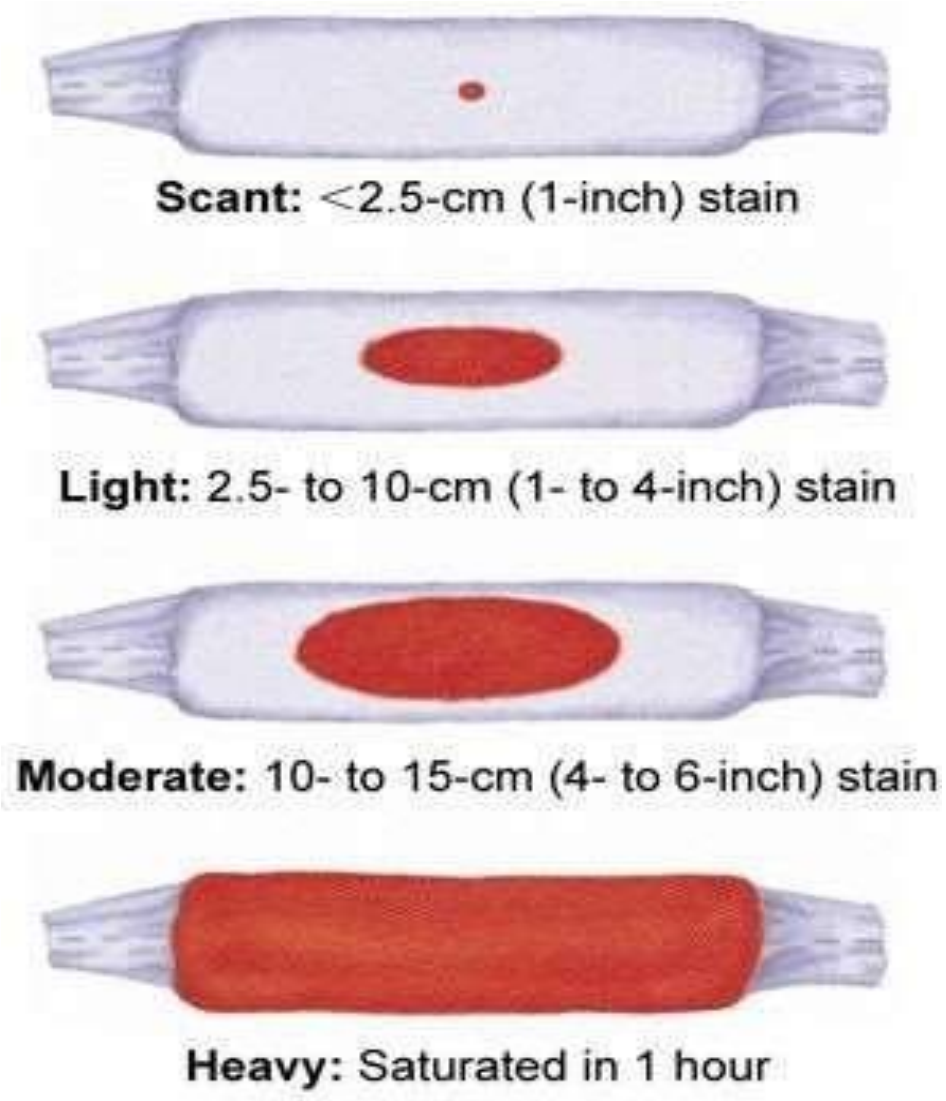
❖ **Assess amount, color, odor, clots**

If soaking 1 or > pads

/hour, assess uterus,

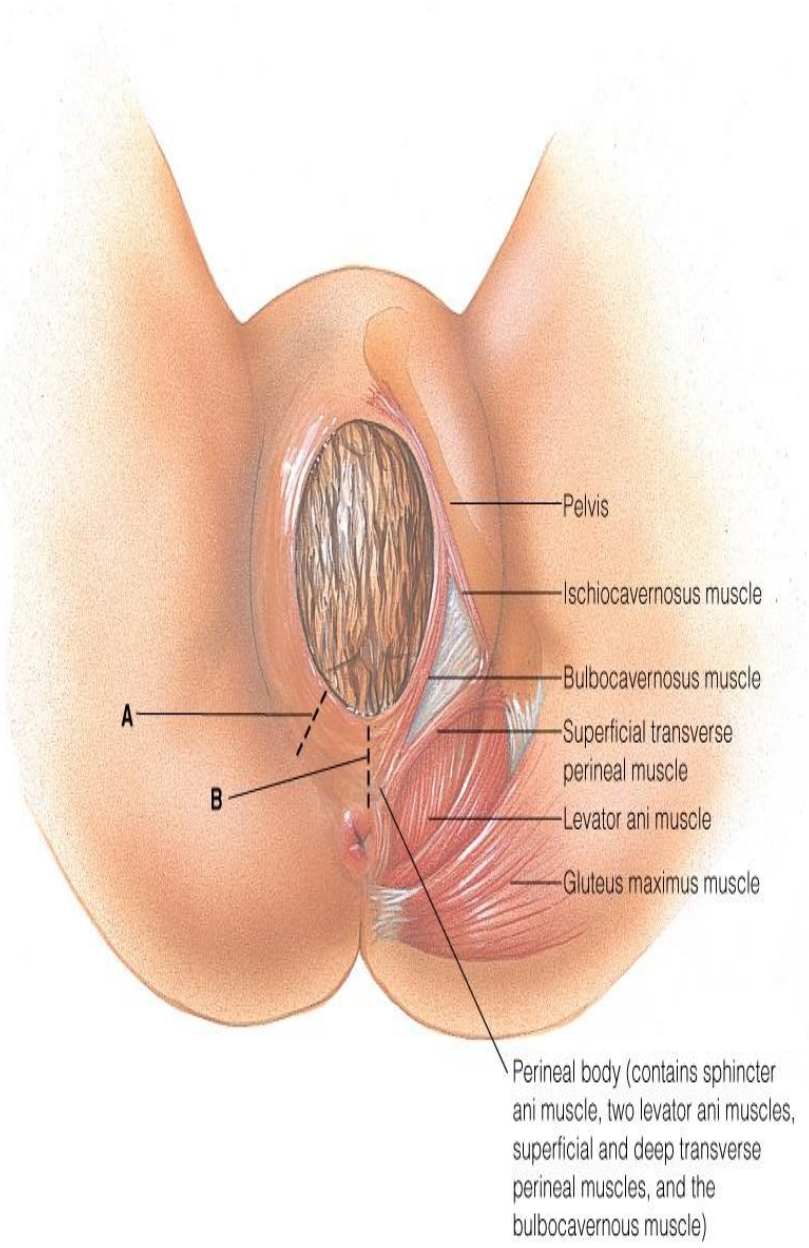
notify health care

provider



❖ PERINEUM

This area between the posterior portion of the labia majora and the anus stretches and thins during birth to accommodate the delivering infant. Lacerations of the perineum may occur during delivery, or an episiotomy (surgical incision) may be performed in this area to accommodate the infant during delivery.



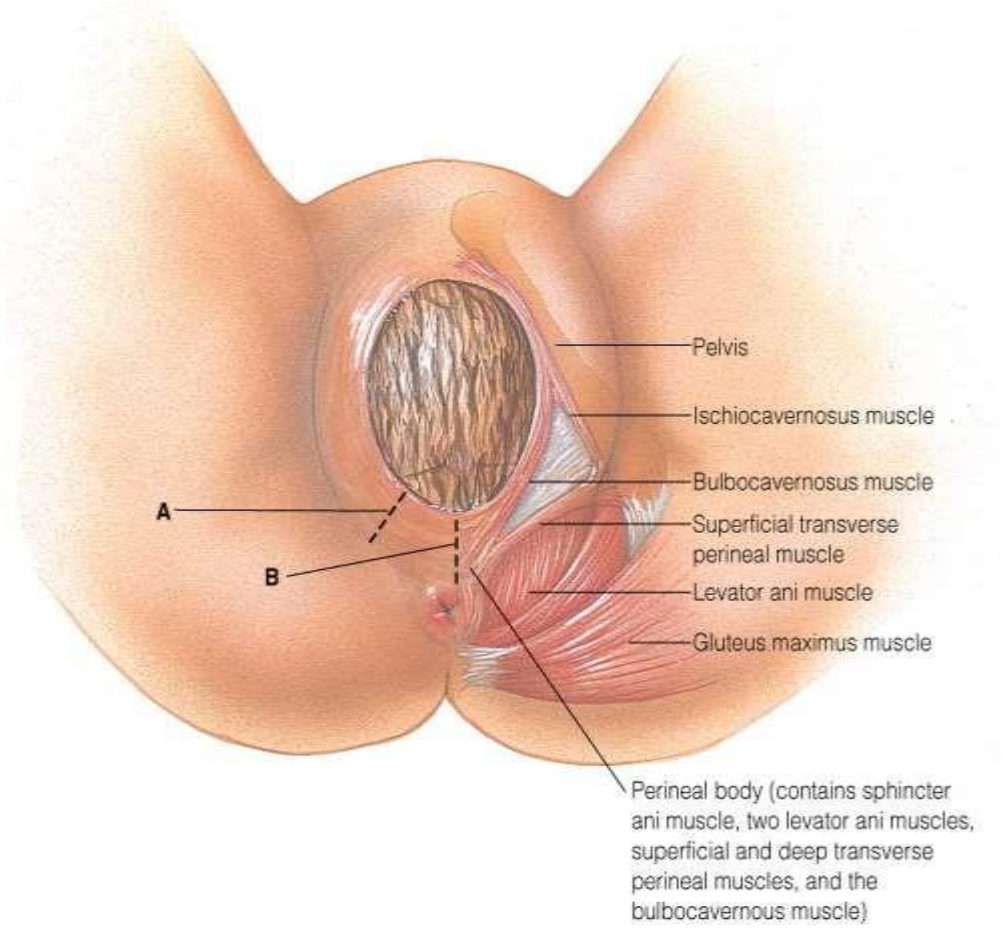
Episiotomy, Lacerations, C/S Incisions

- Inspect the perineum for episiotomy/lacerations with REEDA
- Assessment of the episiotomy/perineum should occur with the woman in lateral Sims (side lying) position.

- Inspect C/S abdominal incisions for **REEDA**

R = redness (erythema)
E = edema
E = ecchymosis
D = drainage, discharge
A = approximation

Episiotomy


Pelvis
Ischiocavernosus muscle
Bulbocavernosus muscle
A
Superficial transverse perineal muscle
B
Levator ani muscle
Gluteus maximus muscle
Perineal body (contains sphincter ani muscle, two levator ani muscles, superficial and deep transverse perineal muscles, and the bulbocavernous muscle)

BREAST ASSESSMENT

After delivery there is a significant decrease in estrogen and progesterone levels.

Before milk production begins, the breasts secrete colostrum, a thin, yellowish fluid that helps maintain the blood glucose level in the breastfeeding infant.

-Nipple stimulation by the infant causes the release of the hormone oxytocin from the posterior pituitary gland,

which triggers the release of the

hormone prolactin from the anterior pituitary.

Prolactin initiates milk production,

and the breasts become full (engorged),

as well as warm and tender,

between postpartum days 3 and 4.

Engorgement → breast distention or vascular congestion. the process of swelling of the breast tissue brought about by an increase in blood and lymph supply to the breast, which precedes true lactation it last about 48 hrs and usually reach a peak between the third and fifth postpartum day.

Mastitis → infection in the beast, usually confined to milk duct, characterized by influenza-like symptoms and redness and tenderness in the affected breast.

1. Inspect the breast for size, contour, asymmetry, engorgement, or erythema.

2.Check the nipples for cracks, redness, fissures, or bleeding, and note whether they are erect, flat, or inverted?? (Flat or inverted nipples can make breastfeeding challenging for both mother and infant.

3.Palpate the breasts lightly to ascertain if they are soft, filling, or engorged.

4.Palpate the breasts for any nodules, masses, or areas of warmth, which may indicate a plugged duct that may progress to mastitis if not treated promptly.

5.Assess for presence of colostrum: a clear , yellow fluid, expressed from breasts in first 72hrs after birth. it is Rich in antibodies, which provide protection from many disease, and high in protein.

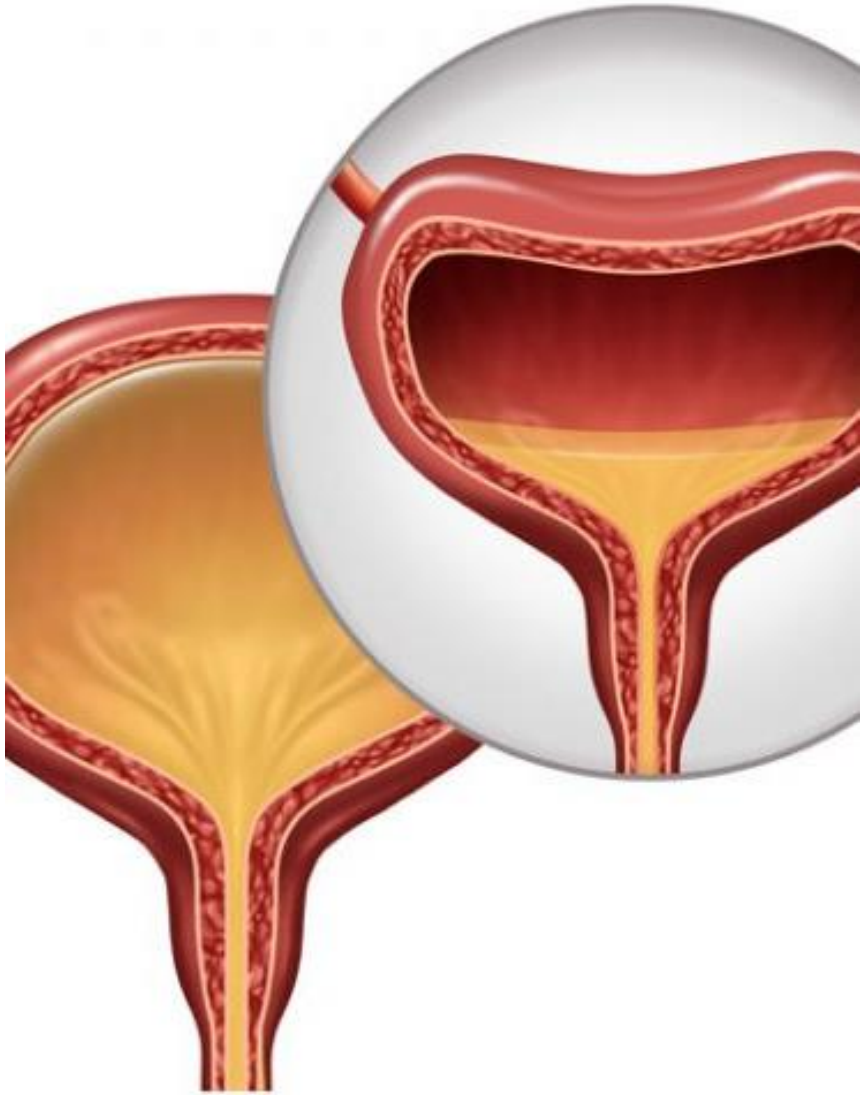
First day or two after delivery, the breast should be soft and not tender.

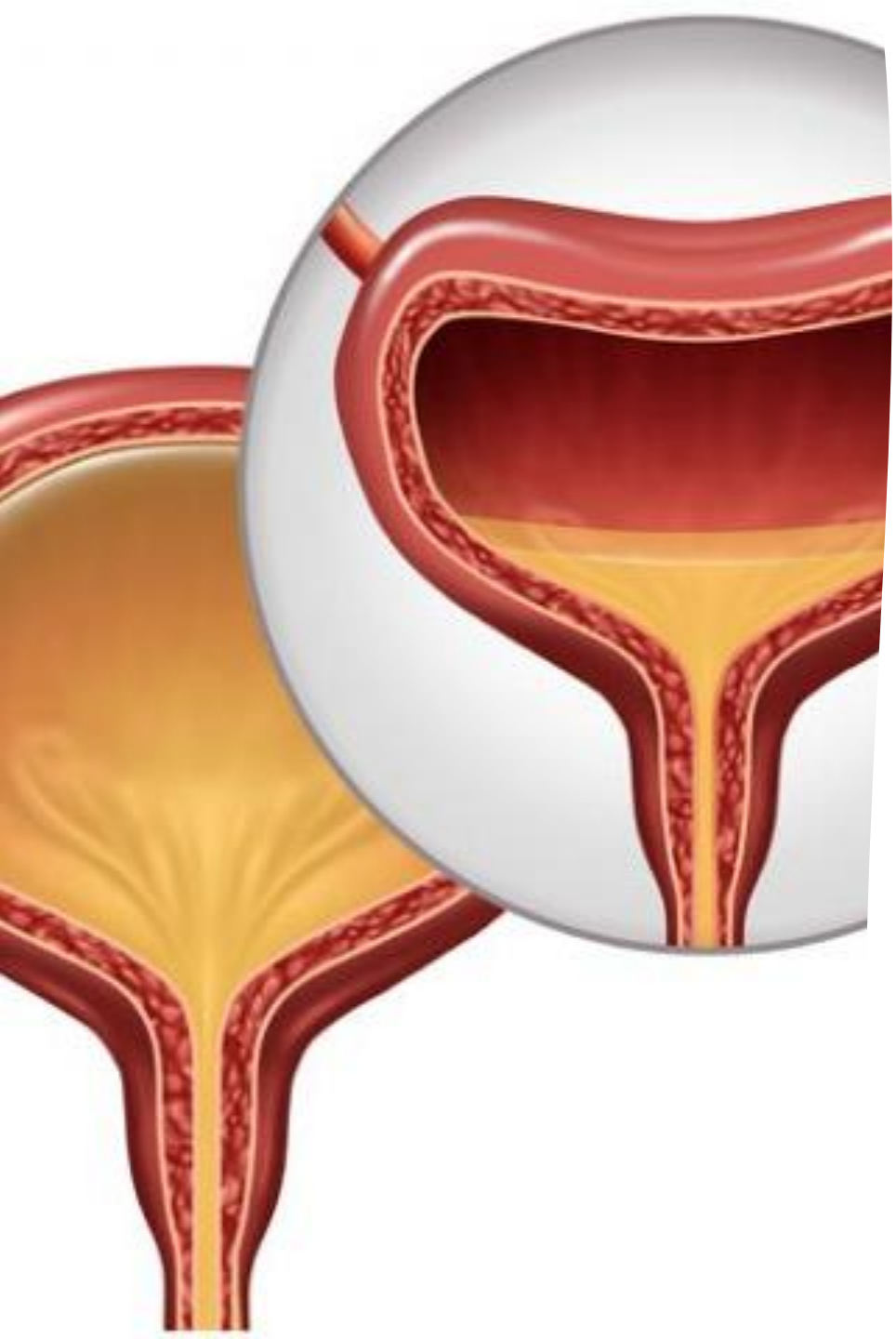
BLADDER ASSESSMENT

-Voiding pattern, complete emptying, pain burning on urination

-Record first three voids with the amount and times voided

-A full bladder displaces the uterus upwards and laterally and prevents contraction of the uterus = UTERINE ATONY = > risk of postpartum hemorrhage.



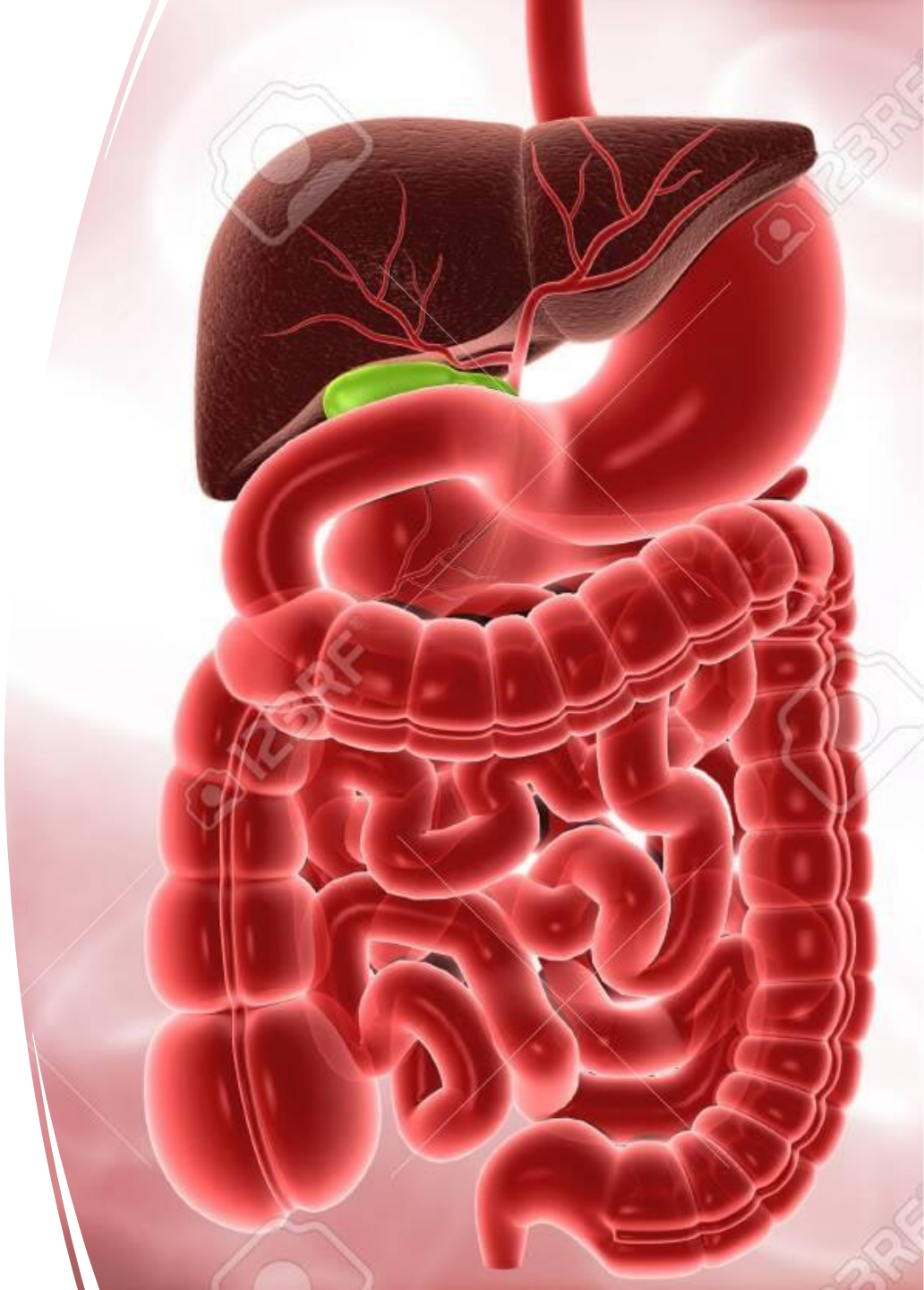


BLADDER ASSESSMENT

-The bladder, urethra, and urinary meatus are edematous after delivery as a result of the fetal head passing through the birth canal. Bladder tone is diminished, and many clients are unable to feel the need to void, despite the rapid diuresis(puereperal diuresis) that occurs following delivery to eliminate 2000-3000ml of extracellular fluids

❖ Bowel

- After delivery the client feel hungry
- May have a regular diet
- Bowels tend to be sluggish
- Cesarean birth clients may receive clear liquids and progress to a regular diet
- Stool softeners may be used



❖Bowel

-Spontaneous bowel movements may not occur for 2 – 3 days after giving birth because of a decrease in muscle tone in the intestine during labor and the immediate puerperium, pre labor diarrhea, lack of food, or dehydration.

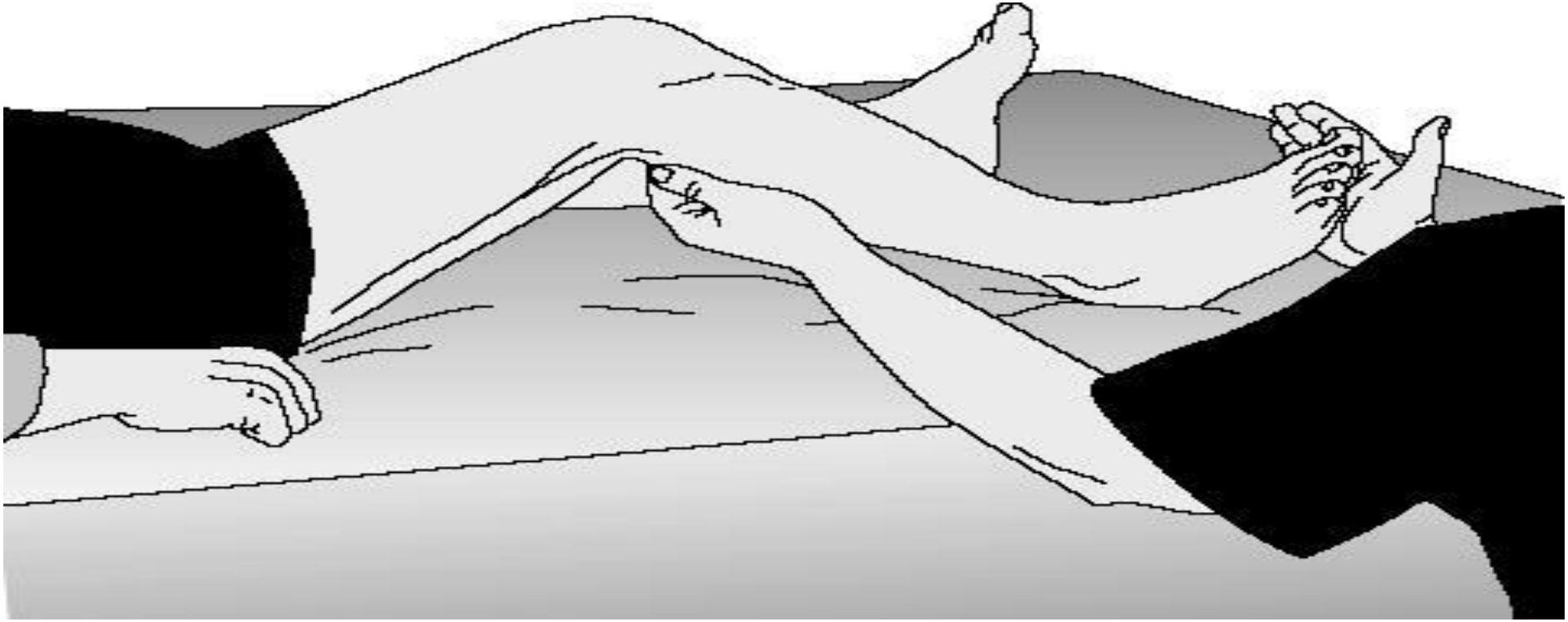
-Inspect the woman's abdomen for distention, auscultate for bowel sounds in the four quadrants, and palpate for tenderness.

❖ Extremities

- Assess for pedal edema, redness, and warmth

Then you can Check Homan's sign – dorsiflex foot with knee slightly bent

- Encourage client to early Ambulate to prevent D.V.T



❖ Vital signs

- Temperature elevations should last for only 24 hours should not be greater than 38c.

- Bradycardia rates of 50 to 70 beats per minute occur during first 6 to 10 days due to decreased blood volume.

- Assess for BP within normal limits :may experience transient rise in BP.

Notify MD for tachycardia, hypotension, hypertension

❖ Blood Values

-White blood cell count often elevated after delivery
→ Elevated WBC to 30,000/mm3 (Leukocytosis)

→ Physiologic Anemia
-Blood loss – 200 – 500 Vaginal delivery
-Blood loss 700 – 1000 ml C/S
-RBC should return to normal w/in 2 - 6 weeks
-Hgb – 12 – 16, Hct – 37% - 47%

→ Activation of clotting factors (PT, PTT, INR) predispose to thrombus formation - hemostatic system reaches non-pregnant state in 3 to 4 weeks
Risk of thromboembolism lasts 6 weeks

❖ _Postpartum Chill and Postnatal Diaphoresis

- **Most clients experience a shaking chill or tremor after delivery. Warm blankets usually relieve this tremor or chill.**

- Chills and fever late in the postpartum period may indicate sepsis.

-Diaphoretic episodes may occur at night, a normal occurrence as the body rids itself of waste products.

Normal Psychological changes

❖ *Rubin's Phase*

Taking in phase: First 3- days

→ **Mother focuses on her own primary needs, such as sleep and food.**

The woman is largely passive ,dependence results partly from her physical discomforts.

→ **The woman usually wants to talk about her pregnancy, especially her labor and birth.**

→ **It is important for the nurse to listen and help the mother interpret the events of delivery to make them more meaningful.**

→ **This phase is not an optimum time to teach the mother a bout baby care.**

❖ Taking hold phase: days 4-10

→ The woman is more in control of independence.

→ The woman begins to assume the tasks of mothering.

→ This phase is an optimum time to teach the mother a bout baby care.

→ Although a woman actions suggest strong independence during this time ,she often still feels insecure about her ability to care for her new child.

❖ Letting-Go phase

→The woman finally re defines her new role. She gives up the fantasized image of her child and accepts the real one.

→ A woman who has reached this phase is well into her new role.

Maternal role attainment →process by which a woman learns mothering behaviors. (anticipatory, formal, informal, and personal)

Postpartum blues

❖ Postpartum blues

→ Transit period of depression during the first few days of postpartum (mood-swing, anger, anorexia& difficulty sleeping)

→Considered normal reaction to new motherhood and causes few problems

→Causes: Exact cause still unknown, but suggested causes may be: hormonal changes cause mood swings (sudden fall in blood progesterone), changes in lifestyle , new responsibilities (motherhood).

→Incidence increase by stress, fatigue , anxiety from family tension or inability to cope with baby demands.

❖ Postpartum blues

→ Women are emotionally labile ,often crying easily and for no apparent reason. This lability seems to peak around the fifth day and subside by the tenth day.

→ If worsen the woman may need evaluation for postpartum depression

POSTPARTUM CESAREAN (CS)

→ In addition to the usual postpartum evaluation, post cesarean mother must be assessed like any other postoperative client.

→ Pain Relief: Assessment of pain level and the effectiveness of pain medication is an important part of nursing care for post cesarean clients.

→ Respiration mothers receive narcotics for postoperative pain relief must be assessed frequently because narcotics depress the respiratory center.

→ The chances of pulmonary infection are increased because of immobility after the use of narcotics and sedatives and because of altered immune response in postoperative clients. Therefore, the woman is encouraged to cough and deep breath every 2 to 4 hours while awake until she is ambulating frequently.

→ Abdomen :Nurses assess gastrointestinal function by auscultating for bowel sounds until normal peristalsis is noted in all abdominal quadrants .

→ Nurses must assess for abdominal distention, absent or decreased bowel sounds, and failure to pass flatus or stool.

→ Observe the incision, which should be approximated , and use the acronym REEDA to assess for signs of infection.

→ Legs: leg exercise encouraged every 2 hrs until the woman is ambulating.

→ The woman should be encouraged to flex her legs and to move her feet and legs frequently to improve peripheral circulation and prevent thrombi.

❖Danger sign postpartum

Inform mother when to return immediately:

1.Fever

2.Vomiting

3.Fainting

4.Abdominal pain

5.Change in the character of the lochia foul smell, return to bright red bleeding, excessive amount, passage of large clots.

6.Pain at the site of a laceration, episiotomy, or abdominal incision.

7. Evidence of thrombophlebitis, such as calf pain, tenderness, redness.

8. Evidence of wound infection including redness, swelling, severe or worsening pain , or foul-smelling discharge.

9. Evidence of mastitis, such as breast tenderness, swelling, reddened areas, malaise.

10. Evidence of urinary tract infection, such as urgency, frequency burning on urination.

11. Sever headache

12. Mood changes or Problem with sleeping.