

Postpartum Assessment and Nursing Considerations

Assessment	Nursing Considerations
Vital signs	<ul style="list-style-type: none"> • Temp of 100.4° F during first 24 h after delivery considered normal. Encourage fluids. • If temp is above 100.48° F, check the following for possible infection: <ul style="list-style-type: none"> > lacerations > sutures > breasts > lochia (foul odor of lochia may indicate infection) > urine • Pulse elevation may be first sign of hemorrhage. • Decreased pulse rate (as low as 50) is considered normal during first postpartal week. • Decreased BP and/or narrowed pulse pressure are signs of shock. • Orthostatic hypotension is common during the early postpartal period. The patient should rise slowly from lying or sitting to prevent "blackouts" or falls. • Assess BP every hour if patient has been preeclamptic.
I&O	Accurate I&O for at least 12 h (urinary retention may occur).
Head	<ul style="list-style-type: none"> • Assess for headache resulting from anesthesia or elevated B • Visual light flashes may indicate preeclampsia
Lungs	<ul style="list-style-type: none"> • Check for adventitious sounds. • Prolonged bed rest, labor, vomiting, or anesthesia may predispose to pneumonia (women who have had spinal or epidural anesthesia may have difficulty coughing or clearing the lower airway until anesthesia wears off). • Chest pain and dyspnea are common symptoms of pulmonary embolism.
Breasts	<ul style="list-style-type: none"> • Colostrum appears within first 12 h. • Breast milk appears by about 72 h. • Breast engorgement occurs on the 3rd or 4th postpartal day and should resolve spontaneously within 36 h. • Assess for infection (warm, painful, reddened area). • Assess for irritation of nipples. • Bra should be worn by all women during the postpartal period.
Abdomen	<ul style="list-style-type: none"> • Assess fundus. Should be firm and at umbilicus immediately after delivery, then fall 1 cm (1 fingerbreadth) each day for next 10 days. • If fundus is boggy, assess first for bladder fullness, and have patient void if indicated. • If fundus is boggy and bladder is empty, massage top of fundus with fingers held together. (Patient may be taught to massage fundus.) • Auscultate to assess peristalsis. • Assess daily for BM. (Analgesics and other aspects of labor and delivery make constipation very common.) Increase fiber and fluid intake to prevent constipation. • Encourage early ambulation.
Perineum	<ul style="list-style-type: none"> • Assess episiotomy for edema, bleeding, or redness. • Assess for hematoma (purplish mass may be seen at introitus of vagina) if patient complains of severe perineal pain or a feeling of fullness in the vagina. • Assess for hemorrhoids. • Assess lochia. Patients who report or are observed to have heavy bleeding

	<p>should be placed on pad count.</p> <ul style="list-style-type: none"> • A continuous flow of bright red lochia or the passage of large and/or frequent clots is abnormal and indicates hemorrhage. Occasional passage of clots in the absence of heavy flow may be normal. • Lochia should progress as follows: <ul style="list-style-type: none"> > Lochia rubra: Dark red, 2–3 days > Lochia serosa: Paler, brownish pink, 4-10 days > Lochia alba: Whitish or yellowish, up to 3 wks • Lochia should be odorless.
Lower extremities	<ul style="list-style-type: none"> • Assess veins for redness and extreme warmth (signs of phlebitis). • Assess for pain while dorsiflexing foot. <ul style="list-style-type: none"> > Pain indicates positive Homans' sign, which is sign of thrombophlebitis. • Ambulation and/or early leg exercises help prevent venous stasis and clot formation.
Psyche	<ul style="list-style-type: none"> • Assess mood. Mild "let-down feeling" is usually considered normal. • Watch for signs of parent-infant bonding: <ul style="list-style-type: none"> > Parents hold baby so that mutual gazing can occur ("enface" position). > Parents talk to baby. > Parents stroke baby. > Parents make positive statements about baby. > Parents give baby cherished name.

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