I. **Purpose:**

To outline the nursing management of obstetric patients during the postpartum period.

II. **Policy:**

This policy describes the routine nursing care for patients in the postpartum period. The immediate recovery period is defined in the [Nursing Management of the Labor Patient](#) policy.

III. **Specific Education Required:**

Unit based orientation

IV. **Process or Procedures:**

A. A complete physical assessment of the postpartum patient is performed by an RN, with specific attention to the perineum, fundus, incision (if applicable), breasts, and post anesthesia motor function.

B. Description of Assessments.
C. Obtain vital signs, which include blood pressure, pulse, respirations, and temperature following the immediate recovery period.
   1. Cesarean Section – Every 4 hours x 24 hours, then every 8 hours until discharged or as directed by provider order.
   2. Vaginal Delivery – Every 4 hours x 3, then if stable, every 12 hours until discharged or as directed by provider order.

D. Perineum and Fundus.
   1. Palpate uterine fundus for position, height and tone. Following the immediate recovery period.
      a. Cesarean Section - Every 30 minutes x 1 hour, then every 4 hours x 24 hours, then every 8 hours until discharged, or as directed by provider order.
      b. Vaginal Delivery – Every 30 minutes x 1 hour; then every 4 hours x 24 hours; then if stable, every 12 hours until discharged, or as directed by provider order.
      c. After the first 12 hours postpartum, if the patient is stable and sleeping, the Q4hour fundal assessment may be deferred for one interval.
   2. Inspect amount and character of lochia, noting any clots.
      a. Inspect perineum for bleeding, edema, hemorrhoids, hematoma and breakdown of episiotomy.
      b. Increase frequency of assessment if hypotonic uterus or abnormal bleeding noted. Abnormal findings which may require intervention include fundus above the umbilicus; fundus deviated to right or left, fundus soft or boggy to palpation, presence of clots > 1-2cm, or bleeding which soaks one or more peripads in one hour.
      c. Apply ice pack with protective covering to perineum following vaginal delivery for the first 24 hours unless patient declines.
      d. Instruct patient to rinse perineum with warm water in peri care bottle after each void, rinsing from front to back. Change peripad and/or ice pack following each void and PRN. Report excessive bleeding (greater than one pad per hour) or pain to health care provider.
   3. Incision.
      a. Check status of dressings and report any significant drainage or discharge to the provider or house officer.
      b. Consult provider orders for specific direction for managing dressing changes and staple removal.
   4. Patient Comfort.
      a. Consult the hospital Pain Management Guidelines policy for screening for pain, effectiveness assessment and appropriate vital sign frequencies following pain medication administration.
      b. Narcotic medications will not be routinely ordered for vaginal deliveries, unless they have experienced a 3rd or 4th degree laceration/episiotomy. If non-narcotic medications are inadequate, notify the provider.
      c. Document administration of analgesia or antiemetic medication including dose given and patient response.
d. Perineal comfort measures include ice packs, sitz bath and an application of topical agents as ordered. Encourage position changes.
e. Notify anesthesia for post-op patients requiring narcotic medication during first 24 hours post delivery.
f. Refer to hospital guidelines (Patient Controlled Analgesia Administration and Management) regarding patients receiving patient controlled analgesia or undergoing continuous epidural anesthesia infusion.

5. Intake and output
   a. Document amount and type of IV fluid present on admission to recovery area.
   b. Assess IV site for appearance and patency and record on I/O flow sheet at least every two hours.
   c. Maintain IV access for all patients having Duramorph within the previous 16 hours.
   d. Assess and document the presence, location and patency of all drainage tubes on admission and upon discharge. Empty and record drainage at least every 4 hours and as needed.
   e. If foley catheter is present document intake and urinary output at least every two hours, more often if directed by provider orders.
   f. Notify provider if urinary output is less than 30 mls/hour.
   g. Document changes in color or clarity of urine.
   h. Measure and document 24-hour intake and output if IV present.
   i. Patients who are unable to void for more than 6 hours may be catheterized (in and out straight cath x 1).
   j. Assess patient’s ability to void within 6 hours of vaginal delivery or following I/O catheter or foley catheter removal. Measure and document first three voids. If voiding < 200cc and a palpable bladder is noted, the patient may be catheterized (in and out x 1). Measure and record next three voids.
   k. After three voids greater than 200cc and/or no bladder distention, assess bladder function by patient interview every 12 hours.
   l. Interview patient for the presence of burning, frequency or urgency with each assessment.
   m. Encourage patient to void every 3-4 hours after delivery to avoid distension and minimize discomfort.
   n. For patients with preeclampsia, refer to the Management of Patients with Preeclampsia policy.
   o. For patients with diabetes, refer to the “Management of patients with Diabetes Mellitus During the Peripartum Period” policy.

6. Respiratory
   a. Assess breath sounds at least every shift.
   b. Obtain a baseline O₂ saturation level per pulse oximeter for post-op patients upon admission to the unit, and more frequently if condition becomes unstable.
   c. Encourage patients to turn, cough and deep breathe every two hours following delivery.
d. Patients receiving IV analgesia or postoperative patients may require incentive spirometer.
e. For patients with preeclampsia, refer to the Management of Patients with Preeclampsia policy.
f. For patients with diabetes, refer to the “Management of Patients with Diabetes Mellitus During the Peripartum Period” policy.

7. GI Function
   a. Auscultate bowel sounds and report abdominal distention or inability to pass flatus within 24 hours post-op to provider.
   b. Interview patient regarding flatus, bowel movements and appetite with nursing assessments.
   c. Encourage early ambulation.
   d. If patient is not on fluid restrictions, encourage at least 2000cc/day fluid when taking P.O well and increased fiber intake.
   e. Administer stool softeners as ordered.
   f. For patients with preeclampsia, refer to the Management of Patients with Preeclampsia policy.
   g. For patients with diabetes, refer to the “Management of Patients with Diabetes Mellitus During the Peripartum Period” policy.

8. Lower Extremities
   a. Assess for presence of erythema, edema, localized redness or pain with nursing assessment.
   b. Assess deep tendon reflexes and Homan’s sign.
   c. Sequential Compression Devices (SCDs) on all postoperative patients until ambulating.

9. Post Anesthesia Recovery
   a. Assess and document for return of sensory and motor function every thirty minutes until normalization following regional or general anesthesia.
   b. No anesthesia - ambulate with assistance when stable.
   c. Regional Anesthesia - assist with ambulation following return of motor and sensory function.
   d. Cesarean delivery - activity as ordered.
   e. Side rails remain up on all patients following epidural or general anesthesia.

10. Safety
    a. All stretchers and beds are in lowest and locked position. The patient is instructed to call for assistance to get out of bed until sensation has returned.
    b. Place all drains, foleys, tubes and limbs inside side rails when transporting.
    c. Regional Anesthesia - assist with ambulation following return of motor and sensory function.
    d. Cesarean delivery - activity as ordered.
    e. Use proper body mechanics when repositioning and transporting patients.
11. Breasts
   a. Assess by patient interview, inspection and palpation for cracked or bleeding nipples, localized redness, tenderness, engorgement, history of breast surgeries, infertility, breast changes during pregnancy, and medications patient is taking.
   b. First 24 hours following delivery, the breasts are soft and not-tender to palpation, colostrum can be expressed, and there should not be areas of erythema, fissures or cracking. After delivery the breasts feel firmer and may become tender and warm to touch. Encourage patients to wear a supportive, non-constricted bra.
   c. If your patient is engorged, encourage breastfeeding, hand expression of milk or application of ice for 20 minute intervals can help to relieve engorgement.
   d. If bottle feeding, avoid breast/nipple stimulation, apply ice packs to breasts for engorgement and encourage supportive bra.
   e. Initial breast feeding should be encouraged within 1 hour after delivery.
   f. Request lactation consult for any breast feeding mother for problems with breast feeding the nursing staff is unable to resolve or per patient or provider request. May require Pediatric notification.
   g. Initiate breast pumping for mothers with babies in the NICU and/or infants who cannot latch on well within 6 hours of delivery.

E. Patient Discharge
   1. Discharge planning
      a. Occurs in a planned and systematic fashion for all postpartum women in order to enhance care and minimize complications or the need for rehospitalization. A collaborative discharge plan involving the patient and family, RN and provider includes expected perinatal events, possible complications, and immediate care instructions to follow in the event of an emergency or complication.
      b. Anticipate discharge within 24-72 hours if:
         i. the mother is stable following delivery
         ii. the mother is sufficiently recovered to be discharged to outpatient care.
         iii. Laboratory evaluations have been obtained to include ABO blood group and Rh typing with appropriate use of Rh immune globulin and adequate hematocrit.
         iv. RN verifies presence of provider discharge order.
         v. RN verifies appropriate discharge teaching relevant to diagnosis and verifies that the patient has received suitable discharge information.
         vi. Appropriate follow-up appointments are made and verified or patient instructed to call for follow-up appointment.
      c. Education methods include, but are not limited to:
         i. One-on-one instruction
         ii. Classroom review of discharge materials
         iii. Skylight video review of discharge materials
iv. Demonstration and/or return demonstration
d. Patients should be provided adequate time for questions and answers
to ensure adequate understanding.
e. For non-English speaking patients, Interpreter Services, either on the
telephone or in person, should be utilized to ensure adequate
understanding.

2. Discharge
a. All patients are transported or escorted from the hospital by a VUMC
employee.
i. Transport services are provided for all patients
ii. If a patient wishes to walk out, a staff member must
accompany them to the parking lot
b. RN or Medical Receptionist completes appropriate log book and
computer discharge information, disassembles patient chart in proper
order and places necessary completed forms in appropriate location.

V. Clinical Implications:

Nursing notifies the Rapid Response Team, OB Emergency Team or Provider, as
clinically appropriate for any of the following:
A. BP > 140/90
B. BP <90/60 or S/S of hypotension such as N/V, sweating, dizziness,
tachycardia or alteration in mental status.
C. Pulse >120 or < 50
D. Respirations > 24 or < 10
E. Sa02 < 92%
F. Presence of adventitious breath sounds
G. Temperature >100.4
H. Bladder distention and/or inability to void for more than six (6) hours
following straight catheterization
I. Excessive vaginal bleeding, unresponsive to fundal massage
J. Bleeding or leakage on abdominal dressing
K. Urinary output <30 mls per hour
L. Excessive perineal edema or development of hematoma
M. Discomfort not relieved by pain medications
N. Altered level of consciousness or unresponsive to stimuli
O. Refer to Physician Notification for Change in Patient Condition policy
P. For patients with preeclampsia, refer to the Management of Patients with
Preeclampsia policy.
Q. For patients with diabetes, refer to the “Management of Patients with
Diabetes Mellitus During the Peripartum Period” policy.
VI. **Patient/Family Education:**

Educate patient/family at the level of their understanding. Utilize Interpreter Services as necessary. Teaching is to be initiated on admission and reinforced throughout the patient stay (Refer to Mother & Baby New Life Handbook)

A. Recovery routine
B. Visitor Policy
C. Postpartum/Nursery Unit Routine
D. Shift change and handover communication process
E. Patient Safety
   1. Falls Prevention
   2. Infant Safety & Security
      a. Overview of Infant Security Procedures
      b. Safe sleeping practices with infant
      c. Safe infant positioning
F. Self-care
G. Peri care
H. Fundal massage
I. Vaginal bleeding
J. Personal hygiene
K. Appropriate breast care for desired infant feeding method
L. Nutrition-Menu and ordering process
M. Lactation
N. Pain medications
O. Emotional responses
P. Activity and exercise
Q. Sexual activity
R. Postpartum birth control
S. Danger signs/complications to report to health care provider
T. Infant security after going home

VII. **Documentation:**

Document patient assessments at the appropriate intervals in the nursing flow sheet; and patient/family education in the appropriate electronic medical record.

VIII. **Cross References:**

A. [Pain Management Guidelines](#) CL 30-02.04
B. [Falls Prevention Policy](#) CL 30-02.09
C. [Nursing Management of the Laboring Patient](#) AS 201111-20.03
D. [Patient Controlled Analgesia Administration and Management](#) CL 30-06.12
E. [Interpretive Services: Hard of Hearing and Deaf, Visually-Impaired and Limited English Proficiency (LEP) Communications](#) OP 10-50.01
F. [Rapid Response Team Activation](#) CL 30-08.16
G. [Obstetric Emergency Team (OBET) Activation](#) AS 201111-20.16
H. **Physician Notification for Change in Patient Condition** CL 20-06.08
I. **Management of Patients with Preeclampsia** AS 201111-20.04
J. “Management of Patients with Diabetes Mellitus During the Peripartum Period”

**IX. References:**


**X. Contributors:**

Stephanie Abbu
Kim Domaradzki
Joanne Tennyson
Michelle Browning
Robin Seaton

**XI. Approval:**

Anisha Fuller, BSN, RN Nurse Manager September 27, 2011

Dennis McWeeney, MD Medical Director October 17, 2011