BUBBLE-HE

BUBBLE-HE is an acronym used to denote the components of the focused postpartum maternal nursing assessment. These are in addition to Vital signs, general head to toe assessment which also includes Reflexes.

For stable patients, vital signs are taken every 15 minutes during the first hour following delivery and then gradually less frequently, per hospital protocol. While performing the BUBBLE-HE, the RN often uses the assessment time to provide for patient education.

The BUBBLE-HE Acronym

- B: Breast
- U: Uterus
- B: Bladder
- B: Bowels
- L: Lochia
- E: Episiotomy and perineum
- H: Homan
- E: Emotions

B: Breast

Breast assessment

- Assessment includes evaluating the breast in the postpartum period.
- The first step is to determine if the new mother is breastfeeding or bottle-feeding. This will guide the assessment along with patient education.

Breast Evaluation

- Size
- Shape
- Firmness
- Redness
- Symmetry

Bottle-Feeding Mom: Lactation Suppression

- Teach the mom about breast engorgement: This usually occurs about 72 hours after birth.
- The breasts will be very tender with a feeling of heaviness
- A firm, snug-fitting bra Is ideal for the woman who's not breastfeeding even though engorgement may still occur
- Ice and cabbage leaves can provide relief. There is an enzyme in the cabbage leaves that helps.
- Do not express milk as it will encourage additional colostrum/milk production. Avoid breast/nipple stimulation either manually or even with warm showers.

Breastfeeding Mom

- Focus on the nipple and areola. The nipple should be erect, but some are flat or inverted. Hopefully, this was identified during the pregnancy in order for shield to be placed upon them.

- Assess the nipples for signs of bruising, crackling, chapping. A deep crack or blister may indicate incorrect placement or another issue with the infant's latch.
- Avoid placing want cold packs on the breasts

Mastitis Infection: Nursing Considerations

- Mastitis is an infection of the breast surrounding the ducts that's characterized by fullness, pain, warmth, and hardness of the breast. It's crucial to differentiate infection from engorgement. Mastitis may involve fever, while localized symptoms are limited to specified area that usually appears red and feels warm and possibly hardened
- Mastitis needs to be treated with antibiotics and the patient is usually encouraged to continue breastfeeding. The cause of infection is associated with stagnant milk in the ducts. In most cases, the milk is not infected; only the ducts.
- The best way to feed is to start on the uninfected breast first. The mother should then switch to the affected breast within a few minutes so this breast can be fully emptied and drained. The infant is the best "drainer"- no breast pump can ever compare. The only time a breastfeeding mom is asked to stop is when boils and/or cysts are present.

Breast and Bottle Feeding

- The decision to breast or bottle feed is highly personal. While the benefits of breast milk nutritionally and physiologically outweigh those of formula, it may not always be possible or in the best interest of the mom and baby to breastfeed. The nurse's role is to educate the mom and support the family in whatever choice is made, not pass judgment.

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Benefits of Bottle Feeding

- Not solely a "Mom-only" responsibility
- Breastfeeding does not always "come naturally" to all moms- it may be difficult for some
- May be considered more socially acceptable to whip out a bottle in the middle of a restaurant versus a breast

- May be easier for moms who work outside of the home
- Bonding ←--> dad and baby or other relatives who feed

Disadvantages of Bottle Feeding

- No passive immunity
- Harder for baby to digest
- Expensive, especially if a specialized formula is needed
- More allergies
- Overfeeding is easier
- Stool is more odorous

Benefits of Breast Feeding

- Passive immunity
- Less incidents of ear infections (formula pools into the Eustachian tube)
- Easy digestibility
- Bonding between mom and baby.
- No cost and always available and at the right temperature
- For the foodies: Some moms may enjoy being able to eat an extra 500 calories/day
- Benefits to Mom: Release of oxytocin (the "let-down") causes the uterus to contract, which promotes quicker return to pre-pregnancy size; burning the extra calories may help lose some of the pregnancy weight. It also decreases risks of ovarian and breast cancer

Breastfeeding Teaching

- Positioning: holds- chest to chest or tummy to tummy in some way, grab under the breasts and push down and out (taking the milk ducts and pushing it forward, make a C-Hold around the areola (pull back, down, and forward while bringing forward)

- get a nice big drop of colostrum on the nipple

- tickle the lip with nipple, help infant take as much breast (not just the nipple) as possible into the mouth once it's open

- 5 to 15 minutes at first to prevent soreness

- Start with the breasts that was left from
- Try to feed every 2 hours

Formula Teaching

- Ready-to-feed: most expensive but convenient
- Concentrate: do not ever add more water or dilute it

Powder: follow directions per label

Throw the bottle contents out after the feeding- do not save for next feeding

Start off small by only preparing 2 ounces at a time

- No need to warm formula up

U: Uterus

Uterine Assessment

1 **. Fundus**: firm or boggy- make a "C-shape" with your hand and push up on the lower fundus (except with c-sections) ; if it's not stabilized, the uterus can prolapse, or fall into the vagina. Observe lochia during assessment. Massage of not firm- secure lower uterine segment. The concern is for hemorrhage; the primary causes are a distended bladder
(uterus can't contract or uterine atony, or failure to contract fully) and retrained placental fragments (usually a later cause)

2. **Fundal Height:** where is it in relation to the umbilicus? "U/U" or "At the U" (I/U = 1 cm above the umbilicus)- The position drops one centimeter on average every 24 hours for 10 days postpartum

3. **Midline or Deviated to the Left or Right: if deviated, it's usually a sign of a full bladder**

Uterine after-pains of a breastfeeding mom get worse with each pregnancy. The uterus is a muscle and the more it is stretched, the more force is needed in order to contract.

Nursing Consideration. A boggy fundus may be a sign of uterine atony, which places the patient at risk for developing a postpartum hemorrhage and other complications. Also, fundal location that lies out of range with anticipated location according to postpartum status may be another indication. The nurse should perform a uterine massage, which promotes blood movement out of the uterus, and also encourage the patient to void, as a full or distended bladder can impede uterine involution and contractions. The nurse is often in the position as the first member health care team to learn of these warning signs and therefore must take swift action if an issue is suspected.

B: Bladder

Bladder Assessment

- Ask mom when she last voided
- Establish a Voiding Schedule to prevent bladder distension and urinary stasis
- Encourage mom to urinate every time before she feed baby (as they may fall asleep)

Possible Obstacles to Voiding

- May have some initial lack of sensation due to epidural anesthesia
- Mom may become so engrossed with baby that she forgets to void
- Internal inflammation from labor trauma may impair ability to void
- Mom may hesitate to void from fear of pain, especially if she has an episiotomy or vaginal tearing
- C-section patients may also have issue with voiding following removal of the indwelling catheter.

Nursing Interventions for Postpartum Bladder Care

- Ice pads to perineum immediately after vaginal delivery to reduce swelling
- Peri-bottle- teach mom to always bring the bottle, which is used for perineal irrigation, to the restroom to use rather than toilet paper; the bottle is filled with warm (NOT hot) water from the faucet and occasionally mixed with an antiseptic or analgesic solution **if** ordered by the provider or permitted by hospital policy. The contents are sprayed on the area following each void/bowel movement to use rather than toilet paper.
- Teach mom to pat lightly with toilet paper from front to back and not to come back forward.
- Teach mom to use Tuck's Pads, which contain witch hazel, an astringent.
- Dermaplast is a topical anesthetic spray, may be applied to help control pain

- A straight cath may need to be used if mom doesn't void within an acceptable time (usually 12 hours postpartum)

WARNING SIGNS: Perineal area is dark, moist, and bloody, especially when combined urinary stasis.

B: Bowels

Bowels Assessment

- Bowels in shock- just moved into some strange positions.
- Encourage fluids (non-dairy), fresh fruits and vegetables, whole grains
- Take a stool softener- don't want ripping of the episiotomy/tear or trauma to the C-section incision

L: Lochia

Lochia Assessment

- Assess the color, odor, and amount
- The lochia color should go forward in the progression of lightness, never go backwards

Lochia Color

- Lochia Rubra: bright red, may have small clots, usually lasts 3 days
- Lochia Serosa: pink, serous, other tissues
- Lochia Alba: tissue, whitish

Lochia Odor

- NCLEX: lochia should have "no odor" or "no foul odor".
- Real world: virtually all lochia has an unpleasant or at least a neutral odor associated with it and
- moms may be quick to describe it as "foul"

- It's important for the nurse to assess the odor to eliminate subjective patient description of the scent
- A truly foul odor or a change in odor may be a sign of infection

Lochia Amount

- Scant = 2.5 centimeters saturation *
- Light = < 10 centimeters saturation
- Moderate = > 10 centimeters saturation
- Heavy = pad is completely saturated within 2 hours
- Postpartum hemorrhage is clinically defined as a pad saturated within 15-30 minutes
- NCLEX world: The pad is saturated within 15 minutes to be considered a hemorrhage situation.
- In the real world, a pad that becomes saturated within 30 minutes is a cause for additional evaluation
- Scant saturation in the immediate postpartum period can be just as concerning as excessive lochia production. Clots: up to cherry sized are okay, each or plum sized is not. Clots are the most common in the morning following the first void due to the saggy texture of the vagina, which releases the lochia build-up from the night.

E: Episiotomy and Perineum

REEDA Assessment

- R: Redness
- E: edema
- E: ecchymosis
- D: discharge
- A: approximation. Read more about REEDA

Perineal Area Assessment

- Best assessed with mom on her side
- Pull the labia from front to back
- Check the episiotomy or areas of vaginal tearing
- Look for hematoma-a collection of blood in between tissue.
- Look for hemorrhoids (developed during pregnancy or during labor from the pushing process)
- Nursing Intervention: Always help mom get up and ambulate the first two times after birth to assess for mobility and orthostatic hypotension; reduce the risk of falling; and prevent trauma to the perineum and C-section incision.

Hematoma Care

- Start with cold like ice packs to stop the bleeding. Once it stops, begin to use warm packs/warm water/sitz baths.
- Continue to monitor
- If it gets worse, it means that the active area of bleeding is non-healing and it will need to be opened and the active area of bleeding determined and cauterized.

Hemmorrhoids

- Vasculature that forms a pouch
- Color can match the skin of the rectal area and may look more like a blood blister when irritated.
- Severe hemorrhoids appear as grape clusters
- Dermaplast/Dibucaine topical anesthetic spray. If severe, sometimes a topical steroid ointment is used.
- Patient may not be aware, may only know that “business” down there is not as usual.

Nursing Interventions: Sitz bath (portable): a rotating fluid that moves the water. May fit over the commode/toilet or one can be performed with no special equipment using the bathtub with a “bathing ring.” Turn the tub on and fill tube just high enough to cover perineal area then open the drain and continue to run water in as it swirls around the perineum. It is very shallow and only bathes the perineal area.

H: Homan's Sign

Assess for Signs of DVT by the Homan's Sign

- A positive Homan's sign is indicative of DVT, although it's not the most reliable indicator.
- All of the characteristic changes to maternal clotting factors are higher than any other point as the body prepares for labor.
- Combine this with being in bed for a long labor, epidural anesthesia, if mom underwent a C-section, and it's easy to see why the postpartum woman is at such a huge risk for DVT!

Performing the Homan's Test

- Most commonly performed with the mom in a supine position while laying in bed
- The calf is flexed at a 90 ^{0} angle.
- The nurse manipulates the foot in a dorsiflexion movement
- If pain is felt in the calf, the Homan's Sign is said to be positive

Signs of DVT.

- A sudden and unexplainable pain, usually in the back of the leg or calf
- Tachycardia and shortness of breath or dyspnea (from decreased oxygenation status)
- Edema, redness, and warmth localized over the area of the DVT (from the vascular build-up around the clot)

Preventing a DVT

- Dangle at the side of the bed within 2-4 hours

- Stand up within 4-8 hours
- SCDs if c-section or high BMI or need for continued immobility
- Encourage ambulation at first and independent walking when ready

Potential Complications of a DVT

- Pulmonary embolism (PE) occurs when a clot breaks way from the leg area and travels to the lungs
- A PE is medical emergency!

E: Emotional Status

Emotional Status and Bonding Patterns

- Fluctuations in estrogen levels are blamed for the emotional roller-coaster that many moms experience after birth
- High levels of stress, increased responsibility, and sleep deprivation exacerbate this
- Bonding refers to the interactions between the mamma and baby
- Caregiving of self and baby is an indicator of emotional status

Common Postpartum Assessment Findings

- The Taking In Phase. May be considered as a self-focused, re-lived experience. Excitement, talking about the experience. This is different from the maladaptive self-centeredness.
- Taking Hold Phase. A little bit about the mother, a little about the baby. The world appears to revolved around the baby and mother as an unit
- Letting-In Phase. Mother allows other people in

Comparing Blues, Depression, and Psychosis

- Postpartum Blues. Usually occurs within 1-2 weeks. Mother may be sensitive, such as crying during a commercial, mother may view it as humorous in hindsight.
- Postpartum Depression (PPD). When the blues moves to the point where the mother can't care for herself or the baby adequately.
- Postpartum Psychosis. A severe form of depression that warrants immediate intervention. When the mother harms herself or the neonate or considers doing so. Typically is predicated by depressive episodes

Nursing Interventions

- The patient should fill out a form to assess emotional risks. The form will ask if the patient has a history of PPD or depression not associated with pregnancy
- There's always a social worker available in the event that the patient is acting strangely during the hospitalization.
- The nurse may need to help the patient fill out a document such as a Risk Assessment Form. The Edinburgh assessment form is much simpler and easier for patient to do.
- If there is a high risk, the patient's provider should be notified so that postpartum follow-up can be scheduled sooner than the 6 weeks checkup.
- Discharge teaching should always include basic signs and symptoms of postpartum blues versus depression and when the client should call their provider. Often it is best to include the spouse/partner and/or family in this teaching.

N432 Revised 10/18/20