

KEY TERMS-- Be able to define and discuss the following terms:

- **Puerperium** - the period six weeks after childbirth which the reproductive organs return to their normal condition.
- **Postpartum period** - occurs six weeks after childbirth
- **Involution** - the shrinks back to its normal non-pregnant state.
- **Lochia** - discharge that occurs from the uterus after childbirth
- **Afterpains** - the afterpains occur hours and days after birth. It is the sensation of the uterus contracting.
- **Diastasis recti** - parietal or complete separations of the rectus muscles in the stomach. This allows the uterus to grow and accommodate for baby growing.
- **Engorgement** - breast tissue overfills with milk, blood, and other fluids that causes the breast to fill very full, become hard and painful, & nipples to appear flatten and tight.
- **Lactation** - the secretion of milk by the breast. It is brought about the interaction of progesterone, estrogen, prolactin, and oxytocin.
- **Postpartum blues** - this occurs after childbirth. New moms can experience mood signs, crying spells, anxiety, and difficulty sleeping. Usually appear within the first two to three days after delivery and can last for up to two weeks. If it last longer, it can be known as postpartum depression.
- **Taking-in phase** - occurs immediately after birth. Client needs sleeps, depends on others to meet her needs, and relives the events surrounding the birth process. Also known as dependent behavior. Mothers are more passive and allow nurses to make decisions for them. Moms talk about their birth experience. Moms also spend time claiming the newborn and touching.
- **Taking-hold phase** - occurs second or third day postpartum and last up to weeks. Mom regains control of her bodily function. She has an increased autonomy and desire to take charge with support and help from others. She will be more independent with her own cares and learning to care for newborn children.
- **Letting-go phase** - Mom reestablishes her relationship with others outside of the newborn. She has adapted to parenthood. She takes responsibility and care of newborn with confidence. She establishes a lifestyle that includes her newborn.

MEDICATIONS FOR REVIEW--Be able to discuss common uses for each of the following

- **Methergine (brand name: methylergonovine maleate)** : This medication is used to stop

bleeding from the uterus after birth. It increases the rate and strength of contractions and stiffness of uterus muscles.

- **Carboprost tromethamine (brand name: Hemabate)** : This medication is used to treat severe bleeding after childbirth. It is used in emergency postpartum hemorrhage to reduce postpartum bleeding.
- **Oxytocin (brand name: Pitocin)**: This medication causes or strengthens the contractions, controls bleeding after birth, and also is used for inductions.
- **Docusate sodium (brand name: Colace)**: This medication is a stool softener. It makes passing a stool easier. This can be given to help moms who are experiencing constipation.
- **Rho(D) Immune Globulin (Brand name: Rhogam)**: Rhogam is used to prevent an immune response to Rh positive blood in people with Rh negative blood types.
- **Anticoagulants such as Lovenox & Heparin**: To prevent blood clot formation.

1. Review the actions of the nurse during the immediate postpartum period.

The nurse will check vital signs, manage pain with mild analgesics, check pad saturation for hemorrhage, keep partner/ support person informed about birth and postpartum routines and educate them on caring for the newborn.

2. Outline the normal body changes during the postpartum period

	Changes	Signs and Symptoms	Nursing implications
Thermoregulation	Postpartum chill which occurs in the first 2 hours puerperium r/t nervous system response, vasomotor changes, a shift in fluids, and/or the work of labor.	Chills Uncontrollable shakiness	Provide warm blankets & fluids. Assure clients that these chills are self-limiting, common occurrence that will only last a short while.
Uterus (Fundus) Immediately	Physical changes of the uterus include involution of the	Immediately: Palpable at midline and 2 cm below to halfway between	Nurse should assess the fundal height, uterine placement, and uterine consistency

Day 3 Day 10 etc.	uterus.	umbilicus and symphysis pubis Day 3: below the umbilical Day 10: Uterus should be within the true pelvis and should not be palpable	Q8H. (p.118 ATI)
Lochia Day 1 Day 7 Day 14	Physical changes of the uterus include involution of the uterus.	Immediately after childbirth = bright red. 3-4 days = rubra (dark red) 3-10 days: serosa (pinkish brown) 10-14 days: alba (creamy white/light brown)	Lochia amount is assessed by quantity/saturation of perineal pad. <u>Scant</u> : less than 2.5 cm. <u>Light</u> : 2.5-10 cm <u>Moderate</u> : > 10 cm <u>Heavy</u> : one pad saturated within 2 hours. <u>Excessive BL</u> : one pad saturated in 15 min or less/pooling of blood under buttocks.

3. What is included in a postpartum assessment (see the BUBBLE HE handout)? What would be different in assessment for a vaginal delivery postpartum versus a cesarean delivery?

Breast, uterus, bladder, bowels, lochia, episiotomy and perineum, homan, and emotions. For a cesarean delivery the incision would be assessed

4. What are 5 areas of assessment of the perineum postpartum?

Redness, edema, bruising, hemorrhoids, discharge (for signs of infection)

5. What is the teaching the nurse would do in relationship to the postpartum assessment?

- Nap when the infant is sleeping, because getting uninterrupted sleep at night is difficult.
 - Reduce participation in outside activities and limit the number of visitors.
 - Determine the infant's sleep–wake cycles and attempt to increase wakeful periods during the day so the baby sleeps for longer periods at night.
 - Eat a balanced diet to promote healing and to increase energy levels.
 - Share household tasks to conserve your energy.
 - Ask the father or other family members to provide infant care during the night periodically so that mothers can get an uninterrupted night of sleep, if they are not breast-feeding.
 - Review your family's daily routine and see if you can “cluster” activities to conserve energy and promote rest.

6. Define causes of postpartum uterine atony.

Macrosomia (4000-4500g baby); Multiple gestation (twins, triplets, etc); Placenta previa; Precipitous Birth; Fetal Abnormality

The causes are overdistension of the uterus or prolonged, forceful labor. A distended bladder can also displace the uterus and impede its ability to contract and reduce bleeding.

7. List 5 manifestations of abnormal lochia.

Cervical or vaginal tear, hemorrhage, infection, retained placental fragments, and endometriosis.

8. What are the risk factors for hypovolemic shock? Compare the normal cardiovascular system changes during the postpartum period with hypovolemic shock.

Tone: uterine atony, distended bladder

- Tissue: retained placenta and clots; uterine subinvolution
- Trauma: lacerations, hematoma, inversion, rupture
- Thrombin: coagulopathy (preexisting or acquired)

9. Write a paragraph that helps you understand exactly what is occurring with

Disseminated Intravascular coagulation and its treatment.

DIC is a bleeding disorder that occurs when the clotting factors in our blood are reduced due to an extreme loss of blood. With a low number of platelets and clotting factors, our bodies will bleed internally and externally, which is life-threatening. Treatment for DIC is to find the source of the bleed and treat the underlying cause. There is a very high mortality rate with DIC.

10. What are the risk factors for Postpartum hemorrhage? What are the steps for nursing management of Postpartum hemorrhage?

Risk factors: uterine atony, retained placenta, lacerations/hematomas, coagulopathy.

- Nurses are responsible for performing assessments after birth that are crucial to the mother. Nurses perform immediate fundal massage, IV fluid resuscitation, and administration of uterotonic medications. Blood transfusion must be done without hesitation if blood loss is greater than 1,500 mL.

11. What contraindications must the nurse know about Pitocin (oxytocin), Cytotec (misoprostol), methergine (methylergonovine) and hemabate (carboprost tromethamine)?

- Pitocin cannot be given to patients that are eclamptic. CI in placenta previa, fetal distress, multigravida.
- Cytotec may not be used to reduce the risk of stomach ulcers associated with NSAIDs. Methergine cannot be given to patients that have HTN.
- Hemabate is CI in patients with a history of asthma.

12. What is venous thromboembolism and how is it assessed and treated? What education does the nurse provide in relationship to the side effects of anticoagulant use?

A thrombus (blood clot) associated with inflammation- it is assessed by different tests such as a Doppler ultrasound scanning; computed tomography; MRI - physical assessments can include unilateral area of swelling/warmth/redness; hardened vein over the thrombosis; calf tenderness

Management- encourage rest; elevation of extremities above heart; administer intermittent or continuous warm moist compresses; do NOT massage affected limb; measure client's leg circumference; provide anti embolism stockings; administer analgesics

Medications - anticoagulants (heparin/warfarin)

13. Postpartum infection is defined as a temperature ____ or higher for 2 consecutive days during the first ____ days of the postpartum period.

Fever of 38 C or 100.4 F

During the first 10 days PP

14. List three interventions to promote comfort related to breast engorgement for breastfeeding women and three for non-breastfeeding women.

Breastfeeding women: Frequent emptying, warm showers and compresses before feeding, and cold compresses between feedings

Non-breastfeeding women: Ice, tight supportive bra, and breast stimulation

15. List 3 causes and 3 prevention techniques for breast infections (mastitis).

Insufficient drainage of breast, rapid weaning, oversupply of milk, pressure on the breast from a poorly fitting bra, a blocked duct, missed feeding, and breakdown of the nipple via fissures, cracks, or blisters.

Frequent breast emptying, increasing the frequency of nursing, and lactation need not be suppressed.

16. Compare and contrast postpartum (Baby) blues, postpartum depression, and postpartum psychosis.

Postpartum blues - these sign/symptoms only last a few days to a few weeks after baby.

- Mood swings
- Anxiety
- Sadness
- Irritability
- Feeling overwhelmed
- Crying
- Reduced concentration
- Appetite problems
- Trouble sleeping

Postpartum depression - these signs/symptoms last longer and may interfere with the ability for mom to take care of herself/baby/other daily task. The signs/symptoms last longer than two weeks.

- Depressed mood or severe mood swings
- Excessive crying
- Difficulty bonding with baby
- Withdrawing from family and friends
- Loss of appetite or eating much more
- Inability to sleep or sleeping too much
- Overwhelmed, fatigue, or loss of energy
- Reduced interest in activities
- Intense irritability and anger
- Fear that you're not a good mother
- Hopelessness

- Restlessness
- Diminished ability to think clearly or make decisions
- Thoughts of harming yourself or baby
- Recurrent thoughts of death or suicide

Postpartum psychosis - this develops within the first week. The signs and symptoms are severe.

- confusion/disorientation
- Obsessive thoughts about the baby
- hallucinations/delusions
- Sleep disturbances
- Excessive energy and agitation
- Paranoia
- Attempts to harm yourself or baby.

17. What are the risk factors for postpartum depression?

- History of depression (during pregnancy or other times)
- Bipolar disorder
- Postpartum depression after a previous pregnancy
- Family history of depression or mood disorders
- Stressful events during the last year such as pregnancy complications
- Infant has health problems/special needs
- Having twins/triplets/multiple births
- Difficulty breast-feeding
- Relation with spouse or significant other
- Weak support system
- Financial problems
- Pregnancy was unplanned or unwanted

18. Write up 5 things you would include in postpartum discharge teaching comparing a vaginal delivery with a 2nd degree tear versus a cesarean section delivery.

Vaginal tear education:

- Clean the area by squirting warm water over it during and after using the bathroom.
- Pat dry, do not rub the area, with gauze pads.
- Use a fresh maxi pad at least every four to six hours.
- Let yourself heal: do not touch the area to check how the tear is healing. This can delay the process.
- It's natural to be nervous about splitting the stitches during the first postpartum bowel movement. To help things go smoothly, consume whole grains, fresh fruits and veggies, and drink plenty of fluids.

Cesarean delivery teaching:

- Shower as needed, pat the incision dry with gauze pads.
- Watch the incision site for signs of infection, such as redness or drainage.
- Hold a pillow against the incision when you sneeze, laugh, or cough.
- Do not do any heavy lifting.
- Allow others to do things for you, don't hesitate to ask for help.