LEARNING OBJECTIVES

- Identify the priorities of maternal care given during the fourth stage of labor.
- Identify common selection criteria for safe early postpartum discharge.
- Summarize nursing interventions to prevent infection and excessive bleeding, to promote normal bladder and bowel patterns, and to care for the breasts of women who are breastfeeding or bottle-feeding.
- Explain the influence of cultural expectations on postpartum adjustment.
- Identify psychosocial needs of the woman in the early postpartum period.
- Discuss discharge teaching and postpartum home care.

KEY TERMS AND DEFINITIONS

couplet care  One nurse, educated in both mother and infant care, functions as the primary nurse for both mother and infant (also known as mother-baby care or single-room maternity care)

engorgement  Swelling of the breast tissue brought about by an increase in blood and lymph supplied to the breast, occurring as early milk (colostrum) transitions to mature milk, at about 72 to 96 hours after birth

fourth stage of labor  The first 1 or 2 hours after birth

Homans sign  Early sign of phlebothrombosis of the deep veins of the calf in which there are complaints of pain when the leg is in extension and the foot is dorsiflexed

thrombus  Blood clot obstructing a blood vessel that remains at the place it was formed

uterine atony  Relaxation of uterine muscle; leads to postpartum hemorrhage

warm line  A help line, or consultation service, for families to access; most often for support of newborn care and postpartum care after hospital discharge

ELECTRONIC RESOURCES

Additional information related to the content in Chapter 16 can be found on the companion website at http://evolve.elsevier.com/Lowdermilk/Maternity/ or on the interactive companion CD

- NCLEX Review Questions
- Case Study—Fourth Trimester
- Critical Thinking Exercise—Priority Nursing Care: Postpartum Unit
- Plan of Care—Postpartum Care—Vaginal Birth
The goal of nursing care in the immediate postpartum period is to assist women and their partners during their initial transition to parenting. The approach to the care of women after birth has changed from one modeled on sick care to one that is wellness oriented. Consequently, in the United States most women remain hospitalized no more than 1 or 2 days after vaginal birth, and some for as few as 6 hours. Because there is so much important information to be shared with these women in a very short time, it is vital that their care be thoughtfully planned and provided. Care is focused on the woman’s physiologic recovery, her psychologic well-being, and her ability to care for herself and her new baby and includes other family members.

FOURTH STAGE OF LABOR

The first 1 to 2 hours after birth, sometimes called the fourth stage of labor, is a crucial time for mother and newborn. Both are not only recovering from the physical process of birth but are also becoming acquainted with each other and additional family members. During this time, maternal organs undergo their initial readjustment to the nonpregnant state and the functions of body systems begin to stabilize. Meanwhile, the newborn continues the transition from intrauterine to extrauterine existence.

The fourth stage of labor is an excellent time to begin breastfeeding because the infant is in an alert state and ready to nurse. Breastfeeding at this time also aids in the contraction of the uterus and the prevention of maternal hemorrhage. In most centers the mother remains in the labor and birth area during this recovery time. In an institution in which labor, delivery, and recovery (LDR) rooms are used, the woman stays in the same room in which she gave birth. In traditional settings, women are taken from the delivery room to a separate recovery area for observation. Arrangements for care of the newborn vary during the fourth stage of labor. In many settings, the baby remains at the mother’s bedside, and the labor or birth nurse cares for both of them.

In other institutions the baby is taken to the nursery for several hours of observation after an initial bonding period with the parents (Fig. 16-1). Fig. 16-1 and Fig. 16-2 describe the physical assessment of the mother during the fourth stage of labor. Fig. 16-3 shows an easy-to-use flow sheet that combines the essential immediate postpartum and anesthesia recovery assessments.

Physical Assessment

If the recovery nurse has not previously cared for the new mother, her assessment begins with an oral report from the nurse who attended the woman during labor and birth and a review of the prenatal, labor, and birth records. Of primary importance are conditions that could predispose the mother to hemorrhage, such as precipitous labor, large baby, grand multiparity (i.e., having given birth to six or more viable infants), or induced labor. For healthy women, hemorrhage is probably the most dangerous potential complication during the fourth stage of labor.

During the first hour in the recovery room, physical assessments of the mother are frequent. All factors except temperature are assessed every 15 minutes for 1 hour. Temperature is assessed at the beginning and end of the recovery period. After the fourth 15-minute assessment, if all parameters have stabilized within the normal range, the process is usually repeated once in the second hour. Box 16-1 and Fig. 16-2 describe the physical assessment of the mother during the fourth stage of labor. Fig. 16-3 shows an easy-to-use flow sheet that combines the essential immediate postpartum and anesthesia recovery assessments.

During the fourth stage of labor, intense tremors that resemble shivering from a chill are commonly seen; they are not related to infection. Several theories have been offered to explain these tremors or shivering, such as their being the result of a sudden release of pressure on pelvic nerves after birth, a response to a fetus-to-mother transfusion that occurred during placental separation, a reaction to maternal adrenaline production during labor and birth, or a reaction to epidural anesthesia. Warm blankets and reassurance that the chills or tremors are common, are self-limiting, and last only a short time are useful interventions.

The nutritional status of the woman is assessed. Restriction of food and fluid intake and the loss of fluids (blood, perspiration, or emesis) during labor cause many women to express a strong desire to eat or drink soon after birth. In the absence of complications, a woman who has given birth vaginally, has recovered from the effects of the anesthetics; and has stable vital signs, a firm uterus, and small to moderate lochial flow may have fluids and a regular diet as desired (American Academy of Pediatrics [AAP] & American College of Obstetricians and Gynecologists [ACOG], 2002).

Postanesthesia Recovery

The woman who has given birth by cesarean or has received regional anesthesia for a vaginal birth requires special attention during the recovery period. Obstetric recovery areas are held to the same standard of care that would be expected.
of any other postanesthesia recovery (PAR) room (AAP & ACOG, 2002). A PAR score is determined for each patient on arrival and updated as part of every 15-minute assessment. Components of the PAR score include activity, respirations, blood pressure, level of consciousness, and color.

Regardless of her obstetric status, no woman should be discharged from the recovery area until she has completely recovered from the effects of anesthesia.

If the woman received general anesthesia, she should be awake and alert and oriented to time, place, and person. Her respiratory rate should be within normal limits, and her oxygen saturation levels at least 95%, as measured by a pulse oximeter. If the woman received epidural or spinal anesthesia, she should be able to raise her legs, extended at the knees, off the bed or to flex her knees, place her feet flat on the bed, and raise her buttocks well off the bed. The numb or tingling, prickly sensation should be entirely gone from her legs. Often, it takes several hours for these anesthetic effects to disappear.

**NURSE ALERT**

**Assessment during Fourth Stage of Labor**

- Before beginning the assessment, wash hands thoroughly, assemble necessary equipment, and explain the procedure to the patient.

**BLOOD PRESSURE**
- Measure blood pressure per assessment schedule.

**PULSE**
- Assess rate and regularity.

**TEMPERATURE**
- Determine temperature.

**FUNDUS**
- Put on clean examination gloves.
- Position woman with knees flexed and head flat.
- Just below umbilicus, cup hand and press firmly into abdomen. At the same time, stabilize the uterus at the symphysis with the opposite hand.
- If fundus is firm (and bladder is empty), with uterus in midline, measure its position relative to woman's umbilicus. Lay fingers flat on abdomen under umbilicus; measure how many fingerbreadths (fb) or centimeters (cm) fit between umbilicus and top of fundus. If the fundus is above the umbilicus, this is recorded as plus fib or cm; if below, as minus fb or cm.
- If fundus is not firm, massage it gently to contract and expel any clots before measuring distance from umbilicus.
- Place hands appropriately; massage gently only until firm.
- Expel clots while keeping hands placed as in Fig. 16-2. With upper hand, firmly apply pressure downward toward vagina; observe perineum for amount and size of expelled clots.

**BLADDER**
- Assess distention by noting location and firmness of uterine fundus and by observing and palpating bladder. Distended bladder is seen as a suprapubic rounded bulge that is dull to percussion and fluctuates like a water-filled balloon. When the bladder is distended, the uterus is usually boggy in consistency, well above the umbilicus, and to the woman's right side.
- Assist woman to void spontaneously. Measure amount of urine voided.
- Catheterize as necessary.
- Reassess after voiding or catheterization to make sure the bladder is not palpable and the fundus is firm and in the midline.

**LOCHIA**
- Observe lochia on perineal pads and on linen under the mother’s buttocks. Determine amount and color, note size and number of clots; note odor.
- Observe perineum for source of bleeding (e.g., episiotomy, lacerations).

**PERINEUM**
- Ask or assist woman to turn on her side and flex upper leg on hip.
- Lift upper buttock.
- Observe perineum in good lighting.
- Assess episiotomy site or laceration repair for intactness, hematoma, edema, bruising, redness, and drainage.
- Assess for presence of hemorrhoids.

**Fig. 16-2** Palpating fundus of uterus during the fourth stage of labor. Note that upper hand is cupped over fundus; lower hand dips in above symphysis pubis and supports uterus while it is massaged gently.
### Nursing Care during the Fourth Trimester

**Fig. 16-3** An example of a maternity recovery room record. (Courtesy The Regional Medical Center at Memphis [The Med], Memphis, TN.)

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Time</th>
<th>BP</th>
<th>Heart Rate</th>
<th>Respiratory Rate</th>
<th>Temperature</th>
<th>Activity</th>
<th>Pain Scale</th>
<th>Pain Characteristics</th>
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**PCA Medication, Concentration and Volume**

- **Loading Dose**: 
- **Continuous Rate**: 4 hour limit
- **Lockout Interval**: 
- **RN**: RN

**Activity**
- Able to move 4 extremities voluntarily or on command
- Able to move 2 extremities voluntarily or on command
- Able to move 0 extremities voluntarily or on command

**Pain Management Intervention**
- **Medication**: PCA
- **Concentration**: 
- **Volume**: 

**Diagnosis**

**Physician**

**Anesthesia**

**Armands**

**Allergies**

**Pain Management**
- **Observation Code**: 
- **Results Code**: 

**Observation Code**
- **Results Code**: 

**Notes**

**Activity**
- Able to move 4 extremities voluntarily or on command
- Able to move 2 extremities voluntarily or on command
- Able to move 0 extremities voluntarily or on command

**Pain Scale**
- **Pain Scale**: 
- **Pain Characteristics**: 

**Diagnosis**

**Physician**

**Anesthesia**

**Armands**

**Allergies**

**Pain Management**
- **Observation Code**: 
- **Results Code**: 

**Observation Code**
- **Results Code**: 

**Notes**

**Activity**
- Able to move 4 extremities voluntarily or on command
- Able to move 2 extremities voluntarily or on command
- Able to move 0 extremities voluntarily or on command

**Pain Scale**
- **Pain Scale**: 
- **Pain Characteristics**: 

**Diagnosis**

**Physician**

**Anesthesia**

**Armands**

**Allergies**

**Pain Management**
- **Observation Code**: 
- **Results Code**: 

**Observation Code**
- **Results Code**: 

**Notes**
## CARE PATH 24-Hour Vaginal Birth without Complications

The uncomplicated vaginal birth patient’s admission and discharge are based on a 24-hr length of stay after birth based on individual needs.

### TIME

- **CARE PATH**
- **PRIMARY PHYSIOLOGIC FOCUS**
- **IVs/LABWORK/MEDICATIONS**
- **NUTRITION/ELIMINATION**
- **PSYCHOSOCIAL RECOVERY**

### ADM. TO PP UNIT–8 HR

#### RECOVERY

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

#### NA MET VARIANCE

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### 9-16 HR

- **NA MET VARIANCE**

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### 17-24 HR/DISCHARGE

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**Date of Birth:**

**Hour of Birth:**

**Discharge:**

**Time:**

---

**PHYSICAL/PHYSIOLOGIC**

- **Vital signs every 15 min ×1 hr, then every 4 hr. Assess pain and provide intervention as needed. Assess perineum/ episiotomy. Assess lochia.**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

#### NA MET VARIANCE

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### 17-24 HR/DISCHARGE

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**LABWORK**

- **CBC, if not done before birth. Urine drug screen if ordered. UA-dipstick, if ordered. (Send to lab, if abnormal.)**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

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### 17-24 HR/DISCHARGE

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**NUTRITION/ELIMINATION**

- **Assess bladder fullness. Assist to bathroom. Asses for tolerance of oral intake.**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

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### 17-24 HR/DISCHARGE

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**PSYCHOSOCIAL**

- **Woman and family will begin attachment behaviors with newborn.**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

#### NA MET VARIANCE

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### 9-16 HR

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### 17-24 HR/DISCHARGE

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**Encourage mother and family members to hold and touch infant. Provide skin-to-skin contact of mother and infant. Provide mother the opportunity to breastfeed, if applicable.**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

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### 17-24 HR/DISCHARGE

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**Offer flexible rooming-in with infant. Allow verbalization of woman’s feelings. Assess discharge needs and need for social service consult.**

**RECOVERY**

- **ADM. TO PP UNIT–8 HR**
- **9-16 HR**
- **17-24 HR/DISCHARGE**

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### 9-16 HR

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### 17-24 HR/DISCHARGE

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**Reinforce interventions. Completion of birth certificate. Arrange for home visit.**
CARE PATH 24-Hour Vaginal Birth without Complications—cont’d

<table>
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<tr>
<th>Date of Birth: ____________________________</th>
<th>Hour of Birth: ____________________________</th>
<th>Time: ____________________________</th>
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The uncomplicated vaginal birth client’s admission and discharge are based on a 24-hr length of stay after birth based on individual needs.

### CARE PATH

#### SELF-CARE

<table>
<thead>
<tr>
<th>Time: 17-24 HR/DISCHARGE</th>
<th>Self-Care Activity</th>
<th>Teaching/Discharge Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17-24 HR/DISCHARGE</strong></td>
<td>Woman will be up to bathroom or shower independently.</td>
<td>NA MET VARIANCE Instruct woman in pericare and pad changes, and use of ice pack.</td>
</tr>
<tr>
<td><strong>9-16 HR</strong></td>
<td>Woman will be up to bathroom or shower with assistance.</td>
<td>Reinforce proper pericare. Instruct in use of sitz bath.</td>
</tr>
<tr>
<td><strong>9-16 HR</strong></td>
<td>Woman and family will demonstrate appropriate infant-care activities.</td>
<td>NA MET VARIANCE Teaching to include: Reinforcement of teaching from mother/baby-care class.</td>
</tr>
<tr>
<td><strong>9-16 HR</strong></td>
<td>Woman will begin to verbalize and/or demonstrate infant-care activities.</td>
<td>NA MET VARIANCE Teaching to include: Teach breastfeeding latch-on and positioning, if applicable.</td>
</tr>
</tbody>
</table>

**Variance Documentation:**

1. ____________
2. ____________
3. ____________
4. ____________

*IHSP denotes a test done to determine whether follow-up is needed in the Infant Hearing Screening Program (IHSP).*
Transfer from the Recovery Area

After the initial recovery period has been completed, the woman may be transferred to a postpartum room in the same or another nursing unit. In facilities with labor, delivery, recovery, and postpartum (LDRP) rooms, the nurse who provides care during the recovery period usually continues caring for the woman. Women who have received general or regional anesthesia must be cleared for transfer from the recovery area by a member of the anesthesia care team.

In preparing the transfer report the recovery nurse uses information from the records of admission, birth, and recovery. Information that must be communicated to the postpartum nurse includes identity of the health care provider; gravidity and parity; age; anesthetic used; any medications given; duration of labor and time of rupture of membranes; whether labor was induced or augmented; type of birth and repair; blood type and Rh status; group B streptococci status; status of rubella immunity; yphils and hepatitis B serology test results (if positive); intravenous infusion of any fluids; physiologic status since birth; description of fundus, lochia, bladder, and perineum; gender and weight of infant; time of birth; chosen method of feeding; any abnormalities noted; and assessment of initial parent-infant interaction.

Most of this information is also documented for the nursing staff in the newborn nursery. In addition, specific information should be provided regarding the name of the pediatric care provider, the infant's Apgar scores, weight, voiding, stooling, and whether fed since birth. Nursing interventions that have been completed (e.g., eye prophylaxis, vitamin K injection) must also be recorded.

Women who give birth in birthing centers may go home within a few hours, after the woman's and infant's conditions are stable.

**DISCHARGE—BEFORE 24 HOURS AND AFTER 48 HOURS**

Early postpartum discharge, shortened hospital stay, and 1-day maternity stay are all terms for the decreasing length of hospital stays of mothers and their babies after a low risk birth. The trend of shortened hospital stays is based largely on efforts to reduce health care costs coupled with consumer demands to have fewer medical interventions and more family-focused experiences (Meara, Kotagal, Atherton, & Lieu, 2004).

**Laws Relating to Discharge**

Health care providers have expressed concern with shortened stays because some medical problems do not show up in the first 24 hours after birth and new mothers have not had sufficient time to learn how to care for their newborns and identify newborn health problems such as jaundice and dehydration related to breastfeeding difficulties (Meara et al., 2004).

The concern for the potential increase in adverse maternal-infant outcomes from hospital early discharge practices led the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and other professional health care organizations to promote the enactment of federal and state maternity length-of-stay bills to ensure adequate care for both the mother and the newborn. The passage of the Newborns' and Mothers' Health Protection Act of 1996 provided minimum federal standards for health plan coverage for mothers and their newborns (AAP, 2004). Under the Newborns' and Mothers' Health Protection Act, all health plans are required to allow the new mother and newborn to remain in the hospital for a minimum of 48 hours after a normal vaginal birth and for 96 hours after a cesarean birth unless the attending provider, in consultation with the mother, decides on early discharge.

**Criteria for Discharge**

Early discharge with postpartum home care can be a safe and satisfying option for women and their families when it is comprehensive and based on individual needs (AAP, 2004). Hospital stays must be long enough to identify problems and to ensure that the woman is sufficiently recovered and is prepared to care for herself and the baby at home.

It is essential that nurses consider the medical needs of the woman and her baby and provide care that is coordinated to meet those needs in order to provide timely physiologic interventions and treatment to prevent morbidity and hospital readmission. With predetermined criteria for identifying low risk in the mothers and newborns (Box 16-2), the length of hospitalization can be based on medical need for care in an acute care setting or in consideration of the ongoing care needed in the home environment (AAP, 2004). Early follow-up visits are key to reducing readmissions of newborns (Meara et al., 2004).

Care paths provide the nurse with an organized approach toward meeting essential maternal-newborn care and teaching goals within a limited time frame (see Care Path on p. 471). Care paths can be developed for vaginal or cesarean births. Other methods such as postpartum order sets and maternal-newborn teaching checklists (Fig. 16-4) can be used to accomplish patient care and educational outcomes.

Hospital-based maternity nurses continue to play invaluable roles as caregivers, teachers, and patient and family advocates in developing and implementing effective home care strategies. The nurse participates in the determination of whether the mother and newborn meet the criteria for early discharge.

**LEGAL TIP** Early Discharge

Whether or not the woman and her family have chosen early discharge, the nurse and the primary health care provider are held responsible if the woman is discharged before her condition has stabilized within normal limits. If complications occur, the medical and nursing staff could be sued for abandonment.
CHAPTER 16
Nursing Care during the Fourth Trimester

Assessment and Nursing Diagnoses

A complete physical assessment, including measurement of vital signs, is performed on admission to the postpartum unit. If the woman’s vital signs are within normal limits, they are usually assessed every 4 to 8 hours for the remainder of her hospitalization. Other components of the initial assessment include the mother’s emotional status, energy level, degree of physical discomfort, hunger, and thirst. Intake and output assessments should always be included if an intravenous infusion or a urinary catheter is in place.

If the woman gave birth by cesarean, her incisional dressing should also be assessed. To some degree, her knowledge level concerning self-care and infant care can also be determined at this time.

Ongoing physical assessment

The new mother should be evaluated thoroughly during each shift throughout hospitalization (Guidelines/Guías box). Physical assessments include evaluation of the breasts, uterine fundus, lochia, perineum, bladder and bowel function, vital signs, and legs. If a woman has an intravenous line in place, her fluid and hematologic status should be evaluated before it is removed. Signs of potential problems that may be identified during the assessment process are listed in the Signs of Potential Complications box.

Routine laboratory tests

Several laboratory tests may be performed in the immediate postpartum period. Hemoglobin and hematocrit values are often evaluated on the first postpartum day to assess blood loss during childbirth, especially after cesarean birth. In some hospitals a clean-catch or catheterized urine specimen may be obtained and sent for routine urinalysis or culture and sensitivity, especially if an indwelling urinary catheter was inserted during the intrapartum period. In addition, if the woman’s rubella and Rh status are unknown, tests to determine her status and need for possible treatment should be performed at this time.

Nursing diagnoses

Although all women experience similar physiologic changes during the postpartum period, certain factors act to make each woman’s experience unique. From a physiologic standpoint the length and difficulty of the labor, type of birth (i.e., vaginal or cesarean), presence of episiotomy or laceration repair; parity, and whether the mother plans to breastfeed or bottle-feed are factors to be considered with each woman. After analyzing the data obtained during the assessment process, the nurse establishes nursing diagnoses that will provide a guide for planning care. Examples of nursing diagnoses

<table>
<thead>
<tr>
<th>MOTHER</th>
<th>INFANT</th>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Uncomplicated pregnancy, labor, vaginal birth, and postpartum course</td>
<td>• Term infant (38 to 42 weeks) with weight appropriate for gestational age</td>
<td>• No social, family, or environmental risk factors identified</td>
</tr>
<tr>
<td>• No evidence of premature rupture of membranes</td>
<td>• Normal findings on physical assessment</td>
<td>• Family or support person available to assist mother and infant at home</td>
</tr>
<tr>
<td>• Blood pressure, temperature stable and within normal limits</td>
<td>• Temperature, respirations, and heart rate within normal limits and stable for the 12 hours preceding discharge</td>
<td>• Follow-up scheduled within 1 week if discharged before 48 hours after the birth</td>
</tr>
<tr>
<td>• Ambulating unassisted</td>
<td>• At least two successful feedings completed (normal sucking and swallowing)</td>
<td>• Documentation of skill of mother in feeding (breastfeeding or bottle-feeding), cord care, skin care, perineal care, infant safety (use of car seat, sleeping positions), and recognizing signs of illness and common infant problems</td>
</tr>
<tr>
<td>• Voiding adequate amounts without difficulty</td>
<td>• Urination and stooling have occurred at least once</td>
<td></td>
</tr>
<tr>
<td>• Hemoglobin &gt;10 g</td>
<td>• No significant vaginal bleeding: perineum intact or no more than second-degree episiotomy or laceration repair; uterus is firm</td>
<td>• No excessive bleeding at the circumcision site for at least 2 hours</td>
</tr>
<tr>
<td>• No significant vaginal bleeding: perineum intact or no more than second-degree episiotomy or laceration repair; uterus is firm</td>
<td>• Received instructions on postpartum self-care</td>
<td>• Screening tests performed according to state regulations; tests to be repeated at follow-up visit if done before the infant is 24 hours old</td>
</tr>
<tr>
<td>• Hemoglobin</td>
<td>• Urination and stooling have occurred at least once</td>
<td>• Initial hepatitis B vaccine given or scheduled for first follow-up visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Laboratory data reviewed: maternal syphilis and hepatitis B status; infant or cord blood type and Coombs test results if indicated</td>
</tr>
<tr>
<td>• Received instructions on postpartum self-care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Unit Five
## Postpartum Period

### Abbott Northwestern Hospital

**A HealthSpan Organization**

**Self/Family Learning Checklist**

---

**Patient Name, Medical Record #, Date of Birth:**

---

**I learn best by:**

- [ ] Group classes
- [ ] Individual instruction
- [ ] Video instruction
- [ ] Reading it myself

**Please indicate your desired learning needs by placing a check in one of the columns next to each topic.**

**KEY:**

1 = Most important to learn before I go home
2 = I already know

---

### Caring for Yourself

<table>
<thead>
<tr>
<th>Topic</th>
<th>1</th>
<th>2</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episiotomy and perineal care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhoids/Constipation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nutrition</td>
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<td></td>
<td></td>
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<tr>
<td>Activity</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Postpartal exercises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return of menstruation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood clots</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartal emotions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartal warning signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical canal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Caring for Baby

**BREAST FEEDING**

- Some nipples
- Pumping
- Frequency of feedings
- Improving nursing skills
- Nursing while working
- Feeding water
- Weaning

---

### After Discharge

- When to call health care provider
- Englargement
- Family planning
- Blood clots
- Postpartal emotions
- General infant safety/poison control
- Incisional care
- When to call health care provider

---

### Other

- Working mothers
- Day care
- Caring adjustments
- Single parent support
- Frequency of feedings
- Infant safety and security
- Infant as a Person Class
- New Parent Connection

---

### Medications at Home

<table>
<thead>
<tr>
<th>Medications</th>
<th>Strength</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Purpose/Special Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Resources**

- [ ] Physician Discharge Instructions
- [ ] Home Care Agency
- [ ] Other Referrals

**Valuables:**

- [ ] Returned
- [ ] None

**Medications:**

- [ ] Returned
- [ ] None
- [ ] Room checked for belongings

---

**Signatures**

**Support Person:**

**Date:**

---

**Fig. 16-4** Self-family learning checklist. (Copyright Abbott Northwestern Hospital of Allina Health System, Minneapolis and St. Paul, MN.)
commonly established for the postpartum patient include the following:

- **Risk for deficient fluid volume (hemorrhage) related to**
  - uterine atony after childbirth

- **Risk for constipation related to**
  - postchildbirth discomfort
  - childbirth trauma to tissues
  - decreased intake of solid food and/or fluids

- **Acute pain related to**
  - uterine involution
  - trauma to perineum, episiotomy
  - hemorrhoids
  - engorged breasts

- **Disturbed sleep patterns related to**
  - discomforts of postpartum period
  - long labor process
  - infant care and hospital routine

- **Ineffective breastfeeding related to**
  - maternal discomfort
  - infant positioning

**Expected Outcomes of Care**

The nursing plan of care includes both the postpartum woman and her infant, even if the nursery nurse retains primary responsibility for the infant. In many hospitals, **couplet care** (also called mother-baby care or single-room maternity care) is practiced. Nurses in these settings have been educated in both mother and infant care and function as primary nurses for both mother and infant, even if the infant is kept in the nursery. This approach is a variation of *rooming-in*, in which the mother and infant room together and mother and nurse share the care of the infant. The organization of the mother’s care must take the newborn into consideration. The day actually revolves around the baby’s feeding and care times.

**GUIDELINES/GUÍAS**

**Postpartum Physical Assessment**

- ¿Estás planeando darle pecho o biberón al bebé?
- ¿Puede acostarse?
- Sí, está acostado, por favor.
- Si, estoy dispuesto a tomar su temperatura.
- Le voy a tomar sus signos vitales.
- Necesito que me permitan tomar su presión arterial.
- ¿Necesita usar el baño?
- ¿Desea tomar un baño de asiento?
- ¿Desea tomar algún medicamento para el dolor?
- ¿Desea tomar una medicina para calmarse?
- ¿Desea tomar un baño de asiento?

**TEMPERATURE**

- Más de 38° C después de las primeras 24 horas

**PULSE**

- Tachycardia o bradicardia marcada

**BLOOD PRESSURE**

- Hypotension o hipertensión

**ENERGY LEVEL**

- Tired, fatigado, extremadamente fatigado

**UTERUS**

- Desviado de la línea media, consistencia floja, permanece por encima del ombligo después de las primeras 24 horas

**LOCHIA**

- Sangrado intenso, mal olor, sangrado rojo no lochia

**PERINEUM**

- Edema pronunciado, no intacto, signos de infección, gran dolor

**LEGS**

- Positivo signo de Homans; área dolorosa, color rojo; calentura en la parte posterior de la pierna

**BREASTS**

- Rojo, dolor, calor, hinchazón de los pechos, pezones invertidos, masa palpable

**APPETITE**

- No apetito, náusea o vómito

**ELIMINATION**

- Orina: incapacidad para orinar, urgencia, frecuencia, disuria; heces: constipación, diarrea, dolor epigástrico

**REST**

- Incapacidad para descansar o dormir

**NEUROLOGIC**

- Cabeza, visión borrosa

**POTENTIAL COMPLICATIONS**

**Physiologic Problems**

| **TEMPERATURE** | Más de 38° C después de las primeras 24 horas |
| **PULSE** | Tachycardia o bradicardia marcada |
| **BLOOD PRESSURE** | Hypotension o hipertensión |
| **ENERGY LEVEL** | Tired, fatigado, extremadamente fatigado |
| **UTERUS** | Desviado de la línea media, consistencia floja, permanece por encima del ombligo después de las primeras 24 horas |
| **LOCHIA** | Sangrado intenso, mal olor, sangrado rojo no lochia |
| **PERINEUM** | Edema pronunciado, no intacto, signos de infección, gran dolor |
| **LEGS** | Positivo signo de Homans; área dolorosa, color rojo; calentura en la parte posterior de la pierna |
| **BREASTS** | Rojo, dolor, calor, hinchazón de los pechos, pezones invertidos, masa palpable |
| **APPETITE** | No apetito, náusea o vómito |
| **ELIMINATION** | Orina: incapacidad para orinar, urgencia, frecuencia, disuria; heces: constipación, diarrea, dolor epigástrico |
| **REST** | Incapacidad para descansar o dormir |
| **NEUROLOGIC** | Cabeza, visión borrosa |
Plan of Care and Interventions

Nurses assume many roles while implementing the nursing care plan. They provide direct physical care, teach mother-baby care, and provide anticipatory guidance and counseling. Perhaps most important of all, they nurture the woman by providing encouragement and support as she begins to assume the many tasks of motherhood. Nurses who take the time to “mother the mother” do much to increase feelings of self-confidence in new mothers.

The first step in providing individualized care is to confirm the woman’s identity by checking her wristband. At the same time the infant’s identification number is matched with the corresponding band on the mother’s wrist and, in some instances, the father’s wrist. The nurse determines how the mother wishes to be addressed and then notes her preference for the way of supplies and services. If the woman’s usual daily routine before admission differs from the facility’s routine, the nurse works with the woman to develop a mutually acceptable routine.

Infant abduction from hospitals in the United States has increased over the past few years. As a result, many units now have special limited entry systems in place. The mother should be taught to check the identity of any person who comes to remove the baby from her room. Hospital personnel usually wear picture identification badges. On some units, all staff members wear matching scrubs or special badges. Other units use closed-circuit television, computer monitoring systems, or fingerprint identification pads. As a rule, the baby is never carried in a staff member’s arms between the mother’s room and the nursery but is always wheeled in a bassinet, which also contains baby care supplies.

Patients and nurses must work together to ensure the safety of newborns in the hospital environment.

Prevention of infection

One important means of preventing infection is maintenance of a clean environment. Bed linens should be changed as needed. Disposable pads and draw sheets may need to be changed frequently. By not walking barefoot, women avoid contaminating the linens when they return to bed. Personnel must be conscientious about their hand-washing techniques to prevent cross-infection. Standard Precautions must be practiced. Staff members with colds, coughs, or skin infections (e.g., a cold sore on the lips [herpes simplex virus type 1]) must follow hospital protocol when in contact with postpartum patients. In many hospitals, staff members with open herpetic lesions, strep throat, conjunctivitis, upper respiratory infections, or diathrea are encouraged to avoid contact with mothers and infants by staying home until the condition is no longer contagious.

Proper care of the episiotomy site and any perineal lacerations prevents infection in the genitalia area and aids the healing process. Educating the woman to wipe from front to back (urethra to anus) after voiding or defecating is a simple first step. In many hospitals a squeeze bottle filled with warm water or an antiseptic solution is used after each voiding to cleanse the perineal area. Heat lamps and sitz baths, once commonly used to promote healing, are now much less frequently used for this purpose (Box 16-3). The woman should change her perineal pad from front to back each time she voids or defecates and wash her hands thoroughly before and after doing so.

Prevention of excessive bleeding

The most common cause of excessive bleeding after birth is uterine atony, failure of the uterine muscle to contract firmly. The two most important interventions for preventing excessive bleeding are maintaining good uterine tone and preventing bladder distention. If uterine atony occurs, the relaxed uterus distends with blood and clots, blood vessels in the placental site are not clamped off, and excessive bleeding results.

Excessive blood loss after childbirth may also be caused by vaginal or vulvar hematomas, unrepaired lacerations of the vagina or cervix, and retained placental fragments.

NURSE ALERT

A perineal pad saturated in 15 minutes or less and pooling of blood under the buttocks are indications of excessive blood loss, requiring immediate assessment, intervention, and notification of the physician or nurse-midwife.

Accurate visual estimation of blood loss is an important nursing responsibility. Blood loss is usually described subjectively as scant, light, moderate, or heavy (profuse). Fig. 16-5 shows examples of perineal pad saturation corresponding to each of these descriptions.

Although postpartal blood loss may be estimated by observing the amount of staining on a perineal pad, it is...
Underline text
difficult to judge the amount of lochial flow based only on observation of perineal pads. More objective estimates of blood loss include measuring serial hemoglobin or hematocrit values; weighing blood clots and items saturated with blood (1 ml equals 1 g); and establishing how many milliliters it takes to saturate perineal pads being used (Simpson & Creehan, 2001).

Any estimation of lochial flow is inaccurate and incomplete without consideration of the time factor. The woman who saturates a perineal pad in 1 hour or less is bleeding much more heavily than the woman who saturates one perineal pad in 8 hours.

Luegenbiehl (1997) found that nurses in general tend to overestimate, rather than underestimate, blood loss. Different brands of perineal pads vary in their saturation volume.
and soaking appearance. For example, blood placed on some brands tends to soak down into the pad, whereas on other brands it tends to spread outward. Nurses should determine saturation volume and soaking appearance for the brands used in their institution so that they may improve accuracy of blood loss estimation.

**NURSE ALERT** The nurse always checks under the mother’s buttocks as well as on the perineal pad. Blood may flow between the buttocks onto the linens under the mother, although the amount on the perineal pad is slight; thus excessive bleeding may go undetected.

Blood pressure is not a reliable indicator of impending shock from early hemorrhage. More sensitive means of identifying shock are provided by respirations, pulse, skin condition, urination output, and level of consciousness (Benedetti, 2002). The frequent physical assessments performed during the fourth stage of labor are designed to provide prompt identification of excessive bleeding (Emergency box).

---

**EMERGENCY**

**Hypovolemic Shock**

**SIGNS AND SYMPTOMS**

- Persistent significant bleeding—perineal pad soaked within 15 minutes; may not be accompanied by a change in vital signs or maternal color or behavior.
- Woman states she feels weak, light-headed, “funny,” or “sick to my stomach” or that she “sees stars.”
- Woman begins to act anxious or exhibits air hunger.
- Woman states she feels weak, light-headed, “funny,” or that she “sees stars.”
- Woman’s skin turns ashen or grayish.
- Skin feels cool and clammy.
- Pulse rate increases.
- Blood pressure declines.

**INTERVENTIONS**

- Notify primary health care provider.
- If uterus is atonic, massage gently and expel clots to cause uterus to contract; compress uterus manually, as needed, using two hands. Add oxytocic agent to intravenous drip, as ordered.
- Give oxygen by face mask or nasal prongs at 8 to 10 L/min.
- Tilt the woman onto her side or elevate the right hip; elevate her legs to at least a 30-degree angle.
- Provide additional or maintain existing intravenous infusions of lactated Ringer’s solution or normal saline solution to restore circulatory volume.
- Administer blood or blood products, as ordered.
- Monitor vital signs.
- Insert an indwelling urinary catheter to monitor perfusion of kidneys.
- Administer emergency drugs, as ordered.
- Prepare for possible surgery or other emergency treatments or procedures.
- Chart incident, medical and nursing interventions instituted, and results of treatments.

---

**Maintenance of uterine tone**

A major intervention to restore good tone is stimulation by gently massaging the uterine fundus until firm (see Fig. 16-2). Fundal massage may cause a temporary increase in the amount of vaginal bleeding seen as pooled blood leaves the uterus. Clots may also be expelled. The uterus may remain boggy even after massage and expulsion of clots.

Fundal massage can be a very uncomfortable procedure. Understanding the causes and dangers of uterine atony and the purpose of fundal massage can help the woman to be more cooperative. Teaching the patient to massage her own fundus enables her to maintain some control and decreases her anxiety.

Additional interventions likely to be used are administration of intravenous fluids and oxytocic medications (drugs that stimulate contraction of the uterine smooth muscle). (See Table 25-1 for information about common oxytocic medications.)

**Prevention of bladder distention.** A full bladder causes the uterus to be displaced above the umbilicus and well to one side of midline in the abdomen. It also prevents the uterus from contracting normally. Nursing interventions focus on helping the woman to empty her bladder spontaneously as soon as possible. The first priority is to assist the woman to the bathroom or onto a bedpan if she is unable to ambulate. Having the woman listen to running water, placing her hands in warm water, or pouring water from a squeeze bottle over her perineum may stimulate voiding. Other techniques include assisting the woman into the shower or sitz bath and encouraging her to void, or placing oil of peppermint in a bedpan under the woman (the vapors may relax the urinary meatus and trigger spontaneous voiding). Administering analgesics, if ordered, may be indicated because some women may fear voiding because of anticipated pain. If these measures are unsuccessful, a sterile catheter may be inserted to drain the urine.

**Promotion of comfort, rest, ambulation, and exercise**

**Comfort.** Most women experience some degree of discomfort during the postpartum period. Common causes of discomfort include afterbirth pains (afterpains), episiotomy or perineal lacerations, hemorrhoids, and breast engorgement. The woman’s description of the type and severity of her pain is the best guide in choosing an appropriate intervention. To confirm the location and extent of discomfort, the nurse inspects and palpates areas of pain as appropriate for redness, swelling, discharge, and heat and observes for body tension, guarded movements, and facial tension. Blood pressure, pulse, and respirations may be elevated in response to acute pain. Diaphoresis may accompany severe pain. A lack of objective signs does not necessarily mean there is no pain, because there may also be a cultural component to the expression of pain. Nursing interventions are intended to eliminate the pain sensation entirely or reduce it to a tolerable level that allows the woman to care for herself and her...
baby. Nurses may use both nonpharmacologic and phar- 
macologic interventions to promote comfort. Pain relief is 
enhanced by using more than one method or route.

**Nonpharmacologic interventions.** Warmth, 
distraction, imagery, therapeutic touch, relaxation, and in-
terraction with the infant may decrease the discomfort as-
associated with afterbirth pain. Simple interventions that can 
decrease the discomfort associated with an episiotomy or per-
neal lacerations include encouraging the woman to lie on 
she on her side whenever possible and to use a pillow when sitting. 
Other interventions include application of an ice pack; top-
ical application (if ordered); dry heat; cleansing with a 
squeeze bottle; and a cleansing shower, tub bath, or sitz bath. 
Many of these interventions are also effective for hemor-
rhoids, especially ice packs, sitz baths, and topical applica-
tions (such as witch hazel pads). Box 16-3 gives more spe-
cific information about these interventions.

The discomfort associated with engorged breasts may be less-
ened by applying ice, heat, or cabbage leaves to the breasts and 
weeping a well-fitted support bra. Decisions about specific in-
terventions for engorgement are based on whether the woman 
choses breastfeeding or bottle-feeding (see Chapter 20).

**Pharmacologic interventions.** Most health care 
viders routinely order a variety of analgesics to be ad-
ministered as needed, including both narcotic and nonnar-
cotic (nonsteroidal antiinflammatory) medications, with their 
dosage and time frequency ranges. Topical application of an-
tisepic or anesthetic ointment or spray is a common phar-
macologic intervention for minor pain. Patient-controlled 
algiesia pumps and epidural analgesia are technologies 
commonly used to provide pain relief after cesarean birth.

**NURSE ALERT** The nurse should carefully monitor all 
women receiving opioids because respiratory depres-
sion and decreased intestinal motility are side effects.

Many women want to participate in decisions about anal-
gesia. Severe pain, however, may interfere with active par-
ticipation in choosing pain relief measures. If an analgesic is 
to be given, the nurse must make a clinical judgment of 
the type, dosage, and frequency from the medications or-
dered. The woman is informed of the prescribed analgesic 
and its common side effects; this teaching is documented.

Breastfeeding mothers often have concerns about the ef-
ects of an analgesic on the infant. Although nearly all drugs 
present in maternal circulation are also found in breast milk, 
many analgesics commonly used during the postpartum pe-
riod are considered relatively safe for breastfeeding mothers.

Often, the timing of medications can be adjusted to mini-
mize infant exposure. A mother may be given pain med-
ication immediately after breastfeeding so that the interval 
between medication administration and the next nursing pe-
riod is as long as possible. The decision to administer med-
ications of any type to a breastfeeding mother must always 
be made by carefully weighing the woman’s need against ac-
tual or potential risks to the infant.

If acceptable pain relief has not been obtained in 1 hour 
and there has been no change in the initial assessment, the 
nurse may need to contact the primary care provider for ad-
ditional pain relief orders or further directions. Unrelieved 
pain results in fatigue, anxiety, and a worsening perception 
of the pain. It might also indicate the presence of a previ-
ously unidentified or untreated problem.

**Rest.** The excitement and exhilaration experienced af-
ter the birth of the infant may make rest difficult. The new 
mother, who is often anxious about her ability to care for 
her infant or is uncomfortable, may also have difficulty sleep-
ing. The demands of the infant, the hospital environment 
and routines, and the presence of frequent visitors contribute to 
alterations in her sleep pattern.

**Fatigue.** Fatigue is common in the postpartum period 
(Troy, 2003) and involves both physiologic components, as-
associated with long labors, cesarean birth, anemia, and breast-
feeding, and psychologic components, related to depression 
and anxiety. Infant behavior may also contribute to fatigue, 
particularly for mothers of more difficult infants.

Interventions must be planned to meet the woman’s in-
dividual needs for sleep and rest. Back rubs, other comfort 
measures, and medication for sleep for the first few nights 
may be necessary. The side-lying position for breastfeeding 
minimizes fatigue in nursing mothers (Troy, 2003). Support 
and encouragement of mothering behaviors help reduce anx-
iosity. Hospital and nursing routines may be adjusted to meet 
individual needs. In addition, the nurse can help the fam-
ily limit visitors and provide a comfortable chair or bed for 
the partner.

**Ambulation.** Early ambulation is successful in re-
ducing the incidence of thromboembolism and in promot-
ing the woman’s more rapid recovery of strength. Free move-
ment is encouraged once anesthesia has been administered. After the initial recovery pe-
riod is over, the mother is encouraged to ambulate frequently.

**NURSE ALERT** Having a hospital staff or family member 
present the first time the woman gets out of bed after 
birth is wise because she may feel weak, dizzy, faint, or 
light-headed.

The rapid decrease in intrabdominal pressure after birth 
results in a dilution of blood vessels supplying the intestines 
(splanchnic engorgement) and causes blood to pool in the 
viscera. This condition contributes to the development of 
orthostatic hypotension when the woman who has recently 
given birth sits or stands up, first ambulates, or takes a warm 
shower or sitz bath. The nurse also needs to consider the 
baseline blood pressure; amount of blood loss; and type, 
amount, and timing of analgesic or anesthetic medications 
administered when assisting a woman to ambulate.

Prevention of clot formation is important. Women who 
must remain in bed after giving birth are at increased risk for 
the development of a thrombus. They may have antiembo-
lic stockings (TED hose) and/or a Sequential Compression
BACKGROUND

- Well-documented benefits of breastfeeding include significantly reduced mortality in preterm infants; reduced morbidity from gastrointestinal, respiratory, urinary tract, and middle ear infections; and less atopic illness. In developing countries the protective effect against infant and child mortality lasts into the second year of life. Breastfed infants demonstrate significantly higher cognitive abilities and have significantly lower blood pressure through the midteen years.

- Women also experience associated health benefits with breastfeeding. A World Health Organization (WHO) review recommends exclusive breastfeeding for 6 months, with introduction of complementary feedings thereafter. Yet breastfeeding initiation remains discouragingly low in some areas. In developed countries, the typical breastfeeding mother is advantaged, and mothers who are teenagers with low income and less education are the least likely to initiate or continue breastfeeding. Developing countries, on the other hand, are more likely to see breastfeeding in the lower socioeconomic classes than in the educated, advantaged class. Hospitals may be discouraging breastfeeding by dispensing commercial discharge packs with free formula samples, a practice that the UNICEF-WHO Baby Friendly Initiative hopes to make illegal in as many countries as possible, as a standard of good practice. Many interventions, including the "Ten Steps to Successful Breastfeeding" developed by UNICEF-WHO, have been developed to encourage women to initiate and sustain breastfeeding.

OBJECTIVES

- The reviewers hoped to describe the forms of support for breastfeeding women, the timing, and the settings. They wished to evaluate the effectiveness of the interventions, especially with low-income populations, to determine whether the postnatal intervention is strengthened by an antenatal component, to distinguish the different care providers and training, and to explore whether the background breastfeeding rates of a country influence the success of a breastfeeding intervention. The control group received standard care.

METHODS

Search Strategy

- Search strategy includes searching Cochrane, MEDLINE, EMBASE, Zetoc, Midwives Information and Resource Service, and asking experts. Search keywords were not noted.

- The authors found 20 eligible randomized or quasi-randomized, controlled trials involving 23,712 women from Brazil, the United States, Nigeria, Canada, Iran, Bangladesh, the United Kingdom, Belarus, Mexico, and Sweden, dated 1979 to 2000.

Statistical Analyses

- Similar data were pooled in a meta-analysis. Reviewers calculated relative risks for dichotomous (categorical) data, and weighted mean differences for continuous data. The authors accepted differences outside the 95% confidence interval as significant.

FINDINGS

- Overall, there were significant beneficial effects on any breastfeeding outcomes in groups that received extra breastfeeding support, and breastfeeding duration was significantly longer. Treatment effect was greater in areas with a greater background breastfeeding rate in the population. The supported groups were significantly more likely to breastfeed exclusively than the women in control groups. Professional support staff were more effective at preventing the cessation of breastfeeding, up to 9 months. Lay support staff were effective at reducing the cessation of breastfeeding in women who were exclusively breastfeeding, compared with controls. Face-to-face contact was more effective in improving breastfeeding outcomes. The UNICEF-WHO training courses had the most beneficial effect on exclusive and prolonged breastfeeding. Exclusive breastfeeding was especially beneficial to infants with diarrhea. Breastfeeding women expressed greater satisfaction than controls.

- In a related review of commercial discharge packs, nine trials of 3720 women found a decrease in exclusive breastfeeding duration when the women were given formula samples by the hospital.

LIMITATIONS

- The outcomes are measured in myriad ways, such as breastfeeding duration from 2 weeks to 1 year, in a variety of increments. The interventions are not described and therefore not reproducible in many studies. Follow-up was varied. The strengths of the study were the power of the numbers and the consistency of the findings.

CONCLUSIONS

- Increased support for breastfeeding does increase the initiation, duration of exclusive breastfeeding, and duration of any breastfeeding for infants. The UNICEF-WHO training courses are effective for personnel. Face-to-face contact is most effective. There is no evidence that antenatal breastfeeding support improves outcomes. Exclusive breastfeeding is very effective in managing infant diarrhea. Finally, a background culture of breastfeeding seems to act synergistically with support to encourage breastfeeding.

IMPLICATIONS FOR PRACTICE

- Nurses can ensure that all mothers receive support for breastfeeding. They can advocate for a hospital discharge pack with breastfeeding-related items, such as breast pads and pump, and breastfeeding information. They can strive to have their hospital meet the criteria for Baby Friendly status.

IMPLICATIONS FOR FURTHER RESEARCH

- Further research is needed to assess the effectiveness of support personnel and training in a variety of settings, especially in areas of low incidence of breastfeeding. Cost-effectiveness is an important outcome. Implementation of the Baby Friendly Initiative needs ongoing monitoring. Qualitative research is needed to identify elements of effective support strategies.

Device (SCD boots) ordered prophylactically. If a woman remains in bed longer than 8 hours (e.g., for postpartum magnesium sulfate therapy for preeclampsia), exercise to promote circulation in the legs is indicated, using the following routine:

- Alternate flexion and extension of feet.
- Rotate ankile in circular motion.
- Alternate flexion and extension of legs.
- Press back of knee to bed surface; relax.

If the woman is susceptible to thromboembolism, she is encouraged to walk about actively for true ambulation and is discouraged from sitting immobile in a chair. Women with varicosities are advised to wear support hose. If a thrombus is suspected, as evidenced by complaint of pain in calf muscles or warmth, redness, or tenderness in the suspected leg (positive Homans sign), the primary health care provider should be notified immediately, meanwhile the woman should be confined to bed, with the affected limb elevated on pillows.

**Exercise.** Most women who have just given birth are extremely interested in regaining their nonpregnant figures. Postpartum exercise can begin soon after birth, although the woman should be encouraged to start with simple exercises and gradually progress to more strenuous ones. Fig. 16-6 illustrates a number of exercises appropriate for the new mother. Abdominal exercises are postponed until approximately 4 weeks after cesarean birth.

Kegel exercises to strengthen pelvic muscle tone are extremely important, particularly after vaginal birth. Kegel exercises help women regain the muscle tone that is often lost as pelvic tissues are stretched and torn during pregnancy and birth. Women who maintain muscle strength may benefit years later by maintaining urinary continence.

It is essential that women learn to perform Kegel exercises correctly (see Patient Teaching in Chapter 4, p. 93). Approximately one fourth of all women who learn Kegel exercises do them incorrectly and may increase their risk of incontinence (Sampselle et al., 2000). This may occur when women inadvertently bear down on the pelvic floor muscles, thrusting the perineum outward. The woman’s technique can be assessed during the pelvic examination at her checkout by inserting two fingers intravaginally and checking whether the pelvic floor muscles correctly contract and relax.

**Promotion of nutrition**

During the hospital stay, most women display a good appetite and eat well; nutritious snacks are usually welcomed. Women may request that family members bring to the hospital favorite or culturally appropriate foods (Fig. 16-7 on p. 484). Cultural dietary preferences must be respected. This interest in food presents an ideal opportunity for nutritional counseling on dietary needs after pregnancy, such as for breastfeeding, preventing constipation and anemia, promoting weight loss, and promoting healing and well-being (see Chapter 10). Prenatal vitamins and iron supplements are often continued until 6 weeks postpartum or until the ordered supply has been used.

**Promotion of normal bladder and bowel patterns**

**Bladder function.** After giving birth the mother should void spontaneously within 6 to 8 hours. The first several voidings should be measured to document adequate emptying of the bladder. A volume of at least 150 ml is expected for each voiding. Some women experience difficulty in emptying the bladder, possibly as a result of diminished bladder tone, edema from trauma, or fear of discomfort. Nursing interventions for inability to void and bladder distention are discussed on p. 479.

**Bowel function.** Interventions to promote normal bowel elimination include educating the woman about measures to avoid constipation, such as ensuring adequate roughage and fluid intake and promoting exercise. Alerting the woman to side effects of medications such as narcotic analgesics (e.g., decreased gastrointestinal tract motility) may encourage her to implement measures to reduce the risk of constipation. Stool softeners or laxatives may be necessary during the early postpartum period. With early discharge a new mother may be home before having a bowel movement. Some mothers experience gas pains. Antigas medications may be ordered. Ambulation orrocking in a rocking chair may stimulate passage of flatus and relief of discomfort.

**Breastfeeding promotion and lactation suppression**

**Breastfeeding promotion.** The first 1 to 2 hours after childbirth is an excellent time to encourage the mother to breastfeed. The infant is typically in an alert state and will suckle if put to the breast. Breastfeeding aids in the contraction of the uterus and prevention of maternal hemorrhage. This is an opportune time to instruct the mother in breastfeeding and to assess the physical appearance of the breasts and nipples. (See Chapter 28 for further information on assisting the breastfeeding woman.)

**Lactation suppression.** Suppression of lactation is necessary when the woman has decided not to breastfeed or in the case of neonatal death. Wear a well-fitted support bra or breast binder continuously for at least the first 72 hours after giving birth is important. Women should avoid breast stimulation, including running warm water over the breasts, newborn suckling, or pumping of the breasts. A few nonbreastfeeding mothers experience severe breast engorgement (swelling of breast tissue caused by increased blood and lymph supply to the breasts as the body produces milk, occurring at about 72 to 96 hours after birth). If breast engorgement occurs, it can usually be managed satisfactorily with nonpharmacologic interventions. Ice packs to the breasts are helpful in decreasing the discomfort associated with engorgement. The woman should use a 15-minutes-on–45-minutes-off schedule (to prevent the rebound swelling that can occur if ice is used continuously), or she can place fresh cabbage leaves inside her bra. Cabbage leaves have been used to treat swelling in other cultures for years (Ayers, 2000; Mass, 2004). The exact mechanism of ac-
Abdominal Breathing. Lie on back with knees bent. Inhale deeply through nose. Keep ribs stationary and allow abdomen to expand upward. Exhale slowly but forcefully while contracting the abdominal muscles; hold for 3 to 5 seconds while exhaling. Relax.

Reach for the Knees. Lie on back with knees bent. While inhaling, deeply lower chin onto chest. While exhaling, raise head and shoulders slowly and smoothly and reach for knees with arms outstretched. The body should only rise as far as the back will naturally bend while waist remains on floor or bed (about 6 to 8 inches). Slowly and smoothly lower head and shoulders back to starting position. Relax.

Double Knee Roll. Lie on back with knees bent. Keeping shoulders flat and feet stationary, slowly and smoothly roll knees over to the left to touch floor or bed. Maintaining a smooth motion, roll knees back over to the right until they touch floor or bed. Return to starting position and relax.

Leg Roll. Lie on back with legs straight. Keeping shoulders flat and legs straight, slowly and smoothly lift left leg and roll it over to touch the right side of floor or bed and return to starting position. Repeat, rolling right leg over to touch left side of floor or bed. Relax.

Arm Raises. Lie on back with arms extended at 90-degree angle from body. Raise arms so they are perpendicular and hands touch lower slowly.

Combined Abdominal Breathing and Supine Pelvic Tilt (Pelvic Rocks). Lie on back with knees bent. While inhaling deeply, roll pelvis back by flattening lower back on floor or bed. Exhale slowly but forcefully while contracting abdominal muscles and tightening buttocks. Hold for 3 to 5 seconds while exhaling. Relax.

Buttocks Lift. Lie on back with arms at sides, knees bent, and feet flat. Slowly raise buttocks and arch back. Return slowly to starting position.

Single Knee Roll. Lie on back with right leg straight and left leg bent at the knee. Keeping shoulders flat, slowly and smoothly roll left knee over to the right to touch floor or bed and then back to starting position. Reverse position of legs. Roll right knee over to the left to touch floor or bed and return to starting position. Relax.

Buttocks Lift. Lie on back with arms at sides, knees bent, and feet flat. Slowly raise buttocks and arch back. Return slowly to starting position.

Fig. 16-6 Postpartum exercise should begin as soon as possible. The woman should start with simple exercises and gradually progress to more strenuous ones.
tion is not known, but it is thought that naturally occurring plant estrogens or salicylates may be responsible for the effects. The leaves are replaced each time they wilt. A mild analgesic may also be necessary to help the mother through this uncomfortable time. Medications that were once prescribed for lactation suppression (e.g., estrogen, estrogen and testosterone, bromocriptine) are no longer used.

Health promotion for future pregnancies and children

Rubella vaccination. For women who have not had rubella (10% to 20% of all women) or women who are serologically not immune (titer of 1:8 or enzyme immunoassay level less than 0.8), a subcutaneous injection of rubella vaccine is recommended in the postpartum period to prevent the possibility of contracting rubella in future pregnancies. Seroconversion occurs in approximately 90% of women vaccinated after birth. The live attenuated rubella virus is not communicable in breast milk; therefore breastfeeding mothers can be vaccinated. However, because the virus is shed in the urine and other body fluids, the vaccine should not be given if the mother or other household members are immunocompromised. Rubella vaccine is made from duck eggs, so women who have allergies to these eggs may develop a hypersensitivity reaction to the vaccine, for which they will need adrenaline. A transient arthralgia or rash is common in vaccinated women but is benign. Because the vaccine may be teratogenic, women who receive the vaccine must be informed about this fact.

Rubella Vaccination

Informed consent for rubella vaccination in the postpartum period includes information about possible side effects and the risk of teratogenic effects. Women must understand that they must practice contraception to avoid pregnancy for 1 month after being vaccinated (ACOG, 2002).

Prevention of Rh isoimmunization. Injection of Rh immune globulin (a solution of gamma globulin that contains Rh antibodies) within 72 hours after birth prevents sensitization in the Rh-negative woman who has had a fetomaternal transfusion of Rh-positive fetal red blood cells (RBCs) (Medication Guide). Rh immune globulin promotes lysis of fetal Rh-positive blood cells before the mother forms her own antibodies against them.

Medication Guide

Rh Immune Globulin, RhoGAM, Gamulin Rh, HypRho-D, Rhophylac

ACTION

Suppression of immune response in nonsensitized women with Rh-negative blood who receive Rh-positive blood cells because of fetomaternal hemorrhage, transfusion, or accident

INDICATIONS

Routine antepartum prevention at 20 to 30 weeks gestation in women with Rh-negative blood; suppress antibody formation after birth, miscarriage or pregnancy termination, abdominal trauma, ectopic pregnancy, amniocentesis, version, or chorionic villus sampling

DOSEAGE AND ROUTE

Standard dose 1 vial (300 mcg) intramuscularly (IM) in deltoid or gluteal muscle; microdose 1 vial (50 mcg) IM in deltoid muscle; Rhophylac can be given IM or IV (available in prefilled syringes)

ADVERSE EFFECTS

Myalgia, lethargy, localized tenderness and stiffness at injection site, mild and transient fever, malaise, headache, rarely nausea, vomiting, hypotension, tachycardia, possible allergic response

NURSING CONSIDERATIONS

• Give standard dose to mother at 28 weeks of gestation as prophylaxis, or after an incident or exposure risk that occurs after 28 weeks of gestation (e.g., amniocentesis, second trimester miscarriage or abortion, after external version attempt) and within 72 hours after birth if baby is Rh positive.
• Give microdose for first trimester miscarriage or abortion, ectopic pregnancy, chorionic villus sampling.
• Verify that the woman is Rh negative and has not been sensitized, that Coombs’ test is negative, and that baby is Rh positive. Provide explanation to the woman about procedure, including the purpose, possible side effects, and effect on future pregnancies. Have the woman sign a consent form if required by agency. Verify correct dosage and confirm lot number and woman’s identity before giving injection (verify with another RN or use other procedure per agency policy; document administration per agency policy; observe patient for at least 20 minutes after administration for allergic response.
• The medication is made from human plasma (a consideration if woman is a Jehovah’s Witness). The risk of transmitting infectious agents, including viruses, cannot be completely eliminated.
After birth, Rh immune globulin is administered to all Rh-negative, antibody (Coombs')-negative women who give birth to Rh-positive infants. Rh immune globulin is administered to the mother intramuscularly or intravenously. It should never be given to an infant.

The administration of 300 microgram (1 vial) of Rh immune globulin is usually sufficient to prevent maternal sensitization. If a large fetomaternal transfusion is suspected, however, the dosage needed should be determined by performing a Kleihauer-Betke test, which detects the amount of fetal blood in the maternal circulation. If more than 15 ml of fetal blood is present in maternal circulation, the dosage of Rh immune globulin must be increased.

A 1:1000 dilution of Rh immune globulin is cross-matched to the mother’s RBCs to ensure compatibility. Because Rh immune globulin is usually considered a blood product, precautions similar to those used for transfusing blood are necessary when it is given. The identification number on the patient’s hospital wristband should correspond to the identification number found on the laboratory slip. The nurse must also check to see that the lot number on the laboratory slip corresponds to the lot number on the vial. Finally, the expiration date on the vial should be checked to ensure a usable product.

Rh immune globulin suppresses the immune response. Therefore the woman who receives both Rh immune globulin and rubella vaccine must be tested at 3 months to see if she has developed rubella immunity. If not, the woman will need another dose of rubella vaccine.

There is some disagreement about whether Rh immune globulin should be considered a blood product. Health care providers need to discuss the most current information about this issue with women whose religious beliefs conflict with having blood products administered to them.

Assessment and Nursing Diagnoses

Impact of the birth experience

Many women indicate a need to examine the birth process itself and look at their own intrapartal behavior in retrospect. Their partners may express similar desires. If their birth experience was different from their birth plan (e.g., induction, epidural anesthesia, cesarean birth), both partners may need to mourn the loss of their expectations before they can adjust to the reality of their actual birth experience. Inviting them to review the events and describe how they feel helps the nurse assess how well they understand what happened and how well they have been able to put their childbirth experience into perspective.

Maternal self-image

An important assessment concerns the woman’s self-concept, body image, and sexuality. How this new mother feels about herself and her body during the puerperium may affect her behavior and adaptation to parenting. The woman’s self-concept and body image may also affect her sexuality. Overweight women may experience symptoms of depression and anxiety up to 14 months postpartum (Carter, Baker, & Brownell, 2000).

Feelings related to sexual adjustment after childbirth are often a cause of concern for new parents. Women who have recently given birth may be reluctant to resume sexual intercourse for fear of pain or may worry that coitus could damage healing perineal tissue. Because many new parents are anxious for information but reluctant to bring up the subject, postpartum nurses should matter-of-factly include the topic of postpartum sexuality during their routine physical assessment. While examining the episiotomy site, for example, the nurse can say, “I know you’re sore right now, but it probably won’t be long until you (or you and your partner) are ready to make love again. Have you thought about what that might be like? Would you like to ask me questions?” This approach assures the woman and her partner that resuming sexual activity is a
Evidence—Is there sufficient evidence to draw conclusions about counseling women with regard to return to nonpregnant appearance? Does the evidence objectively support your conclusion?

Assumptions—What assumptions can be made about the following issues?
- Appropriate diet for the postpartum mother who wants to improve her appearance
- The relationship between breastfeeding and postpartum weight loss
- Exercises for the postpartum woman who wants to improve her appearance
- The relationship between perceived body image and self-esteem in postpartum women

What implications and priorities for nursing care can be drawn at this time?

Does the evidence objectively support your conclusion?

Are there alternative perspectives to your conclusion?

Return to Nonpregnant Appearance

Deidra is 10 days postpartum. Before pregnancy, her weight was appropriate for her height. However, during pregnancy, she gained 46 pounds. She gave birth vaginally to an 8-pound, 6-ounce boy and is breastfeeding the baby. Deidra is concerned about regaining her figure after childbirth and voices concerns that she will never regain the figure she once had.

1. Evidence—Is there sufficient evidence to draw conclusions about counseling women with regard to return to nonpregnant appearance?
2. Assumptions—What assumptions can be made about the following issues?
   a. Appropriate diet for the postpartum mother who wants to improve her appearance
   b. The relationship between breastfeeding and postpartum weight loss
   c. Exercises for the postpartum woman who wants to improve her appearance
   d. The relationship between perceived body image and self-esteem in postpartum women

3. What implications and priorities for nursing care can be drawn at this time?
4. Does the evidence objectively support your conclusion?
5. Are there alternative perspectives to your conclusion?

Adaptation to parenthood and parent-infant interactions

The psychosocial assessment also includes evaluating adaptation to parenthood, as evidenced by mother’s and father’s reactions to and interactions with the new baby. Clues indicating successful adaptation begin to appear early in the postpartum period as parents react positively to the newborn infant and continue the process of establishing a relationship with their infant.

Parents are adapting well to their new roles when they exhibit a realistic perception and acceptance of their newborn’s needs and his or her limited abilities, immature social responses, and helplessness. Examples of positive parent-infant interactions include taking pleasure in the infant and in the tasks done for and with her or him, understanding the infant’s emotional states and providing comfort, and reading the infant’s cues for new experiences and sensing the infant’s fatigue level (see Chapter 17).

Should these indicators be missing, the nurse needs to investigate further what is hindering the normal adaptation process. There are several questions that the nurse can ask, such as “Do you feel sad often?” or “Are there concerns that you have about being a good parent?” that will help to determine if the woman is experiencing the normal “baby blues” or if there is another more serious underlying process taking place (i.e., postpartum depression) (Jesse & Graham, 2005). See Chapter 25 for further discussion of postpartum depression.

Family structure and functioning

A woman’s adjustment to her role as mother is affected greatly by her relationships with her partner, her mother and other relatives, and any other children. Nurses can help ease the new mother’s return home by identifying possible conflicts among family members and helping the woman plan strategies for dealing with these problems before discharge. Such a conflict could arise when couples have very different ideas about parenting. Dealing with the stresses of sibling rivalry and unsolicited grandparent advice can also affect the woman’s psychological well-being. Only by asking about other nuclear and extended family members can the nurse discover potential problems in such relationships and help plan workable solutions for them.

Impact of cultural diversity

The final component of a complete psychosocial assessment is the woman’s cultural beliefs and values. Much of a woman’s behavior during the postpartum period is strongly influenced by her cultural background. Nurses are likely to come into contact with women from many different countries and cultures. All cultures have developed safe and satisfying methods of caring for new mothers and babies. Only by understanding and respecting the values and beliefs of each woman can the nurse design a plan of care to meet her individual needs.

Sometimes the psychosocial assessment indicates serious actual or potential problems that must be addressed. The Signs of Potential Complications box lists several psychosocial needs that, at a minimum, warrant ongoing evaluation.
Interrupted family processes related to

Excessively preoccupied with self (body image)

Refuses to interact with or care for baby. For example, impaired parenting related to

Refers to self as ugly and useless

Has difficulty sleeping

Sees baby as messy or unattractive

Impaired verbal communication related to

Experiences loss of appetite

Baby reminds mother of family member or friend she does not like

Has difficulty sleeping

Experiences loss of appetite

Expects the following:

Every hospital discharge. Patients exhibiting these needs should be referred to appropriate community resources for assessment and management.

After analyzing the data obtained during the assessment process, the nurse establishes nursing diagnoses to provide a guide for planning care. Nursing diagnoses related to psychosocial issues that are frequently established for the postpartum patient include the following:

- Interrupted family processes related to
  - Unexpected birth of twins
  - Impaired verbal communication related to
    - Patient’s hearing impairment
    - Nurse’s language not the same as patient’s
  - Impaired parenting related to
    - Long, difficult labor
    - Unmet expectations of labor and birth
  - Anxiety related to
    - Newman of parenting role, sibling rivalry, or response of grandparent
  - Risk for situational low self-esteem related to
    - Body image changes

Expected Outcomes of Care

Expected psychosocial outcomes during the postpartum period are based on the nursing diagnoses identified for the individual woman and her family. Examples of common expected outcomes include that the woman (family) will do the following:

- Identify measures that promote a healthy personal adjustment in the postpartum period
- Maintain healthy family functioning based on cultural norms and personal expectations

Plan of Care and Interventions

The nurse functions in the roles of teacher, encourager, and supporter rather than doer while implementing the psychosocial plan of care for a postpartum woman. Implementation of the psychosocial care plan involves carrying out specific activities to achieve the expected outcome of care planned for each individual woman. Topics that should be included in the psychosocial plan of care include promotion of parenting skills and family member adjustment to the newborn infant (see Chapter 17).

Cultural issues must also be considered when planning care. There are many traditional health beliefs and practices among the different cultures within the U.S. population. Traditional health practices that are used to maintain health or to avoid illnesses deal with the whole person (i.e., body, mind, and spirit) and tend to be culturally based.

Women from various cultures may view health as a balance between opposing forces (e.g., cold versus hot), being in harmony with nature, or just “feeling good.” Traditional practices may include the observance of certain dietary restrictions, clothing, or taboos for balancing the body; participation in certain activities such as sports and art for maintaining mental health; and use of silence, prayer, or meditation for developing spiritually. Practices (e.g., using religious objects or eating garlic) are used to protect oneself from illness and may involve avoiding people who are believed to create hexes or spells or who have an “evil eye.” Restoration of health may involve taking folk medicines (e.g., herbs, animal substances) or using a traditional healer. Meditation for developing spiritually. Practices may include the observance of certain dietary restrictions, clothing, or taboos for balancing the body; participation in certain activities such as sports and art for maintaining mental health; and use of silence, prayer, or meditation for developing spiritually.

There are several common traditional health practices used and beliefs held by women and their families during the postpartum period. In Asia, for example, pregnancy is considered to be a “hot” state, and childbirth results in a sudden loss of this state (Kim-Godwin, 2003). Therefore balance must be restored by facilitating the return of the hot state, which is present physically or symbolically in hot food, hot water, and warm air.

Childbirth occurs within this sociocultural context. Rest, seclusion, dietary restraints, and ceremonies honoring the mother and baby are all common traditional practices that are followed for the promotion of the health and well-being of the mother and baby.

Women who have immigrated to the United States or other Western nations without their extended families may not have much help at home, making it difficult for them to observe these activity restrictions (Davis, 2001). The Cultural Considerations box lists some common cultural beliefs about the postpartum period and family planning.

It is important that nurses consider all cultural aspects when planning care and not use their own cultural beliefs as the framework for that care. Although the beliefs and
Cultural Considerations

Postpartum Period and Family Planning

**POSTPARTUM CARE**
- Chinese, Mexican, Korean, and Southeast Asian women may wish to eat only warm foods and drink hot drinks to replace blood loss and to restore the balance of hot and cold in their bodies. These women may also wish to stay warm and avoid bathing, exercises, and hair washing for 7 to 30 days after childbirth. Self-care may not be a priority; care by family members is preferred. The woman has respect for elders and authority. These women may wear abdominal binders. They may prefer not to give their babies colostrum.
- **Arabic women** eat special meals designed to restore their energy. They are expected to stay at home for 40 days after childbirth to avoid illness resulting from exposure to the outside air.
- **Haitian women** may request to take the placenta home to bury or burn.
- **Muslim women** follow strict religious laws on modesty and diet. A Muslim woman must keep her hair, body, arms to the wrist, and legs to the ankles covered at all times. She cannot be alone in the presence of a man other than her husband or a male relative. Observant Muslims will not eat pork or pork products and are obligated to eat meat slaughtered according to Islamic laws (halal meat). If halal meat is not available, kosher meat, seafood, or a vegetarian diet is usually accepted.

**FAMILY PLANNING**
- Birth control is government mandated in mainland China. Most Chinese women will have an intrauterine device (IUD) inserted after the birth of their first child. Women do not want hormonal methods of contraception because they fear putting these medications in their bodies.
- **Hispanic women** will likely choose the rhythm method because most are Catholic.
- **East Indian women** are encouraged to have voluntary sterilization by vasectomy.
- **Muslim couples** may practice contraception by mutual consent as long as its use is not harmful to the woman. Acceptable contraceptive methods include foam and condoms, the diaphragm, and natural family planning.
- **Hmong women** highly value and desire large families, which limits birth control practices.
- **Arabic women** value large families, and sons are especially prized.

Behaviors of other cultures may seem different or strange, they should be encouraged as long as the mother wants to conform to them and she and the baby suffer no ill effects. The nurse needs to determine whether a woman is using any folk medicine during the postpartum period because active ingredients in folk medicine may have adverse physiologic effects on the woman when ingested with prescribed medicines. The nurse should not assume that a mother desires to use traditional health practices that represent a particular cultural group merely because she is a member of that culture. Many young women who are first- or second-generation Americans follow their cultural traditions only when older family members are present or not at all.

**Evaluation**
The nurse can be reasonably assured that care was effective if expected outcomes of care for psychosocial needs have been met.

**DISCHARGE TEACHING**

**Self-Care, Signs of Complications**
Discharge planning begins at the time of admission to the unit and should be reflected in the plan of care developed for each individual woman. For example, a great deal of time during the hospital stay is usually spent in teaching about maternal and newborn care, because all women must be capable of providing basic care for themselves and their infants at the time of discharge. It is also crucial that every woman be taught to recognize the physical signs and symptoms that might indicate problems and how to obtain advice and assistance quickly if these signs appear. Before discharge, women need basic instruction regarding the resumption of sexual intercourse, prescribed medications, routine maternal care, checkups, and contraception (Guidelines/Guiás box).

Just before the time of discharge the nurse reviews the woman’s chart to see that laboratory reports, medications, signatures, and other items are in order. Some hospitals have a checklist to use before the woman’s discharge. The nurse verifies that medications, if ordered, have arrived on the unit; that any valuables kept secured during the woman’s stay have been returned to her and that she has signed a receipt for them; and that the infant is ready to be discharged.

No medication that would make the mother sleepy should be administered if she is the one who will be holding the baby on the way out of the hospital. In most instances the woman is seated in a wheelchair and is given the baby to hold. Some families leave unescorted and ambulatory, depending on hospital protocol. The woman’s possessions are gathered and taken out with her and her family. The woman’s and the baby’s identification bands are carefully checked. Babies must be secured in a car seat for the drive home (see Fig. 19-25).

**Sexual Activity and Contraception**
Many couples resume sexual activity before the traditional postpartum checkup 6 weeks after childbirth. The risk of hemorrhage or infection is minimal by approximately 2 weeks postpartum. Couples may be anxious about the topic but uncomfortable and unwilling to bring it up. It is important that the nurse discuss the physical and psychologic effects that
Giving birth can have on sexual activity (Patient Instructions for Self-Care box). Contraceptive options should also be discussed with women (and their partners, if present) before discharge so that they can make informed decisions about fertility management before resuming sexual activity. Waiting to discuss contraception at the 6-week checkup may be too late. It is possible, particularly in women who bottle-feed, for ovulation to occur as soon as 1 month after birth. A woman who engages in unprotected sex risks becoming pregnant. Current contraceptive options are discussed in detail in Chapter 6. Women who are undecided about contraception at the time of discharge need information about using condoms with foam or creams until the first postpartum checkup.

Prescribed Medications
Women routinely continue to take their prenatal vitamins and iron during the postpartum period. It is especially important that women who are breastfeeding or who are discharged with a lower than normal hematocrit take these medications as prescribed. Women with extensive episiotomies or vaginal lacerations (third or fourth degree) are usually prescribed stool softeners to take at home. Pain relief medications (analgesics or nonsteroidal antiinflammatory medications) may be prescribed, especially for women who had cesarean birth. The nurse should make certain that the woman knows the route, dosage, frequency, and common side effects of all ordered medications.

Routine Mother and Baby Checkups
Women who have experienced uncomplicated vaginal births are still commonly scheduled for the traditional 6-week postpartum examination. Women who have had a cesarean birth are often seen in the physician’s or nurse-midwife’s office or clinic 2 weeks after hospital discharge. The date and time for the follow-up appointment should be included in the

GUIDELINES/GUÍAS
Discharge Teaching

- When you go to the bathroom, always wipe from front to back.
- Siempre seca después de orinar de adelante hacia atrás.
- Sit in a warm tub to relieve discomfort.
- Siéntese en una bañera con agua tibia para aliviarse.
- You will have moderate amounts of vaginal discharge.
- Usted tendrá cantidades moderadas de sangrado vaginal.
- It may last from 4 to 6 weeks.
- Puede durar desde 4 a 6 semanas.
- The color may vary from dark brown to red to pink.
- El color puede variar entre café oscuro a rojo a rosa.
- It may contain blood clots.
- Puede contener coágulos.
- Use a sanitary pad instead of a tampon.
- Use una toalla sanitaria en vez de un tampón.
- Your menstrual period will not resume for 4 to 10 weeks.
- Su regla no regrasará hasta 4 a 10 semanas más tarde.
- You need to drink 8 glasses of fluids a day to support breastfeeding.
- Usted necesita tomar 8 vasos de líquidos diariamente para soportar el dar de pecho.
- Call your doctor (obstetrician) if you have:
  - Llame al médico de obstétricas si tiene cualquier de lo siguiente:
    - Fever >38° C
    - Fiebre >38° C
    - Increased vaginal bleeding (more than a regular period)
    - Aumento de desangre vaginal (más que una regla normal)
    - Chills
    - Escalofríos
    - Painful, burning urination
    - Orin que le duele o le quema
    - Foul-smelling vaginal discharge
    - Desangre vaginal de muy mal olor
    - Increased pain or swelling
    - Aumento de dolor o hinchazón
    - Drainage or separation of incision (cesarean)
    - Desangre o deshecho de la herida
- Gradually increase activity to incorporate everyday routines.
- Aumente las actividades gradualmente hasta llegar a su rutina normal.
- Do your Kegel exercises.
- Haga los ejercicios Kegel.
- Do not lift heavy objects (>10 pounds).
- No levante objetos pesados (de más de 10 libras).
- Eat daily.
- Cómase diariamente:
  - 4 servings of bread/cereals, fruits/vegetables (green), milk or foods made from milk, and 2 servings of meat.
  - 4 porciones de pan/cereal, frutas/vegetales (verduritas), leche o comidas del grupo de leche, y 2 porciones de carne. Usted necesita tomar 8 vasos de líquidos diariamente para soportar el dar de pecho.
  - 8 glasses of fluids a day.
  - 8 vasos de líquidos diariamente.
- Rest as often as possible.
- Descanse mucho.
- Rest when your baby sleeps.
- Descanse cuando duerma su bebé.
- Gradually increase activity to incorporate everyday routines.
- Aumente las actividades gradualmente hasta llegar a su rutina normal.
- Do your Kegel exercises.
- Haga los ejercicios Kegel.
- Do not lift heavy objects (>10 pounds).
- No levante objetos pesados (de más de 10 libras).
- You will have moderate amounts of vaginal discharge.
- Usted tendrá cantidades moderadas de sangrado vaginal.
- It may last from 4 to 6 weeks.
- Puede durar desde 4 a 6 semanas.
- The color may vary from dark brown to red to pink.
- El color puede variar entre café oscuro a rojo a rosa.
- It may contain blood clots.
- Puede contener coágulos.
- Use a sanitary pad instead of a tampon.
- Use una toalla sanitaria en vez de un tampón.
- Your menstrual period will not resume for 4 to 10 weeks.
- Su regla no regrasará hasta 4 a 10 semanas más tarde.
- You need to drink 8 glasses of fluids a day to support breastfeeding.
- Usted necesita tomar 8 vasos de líquidos diariamente para soportar el dar de pecho.
- Call your doctor (obstetrician) if you have:
  - Llame al médico de obstétricas si tiene cualquier de lo siguiente:
    - Fever >38° C
    - Fiebre >38° C
    - Increased vaginal bleeding (more than a regular period)
    - Aumento de desangre vaginal (más que una regla normal)
    - Chills
    - Escalofríos
    - Painful, burning urination
    - Orin que le duele o le quema
    - Foul-smelling vaginal discharge
    - Desangre vaginal de muy mal olor
    - Increased pain or swelling
    - Aumento de dolor o hinchazón
    - Drainage or separation of incision (cesarean)
    - Desangre o deshecho de la herida
- Gradually increase activity to incorporate everyday routines.
- Aumente las actividades gradualmente hasta llegar a su rutina normal.
- Do your Kegel exercises.
- Haga los ejercicios Kegel.
- Do not lift heavy objects (>10 pounds).
- No levante objetos pesados (de más de 10 libras).
You can safely resume sexual intercourse by the second to fourth week after birth when bleeding has stopped and the episiotomy has healed. For the first 6 weeks to 6 months, the vagina does not lubricate well. Your physiologic reactions to sexual stimulation for the first 3 months after birth will likely be slower and less intense. The strength of the orgasm may be reduced.

A water-soluble gel, cocoa butter, or a contraceptive cream or jelly might be recommended for lubrication. If some vaginal tenderness is present, your partner can be instructed to insert one or more clean, lubricated fingers into the vagina and rotate them within the vagina to help relax it and to identify possible areas of discomfort. A position in which you have control of the depth of the insertion of the penis also is useful. The side-by-side or female-on-top position may be more comfortable.

The presence of the baby influences postbirth lovemaking. Parents hear every sound made by the baby; conversely you may be concerned that the baby hears every sound you make. In either case, any phase of the sexual response cycle may be interrupted by hearing the baby cry or move, leaving both of you frustrated and unsatisfied. In addition, the amount of psychologic energy expended by you in child care activities may lead to fatigue. Newborns require a great deal of attention and time.

Some women have reported feeling sexual stimulation and orgasms when breastfeeding their babies. Breastfeeding mothers often are interested in returning to sexual activity before nonbreastfeeding mothers.

You should be instructed to correctly perform the Kegel exercises to strengthen your pubococcygeal muscle. This muscle is associated with bowel and bladder function and with vaginal feeling during intercourse.

discharge instructions. If an appointment has not been made before the woman leaves the hospital, she should be encouraged to call the physician’s or nurse-midwife’s office or clinic and schedule an appointment.

Parents who have not already done so need to make plans for newborn follow-up at the time of discharge. Most offices and clinics like to see newborns for an initial examination within the first week or by 2 weeks of age. If an appointment for a specific date and time was not made for the infant before leaving the hospital, the parents should be encouraged to call the office or clinic right away.

Follow-up after Discharge

Home visits to new mothers and babies within a few days of discharge can help bridge the gap between hospital care and routine visits to health care providers. Nurses are able to assess the mother, infant, and home environment; answer questions and provide education; and make referrals to community resources if necessary. Home visits have been shown to reduce the need for more expensive health care, such as Emergency Department visits and rehospitalization. They can also help to improve the overall quality of care provided to infants and their parents (Paul, Phillips, Widome, & Hollembeck, 2004). Immediate follow-up contact and home visits ideally are available 7 days a week.

Home nursing care may not be available even if needed because there are no agencies providing the service or there is no coverage for payment by third-party payers. If care is available, a referral form containing information about both mother and baby should be completed at hospital discharge and sent immediately to the home care agency. Fig. 16-9 is an example of such a referral form.

The home visit is most commonly scheduled on the woman’s second day home from the hospital, but it may be scheduled on any of the first 4 days at home, depending on the individual family’s situation and needs. Additional visits are planned throughout the first week, as needed. The home visits may be extended beyond that time if the family’s needs warrant it and if a home visit is the most appropriate option for carrying out the follow-up care required to meet the specific needs identified.

During the home visit the nurse conducts a systematic assessment of mother and newborn to determine physiologic adjustment, identify any existing complications, and to answer any questions the mother has for herself and the mother or family has about the newborn or newborn care. Conducting the assessment in a separate room provides private time for the mother to ask questions on topics such as breast care, family planning, and constipation. The assessment focuses on the mother’s emotional adjustment and her knowledge of self-care and infant care.

During the newborn assessment, the nurse can demonstrate and explain normal newborn behavior and capabilities and encourage the mother and family to ask questions or express concerns they may have. The home care nurse must verify if the newborn screen for phenylketonuria and other inborn errors of metabolism has been done. If the baby was discharged from the hospital before 24 hours of age, the newborn screen may be done by the home care nurse or the family will need to take the infant to the clinic or physician’s office.

**Telephone follow-up**

As part of the routine follow-up of a woman and her infant after discharge from the hospital, many providers are implementing one or more postpartum telephone follow-up calls to their patients for assessment, health teaching, and identification of complications to effect timely intervention and referrals. Telephone follow-up may be among the services offered by the hospital, private physician or clinic, or a private agency; it may be either a separate service or combined with other strategies for extending postpartum care. Telephonic nursing assessments are frequently used after a postpartum home care visit to reassess a woman’s knowledge about such

PATIENT INSTRUCTIONS FOR SELF-CARE

**Resumption of Sexual Intercourse**

- You can safely resume sexual intercourse by the second to fourth week after birth when bleeding has stopped and the episiotomy has healed. For the first 6 weeks to 6 months, the vagina does not lubricate well.
- Your physiologic reactions to sexual stimulation for the first 3 months after birth will likely be slower and less intense. The strength of the orgasm may be reduced.
- A water-soluble gel, cocoa butter, or a contraceptive cream or jelly might be recommended for lubrication. If some vaginal tenderness is present, your partner can be instructed to insert one or more clean, lubricated fingers into the vagina and rotate them within the vagina to help relax it and to identify possible areas of discomfort. A position in which you have control of the depth of the insertion of the penis also is useful. The side-by-side or female-on-top position may be more comfortable.
- The presence of the baby influences postbirth lovemaking. Parents hear every sound made by the baby; conversely, you may be concerned that the baby hears every sound you make. In either case, any phase of the sexual response cycle may be interrupted by hearing the baby cry or move, leaving both of you frustrated and unsatisfied. In addition, the amount of psychologic energy expended by you in child care activities may lead to fatigue. Newborns require a great deal of attention and time.
- Some women have reported feeling sexual stimulation and orgasms when breastfeeding their babies. Breastfeeding mothers often are interested in returning to sexual activity before non-breastfeeding mothers.
- You should be instructed to correctly perform the Kegel exercises to strengthen your pubococcygeal muscle. This muscle is associated with bowel and bladder function and with vaginal feeling during intercourse.
OB Homecare

Mother's Name: ____________________________
Address/phone where mother will be staying: ____________________________
City: ____________________________
Phone #: ____________________________
Language spoken: □ English □ Other ____________________________
Understands English: □ Well □ Poor ____________________________
□ Mother Needs Interpreter □ Hearing Impaired ____________________________
Who interpreted in hospital: ____________________________
Mom agrees to this referral: □ Yes □ No ____________________________
Currently being seen by PHN: □ Yes □ No ____________________________
Mom's M.D./Midwife: ____________________________
Phone #: ____________________________
Next Appt: ____________________________

MOTHER:

Gravida: _______ T _______ P _______ A _______ L _______
Marital Status: S M W D Sep ____________________________
Normal Maternal Exam: □ Yes □ No [explain below] ____________________________
Eps/Incision: ____________________________
Hgb pp: ____________________________
Allergies: ____________________________

OTHER ISSUES:

Diabetic: ____________________________
Other: ____________________________
□ Parent/Child Interaction □ Adolescent Mother ____________________________
□ Mental Health Status □ Drug Use/Dependency ____________________________
□ Previous Losses □ Hx of Family Abuse ____________________________
□ Developmentally Delayed Parents □ Limited Support System ____________________________
□ Other: ____________________________

ADDITIONAL COMMENTS or ABNORMAL FINDINGS FOR MOTHER OR BABY:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Husband/Significant Other: ____________________________
Baby's Name: ____________________________ □ M □ F ____________________________
DOB/Time: ____________________________
Mother's Discharge Date/Time: ____________________________
Newborn Discharge Date: (if different than mother's): ____________________________
Baby's M.D. (Full Name): ____________________________
Phone #: ____________________________
Next Appt: ____________________________

BABY:

Gestation: ____________ Weeks □ Fetal Loss ____________________________
Birth Weight: ____________ Discharge Weight: ____________
Apgars: 1" ________ 5" ________ ____________________________
Feeding Issues: ____________________________
□ Newborn screen was done in hospital—after baby 24 hours of age ____________________________
□ Newborn screen to be done at clinic ____________________________
□ Newborn screen to be done at home ____________________________
□ Lab slip sent home with family ____________________________

Fig. 16-9 Referral form (Courtesy OB Homecare of Allina Hospitals and Clinics, Minneapolis, MN.)
things as signs of adequate intake by the breastfeeding infant or, after initiating home phototherapy, to assess the caregiver’s knowledge regarding equipment complications.

The warm line is another type of telephone link between the new family and concerned caregivers or experienced parent volunteers. A warm line is a help line or consultation service, not a crisis intervention line. The warm line is appropriately used for dealing with less extreme concerns that may seem urgent at the time the call is placed but are not actual emergencies. Calls to warm lines commonly relate to infant feeding, prolonged crying, or sibling rivalry. Warm line services may extend beyond the fourth trimester. Families need to call when concerns arise and be given phone numbers for easy access to answers to their questions.

Support groups

A special group experience is sometimes sought by the woman adjusting to motherhood. On occasion, postpartum women who have met earlier in prenatal clinics or on the hospital unit may begin to associate for mutual support. Members of childbirth classes who attend a postpartum reunion may decide to extend their relationship during the fourth trimester. A postpartum support group enables mothers and fathers to share with and support each other as they adjust to parenting. Many new parents find it reassuring to discover that they are not alone in their feelings of confusion and uncertainty. An experienced parent can often impart concrete information that can be valuable to other members in a postpartum support group. Inexperienced parents may find themselves imitating the behavior of others in the group whom they perceive as particularly capable.

Referral to community resources

To develop an effective referral system, it is important that the nurse have an understanding of the needs of the woman and family and of the organization and community resources available for meeting those needs. Locating and compiling information about available community services contributes to the development of a referral system. It is important for the nurse to develop his or her own resource file of local and national services that are used commonly by health care providers (see Resources at the end of this chapter).

Key Points

- Postpartum care is modeled on the concept of health.
- Cultural beliefs and practices affect the patient’s response to the puerperium.
- The nursing care plan includes assessments to detect deviations from normal, comfort measures to relieve discomfort or pain, and safety measures to prevent injury or infection.
- Teaching and counseling measures are designed to promote the woman’s feelings of competence in self-care and baby care.
- Common nursing interventions in the postpartum period include evaluating and treating the boggy uterus and the full urinary bladder; providing for nonpharmacologic and pharmacologic relief of pain and discomfort associated with the episiotomy, lacerations, or breastfeeding; and instituting measures to promote or suppress lactation.
- Meeting the psychosocial needs of new mothers involves taking into consideration the composition and functioning of the entire family.
- Early postpartum discharge will continue to be the trend as a result of consumer demand, medical necessity, discharge criteria for low risk childbirth, and cost-containment measures.
- Early discharge classes, telephone follow-up, home visits, warm lines, and support groups are effective means of facilitating physiologic and psychologic adjustments in the postpartum period.

Answer Guidelines to Critical Thinking Exercises

Return to Nonpregnant Appearance

Yes, there is sufficient evidence to draw conclusions about counseling women with regard to regaining their nonpregnant appearance. Normal weight gain during pregnancy is approximately 25 pounds. Because Deidra gained almost twice that much weight during her pregnancy, she will need to make changes in her diet and exercise regularly in order to reach her prepregnant weight. There are multiple sources of information about diet and exercise during the postpartum period, including health care professionals, dietitians, web sites, television programs, and magazines available to Deidra. Although making changes in her diet and exercise regimens will not be easy, with determination and persistence Deidra can certainly succeed in regaining her prepregnant appearance.
2. a. The postpartum woman will lose weight gradually if she consumes a balanced diet that provides slightly fewer calories than her daily energy expenditure. Most women rapidly lose several pounds during the month after birth. Because fat is the most concentrated source of calories in the diet, the first step in weight reduction is to identify sources of fat in the diet and explore ways to reduce them.

b. Breastfeeding women are encouraged to follow the same well-balanced diet recommended for healthy pregnant women. The lactating woman needs to consume at least 1800 calories per day in order to produce an adequate milk supply. As a result of the caloric demands of lactation, the breastfeeding woman usually has a gradual but steady weight loss.

c. Women can begin exercising soon after birth, although they are encouraged to begin with simple exercises and gradually progress to more strenuous ones.

d. A woman’s self-esteem is often related to her perceived body image. How a new mother feels about herself and her body may affect her behavior and adaptation to parenting.

3. Priority for nursing care at this time is to educate Deidra regarding a weight reduction diet for a breastfeeding woman and a sensible exercise plan for a postpartum patient. She should be encouraged to follow the same balanced diet recommended during pregnancy and urged to avoid strenuous dieting. In addition, Deidra can be encouraged to eliminate “empty” calories, such as sugar-sweetened drinks, desserts, and chips from her diet. She will likely be surprised and pleased to learn that she will burn about 500 calories per day through milk production. Deidra’s individual dietary preferences should also be considered. It is important to inform Deidra that dieting can cause her milk supply to decrease; she should monitor the baby’s intake and output to see if the infant is receiving adequate nutrition. If her milk production is declining, she may need to add more calories to her diet.

Deidra can be encouraged to begin simple exercises immediately, since she is already 10 days postpartum. Taking the baby for a walk each day would provide both an opportunity for exercise and help in regaining a normal routine. Deidra should be encouraged to start with simple exercises and gradually progress to more strenuous ones.

In terms of body image and self-esteem, if Deidra voiced concerns about her body image, having no support, or perceiving that things are now very different and will “never return,” a referral for more extensive evaluation and counseling would be warranted.

4. There is a significant amount of information available concerning diet and exercise for the postpartum woman who is breastfeeding. Data regarding self-esteem in new mothers also exist. Counseling would be warranted. A woman’s self esteem is often related to her perceived body image. How a new mother feels about herself and her body may affect her behavior and adaptation to parenting.

5. Most postpartum women are eager to regain their nonpregnant figures quickly. It can be discouraging when diet and exercise efforts fail to produce the desired results immediately.

Cultural Influences during the Postpartum Period

1. Yes, there is sufficient evidence to draw conclusions about the cultural beliefs of Asians as they relate to the postpartum period and breastfeeding. Potential sources of information include journal articles, books, and interviews with women who are members of that cultural group. Information regarding how traditional Asian beliefs may be adapted by women who emigrate to other countries is also available from these sources.

2. a. Asian women typically prefer warm foods and hot drinks after giving birth and refuse anything cold. In this culture, pregnancy is considered to be a “hot” state, and childbirth results in a sudden loss of this state. Warm food and drinks help to restore balance in the woman’s body by facilitating the return of the “hot” state. Another typical Asian belief is that the mother and baby remain in a weak and vulnerable state for a period of several weeks following birth. During this time the mother may remain in a passive role, take no baths or showers, and stay in bed to prevent cold air from entering her body.

b. Because of the prevalent belief among Asians that the mother should rest and remain in bed to protect herself immediately after childbirth, routine baby care is usually provided by another female. In several cultures, including Asian cultures, colostrum is viewed as unnecessary and unhealthy for newborns. Breastfeeding is begun only several days after birth, when the “true milk” has come in. Before that time, babies may be fed prelactational food. Asian parents often request infant formula for their infant while they are in the hospital.

c. In many cultures, female family members and friends play an essential role in providing care for the new mother and baby immediately after birth. In the Asian culture, new mothers observe specific diet and activity restrictions for several weeks. Following these traditional cultural practices in a different country may prove to be extremely difficult if family members or friends are not available. In the home country, males are often not expected to assist in caring for newborns. Even if a woman’s husband is willing to do so, he may need much instruction and encouragement to provide even minimal care for his wife and baby.

d. Women are routinely taught that the ideal time to initiate breastfeeding is within the first hour after birth. During this time the baby is usually in the quiet alert state. However, women from cultures that wait hours or days to initiate breastfeeding are able to do so successfully.

3. The priority for nursing care at this time is to assist Terri in recovering from childbirth in a way that is congruent with her cultural beliefs. Every effort should be made to determine Terri’s preferences with regard to diet, activity, and hygiene, and to honor them as much as possible. Although Terri’s beliefs may seem unusual, they should be encouraged as long as she wants to conform to them and she and the baby suffer no ill effects. Culturally appropriate accommodations that can be made for Terri on the postpartum unit include providing a bedside bath if desired, offering only warm food and drink, and encouraging family members or friends to bring in especially desired foods if the hospital’s dietary department is unable to provide them. If Terri desires, family members or friends can be encouraged to stay with her as much as possible to assist with her care and the baby’s care.

Breastfeeding will also need to be addressed with Terri. A good way to determine the information Terri needs is to discover why she prefers to feed her baby infant formula. Discussing the benefits of colostrum for newborns may cause Terri to change her mind about delaying breastfeeding.

4. There is a significant amount of information available concerning culturally appropriate care during the postpartum period for Asian women. Women who receive culturally
appropriate care during this time will likely be more satisfied with their care. They will also be better able to assume care for themselves and their babies in the future if their early needs for passive nurturing are met.

5 Not all women belonging to a particular cultural group will desire to use the traditional health practices that represent that group. Many young women who are first- or second-generation Americans follow their cultural traditions only when older family members are present or not at all. Adherents to the “melting pot” theory of acculturation in the United States would assert that women, regardless of their cultural heritage, should “act like Americans” if they live in America.

Resources

Child Welfare League of America
440 First St., NW, Third Floor
Washington, DC 20001-2085
202-638-2952
www.cwla.org/default.htm

Depression After Delivery
P.O. Box 5973
Renton, WA 98058
206-283-9278
www.depressionafterdelivery.com

HAND (Helping After Neonatal Death)
P.O. Box 341
Los Gatos, CA 95031
888-908-HAND
www.handonline.org

La Leche League
1-800 N. Meacham Rd.
 Schaumburg, IL 60168-4808
800-525-3243 (24-hour line)
www.lalecheleague.org

March of Dimes Birth Defects Foundation
National Foundation/March of Dimes
1275 Mamoreneck Ave.
White Plains, NY 10605
888-663-4637 (MODIMES)
www.marchofdimes.com

National Perinatal Association
2090 Ling coatrees Rd., Suite 107
Harrisburg, PA 17110
888-971-3295
www.nationalperinatal.org

Nursing Mothers Council
Consult telephone directory for local chapters

Parent Soup
www.parentsoup.com

Planned Parenthood Federation of America, Inc.
810 Seventh Ave.
New York, NY 10019
800-230-PLAN
www.plannedparenthood.org

Positive Parenting
www.positivereparenting.com

Postpartum Education for Parents
P.O. Box 6154
Santa Barbara, CA 93160
Warmline: 805-564-3888
www.shpp.org

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Food and Consumer Service
3101 Park Center Dr., Room 819
Alexandria, VA 22302
703-305-2286
www.usda.gov/fns/wic.html

References


Davis, R. (2001). The postpartum experience for Southeast Asian
women in the United States. *MCN American Journal of Maternal Child
Nursing, 26*(4), 208-213.

Donnelly, A. et al. (2001). Commercial hospital discharge packs for


measure to identify women at risk for depression in pregnancy.
*MCN American Journal of Maternal Child Nursing, 30*(1), 40-45.

Kim-Godwin, Y. (2003). Postpartum beliefs and practices among non-


*Clinical Obstetrics and Gynecology, 47*(1), 676-682.

newborn discharge legislation and early follow-up visits on infant
outcomes in a state Medicaid population. *Pediatrics, 113*(6), 1659-
1627.

effectiveness of postnatal home nursing visits for prevention of hos-

Sampoule, C., Wyman, J., Thomas, K., Newman, D., Gray, M.,

Sikorski, J. et al. (2001). Support for breastfeeding women (Cochrane
Wiley & Sons.

Simpson, K., & Creehan, P. (Eds.) (2001). *AWHONN’s Perinatal Nurs-
ing* (2nd ed.). Philadelphia: Lippincott.

Troy, N. (2003). Is the significance of postpartum fatigue being over-
looked in the lives of women? *MCN American Journal of Maternal Child
Nursing, 28*(6), 232-237.