HACKETTSTOWN REGIONAL MEDICAL CENTER

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MATERNAL SERVICES
(Scope)

TITLE: POSTPARTUM ASSESSMENT/REASSESSMENT

PURPOSE: To outline the procedure to evaluate condition of breasts, fundus, episiotomy, perineum, lochia, bladder, bowels, emotional status, vital signs, and signs of thrombophlebitis.

SUPPORTIVE DATA: Patient will be assessed at least every shift. Nurse should observe for demonstrated ability to progress to activities of daily living and care of baby by the time of discharge.

EQUIPMENT: Post Partum Flow Sheet/ Patient Care notes

CONTENT:

PROCEDURE STEPS:	KEY POINTS:
1. Wash hands and glove if necessary.	Standard precautions.
2. Explain procedure to patient.	
3. Put bed in flat position.	
4. Check to see if breasts are soft, firm, filling or engorged. Check nipples for any cracks or fissures.	Encourage all postpartum patients to wear bras with good support. Lansinoh is ordered for nipples of nursing mothers. Instruct mother in use of cream. Reassessment of breast/nipple discomfort should be done with each breastfeeding session.
5. Check fundus by starting at umbilicus with fingers and feel how far below or high the fundus is in finger measurement. Massage fundus if boggy after vaginal delivery.	A fundus at umbilicus is @ U. For each finger below umbilicus is U/1, U/2, etc. A fundus above is either 1/U or 2/U, etc Discuss findings witih patient. Instruct and encourage patient to self-assess and report to nurse.
6. At the time of the fundus check, the bladder can be checked.	If fundus is displaced, palpate above the pubic bone for bladder contents. If bladder is full, have patient empty bladder, then recheck fundus.
7. First three voidings after delivery (postpartum) or tubal ligation or removal of Foley catheter are measured.	If each voiding after that is adequate, (greater than 100 cc of urine) amounts need not be measured. A full bladder may interfere with involution of the uterus. Diuresis generally occurs 24 hours after delivery. Frequency and amount should be reassessed at that time (patient may report).
8. Check lochia by removing pad without touching soiled areas. Inquire passing of clots.	Observe color, odor and amount.

9. Inspect perineum and anal area.	Check for hemorrhoids, redness, edema, discharge, ecchymosis , hematoma , inflammation. Check sutures if any.
10. Inquire if patient had a bowel movement.	If no bowel movement by time of discharge, encourage po fluids and ambulation; inform provider.
11. During physical assessment, evaluate the mother's emotional status.	Observe how she is adapting to her baby and her body changes.
12. Check for signs of thrombophlebitis (previous varicose veins, non-varicose veins). May result from intravenous therapy.	Some signs and symptoms of superficial thrombophlebitis: a. sudden throbbing pain in a circumscribed area b. tenderness c. skin erythema d. local subcutaneous swelling e. palpable tender cord Some signs and symptoms of localized deep thrombophlebitis: a. insidious calf heaviness b. sudden aching pain on slight movement of the calf muscles c. calf or thigh tenderness over the involved veins
13. Vital signs protocol as follows. For NSD: (Recovery period)Q. 15 min. x 4, then Q. 4 hour for first 24 hours, then Q. 8 hour . For Cesarean Section: (Following post-op recovery phase): Q. 15 min x 4, then Q 1 hour x 4 or until stable, then Q 4 hour for the first 72 hours, then Q 8 hour.	
14. Check Homan's sign by pressing down gently on the patient's knee (legs extended flat on the bed) and asking her to dorsiflex her foot.	Homan's sign - deep calf pain on dorsiflexion of the foot resulting from traction on the inflamed veins in the muscles.
15. Documentation: Complete shift assessment in Cerner documentation Power forms.	Document assessment every shift.