STANDARD OF CARE:

The patient can expect to receive competent, effective family-centered care directed to meet the needs of the mother, infant and family during the postdelivery and postpartum period.

NURSING PRACTICE GUIDELINES (POST-DELIVERY - SPECIFIC):

1. RN to perform the initial patient assessment as follows:
   a. First hour post delivery: every 15 minutes {x four (4)}
   b. Second hour post delivery: every 30 minutes {x two (2)}
   c. Reassessment can be completed by qualified member of healthcare team.
      Assessment to include:
      b. Uterus / Fundus for firmness, height, position and tenderness.
      c. Bleeding for amount, color, and presence of clots.
      d. Perineum:
         i. Episiotomy, lacerations, and hemorrhoids
         ii. Bruising, hematoma, edema, discharge, and loss of approximation.
      e. Cesarean section incision site, if appropriate:
         i. Dressing and incision (approximation)
         ii. Drainage
         iii. Edema, color changes, or both (redness or ecchymosis)
         iv. On-Q pump assessment (tubing and dressing if appropriate.
      f. Bladder status or urinary catheter patency if applicable.

3. Assess Aldrete score at beginning of post-delivery period and prior to transfer to postpartum care for all patients receiving anesthesia. Patients receiving general anesthesia will be assessed. Refer to Patient Care Services Policy, Care of the Patient Post General Anesthesia for Surgical Procedures in Labor and Delivery and physician order.
4. Perform neurological checks as patient condition warrants. Refer to Patient Care Services Policy, Care of the Postpartum Patient using the pre-established assessment parameter Within Defined Limits (WDL) as a guideline. For frequency of neurological checks, refer to Patient Care Services Policy, Neurological Assessment and physician order.

5. Monitor intake and output until transferred to postpartum care.

6. Assess epidural site upon removal of catheter and prior to transfer to the postpartum unit.

7. Provide appropriate hygiene, including perineal care, oral care, and linen changes.

**NURSING PRACTICE GUIDELINES (POSTPARTUM - SPECIFIC):**

1. RN to assess patient upon admission to postpartum care for the following:
   a. Vital signs: blood pressure, heart rate, respirations and temperature.
   b. Uterus / Fundus: firmness, height, position, and tenderness.
   c. Lochia: type and amount, color, presence of odor; presence of clots.
   d. Perineum:
      i. Episiotomy, lacerations, and hemorrhoids
      ii. Bruising, hematoma, edema, discharge, and loss of approximation.
   e. Cesarean section incision site, if appropriate
      i. Dressing and incision (approximation)
      ii. Drainage
      iii. Edema, color changes, or both (redness or ecchymosis)
   f. Condition of breasts: soft, filling, firm, or engorged; reddened or painful; nipples- erectility, possible cracks and redness.
   g. Bladder status (voiding pattern, distention, pain) or urinary patency catheter if applicable.
   h. Bowel: Bowel movements, bowel sounds – auscultate all four quadrants
   i. Extremities for thrombophlebitis: check for redness, tenderness, and warmth.
   j. Respiratory Status: respiratory rate, rhythm, quality, and breath sounds bilaterally.
   k. Cardiovascular: rate, rhythm, and quality.
   l. Level of pain.
   m. Incentive Spirometry – C-section moms perform incentive spirometry every one (1) hour while awake (needs to do 20 breaths within 4 hours).

2. Frequency of Postpartum Checks:
   a. Vaginal deliveries: above assessments will be repeated in one (1) hour and then every four (4) hours times two (2). Thereafter, if the patient’s assessment remains WDL, assessments will be performed every eight (8) hours. The RN must complete initial
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assessments and must assess patient at least every eight (8) hours. All other assessments may be done by the RN / LPN.

b. Surgical deliveries: assessments will follow the same schedule with exception of vitals signs will be done every four (4) hours for the first 24 hours then every eight (8) hours.

3. Patients receiving epidural anesthesia will be assessed. Refer to Patient Care Services Policy, Care of the Patient Receiving Epidural Intrathecal Opioid or Medication.

4. For patient with Controlled Analgesia (PCA’s) assess level of sedation and end tidal CO2 (ETCO2). Refer to Patient Care Services Policy, Patient Controlled Analgesia (PCA) / Continued Opioid Infusion and Refer to Patient Care Services Policy, ETCO2 policy

5. Perform neurological check as patient condition warrants, using the pre-established assessment parameter (WNL) as a guideline, refer to Patient Care Services Policy, Care of the Antepartum Patient. Neurological checks will be per assessed per policy or physician order, refer to Patient Care Services Policy, Neurological Assessment.

6. Feedings will be assessed at first feeding and every eight (8) hours until discharge. Refer to Patient Care Services Policy, Care of the Newborn After Delivery, Breastfeeding: Care, Maintenance and Instructions for Mothers and Formula for Infant Bottle Feeding.

8. Mother-infant interaction will be assessed every eight (8) hours.

9. Provide appropriate hygiene daily, oral care at least twice daily and as condition warrants. Linen changes as needed. Perineal care will be done. Refer to Patient Care Services Policy, Care of the Postpartum Patient.

NURSING PRACTICE GUIDELINES (POST-DELIVERY / POSTPARTUM GENERAL):

1. Assess IV sites every four (4) hours or more frequently according to medication policies and / or guidelines.

2. Provide assistance with nourishments, oral fluids, elimination, activity, and functional status.

3. Maintain skin integrity including a visual head to toe skin inspection. Refer to Patient Care Services Policy, Skin Assessment and Management.

4. A Fall Risk Assessment will be performed on all adult patients upon admission and repeated every eight (8) hours. Refer to Patient Care Services Policy, Standard Assessment Scale: Morse Fall Scale.

5. Notify and collaborate with physicians and appropriate clinical disciplines for interventions based on holistic patient care assessments.
6. RN to coordinate care delivered to patients and serve as support and advocate to patient and family.

7. Provide appropriate teaching.

8. Implement and maintain patient safety protocol.
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Definitions for Within Defined Limits (WDLs)

<table>
<thead>
<tr>
<th>Assessment Parameters</th>
<th>Post Delivery / Post Partum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neurological</strong></td>
<td>Alert and oriented x 3 (person, place and time) - Arouses easily; minimal drowsiness noted - Pupils equal and round - Communication clear and understandable - Able to respond to commands - Face symmetrical - Moves all extremities to command - No tremors or seizure activity</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Respirations regular and unlabored, no complaints of dyspnea, lung sounds clear bilaterally, occasional normal cough, sputum clear if present.</td>
</tr>
<tr>
<td><strong>Cardiac</strong></td>
<td>Rate regular with absence of bradycardia or tachycardia.</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>Absence of nausea, vomiting or diarrhea. Normal bowel movements noted.</td>
</tr>
<tr>
<td><strong>Gastrointestinal: Surgical Deliveries</strong></td>
<td>No nausea or vomiting. Bowel sounds heard over four (4) quads: may be sluggish or decreased, returning to normal after 1 to 2 days post-op. No distention or tenderness.</td>
</tr>
<tr>
<td><strong>Genitourinary / Urinary</strong></td>
<td>Able to empty bladder without complaint of dysuria, urine clear, yellow to amber, bladder non-distended.</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td>Skin color within patients’ norm, warm, dry and intact (excludes surgical incisions), mucous membranes moist.</td>
</tr>
<tr>
<td><strong>Gestational Hypertension</strong></td>
<td>Reflexes +1 to +2 with absence of hyporeflexia, clonus, severe headache, epigastric pain, blurred vision or visual changes, nausea / vomiting, irritability, acute anxiety or oliguria. Absence of facial edema, less than or equal to +1 in lower extremities, daily weight checked. Seizure precautions maintained.</td>
</tr>
<tr>
<td><strong>Magnesium Sulfate</strong></td>
<td>Absence of hyporeflexia, reflexes +1 to +2, minimal drowsiness, absence of flushing, diaphoresis, excessive thirst, respiratory depression or distress, nausea, vomiting, anxiety, lethargy, ataxia, flaccidity or hypotension. Emergency equipment readily available.</td>
</tr>
<tr>
<td><strong>Fundus</strong></td>
<td>Firm, midline at umbilicus or below, with progressing involution.</td>
</tr>
<tr>
<td><strong>Lochia</strong></td>
<td>Amount scant to moderate with few clots noted. Fleshy, not foul odor.</td>
</tr>
<tr>
<td></td>
<td>Day 1 - 3 Rubra (red)</td>
</tr>
<tr>
<td></td>
<td>Day 4 - 10 Serosa</td>
</tr>
<tr>
<td></td>
<td>After Day 10 Alba</td>
</tr>
<tr>
<td><strong>Perineum</strong></td>
<td>Slight edema, edges of episiotomy and any repaired lacerations intact, if applicable. Absence of discoloration, hemorrhoids, hematoma, varicosities.</td>
</tr>
<tr>
<td><strong>Breasts / Nipples</strong></td>
<td>Breasts: may be soft, firm and/or full without hardness, redness or complaints of pain. Nipples: intact without redness or foul drainage</td>
</tr>
<tr>
<td><strong>Family Newborn Bonding</strong></td>
<td>Smiles / cuddles / talks to infant appropriately. Participating in infant's care.</td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
<td>Characteristics of behavior and communication appropriate to situation, affect appropriate.</td>
</tr>
</tbody>
</table>
DOCUMENTATION:

A. Document all assessments / interventions on electronic / unit specific flow sheet.
B. Document all teaching on electronic / Multidisciplinary Patient Teaching Record.

REFERENCES:

Deleted and / or Combined,

St. Francis Hospital and Health Centers, Patient Care Services Policy, Standard Title: Obstetrics - Post Partum, #460.78. (Combined)

References for this policy,

St. Francis Hospital and Health Centers, Patient Care Services Policy, Breastfeeding: Care, Maintenance and Instructions for Mothers

St. Francis Hospital and Health Centers, Patient Care Services Policy, Care of the Antepartum Patient.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Care of the Newborn After Delivery

St. Francis Hospital and Health Centers, Patient Care Services Policy, Care of the Patient Receiving Epidural / Intrathecal Opioid or Medication.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Care of the Patient Post General Anesthesia for Surgical Procedures in Labor and Delivery

St. Francis Hospital and Health Centers, Patient Care Services Policy, Care of the Post Partum Patient.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Formula for Infant Bottle Feeding.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Neurological Assessment.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Patient Controlled Analgesia (PCA) / Continued Opioid Infusion.

St. Francis Hospital and Health Centers, Patient Care Services Policy, Standard Assessment Scale: Morse Fall Scale.
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St. Francis Hospital and Health Centers, Patient Care Services Policy, Skin Assessment and Management.

AWHONN (Association of Women’s Health, Obstetric, and Neonatal Nurses)


Sister of St. Francis Health Services (SSFHS) Epic Project Standardization Team

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Patient Care Standards Council: - 02/08/11.
Nursing Executive Committee: - 02/11.

Approved by: ____________________________
Susan McRoberts, Vice President and Chief Nursing Officer
Distributed: February 2011

(Signed, original policy on file in Nursing Office)