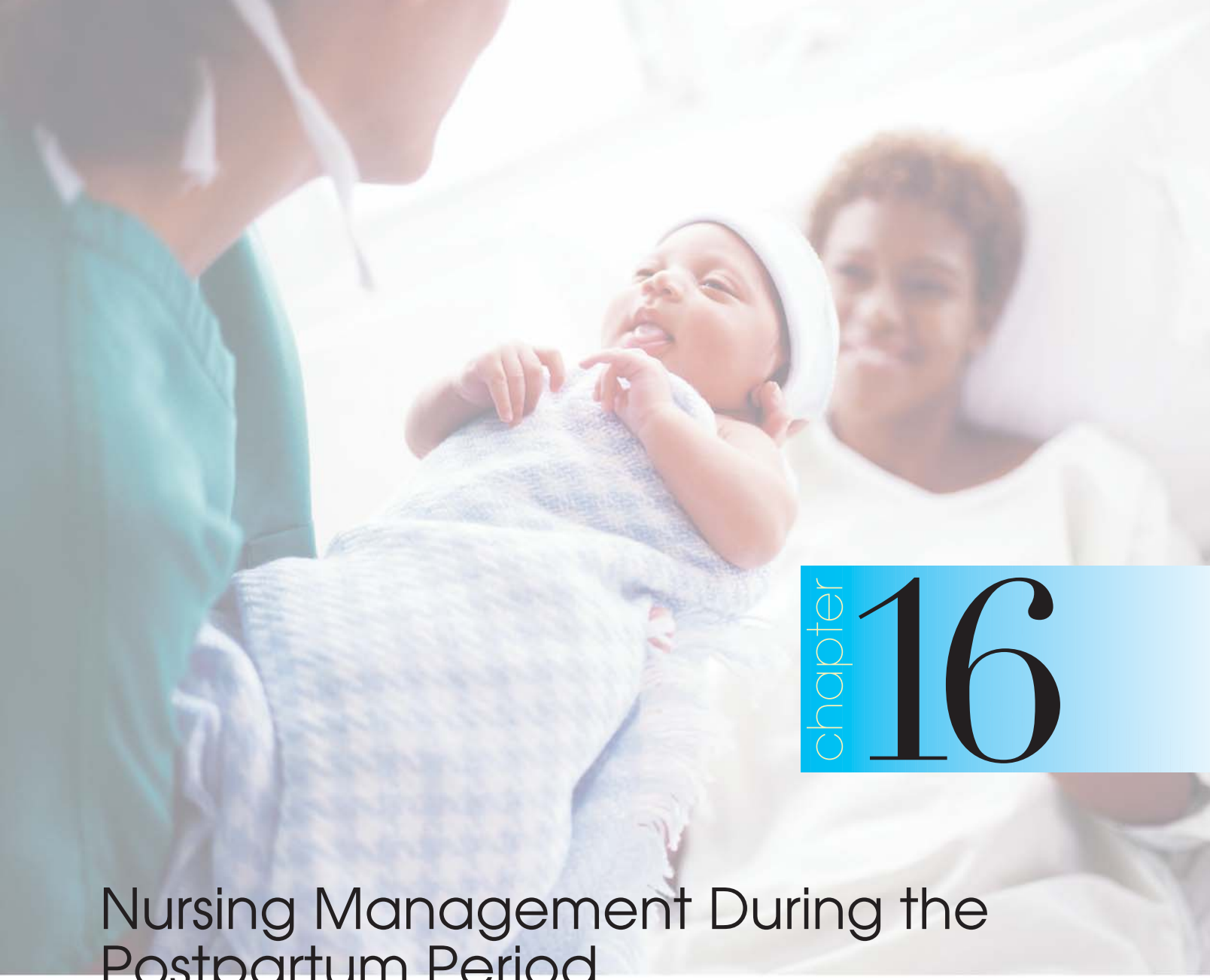


chapter 16

Nursing Management During the Postpartum Period

KeyTERMS

attachment
bonding
en face position
Kegel exercises
mastitis
peribottle
postpartum blues
sitz bath

LearningOBJECTIVES

After studying the chapter content, the student should be able to accomplish the following:

1. Define the key terms.
2. Describe the parameters requiring assessment during the postpartum period.
3. Discuss the bonding and attachment process.
4. Identify behaviors that enhance or inhibit the attachment process.
5. Outline nursing management for the woman and her family during the postpartum period.
6. Discuss the role of the nurse in promoting successful breast-feeding.
7. Identify areas of health education needed for discharge planning, home care, and follow-up.

WOW

Parenting is an intimate, interactive, continuous, life-long process.

The postpartum period is a time of major adjustments and adaptations not just for the mother, but for all members of the family unit. It is during this time that parenting and a relationship with the newborn begins. A positive, loving relationship between parents and their newborn promotes the emotional well-being of all. This early-formed relationship endures through time and has profound effects on the child's growth and development.

Parenting is a skill that is often learned, to varying degrees of success, by trial and error. Successful parenting, a continuous and complex interactive process, requires the acquisition of new skills and the integration of the new member into the existing family unit.

Adapting to the role of a parent is not an easy process. The postpartum period is a "getting-to-know-you" time, when parents begin to integrate the newborn into their lives as they reconcile the fantasy child with the real one. This can be a very challenging period for families. Nurses play a major role in assisting families to adapt to the changes, thereby facilitating a smooth transition into parenthood. For established families with children, the addition of a new member may bring about role conflict and may present challenges to the entire family unit. Anticipatory guidance about other children's responses to the birth and new baby, increased emotional tension, child development, and meeting the multiple needs of their expanding family are key areas of discussion for the nurse. Although the multiparous woman has had previous experience with newborns, a nurse should not assume that it is current, accurate, and remembered, if it has been a while since the woman's last childbirth. Reinforcing previous instruction is important for all families.

As the face of America is changing with increasing diversity, nurses must be prepared to care for childbearing families from various cultures. For years, perinatal nurses have struggled with the issues surrounding the provision of optimal prenatal and postpartal care that meets the needs of women and their families from various cultures and ethnic groups. In many cultures, women and their families are cared for and nurtured by the community around them, sometimes for weeks, and possibly months, after the birth of a new family member. Box 16-1 highlights some of the major cultural influences during the postpartum period.

Sensitivity to how childbearing practices and beliefs vary for multicultural families is essential. Nurses need to understand how best to provide appropriate nursing care to meet their needs. Cultural practices may include the observance of certain dietary restrictions, clothing, or taboos for balancing the body; participation in certain activities for maintaining mental health; and the use of silence, prayer, or meditation for developing spirituality. Restoration of health may involve taking folk medicines or conferring with a tribe healer (Wong, Perry, & Hockenberry, 2002). The concept of family as paramount to beliefs surrounding health prevails among many ethnic cultures.

Nurses are responsible for providing culturally competent care in which the nurse must engage in ongoing cultural self-assessment and overcome any stereotyping that perpetuates prejudice or discrimination against any cultural group (Bowers, 2003). Implementing culturally competent nursing care during the postpartum period requires time, open-mindedness, and patience. Sensitivity to the woman's and family's culture, religion, and ethnic influences is essential in trying to promote positive health outcomes.

Strong social support is vital for positive integration of the newest member into the family unit. However, in today's mobile society, extended families do not live close by and may be unable to provide care for the new family. Subsequently, new parents turn to health care professionals for information as well as physical and emotional support during this adjustment period. Nurses provide a critical link and can be an invaluable resource by bridging the gap and providing mentoring, education about self-care measures and baby care basics, including feeding and the roles of the new family; and providing emotional support. Nurses can "mother" the new mother by offering physical, emotional, and informational support and practical help. The nurse's support and caring throughout this critical time can empower the parents and their families, increasing their confidence level and thereby providing them with a sense of accomplishment and feelings of success about their parenting skills.

One area of importance associated with the postpartum period is breast-feeding. Its importance is emphasized in Healthy People 2010 by the development of a specific goal for maternal, infant, and child health. This objective is presented in Healthy People 2010: National Health Goals Related to Breast-Feeding. Although the Department of Health and Human Services (DHHS) does not recommend universal breast-feeding for all women—such as those who use illicit drugs; who have active, untreated tuberculosis; or who test positive for HIV—the benefits of breast-feeding are well documented and thus are an important area to address.

This chapter describes the nursing management of the woman and her family during the postpartum period. It outlines physical assessment parameters necessary when caring for new mothers and their newborns. It also focuses on **bonding** and **attachment** behaviors of which nurses need to be aware so that appropriate interventions can be

BOX 16-1

CULTURAL INFLUENCES DURING THE POSTPARTUM PERIOD

African-American
- Mother may share care of the infant with extended family members.
- Experiences of older women within the family influence infant care.
- Mothers may protect their newborns from strangers for several weeks.
- Mothers may not bathe their newborns for the first week. Oils are applied to skin and hair to prevent dryness and cradle cap.
- Silver dollars may be taped over the infant's umbilicus in an attempt to flatten the slightly protruding umbilical stump.
- Sleeping with parents is a common practice (Thomas, 2003).

Amish
- Women consider childbearing their primary role in society.
- They generally oppose birth control or family planning practices.
- Pregnancy and childbirth are considered a private matter; they may conceal it from public knowledge.
- Women typically do not respond favorably when hurried to complete a self-care task. Nurses need to take cues from women indicating their readiness to complete morning self-care activities (Troyer & Troyer, 2003).

Appalachian
- Infant colic is treated by passing the newborn through a leather horse's collar or administering a weak catnip tea.
- An asafetida bag (a gum resin with a strong odor) is worn around the neck of the infant to keep away disease.
- Women may avoid eye contact with nurses and health-care providers.
- Women typically avoid asking questions even though they do not understand directions.
- The grandmother may rear the infant for the mother (Stephens, 2003).

Filipino-American
- Grandparents often assist in the care of their grandchildren.
- Breast-feeding is encouraged and some mothers will breast-feed their children for up to 2 years.
- Women have difficulty discussing birth control and sexual matters.
- Strong religious beliefs prevail and bedside prayer is common.
- Families are very close knit and numerous visitors can be expected to the hospital after childbirth (Anonas–Ternate, 2003).

Japanese-American
- Cleanliness and protection from cold are essential components of newborn care. Nurses are to give the daily bath to the infant.
- Newborns routinely are not taken outside the home because it is believed that newborns should not be exposed to outside or cold air. Infants should be kept in a quiet, clean, warm place for the first month of life.
- Breast-feeding is the primary method of feeding.
- Many women stay in their parents' home for 1 to 2 months after birth.
- Bathing the infant can be the center of family activity at home (Yeo, 2003).

Mexican-American
- The newborn's grandmother lives with the mother for several weeks after birth to help with housekeeping and child care.
- Most women will breast-feed more than 1 year. The infant is carried in a *rebozo* (shawl) that allows easy access to breast-feeding.
- Women may avoid eye contact and may not feel comfortable being touched by a stranger. Nurses need to respect this feeling.
- Some women may bring religious icons to the hospital and may want to display them in their postpartum room (Oria de Quinzanos, 2003).

Muslim
- Modesty is a primary concern; nurses need to protect their modesty.
- Most women will breast-feed, but religious events call for periods of fasting, which may increase the risk of dehydration or malnutrition.
- Women are exempt from obligatory prayer five times daily as long as lochia is present.
- Extended family is likely to be present throughout much of the woman's hospital stay and need an empty room to perform their prayers without having to leave the hospital (Badwan, 2003).

Native American
- Women are secretive about pregnancies and do not reveal them early.
- Touching is not a typical female behavior and eye contact is brief.
- They resent being hurried and need time for sitting and talking.
- Most mothers breast-feed and practice birth control (Plemmons, 2003).

HEALTHY PEOPLE 2010

National Health Goals Related to Breast-Feeding

Objective	Significance
Increase the proportion of mothers who breast-feed their babies.	Will help to foster providing infants with the most complete form of nutrition, thereby affecting the infant's health, growth and development, and immunity
Increase in mothers who breast-feed during early postpartum from a baseline of 64% to 75%.	Helpful in improving maternal health via breast-feeding's beneficial effects
Increase in mothers who breast-feed at 6 months from a baseline of 29% to 50%.	Will help increase the rate of breast-feeding, particularly among low-income and certain racial and ethnic populations less likely to begin breast-feeding in the hospital or to sustain it through the infant's first year
Increase in mothers who breast-feed at 1 year from a baseline of 16% to 25%.	

implemented to foster these behaviors. Interventions to address physiologic needs such as comfort, self-care, nutrition, and contraception are described. Additional information is discussed in helping the woman and her family adapt to the birth of the newborn (Fig. 16-1).

Nursing Management During the Postpartum Period

Nursing management during the postpartum period focuses on assessing the woman's ability to adapt to the physiologic and psychological changes occurring at this time (see Chapter 15 for a detailed discussion of these adaptations). Family members are also assessed to determine their transition to this new stage. Based on assessment findings, the nurse plans and implements care to address the family's needs. Because of shortened lengths of stay, the nurse may be able to focus only on those needs considered priority and may be able arrange for follow-up in the home to ensure that all the family's needs are met.

● Figure 16-1 Parents and grandmother interacting with the newborn.

Assessment

Comprehensive nursing assessment begins within an hour after the woman gives birth and continues through discharge. This assessment includes vital signs and physical and psychosocial assessments. Although the exact protocol may vary among facilities, postpartum assessment frequency typically is performed as follows:

- During the first hour: assessment every 15 minutes
- During the second hour: assessment every 30 minutes
- During the first 24 hours: assessment every 4 hours
- After 24 hours: assessment every 8 hours (Scoggin, 2004)

With each assessment, keep in mind possible risk factors that may lead to complications, such as infection or hemorrhage, during this recovery period (Box 16-2). Early identification is key to ensure prompt intervention.

As with any assessment, always review the woman's medical record for information related to her pregnancy,

BOX 16-2

FACTORS INCREASING THE WOMAN'S RISK FOR POSTPARTUM COMPLICATIONS

Risk Factors for Postpartum Infection

- Operative procedure (forceps, cesarean birth, vacuum extraction)
- History of diabetes, including gestational-onset diabetes
- Prolonged labor more than 24 hours
- Use of indwelling urinary catheter
- Anemia (hemoglobin < 10.5 mg/dL)
- Multiple vaginal examinations during labor
- Prolonged rupture of membranes more than 24 hours
- Manual extraction of placenta
- Compromised immune system (HIV positive)

Risk Factors for Postpartum Hemorrhage

- Precipitous labor less than 3 hours
- Uterine atony
- Placenta previa or abruption
- Labor induction or augmentation
- Operative procedures (vacuum extraction, forceps, cesarean birth)
- Retained placental fragments
- Prolonged third stage of labor more than 30 minutes
- Multiparity, more than three births closely spaced
- Uterine overdistention (large infant, twins, hydramnios)

labor, and birth. Note a history of any existing conditions or the development of problems or complications that may have occurred during pregnancy, labor, birth, and immediately afterward, along with any treatments initiated.

Postpartum assessment of the mother typically includes vital signs, pain level, and a systematic head-to-toe review of body systems. The acronym BUBBLE-HE—breasts, uterus, bladder, bowels, lochia, episiotomy/perineum, Homans' sign, emotional status—can be used as a guide to complete this head-to-toe review (Littleton & Engebretson, 2005).

While assessing the woman and her family during the postpartum period, be alert for findings that are considered danger signs (Box 16-3). Notify the primary health care provider immediately if any are noted.

Postpartum assessment also includes assessing the parents and other family members, such as siblings and grandparents, for attachment and bonding with the newborn.

Vital Signs

Obtain vital signs and compare them with the previous values, noting and reporting any deviations. Keep in mind that vital sign changes can be an early indicator of complications.

Temperature

Always assess temperature via the oral, axillary, or tympanic route to prevent the risk of perineal contamination via the rectal route. Typically, temperature during the first 24 hours postpartum is within the normal range. Some women experience a slight elevation in temperature, up to 38° C (100.4° F), during the first 24 hours. This elevation may be the result of dehydration because of fluid loss during labor. It should be normal after 24 hours. With replacement of fluids lost during labor and birth, temperature should stabilize and be within the normal range (Green & Wilkinson, 2004). A temperature greater than 38° C (100.4° F) at any time, or a subnormal temperature after the first 24 hours, may indicate infection and must be reported. Abnormal temperature readings warrant continued monitoring until the presence of an infection can be ruled out through cultures or blood studies.

BOX 16-3

POSTPARTUM DANGER SIGNS

- Fever more than 38° C (100.4° F)
- Foul-smelling lochia or an unexpected change in color or amount
- Visual changes, such as blurred vision or spots, or headaches
- Calf pain experienced with dorsiflexion of the foot
- Swelling, redness, or discharge at the episiotomy site
- Dysuria, burning, or reports of incomplete emptying of the bladder
- Shortness of breath or difficulty breathing
- Depression or extreme mood swings

Pulse

As a result of the changes in blood volume and cardiac output after delivery, relative bradycardia may be noted. The woman's pulse rate may range from 50 to 70 bpm. Pulse usually stabilizes to prepregnancy levels within 10 days (Olds, London, Ladewig, & Davidson, 2004).

Tachycardia in the postpartum woman can suggest anxiety, excitement, fatigue, pain, excessive blood loss, infection, or underlying cardiac problems. Further investigation is warranted to rule out the possibility of complications.

Respirations

Respiratory rates in the postpartum woman should fall within the normal range of 16 to 20 breaths per minute. Any change in respiratory rate out of the normal range might be indicative of pulmonary edema, atelectasis, or pulmonary embolism and must be reported. Lungs should be clear on auscultation.

Blood Pressure

Blood pressure varies among individuals. Therefore, assess the woman's blood pressure and compare it with her usual range. Any deviation from this range must be reported. Elevations in blood pressure from the woman's baseline might suggest pregnancy-induced hypertension; decreases may suggest dehydration or excessive blood loss.

Blood pressure also may vary based on the woman's position, so be sure to assess blood pressure with the woman in the same position. Be alert for orthostatic hypotension, which can occur when the woman changes from a lying or sitting position to a standing one rapidly.

Pain Status

Pain, considered to be the fifth vital sign, is assessed along with the other four parameters. Question the woman about the type of pain, location, and severity. Have the woman rate the pain, such as with a numeric scale ranging from 0 to 10 points.

Many postpartum orders will have the nurse premedicate the woman routinely for afterbirth pains rather than wait for her to experience them first. The goal of pain management is to have the woman's pain scale rating maintained between 0 to 2 points at all times, especially after breast-feeding episodes. This can be accomplished by assessing the woman's pain level frequently and preventing pain by administering analgesics to keep the pain experienced at its lowest level (Fig. 16-2). If the woman complains of severe pain in the perineal region despite use of physical comfort measures, reexamine the area by inspection and palpation for the presence of a hematoma. If one

● Figure 16-2 Nurse administering analgesic to a postpartum woman.

is found, notify the health care provider immediately for corrective intervention.

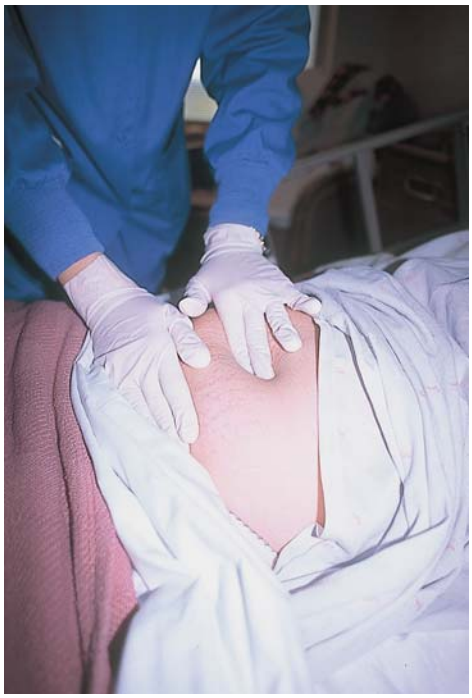
Breasts

Inspect the breasts for size, contour, asymmetry, engorgement, or areas of erythema. Check the nipples for cracks, redness, fissures, or bleeding and note whether they are erect, flat, or inverted. Flat or inverted nipples can make breast-feeding challenging for both mother and infant. Cracked, blistered, fissured, bruised, or bleeding nipples in the breast-feeding woman are generally indications of improper positioning of the infant on the breast. Palpate the breasts to ascertain if they are soft, filling, or engorged, and document your findings. As milk is starting to come in, the breasts become firmer; this is charted as filling. Engorged breasts are hard, tender, and taut. Ask the woman if she is having any nipple discomfort. Also, palpate the breasts for any nodules, masses, or areas of warmth, which may indicate a plugged duct that may progress to **mastitis** if not treated promptly. Any discharge from the nipple should be described and documented if it is not colostrum (creamy yellow) or foremilk (bluish white).

Uterus

Assess the fundus (top portion of the uterus) to determine uterine involution. If possible, have the woman void to empty her bladder before assessing the fundus. Using a two-handed approach with the woman in the supine position and the bed in a flat position, palpate the abdomen gently, feeling for the top of the uterus while the other hand is placed on the lower segment of the uterus to stabilize it (Fig. 16-3).

The fundus should be midline and feel firm. A boggy or relaxed uterus is a sign of uterine atony. This can be the result of bladder distention, which displaces the uterus upward and to the right, or retained placental fragments. Either case predisposes the woman to hemorrhage.



● Figure 16-3 Palpating the fundus.

Once the fundus is located, place your index finger on the woman's fundus and count the number of fingerbreadths between the fundus and the umbilicus (1 fingerbreadth is approximately equal to 1 cm). One to 2 hours after birth, the fundus typically is between the umbilicus and symphysis pubis. Approximately 6 to 12 hours after birth, the fundus usually is at the level of the umbilicus.

Normally, the fundus progresses downward at a rate of one fingerbreadth (or 1 cm) per day after childbirth (Cunningham et al., 2005). So on the first postpartum day, the top of the fundus is located 1 cm below the umbilicus and is recorded as U-1. Similarly, on the second postpartum day, the fundus would be 2 cm below the umbilicus and should be recorded as U-2, and so on.

If the fundus is not firm, gently massage the uterus using a circular motion until it becomes firm.

Bladder

Considerable diuresis—as much as 3000 mL—may follow for several days after childbirth, decreasing by the third day (Littleton & Engebretson, 2005). However, many women may not experience the sensation to void even if their bladder is full. Women who received regional anesthesia during labor are at risk for bladder distention and for difficulty voiding until sensation returns within several hours after birth.

Assess for potential voiding problems by asking the woman the following questions:

- Have you (passed your water, urinated, gone to the bathroom) yet?

- Have you noticed any burning or discomfort with urination?
- Do you have any difficulty passing your urine?
- Do you feel your bladder is empty when you finish urinating?
- Do you have any signs of infection such as urgency, frequency, or pain?
- Are you able to control the flow of urine by squeezing your muscles?
- Have you noticed any leakage of urine when you cough, laugh, or sneeze?

Assess the bladder for distention and adequate emptying after efforts to void. Palpate the area over the symphysis pubis. If empty, the bladder is not palpable. Palpation of a rounded mass suggests bladder distention. Also, percuss the area. A full bladder is dull to percussion. Also note the location and condition of the fundus, because a full bladder tends to displace the uterus up and to the right. Lochia drainage is more than normal because the uterus is not able to contract to suppress the bleeding.

After the woman voids, palpate and percuss the area again to determine adequate emptying of the bladder. If the bladder remains distended, the woman may be retaining residual urine in her bladder, and measures to initiate voiding should be instituted. Be alert for signs of infection, including infrequent or insufficient voiding (<200 mL), discomfort, burning, urgency, or foul-smelling urine (Condon, 2004). Document urine output.

Bowels

Spontaneous bowel movement may not occur for 2 to 3 days after giving birth because of a decrease in muscle tone in the intestines during labor. Normal patterns of bowel elimination usually return to normal within 8 to 14 days after birth (Blackburn, 2003).

Inspect the woman's abdomen for distention, auscultate for bowel sounds in all four quadrants, and palpate for tenderness. The abdomen typically is soft, nontender, and without distention. Bowel sounds are present in all four quadrants. Questioning the woman to see if she has had a bowel movement or has passed gas since giving birth is important, because constipation is a common problem during the postpartum period. Most women do not offer this information unless questioned about it. Finding active bowel sounds, verification of passing gas by the woman, and a nondistended abdomen are normal assessment results.

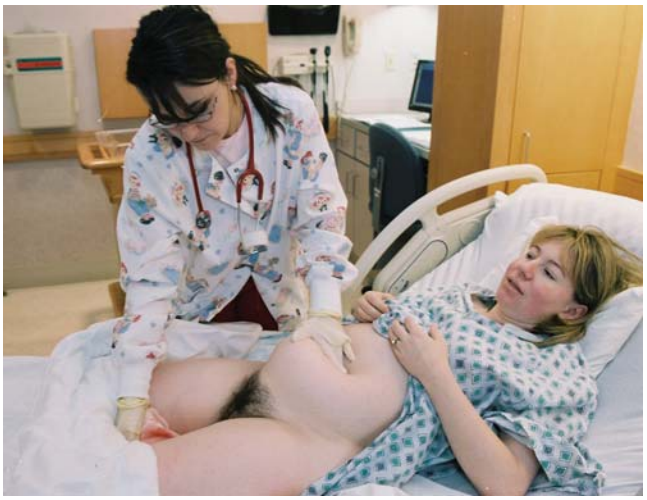
Lochia

Assess lochia according to its amount, color, and change with activity and time. To assess how much a woman is bleeding, ask her to identify how many perineal pads she has used in the past 1 to 2 hours. To determine the amount of lochia, observe the amount of lochia saturation on the perineal pad and relate it to time. A woman who saturates a perineal pad within 30 to 60 minutes is bleeding much more than one who saturates a pad in 2 hours. Typically, describe the amount of lochia present by using the words *scant, light or small, moderate or heavy. Scant* would describe a 1 to 2-inch lochia stain on the perineal pad or an approximate 10-mL loss. *Light or small* would describe an approximate 4-inch stain or a 10- to 25-mL loss. *Moderate* lochia would describe a 4- to 6-inch stain with an estimated loss of 25 to 50 mL. A *large or heavy* lochia loss would describe a saturated pad within 1 hour after changing it (Scoggin, 2004). The total volume of lochia discharge is approximately 240 to 270 mL (8–9 oz) and it decreases daily (Blackburn, 2003).

Women who experience cesarean births will have less lochia discharge than those having a vaginal birth, but stages and color changes remain the same. Although the woman's abdomen is tender after surgery, it is important and necessary for the nurse to palpate the fundus and assess the lochia to make sure they are within the normal range and that there is no excessive bleeding.

Also ask the woman to state how much drainage was on each pad. For example, did she saturate the pad completely or was only half of the pad covered with drainage? Additionally, question the woman about the color of the drainage, odor, and the presence of any clots. Lochia has a definite musky scent, with an odor similar to that for menstrual flow without any large clots. However, foul-smelling lochia suggests an infection, and evidence of large clots suggests poor uterine involution, necessitating additional intervention.

Then inspect the perineal pad, noting the color, amount, and odor, and document your findings (Fig. 16-4). Keep in mind that lochia flow increases when the woman gets out of bed (resulting from pooling in the vagina and the uterus while she is lying down and when she breast-feeds as a result of the effect of oxytocin release causing uterine contractions). Report any abnormal find-



● Figure 16-4 Assessing lochia.

ings, which would include heavy, bright-red lochia with large tissue fragments or a foul odor.

Anticipatory guidance to give the woman at discharge should include information about lochia and the expected changes. Caution the woman to notify her health care provider if lochia rubra returns after serosa and alba lochia transitions have taken place. This is abnormal and may indicate subinvolution or that the woman is too active and needs to rest more.

Lochia is an excellent media for bacterial growth. Frequent changing of perineal pads and handwashing before and after pad changes are important infection control measures.

Episiotomy and Perineum

To assess the episiotomy and perineal area, position the woman on her side with her top leg flexed upward at the knee and drawn up toward her waist. If necessary, use a flashlight or a gooseneck lamp to provide adequate lighting during the assessment. Wearing gloves and standing at the woman's side with her back to you, gently lift the upper buttock to expose the perineum and anus (Fig. 16-5). Inspect the episiotomy for irritation, ecchymosis, tenderness, or hematomas. Also assess for hemorrhoids and their condition.

During the early postpartum period, the perineum tissue surrounding the episiotomy is typically edematous and slightly bruised. The normal episiotomy site should be without redness, discharge, or edema. The majority of healing takes place within the first 2 weeks, but it may take 4 to 6 months for the episiotomy to heal completely (Blackburn, 2003).

Lacerations to the perineal area sustained during the birthing process that were identified and repaired also need to be assessed to determine their healing status. Lacerations are classified based on their severity and tissue involvement as follows:

- First-degree laceration—involves only skin and superficial structures above muscle
- Second-degree laceration—extends through perineal muscles
- Third-degree laceration—extends through the anal sphincter muscle
- Fourth-degree laceration—continues through anterior rectal wall

● Figure 16-5 Inspecting the perineum.

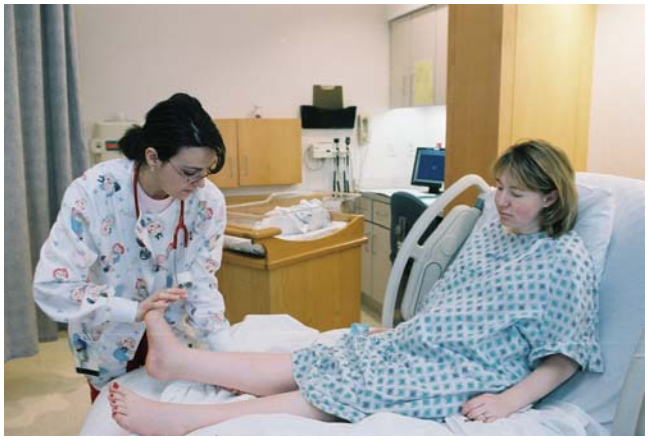
Assess the episiotomy and any lacerations at least every 8 hours to detect the presence of hematomas or signs of infection developing. Large areas of swollen, bluish skin with complaints of severe pain in the perineal area indicate pelvic or vulvar hematomas. Redness, swelling, increasing discomfort, or purulent drainage may indicate the presence of infection. Both discoveries warrant immediate reporting.

A white line the length of the episiotomy is a sign of infection, as is swelling or discharge. Severe, intractable pain; perineal discoloration; and ecchymosis indicate a perineal hematoma—a potentially dangerous condition. Report any unusual findings. Ice can be applied to relieve discomfort and reduce edema; **sitz baths** also can be helpful in promoting comfort and perineal healing.

Homans' Sign

Pregnancy is a state of hypercoagulability. This state coupled with stimulation of the coagulation process at birth increases the risk of thrombosis formation. In addition, the use of stirrups by some women during the birthing process impedes venous return and leads to blood stasis in the legs. Superficial or deep vein thrombophlebitis, a possible complication of childbirth, is caused by hypercoagulability of the blood during pregnancy, severe anemia, pelvic infection, traumatic birth, or obesity (Chalmers, Mangiaterra, & Porter, 2001). Elevations of clotting factors continue for several days or longer after childbirth, placing women at risk during the early postpartum period. It may take 3 to 4 weeks before the homeostasis returns to prepregnant levels (Blackburn, 2003). Women with a history of thrombophlebitis, varicose veins, or those who have had a cesarean birth are at special risk for this condition during the postpartum period and should be advised to wear antiembolism stockings or use sequential compression devices to reduce their risk of developing thrombophlebitis. Encouraging the client to ambulate after childbirth reduces the incidence of thrombophlebitis.

Assessing for Homans' sign may be helpful in identifying possible thrombosis. Position the woman's legs flat on the bed. Then place one hand under the leg near the back of the knee and gently flex her foot forward toward her ankle with the other hand. Repeat the test on the other leg (Fig. 16-6). If the woman experiences calf pain when you flex either foot, the Homans' sign is positive and further assessment is needed. A positive Homans' sign raises the suspicion for superficial thrombosis. Keep in mind that deep venous thrombosis may be silent, and thus does not produce pain on dorsiflexion. Note also the presence of foot or ankle edema, which normally diminishes during the first week postpartum.



● Figure 16-6 Assessing Homans' sign.

Emotional Status

Asses the woman's emotional status by observing how she interacts with her family, her level of independence, energy levels, eye contact with her infant, body posture and comfort level while holding the newborn, and sleep and rest patterns. Be alert for mood swings, irritability, or any crying episodes.

Bonding and Attachment

Meeting the newborn for the first time after birth can be an exhilarating experience for parents. Although the mother has spent many hours dreaming of her unborn and how he or she will look, it is not until after birth that they meet face-to-face. They both need to get to know one another and to develop feelings for one another.

The development of a close emotional attraction to a newborn by the parents during the first 30 to 60 minutes after birth describes bonding. It is unidirectional, from parent to infant. It is thought that optimal bonding of the parents to a newborn requires a period of close contact within the first few minutes to a few hours after birth (Murray & McKinney, 2006). The mother initiates bonding when she caresses her infant and exhibits certain behaviors typical of a mother tending her child. The infant's responses to this, such as body and eye movements, are a necessary part of the process. During this initial period, the infant is in a quiet, alert state, looking directly at the holder. The length of time necessary for bonding depends on the health of the infant and mother, as well as the circumstances surrounding the labor and birth (Baradon, 2002).

The development of strong affectional ties between an infant and a significant other (mother, father, sibling, and caretaker) defines the process of attachment (O'Toole, 2003). This tie between two people is psychological, rather than biologic, and it does not occur overnight. The process of attachment follows a progressive or developmental course that changes over time. Attachment is not inclusive, but must be considered as an individualized and multifactorial process that is dependent on the health status of the newborn or infant, the mother, environmental circumstances, and the quality of care the infant receives (Tideman, Nilsson, Smith, & Stjernqvist, 2002). It occurs through mutually satisfying experiences. Maternal attachment begins during pregnancy as the result of fetal movement and maternal fantasies about the infant, and continues through the birth and postpartum periods. Attachment behaviors include seeking, maintaining close proximity to, and exchanging gratifying experiences with, the infant (Mercer & Ferketich, 1994). In a high-risk pregnancy, the attachment process may be complicated by lack of time to develop a parent–fetal relationship resulting from a premature birth, and by parental stress experienced in response to the fetal and/or maternal vulnerability.

Bonding is a vital component of the attachment process and is necessary in establishing parent–infant attachment and a healthy, loving relationship. During this early period of acquaintance, mothers touch their infants in a very characteristic manner. Mothers visually and physically "explore" their infants, initially using their fingertips on the infant's face and extremities, progressing to massaging and stroking the infant with their fingers. This is followed by palm contact on the trunk. Eventually, mothers draw their infant toward them and hold the infant. Mothers also interact with their infants through eye-to-eye contact in the **en face position** (Koulomzin et al., 2002) (Fig. 16-7).

Generally, research on attachment tends to demonstrate a similar process for fathers as for mothers, even though the pace may be different. Like mothers, fathers manifest attachment behaviors during pregnancy. Indeed, Ferketich and Mercer (1995) found that the best predictor of early postnatal attachment for fathers is fetal attachment. Developmentally, becoming a father requires a man to build on the experiences he has had throughout childhood and adolescence. Fathers develop an emotional tie

● Figure 16-7 En face position.

with their infants in a variety of ways. They seek and maintain closeness with the infant and are capable of recognizing particular characteristics of the infant. They feel a sense of responsibility for the infant's growth and development (Buist, Morse, & Durkin, 2003).

The attachment process is just that—a process. It does not occur instantaneously. Many parents believe in the romanticized version of parenthood, which happens right after birth. A delay or block in the attachment process can occur if a mother's physical and emotional states are adversely affected by exhaustion, pain, the absence of a support system, anesthesia, or an unwanted outcome (Littleton & Engebretson, 2005). Early research by Klaus and Kennel (1982) examined maternal attachment and found that the period when a mother falls in love with her infant was not easily identified. Researchers have not been able to pinpoint precisely the moment in time when attachment is complete. It can occur hours to months after birth or not at all.

The developmental task for the infant is learning to differentiate between trust and mistrust. If the mother or caretaker is consistently responsive to the infant's care, meeting physical and psychological needs, the infant will likely learn to trust his or her caretaker; view the world as a safe place; and grow up to be secure, self-reliant, trusting, cooperative, and helpful toward others. By contrast, if an infant grows up without his or her needs met, the risk of child abuse, developmental delays, and neglect increases (Tilokskulchai, Phatthanasiriwethin, Vichitsukon, & Serisathien, 2002).

Parental role attainment is an interactional and developmental process occurring over a period of time, during which the parents become attached to their infant and acquire competence in their roles as parents. Achieving this role of becoming parents may take 4 to 6 months. This transition to parenthood according to Mercer (1985) follows four stages:

1. Anticipatory stage—allows parents to seek out other role models
2. Formal stage—allows parents to become acquainted with the infant and begin to take cues from the infant
3. Informal stage—encourages parents to respond to the infant as a unique individual
4. Personal stage—attained when the parents feel a sense of harmony in their roles

Factors Affecting Attachment

Attachment behaviors are influenced by three major factors: *parent background,* includes the parent's care by his or her own mother, practices of the culture, relationship within the family, experience with previous pregnancies and planning and course of events during pregnancy; *infant,* which includes the infant's temperament and health status at birth; and *care practices,* the behaviors of physicians, midwives, nurses, and hospital personnel; care and support during labor; first day of life in separation of mother and infant; and rules of the hospital or birthing center (Klaus & Kennel, 1982).

Attachment occurs more readily with the infant whose temperament, health status, appearance, and gender fit the parent's expectations. If the infant does not meet these expectations, attachment can be delayed or hampered (Koulomzin et al., 2002).

In addition, factors associated with the healthcare facility or birthing unit can influence attachment. These include

- Separation of infant and parents immediately after birth, and for long times during the day
- Policies that discourage or inhibit unwrapping and exploring infant, limiting parents' care taking
- Intensive care environment, restrictive visiting policies
- Staff indifference or lack of support for parent's caretaking attempts and abilities

Critical Attributes of Attachment

The terms *bonding* and *attachment* continue to be used interchangeably, even though they cover different time frames and interactions. A group of nursing researchers attempted to clarify attachment by outlining their critical attributes. According to Goulet and fellow researchers (1998), the attributes of parent–infant attachment include proximity, reciprocity, and commitment.

Proximity

Proximity refers to the physical and psychological experience of the parents being close to their infant. This attribute has three dimensions to it:

1. Contact—The sensory experiences of touching, holding, and gazing at the infant are found to be a part of proximity-seeking behavior.
2. Emotional state—The emotional state emerges from the affective experience of the new parents toward their infant and their parental role.
3. Individualization—Parents are also aware of the need to differentiate the infant's needs from themselves, to recognize and respond appropriately, making the attachment process also, in some way, one of detachment.

Reciprocity

Reciprocity is the process by which the infant's capabilities and behavioral characteristics elicit parental response. Reciprocity is described by two dimensions: complementary behavior and sensitivity. Complementary behavior recognizes taking turns and stopping when the other is not interested or becomes tired. An infant can coo and stare at the parent to elicit a similar parenteral response to complement their behavior. Parents who are sensitive and responsive to their infant's cues will promote their development and growth. Parents who develop sensitivity in recognizing the particular ways by which the infant communicates will respond appropriately by smiling, vocalizing, touching, and kissing.

Commitment

Commitment refers to the enduring nature of the attachment relationship. The components of this are twofold: centrality and parent role exploration. In centrality, parents place the infant at the center of their lives. They acknowledge and accept their responsibility to promote the infant's safety, growth, and development. Parent role exploration describes the ability of the parents to find their own way and integrate the parental identity into themselves and their life.

Positive and Negative Attachment Behaviors

Nurses can be very instrumental in facilitating attachment by assessing newborns and parents for attachment behaviors (positive and negative), ultimately intervening appropriately to promote and enhance attachment. Some signs of positive bonding behaviors include maintaining close physical contact; making eye-to-eye contact; speaking in soft, high-pitched tones; and touching and exploring the infant. Table 16-1 highlights typical positive and negative behaviors of attachment.

Nurses must be astute when assessing family units to identify any discord that might interfere with the attachment process. Cultural differences also must be considered because they can significantly influence the relationship between bonding and attachment behavior and affective perception. Recognize that mothers from different cultures may behave in ways that differ from what is expected in one's own culture. Negative labels may be inadvertently attached by health care providers to mothers who assume behavior that is different.

For example, Native American mothers tend to handle their newborns less often and use cradle boards to carry them. Native American mothers and many Asian-American mothers delay breast-feeding until their milk comes in, because colostrum is considered harmful for the newborn (Bowers, 2003). The culturally sensitive nurse needs to understand their sociocultural needs and not label different behavior as negative.

Nursing Interventions

In the health care arena today, "less is more," and this applies to hospital stays. If the woman had a vaginal delivery, she may receive up to 48 hours of continuous nursing care after birth before being discharged. If she experienced a cesarean birth, the woman may remain hospitalized from 72 to 96 hours. This shortened stay leaves little time for nurses to prepare the woman and her family for the many changes that are occurring and will occur as she returns home. Nurses need to use this limited time to address areas of pain and discomfort, immunizations, nutrition, activity and exercise, lactation, discharge teaching, sexuality and contraception, and follow-up (see Nursing Care Plan 16-1). Always adhere to standard precautions when providing direct care to reduce the risk of disease transmission.

Promoting Comfort

The postpartum woman may experience discomfort and pain from a variety of sources, such as an episiotomy,

Table 16-1 Positive and Negative Attachment Behaviors

	Positive Behaviors	Negative Behaviors
Infant	Smiles; is alert visually; demonstrates strong grasp reflex to hold parent finger; sucks well, feeds easily; enjoys being held close; makes eye-to-eye contact; follows parent's face; appears facially appealing; is consolable when crying	Feeds poorly, regurgitates often; cries for long periods, colicky and inconsolable; shows flat affect, rarely smiles even when prompted; resists holding and closeness; sleeps with eyes closed most of time; stiffens body when held; is unresponsive to parenting; shows inattention to parental faces
Parent	Makes direct eye contact; assumes en face position when holding infant; claims infant as family member, pointing out commonalities; expresses pride in infant; assigns meaning to infant's actions; smiles and gazes at infant; touches infant, progressing from fingertips to holding; names infant; requests to be close to infant as much as allowed; speaks positively about infant	Expresses disappointment or displeasure in infant; fails to "explore" visually or physically their infant; fails to "claim" infant into family unit; avoids caring for infant; finds excuses not to hold infant close; has negative self-concept; appears disinterested in having infant in room; requests frequently to have infant taken back to nursery to be cared for; assigns negative attributes to infant and calls infant inappropriate, negative names (e.g., frog, monkey, tadpole)

Sources: Ayers, 2003; Klaus & Kennel, 1982; Sameroff, McDonough, & Rosenblum, 2003; Sears & Sears, 2001.

Nursing Care Plan 16-1

Overview of the Postpartum Woman

Belinda, a 26-year-old gravida 2, para 2 (G2,P2) is a patient on the mother–baby unit after giving birth to a term 8-lb 12-oz baby boy yesterday. The night nurse reports that she has an episiotomy, complains of a pain rating of 7 points on a scale of 1 to 10 points, is having difficulty breast-feeding, and had heavy lochia most of the night. The nurse also reports that the patient seems focused on her own needs and not on her infant. Assessment this morning reveals the following:

B: Breasts are soft with colostrum leaking; nipples cracked
U: Uterus is one finger breath below the umbilicus; deviated to right
B: Bladder is palpable; patient states she hasn't been up to void yet
B: Bowels have not moved; bowel sounds present; passing flatus
L: Lochia is moderate; peripad soaked from night accumulation
E: Episiotomy site intact; swollen, bruised; hemorrhoids present
—
H: Homans' sign negative; no edema over tibia
E: Emotional status is "distressed" as a result of discomfort and fatigue

Nursing Diagnosis: Impaired tissue integrity related to episiotomy

Outcome identification and *evaluation*	Interventions with *rationales*
The woman remains free of infection, *without any signs and symptoms of infection,* and exhibits evidence of progressive healing as demonstrated *by clean, dry, intact episiotomy site.*	Monitor episiotomy site *for redness, edema, and signs of infection.* Assess vital signs at least every 4 hours *to identify possible changes suggesting infection.* Apply ice pack to episiotomy site *to reduce swelling.* Instruct patient on use of sitz bath *to promote healing, hygiene, and comfort.* Encourage frequent perineal care and peripad changing *to prevent infection.* Recommend ambulation *to improve circulation and promote healing.* Instruct patient on positioning *to relieve pressure on perineal area.* Demonstrate use of anesthetic sprays *to numb perineal area.*

Nursing Diagnosis: Pain related to episiotomy, sore nipples and hemorrhoids

The woman experiences a decrease in pain, *reporting that her pain has diminished to a tolerable level, rating it as 2 points or less.*	Thoroughly visually inspect perineum *to rule out hematoma as cause of pain.* Administer analgesic medication as ordered as needed *to promote comfort.* Carry out comfort measures to episiotomy as outlined earlier *to help in reducing pain.* Offer an explanation of discomforts and reassure they are time limited *to assist in coping with pain.* Apply tucks to swollen hemorrhoids *to induce shrinkage and reduce pain.* Suggest use of sitz bath frequently *to assist in reducing hemorrhoid pain.* Administer stool softener and laxative *to prevent straining with first bowel movement.*

Overview of the Postpartum Woman (continued)

Outcome identification and *evaluation*	Interventions with *rationales*
	Observe positioning and latching-on technique while breast-feeding. Offer suggestions based on observation to correct positioning/latching *to minimize trauma to the breast.*
	Suggest air-drying of nipples after breast-feeding and use of plain water *to prevent nipple cracking.*
	Teach relaxation techniques when breast-feeding *to help reduce anxiety and discomfort level.*
Nursing Diagnosis: Risk for ineffective coping related to mood alteration and pain	
The woman copes with mood alterations, *as evidenced by positive statements about newborn and participation in newborn care.*	Provide a supportive, nurturing environment and encourage the mother to vent her feelings and frustrations *to assist in relieving anxiety.*
	Provide opportunities for the mother to rest and sleep *to combat fatigue.*
	Encourage consumption of a well-balanced diet *to increase the mother's energy level.*
	Provide reassurance and explanations that mood alterations are common after birth secondary to waning hormones after pregnancy *to increase the mother's knowledge base.*
	Allow the mother relief from newborn care *to afford opportunity for self-care.*
	Discuss with partner expected behavior from mother and how additional support and help are needed during this stressful time *to promote partner participation in care.*
	Make appropriate community referral to continue mother–infant support *to ensure continuity of care.*
	Encourage frequent skin-to-skin contact and closeness between mother and infant *to facilitate bonding and attachment behaviors.*
	Encourage participation in infant care and provide instruction as needed *to foster a sense of independence and self-esteem.*
	Offer praise and reinforcement of positive mother–infant interactions *to enhance self-confidence in care.*

perineal lacerations, an edematous perineum, inflamed hemorrhoids, engorged breasts, and sore nipples if breast-feeding. Nonpharmacologic and pharmacologic measures can be used.

Applications of Cold and Heat

Commonly, an *ice pack* is the first measure used after a vaginal birth to provide perineal comfort from edema, an episiotomy, or laceration. It is applied during the fourth stage of labor and can be used for the first 24 hours to reduce perineal edema and to prevent hematoma formation, thus reducing pain and promoting healing. Ice packs are wrapped in a disposable covering or clean washcloth and are applied to the perineal area. Usually the ice pack is applied for 20 minutes and removed for 10 minutes. Many commercially prepared ice packs are available, but a latex glove filled with crushed ice and covered can also be used if the mother is not allergic to latex. Ensure that the ice pack is changed frequently to promote good hygiene and to allow for periodic assessments.

The **peribottle** is a plastic squeeze bottle filled with warm tap water that is sprayed over the perineal area after each voiding and before applying a new perineal pad. Usually the peribottle is introduced to the woman when she is assisted to the bathroom to freshen up and void for the first time—in most instances, once vital signs are stable after the first hour. Provide the woman with instructions on how and when to use the peribottle. Reinforce this practice each time she changes her pad, voids, or defecates, making sure that she understands to direct the flow of water from front to back. The peribottle will accompany the woman home to be used over the next several weeks until her lochia discharge stops. The peribottle is used by women who had vaginal and cesarean births to provide comfort and hygiene to the perineal area.

After the first 24 hours, a sitz bath with warm water may be prescribed and substituted for the ice pack to reduce local swelling and promote comfort for an episiotomy, perineal trauma, or inflamed hemorrhoids. The change from cold to warm therapy enhances vascular circulation and healing (Littleton & Engebretson, 2005). Prior to using a sitz bath, the woman should cleanse the perineum with a peribottle or take a shower using mild soap.

Most health care agencies use plastic disposable sitz baths that women can take home when they are discharged. The plastic sitz bath consists of a basin that fits on the commode with a bag filled with warm water hung on a hook connected via a tube onto the front of the basin (Fig. 16-8). Teaching Guidelines 16-1 highlights the steps for teaching a woman how to use a sitz bath.

● Figure 16-8 Sitz bath set up.

TEACHING GUIDELINES 16-1

Using a Sitz Bath

1. Close clamp on the tubing prior to filling bag with water to prevent leakage.
2. Fill the sitz bath basin and plastic bag with warm water (comfortable to touch).
3. Place the filled basin on the toilet with the seat raised and the overflow opening facing toward the back of the toilet.
4. Hang the filled plastic bag on a hook close to the toilet or an IV pole.
5. Attach the tubing into the opening on the basin.
6. Sit on the basin positioned on the toilet seat and release the clamp to allow warm water to irrigate the perineum.
7. Remain sitting atop the basin for approximately 15 to 20 minutes.
8. Stand up and pat the perineum area dry and then apply a clean peripad when finished.
9. Tip the basin to remove any remaining water in it and flush the toilet.
10. Wash the basin with warm water and soap, and dry in the sink after finishing.
11. Store basin and tubing in a clean, dry area until the next use.
12. Wash hands with soap and water when finished with the sitz bath.

Advise the woman to repeat this treatment several times daily to provide hygiene and comfort to the perineal area. Also, encourage the woman to continue this measure after discharge from the healthcare facility.

Some facilities have hygienic sitz baths called *Suri-Gators* in the bathroom that spray an antiseptic, water, or both onto the perineum. The woman sits on the toilet with legs apart so that the nozzle spray reaches her perineal area.

Keep in mind that tremendous hemodynamic changes are taking place within the mother during this early postpartum period and her safety must be a priority. Fatigue, blood loss, effects of medications, and lack of food may contribute to a woman's weakness when standing up. Assisting the woman to the bathroom to instruct her on how to use the peribottle and sitz bath is necessary to ensure her safety. Many women become lightheaded or dizzy on arising from their beds and need direct physical assistance to carry out their task. Staying in the woman's room, ensuring that the emergency call light is readily available, and being available if needed during this early period will ensure safety and prevent accidents and falls.

Topical Preparations

Several treatments may be applied topically for temporary relief of pain and discomfort. One such treatment used for

temporary pain relief consists of local anesthetic sprays such as Dermoplast or Americaine. These agents numb the perineal area. They are used after cleansing the perineal area with water via the peribottle and/or a sitz bath.

For hemorrhoid discomfort, cool witch hazel pads, such as Tucks Pads, can be used. The pads are placed at the rectal area, between the hemorrhoids and the perineal pad. These pads cool the area, help relieve swelling, and minimize itching.

Analgesics

Analgesics such as acetaminophen (Tylenol) and oral nonsteroidal antiinflammatory drugs (NSAIDS) such as ibuprofen (Motrin) are prescribed to relieve mild postpartum discomfort. For moderate to more severe pain, a narcotic analgesic such as codeine or oxycodone in conjunction with aspirin or acetaminophen may be prescribed. Instruct the client about possible side effects of any medication prescribed. Common side effects of oral analgesics include dizziness, lightheadedness, nausea and vomiting, constipation, and sedation (Spratto & Woods, 2005).

Also, inform the client that the drugs are secreted in breast milk. Nearly all medications that the mother takes are passed into her breast milk; however, the mild analgesics (e.g., acetaminophen or ibuprofen) are considered relatively safe for breast-feeding mothers (American Academy of Pediatrics Committee on Drugs, 2001). Administering a mild analgesic approximately an hour before breast-feeding will usually promote comfort.

Assisting with Elimination

The bladder is edematous, hypotonic, and congested immediately postpartum. Consequently, bladder distention, incomplete emptying, and inability to void are common. A full bladder interferes with uterine contraction and may lead to hemorrhage, because it will displace the uterus out of the midline. Encourage the woman to void. Often, assisting her to assume the normal voiding position on the commode facilitates this. If the woman experiences difficulty with voiding, pouring warm water over the perineal area, hearing the sound of running tap water such as in the sink, blowing bubbles through a straw, standing in the shower with warm water turned on, drinking fluids, or placing her hand in a basin of warm water may be helpful to stimulate voiding. If these therapeutic actions are unsuccessful in stimulating urination within 4 to 6 hours after giving birth, catheterization may be needed. Palpate the bladder for distension and question the woman about voiding in small amounts (<100 mL) frequently (retention with overflow). If catheterization is necessary, be sure to use sterile technique during this procedure to reduce the risk of infection.

Intestinal motility can be affected by several factors, predisposing the woman to constipation. These factors may include decreased bowel motility during labor, high iron content in prenatal vitamins, postpartum fluid loss, and side effects of pain medications and/or anesthesia. In addition, the woman may fear that bowel movements will cause pain or injury, especially if she has an episiotomy or has sustained a laceration that was repaired with sutures.

Usually a stool softener, such as docusate (Colace), with or without a laxative might prove helpful if the client experiences difficulty with bowel elimination. Other measures such as ambulating and increasing fluid and fiber intake may be helpful. Nutritional instruction might include increasing fruits and vegetables in diet; drinking plenty of fluids (8–12 cups) to keep the stool soft; drinking small amounts of prune juice and/or hot liquids to stimulate peristalsis; eating high-fiber foods such as bran cereals, whole grains, dried fruits, fresh fruits, and raw vegetables; and walking daily.

Promoting Activity, Rest, and Exercise

The postpartum period is an ideal time for nurses to promote the importance of physical fitness, help women incorporate exercise into their lifestyle, and encourage them to overcome barriers to exercise. Lifestyle changes that occur postpartum may affect a woman's health for decades. Early ambulation is encouraged to reduce the risk of thromboembolism and improve strengthening.

Many changes occur postpartum. Responsibility for a newborn alters eating and sleeping habits, work schedules, and time allocation. Postpartum fatigue is common during the early days after childbirth and it may continue for weeks or months (Troy, 2003). It affects the mother's relationships with significant others and her ability to fulfill household and child care responsibilities. Be sure that the mother recognizes her need for rest and sleep, and be realistic about her expectations. Some suggestions include the following:

- Nap when the infant is sleeping because uninterrupted sleep at night is altered.
- Reduce participation in outside activities and limit the number of visitors.
- Determine the infant's sleep–wake cycles and attempt to increase wakeful periods during the day so longer sleep stretches occur during the night hours.
- Stress the need for a balanced diet to promote healing and to increase energy levels.
- Encourage sharing household tasks to conserve the woman's energy.
- Request the father or other family members provide infant care during the night periodically to provide the mother an uninterrupted night of sleep.
- Review the family's daily routine to ascertain if clustering of activities might be helpful in conserving energy and promoting rest.

The demands of parenthood may reduce or prevent exercise in even the most committed person. Emphasize the benefits of a regular exercise program, which include

- Helping with loss of weight gained during the pregnancy
- Increasing energy level to help cope with new responsibilities
- Providing an outlet for stress
- Speeding the return to prepregnant size and shape (Ringdahl, 2002a)

More than one third of US women are overweight (CDC, 2003). Although the average gestational weight gain is small (approximately 25–35 lb), excess weight gain and failure to lose weight after pregnancy are important and identifiable predictors of long-term obesity. Breast-feeding and exercise may be beneficial to control long-term weight (Rooney & Schauberger, 2002).

Women who have not returned to their prepregnant weight by 6 months are likely to retain the extra weight long term (Ringdahl, 2002b). Encourage women to lose their pregnancy weight by 6 months postpartum, and refer those who fail to lose the weight they gained during pregnancy to community weight-loss programs.

The postpartum woman may face some obstacles to exercise for losing weight, including physical changes (ligament laxity), competing demands (newborn care), lack of information about weight retention (inactivity equates to weight gain), and stress incontinence (leaking of urine during activity).

A healthy woman with an uncomplicated vaginal birth can resume exercise in the immediate postpartum period. Advise the woman to start slowly and build the level of exercise over a period of several weeks as tolerated. Jogging strollers may be an option for some women, allowing them to exercise with their newborns. Also, exercise videos and home exercise equipment allow mothers to work out while the newborn naps.

To help facilitate the recovery process, women are encouraged to exercise after giving birth to promote feelings of well-being and to restore muscle tone lost during pregnancy. Routine exercise should be resumed gradually, beginning with **Kegel exercises** on the first postpartum day and, by the second week, progressing to abdominal, buttock, and thigh-toning exercises (Jeffreys & Nordahl, 2002). Walking is an excellent form of exercise as long as jarring and bouncing movements are avoided during this early period because joints do not stabilize until 6 to 8 weeks postpartum. Exercising too much too soon can cause the woman to bleed more and return her lochia color to bright red.

Recommended exercises for the first few weeks postpartum include abdominal breathing (expand the abdomen by inhaling through the nose and contract the abdominal muscles when exhaling slowly), head lifts (exhale while lifting the head off the floor onto the chest, hold for a few seconds and then relax), modified sit-ups (raise head and shoulders off the floor so that the hands reach the knees, while keeping waist on the floor), double knee roll (while lying flat on the floor with knees bent, roll knees to one side and then roll to the other side), and pelvic tilt (while lying on back, roll pelvis back by flattening the lower back on the floor; tighten buttocks and hold briefly). The number of exercises and their duration is gradually increased as strength is gained. Teaching Guidelines 16-2 highlights the steps for each of these exercises.

Be cognizant of the various cultures' attitudes regarding exercise, because some cultures (e.g., Haitian, Arab-American, and Mexican) have new mothers observe a specific period of bed rest or activity restriction; thus, active exercise would be inappropriate to discuss during the early postpartum period (Moore & Moos, 2003).

Fifty percent of all parous women develop some degree of pelvic prolapse in their lifetime that is associated with stress incontinence (McCrink, 2003). The more vaginal deliveries a woman has had, the more likely she is to have stress incontinence. Stress incontinence can occur with any activity that causes an increase in intraabdominal pressure. Postpartal women might consider alternate low-impact activities (such as walking, biking, swimming, or low-impact aerobics) so they can resume physical activity while strengthening the pelvic floor.

Kegel exercises help to strengthen the pelvic floor muscles if done with enough frequency or regularity. Kegel exercises were originally developed by Dr. Arnold Kegel as a method of controlling incontinence in women after childbirth. The principle behind these exercises is to strengthen the muscle of the pelvic floor, thus improving the urethral sphincter function. The success of Kegel exercises depends on proper technique and adherence to a regular exercise program (Gray, 2004).

Kegel exercises can be done inconspicuously. Therefore, advise women to perform these exercises, doing ten 5-second contractions, whenever they change diapers, talk on the phone, or watch TV. Teach the woman to perform Kegel's exercises properly and assist her to identify the correct muscles by trying to stop and start the flow of urine when sitting on the toilet (Teaching Guidelines 16-3). By doing these exercises frequently, many women can strengthen their pelvic floor muscles and prevent stress incontinence.

Use the opportunity during postpartum care to instruct women on primary prevention of stress incontinence by discussing the value and purpose of Kegel exercises. Approach the subject sensitively, avoiding the term *incontinent.* The terms *leakage*, *loss of urine*, or *bladder control issues* are more acceptable to most women. When properly performed, Kegel exercises have been effective in preventing or improving urinary continence (Shaw, 2004).

Assisting With Self-Care Measures

Demonstrate and discuss with the woman hygienic measures that prevent infection during the postpartum period. Because she may experience lochia drainage for as long as a month after childbirth, advising her of practices that

TEACHING GUIDELINES 16-2

Exercising

Abdominal Breathing

1. While lying on a flat surface (floor or bed), take a deep breath through your nose and expand your abdominal muscles (they will rise up from your midsection).
2. Slowly exhale and tighten your abdominal muscles for 3 to 5 seconds.
3. Repeat this several times to build up progressively.

Head Lift

1. Lie on a flat surface with knees flexed and feet flat on the surface.
2. Lift your head off the flat surface, tuck it onto your chest, and hold for 3 to 5 seconds.
3. Relax your head and return to the starting position.
4. Repeat this several times, building up frequency slowly.

Modified Sit-Ups

1. Lie on a flat surface and raise your head and shoulders off of the flat surface (6 to 8 inches high) so that your outstretched hands reach your knees.
2. Keep your waist on the flat surface while performing this exercise.
3. Slowly return to the flat surface to the starting position.
4. Repeat this maneuver and increase in frequency as comfort level allows.

Double Knee Roll

1. Lie on a flat surface with your knees bent.
2. While keeping your shoulders flat, slowly roll your knees to your right side to touch the flat surface (floor or bed).
3. Roll knees back over your body to the left side until they touch the opposite side of the flat surface.
4. Return to the starting position on your back and rest.
5. Repeat this exercise several times, building up frequency progressively.

Pelvic Tilt

1. Lie on your back with your knees bent and your arms at your side on a flat surface.
2. Slowly contract your abdominal muscles while lifting your pelvis up toward the ceiling.
3. Hold for 3 to 5 seconds and slowly return to your starting position of lying flat.
4. Repeat this maneuver several times with progressive frequency over time.

will promote her well-being and healing also need to be stressed. These measures include

- Frequent changing of perineal pads, applying and removing them from front to back to prevent contamination from the rectal area to the genital area
- Avoiding the use of tampons after giving birth to decrease the risk of infection
- Showering once or twice daily using a mild soap, and avoiding soap on nipples
- Using a sitz bath after every bowel movement to cleanse the rectal area and provide relief from enlarged hemorrhoids
- Using the peribottle filled with warm water after urinating and prior to applying a new perineal pad
- Avoiding tub baths for 4 to 6 weeks to prevent falls until joints and balance are restored
- Washing hands prior to changing perineal pads, after disposing of previous lochia-soaked pad, and after voiding (Fong & Grant, 2005)

To reduce risk of infection at the episiotomy site, reinforce proper perineal care with the client, showing her how to rinse her perineum with the peribottle filled with water after she voids or defecates. Stress the importance of always wiping gently from front to back and washing hands thoroughly before and after perineal care. For hemorrhoids, have the client apply witch hazel-soaked pads (Tucks Pads), ice packs to relieve swelling, or hemorrhoidal cream or ointment if ordered.

Ensuring Safety

One of the safety concerns during the postpartum period is orthostatic hypotension. When the woman changes from a lying or sitting position to a standing one rapidly, her blood pressure can suddenly drop, causing her pulse rate to increase. Subsequently, she may experience dizziness and may faint. Be aware of this potential problem and initiate the following safeguards:

- Check blood pressure first before ambulating client.
- Elevate head of bed for a few minutes before ambulating client.
- Have the client sit on the side of the bed for a few moments before rising.
- Help the client to stand up and stay with her.
- Ambulate alongside the client and provide support.
- Frequently question the client about how her head feels.
- Stay close by to assist if she feels lightheaded suddenly.

Additional safety topics to address concern infant safety within the postpartum room. Instruct the woman to place the newborn back in the open crib on his/her back close to her bedside if she is feeling sleepy or tired.

TEACHING GUIDELINES 16-3

Performing Kegel Exercises

1. Identify the correct pelvic floor muscles by contracting them to stop the flow of urine while sitting on the toilet.
2. Repeat this action of contraction several times to become familiar with it.
3. Start the exercises by emptying the bladder.
4. Tighten the pelvic floor muscles and hold for a count of 10 seconds.
5. Relax the muscle completely for a count of 10 seconds.
6. Perform 10 exercises at least three times daily and progressively increase.
7. Perform the exercises in different positions, such as standing, lying, and sitting.
8. Keep breathing during the exercises.
9. Don't contract the abdominal, thigh, leg, or buttocks muscles during these exercises.
10. Relax while doing Kegel exercises and concentrate on isolating the right muscles.
11. Attempt to tighten the pelvic muscles before sneezing, jumping, or laughing to protect them from additional laxness.
12. Be aware that you can perform Kegel exercises anywhere and in any place without anyone noticing.

Holding the infant and falling asleep might increase the risk of accidental falling from the bed. Providing for the infant's safety by placing him or her back in the open crib will ensure there are no injuries.

Counseling About Sexuality and Contraception

Sexuality is an important and integral part of every woman's life. Despite the importance of sexuality in their lives, many women find it difficult to talk to their health-care provider about concerns. Questions and concerns about sexuality span a woman's entire lifetime.

During postpartum, many women experience fatigue, weakness, vaginal bleeding, perineal discomfort, hemorrhoids, sore breasts, decreased vaginal lubrication resulting from low estrogen levels, and dyspareunia. Women may be hesitant to resume sexual relations for a variety of factors. The physical demands made by the new infant and the stress of new parental roles, responsibilities, and fatigue place particular demands on the emotional reserves of couples. Men may feel they now have a secondary role within the family, and they may lack understanding of their partner's daily routine. These issues, combined with the woman's increased investment in the mothering role, can pose some difficulties with the sexual relationship. Parenthood, at times, allows limited privacy and little rest, both of which are necessary for sexual pleasure (Fogel, 2003). Women want to get back to "normal" as soon as possible after giving birth. However, sexual relations cannot be isolated from the psychological and psychosocial adjustments that are needed by both partners.

Although couples are reluctant to ask, they often want to know when they can safely resume sexual intercourse after childbirth. Typically, sexual intercourse can be resumed once bright-red bleeding has stopped and the perineum is healed from an episiotomy or lacerations. This is usually by the third to the sixth week postpartum. However, there is not a set, prescribed time to resume sexual intercourse after childbirth. Each couple must set their own time frame when they feel it is appropriate to resume sexual intercourse.

When counseling the couple about sexuality, determine what knowledge and concerns the couple has about their sexual relationship. Initiate a discussion of the normality of fluctuations of sexual interest as part of discharge planning. Also inform the couple about what to expect when resuming sexual intercourse and how to prevent any discomfort. Precoital vaginal lubrication may be impaired during the postpartum period, especially in women who are breast-feeding. Use of water-based gel lubricants (KY jelly, Astroglide) can be helpful. Information on pelvic floor exercises to enhance sensation may be beneficial.

Contraceptive options are included in the discussions with the couple so that they can make an informed decision before resuming sexual activity. Many couples are overwhelmed with the amount of new information given to them during their brief hospitalization. Many are not ready for a lengthy discussion about contraceptives. Presenting a brief overview of the various options along with written literature may be appropriate. It may be suitable to ask them to think about contraceptive needs and preferences, and advise them to use a barrier method (condom with spermicidal gel or foam) until another form of contraceptive is chosen. This advice is especially important if the follow-up appointment will not occur for 4 to 6 weeks after childbirth. Many couples will resume sexual activity prior to their postpartum checkup appointment, and may become pregnant before the return of the woman's menses. In addition, some women ovulate before their menstrual period returns and thus need contraceptive protection to prevent pregnancy.

Open and effective communication is necessary for effective contraceptive counseling so that information is clearly understood. Provide clear, consistent information appropriate to the woman and her partner's language, culture, and educational level. Only then can the best contraceptive method to be selected (Niedrach & Foster, 2003).

Promoting Nutrition

For the new mother, the postpartum period may be quite stressful for a myriad reasons, such as the physical stress of pregnancy and birth, the required caregiving tasks associated with the newborn, meeting the needs of other family

members, and fatigue. As a result, the new mother may ignore her own needs for health and nutrition. Whether breast-feeding or bottle feeding, encourage the new mother to take good care of herself and eat a healthy diet so that nutrients lost during pregnancy can be replaced and she can return to a healthy weight. In general, nutrition recommendations for the postpartum woman include the following:

- Eating a wide variety of foods with high nutrient density
- Using foods and recipes that require little or no preparation
- Avoiding high-fat fast foods
- Drinking plenty of fluids daily—at least 2500 mL (approximately 84 oz)
- Avoiding fad weight reduction diets and harmful substances such as alcohol, tobacco, and drugs
- Avoiding excessive intake of fat, salt, sugar, and caffeine
- Eating the recommended daily servings from each food group (Box 16-4)

Nutritional needs for mothers who choose to breast-feed are greater throughout pregnancy. Maternal diet and nutritional status influence the quantity and quality of breast milk. To meet the needs for milk production, the woman's nutritional needs increase as follows:

- Calories: +500 cal/day for the first and second 6 months of lactation
- Protein: +20 g/day, adding an extra 2 cups of skim milk
- Calcium: +400 mg daily—consumption of four or more servings of milk
- Fluid: +2 to 3 quarts of fluids daily (milk, juice or water); no sodas

Certain foods (usually gaseous or strong-flavored ones) eaten by the mother may affect the flavor of the breast milk or cause GI problems for the infant. Not all infants are affected by the same foods. If the particular food item seems to cause a problem, urge the mother to eliminate that food for a few days to determine whether the problem disappears.

During the woman's brief stay in the health care facility, she may demonstrate a healthy appetite and eat well. The nutritional concern usually starts at home when mothers need to make their own food selections and prepare their own meals. This is a crucial area to address on follow-up.

BOX 16-4

NUTRITIONAL RECOMMENDATIONS FOR NUTRITION DURING THE POSTPARTUM PERIOD

General Dietary Guidelines for Americans From the Food Guide Pyramid

- Breads, grains, and cereals: 6 to 11 servings
- Fruits: 2 to 4 servings
- Vegetables: 3 to 5 servings
- Protein foods: 2 to 3 servings (3 servings for lactating women)
- Milk products: 2 to 3 servings
- Fats, oils, and sweets: use sparingly (USDA & USDHHS, 2005)

Recommendations for the Lactating Woman From the Food Guide Pyramid

- Fruits: 4 servings
- Vegetables: 4 servings
- Milk: 4 to 5 servings
- Bread, cereal, pasta: 12 or more servings
- Meat, poultry, fish, eggs: 7 servings
- Fats, oils, and sweets: 5 servings (Dudek, 2006)

Support for Choice of Feeding Method

Many factors influence a woman's choice of feeding method such as culture, employment demands, support from significant other and family, and knowledge base. Although breast-feeding is encouraged, be sure that couples have the necessary information to make an informed decision. Whether a couple chooses to breast-feed or bottle feed the newborn, support and respect their choice.

Keep in mind that although breast-feeding is advocated for newborn and infant health, there are certain situations in which it should be avoided. These would include women taking drugs, such as antithyroid drugs, antineoplastic drugs, alcohol, or street drugs (amphetamines, cocaine, PCP, marijuana), that would enter the breast milk and harm the infant. Women who are HIV positive are cautioned not to breast-feed to prevent postnatal HIV transmission to their newborn. Other contraindications to breast-feeding would include a newborn with an inborn error of metabolism such as galactosemia or PKU and a current pregnancy or a serious mental health disorder that would preclude the mother from remembering to feed the infant consistently.

Feeding Assistance

First-time mothers often have many questions and concerns about feeding. Even women who have had experience with feeding, too, may have questions. Thus, regardless of whether the woman is breast-feeding or bottle feeding her newborn, the postpartum woman can benefit from instruction.

Education About Bottle Feeding

Nutritional needs of infants vary based on gestational age, metabolic state, and physiologic complications. Estimated energy requirements for full-term infants range from 100 to 115 kcal/kg/day at 1 month to approximately 85 to 95 kcal/kg/day from 6 to 9 months of age (Gregory, 2005). Commercial formulas and breast milk both typically provide 20 cal/oz. Commercial formulas are classified as milk based (SMA, Enfamil, Similac), elemental (for infants with

protein allergies), or soy based (Isomil, Nursoy). Newborns need about 108 cal/kg or approximately 650 cal/day (Dudek, 2006). Commercial formulas can be purchased in various forms: powdered (must be mixed with water), condensed liquid (must be diluted with equal amounts of water), ready to use (poured directly into bottles), and prepackaged (ready to use in disposable bottles). Until about age 4 months, most infants need six feedings a day. After this period, the number of feedings declines to accommodate other foods (fruits, cereals, vegetables) introduced to the infant's diet (Engstrom, 2004). For more information on newborn nutrition, see Chapter 18.

Suggestions for mothers about bottle feeding are highlighted in Teaching Guidelines 16-4.

Education About Breast-Feeding

The American Academy of Pediatrics (AAP) advocates breast-feeding for all full-term newborns, maintaining that, ideally, breast milk should be the sole nutrient for the first 6 to 12 months of life (Sloane, 2002). Educating a mother about breast-feeding will increase the likelihood of a successful breast-feeding experience. At birth, all newborns should be quickly dried, assessed, and, if stable, placed immediately in uninterrupted skin-to-skin contact (kangaroo care) with their mother. This is good practice whether the mother is going to breast-feed or bottle feed her infant. Kangaroo care provides the newborn optimal physiologic stability, warmth, and opportunities for the first feed (Kirsten, Bergman, & Hann, 2001).

TEACHING GUIDELINES 16-4

Bottle Feeding

1. Make feeding a relaxing time—a time to provide both food and comfort to your newborn.
2. Always hold the newborn when feeding.
3. Use a comfortable position when feeding the newborn.
   a. Place the newborn in your dominant arm, which is supported by a pillow.
   b. Have the newborn in a semi-upright feeding position supported in the crook of your arm (this position reduces choking and the flow of milk into the middle ear).
4. Tilt the bottle so that the nipple and the neck of the bottle are always filled with formula. (This prevents the infant from taking in too much air.)
5. Refrigerate any formula combined with tap water once it is mixed.
6. Discard any formula not taken; do not keep it for future feedings.
7. Burp the infant frequently and place on back or side for sleeping.
8. Use only iron-fortified infant formula for first year (Youngkin et al., 2004).

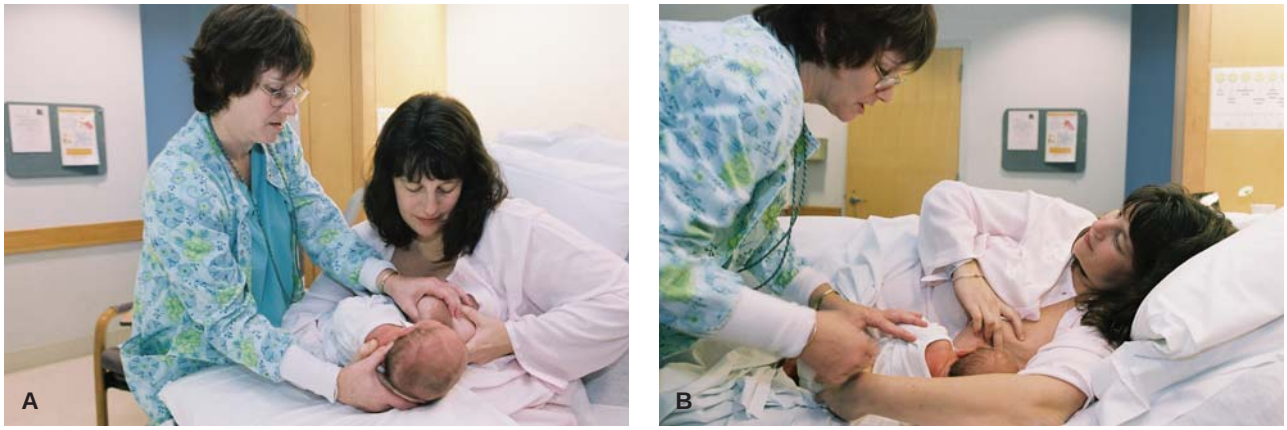
The benefits of breast-feeding are clear (see Chapter 18). To promote breast-feeding, the Baby-Friendly Hospital Initiative, an international program of the World Health Organization and the United Nations Children's Fund, was started in 1991. Based on this program, the hospital or birth center must take steps to provide "an optimal environment for the promotion, protection, and support of breast-feeding." These steps are based on the program's Ten Steps to Successful Breast-feeding as follows:

1. Have a written breast-feeding policy that is communicated to all staff.
2. Educate all staff to implement this written policy.
3. Inform all women about the benefits and management of breast-feeding.
4. Show all mothers how to initiate breast-feeding within 30 minutes of birth.
5. Give no food or drink other than breast milk to all newborns.
6. Demonstrate to all mothers how to breast-feed and maintain it.
7. Encourage breast-feeding on demand.
8. Allow no pacifiers to be given to breast-feeding infants.
9. Establish breast-feeding support groups and refer mothers to them.
10. Practice rooming-in 24 hours daily (Yawman, 2003).

Thus the nurse is responsible for encouraging breast-feeding when appropriate. For the woman who chooses to breast-feed her infant, the nurse or lactation consultant will need to spend time instructing her how to do so successfully. Many women have the impression that breast-feeding is simple with the readily available equipment and supplies. Although it is a natural process, women may experience some difficulty in breast-feeding their newborns. Nurses can assist mothers in smoothing out this transition.

Assist and provide one-to-one instruction to breast-feeding mothers, especially first-time breast-feeding mothers to ensure correct technique:

- Offer a thorough explanation about the procedure involved.
- Instruct the mother to wash her hands prior to starting.
- Inform her that her afterpains will increase during breast-feeding.
- Show her different positions, such as cradle and football holds and side-lying positions (Fig. 16-9).
- Explain that breast-feeding is a learned skill for both parties.
- Make sure the mother is comfortable (pain free) and not hungry.
- Tell the mother to start the feeding with an awake and alert infant showing hunger signs.
- Assist the mother to position herself correctly for comfort.
- Urge the mother to relax to encourage the let-down reflex.



● Figure 16-9 Positions for breast-feeding. (**A**) Cradle hold; (**B**) lying down.

- Guide the mother's hand to form a "C" or "V" to access the nipple.
- Demonstrate stroking the infant's cheek to initiate sucking.
- Help her to elicit latching-on by inserting the nipple into infant's mouth.
- Show her how to check that the newborn's mouth position is correct and tell her to listen for a sucking noise.
- Demonstrate removal from the breast using a finder to break the suction.
- Instruct the mother on how to burp the infant between breasts.
- Reinforce and praise the mother for her efforts.
- Allow ample time to answer questions and address concerns.
- Refer the mother to support groups and community resources.

Reassuring mothers that some infants "latch on and catch on" right away, and some take more time and patience is important to help reduce their feelings of frustration and uncertainty about their ability. Tell them they need to believe in themselves and their ability to accomplish this task. Inform them not to panic if breast-feeding does not go smoothly at first; it takes time and practice.

Additional suggestions for mothers to help them relax and feel more comfortable breast-feeding, especially when the mother and newborn return home, include the following:

- Select a quiet corner or room where you won't be disturbed.
- Use of a rocking chair will soothe both you and your infant.
- Take long, slow deep breaths to help increase relaxation prior to nursing.
- Drink fluids during each breast-feeding session to replenish body fluids.
- Listen to soothing music during breast-feeding sessions.
- Cuddle and caress the infant during each breast-feeding time.
- Set out extra cloth diapers within reach to use as burping cloths.
- Allow sufficient time to enjoy each other in an unhurried atmosphere.
- Involve other family members in all aspects of the infant's care from the start.

Breast Care

Regardless of whether the mother is nursing, urge her to wear a very supportive, snug bra 24 hours a day to support enlarged breasts, prevent stretch marks, and promote comfort. A woman who is breast-feeding should wear a supportive bra throughout the lactation period. A nonnursing mother should wear it until engorgement ceases, and then should wear a less restrictive one. A supportive bra should fit the woman snugly, but still allow the mother to breathe without restriction.

Tell lactating and nonlactating mothers to use plain water to clean their breasts, especially the nipple area. Soap is drying and needs to be avoided.

Instruct the mother how to examine her breasts daily. Daily assessments of the breasts includes determining evidence of the mother's milk supply (breasts will feel full as the breasts are filling), condition of the nipples (red, bruised, fissured, or bleeding), and ascertaining how breast-feeding is going. The fullness of the breasts may progress to engorgement if feedings are delayed or breast-feeding is ineffective. Palpating both breasts will help the nurse identify whether the breasts are soft, filling, or engorged. A similar assessment of the breasts should be completed on the nonlactating mother to identify any problems such as engorgement and or mastitis.

Engorgement

Breast engorgement usually occurs during the first week postpartum. It is a common response of the breasts to the sudden change in hormones and the presence of an

increased amount of milk. When this occurs, reassure the woman that this condition is temporary and usually resolves within 24 hours.

If the mother is breast-feeding, encourage frequent feedings, at least every 2 to 3 hours, with pumping just before feeding, to soften the breast so the newborn can latch on more effectively. Advise the mother to allow the newborn to feed on the first breast until it softens before switching to the other side.

Other tips to reduce engorgement include instructions such as the following:

- Take warm-to-hot showers to encourage milk release.
- Express some milk manually before breast-feeding.
- Wear a supportive nursing bra 24 hours daily to provide support.
- Feed the newborn in a variety of positions—sitting up and then lying down.
- Massage the breasts from under the axillary area down toward the nipple.
- Increase the frequency of feedings.
- Apply warm compresses to the breasts prior to nursing.
- Stay relaxed during the breast-feeding process.
- Use a breast pump if nursing or manual expression is not effective.
- Be aware that this condition is temporary and resolves quickly.

Lactation Suppression

In nonlactating women, breast engorgement is a self-limiting phenomenon that disappears as increasing estrogen levels suppress milk formation. Intervention consists of applying ice packs; wearing a snug, supportive bra 24 hours a day; and taking mild analgesics such as acetaminophen. Encourage the woman to avoid any stimulation to the breasts that might foster milk production, such as warm showers, pumping, or massaging the breasts. Medication is no longer given to hasten this process (see Teaching Guidelines 16-5).

Common Breast-Feeding Concerns

As much as every mother wants to progress through the breast-feeding process without incident, she may experience problems or concerns such as cracked nipples or mastitis. Breast-feeding should not cause the mother to verbalize pain. If the mother complains of sore, cracked nipples, the first step is to find the cause. If the infant is not positioned correctly, the mother takes the infant off the breast without first breaking the suction, the mother wears a bra too tight, or the infant does not latch on well, cracked or sore nipples result. Cracked nipples can increase the risk of lactating mothers for mastitis because a break in the skin may allow *Staphylococcus aureus* or other organisms to enter into the body. To prevent cracked nipples, instruct the mother to

- Apply warm water compresses over the nipple area
- Keep the nipples clean and dry
- Expose the nipples to air by pulling down the nursing bra flaps after each feeding
- Ensure the infant is positioned and latched on the nipple correctly

Sore nipples usually are caused by improper infant attachment on the nipple area, which traumatizes the tissue. First, rule out problems such as monilia, resulting from thrush in the newborn's mouth, and review techniques for proper positioning and latching on. Then recommend the following to the mother:

- Use only water, not soap, to clean the nipples to prevent dryness.
- Express some milk before feeding to stimulate the milk ejection reflex.
- Avoid breast pads with plastic liners, and change pads when they are wet.
- Wear a comfortable bra that is not too tight.
- Apply a few drops of breast milk to the nipples after feeding.
- Rotate positions when feeding the infant to promote complete breast emptying.
- Leave the nursing bra flaps down after feeding to allow nipples to air-dry.
- Inspect the nipples daily for redness or cracks (Edmondson, 2003).

To ease nipple pain and trauma, reinforce actions to ensure appropriate latching on and remind the woman about the need to break the suction at the breast prior to removing the newborn from the breast. Additional measures may include applying cold compresses over the area and massaging breast milk onto the nipple after feeding.

TEACHING GUIDELINES 16-5

Suppressing Lactation

1. Wear a supportive, snugly fitting bra 24 hours daily, but not one that binds the breasts too tightly or interferes with your breathing.
2. Be aware that suppression may take 5 to 7 days to accomplish.
3. Take mild analgesics to reduce breast discomfort.
4. Let shower water flow over your back rather than your breasts.
5. Avoid any breast stimulation in the form of sucking or massage.
6. Drink to quench your thirst. Do not restrict your fluid intake, because this will not dry up your milk.
7. Reduce your salt intake to reduce your body's retention of fluids.
8. Use ice packs or cool compresses (for example, cool cabbage leaves) inside the bra to decrease local pain and swelling; change every 30 minutes (Moore & Catlin, 2003).

Mastitis, or inflammation of the breast, causes symptoms that include soreness, aching, swelling, redness occurring in the upper outer quadrant of the breast, and fever. This condition usually occurs in just one breast when a milk duct becomes blocked, causing inflammation, or through a cracked or damaged nipple, allowing bacteria to infect a portion of the breast. Treatment consists of rest, warm compresses, antibiotics, breast support, and continued breast-feeding (the infection will not pass into the breast milk). Explain to the mother that it is important to keep the milk flowing in the infected breast whether it is through nursing, manual expression, or with a breast pump.

Promoting Family Adjustment and Well-Being

The postpartum period involves extraordinary physiologic, psychological, and sociocultural changes in the life of a woman and her family. Appropriate and timely interventions can facilitate the process of adjustment to the role changes and attachment to the newborn.

Parental Roles

Parental roles develop and grow through interacting with their newborn (see Chapter 15 for additional information on maternal and paternal adaptation). The pleasure they derive from this interaction stimulates and reinforces this contact behavior. With repeated, continued contact with their newborn, parents learn to recognize cues and understand the newborn's behavior. This positive interaction contributes to family harmony.

Nurses need to be fully versed on the various phases and stages parents go through as they attempt to make their new parenting roles "fit" into their life experience. Be sure to assess the parents for attachment behaviors (normal and deviant), adjustment to the new parental role, family member adjustment, social support system, and educational needs. To facilitate parental role adaptation and parent–newborn attachment, include the following nursing interventions:

- Provide an opportunity for parents to interact with their newborn as much as possible. Encourage exploration, holding, and providing care.
- Model behaviors by holding the newborn close and speaking positively.
  - Always refer to the newborn by name in front of the parents.
  - Speak directly to newborn in a calm voice.
  - Encourage both parents to pick up and hold the newborn.
  - Point out the newborn's response to parental stimulation.
  - Point out the positive physical features of the newborn's appearance.
- Involve both parents in the newborn's care and praise them for their efforts.
- Evaluate family strengths and weaknesses, and parenting preparedness.
- Assess for risk factors such as lack of social support and presence of stressors.
- Observe the effect of culture on the family interaction to determine whether it is appropriate.
- Monitor parental attachment behaviors to determine whether alterations require referral.
  - Positive behaviors: holding the newborn closely or in an en face position, talking to or admiring the newborn, or demonstrating closeness
  - Negative behaviors: avoiding contact with newborn, calling it names, or showing a disinterest in caring for the newborn (see Table 16-1)
- Monitor the parental relationship to determine alterations that need intervention.
  - Coping behaviors: positive conversations between partners, both wanting to be involved with newborn care, or absence of arguments
  - Noncoping behaviors: signs of avoidance by not visiting, limited conversations or periods of silence, or heated arguments or conflict
- Identify a support system available to the new family and encourage help.
  - Ask direct questions about home or community support to ascertain availability and degree of assistance.
  - Make additional community resource referrals to meet family needs.
- Arrange for community home visits in high-risk families to provide positive reinforcement of parenting skills and nurturing behaviors with the newborn.
- Provide anticipatory guidance regarding the newborn before discharge to reduce frustration levels by not knowing what to expect:
  - Newborn sleep–wake cycles (warning they may be reversed)
  - Variations in newborn appearance to decrease fears of abnormalities
  - Infant developmental milestones (growth spurts)
  - Interpretation of crying cues (hunger, wet, discomfort)
  - Several comforting techniques to quiet crying infant (car ride)
  - Sensory enrichment/stimulation (colorful mobile)
  - Signs and symptoms of illness and how to assess for fever
  - Important phone numbers, follow-up care, and needed immunizations
  - Physical and emotional changes associated with the postpartum period that may impact her family relationships
  - Need for integrating siblings into care of the newborn with reassurance that sibling rivalry is normal, including ways to reduce it

- Allowance to make time for both parents as a couple
- Appropriate community referral resources

In addition, nurses can assist fathers to feel more competent in assuming their parental role by teaching and providing information (Fig. 16-10). Presenting the facts to them helps to displace any of their unrealistic expectations, ultimately helping them to cope more successfully with the demands of fatherhood and thereby fostering a nurturing family relationship.

ConsiderTHIS!

I have always prided myself in being very organized and in control in most situations, but survival at home after childbirth wasn't one of them. I left the hospital 24 hours after giving birth to my son because my doctor said I could. The postpartum nurse encouraged me to stay longer, but wanting to be in control and sleeping in my own bed again won out. I thought my baby would be sleeping while I sent out birth announcements to my friends and family—*wrong!*

What happened instead was my son didn't sleep as I imagined and my nipples became sore after breastfeeding every few hours. I was weary and tired and wanted to sleep, but couldn't. Somehow I thought I would be getting a full night's sleep because I was up throughout the day, but that was a fantasy too. At two o'clock in the morning when you are up feeding your baby, you feel you are the only one in the world up at that time and feel very much alone. My feelings of being organized and in control all the time have changed dramatically since I left the hospital. I have learned to yield to the important needs of my son and derive satisfaction from being able to bring comfort to him and to let go of my control.

Thoughts: It is interesting to see how a newborn changed this woman's need to organize and control her environment. What "tips of survival" could the postpartum nurse offer this woman to help in her home transition? How can friends and family help when women arrive home from the hospital?

● Figure 16-10 Father participating in newborn care.

Sibling Roles

It can be overwhelming to a young child to have another family member introduced into their small, stable world. Although most parents try to prepare siblings for the arrival of their new little brother or sister, many young children experience stress. They may view the new infant as competition or fear that they will be replaced in the parent's affection. All siblings need extra attention from their parents and reassurance that they are loved and important. Many parents need reassurance that sibling rivalry is normal. Suggest the following to help parents minimize sibling rivalry:

- Expect and tolerate some regression (thumb sucking, bedwetting).
- Explain the childbirth in an appropriate way for the child's age.
- Encourage discussion about the new infant during relaxed family times.
- Encourage the sibling to participate in decisions, such as names, toys to buy.
- Take the sibling on the tour of the maternity suite to prepare him or her.
- Buy a t-shirt that says "I'm the [big brother or big sister]."
- Spend "special time" with the sibling
- Read with the sibling. Some suggested readings may include
  - *Things to Do with A New Baby* (Ormerod, 1984)
  - *Betsy's Baby Brother* (Wolde, 1975)
  - *The Berenstain Bear's New Baby* (Berenstain, 1974)
  - *Mommy's Lap* (Horowitz & Sorensen, 1993)
- Plan time for each child throughout the day.
- Role-play safe handling of a newborn with a doll. Give your preschooler or school-age child a doll to care for.
- Encourage older children to verbalize emotions about the newborn.
- Purchase a gift that can be given to the newborn by the sibling.
- Purchase a gift that can be given to the sibling by the newborn.
- Arrange for the sibling to come to the hospital to see the newborn (Fig. 16-11).
- Move the sibling from his or her crib to a youth bed months in advance of the birth of the newborn.
- Encourage grandparents to pay attention to the older child when visiting (Youngkin & Davis, 2004).

Grandparents' Role

The grandparents' role and involvement will depend on their proximity to the newborn and the nuclear family, their willingness to become involved, and cultural expectations of their role. Just as parents and siblings go through developmental changes, so too do grandparents. These changes can have a positive or negative effect on the relationship.

Newborn care, feeding, and childrearing have changed since grandparents raised the parents. New parents may

● Figure 16-11 Sibling visitation.

lack parenting skills, but want their parents' support without criticism. A grandparent's "take-charge approach" may not be welcome by new parents who are testing their own parenting roles. Thus, family conflict may ensue. Grandparents' involvement can enrich the lives of the entire family if accepted within the right context and dose by the family. Many grandparents realize their adult children's wishes for autonomy, respect these wishes, and remain resource people for them when requested.

Nurses can assist in the grandparents' role transition by assessing the communication skills, role expectations, and support skills of parents and grandparents during the prenatal period. Find out whether the grandparents are included in the couple's social support network and whether their support is wanted or helpful. If they are, and it is, then encourage the grandparents to learn about new parenting, feeding, and childrearing skills their children have learned in childbirth classes. This information is commonly found in "grandparenting" classes. These grandparenting classes may help them understand the new parenting concepts and bring them up-to-date on childbirth practices today. Grandparents can be a source of support and comfort to the new postpartum family if effective communication skills are used and roles are defined.

Postpartum Blues

The postpartum period is typically a happy yet stressful time, because the birth of an infant is accompanied by enormous physical, social, and emotional changes. The postpartum woman may report feelings of emotional lability, such as crying one minute and laughing the next. The blues symptoms (crying spells, sadness, confusion, insomnia, poor appetite, and anxiety) typically begin 3 to 4 days after childbirth and resolve by day 10 (Seyfried & Marcus, 2003). These mood swings may be confusing to new mothers but usually are self-limiting. **Postpartum blues** are transient emotional disturbances beginning within the first week after childbirth and are characterized by such feelings as anxiety, irritability, insomnia, crying, loss of appetite, and sadness (Venis, 2002). Postpartum blues are thought to affect up to 75% of all new mothers; this condition is the mildest form of emotional disturbance associated with childbearing (Condon, 2004). The mother maintains contact with reality consistently and it tends to resolve spontaneously without therapy within 1 to 2 weeks. Postpartum blues have been regarded as brief, benign, and without clinical significance, but several studies have proposed a link between blues and subsequent depression in the 6 months following childbirth (Henshaw, Foreman, & Cox, 2004).

Postpartum blues requires no formal treatment, other than support and reassurance, because it does not usually interfere with the woman's ability to function and care for her infant. Further evaluation is necessary if symptoms persist more than 2 weeks (Nonacs, 2004). Nurses can ease a mother's distress by encouraging the woman to vent her feelings, and by demonstrating patience and understanding with her and her family. Suggesting that housework and infant outside help might assist her to feel less overwhelmed until the blues ease might be helpful during this time period. Providing supportive telephone numbers that she can call when she feels down during the day might also provide her with additional support during this very stressful time. Making women aware of this disorder while they are pregnant will also help increase their knowledge about this mood disturbance. Their knowledge about this mood disorder may lessen their embarrassment and increase their willingness to ask for and accept help.

The postpartum woman also is at risk for more long-term problems affecting her mental health. These problems include postpartum depression and postpartum psychosis. These conditions are discussed in greater depth in Chapter 22.

Preparing for Discharge

The AAP and the American College of Obstetricians and Gynecologists (ACOG) (2002) state that the length of stay in the facility should be individualized for each mother–baby dyad. If a shortened hospital stay is desired, the following criteria should be met:

- Mother is afebrile and vital signs are within normal range.
- Lochia is appropriate amount and color for stage of recovery.
- Hemoglobin and hematocrit values are within normal range.
- Uterine fundus is firm; urinary output is adequate.
- ABO blood groups and RhD status are known and, if indicated, anti-D immunoglobulin has been administered.
- Surgical wounds are healing and no signs of infection are present.
- Mother is able to ambulate without difficulty.
- Food and fluids are taken without difficulty.
- Self-care and infant care are understood and demonstrated.

- Family or other support system is available to care for both.
- Mother is aware of possible complications (AAP & ACOG, 2002)

Immunizations

Prior to discharge, check the immunity status for rubella for all mothers and give a subcutaneous injection of rubella vaccine if they are not serologically immune (titer < 1:10). Be sure that the client signs a consent form to receive the vaccine. Keep in mind that nursing mothers may be vaccinated because the live, attenuated rubella virus is not communicable. Inform all mothers requiring immunization about possible side effects (rash, joint symptoms, and a low-grade fever 5 to 21 days later) and the need to avoid pregnancy for at least 3 months after being vaccinated because of the risk of teratogenic effects (Lowdermilk & Perry, 2004).

If the client is Rh negative, check the Rh status of the newborn. Verify that the woman is Rh negative and has not been sensitized, that Coombs' test is negative, and that the newborn is Rh positive. Mothers who are Rh negative and have given birth to an infant who is Rh positive should receive an injection of Rh immunoglobulin within 72 hours after birth to prevent a sensitization reaction in the Rh-negative woman who received Rh-positive blood cells during the birthing process. The usual protocol is for the woman to receive two doses of Rh immunoglobulin (RhoGAM): one at 28 weeks' gestation and the second dose within 72 hours after childbirth. A signed consent form is needed after a thorough explanation is provided about the procedure, including the purpose, possible side effects, and effect on future pregnancies.

Ensuring Follow-Up Care

New mothers and their families need to be attended to over an extended period of time by nurses knowledgeable about mother care, infant feeding (breast-feeding and bottle feeding), infant care, and nutrition. Although continuous nursing care stops on discharge from the hospital or birthing center, extended episodic nursing care needs to follow the family home. The new family faces numerous challenges after discharge. These challenges are described in Box 16-5.

Many new mothers are reluctant to "cut the cord" after a brief stay in the facility and need expanded services within the community available to them. Early discharge from the hospital subjects a woman to certain risk factors: uterine involution, discomfort at an episiotomy or cesarean site, infection, fatigue, and maladjustment in her new role. Postpartum nursing care should include a range of family-focused care from telephone calls, outpatient clinics, and home visits. Typically, public health nurses, community and home health nurses, and health care provider office staff will carry on in the continuum of postpartum care after hospital discharge.

BOX 16-5

CURRENT CHALLENGES FACING FAMILIES AFTER DISCHARGE

- Lacking number of role models for breast-feeding and infant care today
- The decline in opportunities for family members to care for the newborn as extended families disintegrate
- Inability of many of the new mother's own mothers to provide support because they did not breast-feed
- Feelings of isolation and limited community ties for women working full time
- Feelings of being overwhelmed with learning and taking in all the information exposed to in the facility in 48 hours or less
- Focus of prenatal classes usually on the birthing event rather than skills needed to care for themselves and the newborn during the postpartum period
- Limited access to education and support systems addressing unique needs for many nontraditional families from diverse cultures
- Lack of nearby support system as a result of geographic dispersion and/or careers (Pease & Beigel, 2003)

Telephone Follow-Up

Telephone follow-up typically occurs during the first week after discharge to check on how things are going at home. Calls can be made by perinatal nurses within the agency as part of follow-up care or by the local health department nurses. A disadvantage to a phone call assessment is that the nurse cannot "see" the client and thus must rely on the mother or the family's observations. The experienced nurse needs to be able to cue in on distress and give appropriate advice and referral information if needed.

Outpatient Follow-Up

For mothers with established community health care providers such as private pediatricians and obstetricians, visits to their offices are arranged soon after discharge. For the woman with an uncomplicated vaginal birth, an office visit is usually scheduled for 4 to 6 weeks after childbirth. A woman who had a cesarean birth frequently is seen within 2 weeks after hospital discharge. The needed follow-up time frames are included in hospital discharge orders with the request to call their office to set up an appointment. Newborn examinations and further diagnostic lab studies are scheduled within the first week.

Outpatient clinics are available in many communities for referrals. If family members run into a problem they feel they need to address, the local clinic would be available for an assessment and validation or for assurance to the family. Clinic visits can be used to replace or supplement home visits. Unfortunately, the set daytime hours of operation and unfamiliarity of the staff with the family

are disadvantages of this community resource. Still, it can be a valuable resource for the new family in need of consultation about a postpartal problem or concern.

Home Visit Follow-Up

Home visits are usually made within the first week of discharge to assess the mother and newborn. During the home visit, the nurse provides expertise in recognizing and managing common biomedical and psychosocial problems. In addition, the home nurse can offer understanding and guidance for the parents making the adjustment to a change in their lives. The postpartum home visit usually includes

- Maternal assessment: general well-being, vital signs, breast health and care; abdomen and musculoskeletal status; voiding status; fundus and lochia status; psychological and coping status; family relationships; proper feeding technique; environmental safety check; newborn care knowledge and health teaching needed identified during the assessment (see Fig. 16-12 for sample assessment forms)
- Infant assessment: physical examination, general appearance, and vital signs status; home safety check; child development status; and appropriate education needed for improvement of care-taking process.

The home care nurse must be prepared to support, advise, and educate the woman and her family. Common areas include

- Breast-feeding procedure
- Appropriate parenting behavior and problem solving
- Maternal/newborn physical, psychosocial, and culture–environmental needs
- Emotional needs of the new family, incorporating active listening skills as they deal with change
- Warning signs of problems and where to seek help to eliminate them
- Sexuality issues related to the postpartum period, including contraceptives and their proper use
- Immunization needs for both mother and infant
- Family dynamics for smooth transition
- Links to health care providers and community resources

KEY CONCEPTS

- The transitional adjustment period between birth and parenthood includes education about baby care basics, the role of the new family, emotional support, breast-feeding or bottle-feeding support, and maternal mentoring.
- Sensitivity to how childbearing practices and beliefs vary for multicultural families and how best to provide appropriate nursing care to meet their needs are important during the postpartum period.
- A thorough postpartum assessment is key to preventing complications.
- The postpartum assessment using the acronym BUBBLE-HE (breasts, uterus, bowel, bladder, lochia, episiotomy/perineum, Homans' sign, emotions) is a helpful guide in performing a systematic head-to-toe postpartum assessment.
- Lochia is assessed according to its amount, color, and change with activity and time. It proceeds from lochia rubra to serosa to alba.
- Because of shortened agency stays, nurses must use this brief time with the client to address areas of comfort, elimination, activity, rest and exercise, self-care, sexuality and contraception, nutrition, family adaptation, discharge, and follow-up.
- The AAP advocates breast-feeding for all full-term newborns, maintaining that, ideally, breast milk should be the sole nutrient for the first 6 to 12 months of life.
- Successful parenting is a continuous and complex interactive process that requires the acquisition of new skills and the integration of the new member into the existing family unit.
- Bonding is a vital component of the attachment process and is necessary in establishing parent–infant attachment and a healthy, loving relationship; attachment behaviors include seeking and maintaining close proximity to, and exchanging gratifying experiences with, the infant.
- Nurses can be instrumental in facilitating attachment by first understanding attachment behaviors (positive and negative) of newborns and parents, and intervening appropriately to promote and enhance attachment.
- New mothers and their families need to be attended to over an extended period of time by nurses knowledgeable about mother care, newborn feeding (breast-feeding and bottle feeding), newborn care, and nutrition.

Maternal Assessment

Maternal/Newborn Record System

Page 1 of 2

PATIENT IDENTIFICATION

Record No. _____

Name _____

Home address _____ STREET

CITY STATE ZIP

Date MO / DAY / YR Time begin: _____ Time end: _____ Date of delivery MO / DAY / YR

Medication allergy ☐ None Identify _____

Significant health history ☐ None Identify _____

PHYSICAL

TEMP.	PULSE	RESP.	BP /

Breasts ☐ Nursing ☐ Non-nursing

Color ☐ Normal ☐ Reddened

Condition ☐ Soft ☐ Firm ☐ Engorged ☐ Blocked ducts

Secretion ☐ Colostrum ☐ Milk ☐ Other _____

Support bra ☐ No ☐ Yes, fit ☐ Appropriate ☐ Inappropriate

Nipples (If nursing) ☐ Erect ☐ Flat ☐ Inverted

Condition ☐ Intact ☐ Bruised ☐ Blistered ☐ Fissured ☐ Bleeding ☐ Scabbed

Care ☐ Water only ☐ Soap ☐ Air dry ☐ Topical agent (type/frequency) _____ ☐ Other _____

Self-exam ☐ Accurate ☐ Inaccurate/instructed

Abdomen

Diastasis recti ☐ Absent ☐ Present_____cm ☐ Exercise taught

Incision ☐ None

Type ☐ Transverse ☐ Vertical ☐ Umbilical

Closure ☐ Staples ☐ Sutures ☐ Steri-strips

Condition ☐ Approximated ☐ Open _____ cm ☐ Redness _____ ☐ Swelling _____ ☐ Discharge _____ ☐ Other _____

Reproductive Tract

Uterus ☐ Firm ☐ Firm with massage ☐ Boggy Height _____ ☐ Midline ☐ Displaced L R ☐ Non tender ☐ Tender ☐ With touch ☐ Constant

Lochia ☐ Rubra ☐ Serosa ☐ Alba ☐ Clots (describe) _____ ☐ Fleshy odor ☐ Foul odor

Pads Type _____ Number/day _____

Saturation % 0 25 50 75 100

Perineum ☐ Intact ☐ Laceration ☐ Episiotomy Type _____ Extension _____

Condition ☐ Redness _____ ☐ Edema _____ ☐ Eccymosis _____ ☐ Discharge _____ ☐ Approximation _____

Care ☐ Front-to-back cleansing ☐ Peri-bottle ☐ Soap/water ☐ Ice ☐ Sitz bath ☐ Warm ☐ Cool ☐ Topical agent (type/frequency) _____ ☐ Other _____

Elimination

Urinary tract

Voiding pattern ☐ Normal ☐ Incontinence ☐ Bladder distention ☐ Catheter (type) _____

Signs of infection ☐ None/reviewed ☐ Urgency ☐ Frequency ☐ Dysuria ☐ CVA tenderness L R

Gastrointestinal tract

Bowel pattern ☐ Normal ☐ No BM ☐ Constipation ☐ Diarrhea ☐ Meds/treatments (type, frequency, effect) _____

Hemorrhoids ☐ No ☐ Yes (describe) _____ ☐ Meds/treatments (type, frequency, effect) _____

Lower Extremities

Edema ☐ None ☐ Pedal ☐ Ankle ☐ Pretibial ☐ Thigh ☐ Pitting (describe) _____

Signs of thrombophlebitis ☐ None

	L	R		L	R
Homan's sign	☐	☐	Redness	☐	☐
Pain	☐	☐	Warmth	☐	☐
Swelling	☐	☐			

Pain	No	Yes	
		Managed	Problematic
Abdominal incision	☐	☐	☐
Back	☐	☐	☐
Breasts	☐	☐	☐
Headache	☐	☐	☐
Hemorrhoid	☐	☐	☐
Nipple	☐	☐	☐
Perineum	☐	☐	☐
Uterine cramping	☐	☐	☐
Other _____	☐	☐	☐

Analgesic ☐ No ☐ Yes (type/dose/frequency) _____

Reportable danger signs ☐ Aware ☐ Unaware/instructed

TESTS ☐ None ☐ Urinalysis ☐ CBC ☐ _____

IDENTIFIED NEEDS

Signature _____

● Figure 16-12 Sample postpartum home visit assessment form. (**A**) Maternal assessment. (**B**) Newborn assessment. (Used with permission: Copyright Briggs Corporation. Professional Nurse Associates.)

Maternal Assessment

Maternal/Newborn Record System

Page 2 of 2

PATIENT IDENTIFICATION

Record No. _____

Name _____

Home address _____ STREET

CITY STATE ZIP

ACTIVITIES OF DAILY LIVING - 24 HOUR HISTORY

Date MO / DAY / YR

Nutrition

Appetite ☐ Good ☐ Fair ☐ Poor

Usual pattern ☐ Yes ☐ No _____

Special diet ☐ No ☐ Yes _____

Food intolerance/allergy ☐ No ☐ Yes _____

Vitamin/mineral supplement ☐ No ☐ Yes _____

Fluid intake (type/amount) _____

BREAKFAST	LUNCH	DINNER	SNACKS

General Hygiene ☐ Adequate ☐ Inadequate (describe)

Sleep/Activity

Amount of Activity

Night, uninterrupted _____ hrs

Naps ☐ No ☐ Yes _____ hrs

Fatigue ☐ None ☐ Minimal ☐ Moderate ☐ Exhausted

Activities

Limitations ☐ None Identify _____

☐ Self-care ☐ Infant care

	Appropriate	Inappropriate/instructed
Stair climbing	☐	☐
Lifting	☐	☐
Household tasks	☐	☐
Outside home	☐	☐

Other _____

Exercise

☐ None

	Accurate	Inaccurate/instructed
Kegel	☐	☐
Postpartum	☐	☐

Other _____

PSYCHOLOGICAL

Review of Labor and Birth

Missing pieces ☐ No ☐ Yes

Unmet expectations ☐ No ☐ Yes

Unresolved feelings ☐ No ☐ Yes

Pertinent data _____

Postpartum Tmetable (Key on reverse side)

☐ Taking in ☐ Taking hold ☐ Letting go

Emotional Status ☐ Happy ☐ Ambivalent ☐ Anxious

☐ Sad ☐ Other _____

Postpartum-depression (Key on reverse side)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ Signs/Symptoms Reviewed

General Comments (body image, role changes, concerns) _____

SEXUALITY

	Aware	Unaware/ instructed
Relationship with partner		
Adjustment	☐	☐
Expressions of affection	☐	☐
Resuming Intercourse		
Timing (lack of lochia, comfort)	☐	☐
Vaginal dryness	☐	☐
Milk ejection (if lactating)	☐	☐
Position variation	☐	☐
Libidinal changes	☐	☐
Return of Menses	☐	☐

Contraceptive Method

☐ None ☐ Undecided/aware of options

☐ Natural family planning

☐ Cervical cap

☐ Condom

☐ Diaphragm

☐ Hormones ☐ Pill ☐ Injection ☐ Implant

☐ IUD

☐ Spermicide

☐ Sterilization ☐ Female ☐ Male

☐ Other _____

Accurate use ☐ Yes ☐ No/instructed

IDENTIFIED NEEDS _____

Signature _____

Figure 16-12 (continued)

Maternal Assessment

Maternal/Newborn Record System

PATIENT IDENTIFICATION

Record No. _____

Name _____

Home address _____ STREET

CITY STATE ZIP

Date MO /DAY /YR Time begin: _____ Date of Birth MO /DAY /YR

Time end: _____

Significant history ☐ None Identify _____

PHYSICAL

Temp _____ Pulse (rate/rhythm) _____ Resp _____

Weight _____ Birth weight _____ % Change _____

Length _____ Head _____ Chest _____

HEAD/NECK

	Level	Bulging	Depressed
1. Fontanels			
Anterior	☐	☐	☐
Posterior	☐	☐	☐

Sutures ☐ Open ☐ Closed ☐ Overriding

2. Variations ☐ Molding ☐ Caput ☐ Cephalhematoma

	NORMAL	ABNORMAL	DETAIL VARIATIONS/ ABNORMAL FINDINGS
3. Face (symmetry)	☐	☐	
4. Eyes (symmetry, conjunctiva, sciera, eyelids, PERL)	☐	☐	
5. Ears (shape, position, auditory response)	☐	☐	
6. Nose (patency)	☐	☐	
7. Mouth (lip, mucous membranes, tongue, palate)	☐	☐	
8. Neck (ROM, symmetry)	☐	☐	
Chest			
9. Appearance (shape, breasts, nipples)	☐	☐	
10. Breath sounds	☐	☐	
11. Clavicles	☐	☐	
Cardiovascular			
12. Heart sounds	☐	☐	
13. Brachial/femoral pulses (compare strength, equality)	☐	☐	
Abdomen			
14. Appearance (shape, size)	☐	☐	
15. Cord (condition)	☐	☐	
16. Liver (less than or equal to 3 cm ↓ ®costal margin)	☐	☐	
Genitalia			
17. Female (labia, introitus, discharge	☐	☐	
18. Male (meatus, scrotum, testes)	☐	☐	
19. Circumcision ☐ No ☐ Yes	☐	☐	
Musculoskeletal			
20. Muscle tone	☐	☐	
21. Extremities (symmetry, digits, ROM)	☐	☐	
22. Hips (symmetry, ROM)	☐	☐	
23. Spine (alignment, integrity)	☐	☐	
Neurologic			
24. Reflexes (presence, symmetry)			
Moro	☐	☐	
Grasp	☐	☐	
Babinski	☐	☐	
25. Cry (presence, quality)	☐	☐	

PHYSICAL (CONT'D)

Skin

Turgor ☐ Good ☐ Poor

Condition ☐ Smooth ☐ Dry, cracked ☐ Peeling

Color ☐ Pink ☐ Ruddy ☐ Cyanotic ☐ Pale

☐ Jaundice (note levels)

- ☐ Head (3 mg/dl)
- ☐ Head and upper chest (6 mg/dl)
- ☐ Head and entire chest (9 mg/dl)
- ☐ Head, chest and abdomen to umbilicus (12 mg/dl)
- ☐ Head, chest and entire abdomen (15 mg/dl)
- ☐ Head, chest, abdomen, legs and feet (18 mg/dl)

Variations (Rashes, lesions, birthmarks). _____

NUTRITION

Feeding

Reflexes ☐ Root ☐ Suck ☐ Swallow

Hunger cues identified ☐ Yes ☐ No/instructed

BREAST	FORMULA
Frequency ___ times in _____ hours	Type _____
Time per breast _____ min _____ min	Amount _____ oz.
Positioning ☐ Correct	Frequency _____
☐ Incorrect _____	Preparation ☐ Correct
Latch ☐ Correct	☐ Incorrect _____
☐ Incorrect _____	_____
Appropriate audible swallows	☐ Correct
☐ Yes ☐ No _____	☐ _____

Satiation demonstrated ☐ Yes

☐ No (describe) _____

Regurgitation ☐ No ☐ Yes (describe) _____

Pacifier use ☐ No ☐ Yes (type/pattern) _____

Stool (number/day, color, consistency) _____

Urine (number/day, color) _____

BEHAVIOR

Sleep/Activity Pattern (24 hours)

Sleep (16–20 hrs) ☐ Yes ☐ No (describe) _____

Awake-alert (2–3 hrs) ☐ Yes ☐ No (describe) _____

Awake-crying (2–4 hrs) ☐ Yes ☐ No (describe) _____

Consolability (Key on reverse) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

TESTS ☐ None Time

- ☐ Metabolic screen kit no. _____ _____
- ☐ Bilirubin _____
- ☐ Hematocrit _____
- ☐ _____ _____
- ☐ _____ _____

INENTIFIED NEEDS _____

Signature _____

● Figure 16-12 (continued)

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Web Resources

American College of Nurse-Midwives, **www.midwife.org**
Association for Perinatal Psychology and Health, **www.birthpsychology.com**
Association of Maternal & Child Health Programs, **www.amchpl.org**
Baby-Friendly USA, **www.babyfriendlyusa.org**
Depression after Delivery, **www.depressionafterdelivery.com**
Home-Based Working Moms (HBWM), **www.hbwm.com**
International Lactation Consultants Association, **www.ilca.org**
La Leche League International, **www.lalecheleague.org**
Midwifery Today, Inc., **www.midwiferytoday.com**
National Alliance for Breast-feeding Advocacy, **www.naba-breast-feeding.org**
National Center for Fathering, **www.fathers.com**
National Women's Health Information Center, **www.4women.gov**
Parenthood Web, **www.parenthoodweb.com**
Parenting Q & A, **www.parenting-qa.com**
Parents Anonymous, Inc., **www.parentsanonymous.org**
Parents Helping Parents, **www.php.com**
The Center for Postpartum Health, **www.postpartumhealth.com**
The National Parenting Center, **www.tnpc.com**

ChapterWORKSHEET

MULTIPLE CHOICE QUESTIONS

1. When assessing a postpartum woman, which of the following would lead the nurse to suspect postpartum blues?
   a. Panic attacks and suicidal thoughts
   b. Anger toward self and infant
   c. Periodic crying and insomnia
   d. Obsessive thoughts and hallucinations
2. Which of these activities would be most important for the postpartum nurse to ensure the provision of culturally sensitive care for the childbearing family?
   a. Taking a transcultural course
   b. Caring for only families of their cultural origin
   c. Teaching culturally diverse families Western beliefs
   d. Educating self about diverse cultural practices
3. Which of the following suggestions would be most appropriate to include in the teaching plan for a postpartum woman needing a greater focus on losing weight?
   a. Increase fluid intake and acid-producing food into her diet
   b. Avoid empty-calorie foods and increase exercise
   c. Start a high-protein diet and restrict fluids
   d. Completely avoid eating any snacks at all and carbohydrates
4. After teaching a group of breast-feeding women about nutritional needs, the nurse determines that the teaching was successful when the women state that they need to increase their intake of which nutrients?
   a. Carbohydrates and fiber
   b. Fats and vitamins
   c. Calories and protein
   d. Iron-rich foods and minerals
5. Which of the following would lead the nurse to suspect that a postpartum woman was developing a possible complication?
   a. Fatigue and irritability
   b. Perineal discomfort and pink discharge
   c. Pulse rate of 60 bpm
   d. Swollen, tender, hot area on breast
6. Which of the following would the nurse assess as indicating positive bonding between the parents and their newborn?
   a. Holding infant close to own body
   b. Having visitors hold infant
   c. Buying expensive infant clothes
   d. Requesting nurses care for infant
7. Which activity would the nurse include in the teaching plan for parents with a newborn and an older child to reduce the incidence of sibling rivalry when the newborn is brought home?
   a. Punishing child for bedwetting behavior
   b. Sending the sibling to grandparents' house
   c. Planning special time daily for the older sibling
   d. Allowing the sibling to share a room with the infant

CRITICAL THINKING EXERCISES

1. As a nurse working on a postpartum unit, you enter the room of Ms. Jones, a 22-year-old primipara, and find her chatting on the phone while her newborn is crying loudly in the bassinette that has been pushed into the bathroom. You are assigned to this mother–newborn dyad and proceed to pick up and comfort the newborn. While holding the baby, you ask the client if she was aware her newborn was crying. Ms. Jones replies, "That is about all that monkey does since she was born!" You hand the newborn to her and she places the newborn on the bed away from her and continues her phone conversation.

a. What is your nursing assessment of this encounter?

b. What nursing interventions would be appropriate?

c. What specific discharge interventions may be needed?

2. Jennifer Adamson, a 34-year-old single primipara, left the hospital after a 36-hour stay with her newborn son. She lives alone in a one-bedroom walk-up apartment. As the postpartum home health nurse visiting her 2 days later, you find the following:

- Tearful client pacing the floor holding her crying son
- Home environment cluttered and in disarray
- Fundus firm and displaced to right of midline
- Moderate lochia rubra; episiotomy site clean, dry, and intact
- Vital signs within normal range; pain rating less than 3 points on scale of 1 to 10 points
- Breasts engorged slightly; supportive bra on
- Newborn assessment within normal limits
- Distended bladder upon palpation; reporting frequency
- Negative Homans' sign

a. Which of these assessment findings warrants further investigation?

b. What interventions are appropriate at this time and why?

c. What health teaching is needed before you leave this home?

3. The nurse walks into the room of Lisa Drew, a 24-year-old primigravida. She asks the nurse to hand her the bottle sitting on the bedside table, stating, "I'm going to finish it off because my baby only ate half of it 3 hours ago when I fed him."

a. What response by the nurse would be appropriate at this time?

b. What action by the nurse should take place?

c. What health teaching is needed for Lisa prior to discharge?

STUDY ACTIVITIES

1. Identify three questions that a nurse would ask a postpartum woman to assess for postpartum blues.
2. Find an educational Internet Web site to which to refer new parents who may have questions about breast-feeding.
3. Outline instructions you would give to a new mother on how to use her peribottle.
4. Breast tissue swelling secondary to vascular congestion after childbirth and preceding lactation describes _____.