

Cesarean Birth

Cesarean birth is an alternative to vaginal birth only when the safety of the mother and/or fetus is compromised.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Fatigue may be present.

Circulation

Hypertension (escalating PIH)

Hypotension, ashen color, cool/clammy skin (uterine rupture)

Ego Integrity

May view anticipated procedure as a sign of failure and/or as a negative reflection on abilities as a female

May actually fear intervention/view surgery as life-threatening

Irritable/emotional tension, (emotional response to prolonged labor; physiological response to PIH)

Food/Fluid

Excessive weight gain, nausea/vomiting, generalized edema (PIH)

Pain/Discomfort

Prolonged/dysfunctional contractile pattern (dystocia).

Uterine tenderness may be present; severe abdominal pain (uterine rupture).

Right upper quadrant (RUQ)/epigastric pain (PIH).

Headache (PIH).

Neurosensory

Visual disturbance/scotomata (spots in visual field) (PIH)

Seizure activity (eclampsia)

Hyperreflexia, clonus (PIH)

Safety

Elevated temperature (infectious process/dehydration).

Active STD (e.g., herpes).

Severe Rh incompatibility.

Prolapsed cord.

Fetal distress.

Impending delivery of premature fetus.

Fetal macrosomia (estimated >4000 g).

Unsuccessful external cephalic version to rotate breech presentation, or transverse lie.

Membranes may have been ruptured for 24 hr or longer.

Sexuality

CPD; tumor/neoplasm obstructing the pelvis/birth canal

Multiple pregnancies or gestations (overdistended uterus)

Substantial vaginal bleeding (placenta previa/abruptio placentae)

Previous cesarean delivery with classical incision; previous uterine or cervical surgery

Teaching/Learning

Presence of maternal complication/risk factors, such as severe PIH, diabetes, renal or cardiac disease, or ascending infection; prenatal abdominal trauma; maternal age >35 yr.

Procedure may or may not be planned, affecting client's preparation and understanding of procedure.
Failed induction.
Maternal age.

DIAGNOSTIC STUDIES

Complete Blood Count (CBC), Blood Typing (ABO) and Cross-match, Coombs' test: Preoperative screening tests.

Urinalysis: Determines albumin/glucose levels.

Cultures: Identify presence of herpes simplex virus type II.

X-ray Pelvimetry: Determines CPD, flexion of head in breech position.

Amniocentesis: Assesses fetal lung maturity.

Ultrasonography: Locates placenta; determines fetal growth, lie, and presentation, as well as fetal anomalies/malformations favoring cesarean delivery.

Nonstress Test (NST) or Contraction Stress Test (CST): Assesses fetal response to movement/stress of uterine contractions.

Continuous Electronic Monitoring: Validates fetal status/uterine activity.

NURSING PRIORITIES

1. Promote maternal/fetal well-being.
2. Provide client/couple with necessary information.
3. Support client's/couple's desires to participate actively in birth experience.
4. Prepare client for surgical procedure.
5. Prevent complications.

NURSING DIAGNOSIS:

Knowledge deficit [Learning Need], regarding surgical procedure, expectations, postoperative regimen

May Be Related To:

Lack of exposure/unfamiliarity with information, misinterpretation

Possibly Evidenced By:

Request for information, statement of misconception, exaggerated behaviors

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Verbalize understanding of indications for cesarean birth.

Recognize this as an alternative childbirth method to obtain healthiest outcome possible.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess learning needs.

This birth method is discussed in prepared childbirth classes, but many clients fail to retain the information because it has no personal significance at the time. Clients having a repeat cesarean delivery may not clearly remember or understand the details of their previous delivery. Note: Some facilities provide cesarean preparation classes for those undergoing planned procedure.

Note stress level and whether procedure was planned or unplanned.

Identifies client's/couple's readiness to incorporate information.

Provide accurate information in simple terms, clarify misconceptions. Encourage couple to ask questions and verbalize their understanding.

Stress of the situation can interfere with client's ability to take in/comprehend information needed to make informed decisions. Provides an opportunity to evaluate client's/couple's understanding of situation. Note: Native Americans may fear procedure based on history of unwanted sterilization associated with consent for surgery.

Review indications necessitating alternative birth method.

Currently approximately one in five or six deliveries is a cesarean birth; and although one of CDC's goals for Healthy America 2000 is to reduce the rate to 15% or less, the procedure should be viewed as an alternative, not an abnormal situation, to enhance maternal/fetal safety and well-being.

Describe preoperative procedures in advance, and provide rationale as appropriate.

Information allows client to anticipate events and understand reasons for interventions/actions.

Provide postoperative teaching; including demonstration of leg exercises, coughing/deep breathing; splinting technique; and abdominal tightening exercises.

Provides techniques to prevent complications related to venous stasis and hypostatic pneumonia, and to decrease stress on operative site. Abdominal tightening decreases discomfort associated with gas formation and abdominal distension.

Discuss anticipated sensations during delivery and recovery period.

Knowing what to expect and what is "normal" helps prevent unnecessary concern.

NURSING DIAGNOSIS:

Anxiety [specify level]

May Be Related To:

Situational crisis, threat to self-concept, perceived/actual threat of maternal and fetal well-being, interpersonal transmission

Possibly Evidenced By:

Increased tension, distress, apprehension, feelings of inadequacy, sympathetic stimulation, restlessness

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/COUPLE WILL:

Verbalize fears for the safety of client and infant.

Discuss feelings about cesarean birth.

Appear appropriately relaxed.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess psychological response to event and availability of support system(s).

The greater the client perceives the threat, the greater the level of her anxiety.

Note cultural influences/expectations.

Some cultures (e.g., Latin, Mexican/Arab-American) may view surgical intervention as detrimental to the client's well-being or may believe client will be stigmatized as a "weak woman" (e.g., Puerto Rican).

Ascertain whether procedure is planned or unplanned.

With unplanned cesarean birth, the client/couple usually has no time for physiological or psychological preparation. Even when planned, cesarean birth can create apprehension in the client/couple owing to an actual or perceived physical threat to the mother and infant related to the condition necessitating the procedure and to the surgery itself.

Stay with client, and remain calm. Speak slowly. Convey empathy.

Helps to limit interpersonal transmission of anxiety, and demonstrates caring for the client/couple.

Reinforce positive aspects of maternal and fetal condition.

Focuses on likelihood of successful outcome and helps to bring perceived/actual threat into perspective.

Encourage client/couple to verbalize and/or express feelings (cry).

Helps to identify negative feelings/concerns and provides opportunity to cope with ambivalent or unresolved feelings/grief. The client may also feel an emotional threat to her self-esteem, owing to her feelings that she has failed, that she is weak as a woman, and that her expectations have not been met. Partner may question own abilities in assisting client and providing needed support.

Support/redirect expressed coping mechanisms.

Enhances basic and automatic coping mechanisms, increases self-confidence and acceptance, and reduces anxiety. Note: Some client actions may be viewed as ineffective (e.g., screaming and throwing things) and need to be redirected to enhance client's sense of control.

Discuss past childbirth experience/expectations, as appropriate.

Client may have distorted memories of past delivery or unrealistic perceptions of abnormality of cesarean birth that will increase anxiety.

Provide period of privacy, if possible. Reduce environmental stimuli, such as the number of people present, as indicated by client's desires.

Allows client/couple opportunity to internalize information, marshal resources, and cope effectively.

NURSING DIAGNOSIS:**Self Esteem, risk for situational low****Risk Factors May Include:**

Perceived “failure” at a life event

Possibly Evidenced By:[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]**DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:**

Identify and discuss negative feelings.

Verbalize confidence in herself and in her abilities.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Determine client’s usual feelings about self and pregnancy. Note cultural influences.

Diagnosis of a change in self-concept is based on knowledge of past perceptions and experiences. Cesarean birth, whether planned or unplanned, has the potential to alter the way the client feels about herself. The client sees that the birth plan has been altered and that surgical intervention is needed to deliver the infant, whereas most women are able to deliver without any such intervention.

Encourage verbalization of feelings.

Identifies areas to be addressed. Clients’ reactions vary and may be difficult to diagnose in the preoperative period. Feelings of negative self-image related to disappointment in the birth experience may interfere with postpartal activities related to successful breastfeeding and infant care.

Encourage questions and provide information/ reinforce previous learning.

Enhances understanding and clarifies misconceptions.

Refer to cesarean birth as an alternative method of childbirth.

Terms such as “C-section” and “normal delivery” may reinforce client’s perception that the cesarean birth is different and unnatural, and client may view self as inadequate/flawed or weak.

Provide verbal communication of assessment and interventions. Written information can be provided at a later time.

When a problem of self-esteem arises for the client, it may become more severe in the postpartal period. During the preoperative period, client is focusing on the here and now and may not be ready to read or deal with additional information.

Identify other couples/resources to be referred to after delivery.

At this crucial time, the nature of the situation usually does not allow opportunity to talk with others who have shared the same experience. However, these activities may be beneficial in the future to help with resolution of feelings/ perceptions.

Collaborative

Encourage partner's presence at the delivery as desired.

Provides support for the client, promotes parental bonding, and provides additional input to the client's recall of the birth experience, because memory lapses are more common during periods of crisis. Note: Cultural expectations may prevent participation of father in birth process, necessitating attendance by a female family member.

Encourage the client/couple to participate in delivery-room bonding activities (e.g., breastfeeding and holding the infant) as able.

Provides reinforcement of the birth experience and deemphasizes the surgical nature of the delivery.

NURSING DIAGNOSIS:

Powerlessness

May Be Related To:

Interpersonal interaction, perception of illness-related regimen, lifestyle of helplessness

Possibly Evidenced By:

Verbalization of lack of control, lack of participation in care or decision making, passivity

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/COUPLE WILL:

Verbalize fears and feelings of vulnerability.

Express individual needs/desires.

Participate in decision-making process whenever possible.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess factors contributing to sense of powerlessness.

Unplanned (and sometimes planned) cesarean birth may be characterized by the client's/couple's sense of loss of control over the birth experience. The client becomes subjected to the procedures and equipment used in illness. For those clients experiencing their first hospitalization, which involves fear of the unknown, powerlessness becomes a major stress factor.

Present options in care when possible (e.g., choice of anesthesia, IV placement, and use of mirror).

Allows the client/couple to have some sense of input/control over the situation.

Identify client's/couple's expectations and desires regarding the delivery experience.

Provides opportunity to accommodate needs and promote positive experience.

Provide personal space and time alone for the couple prior to surgery, if possible. Remain with client if partner is absent.

Creates sense of control and lets couple have time to talk about their situation. Leaving client alone may result in feelings of abandonment and increased level of anxiety.

Provide information, and discuss client's/couple's perceptions.

Reduces stress caused by misconceptions/unfounded fears as well as fear of the unknown.

NURSING DIAGNOSIS:**Pain [acute], risk for****Risk Factors May Include:**

Increased/prolonged muscle contractions, psychological reactions

Possibly Evidenced By:[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]**DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:**Verbalize reduced discomfort/pain.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess location, nature, and duration of pain, especially as it relates to the indication for cesarean birth.

Indicates the appropriate choice of treatment. The client awaiting imminent cesarean birth may experience varying degrees of discomfort, depending on the indication for the procedure, e.g., failed induction, dystocia.

Eliminate anxiety-producing factors (e.g., loss of control), provide accurate information, and encourage presence of partner.

Levels of pain tolerance are individual and are affected by various factors. Excessive anxiety in response to the emergency situation may enhance discomfort because fear, tension, and pain are interrelated and impact client's ability to cope.

Instruct in relaxation techniques; position for comfort as possible. Use Therapeutic Touch, as appropriate.

May assist in reduction of anxiety and tension, promote comfort and enhance sense of well-being.

Collaborative

Administer sedative, narcotics, or preoperative medication as indicated.

Promotes comfort by blocking pain impulses. Potentiates the action of anesthetic agents.

NURSING DIAGNOSIS:**Infection, risk for****Risk Factors May Include:**

Invasive procedures, rupture of amniotic membranes, break in the skin, decreased Hb, exposure to pathogens

Possibly Evidenced By:

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Be free of infection.

Achieve timely wound healing without complications.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Review history for preexisting conditions/risk factors. Note time of rupture of membranes.

Underlying maternal conditions, such as diabetes or hemorrhage, potentiate the risk of infection or poor wound healing. Risk of chorioamnionitis increases with the passage of time, placing mother and fetus at risk. Presence of infectious process may increase fetal risk of contamination.

Assess for signs/symptoms of infection (e.g., elevated temperature, pulse, WBC; abnormal odor/color of vaginal discharge, or fetal tachycardia).

Rupture of membranes occurring 24 hr prior to surgery may result in chorioamnionitis prior to surgical intervention and may impair wound healing.

Provide perineal care per protocol, especially once membranes have ruptured.

Reduces risk of ascending infection.

Collaborative

Carry out preoperative skin preparation; scrub according to protocol.

Reduces risk of skin contaminants entering the incision, reducing risk of postoperative infection.

Obtain blood, vaginal, and placental cultures, as indicated.

Identifies infecting organism and degree of involvement.

Note Hb and Hct, and estimated blood loss during surgical procedure.

Risk of postdelivery infection and poor healing is increased if Hb levels are low and blood loss is excessive. Note: Greater blood loss is associated with classic incision than with lower uterine segment incision.

Administer parenteral broad-spectrum antibiotic preoperatively.

Prophylactic antibiotic may be ordered to prevent development of an infectious process, or as treatment for an identified infection, especially if the client has had prolonged rupture of membranes. Note: Research suggests administration of antibiotic up to 2 hr before start of procedure provides the most protection from infection.

(Refer to CP: Labor: Stage I—Latent Phase; ND: Infection, risk for maternal.)

NURSING DIAGNOSIS:

Gas Exchange, risk for impaired fetal

Risk Factors May Include:

Altered blood flow to placenta and/or through umbilical cord

Possibly Evidenced By:

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

DESIRED OUTCOMES/EVALUATION CRITERIA—FETUS WILL:

Display optimal FHR.

Manifest normal variability on monitor strip.

Reduce frequency of late or prolonged variable decelerations.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note presence of maternal factors that negatively affect placental circulation and fetal oxygenation.

Reduced circulating volume or vasospasms within the placenta reduce oxygen available for fetal uptake.

Continue monitoring FHR, noting beat-to-beat changes or decelerations during and following contractions.

Owing to hypoxia, fetal distress may occur; may be manifested by reduced variability, late decelerations, and tachycardia followed by bradycardia. Note: Infection from prolonged rupture of membranes also increases FHR.

Note presence of variable decelerations; change client's position from side to side.

Compression of cord between birth canal and presenting part may be relieved by position changes.

Note color and amount of amniotic fluid when membranes rupture.

Fetal distress in vertex presentation is manifested by meconium staining, which is the result of a vagal response to hypoxia.

Auscultate FHR when membranes rupture.

In the absence of full cervical dilation, occult or visible prolapse of the umbilical cord may necessitate cesarean birth.

Monitor fetal heart response to preoperative medications or regional anesthesia.

Narcotics usually reduce FHR variability and may require administration of naloxone (Narcan) following delivery to reverse narcotic-induced respiratory depression. Maternal hypotension in response to anesthesia commonly causes transient fetal bradycardia, reduced variability, and sleep.

Collaborative

Apply internal lead, and monitor fetus electronically as indicated.

Provides more accurate measurement of fetal response and condition.

Provide supplemental oxygen to mother via mask.

Maximizes oxygen available for placental uptake.

Administer IV fluid bolus prior to initiation of epidural/spinal anesthesia.

Optimizes uteroplacental perfusion, helps prevent hypotensive response.

Assist physician with elevation of vertex, if required.

Position changes may relieve pressure on cord.

Arrange for presence of pediatrician and neonatal intensive care nurse in delivery room for both scheduled and emergency cesarean births.

Owing to underlying maternal condition(s) and/or alternative birth process, infant may be preterm or may experience altered responses, necessitating immediate care/resuscitation.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT WILL:

Injury, risk for maternal

Traumatized tissue, delayed gastric motility, altered mobility, effects of medication/decreased sensation

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Be free of injury.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Remove prosthetic devices (e.g., contact lenses, dentures/bridges) and jewelry.

Reduces risk of accidental injury.

Determine time and content of last meal. Report information to anesthesiologist. Ensure availability and functioning of resuscitation equipment.

If client has eaten just before surgical procedure, risks of vomiting and aspiration increase, and general anesthesia may be contraindicated.

Restrict oral intake once decision for cesarean birth is made.

Reduces possibility of aspiration from vomiting.

Review labor record, noting voiding frequency, output, appearance, and time of last voiding.

May indicate urine retention or reflect fluid imbalance or dehydration in client who has been in prolonged labor.

Monitor urine output and color following insertion of indwelling catheter. Note any blood-tinged urine.

Reflects hydration level, circulatory status, and possible bladder trauma associated with surgical procedure.

Assist with positioning for anesthesia; support legs in postoperative transfer to stretcher. Note client's response during and after anesthesia. (Refer to CP: Care Following Cesarean Birth [4 Hours to 4 Days].)

Essential for placement of anesthesia. Client with epidural or spinal anesthesia may incur weakness/decreased sensation of lower extremities. Idiosyncratic responses to anesthesia can occur, such as anaphylaxis or respiratory paralysis if anesthetic block rises too high.

Keep accurate instrument and sponge counts at critical times during closure, according to hospital protocol.

Ensures that all equipment and sponges are accounted for and not accidentally left in client's body.

Collaborative

Obtain urine specimen for routine analysis, protein, and specific gravity. Ensure that laboratory results are available before surgery is started.

Client is at increased risk if infectious process or hypertensive state is present.

Insert indwelling catheter to continuous gravity drainage system either just before surgical procedure or in the operating room, as indicated.

Administer preprocedural medication (e.g., atropine).

Reduces risk of bladder injury during surgical procedure.

Reduces oral secretions, limiting risk of aspiration.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:****Cardiac Output, risk for decreased**

Decreased venous return, alteration in systemic vascular resistance

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Remain normotensive, with blood loss less than 800 ml.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Note length of labor, if applicable. Assess for dehydration or excess intrapartal fluid losses.

Decreased intake and/or increased fluid losses lead to reduced circulating volume and cardiac output.

Remove nail polish on fingernails/toenails.

Allows clear visualization of nailbeds for assessing circulatory status.

Monitor respirations, BP, and pulse before, during, and after administration of anesthesia.

Hypotension is an anticipated side effect of regional anesthesia (e.g., epidural or spinal anesthesia) because such anesthesia relaxes smooth muscles within vascular walls, affecting circulating volume and reducing placental perfusion.

Place towel or wedge under client's hip.

Shifts uterus off inferior vena cava and increases venous return. Compression caused by obstruction of the inferior vena cava and aorta by the gravid uterus in a supine position may cause as much as a 50% decrease in cardiac output.

Note change in behavior or mental status, cyanosis of mucous membranes.

Oxygen deficits are manifested first by changes in mental status, later by cyanosis.

Collaborative

Administer supplemental oxygen via mask, as indicated.

Increases oxygen available for maternal and fetal uptake. Note: Nasal cannula is not recommended because of excessive oxygen loss to environment.

Initiate IV infusion of electrolyte solution. Administer bolus, as indicated.

Expands circulatory volume, especially prior to administration of epidural/spinal anesthesia; provides route for emergency medication in the event of a complication.

Note alteration in vital signs; assist anesthetist as needed. Estimate and record blood losses.

Administer whole blood, plasma expanders, cryoprecipitate, platelets, or packed cells as indicated. (Refer to CP: Postpartal Hemorrhage; ND: Fluid Volume deficit [isotonic].)

Prepare and administer oxytocin (Pitocin) infusion.

Excess fluid losses and hemorrhage during labor and the intraoperative period may reduce cardiac output and promote vasoconstriction with shunting of blood to major organs. Diminished cardiac output and shock are manifested by decreased BP, increased or thready pulse, and cool/clammy skin.

Replaces fluid losses, increases circulating blood volume, and increases oxygen-carrying capacity.

Once delivery of infant and placenta is completed, Pitocin aids myometrium contraction and reduces blood loss from exposed endometrial blood vessels.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

**DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT WILL:**

Sensory/Perceptual alterations, [overload]

Multiple environmental stimuli, increased number of personnel, excessive noise level, psychological stress

Exaggerated emotional response, irritability, muscle tension

Verbalize understanding of need for increased level of activity.

Appear appropriately relaxed.

Maintain focus, tuning out extraneous distractions.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess environment for factors causing sensory overload.

Identifies factors, which may or may not be controllable. Cesarean birth necessitates many medical and nursing activities necessary to ensure the health of mother and infant. Client tends to focus on the procedures being performed and the conversations going on in the room. The birth experience may be compromised by invasive technology, tending to shift the focus from the birth of the infant to the surgical procedure.

Provide information about the surgical routine, including sounds, lights, dress, and instruments.

Knowledge about procedures, instruments, and alarms can help decrease anxiety, puts perceived “chaos” in perspective.

Decrease noise levels, limit conversations, and use equipment/alarms judiciously.

Client may be keenly aware of sounds. Conversation, noise from equipment, and alarms may confuse client/cause unnecessary anxiety.

Maintain eye contact, especially when wearing mask.

Acknowledges presence of client/couple, conveys feeling of caring.

Include client/couple in operating room conversation or silence, using concerned communication.

Eliminate unnecessary personnel from the environment.

Ignoring the client can increase fear, which detracts from a positive birth experience.

Avoids intrusions into personal space, which could increase anxiety. Individuals who are not involved in care of the client may detract from the intimacy of the birth experience.