

THE CLIENT AT 1 WEEK FOLLOWING DISCHARGE

CLIENT ASSESSMENT DATA BASE

Circulation

Vital signs within normal limits

Ego Integrity

Emotional tone and responses may vary from one of delight to a sense of overwhelming disorganization or anxiety, especially in first-time mother. Irritability, crying, “postpartum blues.”

Elimination

May report voiding difficulty or stress incontinence

May report difficulty with bowel evacuation, with decreased frequency, hard-formed stool

Pain/Discomfort

May report continued discomfort associated with afterpains.

Engorgement may be present in lactating client.

Safety

Episiotomy or cesarean incision free of edema, indurated areas, redness, and exudate; tissue edges approximated

Sexuality

Uterus nontender, palpable at symphysis pubis.

Lochial flow scant and pinkish-brown in color (serosa) and of 4–10 days’ duration.

Breasts in lactating client increased in size with increased milk supply.

Nipples free of redness, cracks, and fissures.

Engorgement may be present in lactating client, subsiding in nonlactating client.

DIAGNOSTIC STUDIES

Urine: Negative for albumin/glucose.

Additional testing as indicated; e.g., UA, culture and sensitivity, Hb/Hct or CBC to include WBC count.

NURSING PRIORITIES

1. Promote maternal/infant well-being.
2. Foster optimal adaptation to physical emotional changes.
3. Provide anticipatory guidance for optimal integration of new family member and adaptation to role changes.

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

Physical and emotional demands of infant and other family members, psychological stressors, continued discomfort

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

Identify basis of fatigue and individual areas of control.

Report improved sense of energy.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Discuss signs of excess physical and emotional fatigue.

Lack of energy, deep circles under the eyes, and statements suggesting extreme fatigue indicate inadequate sleep and rest. Self-monitoring and awareness of developing problem allow for timely intervention.

Review intrapartal and early postpartal events.

Cumulative sleep loss must be overcome as soon as possible to facilitate psychological and physiological recuperation.

Determine infant's sleep-wake cycles. Suggest ongoing efforts to modify the infant's behaviors to promote more wakeful periods during the daytime and recommend that mother naps when infant does.

Helps infant to maintain progressively longer wakeful periods during the day and to sleep longer stretches at night. Note: Approximately 5 wk are needed to regulate the infant's cycle.

Encourage restriction or lessening of outside activities. Limit number of visitors.

Helps prevent overexhaustion.

Provide information about daily iron and vitamin intake and the need for a balanced diet.

Helps restore Hb levels needed for oxygen transport, promotes healing, and overcomes nutritional deficiencies, which may contribute to feelings of excess fatigue and inadequate energy levels.

Determine family structure and number of members. Assess work capabilities and responsibilities of each member.

Household tasks should be shared so that division of labor reduces amount of responsibility that client assumes and allows client to conserve energy.

Review family's daily routine.

Assists client in creative problem solving to identify times available for resting and napping throughout the day.

Assess availability/use of support systems (including doula, as appropriate).

Identifies needs and means of physical and emotional assistance.

Encourage client to establish a quiet, relaxing routine prior to retiring (e.g., reading a book or having a glass of warm milk or wine).

Aids in relaxation; promotes sleep.

NURSING DIAGNOSIS:

KNOWLEDGE deficit [LEARNING NEED], regarding self care and infant care

May Be Related To:

Lack of exposure/recall, misinterpretation, unfamiliarity with resources

Possibly Evidenced By:

Verbalization of concerns/misconceptions, hesitancy in or inadequate performance of activities, inappropriate behaviors (e.g., excessive crying)

DESIRED OUTCOMES/EVALUATION

CRITERIA—CLIENT WILL:

Identify individual learning needs.

Perform necessary activities/procedures correctly and explain reasons for the actions.

Verbalize understanding of physiological changes, individual and infant needs.

Modify behaviors, when appropriate.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine client’s perception of problems and needs.

Establishes individual needs and promotes problem solving.

Ascertain understanding of normal physical changes at 1 wk following discharge. Provide information about appropriate measures to take, should a problem arise.

Identifies normal and abnormal physical findings, and encourages anticipatory planning, enhancing independence.

Identify emotional concerns at this time, and discuss normalcy of these feelings. Note reports of depressed mood/tearfulness, emotional lability, with insomnia, poor concentration, headaches.

Most mothers, especially first-time mothers, verbalize a sense of disorganization and feeling of an emotional letdown in the early postpartal period. Such feelings are intensified by fatigue and crying infant. In addition, postpartal or “baby” blues occur in 50%–80% of clients. Symptoms are usually transient, beginning about day 3 postpartum and often resolve without therapeutic intervention in 1–2 wk.

Provide information as needed about signs and symptoms associated with endometritis, mastitis, incisional infection, and UTI, and the need to notify healthcare provider.

Identifies potential problems necessitating prompt evaluation/intervention.

Provide information regarding resumption of menstrual cycle/ovulation and sexual intercourse.

Among nonlactating women, 40% menstruate by 2 wk postpartum; of these, 50% do not ovulate during the first menstrual cycle. Among lactating women, 15% resume menstrual cycle by 6 wk postpartum, and 80% of the first menstrual cycles are anovulatory. Couple can resume sexual activity when client is comfortable and lochial flow has ceased (usually 3–4 wk after vaginal delivery). Client who underwent cesarean delivery should delay intercourse until 6 wk postpartum.

Discuss plans for contraceptive usage.

Conception could occur prior to the 4- to 6-wk checkup, and studies indicate increased risk of complications or untoward outcomes for pregnancies spaced close together. Couple needs to select and use a temporary or permanent method of family planning that meets their individual needs.

Provide information about physiological changes in sexual response postpartum. (Refer to CP: The Client at 4 to 6 Weeks Following Delivery; ND: Sexuality Patterns, altered.)

Reinforce information, as appropriate, for lactating client regarding physiology of lactation, dietary concerns, measures to reduce discomfort of engorgement, and nipple/breast care. Recommend books and other written materials, videos, and related support groups.

Review nutritional needs for lactating or nonlactating client; include information on caloric needs, protein, iron, and vitamin C. (Refer to ND: Nutrition: altered, less than body requirements.)

Emphasize need to prevent venous stasis, and review signs of phlebitis formation, e.g. warmth, redness, tenderness, calf pain.

Instruct client in appropriate perineal muscle-tightening exercises, e.g., Kegel exercise.

Discuss/evaluate ongoing exercise program. Provide information about importance of adhering to prescribed program.

Provide information for client with cesarean birth regarding activity level and exercise and the need to avoid strenuous lifting/stretching.

Reinforce need for evaluation by healthcare provider at 4–6 weeks after delivery.

Identify community resources, e.g., breastfeeding support groups, parenting classes, Family Effectiveness Training (FET).

Reduction in rapidity and intensity of sexual response is normal. Continued low estrogen levels result in vaginal dryness, possibly necessitating use of water-soluble jelly, cocoa butter, or contraceptive creams or jellies for lubrication. Size of orgasmic platform and strength of orgasmic contraction are reduced, and vasoconstriction of labia minora and labia majora is delayed.

Facilitates positive adaptation to breast feeding role.

Helps client meet nutritional needs necessary for recuperation, restoration, and healing in postpartal period.

Changes in circulating volume or cellular components and alterations in mobility increase risk of thrombophlebitis.

Helps strengthen and tone perineal urethral muscles to improve control of urine flow.

Exercise helps tone muscles and restore body contours.

Lifting any object heavier than the baby for 2 wk after delivery may contribute to stress on healing tissues and result in wound dehiscence.

Necessary to ensure that physiological/emotional homeostasis has been re-established.

Helps meet continued educational and developmental needs of client/couple.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT/COUPLE WILL:**

PARENT/INFANT ATTACHMENT; PARENTING, risk for altered

Lack of support between/from significant others, multiple demands of home/family, excess fatigue, unrealistic expectations for self/infant/partner, presence of stressors (e.g., financial, housing, employment, use of outside helper/extended family members)

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

Demonstrate appropriate bonding behaviors.

Identify concerns related to parenting.

Discuss parenting role realistically.

Identify available resources.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess client's/couple's interaction with infant.
Document verbal and nonverbal responses and presence of positive or negative behaviors.

In American culture, attachment is considered positive if the parent makes eye contact with the infant, calls the infant by name, uses an en face position, talks in a high-pitched voice, and holds the baby close. Lack of culturally appropriate attachment behaviors places infant at risk for abuse.

Note impact of culture on interaction.

Different cultures have different values/beliefs about what constitutes positive attachment behaviors.

Assess client's/couple's strengths and weaknesses, maturity level, reaction to conception, and preparation for parenting.

Directly impacts on ability/desire to gain comfort/skill in parenting.

Determine client's/couple's perception of infant behaviors.

Client/couple with unrealistic perception of infant behaviors or who voices displeasure with specific caretaking tasks (e.g., diapering/feeding) will need closer monitoring and more extensive support.

Develop plan for subsequent visits, highlighting areas of particular concern.

Helps promote positive adaptation to new role; helps client focus on possible problems.

Collaborative

Refer family to social services, home healthcare agency, volunteer support program (e.g., Bright Beginnings, First Visitor), or to community resource groups.

Provides support and reduces possible negative outcomes for infant/family. Volunteer support programs provide home visitation, ongoing follow-up as indicated, and role modeling of parenting skills.

NURSING DIAGNOSIS:

PAIN/[DISCOMFORT], risk for

Risk Factors May Include:

Tissue edema/engorgement, mechanical trauma, excessive fatigue

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION

Use appropriate measures to promote comfort.

CRITERIA—CLIENT WILL:

Verbalize relief of pain/discomfort.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine location/nature of discomfort.

Review sleep/rest pattern; note feelings of excess fatigue.

Inspect breasts for degree of engorgement.

Encourage use of supportive bra.

Recommend application of ice or cool compresses for 20–30 min 3–4 times daily, for nonlactating client; apply breast binder. Advise client to avoid breast stimulation or milk expression.

Encourage use of creams, air drying of nipples for 20 min after feedings, avoidance of soaps, and avoidance of plastic liners inside nursing pads. Instruct client to change pads when wet or moist.

Note frequency and length of feedings in lactating client.

Suggest warm compresses/shower before feedings for lactating client.

Instruct lactating client in removal of milk through manual expression or use of breast pump.

Inspect nipples for any areas of indurated masses, cracks, fissures, or redness.

Limit feedings to 5 min on each breast when nipple is cracked, gradually increasing feedings by 2 min each day. Initiate feeding on nontender/less tender nipple for several feedings in succession if only one nipple is sore or cracked.

Note fundal height; assess for rigidity or guarding on examination. Note presence of foul-smelling lochia.

Inspect site of episiotomy repair or cesarean incision.

Suggest continued sitz baths 3–4 times daily for 20 min if site of episiotomy is uncomfortable, or if third- to fourth-degree lacerations were present at delivery.

Identifies individual needs.

Fatigue can negatively affect lactation and increase discomforts associated with engorgement, as well as impair coping and client's response to pain.

Helps determine severity of problem. Engorgement is usually more severe in primipara than in multipara.

Supports and uplifts, alleviating pain and tenderness caused by heavy, engorged breasts.

Provides vasoconstriction of blood vessels; promotes local anesthesia and comfort. Prevents or reduces milk production and engorgement.

Helps toughen nipples and prevent cracking. By allowing nipples to remain in a moist environment, plastic liners promote bacterial growth and may cause skin breakdown.

Engorgement may interfere with breastfeeding, because it makes the breast and nipple hard, making it difficult for the infant to suckle. Increasing frequency of feedings during engorgement promotes comfort and helps to empty breasts to ensure an adequate milk supply.

Aids in let-down reflex to promote easier emptying during feeding.

Removal of milk from breast often provides relief from engorgement; however, removal of too much milk increases the milk supply, possibly causing further engorgement.

Sore or cracked nipples can create intense discomfort during lactation, especially at the beginning of the feeding when the infant is most hungry and sucking is most intense.

Helps limit exposure to trauma; however, limiting sucking for too long reduces milk supply and promotes engorgement. Baby suckles most intensely in the first 5 min of the feeding, creating greater pressure on the initial breast.

Uterine discomfort should have disappeared by 1 wk following discharge. Continued tenderness may signify infection.

Continued discomfort, tenderness, edema, or loss of tissue approximation indicates need for further evaluation by healthcare provider.

Promotes vasodilation and increased tissue oxygenation/nutrition, enhancing healing.

Collaborative

Suggest use of mild, nonaspirin analgesics if necessary, especially 30–60 min before breastfeeding.

Refer to healthcare provider if uterine or wound discomfort is excessive.

Reduces discomfort and promotes relaxation during feeding; facilitates the let-down reflex in lactating client.

Further evaluation is needed to determine the cause of discomfort and appropriate interventions.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/FAMILY WILL:

FAMILY COPING: potential for growth

Sufficiently meeting individual needs and adaptive tasks, enabling goals of self-actualization to surface

Family member(s) moving in direction of health-promoting and enriching lifestyle

Verbalize gradual improvement and smooth transition of new family member into home situation.

Identify tasks leading to desired changes.

Express feelings of self-confidence and satisfaction with progress and adaptation being made.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Evaluate situational support and home assistance used (e.g., husband, relatives, friends, private duty nurses, home care service).

Determine past successful coping mechanisms.

Encourage client to rest and to assume only the responsibilities directly related to care of herself and of the newborn. Encourage client to allow others to take on responsibilities related to upkeep of the house and meals.

Discuss client's/couple's perceptions of adjustment to the infant and to parenting roles and responsibilities. Provide information about normalcy of feelings of inadequacy, stress, and disequilibrium associated with role transition, especially for first-time parents. Document areas of concern for future assessments.

Home assistance is an essential element in facilitating postpartal adaptation.

Building on strengths promotes self-esteem and enhances ability to deal with current situation.

Allows client to focus energy on interaction between infant and herself; allows client to conserve energy for physical and emotional recuperation.

First-time parents have been known to experience varying degrees of stress and crisis associated with adjustment to their child and integration of this child into the family. The challenge of the crisis can serve as a catalyst to growth and enhanced adaptive capacity.

Evaluate family structure and situation, relationships of individual members to one another, and cultural background.

Provide anticipatory guidance related to the time needed to adjust to the new situation and family member.

Collaborative

Refer to parent support group.
Discuss need for family counseling; make appropriate referrals, when indicated.

Blended family resulting from remarriage may require a longer period of adaptation and present a more complex situation than a nuclear family. Extended families may provide added physical and emotional support if available, especially for adjustment to single parent. Note: Folk beliefs/rituals/customs may dictate who provides assistance for client/family.

Period of stress associated with adjustment to the birth of a newborn is often resolved in 4–6 wk. However, because of the potentially overwhelming transition required, this period may last as long as 3 mo.

May be necessary to help members resolve changes and to continue positive adjustment to new roles.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

NUTRITION: altered, risk for less than body requirements

Intake insufficient to meet metabolic demands/correct existing deficiencies (e.g., lactation, anemia/excessive blood loss, infection/excessive tissue trauma, desire to regain prenatal weight)

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

Report dietary intake that meets needs for lactation (as appropriate) and tissue healing/general physical restoration.

Continue to take daily vitamin preparation as indicated.

ACTIONS/INTERVENTIONS

Independent

Determine dietary intake for past 24 hr, history of dietary habits prior to and during pregnancy, and cultural beliefs/background.

Provide information regarding the basic food groups. Stress need for increased amounts (and food sources) of dietary protein, calories, and vitamin C while considering constraints of family budget and cultural preferences.

RATIONALE

Identifies usual eating habits/deficiencies and individual needs. Cultural practices may dictate intake of special foods (e.g., Hmong people eat only chicken and white rice for 30 days postpartum).

Helps correct deficiencies and inadequacies. Protein is needed to promote tissue growth, healing, and regeneration and to offset catabolic process. Calories are necessary for normal metabolic processes, especially for the underweight client; vitamin C is necessary for cell wall synthesis. Financial needs may necessitate use of protein sources other than meat.

Review prenatal Hb and Hct and the amount of blood loss at delivery. Note signs of anemia (e.g., dizziness, excess fatigue, and pallor).

Provide information about need for daily intake of vitamin and iron preparation, as indicated.

Suggest temporary use of ready-made convenience foods or having meals prepared by relatives, friends, or significant other(s).

Weigh client. Establish desired weight, and compare with prepregnancy and initial postpartum weight.

Determine caloric requirements for nonlactating client and possible weight reduction diet.

Discuss dietary needs for the lactating client. Identify foods that may have risk of allergic or other adverse effects on infant. Identify ways of assessing infant's discomfort.

Review importance of fluid intake of 2500–3000 ml/day for lactating client.

Provide information regarding progressive postpartal exercise program. Provide illustrations/demonstration as needed.

Collaborative

Consult with dietitian, as needed.

Preexisting anemic state or excessive blood loss may result in pallor and listlessness. Reduced Hb levels may retard healing process.

Iron and vitamin intake for 4–6 wk postpartum can overcome dietary deficiencies, ensure nutritious milk supply (as desired), and aid in tissue healing.

Demands of caring for newborn leave little time for preparation of balanced meals.

Average weight loss at delivery is 10–12 lb, mainly attributable to infant and products of conception. An additional loss of approximately 5 lb usually follows over the next 2 wk.

Caloric requirements return to prepregnancy levels, unless client was severely underweight. Desired weight can be obtained by reducing caloric intake by 300 kcal/day and establishing an appropriate exercise program.

Intake needs to be increased by 500–800 kcal/day to provide adequate milk production and infant nourishment. Protein needs are 10 g less than they were during pregnancy. Needs for iron, calcium, thiamine, ascorbic acid, and vitamin D are similar to those during pregnancy; the need for vitamin A, niacin, and riboflavin increases. Some foods are passed through the mother's milk and may cause discomfort or allergic reaction in the infant.

Necessary to support adequate milk production to meet infant's needs as well as client's own bodily needs.

Exercise increases metabolic rate and improves utilization of calories while enhancing muscle tone.

May be necessary to plan and restructure diet to meet individual needs/restrictions.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

INFECTION, risk for

Tissue trauma and/or broken skin, decreased Hb, invasive procedures and/or increased environmental exposure, malnutrition

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

Relate techniques to reduce risks and promote healing.

Display signs of wound healing and be free of purulent drainage.

Be free of infection.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Check vital signs; assess client's general physical status.

Temperature greater than 100.4°F (38°C), general malaise, anorexia, and chills suggest infection.

Review intrapartal and postpartal events, noting prolonged labor, premature rupture of membranes, excessive blood loss, or retained/adherent placenta.

These factors increase risk of endometritis or other infectious process.

Determine whether infant was colonized with staphylococci in the nursery.

Increases risk of cross-contamination, especially to lactating clients.

Evaluate client's hygiene practices. Stress need for washing hands before and after perineal pad changes and before handling breasts or infant.

Identifies practices that could contribute to development of infection.

Assess height of fundus. Note color, amount, and character of lochial flow.

Endometritis may be associated with subinvolution or with presence of foul-smelling or purulent lochial flow.

Inspect site of episiotomy repair or cesarean incision. Note redness, exudate, or loss of tissue approximation.

These signs indicate presence of infectious process, requiring further evaluation/intervention.

Assess nipples for cracks or fissures. Provide or reinforce information regarding breast and nipple care. Discuss use of creams, air drying of nipples, and need to avoid use of plastic-lined nursing pads.

Identifies potential source of infection. Breast care measures help toughen nipples, prevent skin breakdown and cracking, and limit presence of moisture, reducing risk of irritation/infection.

Discuss dietary practices. Stress need for increased amounts of food rich in protein, carbohydrates, iron, zinc and vitamins A, B-complex, and C.

Protein helps in tissue growth and healing; carbohydrates are necessary to spare proteins. Iron is used for Hb synthesis; zinc strengthens cell membranes; vitamin A supports differentiation and cell proliferation, and stimulates epithelialization; vitamin B enhances metabolism of proteins, carbohydrates, and lipids; vitamin C is needed for cell wall synthesis.

Note presence of risk factors such as delivery trauma, malnutrition, diabetes, previous UTI/renal problems, or use of indwelling catheter during hospital stay.

These factors may predispose the client to UTI following delivery.

Assess for, and review signs and symptoms of, UTI (e.g., dysuria, hematuria, frequency, urgency, retention, fever, and pain in suprapubic region or costovertebral angle).

UTI requires prompt evaluation and intervention to prevent further involvement and complications.

Note reports of stress incontinence.

May indicate cystocele and the need for further evaluation or surgical repair.

Instruct in use of appropriate muscle-tightening exercises (e.g., Kegel exercise).

Exercise strengthens and tones perineal and urethral muscles to improve control of urine flow and reduce risk of infection.

Test urine pH.

Encourage client to increase fluid intake, especially with cranberry or orange juice.

Collaborative

Assess laboratory results, especially WBC count.

Obtain cultures of lochia, nipple discharge, wound drainage, or urine as indicated.

Discuss antibiotic administration, as appropriate.

Refer for urologic consultation, as indicated.

Alkaline urine increases potential for bacterial growth.

Helps prevent urinary stasis; produces more acidic urine reducing adherence of bacteria to bladder wall.

Leukocytosis during initial 10–12 days postpartum is a normal protective mechanism associated with an increase in neutrophils and a shift to the left and must be distinguished from an abnormal finding indicating infection.

Confirms presence of infection and identifies type.

Antimicrobial agent whose selection is based on culture and sensitivity findings helps eradicate pathogenic bacteria.

May be needed for persistent symptoms, cystocele, or failure to respond to antimicrobial agents.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

ROLE PERFORMANCE, altered

Situational crisis (addition and demands of new family member, changes in responsibilities of family members)

Change in usual patterns or responsibility, conflict in roles

Verbalize awareness of role expectations and potential problems.

Begin to set realistic goals.

Talk with family members about situation and changes that have occurred.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine family structure and individual expectations.

The ease with which each family member adapts to the new role and accommodates the new member may be influenced by the size, stability, and complexity of the family. For example, the blended family may create special concerns, whereby the newborn is a half-brother or half-sister. Although all members of the family are to some extent influenced by the transition, the client herself often suffers the greatest impact in terms of personal and professional responsibilities and must make the most significant accommodations and sacrifices in terms of her time and energy.

Evaluate individual and family goals and client's perception of new family situation. Encourage open communication and sharing of feelings and concerns among family members.

Aid client in setting realistic goals and expectations for herself.

Assist client in acquiring skill and comfort in feeding and bathing infant.

Reinforce client's successes at mothering and specific accomplishments of individual family members.

Discuss concerns; provide information about potential sources and ways of evaluating child care providers.

Collaborative

Refer client to visiting nurse services or community support groups (e.g., La Leche League, step-family organizations).

Refer for professional counseling.

Client who feels cheated, disappointed, or unfulfilled with the mothering role may have difficulty adapting, as may the mother who is forced to return to work for economic reasons but would prefer to remain at home. Identification of problems can be helpful in reaching solutions that are compatible for all concerned.

Too much activity and unrealistic goals compound fatigue and reduce energy levels needed for coping and role integration.

Client who is having difficulty or feels awkward providing care may believe that she is failing in her mothering skills.

Client's self-confidence may be tenuous; she may need constant assurance that she is performing well. Recognition of efforts of those involved supports ongoing change and participation in problem solving.

Sufficient time is required to select safe and appropriate resources that will meet individual needs and allow client to return to personal and professional activities.

Client may need additional assistance in home adjustment. Four weeks may be required for families to integrate infant care into their patterns of daily living.

Further intervention may be needed to promote positive individual and family adjustment.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

BODY IMAGE disturbance

Unrealistic expectations of postpartum recovery, permanency of some changes

Verbalization of negative feelings about body, feelings of helplessness, preoccupation with change, focus on past appearance, fear of rejection/reaction by others

Verbalize realistic perceptions of new body contours.

Report acceptance of self as she is at this moment.

Dress comfortably.

Set realistic goals for change.

Initiate progressive, ongoing prescribed exercise program.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine perception of new body image and of actual or imagined changes that pregnancy and childbirth created.

Client's self-esteem and adaptation to body image are influenced by her perceptions. The client who has fantasized or imagined that she would resume her pregravid appearance and body contours following delivery may be depressed or disappointed when this has not occurred. The client may actually grieve the loss of her prepregnancy appearance. A potential crisis exists, particularly for the emotionally immature client who places much emphasis on appearance. The adolescent, whose primary focus may be dating or reentry into a heterosexual relationship, may experience even greater difficulty adapting to, and coping with, a new body image.

Provide information honestly regarding integumentary and musculoskeletal changes.

Chloasma, nevi, palmar erythema, fine hair growth, changes in condition of hair and fingernails, and joint hypermobility usually disappear or return to pregravid state. Coarse hair, areolar hyperpigmentation, linea nigra, increased foot growth, and spider nevi may not regress completely postpartum. Approximately 6 wk is required for abdominal wall and uterus to return to prepregnancy state.

Discuss ways of dressing attractively and the importance of taking time for personal appearance with application of cosmetics, trips to the hairdresser, and so forth.

Attractive, loose-fitting, nonmaternity clothes and new hairstyle enhance self-esteem and feelings of attractiveness.

Evaluate client's normal physical activity level and participation in sports or exercise program.

Involvement in physical activities aids client in regaining both a positive self-image and her pregravid shape.

Provide information about postpartal exercises (e.g., lifting hips off bed) or sleeping on abdomen. trim figure and increase muscle tone.

Regular exercise program that is specific for each day up to 1 wk postpartum is continued thereafter, as indicated, to

Weigh client, review ideal weight, and discuss proper nutrition as the key to losing weight. Discourage dieting in the lactating client until she stops breastfeeding.

The client retains approximately 60% of weight gained in excess of 24 lb (11 kg), which must be lost through proper diet and exercise. Restriction of calories in the lactating mother results in inadequate milk production.

Ascertain male partner's perception of client's physical appearance. Recommend avoidance of jokes or negative comments regarding her weight and appearance. Encourage male to express caring through increased time and attention or small gifts such as flowers and cards.

Helping male partner become aware of the client's emotional feelings may prevent him from making comments about her body that could reinforce negative feelings. Client may misinterpret the male's focus on the newborn as lack of interest in her, which may enhance her feelings of unattractiveness.

Collaborative

Refer to support groups, follow-up with community resources, or for counseling as needed.

May be necessary to resolve conflicts of self-esteem and poor body image.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT WILL:**

CONSTIPATION, risk for

Inadequate fluid/fiber intake, decreased physical activity, pain on defecation

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

Re-establish usual/optimal evacuation pattern.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Discuss normal evacuation pattern. Determine presence of hemorrhoids, perineal trauma, or third-degree lacerations.

A history of problems with evacuation or constipation may contribute to problems following delivery, especially after the dilating and relaxing effects of progesterone experienced during the prenatal period.

Review role of client's current intake and the role of fluid and diet in stool formation and evacuation.

Lack of roughage and inadequate fluid intake reduce peristaltic motion of fecal matter through intestine, thereby increasing water reabsorption, resulting in dry, hard stools.

Encourage adequate fluid intake (including lactation needs, as appropriate) and diet high in roughage, fruits, and vegetables.

Use of warm beverages (hot water, coffee, tea), fruits/juices, and roughage promotes soft formed stool, eases evacuation, and supports client self-care.

Assess healing of episiotomy or lacerations. Provide information regarding the use of sitz baths 3–4 times daily.

Warmth from sitz bath helps relax anal sphincter, promotes healing, encourages general relaxation, and reduces discomfort associated with evacuation.

Recommend regular exercise, including daily walking program.

Activity enhances muscle tone, stimulates peristalsis, and enhances sense of well-being. Note: Some cultures limit activity following delivery for a prescribed period of time.

Collaborative

Encourage continued use of stool softener, if appropriate.

Helps prevent straining and reduces pain associated with evacuation.

Provide information regarding use of laxatives, enemas, or suppositories.

May be necessary to stimulate peristalsis, promote evacuation, and prevent fecal impaction. Note: Laxatives are not recommended for lactating clients.

NURSING DIAGNOSIS:**Risk Factors May Include:****FLUID VOLUME, risk for deficit**

Increased fluid needs/inadequate intake, active vascular loss (retained placental fragments)

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Demonstrate fluid balance as evidenced by adequate urine output, moist mucous membranes, good skin turgor, vital signs within normal limits.

Display scant lochial flow that is brownish pink in color (serosa) and is free of clots following vaginal delivery.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Ascertain frequency of voiding and character of urine. Note condition of skin, lips, and mucous membranes.

Declining frequency/amount, presence of dark/strong urine, dry lips/mucous membranes, and poor skin turgor suggest inadequate fluid intake in relation to fluid needs.

Note reports of excessive fatigue or dizziness. Assess BP and pulse.

Hypovolemia may result in orthostatic changes.

Decrease in BP and increase in pulse may reflect hypovolemia.

Determine fundal height and note character and amount of lochial flow.

Failure of the fundus to involute properly (should be located at the symphysis pubis) is associated with increased vaginal flow. A return to bright red bleeding is abnormal. Brisk, heavy flow indicates late postpartal hemorrhage secondary to retained placental fragments. (Refer to CP: Postpartal Hemorrhage.)

Review client's activity level.

Slight increase in flow may be secondary to inadequate rest associated with periods of increased activity.

Assess condition of perineum or cesarean incision; note healing.

To identify delayed healing and the potential for hemorrhage or dehiscence.

Collaborative

Obtain screening Hb/Hct and compare with levels obtained prior to discharge (if done), or with prenatal levels.

Provides comparative readings to assess severity of blood loss. Hb/Hct should return to normal within 3 days postpartum. Hb should not drop more than 2 g/100 ml unless blood loss is excessive. (Each milliliter of blood lost contains 0.5 mg of Hb.)

Notify healthcare provider and prepare client for additional evaluation/intervention, as necessary.

Repeat laboratory studies or more invasive procedure such as surgical D & C may be necessary to determine severity of condition, or to diagnose/correct problem.

Provide information regarding medications such as methylergonovine (Methergine) 0.2 mg PO every 3–4 hr for 1–2 days, as needed.

Used to promote uterine contractility, which may foster passage of retained placental tissue if BP is below 140/90.

NURSING DIAGNOSIS:**Risk factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION****CRITERIA—CLIENT/FAMILY WILL:****FAMILY COPING: ineffective, risk for compromised**

Situational/developmental changes, temporary family disorganization and role changes, little support provided by client for partner/family members

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

Identify individual stressors.

Set realistic goals and expectations.

Verbalize resources within themselves to deal with the transition.

Recognize need for and use outside support appropriately.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Evaluate client's actual and perceived physiological state.

Negative feelings, especially in the primipara, may be manifested by real or imagined physiological symptoms. Perhaps owing to unrealistic perceptions, first-time parents tend to experience the greatest degree of crisis, disintegration, and problems with adjustment.

Assess psychological status and discuss normalcy of negative feelings in the client/couple.

The fourth trimester, a transitional period lasting approximately 3 mo following birth, is a difficult period, because the client is vulnerable to negative feelings during crisis resolution and adaptation to stress. Negative feelings of anxiety, depression, and isolation are common, and awareness of the normalcy of these feelings may offset excessive self-concern or self-preoccupation.

Determine individual stressors for client/couple. Note strengths, weaknesses, coping mechanisms, and presence of realistic problem-solving capabilities.

The degree of individual and family stress depends on realistic perception of events, available coping mechanisms, and situational support. Crisis "balancing" factors help facilitate quick resolution of problems, positive adaptation, and growth for client/couple and family. Lack of balancing factors results in continued state of disorganization and persistence of crisis state.

Assist couple with identification of anticipated and unanticipated stressors and formulation of realistic problem solving.

Emotional disorganization associated with crisis is often accompanied by distortion of cognitive perceptions and the ability to respond appropriately to stressors.

Assess available means of assistance with housework and meal preparation.

Assistance with physical labor needed for household maintenance frees the client to devote her psychological energies to herself and infant.

Assess for maladaptive behaviors or ineffective coping.

Provide telephone contact number for 24-hr access.

Collaborative

Refer client to appropriate community agency, counselor, or social services.

Potential for maladaptation, disequilibrium, and continued crisis exists, necessitating immediate intervention, especially if existing support systems are inadequate for the postpartal mother.

New mothers (regardless whether first or fifth child) need access to healthcare resources early in the postpartal period and thereafter to facilitate adaptation.

May need additional assistance if existing support systems are inadequate or not available.