

THE CLIENT AT 24 TO 48 HOURS FOLLOWING EARLY DISCHARGE

This plan of care focuses on the client who is discharged within 30 hr of delivery. It is to be used in conjunction with CP: The Client at 4 Hours to 2 Days Postpartum.

CLIENT ASSESSMENT DATA BASE

Circulation

BP remains at same level as pregnant readings (slightly below baseline).
Pulse between 60 and 90 bpm.
Superficial varicosities may be visible in lower extremities.

Ego Integrity

May feel isolated, anxious, depressed, or fatigued, even though early discharge had been desired by client
May report stressors (e.g., employment, financial, living situation), concerns about personal abilities and assumption of mothering role

Elimination

Voiding 100 ml or greater in amount, without suprapubic tenderness or retention.
Probably has not experienced a return of normal bowel habits.
Hemorrhoids varying in size and number may be present.
Abdominal musculature may be weak and of “bread dough” consistency.

Food/Fluid

Weight reduced by 10–12 lb following delivery.
Physiological edema may still be present.

Pain/Discomfort

Discomforts associated with episiotomy, perineal trauma, hemorrhoids, or afterpains.
Breast tenderness/engorgement may occur between days 3–5 postpartum.
Uterine contractions diminishing daily in frequency and intensity.

Safety

Lochia rubra moderate in amount with fleshy odor; may increase during breastfeeding.
Striae may be present on abdomen, breasts, and thighs.
Perineum or site of episiotomy repair may be edematous with good approximation of wound edges.

Sexuality

Breasts soft, nontender, and free of masses
Nipples soft and free of fissures or lesions
Uterus firm, midline, and located at or just below the umbilicus (uterus is larger in multipara or in client with overdistension)

Social Interactions

May now report lack of/or inadequate support systems; concerns regarding roles of individual family members, role mastery, or disequilibrium (especially in blended family)

DIAGNOSTIC STUDIES

Routine assessment may include CBC or Hb/Hct and UA, and culture and sensitivity, as indicated by physical findings.

NURSING PRIORITIES

1. Determine postpartum status of client.
2. Promote optimal physical and emotional well-being.
3. Facilitate client's/couple's positive adaptation to parenting roles, family growth, and autonomy.

NURSING DIAGNOSIS:	PAIN [acute]/[DISCOMFORT]
May Be Related To:	Mechanical trauma, tissue edema/engorgement or distension, hormonal effects, excessive fatigue
Possibly Evidenced By:	Reports of cramping (afterpains) and perineal discomfort, guarding/distraction behaviors
DESIRED OUTCOMES/EVALUATION	Identify sources of discomfort.
CRITERIA—CLIENT WILL:	Take appropriate measures to reduce discomfort.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Inspect breast and nipple tissue; note presence of engorgement and/or cracked nipples.

Breast engorgement, nipple tenderness, or presence of cracks on nipple (in lactating client) may occur 2–3 days postpartum and result in severe discomfort.

Review appropriate interventions specific to lactating/nonlactating client. (Refer to CP: The Client at 4 Hours to 2 Days Postpartum; ND: Pain, [acute]/[Discomfort].)

Reduces level of discomfort/pain, enhancing self-care ability and sense of control.

Assess uterine tenderness; determine presence and frequency/intensity of afterpains.

Afterpains may continue for 2–3 days postpartum, although their frequency and intensity lessen with time. Factors intensifying afterpains include multiparity, uterine overdistension, and breastfeeding.

Ascertain frequency/amount of voidings. Instruct client in use of Kegel exercise. (Refer to ND: Urinary Elimination, risk for altered.)

Return of normal bladder function may take 4–7 days, and overdistension of bladder may create feelings of urgency and discomfort. Kegel exercise aids in healing and recovery of tone of pubococcygeal muscle to limit urinary stress incontinence.

Inspect condition of perineum or site of episiotomy repair. Note swelling, ecchymosis, lacerations, or discomfort. Recommend that client inspect area daily to evaluate healing process.

Identifies potential sources of pain and discomfort. Routine monitoring may prevent or lessen development of complications.

Recommend use of ice, topical sprays, ointments, creams; sitting with gluteal muscles contracted over site of episiotomy repair, and warm sitz (tub) baths.

Inspect perineum for hemorrhoids. Suggest reinsertion of hemorrhoid with lubricated finger cot or rubber glove.

Discuss continuing increased intake of fluid/dietary fiber, and regular exercise program.

Provide information about needs for sleep and rest; assess emotional state and well-being. the postpartal period.

Encourage client to adopt progressive level of ambulation and activity. Assess cultural impact on activity.

Collaborative

Suggest use of mild analgesics as recommended or prescribed by healthcare provider. Emphasize need to avoid products containing aspirin. For lactating client, medications should be taken 30–60 min prior to breastfeeding.

Suggest use of bulk additives, such as Metamucil, or use of stool softeners, as indicated.

Ice or other cold application is useful in the first 24 hr postpartum to reduce edema and provide localized anesthesia. After that, use of heat promotes vasodilation and perineal healing. Topical medications contain local anesthetics and reduce discomfort. Use of gluteal tightening while sitting reduces stress and direct pressure on perineum.

Aids in regression of hemorrhoids, reduces vulvar varicosities, and promotes return to normal bowel functioning.

Prevention of constipation helps limit discomfort of defecation/hemorrhoids.

Overwhelming fatigue and negative feelings may magnify discomfort associated with normal healing and regeneration in

Early, progressive ambulation facilitates bladder and bowel functioning and enhances circulation, thereby reducing edema and promoting healing. Various cultural groups believe in restricting activity (e.g., some Southeast Asians may believe that the mother should remain in bed close to a fireplace for 30 days after delivery; some Latin cultures adhere to both dietary and rest restrictions for specific periods of time; some Native-American mothers may remain indoors with their infant for 20 days or until the umbilical cord drops off).

Promotes comfort without side effects of acetylsalicylic acid (reduced prothrombin synthesis may possibly increase lochial discharge). Analgesics given early enough to allow onset of action can reduce discomfort associated with oxytocin stimulation of myometrium during lactation.

Enhances bowel elimination, reducing discomfort of constipation and associated hemorrhoids. (Refer to CP: The Client at 4 Hours to 2 Days Postpartum; ND: Constipation.)

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

KNOWLEDGE deficit [LEARNING NEED], regarding progression of condition, self care needs, and possible complications

Unfamiliarity with information resources, lack of recall/incomplete information presented, misinterpretation

Verbalizations of concerns/misconceptions, hesi-tancy in or inadequate performance of activities

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

Verbalize understanding of physiological changes,
individual needs, expected outcomes.

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

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess client's knowledge, understanding, and
ability to apply concepts related to self-care.

Usually, some information is presented during
hospitalization; however, fatigue, anxiety, or time
limitations may have a negative impact on learning at
that time. Additional teaching and/or reinforcement
may therefore be needed.

Identify client's perception of learning needs
regarding self-care and of needs related to
anticipated physical and emotional changes.

Collaborative plan based on client's perceived
needs reduces anxiety, promotes self-
responsibility, and optimizes learning.

Provide information related to normal uterine
involution, lochial changes, and the benefits of
fundal massage.

Self-massage stimulates uterine contractility,
reduces lochial flow, and promotes involution.

Review nutritional status; note prenatal Hb/Hct
levels and estimated blood loss during delivery.
Provide appropriate information about dietary
and fluid needs. (Refer to CP: The Client at 1 Week
Following Discharge; ND: Nutrition: altered,
risk for less than body requirements)

Healthy dietary intake is essential to facilitate
recuperation, and promote lactation as desired.

Provide information about breast care for
nonlactating client, including discussion of the
need for support, application of ice, decreased
nipple stimulation, and only minimal expression
of breast milk to relieve pressure.

Mechanical means of lactation suppression
through use of binder and ice are recommended
over lactation suppressants, which have fallen out
of favor because of the high rate of rebound
engorgement.

Provide information for lactating client, including
nipple and breast care, physiology of lactation,
concept of demand feedings, infant positioning,
dietary and fluid needs, and the need to avoid
taking medications without first consulting
healthcare provider.

Helps promote successful lactation, enhances milk
supply, and reduces possible trauma to nipples.
Some drugs are contraindicated and should be
used with caution during lactation because of
possible effects on newborn.

Discuss need for adequate sleep and rest. (Refer to
ND: Sleep Pattern disturbance).

Extra sleep and rest are needed to overcome sleep
deficit and fatigue, and to facilitate coping.

Provide information regarding hygiene and
perineal care.

Helps facilitate autonomy, prevent infection, and
aid healing.

Discuss importance of progressive postpartal
exercise program.

Beneficial in toning musculature; increases
circulation, and enhances feelings of general well-being.

Review importance of preventing venous stasis and signs/symptoms of complications (e.g., warmth, redness, tenderness, presence of positive Homans' sign).

Discuss relationship between parenting role, use of effective coping mechanisms, and physical and emotional factors (e.g., adequate rest, nutrition, and support).

Review symptoms/normalcy of transitory depression (postpartal blues).

Provide number of 24-hr telephone resource contact.

Reinforce importance of 4- to 6-wk postpartal examination by healthcare provider.

Refer family to community resource groups or for follow-up with social services or home healthcare agency as indicated.

Plasma losses, increased platelets, and persistent vasodilation from progesterone increase likelihood of venous stasis (e.g., visible varicosities) and thrombophlebitis.

Provides information to assist client in making decisions regarding routine activities that foster positive physical and emotional adaptation.

As many as 80% of mothers experience a transitory depression, which usually resolves spontaneously within a week or so. Persistence of mood swings and emotional lability indicates need for further evaluation.

Promotes reassurance that assistance is available if needed.

Follow-up visit is necessary to evaluate recovery of reproductive organs, healing of incision/episiotomy repair, general well-being, and adaptation to life changes.

Provides information and emotional support; reduces possibility of negative outcome for infant and family.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

SLEEP PATTERN disturbance

Hormonal and psychological responses (intense exhilaration, anxiety, excitement), pain/discomfort, exhausting process of labor and delivery, needs/demands of family members

Verbal reports of difficulty falling asleep/not feeling well rested, irritability, dark circles under eyes, frequent yawning

Identify adjustments to accommodate changes required by demands of new family member.

Attain at least 8 hr of sleep per night and nap daily.

Report feeling rested.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess client's perception of fatigue, needs for sleep, and sleep deficits.

Identifies client's perception of the severity of the problem.

Assess home environment, family size and situation, routine, and available help including whether client's partner can take paternity leave.

Assist client in planning rest/sleep periods during day (especially when infant is napping), being realistic within the schedule of family members. Discuss need to retire earlier than usual while infant is waking for night feedings.

Provide information related to positive aspects of sleep and rest.

Encourage client to take a vitamin and iron tablet daily, and to select appropriate diet.

Encourage limitation of number and length of visiting sessions/use of visitors to assist with childcare, homemaker activities.

Note prenatal Hb/Hct levels and estimated blood loss.

The client who is discharged early may believe that she has to take on sole responsibility for infant care tasks, as well as immediately assuming her former roles associated with household management and mother tasks. Such a situation results in excess fatigue, intensifying a sleep deficit.

Examination of household pattern allows realistic appraisal of available times for resting and sleeping, and how family schedule can be revised.

Sleep and inactivity reduce basal metabolic rate and allow oxygen and nutrients to be used for healing.

Helps restore Hb levels needed to transport oxygen and promote healing; helps overcome nutritional deficiencies, which contribute to feelings of excess fatigue and inadequate energy levels.

Overexhaustion may result from time spent with frequent visitors and well-meaning friends. Involving friends in providing meaningful assistance can be rewarding for the client and her support group.

Low Hb/Hct levels increase feelings of fatigue, weakness, and faintness necessitating further evaluation/intervention.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

SELF CARE risk for deficit

Fatigue, decreased endurance, pain/discomfort

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

Demonstrate interest in learning concepts of self-care.

Assume increasing responsibility for own care.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess client's physical and psychological well-being.

Any alteration in physical or emotional well-being may retard assumption of autonomous role in self-care. Until client moves from a "taking in" to a "taking hold" phase, she may require assistance with self-care and infant care.

Determine client's fatigue level, length of labor, time of delivery (i.e., day or night), and sleep deficit before and since delivery. (Refer to ND: Sleep Pattern disturbance.)

Physical need for sleep must be met before client can begin to assume self-care.

Note degree of autonomy and self-responsibility.
Determine cultural influence.

Evaluate client's understanding of postpartal needs and self-responsibility. Provide information as needed.

Review plans for home assistance during recovery period.

Discuss available community resources (e.g., additional discharge visit by hospital/health maintenance organization [HMO] nurse, visiting nurse services, home care aide).

Client begins to assume increasing responsibility for her own care as her condition improves. However, some cultures require specific periods of bedrest for the new mother following delivery and may even restrict personal hygiene activities (e.g., some Arab- or African-Americans may be reluctant to shower or bathe until after cessation of lochial flow, and some Mexican-Americans believe the new mother should care for her infant while other family members take responsibility for her care).

Knowledge base determines amount of information necessary to facilitate assuming self-care role.

Help in home, especially for the first several days following discharge, is critical to assist the client and her family with household management and meal preparation, and to provide care as needed for client and infant.

Visiting nurse can assess health status of client. Home care aide, now an integral part of many hospital early-discharge programs, assists in home management and provides specific infant/client care as necessary. Note: Some doulas may provide services to mother during early-discharge period.

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

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

Identify techniques to reduce risks and/or promote healing.

Display wound free of purulent drainage.

Be free of infection, be afebrile, and have normal lochial flow and character.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess client's temperature, pulse, and respirations.

Elevation of vital signs may reflect developing infection.

Reinforce medical asepsis for pad changes, and application of topical sprays, ointments, or witch hazel compresses.

Helps prevent rectal contaminants from entering vagina or urethra.

Encourage client to take warm sitz baths 3–4 times daily for 20 min, especially if signs of localized congestion/infection are present.

Reiterate instructions regarding fundal massage (i.e., gently 4–5 times, several times per day, with cupped hand, using second hand for support above symphysis pubis).

Note amount and odor of lochial discharge. Review normal progression from rubra to serosa to alba.

Evaluate condition of nipples.

Recommended routine examination of breasts and perineum.

Provide information about UTI and evaluate client for signs and symptoms, including dysuria, frequency, urgency, and pain. Note any tenderness of suprapubic or costovertebral angle.

Review importance of nutrition, fluid intake, and adequate test.

Collaborative

Obtain “clean catch” urine specimen for culture, if signs or symptoms present. Notify healthcare provider.

Discuss rationale and protocol for administration of antibiotic therapy if UTI is present.

Discuss findings suggestive of endometritis with physician or nurse midwife. Help family arrange for transportation to health center or hospital emergency room for further assessment.

Initiate use of home IV service or visiting nurse services if antibiotic by parenteral infusion is ordered. (Refer to CP: Puerperal Infection.)

Promotes localized vasodilation, and increased oxygenation of tissues, enhancing healing.

Enhances uterine contractility. Uterus involutes approximately 1–2 cm (1 finger breadth) per day from the level of the umbilicus. Delayed involution may suggest infection.

Lochia normally has a fleshy odor; however, in endometritis, the discharge may be purulent and foul-smelling, and may fail to demonstrate normal progression.

The development of nipple fissures/cracks potentiates risk of mastitis.

Early detection of developing problems allows for timely intervention, thereby reducing the risk of serious complications.

Stasis, poor hygiene, overdistension, or bacteria introduced during labor and delivery may predispose client to development of UTI.

Promotes healing and general well-being, reducing risk of infection.

Verifies presence and type of infection, and appropriate treatment needs.

Antibiotic therapy eradicates pathogenic organisms.

Findings need to be confirmed by healthcare provider and laboratory culture.

Allows client to remain at home while receiving treatment to eradicate infection. Note: Obstetric department may provide follow-up/home visit services during initial recovery period.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

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

FLUID VOLUME, risk for deficit

Reduced intake and/or inadequate replacement, increased urine output, excessive bleeding at delivery/early postpartum

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

Display BP and pulse within normal limits, firm uterus at or slightly below the umbilicus, with moderate flow of lochia rubra.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess BP and pulse.

Risk of postpartal hemorrhage exists up to 28 days following delivery. Possible causes of hemorrhage include inadequate myometrial contractions (uterine atony), retention of placental tissue, and birth canal lacerations. Hypotension and tachycardia may reflect hypovolemia.

Reinforce the use of uterine massage and fundal monitoring.

Promotes uterine contractility, reducing risk of atony and hemorrhage.

Discuss normal involutionary changes and signs of subinvolution.

Client should be able to identify signs of hemorrhage and institute appropriate interventions if excessive bleeding occurs. (Refer to CP: Postpartal Hemorrhage.)

Assess client's understanding of normal lochial changes.

Briskly flowing, bright red lochia with clots is abnormal and indicates possible hemorrhage. Multiparas or clients with overdistension of the uterus tend to have more lochia than primiparas. Breastfeeding clients have an increased amount of lochia during or just after feedings.

Assist client using a mirror to assess own episiotomy/laceration repair.

Lacerations of the birth canal constitute the second leading cause of postdelivery hemorrhage.

Discuss needs for fluid replacement and signs of dehydration, especially in lactating client.

Client should consume at least eight glasses or more of fluid per day to replace losses and to provide sufficient fluid for milk production.

Assess voiding frequency and amounts.

Kidney function is an indicator of circulating blood volume.

Collaborative

Notify healthcare provider if fundus remains boggy or fails to contract with massage.

Oxytocin (Pitocin) or methylergonovine (Methergine) may be required to correct uterine atony/reduce bleeding. Client may need to be evaluated by healthcare provider for possible readmission to acute-care setting or administration of medication in outpatient clinic.

Prepare client and her family for transfer to clinic or hospital setting, if necessary.

Situation may warrant additional evaluation/intervention, use of hospital emergency equipment, or treatment for stabilization purposes.

NURSING DIAGNOSIS:

URINARY ELIMINATION, risk for altered

Risk Factors May Include:

Hormonal effects (fluid shifts and/or increased renal plasma flow), mechanical trauma, tissue edema

Possibly Evidenced By:

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

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

Empty bladder with each void.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess urinary functioning, noting frequency and amount of voidings per day, and feelings of urine retention or bladder fullness.

Voidings should be moderate in amount (at least 100 ml) to be considered sufficient, although client usually does not measure them at home. Client should empty her bladder 5–7 times per day, depending on amount of prenatal fluid retention and degree of diuresis. Retention may occur, possibly leading to infection or overdistension, which may cause nerve damage.

Assess fundal height and location before and after voiding. Note displacement to the right of umbilicus.

A full bladder displaces the fundus and may interfere with contraction or involution of uterus.

Discuss normal fluid needs and replacement.

Six to eight glasses of fluid per day help prevent stasis and dehydration, replacing fluid lost at delivery.

Note prenatal and intrapartal history of episodes of UTI, catheterizations, or bladder trauma.

These factors may contribute to infection, with consequent alteration in pattern of elimination.

Instruct client to do 50–100 Kegel exercises daily.

Increases circulation to perineum and helps treat stress incontinence.

Encourage client to sit in warm bath or take a warm shower if she has difficulty voiding.

Warm water running over the body enhances relaxation of the perineum and urethra, facilitating voiding.