

THE CLIENT AT 4 HOURS TO 2 DAYS POSTPARTUM

CLIENT ASSESSMENT DATA BASE

Progressive continuation of data base for stage IV.

Activity/Rest

Extreme fatigue and decreased energy level may be noted.
Insomnia may be noted.

Circulation

Diaphoretic episodes occur more often during night.

Ego Integrity

Irritability, tearful/crying (“postpartum blues” often noted about day 3 following delivery)

Elimination

Diuresis between day 2 and 5.
Constipation may occur.

Food/Fluid

Loss of appetite may be reported at about day 3.

Pain/Discomfort

Perineal soreness from stretching, and sutures if episiotomy performed/laceration occurred
Uterine contractions strong and regular in first 24-hr period, diminishing daily in frequency and intensity

Safety

Headache may be reported (subarachnoid/spinal block).

Sexuality

Uterus between one finger breadth above to two finger breadths below umbilicus at 12 hr following delivery, descending approximately one finger breadth daily thereafter
Lochia rubra continues for 2–3 days, progressing to lochia serosa with flow dependent on position (e.g., recumbent versus up and ambulating) and activity (e.g., breastfeeding or exercise).
Breasts: Production of colostrum first 48 hr progressing to mature milk, usually by day 3; may be earlier, depending on when breastfeeding is begun and how frequently mother nurses infant

NURSING PRIORITIES

1. Promote comfort and general well-being.
2. Prevent complications.
3. Support family bonding.
4. Provide information and anticipatory guidance.

DISCHARGE GOALS

1. Physiological/psychological needs being met
2. Complications prevented/resolving
3. Family bonding initiated
4. Postpartal needs understood

NURSING DIAGNOSIS:**May Be Related To:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT WILL:****PAIN [acute]/[DISCOMFORT]**

Mechanical trauma, tissue edema/engorgement or distension, hormonal effects

Reports of cramping (afterpains), headache, perineal discomfort, and breast tenderness; guarding/distraction behaviors, facial mask of pain

Identify and use appropriate interventions to manage discomfort.

Verbalize lessening of levels of discomfort.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Determine presence, location, and nature of discomfort. Review labor and delivery record.

Inspect perineum and episiotomy repair. Note edema, ecchymosis, localized tenderness, purulent exudate, or loss of approximation of suture line. (Refer to ND: Infection, risk for.)

Apply ice pack to perineum, especially during the first 24 hr following delivery.

Encourage use of moist heat (e.g., sitz/tub bath) between 100°F and 105°F (38.0°C–43.2°C) for 20 min, 3–4 times daily, after the first 24 hr.

Recommend sitting with gluteal muscles contracted over episiotomy repair.

Inspect perineum for hemorrhoids. Suggest application of ice for 20 min every 4 hr, use of witch hazel compresses, and elevation of pelvis on pillow. (Refer to ND: Constipation, risk for.)

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

Suggest client lie prone with pillow under abdomen. Encourage use of visualization techniques or diversional activities.

Identifies specific needs and appropriate interventions.

May reflect excess trauma to perineal tissue and/or developing complications requiring further evaluation/intervention.

Provides localized anesthesia, promotes vasoconstriction, and reduces edema and vasodilation.

Increases circulation to perineum, enhances oxygenation and nutrition of tissues, reduces edema, and promotes healing.

Use of gluteal tightening while sitting reduces stress and direct pressure on perineum.

Aids in regression of hemorrhoids and vulvar varicosities by promoting localized vasoconstriction; reduces discomfort and itching, enhancing return to normal bowel function.

During the first 12 hr postpartum, uterine contractions are strong and regular, and they continue for the next 2–3 days, although their frequency and intensity are reduced. Factors intensifying afterpains include multiparity, uterine overdistension, breastfeeding, and administration of oxytocin/ergot preparations.

Promotes comfort, enhances sense of control, and refocuses attention.

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

Encourage wearing of supportive bra.

Provide information regarding increasing the frequency of feedings, applying heat to breasts before feedings, positioning the infant properly, and expressing milk manually.

Suggest client initiate feedings on nontender nipple for several feedings in succession if only one nipple is sore or cracked.

Apply ice to axillary area of breasts if the client is not planning to breastfeed. Provide tight compression with binder for 72 hr or use of well-fitting supportive bra. Avoid excess exposure of breasts to heat or stimulation of breasts by infant, sexual partner, or client until suppression process is completed (approximately 1 wk).

Assess client for bladder fullness; implement measures to facilitate voiding. Instruct client in use of Kegel exercise after anesthesia wears off. (Refer to ND: Urinary Elimination, risk for altered.)

Evaluate for headache, especially following subarachnoid anesthesia. Avoid medicating client before nature and cause of headache are determined. Note character of headache (e.g., deep location behind the eyes, with pain radiating to both temples and occipital area; relieved in supine position but increased in sitting or standing position) to distinguish from headache associated with anxiety or PIH. Encourage bedrest, increase oral fluids, and notify healthcare provider or anesthesiologist, as indicated.

At 24 hr postpartum, breasts should be soft and nontender, and nipples should be free of cracks or reddened areas. Breast engorgement, nipple tenderness, or presence of cracks on nipple (if client is lactating) may occur at 2 or 3 days postpartum. Note: Presence of flat or inverted nipples may prevent infant from “latching on,” resulting in engorgement/nipple soreness.

Lifts breasts inward and upward, creating a more comfortable position.

These measures can help the lactating client stimulate the flow of milk and relieve stasis and engorgement. (Refer to ND: Breastfeeding [specify].)

Initial suckling response is strong and may be painful. Starting feeding with unaffected breast and then proceeding to involved breast may be less painful and may enhance healing.

Binding and ice prevent lactation by mechanical means and are the preferred method for suppression of lactation. Discomfort lasts approximately 48–72 hr but eases or ceases with avoidance of nipple stimulation.

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/prevent urinary stress incontinence.

Leakage of cerebrospinal fluid (CSF) through the dura in the extradural space reduces volume needed to support brain tissue, causing the brain stem to fall onto the base of the skull when client is in an upright position, resulting in a headache on about the 2nd postpartal day. Fluids help stimulate production of CSF. PIH may result in cerebral edema, necessitating other interventions. (Refer to ND: Fluid Volume, risk for excess.)

Collaborative

Administer mild analgesic 30–60 min prior to breastfeeding. For nonlactating client, administer analgesics every 3–4 hr for breast engorgement and afterpains.

Provide anesthetic sprays, topical ointments, and witch hazel compresses for perineum, as appropriate.

Assist as needed with saline injection or administration of “blood patch” over site of dural puncture. Keep client in horizontal position following the procedure.

Provides comfort, especially during lactation, when afterpains are most intense owing to the release of oxytocin. When client is free of discomfort, she can focus on care of herself and her infant, and on mastering mothering tasks.

Promotes localized comfort.

Effective for relief of severe spinal headache. The blood patch procedure has a 90%–100% success rate; creates a blood clot that produces pressure and seals the leak. Note: Postspinal headache may last several days to a week.

NURSING DIAGNOSIS:

BREASTFEEDING [specify] (depends on whether mother-infant dyad exhibits satisfaction or dissatisfaction with breastfeeding experience)

May Be Related To:

Level of knowledge, previous experiences, infant gestational age, level of support, physical structure/characteristics of the maternal breasts

Possibly Evidenced By:

Maternal verbalization regarding level of satisfaction, observations of breastfeeding process, infant response/weight gain

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Verbalize understanding of breastfeeding process/situation.

Demonstrate effective techniques for breastfeeding.

Display mutually satisfactory breastfeeding regimen, with infant content after feedings.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess client’s knowledge and previous experience with breastfeeding.

Helps in identifying current needs and developing plan of care.

Determine support systems available to client, and attitude of partner/family. Note cultural expectations.

Having sufficient support enhances opportunity for a successful breastfeeding experience. Negative attitudes and comments interfere with efforts and may cause client to abandon attempt to breastfeed. Some cultures may require client to postpone initiation of breastfeeding until milk comes in.

Provide information, verbal and written, regarding physiology and benefits of breastfeeding, nipple and breast care, special dietary needs, factors that facilitate or interfere with successful breastfeeding, use of breast pump/appropriate suppliers.

Demonstrate and review breastfeeding techniques, including latching on and removal from breast. Note positioning of infant during feeding and length of feedings.

Assess client's nipples; recommend that client inspect nipples after each feeding.

Encourage client to air-dry nipples for 20–30 min after feedings (after first expressing some breast milk on sore nipples) and to apply lanolin preparation after feedings, or to use heat lamp with 40-W bulb placed 18 in from breast for 20 min. Instruct client to avoid the use of soaps or the use of plastic liners inside bra pads, and to change nursing pad when wet or moist.

Instruct client to avoid use of nipple shield, unless specifically indicated.

Provide special nipple breast shields (e.g., Eschmann shields) for lactating client with flat, inverted nipple. Suggest application of ice prior to feedings and exercise of nipple by rolling between thumb and forefinger and using Hoffman's technique.

Collaborative

Refer client to support groups; (e.g., La Leche League International, Lact-Aid) or lactation consultant.

Identify available community resources as indicated, e.g., Women, Infants, and Children (WIC) program.

Helps ensure adequate milk supply, prevents nipple cracking and soreness, facilitates comfort, and establishes role of breastfeeding mother. Benefits include providing comfort for infant, stimulation of hormones to contract uterus after birth, decrease risk of hemorrhage, and facilitate client's return to pregravid weight. Pamphlets and books provide resources that client can refer to as needed.

Proper positioning usually prevents sore nipples, regardless of the length of feedings.

Early identification and intervention may prevent/limit development of nipple soreness or cracking, which could impair breastfeeding process.

Exposure to air or heat helps toughen nipples, whereas soaps may cause drying. Keeping nipples in a wet medium promotes bacterial growth and skin breakdown. Note: Studies suggest that applying a small amount of breast milk to the nipple area may be useful for treating cracked nipples by keeping the area soft and pliable and allowing live antibodies in the milk to facilitate healing.

These have been found to contribute to lactation failures. Shields prevent the infant's mouth from coming into contact with the mother's nipple, which is necessary for continued release of prolactin (promoting milk production), and can interfere with or prevent establishment of adequate milk supply. Note: Temporary use of shield may be beneficial in the presence of severe nipple cracking.

Lacted cups/breast shields, exercises, and ice help make nipple more erect; Hoffman technique breaks adhesions, which cause inversion of nipple.

Provides ongoing help to promote a successful outcome.

WIC and other federal programs support breastfeeding through client education and enhanced nutritional intake.

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

Biochemical, regulatory function (e.g., orthostatic hypotension, development of PIH or eclampsia); effects of anesthesia; thromboembolism; abnormal blood profile (anemia, rubella sensitivity, Rh incompatibility)

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

Demonstrate behaviors to reduce risk factors/protect self.

Be free of complications.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Review Hb level and blood loss at delivery. Note signs of anemia (e.g., fatigue, dizziness, pallor).

Anemia or excessive blood loss predisposes client to syncope or fainting spells, owing to inadequate delivery of oxygen to the brain.

Encourage early ambulation and exercise except in client who has received subarachnoid anesthesia, who may remain flat for 6–8 hr, without use of pillow or raising head, as indicated by protocol and return of sensation/muscle control. (Refer to ND: Pain [acute]/[Discomfort].)

Enhances circulation and venous return of lower extremities, reducing risk of thrombus formation, which is associated with stasis. Although recumbent position after subarachnoid anesthesia is debatable, it may aid in prevention of CSF leakage and resultant headache.

Assist client with initial ambulation. Provide adequate supervision in shower or sitz bath. Leave call bell within client's reach.

Orthostatic hypotension may occur when changing from supine to upright position on initial ambulation, or it may result from vasodilation caused by the heat of the shower or sitz bath.

Have client sit on floor or chair with head between legs, or have her lie down in a flat position, if she feels faint. Use ammonia capsule (smelling salts).

Helps maintain or enhances circulation and delivery of oxygen to brain.

Assess client for hyperreflexia, right upper quadrant (RUQ)/epigastric pain, headache, or visual disturbances. Maintain seizure precautions, and provide quiet environment, as indicated. (Refer to ND: Fluid Volume, risk for excess; CP: Pregnancy-Induced Hypertension; ND: Injury, risk for maternal.)

Danger of eclampsia caused by PIH exists for up to 72 hr postpartum, although literature suggests that the convulsive state has occurred as late as the 5th day postpartum.

Note effects of MgSO₄, if administered. Assess patellar response, and monitor respiratory rate.

Absence of patellar reflex and respiratory rate below 12/min indicate toxicity and a need to reduce or discontinue drug therapy.

Inspect lower extremities for signs of thrombophlebitis (e.g., redness, warmth, pain/tenderness). Note presence or absence of Homans' sign. (Refer to CP: Postpartal Thrombophlebitis.)

Apply local heat; promote bedrest with affected limb elevated.

Evaluate rubella status on prenatal chart (less than 1:10 titer indicates susceptibility). Assess client for allergies to eggs or feathers; if present, withhold vaccine. Provide written and oral information, and obtain informed consent for vaccination after reviewing side effects, risks, and the necessity to prevent conception for 2–3 mo following the vaccination.

Collaborative

Administer $MgSO_4$ by infusion pump, as indicated.

Apply support hose or elastic wrap to legs when risk or symptoms of phlebitis are present.

Administer anticoagulant; evaluate coagulation factors, and note signs of failure to clot. (Refer to CP: Postpartal Thrombophlebitis.)

Administer $Rh_0(D)$ immune globulin ($RhIgG$) intramuscularly (IM), within 72 hours' postpartum, as indicated, for Rh-negative mother who has not been previously sensitized and who delivers an Rh-positive infant whose direct Coombs' test on cord blood is negative. Obtain Betke-Kleihauer smear if significant fetal-maternal transfusion is suspected at delivery.

Elevated fibrin split products (possibly released from placental site), reduced mobility, trauma, sepsis, and extensive activation of blood clotting following delivery predispose the client to the development of thromboembolism. Homans' sign may be present with deep venous thrombus, but may be absent with superficial phlebitis.

Stimulates circulation and decreases venous pooling in lower extremities, reducing edema and promoting healing.

Helps prevent teratogenic effects in subsequent pregnancies. Administration of vaccine in the immediate postpartal period may cause side effects of transient arthralgia, rash, and cold symptoms during incubation period of 14–21 days. Allergic anaphylactic or hypersensitivity response may occur, necessitating administration of epinephrine.

Helps reduce cerebral irritability in presence of PIH or eclampsia. (Refer to ND: Fluid Volume risk for excess.)

Reduces venous stasis, enhancing venous return.

Although usually not required, anticoagulant may help prevent further development of thrombus.

Dose of 300 mg is usually sufficient to promote lysis of fetal Rh-positive red blood cells (RBCs) that may have entered maternal circulation during delivery, and that may potentially cause sensitization and problems of Rh incompatibility in subsequent pregnancies. Presence of 20 ml or more of Rh-positive fetal blood in maternal circulation necessitates higher dose of $RhIgG$. Note: If drug is not administered within 72 hr of delivery, a window of opportunity exists for up to 2 wk, although the degree of effectiveness may be reduced.

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, prolonged rupture of amniotic membranes, malnutrition

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

Demonstrate techniques to reduce risks/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 prenatal and intrapartal records, noting frequency of vaginal examinations and complications such as premature rupture of membranes (PROM), prolonged labor, lacerations, hemorrhage, or retained placenta.

Monitor temperature and pulse routinely and as indicated; note signs of chills, anorexia, or malaise.

Assess location and contractility of uterus; note involuntional changes or presence of extreme uterine tenderness.

Note amount and odor of lochial discharge or change in normal progression from rubra to serosa.

Evaluate condition of nipples, noting presence of cracks, redness, or tenderness. Recommend routine examination of breasts. Review proper care and infant feeding techniques. (Refer to ND: Pain [acute]/[Discomfort].)

Inspect site of episiotomy/laceration repair every 8 hr. Note excessive tenderness, redness, purulent exudate, edema, gapping at suture line (loss of approximation).

Note frequency/amount of voidings.

Assess for signs of urinary tract infection (UTI) or cystitis (e.g., increased frequency, urgency, or dysuria, cloudy/foul-smelling urine, visible hematuria, and presence of suprapubic pain).

Helps identify risk factors that may impair healing and/or retard epithelial growth of endometrial tissue and predispose client to infection.

Elevation of temperature to 101°F (38.3°C) within the first 24 hr is highly indicative of infection; an elevation to 100.4°F (38.0°C) on any 2 of the first 10 days postpartum is also significant. Note: Research suggests epidural anesthesia during labor is associated with postpartal fever (100.4°F [40.0°C] or greater) in some clients, with rate of occurrence rising in proportion to length of labor. However, actual infection is rare.

The fundus, which is initially 2 cm below the umbilicus, rises to the level of the umbilicus and involutes at the rate of 1–2 cm/day (one finger breadth per day). Failure of the myometrium to involute at this rate, or development of extreme tenderness, signals possible retained placental tissue or infection. Note: Size of the uterus is influenced by the size of the infant just delivered. (Refer to CP: Puerperal 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 from rubra to serosa to alba.

The development of nipple fissures/cracks potentiates risk of mastitis. Note: Use of soap is not recommended for nipple care because it is drying and increases risk of cracking.

Early diagnosis of localized infection may prevent spread to uterine tissue. Note: Presence of third- to fourth-degree lacerations increases risk of infection.

Urinary stasis increases the risk of infection.

Symptoms of UTI may appear on days 2–3 postpartum owing to ascending tract infection from urethra to bladder and possibly to kidney.

Encourage perineal care using perineal bottle or sitz bath 3–4 times daily or after voiding/defecation. Recommend that client shower daily and change perineal pads at least every 4 hr, applying pad from front to back.

Demonstrate and encourage use of careful handwashing technique and appropriate disposal of soiled underpads, perineal pads, and contaminated linen. Discuss with client the importance of continuing these measures after discharge.

Assess client's nutritional status. Note appearance of hair, fingernails, skin, and so forth. Review prepregnancy weight and prenatal weight gain.

Provide information about selecting foods high in protein, vitamin C, and iron. Encourage client to increase fluid intake to 2000 ml/day.

Promote sleep and rest.

Collaborative

Assess white blood cell (WBC) count.

Note Hb and Hct. Administer iron preparations and supplemental vitamins, as necessary.

Administer methylergonovine maleate (Methergine) or ergonovine maleate (Ergotrate) every 3–4 hr, as appropriate.

Assist with, or obtain cultures from, vagina, serum, and site of episiotomy repair, as indicated.

Encourage client to apply antibiotic creams to perineum, as indicated.

Frequent cleaning from front to back (symphysis pubis to anal area) helps prevent rectal contaminants from entering vagina or urethra. Sitz or tub baths stimulate perineal circulation and promote healing. Note: Some cultures (e.g., African- or Arab-American) may abstain from tub/shower bath or even washing hair until after cessation of lochial flow, or possibly longer. Other cultures (e.g., Haitian) may engage in ritual baths for several days following delivery.

Helps prevent or retard spread of infection.

Client who is 20% below normal weight, or who is anemic or malnourished is more susceptible to postpartal infection and may have special dietary needs for protein, iron, and calories.

Protein helps promote healing and regeneration of new tissue and overcomes delivery losses. Iron is necessary for hemoglobin synthesis. Vitamin C facilitates iron absorption and is necessary for cell wall synthesis. Increased fluid helps prevent urinary stasis and kidney problems.

Reduces metabolic rate and allows nutrition and oxygen to be used for healing process rather than for energy needs.

An increase in WBC count the first 10–12 days postpartum normally occurs as a protective mechanism and is associated with an increase in neutrophils and a shift to the left, which may interfere initially with identification of infection.

Determines whether anemic state is present. Helps correct deficiencies.

Fosters myometrial contraction and uterine involution in nonlactating client, reducing risk of infection. Note: May be contraindicated in presence of elevated BP.

To identify causative organism, if present, and determine appropriate antibiotic.

Eradicates local infectious organisms.

Obtain clean catch (midstream) urine specimen for analysis as needed.

Administer antipyretic after cultures are obtained.

Administer broad-spectrum antibiotic until culture/sensitivity report is returned; then alter therapy as indicated. (Note: Parenteral route via saline lock is preferred for treatment of endometritis and sepsis.)

Contact appropriate community agencies, such as visiting nurse/homecare services, for follow-up on diet, antibiotic course, possible complications, and return medical examination.

Urine retention, bacteria introduced by catheterization, and/or bladder trauma during delivery combine to create an excellent environment for bacterial growth. Bacterial concentrations of 100,000 microorganisms per 100 ml of fresh urine usually indicate an infection.

When administered before identification of infectious process, antipyretics may mask signs and symptoms necessary for a differential diagnosis.

Prevents infection from spreading to surrounding tissues or bloodstream. Choice of antibiotic depends on sensitivity of infecting organism.

Any postpartal infection places the client in a debilitated state that requires more rest, closer monitoring, and assistance with home maintenance and self/infant care.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

URINARY ELIMINATION, altered

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

Increased bladder filling/distension, changes in amount/frequency of voiding

Void unassisted within 6–8 hr after delivery.
Empty bladder with each void.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess current fluid intake and urine output.
Note intrapartal I/O and length of labor.

In the early postpartal period, approximately 5 lb of fluid is lost through urine output and insensible losses, including diaphoresis. Prolonged labor and ineffective fluid replacement may result in dehydration and reduced urine output.

Palpate bladder. Monitor fundal height and location, and amount of lochial flow.

Renal plasma flow, which increases by 25%–50% during the prenatal period, remains elevated in the first week postpartum, resulting in increased bladder filling. Bladder distension, which can be assessed by degree of uterine displacement, causes increased uterine relaxation and lochial flow.

Note presence of edema or lacerations/episiotomy, and type of anesthesia used.

Trauma to bladder or urethra, or edema, may hinder voiding; anesthesia may interfere with sensation of fullness.

Test urine for albumin and acetone. Distinguish between proteinuria associated with PIH and that associated with normal processes. (Refer to ND: Fluid Volume, risk for excess.)

Encourage voiding within 6–8 hr postpartum, and every 4 hr thereafter. If condition permits, have client walk to bathroom. Pour warm water over the perineum, run water from the faucet, add spirits of peppermint to bedpan, or have client sit in sitz bath or take a warm shower, as indicated.

Instruct client to use Kegel exercise daily after effects of anesthesia subside.

Encourage drinking 6–8 glasses of fluid per day.

Assess for signs of UTI (e.g., burning on urination, increased frequency, cloudy urine).

Collaborative

Catheterize, using straight or indwelling catheter, as indicated.

Obtain urine specimen, using clean catch technique or catheterization, if client has symptoms of UTI.

Monitor laboratory test results, such as blood urea nitrogen (BUN) and 24-hr urine for total protein, creatinine clearance, and uric acid as indicated.

Catalytic process associated with uterine involution may result in normal proteinuria (1+) for the first 2 days postpartum. Acetone may indicate dehydration associated with prolonged labor/delivery.

A variety of nursing interventions may be necessary to stimulate or facilitate voiding. A full bladder interferes with uterine motility and involution, and increases lochial flow. Prolonged bladder overdistension can damage the bladder wall and result in atony.

Performing Kegel exercise 100 times per day increases circulation to perineum, aids in healing and recovery of tone of pubococcygeal muscle, and prevents or reduces stress incontinence.

Helps prevent stasis and dehydration, and replaces fluid lost at delivery.

Stasis, poor hygiene, and introduction of bacteria may predispose client to UTI. (Refer to ND: Infection, risk for.)

May be necessary to reduce bladder distension, allow for uterine involution, and prevent bladder atony associated with bladder overdistention.

Presence of bacteria or positive culture and sensitivity are diagnostic for UTI.

In the client who has had PIH, kidney or vascular involvement may persist, or it may appear for the first time during the postpartal period. As steroid levels decrease following delivery, renal function, reflected by BUN and creatinine clearance, begins to return to normal within 1 wk; anatomic changes (e.g., dilation of ureters and renal pelvis) may take up to 1 mo to return to normal.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

FLUID VOLUME, risk for deficit

Reduced intake/inadequate replacement, excessive losses (vomiting, diaphoresis, increased urine output and insensible losses, hemorrhage)

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

Remain normotensive with fluid intake and urine output appropriately balanced, and Hb/Hct within normal levels.

ACTIONS/INTERVENTIONS

RATIONALE

(Refer to CP: Stage IV [First 4 Hours Following Delivery of Placenta].)

Independent

Note fluid losses at delivery; review intrapartal history. (Refer to CP: Postpartal Hemorrhage.)

Potential hemorrhage or excess blood loss at delivery that continues into the postpartal period may result from prolonged labor, oxytocin stimulation, retained tissue, uterine overdistension, or general anesthesia.

Evaluate location and contractility of uterine fundus, amount of vaginal lochia, and condition of perineum every 2 hr for the first 8 hr, as appropriate, then every 8 hr for the remainder of hospitalization. Note administration of medication, such as MgSO₄, that would cause uterine relaxation.

Differential diagnosis may be needed to determine cause of fluid deficit and protocol of care. A relaxed or boggy uterus with increased lochial flow may result from myometrial fatigue or retained placental tissue. Immediately after delivery, the fundus should be firm and located at the umbilicus, and then involute approximately one finger breadth per day.

Gently massage fundus if uterus is boggy.

Stimulates uterine contraction; may control bleeding.

Note presence of thirst; provide liquids as tolerated.

Thirst may be a homeostatic means of replacing fluid losses through increased oral intake.

Evaluate status of bladder; promote emptying if bladder is full. (Refer to ND: Urinary Elimination, altered.)

A full bladder interferes with uterine contractility and causes displacement and relaxation of fundus.

Monitor temperature, pulse, BP, as indicated.

Increased temperature may signify dehydration, or infection. (Refer to CP: Puerperal Infection.) Tachycardia may occur to maximize fluid circulation in the event of dehydration or hemorrhage, whereas elevation of BP may be due to the effects of oxytocin vasopressor drugs, or to preexisting or newly developed PIH. Falling BP may be a late sign of excess fluid loss, especially if accompanied by other signs or symptoms of shock.

Evaluate fluid intake and urine output during IV infusion, or until normal voiding patterns are re-established.

Helps in analyzing fluid balance and degree of deficit.

Monitor filling of breasts and milk supply if lactating.

The dehydrated client is unable to produce sufficient milk supply.

Collaborative

Replace fluid losses with IV infusion containing electrolytes.

Helps re-establish circulating blood volume and replace losses from delivery and diaphoresis.

Administer ergot products such as ergonovine maleate (Ergotrate) or methylergonovine maleate (Methergine) parenterally or orally, or administer IM/IV synthetic oxytocin preparations (Syntocinon, Pitocin). Assess BP before administering ergot preparations; withhold medication and notify healthcare provider if BP is elevated.

These products act directly on the myometrium to promote uterine contraction. Ergot, a vasoconstrictor, may cause hypertension and should be withheld if BP is 140/90 mm Hg or greater.

Initiate or increase rate of IV fluid such as lactated Ringer's solution with 10–20 units of oxytocin.

Review prenatal Hb/Hct levels; note blood loss at delivery. Obtain postpartal Hb/Hct as indicated.

Oxytocin (Pitocin) may be needed to stimulate the myometrium if excess bleeding persists and if uterus fails to contract. Persistent bleeding in presence of firm fundus may indicate lacerations and the need for further investigation. (Refer to CP: Postpartal Hemorrhage.)

Hb/Hct usually return to normal within 3 days. Hb should not drop more than 2 g/100 ml unless blood loss is excessive. Elevation of Hct levels occurs normally by the 3rd–7th day postpartum, owing to plasma loss in excess of blood cell decreases that occurs during the first 72 hr. However, such elevation may also indicate excess shift of intravascular fluids to extracellular spaces.

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

FLUID VOLUME, risk for excess

Fluid shifts following placental delivery, inappropriate fluid replacement, effects of oxytocin infusion, presence of PIH

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

Display BP and pulse within normal limits, be free of edema and visual disturbances, breathe with clear sounds.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Review prenatal and intrapartal history for PIH, noting elevated BP, proteinuria, and edema.

Monitor BP and pulse. Auscultate breath sounds, noting moist cough, rales, or rhonchi. Note presence of dyspnea or stridor.

Monitor fluid intake and urine output; measure urine-specific gravity.

Note dosage of oxytocin (Pitocin) when it is administered parenterally.

Assess presence, location, and extent of edema. Monitor for signs of progressive edema (e.g., visual disturbances, hyperreflexia, clonus, RUQ/epigastric pain, and headache). (Note: Assess for headache prior to administering any analgesics.)

Helps determine likelihood of similar complications persisting/developing in postpartal period.

Circulatory overload is manifested by increases in BP and pulse, and by fluid accumulation in the lungs. Elevated BP may also be related to PIH and fluid retention associated with oxytocin infusion.

Indicates fluid needs/adequacy of therapy.

Oxytocin increases sodium/water resorption from the kidney tubules and may result in elevated BP.

Danger of eclampsia or convulsive state exists for 72 hr, but can actually occur as late as 5 days after delivery. Medication may mask signs of headache caused by cerebral edema.

Using a dipstick, test for presence of proteinuria every 4 hr.

Evaluate client's neurological status. Note hyperreflexia, irritability, or personality changes.

Have client monitor weight daily, especially if postpartal toxemia is present.

Collaborative

Note test results for uric acid, 24-hr protein and creatinine clearance, and serum creatinine levels.

Insert indwelling catheter, as indicated.

Evaluate for HELLP syndrome (i.e., hemolysis of RBC, elevated liver enzymes, and low platelet count).

Administer medications as indicated, e.g.:

MgSO₄ per infusion pump (refer to CP: Pregnancy-Induced Hypertension; ND: Injury, risk for maternal);

Hydralazine (Apresoline) or methyldopa (Aldomet) per protocol (e.g., if diastolic readings are 110 mm Hg or greater);

Furosemide (Lasix);

Mannitol (Osmitol).

Postpartal proteinuria of 1+ is normal, owing to catalytic process of uterine involution. Levels of 2+ or greater may be associated with glomerular spasms of PIH.

Cerebral intoxication is an early indicator of excess fluid retention.

At delivery, client should lose approximately 10–12 lb, attributable to infant, products of conception, urine, and insensible losses, and 5 lb more in the early postpartal period through fluid and electrolyte shifts.

Abnormal results, such as increasing uric acid (> 7 mg/100 ml) and elevated creatinine levels, indicate deterioration of renal function.

May be needed to monitor urine output on hourly basis if warranted by client's condition (e.g., severe PIH or oliguria).

HELLP syndrome is a potential postpartal consequence of PIH with liver involvement or with hemorrhage of hepatic vessels.

MgSO₄ acts at myoneural junction and may have transient effects of lowering BP and increasing urine output.

Hydralazine relaxes peripheral arterioles and promotes vasodilation to lower BP, whereas methyldopa acts on postganglionic nerve endings, interfering with chemical neurotransmission to reduce peripheral vascular resistance.

Lasix acts on loop of Henle to increase urine output and relieve pulmonary edema.

For client with PIH, impending renal failure, or oliguria, mannitol acts as osmotic diuretic to draw fluids into vascular bed and increase renal plasma flow and urine output.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

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

CONSTIPATION

Decreased muscle tone (diastasis recti), effects of progesterone, dehydration, excess analgesia or anesthesia, prelabor diarrhea, lack of intake, perineal/rectal pain

Reported abdominal/rectal fullness or pressure, nausea, less than usual amount of stool, straining at stool, decreased bowel sounds

Resume usual/optimal bowel habits within 4 days after delivery.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Auscultate for presence of bowel sounds; palpate for diastasis recti, determine normal evacuation habits.

Assess for presence of hemorrhoids. Provide information about reinserting hemorrhoid into anorectal canal with lubricated finger cot or rubber glove, and applying ice or witch hazel compresses or local anesthetic creams.

Provide appropriate dietary information regarding importance of roughage, increased fluids, and the attempt to establish normal evacuation pattern.

Encourage increase in activity level and ambulation, as tolerated.

Assess episiotomy; note presence of laceration and degree of tissue involvement.

Evaluates bowel function, identifies deviation from client's "normal" or usual routine. Presence of severe diastasis recti (separation of the two rectus muscles along the median line of the abdominal wall) reduces abdominal muscle tone needed for efforts to bear down during evacuation.

Promotes localized vasoconstriction, reducing size of hemorrhoids, relieving itching and discomfort.

Roughage (e.g., fruits and vegetables, especially with seeds and skins) and increased fluids provide bulk, improve consistency of stool, and stimulate elimination.

Helps promote gastrointestinal peristalsis.

Excess edema or perineal trauma with third- and fourth-degree lacerations may cause discomfort and prevent client from relaxing perineum during evacuation for fear of further injury.

Collaborative

Administer stool softeners, suppositories, enemas, laxatives as indicated.

May be necessary to promote return to normal bowel habits and to prevent straining or perineal stress during evacuation. Note: Administration of suppositories or enemas in presence of third- or fourth-degree perineal laceration may be contraindicated because further trauma may occur. In addition, laxatives are contraindicated for the lactating client.

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 other(s), lack of knowledge, ineffective and/or no available role model, anxiety associated with the parent role, unrealistic expectations for self/infant/partner, unmet social/emotional maturation needs of client/partner, presence of stressors (e.g., financial, housing, employment)

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

Engage in mutually satisfying interactions with infant.

Verbalize concerns and questions about parenting.

Discuss parenting role realistically.

Identify available resources to meet needs of family members.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess strengths, needs, age, marital status, available sources of support, and cultural background.

Identifies potential risk factors and sources of support, which influence the client's/couple's ability to take on the challenging role of parenthood. For example, the adolescent may still be formulating goals and an identity. She may have difficulty accepting the infant as a person and coping with full-time parenting responsibility. The single parent who lacks support systems may have difficulty assuming sole responsibility for parenting. Cultures in which the extended family members live together may provide more emotional and physical support, facilitating adoption of the new role.

Note client's/partner's response to birth and to parenting role.

Client's ability to adapt positively to parenting may be strongly influenced by the father's reaction.

Initiate primary nursing care for mother and baby as a unit.

Promotes family-centered care, continuity, and individualization of care, and may facilitate development of positive family bonds.

Evaluate nature of emotional and physical parenting that client/couple received during childhood.

Parenting role is learned, and individuals use their own parents as role models. Those who experienced a negative upbringing or poor parenting are at greater risk for failing to meet the challenge than those who received positive parenting.

Assess partners' interpersonal communication skills and their relationship to one another.

A strong relationship characterized by honest communication and good interpersonal and listening skills fosters growth.

Review intrapartal record for length of labor, presence of complications, and role of partner in labor.

Long, difficult labor may temporarily deplete the physical and emotional energy necessary for learning the mothering role and may negatively affect lactation. Note: It often takes 24 hr following delivery for the mother to progress beyond her own "taking-in" phase.

Evaluate past and present physical status and occurrence of prenatal, intrapartal, or postpartal complications.

Events such as preterm labor, hemorrhage, infection, or any maternal complication may influence client's psychological status, reducing her ability to learn new parenting skills and undermining her attachment to, and ability to care for, the newborn.

Determine infant's condition; communicate with nursery staff, as indicated. Note any special problems or concerns.

Administer the Neonatal Perception Inventory (NPI), part I, within the first 2 days postpartum when indicated. Arrange for the follow-up inventory, part II, to be administered at 1 mo postpartum.

Monitor and document the client's/couple's interactions with infant. Note presence of bonding (acquaintance) behaviors, e.g.: making eye contact, using high-pitched voice and en face (face-to-face) position, calling infant by name, and holding infant closely. Determine family cultural background.

Encourage "rooming-in" or provide physical space and privacy for contact between mother, father, and infant.

Encourage couple/siblings to visit and hold the infant and to participate in infant care activities, as permitted. Provide telephone number of special care nursery if baby remains in the hospital for observation or special procedures; take pictures of the infant for the couple.

Assess client's readiness and motivation to learn.

Provide formal and informal educational opportunities followed by staff demonstration, staff assistance, and educational videotapes on infant care, infant feeding, and parenting.

Have client demonstrate learned behaviors associated with infant feeding and care. Provide written information and telephone number of contact person for client to take home.

Initiate follow-up telephone call or home visit by primary nurse, if possible, at 1 wk, and at 4–6 wk postpartum.

Mothers often undergo grief for the loss of the idealized perfect infant in contrast with their own infant. Emotional problems and the inability to adjust positively to parenting may result from the infant's temporary birth disfigurement, the birth of a high-risk infant, or the mother's inability to reconcile differences between prenatal fantasies and postnatal reality.

The NPI may be used to assess adaptive potential of mother-infant pair by evaluating the mother's perceptions of average baby versus her own. This tool is particularly helpful in assessing the mothering potential of the adolescent, who often fantasizes about the infant's behaviors and capabilities, and who may not cope positively with stressor of caring for a newborn. This inventory provides a statistically significant relationship between its indications at 1 mo and the emotional development of children at age 4½ yr and later at age 10–11 yr.

Few mothers or fathers experience significant love at first; instead, they become acquainted with the infant gradually. Infant and parent who do not develop positive attachment are at risk for physical or emotional abuse. Cultural background often determines type of bonding and acquaintance behaviors.

Facilitates attachment behaviors; fosters acquaintance process.

Helps promote bonding and prevent feelings of helplessness. Emphasizes the reality of baby's existence.

Many factors influence individual learning (e.g., understanding of need for information, anxiety, postdelivery euphoria).

Helps parents learn the fundamentals of infant care, promotes discussion and mutual problem solving, and provides group support. Helps parents to become more comfortable and gain skills and comfort in handling and caring for infant prior to discharge.

Helps reinforce teaching program and prevent anxiety related to unanswered questions, especially if family is part of early discharge program or if delivery took place in an alternative birth setting.

Some maternity centers now include such follow-up, especially for the adolescent or for the family at high risk for parenting problems.

Collaborative

Refer to community support groups, such as visiting-nurse/home-care services, social services, parenting groups, or adolescent clinics.

Refer to counseling if family is at high risk for parenting problems or if positive bonding between client/couple and infant is not occurring.

Helps promote positive parenting through group support and mutual problem-solving experience. Adolescents, particularly, may benefit from such support.

Negative parenting behaviors and ineffective coping may need to be corrected through counseling, nurturing, or even lengthy psychotherapy, and new behaviors and role models incorporated, to avoid repetition of parenting mistakes and child abuse.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION

CRITERIA—CLIENT WILL:

COPING, INDIVIDUAL, risk for ineffective

Maturational crisis of pregnancy/childbearing and assuming the role of motherhood and parenting (or relinquishing for adoption), personal vulnerability, inadequate support systems, unrealistic perceptions

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

Verbalize anxieties and emotional responses.

Identify individual strengths and own coping abilities.

Seek appropriate resources as needed.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Observe client's emotional response during prenatal and intrapartal periods and ascertain client's perception of her performance during labor. (Refer to CP: First Trimester; ND: Role Performance, risk for altered.)

Encourage discussion by client/couple of perceptions of birth experience.

Discuss for symptoms of transitory depression (postpartal "blues"), which may occur on about 3rd day postpartum (e.g., anxiety, tearfulness, despondency, poor concentration, and mild or severe depression). Provide information about the normalcy of this condition and associated mood swings and emotional lability.

There is a direct correlation between positive acceptance of the feminine role and uniquely feminine functions on the one hand, and positive adaptation to childbirth, mothering, and lactation on the other. In addition, the client who is relinquishing her child encounters these issues in a different context and needs support for her decisions.

Assists client/couple to work through process and clarify reality from fantasized experience.

As many as 80% of mothers experience a transitory depression or a feeling of emotional let-down following delivery, perhaps related to genetics, social or environmental factors, or physiological endocrine responses. These symptoms usually resolve spontaneously within a week or so following discharge. For some, however, initial feelings of discouragement may be replaced by excessive depression caused by a cycle of anxiety, anorexia, and excessive fatigue beginning soon after discharge.

Identify client's past coping abilities, cultural background, support systems, and plans for domestic help on discharge.

Provide emotional support and anticipatory guidance to help client learn new roles and strategies for coping with newborn. Discuss the normal emotional responses that occur after discharge.

Evaluate and document client-infant interaction. Note presence or absence of bonding (attachment) behaviors. (Refer to ND: Parenting, risk for altered.)

Encourage verbalization of negative thoughts, feelings of guilt, personal failure, or doubt about individual parenting abilities, especially if family is at high risk for problems with parenting. (Refer to CP: The Parents of a Child with Special Needs.)

Provide opportunity for client to review decision to relinquish child, when appropriate.

Collaborative

Refer client/couple to parenting, classes/support group, social services, community groups, or visiting nurse/homecare services.

Helps in assessing client's ability to handle stress. The ability to cope positively is also influenced by father's reaction. The emotional and physical support offered by extended families or other home assistance may facilitate coping.

Mothering/parenting skills are not instinctive but must be learned. Coping with interrupted sleep and meeting the infant's needs on a 24-hr basis may be difficult, and coping strategies must be developed.

Mother and infant are equal participants in the attachment process, and both must receive rewarding responses during the interaction. A lack of maternal attachment or absence of maternal behaviors evident in the postpartal period can lead to serious long-term consequences.

Helps couple to evaluate strengths and problem areas realistically and recognize the need for appropriate professional help.

Following delivery, the normal emotional responses are compounded by the previous decision to have child adopted. The client may experience conflict and require nonjudgmental support to facilitate coping at this time.

Support and role modeling enhances coping and facilitates assumption of parenting role. However, approximately 40% of women with mild postpartal depression have symptoms that persist for up to 1 yr and may require further follow-up.

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

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.

Report increased sense of well-being and feeling rested.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess level of fatigue and need for rest. Note length of labor and type of delivery.

Determine factors, if any, interfering with rest. Organize care to allow minimum disturbances and extra resting or sleeping periods. Encourage verbalization about birth experience. Provide quiet environment.

Provide information about needs for sleep/rest following discharge.

Provide information about effects of fatigue and anxiety on milk supply.

Assess home environment, availability of assistance, and presence of siblings and other family members.

Collaborative

Administer analgesics as indicated.

Long, difficult labor or delivery, especially when it occurs during the night, increases the level of fatigue.

Helps promote rest, sleep, and relaxation. If mother does not get needed sleep, "sleep hunger" may result, prolonging the restorative processes of the postpartal period.

Creative planning to allow retiring early with the baby and napping during the day helps meet bodily needs and overcome excess fatigue.

May negatively affect psychological adjustment, milk supply, and let-down reflex.

The multipara with children at home may need more sleep to overcome sleep deficits and meet her needs and the needs of her family.

May be needed to promote relaxation and sleep.

NURSING DIAGNOSIS:

KNOWLEDGE deficit (LEARNING NEED), regarding self and infant care

May Be Related To:

Lack of exposure/recall, misinterpretation, unfamiliarity with resources

Possibly Evidenced By:

Verbalizations of concerns/misconceptions; hesitancy in, or inadequate performance of, activities; inappropriate behaviors (e.g., apathy)

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

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

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

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Ascertain client's perception of labor and delivery, length of labor, and client's fatigue level.

There is a correlation between length of labor and the ability of some clients to assume responsibility for self-care/infant care tasks and activities. The longer the labor is, the more negative the client's perception tends to be of her performance in labor, and the longer it may take her to refocus and assume responsibility for her own care and to synthesize new information and learn new roles.

Assess client's readiness and motivation for learning. Assist client/couple in identifying needs.

The postpartal period can be a positive experience if opportune teaching is provided to foster maternal growth, maturation, and competence. However, the client needs time to move from a "taking in" to a "taking hold" phase, in which her receptiveness and readiness is heightened and she is emotionally and physically ready for learning new information to facilitate mastery of her new role.

Initiate written teaching plan using standardized format, checklist, or clinical pathway. Document information given and client's response.

Helps standardize the information parents receive from staff members, and reduces client confusion caused by dissemination of conflicting advice or information.

Provide information about role of a progressive postpartal exercise program.

Exercise helps tone musculature, increases circulation, produces a trimmer figure, and enhances feelings of general well-being.

Provide information about self-care, including perineal care and hygiene; physiological changes, including normal progression of lochial discharge; needs for sleep and rest; role changes; and emotional changes. Have client demonstrate the material learned, when appropriate.

Helps prevent infection, fosters healing and recuperation, and contributes to positive adaptation to physical and emotional changes.

Discuss sexuality needs and plans for contraception. Provide information about available methods, including advantages and disadvantages. (Refer to CP: One Week Following Discharge; ND: Knowledge deficit [Learning Need].)

Couple may need clarification regarding available contraceptive methods and the fact that pregnancy could occur even prior to the 4- to 6-wk visit.

Reinforce importance of 4- to 6-wk postpartal examination by healthcare provider and interim follow-up, as appropriate.

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

Identify potential problems necessitating medical evaluation prior to the scheduled 4- to 6-wk visit (e.g., a return to bright red vaginal bleeding, foul-smelling lochia, elevated temperature, malaise, prolonged feelings of anxiety/depression).

Further intervention or treatment may be needed before the 4- to 6-wk visit to prevent or minimize potential complications.

Discuss normal physical and psychological changes and needs associated with the postpartal period.

Identify available resources; e.g., visiting nurse services, Public Health Service, WIC program, La Leche League International.

Client's emotional state may be somewhat labile at this time and often is influenced by physical well-being. Anticipating such changes may reduce the stress associated with this transition period that necessitates learning new roles and taking on new responsibilities.

Promotes independence and provides support for adaptation to multiple changes.

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 desire to undertake tasks leading to incorporation of new family member.

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

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess relationship of family members to one another; establish primary nurse.

Provide for unlimited participation for father and siblings. Ascertain whether siblings attended an orientation program.

Initiate parent support group and individual or group instruction in breastfeeding, infant care, and the physical and emotional changes during the postpartal period.

Encourage equal participation of parents in infant care.

Provide anticipatory guidance regarding the normal emotional changes associated with postpartal period.

The nurse can help to provide a positive hospital experience and prepare the family for growth through the developmental stages that accompany acquisition of a new family member.

Facilitates family development and ongoing process of acquaintance and attachment. Helps family members feel comfortable caring for newborn.

Verbalization and discussion in group setting fosters sharing of ideas, opportunities for problem solving, and group support. Aids development of positive self-esteem, mastery, comfort, and understanding of new role.

Flexibility and sensitization to family needs help foster self-esteem and sense of competence in caring for newborn following discharge.

Helps prepare couple for possible changes they may experience; reduces stress associated with the unknown or with unexpected events, and may promote positive coping.

Provide written information regarding suggested books for children (siblings) about the new baby. Encourage siblings to verbalize feelings of replacement or abandonment. Recommend that parents spend extra time with older children.

Suggest that friends include older children in activities outside of the home.

Collaborative

Refer client/couple to postpartal parent groups in community.

Helps children to identify and cope with new feelings/fears. Parents should know that feelings of jealousy are normal.

School-age children probably adjust more easily to a new baby when their horizons are already expanded to include attachment activities outside of the home.

Increases parents' knowledge of child rearing and child development, and provides supportive atmosphere while parents incorporate new roles.