

# POSTPARTAL HEMORRHAGE

Postpartal hemorrhage is usually defined as the loss of more than 500 ml of blood during or after delivery. It is one of the leading causes of maternal mortality. Hemorrhage may occur early, within the first 24 hr after delivery, or late, up to 28 days postpartum (the end of the puerperium).

## CLIENT ASSESSMENT DATA BASE

### *General Findings*

#### **Activity/Rest**

May report excessive fatigue

#### **Circulation**

Blood loss at delivery generally 400–500 ml (vaginal delivery), 600–800 ml (cesarean delivery), although research suggests that blood loss is often underestimated

History of chronic anemia, congenital/incidental coagulation defects, idiopathic thrombocytopenia purpura

#### **Ego Integrity**

May be anxious, fearful, apprehensive

#### **Sexuality**

Labor may have been prolonged/augmented or induced, precipitous/traumatic; use of forceps/vacuum extractor, general anesthesia, tocolytic therapy.

Difficult or manual delivery of placenta.

Examination of placenta following birth may have revealed missing placental fragments, tears, or evidence of torn blood vessels.

Vaginal birth after cesarean (VABC).

#### **Teaching/Learning**

Previous postpartal hemorrhage, PIH, uterine or cervical tumors, grand multiparity

Ongoing/excess aspirin ingestion

### *Early Postpartal Hemorrhage (Up to 24 Hr Following Delivery)*

#### **Circulation**

Changes in BP and pulse (may not occur until blood loss is significant)

Delayed capillary refill

Pallor; cold/clammy skin

Dark, venous bleeding from uterus externally evident (retained placenta)

May have excessive vaginal bleeding, or oozing from cesarean incision or episiotomy; oozing from IV catheter, sites of intramuscular injections, or urinary catheter; bleeding gums (signs of disseminated intravascular coagulation [DIC])

Profuse hemorrhage or symptoms of shock out of proportion to the amount of blood lost (inversion of uterus)

#### **Elimination**

Difficulty voiding may reflect hematoma of the upper portion of the vagina.

Bladder distension (urinary retention).

## **Pain/Discomfort**

Painful burning/tearing sensations (lacerations), severe vulvar/vaginal/pelvic/back pain (hematoma formation), lateral uterine pain, flank pain (hematoma into the broad ligament), abdominal tenderness (uterine atony, retained placental fragments), severe uterine and abdominal pain (uterine inversion)

## **Safety**

Lacerations of the birth canal: Persistent trickle of bright red blood (may be profuse) with firm, well-contracted uterus; visible tears in labia majora/labia minora, from vaginal introitus to perineum; extended tears from episiotomy, extension of episiotomy into vaginal vault, or tears in cervix

Hematomas: Unilateral, tense, fluctuant, bulging mass at vaginal introitus or encompassing labia majora; firm, painful to touch; unilateral bluish or reddish discoloration of skin of perineum or buttocks; (abdominal hematoma following cesarean delivery may be asymptomatic except for changes in vital signs)

## **Sexuality**

Uterus: Soft, boggy, or enlarging, difficult to palpate; bright red bleeding from vagina (slow or profuse); large clots expressed on massage of uterus (uterine atony)

Firm, well-contracted or partially contracted, and slightly boggy (retained placental fragments, which may necrose and over time form polyps)

Fundus of uterus inverted; comes into close contact with, or may protrude through, the external os (uterine inversion)

Current pregnancy may have involved uterine overdistension (multiple gestation, hydramnios, macrosomia), abruptio placentae, placenta previa

## ***Late Postpartal Hemorrhage (24 to 28 Days Following Delivery)***

### **Circulation**

Continued oozing or sudden bleeding

May appear pale, anemic

### **Pain/Discomfort**

Uterine tenderness (retained placental fragments)

Vaginal/pelvic discomfort, backache (hematoma)

### **Safety**

Foul-smelling lochial discharge (infection)

Reported premature rupture of membranes (risk for infection)

### **Sexuality**

Fundal height or uterine body fails to return to prepregnancy size and function (subinvolution).

Leukorrhea may be present.

Continues to pass tissue.

## **DIAGNOSTIC STUDIES**

**Blood Typing:** Determines Rh, ABO group, and cross-match.

**CBC:** Reveals decreased Hb/Hct and/or elevated WBC count (shift to the left, and increased sedimentation rate suggests infection).

**Platelet Count:** Levels below 50,000/ $\mu$ L can lead to spontaneous bleeding.

**Uterine and Vaginal Culture:** Rules out/identifies specific postpartal infection.

**Urinalysis:** Ascertains damage to bladder.

**Coagulation Profile:** Elevated fibrin degradation product/fibrin split product (FDP/FSP) levels, decreased fibrinogen levels; activated partial thromboplastin time/partial thromboplastin time (APTT/PTT), prothrombin time (PT) prolonged in presence of DIC.

**Sonography:** Determines presence of retained placental tissue.

## NURSING PRIORITIES

1. Maintain or restore circulating volume/tissue perfusion.
2. Prevent complications.
3. Provide information and appropriate support for client/couple.
4. Have plan in place to meet needs after discharge.

## DISCHARGE GOALS

1. Tissue perfusion/organ function WNL
2. Complications prevented/resolving
3. Clinical situation and treatment needs understood

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<b>NURSING DIAGNOSIS:</b>	<b>FLUID VOLUME deficit [isotonic]</b>
<b>May Be Related To:</b>	Excessive vascular loss
<b>Possibly Evidenced By:</b>	Hypotension, tachycardia, changes in mentation, decreased/concentrated urine, dry skin/mucous membranes, delayed capillary refill
<b>DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:</b>	Demonstrate stabilization/improvement in fluid balance as evidenced by stable vital signs, prompt capillary refill, appropriate sensorium, and individually adequate urine output and specific gravity.

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## ACTIONS/INTERVENTIONS

## RATIONALE

### Independent

Review records of pregnancy and labor/delivery, noting causative factors or those contributing to hemorrhagic situation (e.g., lacerations, retained placental fragments, sepsis, abruptio placentae, amniotic fluid emboli, or retention of dead fetus for more than 5 wk).

Assess and record amount, type, and site of bleeding; weigh and count pads; save clots and tissue for evaluation by physician.

Aids in establishing appropriate plan of care and provides opportunity to prevent or limit developing complications. Note: Approximately 20% of early postpartal hemorrhage is related to lacerations of the perineum, vagina, or cervix. Late postpartal hemorrhage is usually caused by abnormal involution of the uterus or retained placental fragments.

Estimate of blood loss, venous versus arterial, and presence of clots helps to make a differential diagnosis and determines replacement needs. Note: One gram of increased pad weight is equal to approximately 1 ml of blood loss. Blood losses of more than 1000 ml lead to shock state and increase risk of other complications, e.g., infection, extensive pelvic thrombophlebitis.

Assess location of uterus and degree of uterine contractility. Massage boggy uterus with one hand while placing second hand just above the symphysis pubis.

Note presence of vulvar hematoma; apply ice pack as indicated and observe periodically.

Monitor BP, pulse; observe capillary refill, nail beds, and mucous membranes.

Measure hemodynamic parameters, such as central venous pressure (CVP) or pulmonary artery wedge pressure (PAWP), if available.

Institute bedrest with legs elevated 20–30 degrees and trunk horizontal.

Maintain nothing-by-mouth (NPO) regimen while determining client status/needs.

Measure intake and output, and urine specific gravity, as indicated. Investigate reports of difficulty voiding/emptying bladder.

Avoid repeat/use caution when performing vaginal and/or rectal examinations.

Provide quiet environment and psychological support.

Investigate reports of persistent perineal pain or feeling of vaginal fullness. Apply counterpressure on labial or perineal lacerations.

Monitor clients with placenta accreta (slight penetration of myometrium by placental tissue), PIH, or abruptio placentae for signs of DIC. (Refer to CP: Prenatal Hemorrhage; ND: Injury, risk for maternal.)

Degree of uterine contractility aids in differential diagnosis. Increasing myometrial contractility may decrease blood loss. Placing one hand above symphysis pubis prevents possible uterine inversion during massage.

Small hematomas may be controlled by ice and rest.

Hypotension, tachycardia, delayed capillary refill; cyanosis of nail beds, mucous membranes, and lips reflects severe hypovolemia and developing shock. Changes in BP are not detectable until fluid volume has decreased by 30%–50%. Cyanosis is a late sign of hypoxia. (Refer to ND: Tissue Perfusion, altered.) Note: Reports of fatigue, headache, thirst, presence of pallor, orthostatic hypotension may be signs of slow moderate blood loss that may be reported during follow-up visit.

Provides more direct measurement of circulating volume, replacement needs, and response to therapy in severe/life-threatening situations.

Bleeding may decrease or cease with reduction in activity. Proper positioning increases venous return, ensuring greater availability of blood to brain and other vital organs.

Prevents aspiration of gastric contents in the event that sensorium is altered and/or surgical intervention is required.

Useful in estimating extent/significance of fluid loss. Adequate perfusion/circulating volume is reflected by output 30–50 ml/hr or greater. Note: Difficulty voiding may occur with hematomas in the upper portion of the vagina causing pressure on the urethra or meatus.

May increase hemorrhage if cervical, vaginal, or perineal lacerations or hematomas are present. Note: Careful examination may be required to monitor status of hematomas.

Promotes relaxation; reduces anxiety and metabolic demand.

Hematomas often result from continued bleeding from lacerations of the birth canal.

Thromboplastin released during attempts at manual removal of the placenta may result in coagulopathy as manifested by continued vaginal bleeding; epistaxis; oozing from incisions, mucous membranes, gums, IV site.

## Collaborative

Start 1 or 2 IV infusion(s) of isotonic or electrolyte fluids with 18-gauge catheter or via central venous line. Administer whole blood or blood products (e.g., plasma, cryoprecipitate, platelets), as indicated.

Administer medications as indicated, e.g.:

Oxytocin (Pitocin), methylergonovine maleate (Methergine), prostaglandin F<sub>2a</sub> (Prostin 15M);

MgSO<sub>4</sub>;

Heparin;

Antibiotic therapy (based on culture and sensitivity of lochia).

Monitor laboratory studies as indicated, e.g.:

Hb and Hct;

Platelets, FDP, fibrinogen and APTT.

Insert indwelling urinary catheter.

Assist with procedures as indicated, e.g.:

Manual separation and removal of placenta;

Insertion of large indwelling catheter into cervical canal;

Uterine replacement or packing if inversion seems about to recur.

Prepare for surgical intervention as indicated; e.g., exploration/repair to close tear, laceration, or episiotomy extension; evacuation of hematoma and ligation of bleeding point; D & C; bilateral ligation of hypogastric arteries, supracervical hysterectomy, or immediate abdominal hysterectomy.

Necessary for rapid or multiple infusions of fluid or blood products to increase circulating volume and enhance clotting. Note: Each unit of whole blood raises the Hct by 3 percentage points.

Increases contractility of boggy uterus and myometrium, closes off exposed venous sinuses, and stops hemorrhage in presence of atony. Some studies report use of MgSO<sub>4</sub> to facilitate uterine relaxation during manual examination. While controversial, if other means fail, heparin may be used cautiously to stop the clotting cycle in DIC. Antibiotics act prophylactically to prevent infection or may be needed for infection that caused or contributed to uterine subinvolution or hemorrhage.

Helps in determining amount of blood loss. Each milliliter of blood carries 0.5 mg of Hb. Hct levels below 30% require red cell replacement. Measures severity of DIC; determines replacement needs and effects of therapy.

Provides more accurate assessment of renal function and perfusion relative to fluid volume. Note: If vaginal packing has been inserted, pressure on urethra may obstruct urine flow/cause bladder distension.

Hemorrhage stops once placental fragments are removed and uterus contracts, closing venous sinuses.

Some studies have reported success in controlling hemorrhage caused by implantation of placenta into noncontractile cervical segment by placing an indwelling catheter in the cervical canal and filling the balloon with 60 ml of saline solution to act as a tamponade.

Replacement of uterus allows uterus to contract, closing venous sinuses and controlling bleeding.

Surgical repair of lacerations/episiotomy, incision/evacuation of hematomas, and removal of retained tissues will stop bleeding. Immediate abdominal hysterectomy is indicated for abnormally adherent placenta. Note: D & C may be contraindicated if there is concern that the procedure may traumatize the implantation site and increase bleeding.

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**NURSING DIAGNOSIS:****May Be Related To:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION  
CRITERIA—CLIENT WILL:****TISSUE PERFUSION, altered**

Hypovolemia

Diminished arterial pulsations, cold extremities, changes in vital signs, delayed capillary refill, changes in sensorium, decreased milk production

Display BP, pulse, arterial blood gases (ABGs), and Hb/Hct WNL.

Demonstrate normal hormonal functioning by adequate milk supply for lactation (as appropriate) and resumption of normal menses.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**Note Hb/Hct prior to and following blood loss.  
Assess nutritional state, height, and weight.Monitor vital signs; record degree and duration  
of hypovolemic episode.Note level of consciousness and any behavior  
changes.Observe color of nail beds, buccal mucosa, gums,  
and tongue; note skin temperature.Inspect breasts daily, noting presence or absence  
of lactation and changes in breast size.Comparative values help determine severity of  
blood losses. Preexisting state of poor health  
increases extent of injury from oxygen deficits.Extent of pituitary involvement may be related to  
degree and duration of hypotension. Increased  
respiratory rate may reflect an effort to combat  
metabolic acidosis.Changes in sensorium are early indicators of  
hypoxia. Cyanosis, a later sign, may not appear until  
PO<sub>2</sub> levels fall below 50 mm Hg.With compensatory vasoconstriction and shunting  
to vital organs, circulation in peripheral blood vessels  
is reduced, with resulting cyanosis and cool skin  
temperatures.Anterior pituitary damage or involvement  
(Sheehan's syndrome) reduces prolactin levels,  
resulting in absence of milk production and  
eventually a decrease in breast tissue.**Collaborative**

Monitor ABGs and pH level.

Provide supplemental oxygen as needed.

Insert airway; suction as indicated.

Administer sodium bicarbonate.

Helps in diagnosing degree of tissue hypoxia or  
acidosis, reflecting lactic acid buildup from resulting  
anaerobic metabolism (prolonged shock).Maximizes available oxygen for circulatory transport  
to tissues.Facilitates oxygen administration in presence of  
retained secretions.

May be necessary to correct metabolic acidosis.

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**NURSING DIAGNOSIS:****May Be Related To:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION  
CRITERIA—CLIENT WILL:****ANXIETY [specify level]**

Situational crisis, threat of change in health status or death, interpersonal transmission/contagion, physiological response (release of catecholamines)

Increased tension, apprehension, feelings of inadequacy/helplessness, sympathetic stimulation, focus on self, restlessness

Verbalize awareness of feelings and causes of anxiety (postpartal hemorrhage is perceived as a threat to her physical integrity).

Identify healthy ways to deal with feelings.

Report anxiety is lessened.

Appear relaxed, able to sleep/rest appropriately.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Evaluate client's psychological response to postpartal hemorrhage and perception of events. Clarify misconceptions.

Evaluate physiological response to postpartal hemorrhage, e.g., tachycardia, tachypnea, restlessness, or irritability.

Convey calm, empathic, supportive attitude.

Provide information about treatment modalities and effectiveness of interventions.

Encourage client to verbalize feelings. Assist client and family to identify feelings of anxiety.

Assess coping strategies and long-term implications of hemorrhagic episode. (Refer to ND: Parent/Infant Attachment, risk for altered.)

**Collaborative**

Refer client/couple to a community support group such as Coping with Overall Pregnancy/Parenting Experience (COPE) or for counseling, as indicated.

Aids in formulation of plan of care. Client's perception of the event may be distorted, intensifying her anxiety.

Although changes in vital signs may be due to physiological responses, they may be intensified or complicated by psychological factors.

Can help client maintain emotional control in response to changing physiological status. Aids in reducing interpersonal transmission of anxiety.

Accurate information can reduce anxiety and fear of the unknown.

Verbalization provides an opportunity to clarify information, correct misconceptions, and gain perspective, facilitating the problem-solving process.

Prolonged or excessive anxiety may be anticipated if complications are permanent (such as with anterior pituitary necrosis).

Helps reduce anxiety through peer or professional support and interaction.

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

Excessive/rapid replacement of fluid losses, intravascular fluid shifts (PIH)

**Possibly Evidenced By:**

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

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

Display BP, pulse, urine specific gravity, and neurological signs WNL, without respiratory difficulties.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Monitor for increasing BP and pulse; note respiratory signs of dyspnea, stridor, moist crackles, or rhonchi.

If fluid replacement is excessive, symptoms of circulatory overload and respiratory difficulties (e.g., pulmonary edema) may occur.

Monitor infusion rate manually or electronically (preferable). Record intake/output. Measure urine specific gravity.

With stabilization of fluid levels, intake should approximate output. Specific gravity readings change inversely to output so that as kidney function improves, specific gravity readings decrease, and vice versa. Note: In the client with glomerular spasms caused by PIH, output may be diminished until extracellular fluids return to general circulation.

Assess neurological status, noting behavior changes and increasing irritability.

Changes in mentation/behavior may be an early sign of cerebral edema caused by fluid retention.

**Collaborative**

Monitor Hct level.

As plasma volume is restored, the Hct level drops.

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

Traumatized tissue, stasis of body fluids (lochia), decreased Hb, invasive procedures

**Possibly Evidenced By:**

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

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

Verbalize understanding of individual causative/risk factors.

Display WBC count and vital signs WNL, lochia free of odor.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Demonstrate proper handwashing and self-care techniques. Review appropriate handling and disposal of contaminated materials (e.g., peripads, tissues, dressings).

Monitor vital signs.

Observe perineum/episiotomy site, abdominal wound (cesarean birth).

Note symptoms of malaise, chills, anorexia, uterine tenderness, or pelvic pain.

Monitor rate of uterine involution and nature and amount of lochial discharge. (Refer to CP: Puerperal Infection.)

Investigate other potential sources of infection, such as respiratory (changes in breath sounds, productive cough, purulent sputum), mastitis (swelling, erythema, pain), or urinary tract infection (cloudy, odoriferous urine; urgency, frequency, pain).

### **Collaborative**

Review WBC count.

Assess Hb/Hct levels. Administer iron supplement, as indicated.

Obtain Gram's stain or bacterial culture if lochia is foul-smelling or profuse/purulent wound drainage is present.

Administer IV antibiotics, as indicated.

Assist as necessary with surgical procedures (e.g., D & C, hysterectomy).

Prevents cross-contamination/spread of infectious organisms.

Temperature elevations of 100.4°F (38°C) on 2 consecutive days (not counting the first 24 hr postpartum), tachycardia, suggest infection.

Erythema, edema, induration, tenderness, separation of wound edges, purulent drainage suggest localized infectious process requiring prompt intervention to prevent systemic complications.

These symptoms indicate systemic involvement, possibly leading to bacteremia, shock, or death if not treated.

Uterine infection delays involution and prolongs lochial flow.

Differential diagnosis is critical for effective treatment.

Leukocytosis with shift to the left signifies infection.

Anemia often accompanies infection, delays healing, and impairs the immune system.

Gram's stain identifies type of infection, whereas cultures identify specific pathogen.

Broad-spectrum antibiotic may be ordered until results from culture and sensitivity studies are available, at which time organism-specific antibiotic may be started.

D & C may be necessary to remove any remaining placental fragments; hysterectomy may be necessary in septic shock.

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### **NURSING DIAGNOSIS:**

#### **Risk Factors May Include:**

#### **Possibly Evidenced By:**

### **PAIN, risk for**

Tissue trauma/distension

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

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

Identify individually appropriate methods to promote comfort.

Verbalize relief of pain and discomfort.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Determine characteristics, type, location, and duration of pain. Rate intensity on a 0–10 scale. Assess client for persistent perineal pain, feeling of fullness in vagina, uterine contractions, or abdominal tenderness.

Aids in differential diagnosis and selection of treatment methods. Discomfort associated with hematomas is caused by pressure from concealed hemorrhage into vaginal or perineal tissues. Abdominal tenderness may result from uterine atony or retained pieces of placenta. Severe pain, both uterine and abdominal, may occur with inversion of the uterus. Lacerations may result in painful burning or tearing sensations.

Assess possible psychological causes of discomfort.

Emergency situation may precipitate fear and anxiety, which intensify perception of discomfort. (Refer to ND: Anxiety [specify level].)

Instruct client in relaxation techniques; provide diversional activities as appropriate.

Educating client in physiological and psychological methods of pain control decreases anxiety and perception of discomfort.

Provide comfort measures, such as application of ice to perineum or heat lamp to episiotomy extension, use of sitz bath.

Cold applications minimize edema and reduce hematoma and pain sensation; heat (after first 24 hr) promotes vasodilation, which facilitates resorption of hematoma.

**Collaborative**

Administer analgesics, narcotics, or sedatives, as indicated.

Decreases pain and anxiety; promotes relaxation.

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**NURSING DIAGNOSIS:**

**KNOWLEDGE deficit [LEARNING NEED], regarding condition, prognosis, and treatment needs**

**May Be Related To:**

Lack of exposure to, and unfamiliarity with, information resources

**Possibly Evidenced By:**

Request for information, statement of misconceptions, inappropriate or exaggerated behaviors

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

Verbalize in simple terms the pathophysiology and implications of her clinical situation.

Identify behaviors to enhance recovery.

Use resources effectively.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Explain predisposing or causative factors and treatment specific to the cause of hemorrhage.

Assess client's/couple's level of knowledge, readiness, and ability to learn. Listen, talk calmly, and allow time for questions and review of material.

Discuss short-term implications of postpartal hemorrhage, such as delay or interruption in process of maternal-infant attachment, inability to assume care of self and infant as soon as desired.

Discuss long-term implications of postpartal hemorrhage as appropriate; e.g., risk of postpartal hemorrhage in subsequent pregnancies, uterine atony, or the inability to bear children in the future if hysterectomy is performed.

Instruct client to report failure to lactate, fatigue, loss of pubic or axillary hair, amenorrhea, genital atrophy, premature aging (cachexia).

Determine availability of personal resources/supports. Discuss necessity of adequate rest/sleep, healthy nutritional intake, and pacing of activities.

Recommend client be seated when holding infant and to change position slowly when lying down or seated.

Refer to support group(s) as appropriate.

Provides information to help client/couple understand and cope with situation.

Provides information necessary to develop individual plan of care and engage in problem-solving activities. Reduces anxiety and stress, which can block learning, and provides clarification and repetition to enhance understanding.

Reduces anxiety and provides realistic time frame for resumption of bonding and infant/self-care activities. (Refer to ND: Parent/Infant Attachment, risk for altered.)

Permits client to make informed decisions and to begin to resolve feelings about current and past events.

These signs suggest Sheehan's syndrome, which occurs in 15% of survivors of severe postpartal hemorrhage; causes partial or total loss of thyroid, adrenocortical, and gonadal functions and requires long-term treatment with estrogen, thyroid, or cortisone replacement therapy. Note: Sheehan's syndrome often results in irreversible infertility, reduced resistance to infection, premature aging, and increased risk of shock.

Fatigue associated with anemia/hemorrhage will delay client's resumption of normal activities, necessitating problem solving and reliance on others for a period of time. Note: This may be very frustrating for client (and her family).

Orthostatic hypotension places client at risk for lightheadedness/falls.

Specific groups, such as a hysterectomy support group, may provide ongoing information and role models to facilitate positive adaptation.

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### **NURSING DIAGNOSIS:**

#### **Risk Factors May Include:**

#### **Possibly Evidenced By:**

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

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### **PARENT/INFANT ATTACHMENT, risk for altered**

Interruption in bonding process, physical condition, perceived threat to own survival

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

Demonstrate appropriate behaviors associated with positive attachment to infant.

Assume responsibility for physical and emotional care of the newborn, as able.

Express comfort with parenting role.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Explain factors resulting from postpartal hemorrhage that necessitate separation of mother and infant.

Helps reduce anxiety and feelings of frustration and helplessness related to client's inability to assume caregiving role with infant.

Provide opportunity for client/couple to express their fears and anger at the situation.

Promotes acceptance of physiological and psychological constraints, which may help reduce anxiety associated with development of complications.

Discuss client's perceptions of infant care responsibilities and parenting role.

Provides information about how client views these role changes; identifies areas of learning need.

Encourage contact with infant (verbal reports, photos, information from significant other who has seen baby) until client can see and begin to care for the infant.

Reassures mother of infant's health status and of proper care being provided to the infant.

Evaluate attachment process, bonding behaviors, and parenting abilities once client assumes care of her infant.

Provides information on psychological and physiological capabilities related to parenting; identifies client's needs.

Provide client/couple with information on community resources and with follow-up healthcare referrals, including parenting classes, child care facilities, and well-baby clinics.

Reinforces positive information previously given by health team. Reduces anxiety; promotes independence and personal growth.