**CARE TO A POSTPARTUM WOMAN**

Care within the First 24 Hours

Providing nursing CARE TO A POSTPARTUM WOMAN during the first 24 hours entails the following:

* Assess the woman’s family profile to determine the impact that the newborn would give to the family and to the woman.
* Assess the woman’s pregnancy history, especially if the pregnancy was planned or unplanned as it will determine the ability of the woman to bond with the newborn.
* Assess the [labor](https://nurseslabs.com/labor/) and birth history such as the length of [labor](https://nurseslabs.com/labor-stages-labor-induced-nursing-care-plan/) and if any analgesia or [anesthesia](https://nurseslabs.com/certified-registered-nurse-anesthetist-how-to-become-a-crna/) was used to determine any necessary procedures to be done.
* Determine the infant’s data and profile to help with planning the care of the newborn and promote bonding between the parents.
* The woman would also need a postpartum course such as her activity level after birth, any difficulties or [pain](https://nurseslabs.com/acute-pain/) felt, and if she is successful with infant feeding to determine any need for anticipatory guidance in home care.
* Assess any laboratory data of the woman to be certain that she is recovering well and if any procedures or additional diagnostic tests need to be performed.
* Assess the woman’s general appearance because it is a reflection of how well the woman is moving into the [taking hold phase](https://nurseslabs.com/postpartum-changes/) of recovery.
* Assure the woman that losing a quantity of her [hair](https://nurseslabs.com/integumentary-system/) is not a sign of illness but because she is returning to her nonpregnant state, as hair grows rapidly during pregnancy because of increased metabolism.
* Assess for facial edema, especially for a woman with pregnancy-induced [hypertension](https://nurseslabs.com/hypertension-nursing-care-plans/).
* Advise the woman to purchase a nursing bra that is one to two sizes larger than her pregnancy size to allow for increase.
* Assess the woman’s breast for any cracks or fissures, and avoid squeezing the nipple. Also, assess for signs of mastitis such as inflammation of a certain part of the breast.
* Assess the location, consistency, and height of the fundus through palpation.
* If the uterus is not firm upon palpation, massage it gently. Placing the infant on the mother’s breast also aids in stimulating contractions.
* Lochia is expected in a postpartum woman for 2 to 6 weeks, so [assessment](https://nurseslabs.com/nursing-process/) of its characteristics is necessary to determine if it is the normal lochia or not.
* Observe the perineum for ecchymosis, [hematoma](https://nurseslabs.com/postpartum-hemorrhage-nursing-care-plans/). Edema or any drainage and [bleeding](https://nurseslabs.com/risk-for-bleeding/) from the stitches.

Care in Preparation for Discharge

Before the woman is discharged, she must be educated properly regarding the care of the newborn and herself at home.

* Assess first the ability of the mother to absorb new instructions and to listen.
* Conducting group classes regarding [newborn care](https://nurseslabs.com/care-of-the-newborn/) could greatly help mothers learn not only what the instructors teach but also from the experiences that some mothers could share to the group.
* It is also recommended for fathers to attend such classes so the mother would have someone she can rely on with the newborn care.
* Individual instruction is also sought after postpartum, as the family will need to know how to care for the woman and the newborn after discharge.
* Teaching should not always be formal; it may come in the form of comments during classes or procedures.
* Instruct the woman to avoid lifting heavy objects for the first three weeks after birth.
* Advise the woman to allot a rest period every day, or to rest and [sleep](https://nurseslabs.com/helping-our-patients-to-sleep-will-reduce-their-pain/) while her newborn is also asleep so she can regain her energy.
* Be certain that the woman is aware that she must return to the healthcare facility after 4 to 6 weeks for examination and that she must arrange an appointment for her baby to be examined by a pediatrician at 2 to 4 weeks of age.
* Make sure that the woman and the family understood the discharge instructions amidst all the frenzy of the new baby; review instructions with parents before they leave.
* Calling or visiting 24 hours after discharge is the best way to evaluate whether the family has been able to grasp all instructions and integrate the newborn into the family.

Care after Discharge

Discharge from the healthcare facility usually occurs after 2 to 3 days after birth.

* The woman can rest better at home and may eat better if she has cultural preferences regarding food.
* The newborn can also be exposed earlier to the routines of the family, and make it easier for her to adjust to extrauterine environment.
* A home visit after the discharge is usually recommended to check on how the family is doing now that they have a newborn in the house.
* High-risk newborns, newborns born to adolescent mothers, and newborns with mothers who have abused drugs during pregnancy need to have a specially planned discharge and home visit.
* Pregnancy history is assessed during the postpartum visit and if there are any difficulty with the bonding between the mother and the baby, and allow the woman to relate her labor and birth experiences.
* Assess the newborn history and if there are any concerns about the newborn that the woman has noticed.
* Assess the woman’s future plans, whether she is going back to work outside home and if she had already arranged the care of her newborn while she is away.
* Conduct a family assessment and ask if other members of the family are adapting well with a newborn in the house.
* Examine both the mother and the newborn physically to note any signs of postpartum complications or defects.
* Remind the mother about the health maintenance visit of the newborn once she reaches 2 to 4 weeks old, and her return checkup 4 to 6 weeks after birth.

## Nursing Care Plans Related to Postpartum Care

### INEFFECTIVE BREASTFEEDING CARE PLAN

Difficulty with infant latching, pain with breastfeeding, or poor breastfeeding experiences can lead to ineffective breastfeeding.

Nursing Diagnosis: Ineffective Breastfeeding

#### Related to:

* Infant prematurity
* Infant anomaly (cleft palate)
* Poor sucking reflex of infant
* Maternal anxiety or disinterest
* Knowledge deficit
* Interruptions in breastfeeding
* History of ineffective breastfeeding attempts

#### As evidenced by:

* Expresses or observed difficulty in breastfeeding
* Complaints of pain or nipple soreness
* Insufficient emptying of breastmilk when feeding/inadequate milk supply
* Infant displaying inadequate wet diapers or weight loss/inadequate weight gain
* Failure to latch

#### Expected Outcomes:

* Mother will implement two techniques to improve breastfeeding
* Infant will display effective breastfeeding as evidenced by appropriate weight gain

#### INEFFECTIVE BREASTFEEDING ASSESSMENT

**1. Assess knowledge.**
Assess the mother’s knowledge about breastfeeding as well as cultural conflicts and any myths or misunderstandings.

**2. Perform physical assessment.**
Perform a breast assessment for engorgement, mastitis, and inverted nipples as well as an assessment of the infant’s ability to latch and suck.

**3. Assess support system.**
A supportive partner is an important factor in effective breastfeeding. Supportive family members and the healthcare team can also contribute.

#### Ineffective Breastfeeding Interventions

**1. Provide 1:1 support.**
Breastfeeding for new mothers may take time and practice. Allow 1:1 time with emotional support. Sessions can be 30 minutes or longer in the beginning.

**2. Teach to recognize cues.**
Educate the mother on early cues from the infant. Rooting, lip-smacking, and sucking fingers/hands signal a desire to eat. Recognizing cues for timely feeding promotes a better experience for mom and baby.

**3. Prevent and treat breastfeeding complications.**
If ineffective breastfeeding is related to nipple pain or engorgement, intervene accordingly. Heat or cool application and massage can ease engorgement. Apply lanolin to nipples and do not use harsh soaps. Use cotton bras or pads.

**4. Coordinate with a lactation consultant.**
Lactation consultants help instruct on breastfeeding positions, feeding schedules, increasing the milk supply, and using a breast pump.

### RISK FOR IMPAIRED PARENTING CARE PLAN

An inability to create or maintain an environment to promote growth and attachment of the parent and child.

Nursing Diagnosis: Risk For Impaired Parenting

#### Related to:

* Premature birth
* Multiple births
* Unwanted pregnancy
* Physical handicap of infant
* Prolonged separation from the parent
* Lack of maturity level for parenting
* Low educational level
* Low socioeconomic level
* Young maternal age
* Closely spaced pregnancies
* Difficult birthing process
* Sleep deprivation
* History of depression or mental illness
* Substance abuse
* History of familial or intimate partner abuse
* Lack of family or spousal support

**Note:** A risk diagnosis is not evidenced by signs and symptoms as the problem has not yet occurred. Interventions are aimed at prevention.

#### Expected Outcomes:

* Parent will verbalize individual risk factors that increase the risk of impaired parenting
* Parent will identify resources and personal strengths to overcome parenting barriers
* Parent will participate in classes to promote effective parenting

#### RISK FOR IMPAIRED PARENTING ASSESSMENT

**1. Assess family support and dynamics.**
Assess if the infant’s father is involved in parenting. Assess for other family support such as the mother’s parents or other family members. Assess for additional children in the home.

**2. Observe attachment between parents and infant.**
Observe the parent’s attitude toward the infant. Monitor interactions when feeding and changing the infant or a reluctance or indifference in parenting.

**3. Determine challenges in the parent’s capabilities.**
Young parents with an unplanned or unwanted pregnancy may lack the skills and knowledge for parenting. Consider the parent’s intellectual and emotional level as well as any physical weaknesses.

#### Risk For Impaired Parenting Interventions

**1. Display positivity and allow time for bonding.**
When interacting with the infant and parents, the nurse should display a positive attitude to model interactions. Provide plenty of time for bonding by keeping the infant in a bassinet at the bedside and educating the parents on how to feed, hold, swaddle, and bathe.

**2. Encourage time for themselves.**
Parental stress is linked to postnatal depression. Remind parents to identify positive outlets for themselves and to take time from parenting to reduce anxiety.

**3. Perform a depression screening.**
Post-partum depression can affect up to 18% of new mothers. Symptoms displayed often show a loss of sensitivity and response to their infant’s needs. This serious condition requires intervention for both mom and baby.

**4. Offer community resources.**
Young, single, or unprepared parents may require the support of community resources. Provide information on parenting classes and government assistance programs to aid in the safety and health of the infant.

### RISK FOR INFECTION CARE PLAN

Childbirth can carry an increased risk for infection from trauma, sepsis, and surgical procedures.

Nursing Diagnosis: [Risk For Infection](https://www.nursetogether.com/risk-for-infection-nursing-diagnosis-care-plan/)

#### Related to:

* Trauma to the abdominal wall (cesarean section)
* Trauma to the uterus, genitals, and urinary tract
* Episiotomy
* Advanced maternal age
* High BMI
* Chronic conditions (diabetes, hypertension, immunosuppression)
* Sexually transmitted diseases
* Pre-term or post-term labor
* Prolonged rupture of membranes (PROM)
* Excessive internal exams
* Endometritis

**Note:** A risk diagnosis is not evidenced by signs and symptoms as the problem has not yet occurred. Interventions are aimed at prevention.

#### Expected Outcomes:

* Patient will not develop an infection during the postpartum period
* Patient will display surgical site healing following c-section or episiotomy without signs of redness, warmth, or drainage

#### Risk For Infection Assessment

**1. Identify risk factors.**
Gestational diabetes, intrapartum infections, PROM, preeclampsia/eclampsia, and prolonged labor increase the incidence of infection.

**2. Assess signs and symptoms.**
Fever, uterine tenderness, bleeding, and foul-smelling lochia are signs of endometritis. Localized infections to surgical incisions include pain, erythema, and purulent drainage without approximation of wound borders.

**3. Monitor lab work.**
The white blood count will be elevated along with neutrophils and lactic acid. Blood cultures can also be obtained prior to starting antibiotics.

#### Risk For Infection Interventions

**1. Administer antibiotics.**
Broad-spectrum antibiotics should be administered until cultures or pathogens are identified. Very ill patients or serious infections require IV antibiotics. Less severe infections can be treated outpatient with oral antibiotics.

**2. Decrease the risk prior to delivery.**
It’s vital for the healthcare team to reduce the risk of infection through proper handwashing, NOT shaving before delivery, preoperative showering before cesarean section, maintaining glycemic control <200 mg/dL, limiting vaginal examinations, and avoiding internal fetal monitoring.

**3. Provide education on symptoms.**
Nurses should educate patients at discharge on signs and symptoms of infection and when to seek prompt treatment (fever, persistent pain, changes in lochia).

**4. Demonstrate wound care.**
Teach the patient to care for their episiotomy incision by not bearing when defecating (may need to take stool softeners), use ice packs to decrease the swelling, begin warm sitz baths 24 hours after birth, change postpartum pads every 2-4 hours, and always wipe front to back after using the bathroom and clean the area by spraying warm water over the area and patting dry with a clean towel. For a C-section incision, keep the dressing clean and dry until instructed to remove. Wash with soap and water as instructed and do not scrub.