Q Shift Postpartum Assessment

Action	Resource
1. Initiate breast feeding as soon after admission as possible (if consistent with mother's plan for infant feeding). If mother is awake, facilitate skin-to-skin contact/maternal-infant contact and place babe to breast. Early breast feeding promotes the following: • Uterine contractions to maintain tone and decrease post partum bleeding • Even a few drops of colostrum (saved in 3 ml syringe) may reduce life-threatening complication in premature/high risk neonates • Provides natural immunity to neonate • Preserves the mothers ability to breast feed (if this is her wish) after recovery from a critical illness	Use of hospital breast pump Lactation Consultants: Pager 14087 (daytime) Mother Baby Charge Nurse (MBCU) direct phone 72079
2. Consult with MBCU or OBCU as required for support regarding maternal assessment.	MBCU direct phone 72079 OBCU 58168 Pager 14899 (immediately post birth)
3. Add the following additional parameters to the CCTC 12-hr AI tracking sheet: • Breast/nipple assessment • Epidural/spinal anaesthesia (if indicated) • Parental attachment/grief (as indicated) • Caesarean incision (if present) • Preeclampsia/eclampsia monitoring	CCTC 12 hour AI record http://www.lhsc.on.ca/priv/perinatal/patcare/info.htm
4. Track obstetrical assessment in obstetrical section of CCTC 24 hour Flowsheet (panel 6) including the following: • Lochia and perineum • Fundus • Breasts • Incisions (if indicated) • Preeclampsia/eclampsia if indicated	CCTC 24 hour Flowsheet
5. Maintain current blood transfusion specimen	Power Chart
6. If Rh Negative mother, review indication for Rh Immune globulin with Obstetrical team. Rh Immune globulin destroys Rh positive cells and is given before and within 72 hours of birth (including stillbirth). It is also indicated in a pregnant patient with prenatal bleeding.	Blood Transfusion Manual

Post Partum Specific Assessments

ASSESSMENT	FREQUENCY	DEFINITIONS FOR WDL * AND DAR IF FINDINGS NOT WDL
1. Post spinal or epidural anaesthesia	**Non-ventilated, post spinal or epidural:** • Assess RR rate, rhythm and depth and SpO_2 Q10 minutes X 6, then Q30 minutes until WDL ***AND*** upper and lower motor strength ≥3/5 bilaterally • **Ventilated or no epidural/spinal:** Per CCTC routine • **Spinal testing (motor and sensory)**	**WDL:** • RR 15-22 breaths per minute • Able to DB&C • No dyspnea, minimal secretions **Document**: • Respiratory section of 12 hour AI Record and 24 Hour Flowsheet • Document motor strength q 1 h until 4-5/5 in neuro section of 24 hour Flowsheet
2. Hypertension of pregnancy	• Cardiovascular monitoring as per CCTC routine • Monitor for signs of preeclampsia/eclampsia and HELLP syndrome (below) • Hypertension usually treated with labetalol or hydralazine • Magnesium sulphate is not used to treat hypertension (it may be used if preeclamptic to reduce risk for progression to eclampsia)	
3. Preeclampsia/Eclampsia **Preeclampsia:** new onset of hypertension and either proteinuria or end-organ dysfunction after 20 weeks of gestation in a previously normotensive woman **Eclampsia:** Preeclampsia PLUS generalized seizure that is not due to another neurological cause The treatment for preeclampsia is birth. Treatment may be required following delivery until patient recovers. Hypertensive patients are at high risk for seizures for 48-72 hours	**During $MgS0_4$ administration:** • Neurological assessment Q1h • **Deep Tendon Reflexes (patellar) Q1h** • **Assessment for clonus Q1H** • **Assessment for headache, vision changes or epigastric pain Q1H** • Continuous monitoring for seizure activity • Continue assessment Q4h following discontinuation of $MgS0_4$ until WDL and monitoring is discontinued by Obstetrics	**WDL:** • GCS 15. Motor assessment 4-5/5 and symmetrical • Normal reflexes. Decreased reflex (1-2 out of 4) may indicate magnesium toxicity. Increased (3-4 out of 4) may indicate hyperreflexia of preeclampsia. • Clonus (5 or more “beats” after forceful dorsiflexion) is an indicator of worsening preeclampsia. • No headache, visual changes. Presence of either important predictor that a patient may seizure • Right upper quadrant, epigastric or R shoulder pain (markers of liver inflammation) and/or severe nausea and vomiting are important signs of possible HELLP syndrome

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post birth. Preclampsia/ eclampsia can develop or become more severe up to 6 weeks post partum (peak period is 2 weeks post partum). Signs of worsening preeclampsia or impending eclampsia include: visual changes, headache, epigastric pain, edema or hyperreflexia. HELLP syndrome may be a variant of preeclampsia.	Monitor for signs of HELLP (Hemolysis, Elevated Liver enzymes and Low Platelets) as per physicians orders including: • LDH, bilirubin and blood smear (to identify hemolysis) • Liver enzymes • Platelets	
4. Monitor for Complications of Magnesium Sulphate $MgS0_4$ is indicated to prevent progression of preeclampsia to eclampsia (defined by onset of seizures). It is the drug of choice for the treatment of seizures due to eclampsia (this is the one indication where benzodiazepines are not the first line anticonvulsants). Reflex testing is important during administration of $MgS0_4$ as decreased reflexes (hyporeflexia) may indicate $MgS0_4$ toxicity. Toxicity risk increases in renal failure. $MgS0_4$ can also cause respiratory depression/arrest or hypotension and cardiac arrest. Sudden hemodynamic instability or cardiac arrest during $MgS0_4$ therapy is treated with calcium chloride.	**During $MgS0_4$ administration:** • Neurological assessment Q1h • Deep Tendon Reflexes (patellar) Q1h to identify hyporeflexia (sign of magnesium toxicity) • Monitor for hypotension, cardiac arrhythmias, and respiratory depression • Increase surveillance for toxicity during renal insufficiency • Keep Calcium Chloride at bedside • Continue assessment Q4h following discontinuation of $MgS0_4$ until WDL and monitoring is discontinued by Obstetrics	**Magnesium is a high risk medication. Independent double check is recommended.** Usual dosing for the management of eclampsia is a loading dose of 4 gm over 30 minutes followed by an infusion of 2 gm/hr Obstetrical guidelines are available for review at: https://intra.lhsc.on.ca/obstetrical-care-unit/patient-care-resources
5. Lochia (flow) assessment Increased flow and/or decreased fundal tone are the most important and earliest indicators of post partum hemorrhage. By the time hypotension develops, blood loss may be 1.5-2 litres.	• Q15 minutes X 4, then Q30 X2, then Q1h X 24 hours or until WDL, then Q 4 H.	**WDL:** • < 1 pad saturated in first hour • Clots < size of quarter • No continuous bright blood • Amount decreases in first 24 hours • Lochia becomes pink/brown day 3-4 • No foul order (normal menstrual odor) • By second week, lochia becomes mucoid and yellowish/white • Flow usually stops by 4- 6weeks

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		when cervix closes *Larger clots may be passed during breast feeding or ambulation; record in DAR. Frequent clots or increased flow should be reported to Obstetrical team. Clots > Tooney size require investigation to ensure they are not placental fragments. **Document:** • 12 hour shift assessment, AI q4h and prn • 24 hour graphic ☑ if WDL or * and DAR
6. Perineum assessment	• Q15 minutes X 4, then Q30 X2, then Q1h X 24 hours or until WDL, then Q 4 H.	**WDL:** • No Redness, Ecchymosis, Edema or Drainage, wound Approximated and free Pain free (REEDAP) • No hemorrhoids or fissures. **Document:** • 12 hour shift assessment, AI q4h and prn • 24 hour graphic ☑ if WDL or * and DAR
7. Fundus assessment (uterus involution) Cup one hand around the uterine fundus (which should be about the level of the umbilicus post birth). Place other hand over the symphysis pubis to stabilize the uterus. Massage the uterus from the top down using the hand on the fundus and massage until the uterus becomes a firm globe. Record number of finger widths from umbilicus. If above the umbilicus add a + sign, if below the umbilicus use the – sign. If at the umbilicus, record "0".	• Q15 minutes X 4, then Q 30 minutes X 2, then Q4h X 2 hours, then q shift • Assess more frequently if findings not within normal	**WDL:** • The fundus should be firm and midline. • Mild discomfort during assessment. • Fundus contracts (decreases) by one finger width (1-1.5 cm) every 24 hours. A soft or boggy uterus is atonic (loss of tone or contraction). Hemorrhage can occur if tone is lost. A boggy uterus should be massaged to restore contraction. Assess the response of the uterus to the massage. If it is displaced to the right instead of being midline or elevated, check

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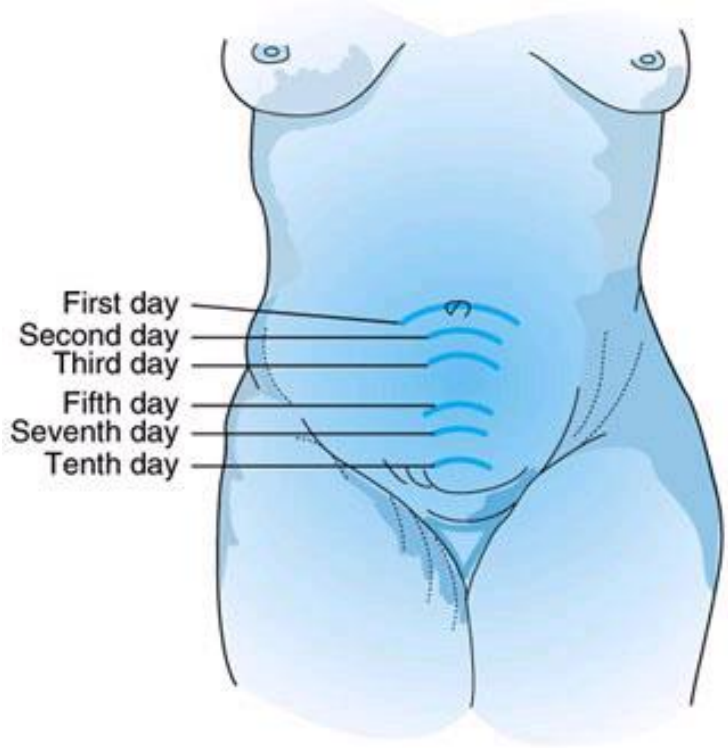
		bladder/bladder catheter. If firmness is not attained after a massage and emptying of the bladder, uterine stimulants may need to be order. Consult obstetrics. Assessment of the fundus and vaginal flow are the most critical for determination of normal bleeding postpartum vs. postpartum hemorrhage. Due to changes in pregnancy, women can lose 500 – 1000 ml of blood without change to their vital signs. Turning is recommended to ensure drainage of trapped blood.
 Source: DeCherney AH, Nathan L: *Current Diagnosis & Treatment Obstetrics & Gynecology*, 10th edition: http://www.accessmedicine.com		
8. Breast and nipple assessment	• Q 4 h • Pre and post breast feeding	**WDL:** • Nipples averted with stimulation. • Nipples free of bruising, redness, pain or fissures. • Latch-on discomfort decreases with correct latch and following let-down. • No compression stripe or change in

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		nipple shape following nursing. • Breast tissue is free of non-compressible tissue or lumps • Red streaks or cellulitis could indicate a mastitis • No redness, pain or swelling if mother is not breast feeding. **Document:** • Descriptive12 hour shift assessment, AI q4h and prn • 24 hour graphic ☑ if WDL or * and DAR
9. Comfort (Consult MBCU as required): Strategies for breast discomfort: • Massage or "milk" any hard tissue areas (blocked ducts) • Lansinoh cream for nipples Strategies for perineal discomfort: • Ice X 24 hours for swelling and discomfort • Anusol for hemorrhoids • Pericare	Assess and document as per CCTC routine	**WDL:** • Minimal breast discomfort following let-down • No breast engorgement • No cramping or abdominal pain (contraction pain during breast feeding is normal, but should be noted in DAR • Refer to Breast Feeding Resources
10. Initiate stool softener and feed as per CCTC protocol Monitor closely for rectal tears, hemorrhoids or discomfort.	Assess and document as per CCTC routine	**WDL:** • Flatus by day 1-2 • No abdominal pain on palpation • Bowel movement within 2-3 days **Document:** Per usual documentation
11. Neonatal safety	Have neonatal suction setup available in mother's room. For infant emergency, call PCCOT or Code Pink.	**PCCOT 15555** **Code Pink 55555**

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	Post “protect me against infection signs” at entrance to patient room Minimize entry to room to individuals who need to provide care. Nurses to wear clean gowns when having contact with neonate. Neonates should not be outside the mother’s room except during transfer (infection control and abduction risk). Neonates should not be carried (safety); transport in stroller or infant bed only.	
12. Maternal bonding	With infant interactions, document q shift and prn	**WDL:** • Mother awake and well enough to engage • Responding to baby’s cues • Calls baby by name • Holds baby face-to-face • Attempting to comfort **Document:** AI Record
13. Parental support/coping/ grief	With interactions, documents q shift	**Document:** • AI Record
14. Mother-Baby Teaching	Upon maternal readiness, consult MBCU for maternal teaching. Term babies are usually not bathed until discharge to home (unless prolonged admission) as vernix is now recognized to be protective.	