Childbearing Exam #2 Study Guide

Yellow was on EXAM

Unit 4: Postpartum

- Nursing Management
  - **Priority**
  - If HR more than 100 (red flag) hemorrhaging?
  - If Temp 100.4 24 hours after delivery maybe infection?
  - **IF 100.4 temp IN 1st 24 hours = NORMAL = HYDRATE; drink water**
  - If Low BP signs ..maybe hemorrhage
  - If a lot of lochia check fundus FIRST could be boggy; If boggy massage it). If still boggy= (could be bladder) Ask patient to use bathroom; if still boggy could be **neutrogenic bladder** –Tell Dr. Right away (full bladder will displace uterus, full bladder will make it feel boggy)
  - If clot bigger than a dime could be hemorrhage
  - Electrolytes to check after giving birth – Chloride and sodium
    - Actions
      - **Postpartum bleeding** – all women who give birth are at risk for excessive bleeding that can progress to postpartum hemorrhage
        - Assess vital signs (hypotension and tachycardia = shock, hemorrhaging)
        - **Most frequent cause** = uterine atony (failure of the uterine muscle to contract firmly)
          - Maintain uterine tone
            - **MASSAGE THE FUNDUS; only if boggy**
          - Prevent bladder distension
            - Full bladder causes the uterus to be displaced – prevents normal contraction that is necessary after birth
          - Medications
            - **Oxytocin (Pitocin), misoprostol (Cytotec), Methergine, Meth prostaglandin**
            - Assess Blood pressure when giving these meds
        - **Other causes:** overdistended uterus, general anesthesia, prolonged labor, history of uterine atony, retained placental fragments, trauma during labor or birth, unrepaired lacerations, ruptured uterus, placenta accreta – previa – abruption, coagulation disorders, hypertension
        - **S/S of hemorrhagic shock:** rapid and shallow respirations, rapid and weak pulse, low BP is a LATE sign,cool–pale–clammyskin,decreased urinaryoutput, lethargy,anxiety
          - If suspected, **GET HELP.** Start IV. Ensure airway.
        - **Involution:** uterus returns to pre-pregnancy state: should not feel fundus after two weeks
        - **Subinvolution**: uterus is not shrinking
      - **Lochia findings:** notice color and amount/ weight perineal pads before and after use.
        - **Rubra**: deep, red/brown
          - 3-4 days
        - **Serosa**: lighter brown/pink
          - Up to 4-10 days
        - **Alba**: 10 and more "normal" discharge – lighter, whiter, creamy
        - A perineal pad that is soaked in 15 minutes or less or pooling of blood under the buttocks are indications of excessive blood loss and requireimmediateassessment andintervention
        - Color and amount should gradually lighten and decrease in amount, NOT return to a previous state
        - **Clots – NORMAL** but should be smaller than a dime (1cm); **IF LARGER THAN DIME TELL HCP ASAP**
        - NO bright red blood – indicates active and continuous bleeding
        - Lochia finding should always improve and never go back to previous color or stage
        - **Endometritis**- heavy foul smelling lochia
        - How many times have you changed your pad ?
        - Average 6 peripads/ day NORMAL
    - Who to see first? Remember ; 2-3 days later pain not normal sore is fine
      - Who is the most high-risk?
    - Assessment findings that require follow-up
      - **Placental complications (placenta accreta):** an abnormally implanted, invasive, or adhered placenta
        - Hysterectomy can be indicated, depending on how deep the placenta is implanted
        - Causes abnormal postpartum bleeding
      - **Laceration or episiotomy**

- Prevent infection
- Maintain a level of comfort
- Avoid constipation (fiber, stool softner, fluids)
- **Perineal care** – topical lidocaine cream; ice pack (vasocontraction (helps with swelling and pain), witch hazel, ice packs, peri bottle (cold water); sitz bath connected to cath and basin. Unclamp fluid is sprayed on perineum

- **Hematomas- localized collection of blood into tissues of reproductive sac**
  - Pain is the most common symptom
  - **Risk factors-** use of epidural, prolonged 2nd stage labor, forceps for delivery
  - Provide pain relief, monitor for any abnormal bleeding, replace fluids, monitor labs (H&H)
  - **Teaching:** need antibiotic, help with house keeping, nurse baby on side, no iontercourse til stiches heal
- **Thrombophlebitis and thrombosis**
  - Promote early ambulation
- **Uterine inversion**
  - Occurs when fundus collapses into the uterine cavity (turns inside out)
  - Primary symptoms include hemorrhage, shock and pain
- **Mastitis**
  - Flu-like symptoms
  - Localized breast pain and tenderness – hot and reddened area
  - Risk factors: inadequate emptying of breasts, sore – cracked, bleeding nipples, not washing hands
  - **Tx:** bed rest, antibiotics, reduce pain and swelling, continued lactation
  - **Teaching:** continue breast feeding, or pumping; empty breasts; use antibiotics; ice pack, analgesics
- **Engorgement**
  - Breasts become "too full"
  - Breasts can become firm, tender and hot – can appear shiny or taut
  - If milk is not removed, breast milk production may reduce
  - **If breastfeeding,** feed or pump regularly (you can store it, save it, donate it), and apply warm water;storage
  - **If NOT breastfeeding,** 1st pump milk out then; do not touch breasts, apply cold water or cabbage leaves,wearatightform-fittingbra;keephusband offbreast (3-4days)
- Psychosocial complications
  - **Postpartum blues** ("baby blues")
    - Considered normal (due to fluctuating and changing hormones)
    - Treatment is not necessary
    - Symptoms should subside in less than two weeks
  - **Postpartum depression**
    - Onset generally occurs in first few months after giving birth
    - Intense and pervasive sadness with labile mood swings
    - More persistent and serious than the baby blues – lasting more than 2 weeks
    - Treatment is similar to "regular" depression
  - **Postpartum psychosis**
    - Can be related to previous depression and bipolar diagnoses
    - Most often occurs 2-4 weeks after birth
    - Can lead to suicide or infanticide
    - **NEEDS TO BE TREATED AND RECOGNIZED**

- **Abnormal BUBBLE-HE** assessment findings – questions to ask, priority actions
  - **Breasts**
    - Assessment includes nipples, breast tissue, temperature and color
    - Redness? Hardening? Swelling?
    - Teaching about Engorgement-
  - **Uterus** – fundal height
    - 1st hours uterus is 1cm above umbilicus
    - By day 10 fundus not palpable
    - **Fundal assessment= 1st encourage mom to void, then massage fundus**
    - **Fundal assessment – lie flat with knees flexed**
    - Involution NEEDS to occur – pre-pregnancy uterine state by 2 weeks after birth
    - Tone = needs to be firm

        - Boggy = spongy
        - Massage the fundus
        - Full bladder can prevent fundus from remaining firm
    - If deviated, is the bladder full?
        - Always have mom urinate before the assessment
        - **1st 24 hours** uterine atony – boggy fundus
        - **After 24**- placenta fragments

- placenta fragments still in uterus can cause boggy fundus

- **Bladder and bowel**
    - **"COLA"** assessment
        - Color, odor, last void/BM, amount
        - Bowel movement is not "necessary" before discharge
        - Must hear flatulence/ passing gas before advancing diet
    - **Neurogenic bladder=** looseabilitytofeelwhentogottobathroom= CallHCP(ordercatheter)
- **Lochia**
    - **Rubra**: deep, red/brown
        - 3-4 days
    - **Serosa**: lighter brown/pink
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    - **Alba**: 10 and more "normal" discharge – lighter, whiter, creamy
    - A perineal pad that is soaked in 15 minutes or less or pooling of blood under the buttocks are indications of excessive blood loss and requireimmediateassessment andintervention
    - Color and amount should gradually lighten and decrease in amount, NOT return to a previous state
    - **Clots** – normal, but should be smaller than a dime
    - **NO bright red blood** – indicates active and continuous bleeding
    - Lochia finding should always improve and never go back to previous color or stage
    - **How many times have you changed you pad?**
    - Lochia amount:
        - scant 1inch; Light (4 inches);
        - Moderate (6 inches) dime size clot are normal
        - Severe: bigger than dime clots.. bad hemorrhage
        - PRIORITY ASSESSMENT: assess for boggy fundus can cause hemoraging
- **Episiotomy or incision**
    - Monitor "REEDA"
    - Redness, edema, ecchymosis, discharge, approximation
    - Proper hygiene: topical medications, ice packs, Sitz baths, **Peri-bottle**
    - **Infection: white/ silver line down abd**
    - **Endometritis-** heavy foul smelling lochia
    - Perniuem assessment – hematoma, open laceration; dehiscence, evisceration;
- **Hemorrhoids**
    - Prevent constipation- fiber, stool softener and fluids
    - **SIMS-** best view of hemorrhoids (one with leg up)
    - Check before advancing diet = check bowel sounds
    - Signs infection- painful, bleeding (bright red), itchy, cant sit= use
- **Emotional status**
    - Monitor for signs and symptoms of depression (2 weeks)
    - Teach mom and family the difference between **baby blues (normal 3-4 days**), depression (needs meds) and psychosis (needs meds) (and how to monitor for each)
    - Normal versus abnormal feelings after birth

NON – Bubble he assessment

Vital signs -

- Nursing assessment/interventions
    - Interpreting values
- **Labs**
    - H&H is critical to monitor
        - They will decrease slightly during the first 24 hours after birth
        - Should return to normal after 4-8 weeks
    - **WBC** will increase

- Return to normal after 1-2 weeks
- Clotting factors and fibrinogen are normally increased
- **Platelets**= 150,000- 450,000

- **Vital signs**
  - Temp: can increase up to 100.4, should return to normal within 24 hours
  - Pulse: can remain elevated directly after birth, return to normal within 48 hours
  - Respirations: if increased during birth, should return to normal quickly
  - BP: Minimal increase should occur, any hypotension can be a late sign of hemorrhage
  - **Remember signs of Hemorrhagic shock- tachycardia, hypotension**

- What indicates a nursing intervention to manage a postpartum condition was effective?

- Recognizing high-risk patients
  - Any possible postpartum complication
    - Pre eclapsmia
    - Diabetes
  - Any type of incision
  - Possibility for bleeding?
- **Facilitating bonding**
  - Skin-to-skin contact ASAP – for at least an hour directly after birth
  - Have mom engage in ALL of the care of their child
  - Help mom take baby a bath
  - Maladaptive behavior bad- avoiding caring for patient
    - Lets baby cry, and stays on phone;
- Therapeutic communication
  - Culturally appropriate care following delivery
    - Not every mother follows the same "routine" following labor and birth (recognize and remember that!)
    - Circumcision for Jewish newborn
    - **Asian patient/ diet /pain/**
      - Does not emphasize touch
      - Delayed breastfeeding
      - Pain management
      - Look at chart 1st; then ask patient

- Education

  - Appropriate teaching/responses for managing postpartum discomforts
    - **Breastfeeding difficulties**
      - Pain and improper latching
        - **Latch on:** mouth over nipple, areola and breast
          - Make a complete seal
        - If a baby does not latch properly, dry–cracked nipples (can become mastitis)
      - Painful, swollen breasts
  - Managing conditions in the postpartum period
    - **Diabetes mellitus** I
      - Lower glucose levels in the immediate postpartum period
      - Many diabetic mothers will require much less insulin for several days after birth, especially if they are breastfeeding
  - Knowing if teaching is effective or ineffective
    - **Breastfeeding (**best practices and managing complications) 1-6 months
    - Benefits- less sick, economical,
      - Breastfeeding mom-additional **500 calories**
      - Ideal time to initiate breastfeeding is within **1-2 hours after birth**
      - Breastfeeding aids in contracting the uterus and preventing maternal hemorrhage
        - (**Prolactin** and **Oxytocin**) – baby sucking stimulates these hormones
      - Feed in any position that is comfortable for both mom and baby
      - How to know feeding is successful?
        - Mother reports firm tugging, no pinching or pain
        - Baby sucks with rounded cheeks, NOT dimpled
        - Baby's jaw glides smoothly
        - Swallowing is usually audible

- Clostrum- first milk 1-3 days

- break suction- take out clean finger between mouth and nipple.
Plugged milk ducts- massage breasts

- What to include in teaching
  - **Medications**
    - Varicella and Rubella vaccination **(MMR)**
      - If mom receives these postpartum, teach to not get pregnant for AT LEAST one month after vaccination – risk for teratogenic effects; mom should be on birth control for at least 3 months
    - **Rh isoimmunization**
      - WhenmomisRhnegativeandbabyisRhpositive,Rhogamgivenwithin72hours after birth
      - used to prevent complications in future pregnancies

Unit 5: Newborn Care

- Nursing management
  - **Priority**
    - Actions
      - **Care of the newborn born to a diabetic mother**
        - **Appearance**: macrosomia
        - Increased risk for birth injuries and congenital abnormalities
        - Increased risk for hypoglycemia
        - Maintain adequate thermoregulation
        - **Serum glucose levels** 35-45 CRITI AL
        - **Newborn Normal Glucose 70-150**
          - IF below 45 – feed baby first !!!
          - If **less than 30, IV dextrose!**

Newborncomesinwithtremors ofextremities;glucoseof50=Priorityaction=feedbaby

      - **Follow-up situations**
        - Orders that may violate cultural practices
          - You CAN question doctors' orders
        - Newborn assessment findings
          - Do not assume
          - Follow up on any abnormality, even if may be expected or "normal"
          - **Hypospadias-** Dorsal Urethra on bottom of penis (requires surgery)
          - **Epispadias-** ventral top of penis
      - **Immediate interventions following delivery**
        - **Newborn resuscitation precedes APGAR!**
        - APGAR scoring and initial assessment (perfect score is 10)
        - General appearance and vital signs (cyanotic vs pink (Normal)
          - **Normal newborn vital signs**
          - **IF Cyanosis, Jaundice, low set ears (down syndrome), dimple on back (spina bifida) =TELL HCP**
        - Baseline measurement and physical size
          - **Normal weight**: 5lb5oz – 8lb8oz
          - **Normal length**: 19.5in
          - **Normal head circumference**: 12.9-13.7in
        - Maintain body temperature
          - Cold stress increases glucose and oxygen needs
          - Babies CANNOT regulate their own temperature
            - **Dry baby 1st (vigorous rub); skin to skin, warmer**
        - Neurological assessment/ (Assess reflexes) aka Primitive reflexes
          - **Tonic neck reflex-** fencing ; infant head turned leg and arm on side will straight ; opposite will flex
          - **grasp reflexes-** palmar ; place finger in baby hand; hand will close; 4-6 m
          - **Plantar reflex -** Finger under toes; 9m -1y
          - **step reflex-** hold baby upright ; baby will take step s; 3-4m
          - **crawl reflex- bower;** place on stomach ; pressure on sole; move arm and les weeks, to months
          - **Babinski-** stroke foot; big toe dorsiflex, other toes fan out; 1 year
          - **rooting –** cheek stroke, head turn towards 4m
          - **Sucking-** touch of infant mouth baby will suck; 4m

- **Moror(startle)-** sudden loud noise; supine head lower than body , move arm stays back body 6m
- Establish breastfeeding
  - After 2-3 days
    - Feed baby every 2-3 hours (if breastfeeding)
    - Feed baby every 3-4 hours (if formula feeding)
    - Check if after 2-4 days 6 wet diapers a day
    - NO cows milk til 12 months old
  - **Stomach capacity**
    - Day 1: 5-7mL
    - Day 3: 0.75-1oz
    - Day 7: 1.5-2oz
- **Eye prophylaxis:** gonorrhea, chlamydia (erythromycin ointment)
- **Vitamin K prophylaxis**
  - Newborn has a sterile bowel, E-coli makes Vitamin K
  - Vitamin K needed for clotting
  - IM injection **(vastus lateralis)**
  - Newborns start to make their own Vitamin K by day 8 – have a sufficient supply by 4 months
- **Suction with bulb syringe**
  - Squeeze bulb first then insert
  - Suction mouth then nose
- **Promote bonding**
  - SKIN TO SKIN
- **Based on APGAR score (1st min , then 5 mins ; then 10 mins after birth if score less than 7)**
  - 0-3: chest compressions and medication
  - 4-6: oxygen, intubation, bag valve mask
  - 7+: stimulation, warm, dry, position, suction
- **Universal Newborn Screening (heel stick)**
  - Tests for sickle cell, PKU, thyroid issues, hearing loss, congenital heart disease, galactosemia
  - **PKU done 24 hours after newborn eats**

- Assessment findings that require the physician to be notified
  - Cyanotic, Jaundice, low set ears, tuff on back (spina bifida), bulging fontonelle
- **Who to see first? (ABC)**
- Assessments
  - Transitioning from intrauterine life to life outside the uterus (STABILIZATION)
    - **Respiratory system**
      - Periodic apnea: up to 15 seconds (normal)
      - Irregular or pausing is normal
      - **RR**: 30-60/min
      - **ABNORMAL:** Tachypnea, retractions (1st signs); distress grunting, flaring,
    - **Cardiovascular**
      - Foramen ovale closes: between R and L atrium
      - Ductus arteriosis constricts: between aorta and pulmonary artery
      - HR: **110-170bpm** (can range from 80-170)
      - **BP: 60-85/40-55**

- **Nursing assessment/interventions**
  - Recognizing normal/abnormal findings
    - **NORMAL**: vernix, lanugo, Mongolian spots, acrocyanosis, Milia, Epstein pearls, plantar creases
    - Preterm vs term newborn
      - **Gestational assessment:** assesses maturity markers in newborn to correlate with gestational age
        - "predicts" gestational age
        - Usually used with premature babies or ones with no prenatal care
      - **Sleep:** 16-18 hours per day
      - **Vision**: can see up to 2.5 feet away
        - Newborns see in black and white
        - See color at about 2 months
        - Can "track" or follow
      - Edema of genitals is common (normal)

- Hydration status
  - Measure by the number of wet diapers
    - Days 1-4: 1 wet diaper/day
    - **THEN after 4 days, a MINIMUM of 6 a day**
- **Hypoglycemia** – tremors, jittery
- **Vernix** – protects the skin from amniotic fluid
  - More vernix = younger gestational age
- **Milia** – distended, small, white sebaceous glands

- Signs of **respiratory distress**
  - Apnea longer than 15 seconds
  - Retractions
  - Nasal flaring
  - Grunting with respirations
  - Cyanosis
  - Decreased O2
- Abnormal physical findings
  - Complete a head to toe assessment
  -
- **Periods of reactivity**
  - **1st period: birth to 30 minutes after**
    - HR increase – return to baseline after 30 minutes
    - Infant alert, spontaneous startles, cries and head movement
  - **Period of decreased responsiveness: 60-100 minutes**
    - Infant is pink
    - Respirations shallow and rapid
    - Sleeping or significant decrease in motor activity
  - **2nd period: lasts from 10 minutes to several hours, occurs between 2 and 8 hours after birth**
    - Tachycardia, tachypnea - normal
    - **Meconium** passed within 24 hours; if not Red flag
      - Dark green/black, sticky, tarry
    - Increased muscle tone, changes in skin color and mucus production

- Assessment findings that require follow-up
- Assessment of newborn born to a Rh immunized mother
  - Only a concern if baby is Rh positive and mom is Rh negative
  - RHOGAM
  - 1st pregnancy generally no issues, 2nd pregnancy – mom's body will attack baby
  - Intrauterine or exchange transfusions
  - Treat jaundice
- Creating care plans
  - **Jaundice**
    - Prevention
      - Feeding is important! (**Meconium releases bilirubin, must poop in 1st 24 hours)**
        - It stimulates peristalsis and produces a more rapid passage of meconium = diminishes the amount reabsorbed
    - Managing the jaundiced newborn
      - Phototherapy – expose as much skin as possible
        - **Phototherapy Nursing interventions=** cover infant eyes, reposition every 2hours,nakedexceptdiaper,assesstempevery2hours,feedevery2hours
      - Exchange transfusions

Physciological Jaundice in 1st 24 hours= caused by Rh and blood incompatibility
IF jaundice left untreated = **Kernicterus** (Bilirubin more than 24 can cause encephalopathy, perm brain damage

- Knowing when to intervene
  - Observing newborn care
    - Provide redirection
- **First bath**
  - Consider their thermoregulation status and ability
  - Start from head cleanest areas first.
- **APGAR** (interpreting score and best practices)
  - Baby gets a rating of 0, 1 or 2 for each category
  - Done 1 minute and 5 minutes after birth

- CAN do a 10-minute score if the first two were still low
- A – appearance and color
  - 0: blue, pale
  - 1: acrocyanosis (blue hands and feet)
  - 2: pink
- P – pulse
  - 0: 0
  - 1: less than 100
  - 2: greater than 100
- G – grimace, irritability
  - 0: no response
  - 1: grimace (face changes to stimuli or irritation)
  - 2: full cry
- A – activity, muscle tone
  - 0: limp
  - 1: some flexion
  - 2: well flexed
- R – respiration
  - 0: no breathing
  - 1: weak, sporadic, or gasping
  - 2: strong cry or easy, irregular is OK

♣ APGAR score of 8 means baby is adjusting to extaruterine life ; no action needed.

♣ **Caring for the newborn that has died = therapeutic care and support**

- Allow parents to dress, bathe and hold baby; private room

- **Education**
  - What to include in teaching
    - ♣ Maintaining safety
      - Car seat teaching
      - Preventing abduction
      - Position when sleeping
    - ♣ Newborn prophylaxis care
    - ♣ **Umbilical cord care**
      - USE Alcohol dries up the cord
        - Note: Saunders says soap and water every 2-3 days
      - Do not submerge in water until the cord falls off (NATURALLY)
      - Do not pull cord off manually
    - ♣ **Circumcision care**
      - **1st 24 hours dry blood and milky discharge (yellow exudate) is normal > continue to monitor**
      - Required informed consent; NPO 2-3hrs before; check every 15mins for 1st hours; check hourly for 4-6 hours
      - If moderate bleeding= pressure dressing
      - If unable to stop bleeding/ continuous bleeding call HCP
      - Every time you change diaper, gauze and petroleum jelly on tip of penis
      - (plasti-bell doesn't need Petroleum jelly)
      - Let coating fall off on its own
    - ♣ **High-risk newborns**
      - Energy conservation = cluster care
      - Minimal stimulation
        - Darken room
        - Quiet
        - Rocking or limit handling
      - **Fractured clavicle= feel/ hear crepitus**
        - Feel crepitus at fracture site
        - Do not lay infant on affected side
        - No other treatment needed
      - **Erb's Palsy= injury Brachial plexus**
        - Usually seen with shoulder dystocia
        - Injury to brachial plexus
        - Usually temporary
        - Startle reflex – only one side will engage

- **TORCH** Complex
  - Toxoplasmosis
    - Cat litter
  - Other
    - Hep B, HIV, parovirus, west nile
  - Rubella
  - Cytomegalovirus
  - Herpes Simplex Virus
    - Can cause hearing loss
    - Encourage C-section
- **Fetal Alcohol Syndrome**
  - Microcephaly, small eyes, thin upper lip, growth restriction, neurodevelopmental deficits
  - **Nursing interventions**= low stimuli, swaddle , cluster care, only touch/hold when necessary

- Reflexes (know their name, how to elicit the response, what is the proper response, and when it should disappear)
  - **Rooting and sucking**
    - Touch/stroke infant's cheek
    - Infant should turn head and open mouth towards stimulus
    - Usually disappears after **3-4 months**
  - **Palmar**
    - Place finger in palm
    - Infant's fingers close around finger
    - Lessens by **3-4 months**
  - **Plantar**
    - Place finger at base of toes
    - Toes curl downwards around finger
    - Lessens by **8 months**
  - **Tonic neck or fencing**
    - When infant in supine position, turns head to one side
    - With infant facing one side, arm and leg on that side extend, opposite side will flex
    - Complete response disappears by **3-4 months**
  - **Moro or startle**
    - "Scare" the baby – with a clap or noise, allow head/neck to start to fall back
    - Arms and legs spread out
    - Complete response may be seen until **8 weeks**
    - Response is absent by **6 months**
  - **Stepping**
    - Hold infant and allow foot to touch surface
    - Infant will simulate walking
    - Normally present for **3-4 weeks**
  - **Crawling**
    - Place newborn on stomach
    - Newborn makes crawling movements
    - Should disappear by **6 weeks**
  - **Babinski**
    - Begin at heel and stroke upwards
    - All toes hyperextend and big toe with dorsiflex
    - Should disappear by **1 year old**

- **Heat loss for Newborns**
  - **Evaporation=** temp loss when wet....Nurse should dry infant
  - **Conduction-** Cold from fan and a/c units= Nurse should use blanket
  - **Convection-** cold from cool surfaces= use warmer
  - **Radiation-** cold from window= close room door