Complicated Postpartum Period NCLEX Review

I. Cystitis

A. Description: Cystitis, an infection of the bladder, can occur in the postpartum period, and the postpartum woman should be encouraged to consume adequate fluids and void frequently to avoid bladder distention.

NOTE: If a urine specimen for culture and sensitivity is prescribed, obtain the specimen before initiating antibiotic therapy.

II. Hematoma

A. Description

1. A hematoma is a localized collection of blood in the tissues and can occur internally, involving the vaginal sulcus or other organs; vulvar hematomas are the most common.

2. Predisposing conditions include operative delivery with forceps and injury to a blood vessel.

3. A hematoma can be a life-threatening condition.

B. Assessment

1. Abnormal, severe pain

2. Pressure in the perineal area

3. Sensitive, bulging mass in the perineal area with discolored skin

4. Inability to void

5. Decreased hemoglobin and hematocrit levels

6. Changes in vital signs indicating shock such as tachycardia and hypotension

C. Interventions

1. Monitor client for abnormal pain or perineal pressure, especially when forceps delivery has occurred.

2. Monitor vital signs and for signs of shock.

3. Place ice at the hematoma site.

4. Administer analgesics as prescribed.

5. Prepare for urinary catheterization if the client is unable to void.

6. Administer blood products as prescribed.

7. Monitor for signs of infection, such as increased temperature, pulse rate, and whiteblood cell count.

8. Administer antibiotics as prescribed because infection is common after hematoma formation.

9. Prepare for incision and evacuation of hematoma if necessary.

III. Uterine Atony

A. Description: A poorly contracted uterus that does not adequately compress large open vessels at the placental site; this can result in hemorrhage.

B. Assessment: A soft (boggy) uterus noted on palpation of the uterine fundus

C. Interventions

1. Massage the uterus until firm

2. Empty the woman’s bladder (by voiding or catheterization) if that is contributing to the uterine atony.

3. Notify the health care provider (HCP) if interventions do not resolve the atony, because this could be an indication of hemorrhage.

IV. Hemorrhage and Shock

A. Description

1. Bleeding of 500 mL or more after delivery

2. Can occur early during the first 24 hours after delivery, or later after the first 24 hours following delivery

3. Causes and predisposing factors

B. Assessment

1. Persistent significant bleeding: Perineal pad is soaked within 15 minutes.

2. Restlessness, increased pulse rate, decrease in blood pressure, cool and clammy skin, ashen or grayish color

3. Complaints of weakness, lightheadedness, dyspnea

C. Interventions: See Priority Nursing Action

V. Infection

A. Description: Any infection of the reproductive organs that occurs within 28 days of delivery or abortion

B. Assessment

1. Fever

2. Chills

3. Anorexia

4. Pelvic discomfort or pain

5. Vaginal discharge that is malodorous; normal vaginal discharge has a fleshy odor or an odor similar to a menstrual period.

6. Elevated white blood cell count

A temperature of 100.4 °F (38°C) is normal during the first 24 hours postpartum because of dehydration; a temperature of 100.4°F(38°C) or greater after 24 hours postpartum indicates infection.

C. Interventions

1. Monitor vital signs and temperature every 2 to 4 hours.

2. Make the client as comfortable as possible; position the client to promote vaginal drainage.

3. Keep the client warm, if chilled.

4. Isolate the newborn from the client only if the client can infect the newborn.

5. Provide a nutritious,high-calorie,high-protein diet.

6. Encourage fluids to 3000 to 4000 mL/day, if not contraindicated.

7. Encourage frequent voiding and monitor intake and output.

8. Monitor culture results if cultures were prescribed.

9. Administer antibiotics according to identified organism, as prescribed.

VI. Mastitis

A. Description

1. Mastitis is inflammation of the breast as a result of infection.

2. Mastitis occurs primarily in breast-feeding mothers 2 to 3 weeks after delivery, but may occur at any time during lactation.

B. Assessment

1. Localized heat and swelling

2. Pain; tender axillary lymph nodes

3. Elevated temperature

4. Complaints of flulike symptoms

C. Interventions

1. Instruct the client in good hand-washing and breast hygiene techniques.

2. Promote comfort.

3. Apply heat or cold to the site as prescribed.

4. Maintain lactation in breast-feeding mothers.

5. Encourage manual expression of breast milk or use of a breast pump every 4 hours.

6. Encourage the client to support the breasts by wearing a supportive bra; avoid wearing an underwire bra.

7. Administer analgesics as prescribed.

8. Administer antibiotics as prescribed.

VII. Pulmonary Embolism

A. Description: Passage of a thrombus, often originating in a uterine or other pelvic vein, into the lungs, where it disrupts the circulation of the blood

B. Assessment

1. Sudden dyspnea and chest pain

2. Tachypnea and tachycardia

3. Cough and lung crackles

4. Hemoptysis

5. Feeling of impending doom

C. Interventions

1. Administer oxygen.

2. Position the client with the head of the bed elevated.

3. Monitor vital signs frequently, especially respiratory and heart rate and breath sounds.

4. Monitor for signs of respiratory distress and for signs of increasing hypoxemia.

5. Administer intravenous fluids as prescribed.

6. Administer anticoagulants as prescribed.

7. Prepare to assist the HCP to administer medications to dissolve the clot, if prescribed.

VIII. Sub-involution

A. Description: Incomplete involution or failure of the uterus to return to its normal size and condition

B. Assessment

1. Uterine pain on palpation

2. Uterus larger than expected

3. More than normal vaginal bleeding

C. Interventions

1. Assess vital signs.

2. Assess uterus and fundus.

3. Monitor for uterine pain and vaginal bleeding.

4. Elevate legs to promote venous return.

5. Encourage frequent voiding.

6. Monitor hemoglobin and hematocrit.

7. Prepare to administer methylergonovine maleate, which provides sustained contraction of the uterus, as prescribed.

IX. Thrombophlebitis

A. Description

1. A clot forms in a vessel wall as a result of inflammation of the vessel wall.

2. A partial obstruction of the vessel can occur.

3. Increased blood-clotting factors in the postpartum period place the client at risk.

4. Early ambulation in the postoperative period after cesarean section is a preventive measure.

B. Types

1. Superficial thrombophlebitis
2. Femoral thrombophlebitis
3. Pelvic thrombophlebitis

C. Assessment (Box 30-2)

D. Interventions

1. Specific therapies may depend on the location of thrombophlebitis.

2. Assess the lower extremities for edema, tenderness, varices, and increased skin temperature.

3. Maintain bed rest.

4. Elevate the affected leg.

5. Apply a bed cradle and keep bedclothes off the affected leg.

6. Never massage the leg.

7. Monitor for manifestations of pulmonary embolism.

8. Apply hot packs or moist heat to the affected site as prescribed to alleviate discomfort.

9. Apply elastic stockings (support hose) if prescribed.

10. Administer analgesics and antibiotics as prescribed.

11. Heparin sodium intravenously may be prescribed for femoral or pelvic thrombophlebitis to prevent further thrombus formation.

E. Client education

X. Perinatal Loss

A. Description

1. Perinatal loss is associated with miscarriage, neonatal death, stillbirth, and therapeutic abortion.

2. Loss and grief also may occur with the birth of a preterm baby, a newborn with complications of birth, or a newborn with congenital anomalies; it also may occur in a client who is giving up a child for adoption.

B. Interventions

Not all interventions are appropriate for every woman and her family who has experienced perinatal loss. It is crucial to consider religious, spiritual, and cultural health care practices and beliefs when planning care for a woman and family who have experienced perinatal loss.

1. Communicate therapeutically and actively listen, providing parents time to grieve.

2. Notify the hospital chaplain or other religious person.

3. Discuss with the parents options such as seeing, holding, bathing, or dressing the deceased infant; visitation by other family members or friends; religious, spiritual, or cultural rituals; and funeral arrangements.

4. Prepare a special memories box with keepsakes such as footprints, hand-prints, locks of hair, and pictures, if appropriate.

5. Admit the mother to a private room; if possible, mark the door to the room with a special card (per agency procedure and maintaining confidentiality) that denotes to hospital staff that this family has experienced a loss.