

**PROTOCOL FOR:** Cesarean Delivery: Care of the Patient following

**PURPOSE:** To delineate nursing care/management of a post-cesarean delivery.

- POLICY:**
1. Patients who have undergone a Cesarean Delivery under general or regional anesthesia are transferred directly to recovery area via stretcher bed.
  2. All post anesthesia patients will be accompanied to recovery area by an anesthesiologist and a nurse. Anesthesiologist will remain with the patient until vital signs and condition of the patient have been assessed.
  3. Patients must be discharged by an anesthesiologist before leaving the MFICU. A telephone discharge order is acceptable.

**DESIRED  
PATIENT OUTCOME:**

1. The patient will recover from her Cesarean Delivery hemodynamically stable and free of infection and other complications.
2. The patient will have adequate pain control by patient's self report.

**CLINICAL  
ASSESSMENT  
AND CARE:**

1. Assist in transport of patients from OR table to bed.
2. Place siderails in upright position until patient is fully awake.
3. Assess adequacy of patient's airway after general anesthesia.
4. After general anesthesia, assess state of consciousness, including response to commands and presence of swallow reflex. For all patients, assess movement of body parts.
5. Assess pulse, RR, BPs, pain, fundus, lochia, dressing or incision every 15 minutes x 4; then every 30 minutes x 2; then every 4 hours x 24 hours; then every eight hours until discharge (Assess temperature within an hour of recovery and upon transfer to post-partum; when on post-partum, assess temperature every 4 hours x 24 hours, then every 8 hours until discharge).
6. Apply O<sub>2</sub> and/or Pulse Oximeter as ordered by Anesthesia.
7. Assess Foley for patency every 2 hours.
8. Assess I & O every hour for 4 hours and then every 4 hours until Foley discontinued; Assess and measure voids x 2 post-catheter removal.

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9. Assess IV every hour for accurate rate and function in recovery area. Assess site every 8 hours for s/s of infiltration, and/or inflammation.
10. After regional anesthesia, assess sensation and movement of lower extremities. Assess dressing at site of anesthesia administration. For all patients, assess movement of body.
11. Initiate PCA pump as ordered or administer analgesics as ordered and as needed.
12. Assess bowel sounds at least every eight hours.
13. Assist patient in turning from side to side. Maintain good body alignment until ambulation is possible.
14. Encourage coughing and deep breathing and use of incentive spirometer as ordered.
15. Assess breasts for engorgement. If breastfeeding, assess breasts for nipple inversion, cracked or tender nipples, presence of colostrum/milk on admission/initiation of breastfeeding and/or pumping, then prn.
16. Assess for fall risk and assist in first ambulation and thereafter if patient is unsteady on her feet.
17. Encourage and assist patient to ambulate when stable.
18. Assist in transferring baby and caring for baby in room until mother is alert and demonstrates safe and independent ambulation.
19. Instruct patient and assist, as needed, in peri-care after each urination.
20. Encourage patient to wear supportive bra or breast binder at all times.

- PATIENT TEACHING:**
1. Initiate Patient/Family Teaching Record for Maternal Self-Care/Infant Care.
  2. Instruct patient on the importance of following protocol for infant security.

- DOCUMENTATION:**
1. Document education/teaching on Patient/Family Teaching Record.
  2. Document on Post Anesthesia Care Record.
  3. Note exact time of transfer to recovery area on the Operative Record.

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APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/88

REVISION DATES: 5/89, 6/90, 1/91, 3/93, 5/93, 11/96, 3/97, 3/00, 7/03, 3/09