TEACHING PLAN: Maternal Self Care Education Needs

PURPOSE: To delineate the educational needs/self-care instruction of a patient who has had a vaginal or cesarean section.

SUPPORTIVE DATA: Following a delivery there is a period of physiological and psychosocial adjustments. This protocol addresses the educational needs of a patient while hospitalized and in preparation of self care after discharge. This protocol is to be used as a guide, in adjunct with physician orders, for each patient. Refer any questions about care to the physician/primary RN.

ASSOCIATED STANDARDS: OB-GYN Unit Practice Manual:
Protocol for: Cesarean Delivery, Care of the Patient
Protocol for: Vaginal Delivery, Care of the Delivered Patient

NICU/NBN/OB-GYN/L&D/Pedi Unit Practice Manuals:
Teaching Plan for: Breast Feeding: Use of Breast Milk
Protocol for: Breast Feeding: Storage and Use of Breast
Procedure for: Breast Pumping, Electric

DESIRED PATIENT OUTCOMES: Patient will demonstrate and/or verbalize understanding of the self care measures necessary to promote well-being after delivery.

ASSESSMENT:

1. Assess previous experience with self care after a delivery.
2. Assess ability to understand instruction - language barrier, disabling mental/emotional capacity.
3. Assess level of consciousness 2° narcotic medication and/or Magnesium Sulfate administration.
4. Assess physical ability to perform self care activities.

INTERVENTION:

1. Initiate Self Care Educational Needs Flowsheet upon admission to unit.
2. Instruct patient in a quiet environment.

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3. Instruct patient using lay terms.

4. Reinforce verbal instructions using videos, pamphlets, handouts.

5. Have patient demonstrate activities taught when possible, and/or verbalize understanding of instructions given.

PATIENT EDUCATION: The nurse is responsible for identifying the educational needs of the patient and teaching basic self-care measures using the guidelines that follow:

1. Fundal changes and lochia: Involution is the process by which the uterus returns to its nonpregnant state within four to six weeks. The nurse will provide the following information:

A. Contractions

1) Explain to patient that contractions decrease uterine size, increase uterine tone and help to expel clots.

2) Explain that massaging uterus, emptying bladder and breast feeding cause contractions.

3) Encourage patient to empty bladder q three to four hours.

B. Lochia

1) Vaginal discharge containing blood, mucous and cellular debris which changes in color and consistency over time: Rubra - dark red, lasts from delivery to third day; Serosa - pinkish brown, lasts fourth to tenth day; Alba - yellowish brown, lasts up to six weeks.

2) Describe above expected changes to patient.

3) Explain lochia will increase with activity and first ambulation.

4) Instruct patient to change pad each time after going to bathroom.

5) Instruct patient to report foul odor, return to bright red bleeding and clots larger than a quarter to staff or M.D. if after D/C.

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6) Menstrual period will return in four to six weeks.

2. Perineal Care: Proper care of the perineum is important in preventing infection and promoting healing. The external os of the cervix remains dilated several days after delivery leaving the uterus open to infection. The nurse will instruct the patient in the care of the perineum by explaining:

A. Pericare

1) Fill bottle with warm water before going to bathroom.

2) Spray perineum from vulva to rectum after every void and bowel movement.

3) Change pad each time after going to the bathroom.

B. Inform patient as to the condition of her perineum: swelling, tears and hemorrhoids.

C. Explain importance of washing hands before and after pad change.

D. Explain that sutures will dissolve.

E. Offer comfort measures: tucks, epifoam, ice, sitz bath, dermoplast spray and pain medication.

F. Explain kegel exercises.

G. Instruct patient not to place anything in vagina; no tampons, douching or intercourse for four to six weeks.

3. Elimination Patterns

A. Bladder and bowel function patterns may be temporarily disrupted after delivery as a result of decreased bladder sensitivity and patient activity. Patient should void spontaneously within six to eight hours of delivery or after indwelling catheter removal. Straight cath may be done if unable to void at this time. Normal bowel function should return by third or fourth PP day. Instruct patient to:

1) Call for assistance with first void.

2) Use pericare after every void and BM.

3) Use of measures to enhance spontaneous void:

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a. Warm water on vulva.

b. Voiding in shower or sitz bath.

c. Straddling toilet to decrease perineal discomfort.

d. Running tap water or shower.

4) Report S/S infection: burning, frequency, urgency and retention.

5) Urine volume may increase first 48 hours as body diureses retained tissue fluid.

6) Explain the importance of fluids, fiber and ambulation in re-establishing regular bowel habits.

7) Ask patient to report first BM.

8) Provide measures to promote comfortable BMs.

a. Meds per M.D. orders: MOM, suppositories and stool softeners.

b. Nutritional guidance.

c. Assistance with ambulation.

9) Reassure patient that BM will not affect episiotomy or abdominal incision if cesarean section.

4. Cesarean Section Incision/Abdominal Care: Caretaking measures following a cesarean section involve maintaining physical stability, and informing the patient of the healing process and instructing them in the care of the incision/abdomen. Instructions should include:

A. Type of incision closure used: staples or subcuticular.

B. Encourage splinting of incision with towel or pillow while T, C and DB.

C. Instruct patient to air dry incisional area and to avoid heavy restrictive clothing over abdominal area.

D. Instruct patient to report S/S infection: redness around incision, purulent discharge from incision and extreme abdominal tenderness.

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E. Encourage ambulation for abdominal distention related to gas.

F. Tell patient she may shower as usual after removal of dressing and to pat dry incisional area.

G. Instruct patient not to use oils or lotions over incisional area.

H. Encourage patient to ask for medication to relieve pain.

I. Instruct patient to call with first OOB.

5. Breast Care: Non-Nursing - Breast engorgement is a normal process that occurs as milk is produced. Milk production usually occurs three to five days after delivery and lasts for 24 to 48 hours. For mothers who are not going to breastfeed the following should be addressed:

A. Explain physiological changes in breasts after delivery to engorgement:

1) Colostrum: thin, yellowish secretion present in breast before and just after delivery.

2) Breast milk: thin, bluish-white substance.

3) Increase in blood and lymph supply make breasts appear full, shiny and with distended veins.

4) Breasts may feel warm, tender and nodular.

B. Encourage patient to shower daily, but to avoid direct spray of hot water on breasts.

C. Wear supporting bra or binder to decrease stimulation.

D. Instruct patient not to stimulate expression of milk; leakage of breast milk is normal.

E. Instruct patient to frequently change breast pads used to collect leaking breast milk.

F. Explain comfort measures:

1) Ice to swollen breasts.

2) Analgesics, i.e. tylenol for discomfort.

G. Instruct patient to report S/S infection:

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1) Warm, reddened, tender area of breast.

2) May palpate hard nodular area that is tender to touch.

3) Fever, aches and chills.

6. Breast Care: Nursing Mothers - Lactation is a process caused by hormonal changes. Decreases in estrogen and progesterone, and an increase in prolactin stimulate milk production with delivery. Refer to Teaching Plan: Use of Breast Milk.

7. Activity: Patient activity level is dependent on type of delivery. Generally, a patient may be OOB when comfortable and able to ambulate with minimal assistance. The following guidelines should be addressed when patient is alert and oriented:

A. Instruct patient to ring for assistance with first OOB.

B. Encourage patient ambulation.

C. Instruct patient to balance activity with rest.

D. Encourage patient not to lift heavy objects (heavier than term baby) two to four weeks after vaginal delivery or four to six weeks after cesarean section.

E. Instruct patient to slowly increase activity with tolerance.

F. Instruct patient not to drive for two weeks after c/section; encourage limited driving after vaginal delivery for first two weeks.

G. Instruct patient to avoid excessive stair climbing two to four weeks after c/section.

H. Instruct patient not to engage in strenuous exercise until six week check-up with M.D.

8. Nutrition: Well balanced meals from basic food groups are needed to regain strength, promote healing of tissues and establish breast milk supply. Review of nutrition should include:

A. Encourage patient to plan well rounded nutritious meals from all food groups.

B. Instruct patient on progression of diet while hospitalized.

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1) No restrictions after vaginal delivery.

2) Foods and fluids are advanced as bowel function returns.

C. Encourage fluids and fibers to promote comfortable bowel movements, and avoid abdominal distention.

D. Encourage breast feeding mothers to continue increased caloric intake of pregnancy (500-800 calories).

E. Reassure patient that restriction of foods while breastfeeding is not necessary, i.e. cabbage family.

1) Discuss allergic-type foods, i.e. chocolate, eggs, milk, and the infant's reaction to them if sensitive (gas, constipation, distention).

9. Birth Control: Sexuality changes and emotional adjustments are experienced after delivery by both mother and father. Information regarding birth control decisions should include:

A. Discussion of options available.

B. Assist patient with decision.

C. If tubal requested, discuss interventions necessary: consent, time and place of procedure.

REPORTABLE CONDITIONS:

1. Patient unable to comprehend instructions.

2. Patient physically unable to perform tasks.

DOCUMENTATION: Document per Documentation Policies, Department of Nursing.

APPROVAL: Nursing Standards Committee

CREDENTIALS: RN

EFFECTIVE DATE: 1/91, 9/94

REVISION DATES: