CHAPTER 25

Postpartum Period

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Priority Concepts

Health Promotion, Reproduction

I. Postpartum

A. Description: Period when the reproductive tract returns to the normal, nonpregnant state

B. The postpartum period starts immediately after **birth** and is usually completed by week 6 following birth.

II. Physiological Maternal Changes

A. Involution

1. Description

a. Involution is the rapid decrease in the size of the **uterus** as it returns to the nonpregnant state.

b. Clients who breast-feed may experience a more rapid involution because of the release of oxytocin during breast-feeding.

2. Assessment

a. The weight of the uterus decreases from approximately 2 lb (900 g) to 2 oz (57 g) in 6 weeks.

b. The endometrium regenerates.

c. The fundus steadily descends into the pelvis.

d. Fundal height decreases about 1 cm/day (Fig. 25-1).

e. By 10 days postpartum, the uterus cannot be palpated abdominally.

f. A flaccid fundus indicates uterine atony, and it should be massaged until firm; a tender fundus indicates an infection.

g. Afterpains decrease in frequency after the first few days.

B. Lochia

1. Description: Discharge from the uterus that consists of blood from the vessels of the placental site and debris from the decidua
2. Assessment (Box 25-1)
    a. Rubra is bright red discharge that occurs from day of birth to day 3.
    b. Serosa is brownish pink discharge that occurs from days 4 to 10.
    c. Alba is white discharge that occurs from days 11 to 14.
    d. Discharge should smell like normal menstrual flow.
    e. Discharge decreases daily in amount.
    f. Discharge may increase with ambulation.

C. Cervix: Cervical involution occurs, and the muscle begins to regenerate after 1 week.

D. **Vagina**: Vaginal distention decreases, although muscle tone is never restored completely to the pregravid state.

E. Ovarian function and menstruation
1. Ovarian function depends on the rapidity with which pituitary function is restored.
2. Menstrual flow resumes within 1 to 2 months in non–breast-feeding mothers.
3. Menstrual flow usually resumes within 3 to 6 months in breast-feeding mothers.
4. Breast-feeding mothers may experience amenorrhea during the entire period of lactation so long as they are exclusively breastfeeding.

Women may ovulate without menstruating, so breast-feeding should not be considered a form of birth control.

F. Breasts
1. Breasts continue to secrete colostrum for the first 48 to 72 hours after birth.
2. A decrease in estrogen and progesterone levels after birth stimulates increased prolactin levels, which promote breast milk production.
3. Breasts become distended with milk on the third day.
4. Engorgement occurs on approximately day 4 in both breast-feeding and non–breast-feeding mothers. Box 25-2 summarizes care of breasts for non–breast-feeding mothers.
5. Breast-feeding relieves engorgement.

G. Urinary tract
1. The client may have urinary retention as a result of

loss of elasticity and tone and loss of sensation in the bladder from trauma, medications, anesthesia, and lack of privacy.

2. Diuresis usually begins within the first 12 hours after birth.

H. Gastrointestinal tract

1. Clients are usually hungry after birth.
2. Constipation can occur, with bowel movement (soft, formed stool) by the second or third postpartum day.
3. Hemorrhoids are common.

I. Vital signs (Table 25-1)

III. Postpartum Interventions

A. Assessment

1. Monitor vital signs.
2. Assess pain level.

3. Assess height, consistency, and location of the fundus (have client empty the bladder before fundal assessment) (Fig. 25-2).

4. Monitor color, amount, and odor of lochia.
5. Assess breasts for engorgement.
6. Monitor perineum for swelling or discoloration.
7. Monitor for perineal lacerations or episiotomy for healing.
8. Assess incisions or dressings of client who had a cesarean birth.
9. Monitor bowel status.
10. Monitor intake and output.
11. Encourage frequent voiding.
12. Encourage ambulation.
13. Assess extremities for thrombophlebitis (redness, tenderness, or warmth of the leg).

14. Administer Rho(D) immune globulin if prescribed within 72 hours postpartum to Rh-negative client who has given birth to Rh-positive **newborn.**
15. Evaluate rubella immunity. If not immune, administer rubella immunization.

16. Assess bonding with the newborn.
17. Assess emotional status.

B. Client teaching

1. Demonstrate newborn care skills as necessary.
2. Provide the opportunity for the client to bathe the newborn.
3. Instruct in feeding technique.
4. Instruct the client to avoid heavy lifting for at least 3 weeks.
5. Instruct the client to plan at least 1 rest period per day.
6. Instruct the client that contraception should begin after birth or with the initiation of intercourse (intercourse should be postponed at least until lochia ceases). With rubella immunization, avoid conception for 1 to 3 months based on primary health care provider (PHCP) or obstetrician/gynecologist (OB/GYN) recommendation.
7. Instruct the client in the importance of follow-up, which should be scheduled at 4 to 6 weeks.
8. Instruct the client to report any signs of chills, fever, increased lochia, or depressed feelings to the PHCP immediately.

IV. Postpartum Discomforts

A. Afterbirth pains
1. Occur as a result of contractions of the **uterus**.
2. Are more common in multiparas, breast-feeding mothers, clients treated with oxytocin, and clients who had an overdistended uterus during pregnancy, such as with carrying twins.

B. Perineal discomfort
1. Apply ice packs to the perineum during the first 24 hours to reduce swelling.
2. After the first 24 hours, apply warmth by sitz baths.

C. Episiotomy
1. If done, instruct the client to administer perineal care after each voiding.
2. Encourage the use of an analgesic spray as prescribed.
3. Administer analgesics as prescribed if comfort measures are unsuccessful.

D. Perineal lacerations
1. Care as for an episiotomy; administer perineal care and use analgesic spray and analgesics for comfort.
2. Rectal suppositories and enemas may be contraindicated (to avoid injury to sutures).

E. Breast discomfort from engorgement
1. Encourage the client to wear a support bra at all times, even while she is sleeping.
2. Encourage the use of ice packs between feedings if the client is not breast-feeding. Use of ice packs could diminish milk supply in the breast-feeding mother.

3. Encourage the use of warm soaks or a warm shower before feeding for the breast-feeding mother.
4. Administer analgesics as prescribed if comfort measures are unsuccessful.

F. Constipation

1. Encourage adequate intake of fluids (2000 mL/day).
2. Encourage diet high in fiber.
3. Encourage ambulation.
4. Administer stool softener, laxative, enema, or suppository if needed and prescribed.

G. Postpartum emotional changes (Box 25-3)

1. Acknowledge the client's feelings and demonstrate a caring attitude.
2. Determine availability of family support and other support systems and resources as needed.
3. Encourage and assist the client to verbalize her feelings.
4. Monitor the newborn for appropriate growth and development expectations.
5. Assist the significant other and other appropriate family members to discuss feelings and identify ways to assist the client.

All clients should be assessed for depression during pregnancy and in the postpartum period.

V. Nutritional Counseling

A. Discuss caloric intake with breast-feeding and non–breast-feeding mothers.

B. Nutritional needs depend on prepregnancy weight, ideal weight for height, and whether the client is breast-feeding.

C. If the client is breast-feeding, calorie needs increase by 200 to 500 calories/day, and the client may require increased fluids and the continuance of prenatal vitamins and minerals.

VI. Breast-Feeding

A. Interventions

1. Put the newborn to the mother's breast as soon as the mother's and newborn's conditions are stable (on delivery table, if possible).
2. Stay with the client each time she nurses until she feels secure and confident with the newborn and her feelings.
3. Assess *LATCH* (*l*atch achieved by newborn; *a*udible swallowing; *t*ype of nipple; *c*omfort of mother; *hold* or position of baby).

4. Uterine cramping may occur the first day after birth while the client is nursing, when oxytocin stimulation causes the uterus to contract.
5. Instruct the client to use general hygiene and wash the breasts once daily.
6. If engorgement occurs, breast-feed frequently, apply warm packs before feeding, apply ice packs between feedings, and massage the breasts.
7. The client should not use soap on the breasts because it tends to remove natural oils, which increases the chance of cracked nipples.
8. If cracked nipples develop, the client should expose the nipples to air for 10 to 20 minutes after feeding, rotate the position of the baby for each feeding, and ensure that the baby is latched on to the areola, not just the nipple. Colostrum can also be expressed after the feeding as a moisturizer for the nipple to prevent cracked, dry skin.
9. The bra should be well fitted and supporting; avoid an underwire bra.
10. Breasts may leak between feedings or during coitus; place breast pad in bra.
11. Calories should be increased by 200 to 500 calories/day, and the diet should include additional fluids; prenatal vitamins should be taken as prescribed.
12. Newborn's stools are usually light yellow, seedy, watery, and frequent.
13. Medications, including over-the-counter medications, need to be avoided unless prescribed because they may be unsafe when breast-feeding.
14. Gas-producing foods and caffeine should be avoided.
15. Oral contraceptives containing estrogen are not recommended for breast-feeding mothers; progestin-only birth control pills are less likely to interfere with the milk supply.
16. The infant will develop her or his own feeding schedule.

B. Breast-feeding procedure for the mother (Box 25-4)

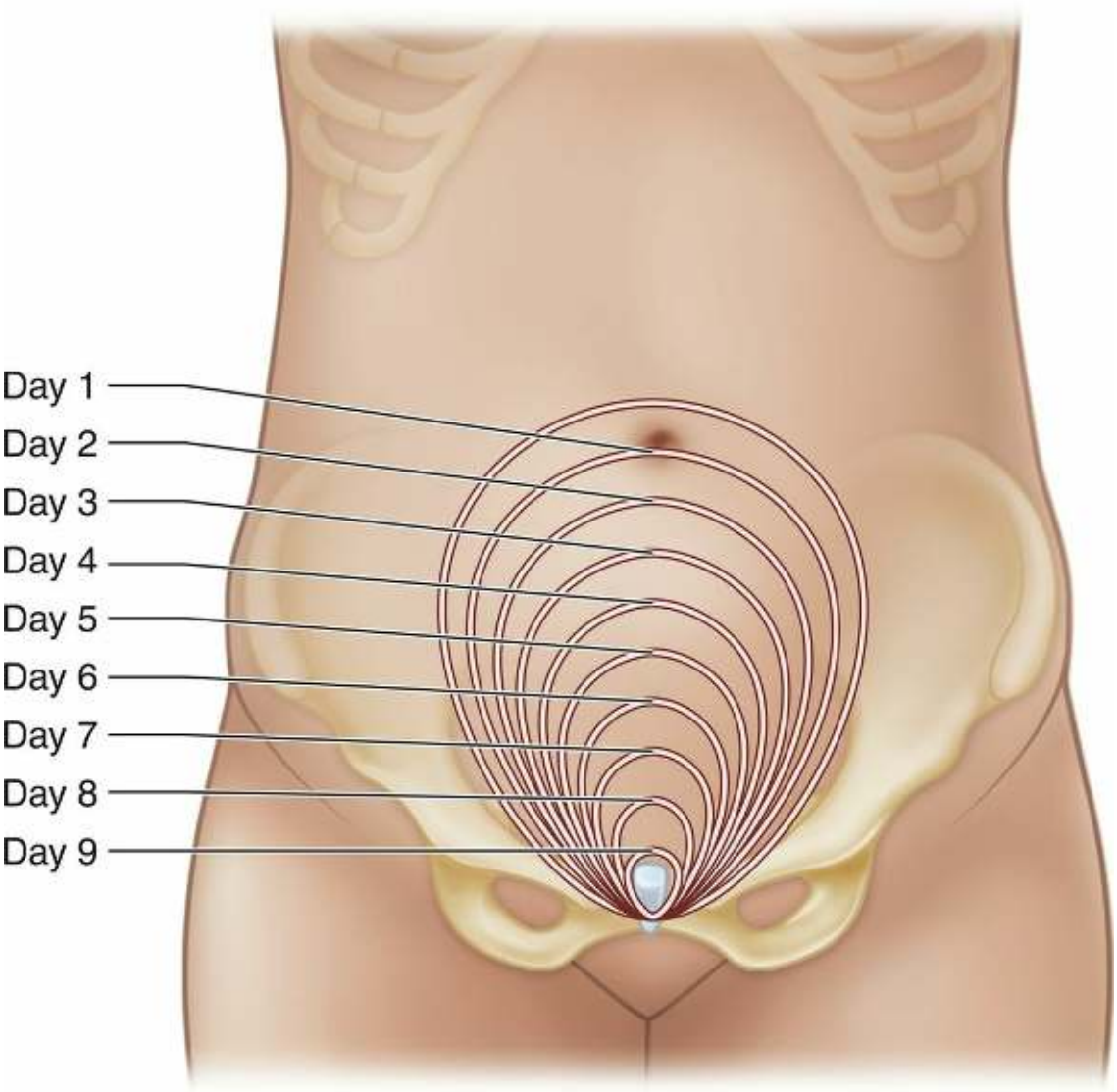

FIG. 25-1 Involution of the uterus. The height of the uterine fundus decreases by approximately 1 cm/day.

Box 25-1

Amount of Lochia

Scant: Less than 2.5 cm (< 1 inch) on menstrual pad in 1 hour
Light: Less than 10 cm (< 4 inches) on menstrual pad in 1 hour
Moderate: Less than 15 cm (< 6 inches) on menstrual pad in 1 hour
Heavy: Saturated menstrual pad in 1 hour
Excessive: Menstrual pad saturated in 15 minutes

From Murray S, McKinney E: *Foundations of maternal-newborn and women's health nursing*, ed 5, Philadelphia, 2010, Saunders.

Box 25-2

Breast Care for Non–Breast-Feeding Mothers

- Avoid nipple stimulation.
- Apply a breast binder, wear a snug-fitting bra, apply ice packs, or take a mild analgesic for engorgement.
- Engorgement usually resolves within 24 to 36 hours after it begins.

Table 25-1

Normal Postpartum Vital Signs

Vital Sign	Description
Temperature	May increase to 100.4° F (38.0° C) during the first 24 hr postpartum because of dehydrating effects of labor. Any higher elevation may be caused by infection and must be reported.
Pulse	May decrease to 50 beats per minute (normal puerperal bradycardia). Pulse > 100 beats per minute may indicate excessive blood loss or infection.
Blood pressure	Should be normal; suspect hypovolemia if it decreases.
Respirations	Rarely change; if respirations increase significantly, suspect pulmonary embolism, uterine atony, or hemorrhage.

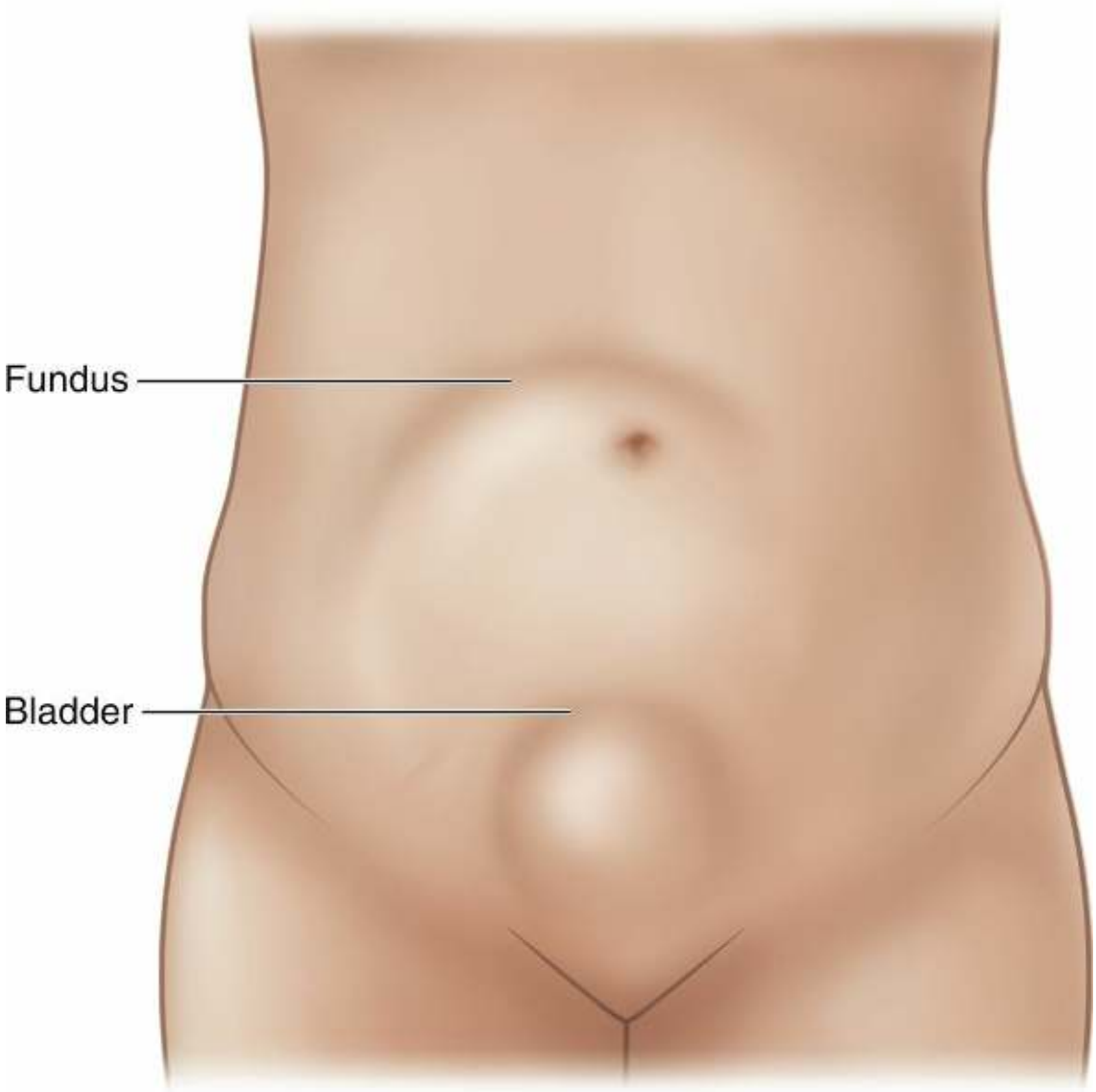

FIG. 25-2 A full bladder displaces and prevents contraction of the uterus.

Box 25-3

Signs and Symptoms of Emotional Changes

Postpartum Blues

- Anger
- Anxiety
- Cries easily for no apparent reason
- Emotionally labile
- Expresses a let-down feeling
- Fatigue
- Headache

- Insomnia
- Restlessness
- Sadness

Postpartum Depression

- Anxiety
- Appetite changes
- Crying, sadness
- Difficulty concentrating or making decisions
- Fatigue, unable to sleep
- Feelings of guilt
- Irritability and agitation
- Lack of energy
- Less responsive to the infant
- Loss of pleasure in normal activities
- Suicidal thoughts

Postpartum Psychosis

- Break with reality
- Confusion
- Delirium
- Delusions
- Hallucinations
- Panic

Data from Lowdermilk D, Cashion MC, Perry S: *Maternity & women's health care,* ed 9, St. Louis, 2011, Mosby; Lowdermilk D, Perry S, Cashion MC, Alden K: *Maternity & women's health care,* ed 10, St. Louis, 2012, Mosby; and Perry S, Hockenberry M, Lowdermilk D, Wilson D: *Maternal-child nursing care,* ed 4, St. Louis, 2013, Mosby.

Box 25-4

Breast-Feeding Procedure for the Mother

1. Wash hands and assume a comfortable position.
2. Start with the breast with which the last feeding ended.
3. Brush the newborn's lower lip with nipple.
4. Tickle the lips to have the newborn open the mouth wide.
5. Guide the nipple and surrounding areola into the newborn's mouth.
6. Encourage the newborn to nurse on each breast for 15 to 20 minutes.

7. After the newborn has nursed, release suction by depressing the newborn's chin or inserting a clean finger into the newborn's mouth.
8. Burp the newborn after the first breast.
9. Repeat the procedure on the second breast until the newborn stops nursing.
10. Burp the newborn again.
11. Listen for audible sucking and swallowing.

Practice Questions

246. The postpartum nurse is taking the vital signs of a client who delivered a healthy newborn 4 hours ago. The nurse notes that the client's temperature is 100.2° F. What is the **priority** nursing action?
    1. Document the findings.
    2. Notify the obstetrician.
    3. Retake the temperature in 15 minutes.
    4. Increase hydration by encouraging oral fluids.
247. The nurse is assessing a client who is 6 hours postpartum after delivering a full-term healthy newborn. The client complains to the nurse of feelings of faintness and dizziness. Which nursing action is **most appropriate**?
    1. Raise the head of the client's bed.
    2. Obtain hemoglobin and hematocrit levels.
    3. Instruct the client to request help when getting out of bed.
    4. Inform the nursery room nurse to avoid bringing the newborn to the client until the client's symptoms have subsided.
248. The postpartum nurse is providing instructions to a client after birth of a healthy newborn. Which time frame should the nurse relay to the client regarding the return of bowel function?
    1. 3 days postpartum
    2. 7 days postpartum
    3. On the day of birth
    4. Within 2 weeks postpartum
249. The nurse is planning care for a postpartum client who had a vaginal delivery 2 hours ago. The client required an episiotomy and has several hemorrhoids. What is the **priority** nursing consideration for this client?
    1. Client pain level
    2. Inadequate urinary output
    3. Client perception of body changes
    4. Potential for imbalanced body fluid volume
250. The nurse is providing postpartum instructions to a client who will be breast-feeding her newborn. The nurse determines that the client has understood the instructions if she makes which statements? **Select all that apply.**
    - ☐ 1. "I should wear a bra that provides support."
    - ☐ 2. "Drinking alcohol can affect my milk supply."
    - ☐ 3. "The use of caffeine can decrease my milk supply."

❑ 4. "I will start my estrogen birth control pills again as soon as I get home."
❑ 5. "I know if my breasts get engorged, I will limit my breast-feeding and supplement the baby."
❑ 6. "I plan on having bottled water available in the refrigerator so I can get additional fluids easily."

251. The nurse is teaching a postpartum client about breast-feeding. Which instruction should the nurse include?
    1. The diet should include additional fluids.
    2. Prenatal vitamins should be discontinued.
    3. Soap should be used to cleanse the breasts.
    4. Birth control measures are unnecessary while breast-feeding.
252. The nurse is preparing to assess the uterine fundus of a client in the immediate postpartum period. After locating the fundus, the nurse notes that the uterus feels soft and boggy. Which nursing intervention is appropriate?
    1. Elevate the client's legs.
    2. Massage the fundus until it is firm.
    3. Ask the client to turn on her left side.
    4. Push on the uterus to assist in expressing clots.
253. The nurse is caring for four 1-day postpartum clients. Which client assessment requires the **need for follow-up**?
    1. The client with mild afterpains
    2. The client with a pulse rate of 60 beats per minute
    3. The client with colostrum discharge from both breasts
    4. The client with lochia that is red and has a foul-smelling odor
254. When performing a postpartum assessment on a client, the nurse notes the presence of clots in the lochia. The nurse examines the clots and notes that they are larger than 1 cm. Which nursing action is **most appropriate**?
    1. Document the findings.
    2. Notify the obstetrician (OB).
    3. Reassess the client in 2 hours.
    4. Encourage increased oral intake of fluids.
255. The nurse is monitoring the amount of lochia drainage in a client who is 2 hours postpartum and notes that the client has saturated a perineal pad in 15 minutes. How should the nurse respond to this finding **initially**?
    1. Document the finding.
    2. Encourage the client to ambulate.
    3. Encourage the client to increase fluid intake.
    4. Contact the obstetrician (OB) and inform him or her of this finding.
256. The nurse has provided discharge instructions to a client who delivered a healthy newborn by cesarean delivery. Which statement made by the client indicates a **need for further instruction**?
    1. "I will begin abdominal exercises immediately."
    2. "I will notify my obstetrician if I develop a fever."

3. "I will turn on my side and push up with my arms to get out of bed."
4. "I will lift nothing heavier than my newborn baby for at least 2 weeks."

257. After a precipitous delivery, the nurse notes that the new mother is passive and touches her newborn infant only briefly with her fingertips. What should the nurse do to help the woman process the delivery?
    1. Encourage the mother to breast-feed soon after birth.
    2. Support the mother in her reaction to the newborn infant.
    3. Tell the mother that it is important to hold the newborn infant.
    4. Document a complete account of the mother's reaction on the birth record.

Answers

246. ***Answer:*** 4

Rationale: The client's temperature should be taken every 4 hours while she is awake. Temperatures up to 100.4° F (38° C) in the first 24 hours after birth often are related to the dehydrating effects of labor. The appropriate action is to increase hydration by encouraging oral fluids, which should bring the temperature to a normal reading. Although the nurse also would document the findings, the appropriate action would be to increase hydration. Taking the temperature in another 15 minutes is an unnecessary action. Contacting the obstetrician is not necessary.

Test-Taking Strategy: Note the **strategic word,** *priority,* and use knowledge regarding the physiological findings in the immediate postpartum period to answer this question. Recalling that a temperature elevation often is related to the dehydrating effects of labor will direct you to the correct option. Also, increasing hydration relates to a physiological client need.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Maternity: Postpartum
Health Problem: Maternity: Infections/Inflammation
Priority Concepts: Reproduction; Thermoregulation
Reference: Lowdermilk et al. (2016), p. 486.

247. ***Answer:*** 3

Rationale: Orthostatic hypotension may be evident during the first 8 hours after birth. Feelings of faintness or dizziness are signs that caution the nurse to focus interventions on the client's safety. The nurse should advise the client to get help the first few times she gets out of bed. Option 1 is not a helpful action in this situation and would not relieve the symptoms. Option 2 requires a prescription. Option 4 is unnecessary.

Test-Taking Strategy: Note the **strategic words,** *most appropriate*. Focus on the **subject,** client safety. Option 4 is unnecessary and should be eliminated first. Elevating the client's head is not a helpful intervention. To select from the remaining options, recall that safety is a primary issue.
Level of Cognitive Ability: Applying
Client Needs: Safe and Effective Care Environment
Integrated Process: Nursing Process—Implementation
Content Area: Maternity: Postpartum
Health Problem: N/A
Priority Concepts: Perfusion; Safety
Reference: McKinney et al. (2018), pp. 401, 408.

248. ***Answer:*** 1

Rationale: After birth, the nurse should auscultate the client's abdomen in all 4 quadrants to determine the return of bowel sounds. Normal bowel elimination usually returns 2 to 3 days postpartum. Surgery, anesthesia, and the use of opioids and pain control agents also contribute to the longer period of altered bowel functions. Options 2, 3, and 4 are incorrect.
Test-Taking Strategy: Focus on the **subject** and use general principles related to postpartum care. Eliminate options 2 and 4 first because of the length of time stated in these options. From the remaining options, eliminate option 3, because it would seem unreasonable that bowel function would return that quickly in the postpartum woman.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Maternity: Postpartum
Health Problem: N/A
Priority Concepts: Client Education; Elimination
Reference: McKinney et al. (2018), p. 398.

249. ***Answer:*** 1

Rationale: The priority nursing consideration for a client who delivered 2 hours ago and who has an episiotomy and hemorrhoids is client pain level. Most clients have some degree of discomfort during the immediate postpartum period. There are no data in the question that indicate inadequate urinary output, the presence of client perception of body changes, and potential for imbalanced body fluid volume.
Test-Taking Strategy: Note the **strategic word,** *priority*. Use **Maslow's Hierarchy of Needs theory** to eliminate option 3, because this is a psychosocial, not a physiological, need. To select from the remaining options, focus on the **data in the question**.
Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Analysis
Content Area: Maternity: Postpartum

Health Problem: N/A
Priority Concepts: Pain; Reproduction
Reference: Lowdermilk et al. (2016), pp. 488-489.

250. ***Answer:*** 1, 2, 3, 6

Rationale: The postpartum client should wear a bra that is well fitted and supportive. Common causes of decreased milk supply include formula use; inadequate rest or diet; smoking by the mother or others in the home; and use of caffeine, alcohol, or medications. Breast-feeding clients should increase their daily fluid intake; having bottled water available indicates that the postpartum client understands the importance of increasing fluids. If engorgement occurs, the client should not limit breast-feeding but should breast-feed frequently. Oral contraceptives containing estrogen are not recommended for breast-feeding mothers.
Test-Taking Strategy: Focus on the **subject** and note the words *understood the instructions*. Think about the physiology associated with milk production and the complications of breast-feeding to answer correctly.
Level of Cognitive Ability: Evaluating
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process—Evaluation
Content Area: Maternity: Postpartum
Health Problem: N/A
Priority Concepts: Health Promotion; Reproduction
Reference: Lowdermilk et al. (2016), pp. 620-621.

251. ***Answer:*** 1

Rationale: The diet for a breast-feeding client should include additional fluids. Prenatal vitamins should be taken as prescribed, and soap should not be used on the breasts because it tends to remove natural oils, which increases the chance of cracked nipples. Breast-feeding is not a method of contraception, so birth control measures should be resumed.
Test-Taking Strategy: Note the **subject,** teaching for the breast-feeding client. Remember that fluids and calories should be increased when the client is breast-feeding.
Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Teaching and Learning
Content Area: Maternity: Postpartum
Health Problem: N/A
Priority Concepts: Client Education; Nutrition
Reference: McKinney et al. (2018), pp. 268-269.

252. ***Answer:*** 2

Rationale: If the uterus is not contracted firmly, the initial intervention is to massage the fundus until it is firm and to express clots that may have accumulated

in the uterus. Elevating the client's legs and positioning the client on the side would not assist in managing uterine atony. Pushing on an uncontracted uterus can invert the uterus and cause massive hemorrhage.

Test-Taking Strategy: Focus on the **subject,** a soft and boggy uterus. Visualize the situation and recall the therapeutic management for uterine atony. Remember that a full bladder displaces the uterus.

Level of Cognitive Ability: Applying
Client Needs: Health Promotion and Maintenance
Integrated Process: Nursing Process—Implementation
Content Area: Maternity: Postpartum
Health Problem: Maternity: Postpartum Uterine Problems
Priority Concepts: Health Promotion; Reproduction
Reference: McKinney et al. (2018), pp. 600-601.

253. ***Answer:*** 4

Rationale: Lochia, the discharge present after birth, is red for the first 1 to 3 days and gradually decreases in amount. Normal lochia has a fleshy odor or an odor similar to menstrual flow. Foul-smelling or purulent lochia usually indicates infection, and these findings are not normal. The other options are normal findings for a 1-day postpartum client.

Test-Taking Strategy: Note the **strategic words,** *need for follow-up.* These words indicate a **negative event query** and the need to select the abnormal assessment finding. Note the words *foul-smelling* in the correct option.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Analysis
Content Area: Maternity: Postpartum
Health Problem: Maternity: Infection/Inflammations
Priority Concepts: Infection; Reproduction
Reference: McKinney et al. (2018), pp. 329, 396.

254. ***Answer:*** 2

Rationale: Normally, a few small clots may be noted in the lochia in the first 1 to 2 days after birth from pooling of blood in the vagina. Clots larger than 1 cm are considered abnormal. The cause of these clots, such as uterine atony or retained placental fragments, needs to be determined and treated to prevent further blood loss. Although the findings would be documented, the appropriate action is to notify the OB. Reassessing the client in 2 hours would delay necessary treatment. Increasing oral intake of fluids would not be a helpful action in this situation.

Test-Taking Strategy: Note the **strategic words,** *most appropriate.* Focus on the words *larger than 1 cm*. Think about the significance of lochial clots in the postpartum period to answer correctly.

Level of Cognitive Ability: Applying
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation

Content Area: Maternity: Postpartum
Health Problem: Maternity: Postpartum Uterine Problems
Priority Concepts: Clinical Judgment; Clotting
Reference: McKinney et al. (2018), p. 329.

255. ***Answer:*** 4

Rationale: Lochia is the discharge from the uterus in the postpartum period; it consists of blood from the vessels of the placental site and debris from the decidua. The following can be used as a guide to determine the amount of flow: scant = less than 2.5 cm (< 1 inch) on menstrual pad in 1 hour; light = less than 10 cm (< 4 inches) on menstrual pad in 1 hour; moderate = less than 15 cm (< 6 inches) on menstrual pad in 1 hour; heavy = saturated menstrual pad in 1 hour; and excessive = menstrual pad saturated in 15 minutes. If the client is experiencing excessive bleeding, the nurse should contact the OB in the event that postpartum hemorrhage is occurring. It may be appropriate to encourage increased fluid intake, but this is not the initial action. It is not appropriate to encourage ambulation at this time. Documentation should occur once the client has been stabilized.

Test-Taking Strategy: Note the **strategic word,** *initially.* Focus on the **data in the question,** a saturated perineal pad in 15 minutes. Next, **determine if an abnormality exists**. The data and the use of guidelines determine the amount of lochial flow will help you determine that this is abnormal and warrants notification of the OB.

Level of Cognitive Ability: Analyzing
Client Needs: Physiological Integrity
Integrated Process: Nursing Process—Implementation
Content Area: Complex Care: Emergency Situations/Management
Health Problem: Maternity: Postpartum Uterine Problems
Priority Concepts: Clotting; Reproduction
Reference: McKinney et al. (2018), p. 396.

256. ***Answer:*** 1

Rationale: A cesarean delivery requires an incision made through the abdominal wall and into the uterus. Abdominal exercises should not start immediately after abdominal surgery; the client should wait at least 3 to 4 weeks postoperatively to allow for healing of the incision. Options 2, 3, and 4 are appropriate instructions for the client after a cesarean delivery.

Test-Taking Strategy: Note the **strategic words,** *need for further instruction*. These words indicate a **negative event query** and ask you to select an option that is an incorrect statement. Keeping in mind that the client had a cesarean delivery and noting the word *immediately* in the correct option will assist in directing you to this option.

Level of Cognitive Ability: Evaluating
Client Needs: Health Promotion and Maintenance
Integrated Process: Teaching and Learning
Content Area: Maternity: Postpartum
Health Problem: N/A

Priority Concepts: Client Education; Reproduction
Reference: McKinney et al. (2018), pp. 405-406.

257. ***Answer:*** 2

Rationale: Precipitous labor is labor that lasts 3 hours or less. Women who have experienced precipitous labor often describe feelings of disbelief that their labor progressed so rapidly. To assist the client to process what has happened, the best option is to support the client in her reaction to the newborn infant. Options 1, 3, and 4 do not acknowledge the client's feelings.
Test-Taking Strategy: Use **therapeutic communication techniques**. The correct option is the only option that acknowledges the client's feelings.
Level of Cognitive Ability: Applying
Client Needs: Psychosocial Integrity
Integrated Process: Caring
Content Area: Maternity: Postpartum
Health Problem: Maternity: Precipitous Labor and Delivery
Priority Concepts: Caregiving; Reproduction
Reference: McKinney et al. (2018), pp. 27-28, 579.