British Columbia Maternal Cesarean Section Care Path

HOSPITAL NAME | DATE

SURNAME | GIVEN NAME

ADDRESS | PHONE NUMBER

PHYSICIAN / MIDWIFE NAME

Delivery Date: _____ Time: _____

- ☐ Epidural
- ☐ Spinal
- ☐ GA

Initial Assessment and then as indicated

0 - 24 HOURS

Shaded area: Q 4 hrs. x 24 hrs.

	DATE						
	TIME						
	PP HRS.						
1. Assessment of Physiologic Status	TEMP.: 36.7 - 37.9						
	PULSE: 55 - 100 bpm						
	RESP.: 12 - 24 (unlaboured)						
	BP: (90 - 140) Systolic (50 -90) Diastolic						
	FUNDUS: firm, midline at umbilicus						
	LOCHIA: scant to moderate, rubra						
	INCISION: dressing dry and intact, nil / scant oozing						
	BLADDER: foley draining , clear urine > 30 cc/hr.						
	BOWEL: abdomen soft						
	PAIN: comfortable with / without analgesia						
	BREASTS: soft, comfortable, everted nipples						
	LEGS: moving in bed						
2. Assessment of Emotional Needs	Mother / family interact with baby by holding, talking, cuddling, making eye contact, breastfeeding						
3. Treatment/ Medications	Analgesia as ordered: ☐ Epidural / Spinal morphine ☐ IM Narcotics ☐ PCA						
4. Tests/ Procedures	Epidural catheter removed intact at _____ hrs.						
	IV site free from redness and swelling and infusing well						
	IV removed at _____ hrs. as ordered						
	Foley removed at _____ hrs. as ordered						
	If mom is Rh neg., maternal / infant investigation sent: ☐ Yes						
5. Activity	Transfer to Postpartum unit at _____ hrs.						
	Ambulate in 6 - 8 hrs.						
6. Nutrition	☐ Ice chips / sips						
	☐ Clear fluids						
7. Teaching/ Discharge Planning	**Skin to skin contact**						
	Attempts to put baby to breast with assistance						
	Mother recognizes firm fundus and normal vaginal flow and will inform caregiver of any abnormal findings						
	Mother verbalizes understanding of peri-care						
	Reinforce mom and baby care (combined care) with family or significant others						
	Newborn security precautions reinforced						

24 - 48 HOURS

Shaded area: Once Q 8 - 12 hrs.

	DATE				
	TIME				
	PP HRS.				
	TEMP.				
	PULSE				
	RESP.				
	BP				
	FUNDUS: firm, at umbilicus, or 1 above or below umbilicus				
	LOCHIA: small to moderate rubra, small clots				
	INCISION				
	BLADDER: voiding q.s. without difficulty				
	BOWELS: abdomen soft / bowel sounds present				
	PAIN: comfortable with / without analgesia				
	Remaining categories will be assessed once every 8 -12 hours if normal and no other indications				
	BREASTS: as at 0-24 hrs.				
	LEGS: no sign of calf discomfort, redness or swelling				
	Support systems - partner / family present				
	Emotional status				
	Family safety (see Care Path Guideline)				
	Verbalizes regarding birth experience				
	Responds to baby as per 0-24 hours				
	Verbalizes understanding of postpartum adjustment including postpartum blues				
	Hemorrhoid care prn				
	Analgesia as ordered: ☐ IM Narcotics ☐ PO				
	Routine perineal care				
	If PPH > 1000 cc, CBC sent				
	IV site free from redness and swelling and infusing well				
	IV removed at _____ hrs. as ordered				
	Foley removed at _____ hrs. as ordered				
	Mobilizing ☐ with assistance ☐ independently				
	Participates in self and baby care				
	☐ Clear fluids / full fluids				
	☐ DAT when bowel sounds present				
	Mother understands her nutritional need for breastfeeding (if applicable)				
	Instructions given regarding				
	Hospital routines/newborn security/bracelet, combined mother / baby care				
	Mother is taught and verbalizes/demonstrates understanding of (ongoing): **Breastfeeding positioning, latch, burping, frequency, duration, prevention of engorgement, nipple care adequate infant hydration, (voiding/stooling, weight gain, alertness, skin turgor, mucous membranes)**				
	Demonstrates increasing ability to latch and position baby				
	Formula feeding: preparation, frequency, positioning/burping adequate hydration				
	Infant care: e.g. bathing, diapering, cord care, positioning for sleep, infant handling				
	Newborn behaviour: e.g. feeding cues, sleep/wake patterns, crying				
	Jaundice				
	Car seat safety				
	Circumcision care if applicable				
	Discharge process: consider discharge preparation complete discharge process overleaf (bottom of 72-96 hours)				

48 - 72 HOURS

Shaded area: Once Q 8 - 12 hrs.

	DATE				
	TIME				
	PP HRS.				
	TEMP.				
	PULSE				
	RESP.				
	BP				
	FUNDUS: firm, midline, involuting				
	LOCHIA				
	INCISION				
	BLADDER				
	BOWELS: passing flatus				
	PAIN: comfortable, need for analgesia decreasing				
	Remaining categories will be assessed once every 8 -12 hours if normal and no other indications				
	BREASTS: soft → filling, tender, nipples intact				
	LEGS: as at 24 - 48 hours				
	Support systems				
	Emotional status				
	Family safety (see Care Path Guideline)				
	Verbalizes regarding birth experience				
	Responds to baby as per 0-24 hours and responds to newborn's needs i.e. diapering, feeding, cuddling, settling				
	Verbalizes understanding of postpartum adjustment including postpartum blues				
	Hemorrhoid care, stool softeners prn as ordered				
	Analgesia as ordered: ☐ IM Narcotics ☐ PO				
	Routine perineal care / shower prn				
	Rh immunoglobulin IM, if eligible Date _____ Dose _____ Lot# _____				
	MMR SC, if eligible Date _____ Dose _____ Lot# _____				
	Mobilizing independently				
	Participates in self and baby care				
	Bowel sounds present, general diet				
	Mother understands her nutritional need for breastfeeding (if applicable)				
	As at 24-48 hours				
	As at 24-48 hours				
	Increasing ability to latch and position baby independently				
	As at 24-48 hours				
	As at 24-48 hours				
	As at 24-48 hours				
	As at 24-48 hours				
	As at 24-48 hours				
	As at 24-48 hours				
	Discharge process: consider discharge preparation complete discharge process overleaf (bottom of 72-96 hours)				

Bold lettering indicates teaching which requires reinforcement

INSTRUCTIONS FOR USE

1. Initial the activity and/or outcome (put full signature on central sign in record)
2. Code **V** for variance (chart on variance record)
3. **N/A** - not applicable
4. **D** - deferred

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72 - 96 HOURS AND BEYOND

Shaded area: Once Q 8 - 12 hrs.

	DATE										
	TIME										
	PP HRS.										
1. Assessment of Physiologic Status	TEMP.: 36.7 - 37.9										
	PULSE: 55 - 100 bpm										
	RESP.: 12 - 24 (unlaboured)										
	BP: (90 - 140) Systolic (50 -90) Diastolic										
	FUNDUS: firm, midline, involuting										
	LOCHIA: scant rubra / serosa										
	INCISION: clean and dry, skin edges approximated										
	BLADDER: voiding without difficulty										
	BOWELS: has passed BM										
	PAIN: comfortable, need for analgesia decreasing										
	Remaining categories will be assessed once every 8 -12 hours if normal and no other indications										
	BREASTS: filling, nipples intact										
	LEGS: no sign of calf discomfort, redness or swelling										
2. Assessment of Emotional Needs	Support systems - partner / family present										
	Emotional status										
	Family safety (see Care Path Guideline)										
	Verbalizes regarding birth experience										
	Responds to baby as per 0-24 hours										
	Verbalizes understanding of postpartum adjustment including postpartum blues										
3. Treatment/ Medications	Abdominal dressing changed and staples / sutures removed as ordered										
	Hemorrhoid care prn. Stool softeners / laxatives as ordered										
	Analgesia as ordered										
	Routine perineal and incision care / shower prn										
4. Tests/ Procedures											
5. Activity	Mobilizing independently										
	Participates in self and baby care										
6. Nutrition	Adequate food and fluid intake										
	Mother understands her nutritional need for breastfeeding (if applicable)										
7. Teaching/ Discharge Planning	**Instructions given regarding** **Hospital routines/newborn security/bracelet, combined mother / baby care**										
	Mother is taught and verbalizes /demonstrates understanding of (ongoing): **Breastfeeding positioning, latch, burping, frequency, duration, prevention of engorgement, nipple care** **adequate infant hydration, (voiding/stooling, weight gain, alertness, skin turgor, mucous membranes)**										
	Ability to latch and position baby independently prior to discharge										
	Formula feeding: preparation, frequency, positioning/burping adequate hydration										
	Infant care: e.g. bathing, diapering, cord care, positioning for sleep, infant handling										
	Newborn behaviour: e.g. feeding cues, sleep/wake patterns, crying										
	Jaundice										
	Car seat safety										
	Circumcision care if applicable										
	Discharge process: Date: Time:										
	Length of stay: ☐ 48-72 hrs. ☐ 72 -96 hrs. ☐ > 96 hrs.										
	Live Birth Registration form given ☐ Yes										
	Notice of Live Birth completed ☐ Yes										
	Mom and baby bracelets checked ☐ Yes Signature: ____________										
	Handouts reviewed: ☐ Baby's Best Chance ☐ Other										
	Mother / family aware of community resources and how to access ☐										

Variance Record

DATE	TIME	FOCUS	