Maternal Postpartum and Newborn Clinical Paths

Case Scenario

Acute Care

You have just assisted in the nursing care for the spontaneous vaginal birth of Arthur who has been born to Leanne and Edward. Arthur was born at 1300 today. Leanne experienced a small first degree tear which was not repaired. Leanne used Nitronox during the last part of her first stage of labour. The blood loss from the delivery was < 500ml.

Leanne is G1 T0 P0 A0 L0, Her LMP was April 2nd. The U/S and dates confirmed her EDD to be January 9th; making her 40^{+1} today.
She is A Neg and received Rh Immune globulin at 28 weeks.
Leanne went to prenatal in a day and attended prenatal yoga. Leanne and Edward have recently moved to your town and their family and close friends live far away.

She is a healthy woman and has had a healthy pregnancy. She has taken vitamins only and plans to breastfeed.

Leanne has no allergies and has not been in contact with communicable diseases or had any recent hospitalization. GBS, HBsAG, and HSV are all negative, Rubella status: immune. She has never smoked cigarettes and did not drink alcohol during her pregnancy. Leanne does not use illegal substances and only drinks occasionally when not pregnant.

Arthur goes skin-to skin immediately after birth.
His apgars are 9 and 9. Weight is 3500 gms.

Leanne's vital signs at 1315, 1330 and 1345 (respectively) are:
BP 115/75, 120/70, 115/70,
P: 92, 88, 80 bpm
R: 24, 20, 18 per minute.
Pain scale 6, 7, 7 and she wants no analgesia.
The fundus is firm, 1↓ Umbilicus, lochia is small rubra at 1315, 1330 and 1345.

At 1315 Arthur's vital signs are:
T: 37^0C,
R: 40 breaths per minute,
HR: 130 bpm

All the other observations are normal and Arthur eagerly goes to the breast and effectively latches at both breasts. Leanne responds to his cues and appears confident in handling the baby.

At 1400 Leanne's vital signs are:
T: 37^0C
BP: 115/70,
P: 72
R: 24
Pain scale 9 – Leanne wants analgesia. You give her 400mg Ibuprofen. The fundus is firm with massage, 2↑ Umbilicus. Lochia is moderate rubra.

Arthur's vitals are:
T: 36^7,
R: 40,
HR: 130 bpm
There are no variances noted on the head to toe assessment. After Edward cuddles Arthur he changes the diaper, with your help, for meconium and urine.

Leanne needs to void and is hungry. You assist her to the bathroom and she voids 300ml. She performs pericare, as instructed, puts on clean pads and gowns and settles back to bed for her head to toe assessment which you perform. The fundus is firm, 1↓ umbilicus, lochia is small rubra.

Breasts are soft, nipples intact. Perineum is slightly bruised but clean and not inflamed.

You show Leanne how to check her fundus and go to get her something to eat.

1445
On return you demonstrate to Edward how you perform a newborn head to toe assessment. Edward is eager to learn more about how to care for Arthur.

1500
Leanne's vital signs are:
BP: 115/70,
P: 75,
R: 24,
T: 36^9
Pain scale has returned to 7. The fundus is firm, 1↓ umbilicus, lochia is small rubra.

Arthur's vital signs are stable at 2 hrs of life:
T: 36^6,
R: 46,
P: 120bpm
And at 6 hours (1800),
T: 36^8,
R: 42,
HR: 126bpm

The nurse covering the night shift did a set of vitals and assessed Leanne at 2015.
BP: 115/75,
P: 80,
R: 28,
T: 37^0
The fundus was firm, 1↓ umbilicus, lochia was small rubra.

Arthur's vitals were:
T: 36^7,
R: 44,
HR: 128bpm

Next day
You return the next day to care for Leanne and Arthur.

On report you discover that Leanne was unable to void and required an I&O catheterization at 0400 for 400ml. Other than that there were no variances found on mother or baby when the night nurse performed her assessments at 0400. During the night Arthur went to the breast 4 times and had 2 active feedings with 2 unsuccessful attempts of breast feeding only. He had voided twice and had another BM.

0730
You enter Leanne's room and she says her pad feels wet and she has not voided since the catheterization. On palpation her bladder feels full with the fundus firm at 2 ↑ Umbilicus and there is moderate rubra.

Leanne's vital signs are:
BP: 115/70,
P: 72
R: 18,
T: 37^0C
Pain scale 2, on self medication program.

As well Leanne and Edward tell you that Edward has been called away on a family emergency and is leaving for the airport soon.

0745
Arthur's T is 36^2
R: 55
HR: 150bpm
He was unwrapped and in the cot beside the bed as Edward was consoling Leanne who was upset as she did not know who would be available to assist her when she goes home.

You encourage Edward to put Arthur skin-to-skin (with him) while you get Leanne up to the bathroom.

After using measures to assist with voiding (warm water over perineum and running water) Leanne voids qs, performs pericare and gets into the bed.

0800
You check Leanne and the fundus is firm, 1↓ Umbilicus, lochia is small rubra.
Vital signs are:
BP 115/75,
P: 82,
R: 18,
T: 36^{5}C

She has a good appetite and wants to know more about Vitamin D and continues to express concern over being alone at home with Arthur. You ask her if she would like you to assist her in finding support. After she agrees you contact the hospital social worker.

The social worker arrives within the hour and suggests a doula or another type of support to assist Leanne until either Edward returns or another support person is identified. Leanne and Edward think that is a good idea (can afford to pay if necessary) and they think that her sister (who lives far away) may be available in a few days. They later confirm this with you by stating that her sister will be coming to help in 2 days and that they would like to go home today if everything is stable with both Leanne and Arthur.

0845
Arthur's T is 36^{8},
R 40
HR 144bpm

On his head to toe assessment all criteria are normal. You check his temp at 0945 (36^{9}) and 1045 (36^{9}). All other vital signs and assessment criteria are within normal limits.

By 1030 you have witnessed 2 successful breast feedings and review a feeding plan with Leanne including hand expression.

Leanne feels fine and has no variances (other than Edward not being home with Arthur and her) when you perform an assessment. She says with the support of the doula (or other person) she will be okay until her sister comes in 2 days. Edward will be away for 5 days.

1100
You complete the Discharge Summary with Leanne and Edward (the night nurse had reviewed sections 1-8 on Arthur's Discharge Summary and 1-16 on Leanne's Discharge Summary). You remove the cord clamp and the umbilical area looks clean and dry. You give Leanne her Rh Immune globulin as ordered.

You complete the Intake and Output record with the information taken from the form that Leanne had been using at the bedside. From the 2-24 hour column you see that from 1900-0700 Arthur went to the breast 4 times and had 2 active feedings with 2 unsuccessful attempts of breast feeding only. He had voided twice and had another BM. From 0700-1100 Arthur went to the breast 3 times and had 3 active feedings. He had voided twice and had another BM.

1330
Leanne, Arthur, and Edward are discharged home together with Arthur safely in his car seat, following his newborn hearing screening and blood spot card being completed.