**Post natal Assessment**

* **Introduction:**

The postnatal period is also known as Puerperium. Puerperium is the period following childbirth during which the body tissues, specially the pelvic organs revert back approximately to the pre pregnant state both anatomically and physiologically. The woman is termed as a puerperal.

Puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non pregnant size. The period is arbitrarily divided into – a) Immediate: within 24 hours; b) early: up to 7 days; and c) remote: up to 6 weeks. Similar changes following abortion but takes a shorter period for the involution to complete.

* **Objectives of Post Natal assessment**:
* To identify the mother’s postpartum condition.
* To identify the normal Puerperium.
* To recognize deviations from the normal postnatal changes.
* Detect any postnatal complication and make appropriate referral.
* **Preliminary Assessment**:
* Check for right patient.
* Check the patient condition.
* Check the doctor’s order for any specific order.
* **Preparation of Environment:**
* Maintenance of Privacy: A separate examination room is needed. Keep the doors closed. The relatives are not allowed. Drape the patient according to the parts that are exposed.
* Lighting: As far as possible natural light should be available in the examination room.
* Comfortable bed or examination table: The patient should be placed comfortably throughout the examination. There should be provision for the maintenance of a suitable position.
* **Preparation of the patient**
* Explain the procedure to the patient.
* Ask the patient for Urination or Evacuation.
* Drape the patient with extra sheets and expose only the needed areas.
* Avoid unnecessary exposure.
* **Preparation of the Articles**:

|  |  |  |
| --- | --- | --- |
| **Sr. No.** | **Articles** | **Use** |
| 1 | Sphygmomanometer | To measure B.P. |
| 2 | Stethoscope | To listen the heart sound. |
| 3 | T.P.R. Tray | To assess the Vital signs. |
| 4 | Tape Measure | To measure Fundal Height. |
| 5 | Flash Light | To visualize any part. |
| 6 | Weight machine | To check the weight. |
| 7 | Gloves | To do vaginal Examination. |
| 8 | Long Sheet | To cover the patient. |
| 9 | Spirit Swabs | To clean the Stethoscope. |
| 10 | Kidney tray/ Paper bag | To collect the waste. |
| 11 | Screen | To maintain Privacy. |

* **Steps of the procedure**:
* **General Appearance:**

**Nourishment:** Well nourished or under nourished

**Body Build:** Thin or obese.

**Health Status:** Healthy or Unhealthy

**Activity:** Active, Lethargic, Weakness, Fatigue

* **Mental Status:**

**Level of conscious:** Conscious or Unconscious, Delirious, Incoherently.

**Look:** Anxious or worried, Depressed

* **Posture:**

**Body Curve:** Lordosis, Kyphosis, scoliosis

**Movement:** any limp

* **Weight:** Weight loss is occurring due to delivery of baby and placenta. In addition to the weight loss as a consequence of the expulsion of the uterine contents, a further loss of about 2 kg (5 lb.) occurs during Puerperium chiefly caused diueresis.
* **Vital Signs**:

**Temperature:** The temperature should not be above 37.2 0 Cwith in the first 24 hours. There may be slight reactionary rise following delivery by 0.5o F but comes down to normal within 12 hours. On the 3rd day, there may be slight rise of temperature due to breast engorgement which should not last for more than 24 hours. However, genitourinary tract infection should be excluded if there is rise of temperature.

Puerperal pyrexia is due to infection in genital or urinary tract infection, congestion in breast or within the venous system (white leg). Temperature 37.40 C three times a day or 380 C more 1 time a day is a matter of concern. Some underlined cause of rise in fever should be ruled out. E.g., Common cold etc.

**Pulse:** For a few hours after normal delivery, the pulse rate is likely to be raised, which settles down to normal during the second day. However, the pulse rate often rises with after pain excitement.

**Respiration:** After delivery respiration rate should be normal 16 – 20 per minute to that of the pregnant level as circulatory haemodilution subside and upward pressure on diaphragm cases.

Respiratory stress increases in condition of muscular strain, Complications of anesthesia (e.g., atalactesis, Bronchopneumonia) as response to infection, PPH affecting blood volume, pulmonary embolism. It could be due to some other reason which should be ruled out and treated.

**Blood Pressure:** Women who had normal blood pressure their BP should be check in 1st 24 hours. Whereas those who were pre eclamptic, hyper or hypotensive are to be check regularly till stabilized, also in cases of PPH, after any surgical interventions (e.g., caesarean section). It has been known that recovery from preeclampsia takes time and chances of eclampsia and maternal death are there. Therefore it is important and advisable for high risk women to remain or referred to health facilities at least for few days for the close observation.

* **Head to toe Examination:**

**Skin:** After delivery the skin changes caused by pregnancy begin to recede. As the melanocyte stimulating hormone that causes pigmentation al changes is eliminated, melasama disappears, unless excessive pigmentation has occurred.

Striae gravidarum may fade to a silvery colour in light skinned women but they remain deeper on darker skin. The linea nigra and darkened areola fade but in some women faint traces will persist. In few months’ hair and nail growth will return to pre pregnant pattern.

**Head:** Examine for Cleanliness, dandruff, pediculi, texture of hair, any infection in scalp or injury marks in the scalp.

**Face:** Examine for Pale, Flushed, Puffiness, Fatigue on the face, any skin discoloration on the face.

**Mouth:** Color of lips, odor of the mouth, bleeding from the gum, Discoloration of the teeth, any throat infection.

**Eyes:** Vision, pain,any discoloration or discharge from the eyes. Colour of the conjunctiva – Pink or Pale.

**Ears:** Hearing ability, discharge from the ear, and pain in the ear.

**Nose:** Nasal septal deviation, any discharge

**Mouth and Pharynx:**

* **Lips:** dry, redness, swelling, crusts, cyanosis etc.
* **Odour of the mouth:** Foul smelling
* **Teeth:** Discoloration and dental caries
* **Mucous membrane and gums:** Ulceration and bleeding, swelling, Pus formation.
* **Tongue:** Pale, Dry, Lesions etc.
* **Throat and Pharynx:** enlarged tonsils, redness

**Neck:** Neckmass, neck rigidity, Thyroid enlargement, Range of motion.

**Chest:** Shape of the chest, Movement of the chest.

**Brest:** Gently palpate each breast. If mother feel nodules in the breast, the ducts may not have been emptied at last. Stroke downward towards the nipple, and then gently release the milk by manual. If nodules remain, notify the doctor. Also observe and examine the breast for pain, heaviness, cracked or sore nipple, engorged breast etc.

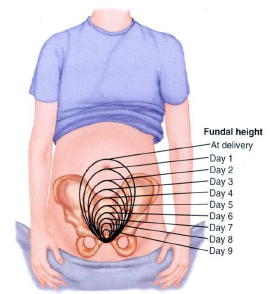
Take this opportunity to explain the process of milk production, what to do about engorgement, how to perform self breast examinations, and answer any questions she may have about breastfeeding.

**Abdomen:** The abdomen is examined while the patient is in a dorsal recumbent position and the knees are slightly flexed to promote relaxation of the abdominal muscles.

* **Inspection:** Inspect relaxed or tense muscles, Striae gravidarum and linea nigra etc.
* **Palpation**: Palpate for examine the involution of Uterus.

After the delivery uterus becomes firm and retracted with alternate hardening and softening. The uterus measures about 20 x12x7.5 cms. (Length, breadth, and thickness) and weighs about 1000 gms. At the end of 6 weeks it returns to pregravid size.

* **Reduction of Fundal height**:



Immediately after labour fundus is 5 cms. Below umbilicus or 12 Cms. above the symphysis pubis. Within 12 hours it rises to the level of umbilicus or slightly above it. Uterus begins to descend into the pelvic cavity at a rate of about 1 cm a day until the 10th day, when it may be palpated at or below the level of symphysis pubis.

**Extremities:** Examine the legs for any redness, heat, tenderness; presence of these suggests superficial or deep veins thrombosis. Check for homon’s sign. An examination is done by give supine position to the patient and asks the patient to extend the toes towards the knee. If the Patient feels pain then Homon’s sign is present. Examine for ankle oedema, movement of joints etc.

**Back:** Examine the curve of the spine.

**Genitalia:** Delivery cause some injury and swelling to perineum and external genitalia which get subsided by third or fourth day of the postnatal. There may be cervix or extended tear deep within the vagina which may not be seen. Larger tear of this nature likely to give rise to per vaginal bleeding even if uterus is well contracted. Such condition requires prompt intervention or else it will leads to hypovolaemic shock. There will be vulval hematoma which can be seen as tender, purple, swelling which is very painful specially while standing. It can burst and cause shock.

Also examine for Episiotomy suturing like gaping, bleeding, infection etc. Hemorrhoids (Piles) which have developed during pregnancy get resolved gradually itself after delivery, but cause pain during defecation, such woman may require local application of cream that reduces pain and shrinks piles, oral analgesics before defecation help in reducing pain and sitz warm saline bath help in resolving of the piles and reduces pain.

* **Lochia:** It is the vaginal discharge for the first fortnight during Puerperium. The discharge originates from the uterine body, cervix and vagina.
* Odour and reaction: It has got a peculiar offensive fishy smell. Its reaction is alkaline tending to become acid towards the end.
* Colour: Depending upon the variation of the colour of the discharge, it is named as,

1. **Lochia rubra** –red, 1 – 4 days
2. **Lochia serosa** – Yellowish or pink or pale brownish, 5 – 9 days
3. **Lochia alba** – Pale white, 10 – 15 days

The average amount of discharge for the first 5-6 days is estimated to be 250 ml.

* Clinical importance:

The character of the lochia discharge gives useful information about the abnormal puerperal state. The vulval pads are to be inspected daily to get information:

* Odour- If offensive indicates infection. Retained plug or cotton pieces inside the vagina should be kept in mind.
* Amount- Scanty or absent – signifies infection or lochiometra. If excessive – indicates infection.
* Colour- Persistence of red colour beyond the normal limits signifies sub involution or retained bits of conceptus.
* Duration- Duration of lochia Alba beyond 3 weeks suggests local genital lesion.
* **After Care of Patient and Articles**:
* Provide comfortable position to the patient.
* Discuss the findings with the patient.
* Take all the articles to the utility room.
* Wash the used articles properly and Keep in proper place.
* Replace the articles.
* Do hand washing.
* Record the procedure.

**GujaRAT INSTITUTE OF NURSING EDUCATION**

**AND RESEARCH, AHMEDABAD**

**F.Y.M.Sc. NURSING (BATCH 2012-2014)**

**SUBJECT:-OBTETRIC AND GYNECOLOGICAL NURING**

**TOPIC :- PROCEDURE ON “POSTNATAL ASSESMENT”**

***SUBMITTED TO,***

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**POSTNATAL ASSESSMENT PERFORMA**

**Name of the Patient:**

**Age: Admission Date:**

**Registration number: Cot no:**

**Religion: Doctor’s Unit:**

**Address: Education:**

**Her Occupation: Income:**

**Husband’s Occupation: Special Interest:**

**Addiction/ Habit: Diet:**

**Special Liking in diet: Date of Marriage:**

**Diagnosis:**

**Date of delivery :-**

**MOTHER’S PAST HEALTH HISTORY:**

**PRESENT OBSTETRICAL HISTORY:**

**Menstrual History:**

**Menarchy: Duration:**

**Regularity: Flow of Bleeding:**

**Gravida: Para:**

**L.M.P.: E.D.D.:**

**Period of Gestation:**

**Immunization:**

**Types of Delivery: Normal / Abnormal**

**If abnormal, specify:**

**If LSCS: Planned / Emergency:**

**Date and time when labour started:**

**Date of delivery:**

**Time of birth of baby: Sex of Baby:**

**Type of Delivery:**

**PAST OBSTETRIC HISTORY:**

**G*eneral examination*:**

**General Appearance:**

**General Nutrition:**

**Height of Fundus:\_\_\_\_\_ cm Weight:\_\_\_\_\_\_ kg Blood Pressure:\_\_\_\_\_\_\_\_\_**

**Temperature:\_\_\_\_\_ /F Pulse: \_\_\_\_ /min Respiration: \_\_\_\_\_ /min**

**Height: --------cm**

**Eye:**

**Pallor:**

**Tongue, teeth, gums, and tonsils:**

**Neck:**

**Breast:**

**Episiotomy Wound:**

**Perineal Laceration:**

**Oedema of legs:**

**Sleep:**

**Neurological assessment :-**

**PERINEAL ASSESSMENT :-**

1. **Inspection :-**
2. **Lochia :-**