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**Purpose/Summary:**

Purpose: The purpose of this policy is to ensure mothers and babies receive an accurate and comprehensive postpartum assessment for their health and safety.

Summary: Inadequate postpartum assessments can affect mothers and their babies physically, mentally, and emotionally. This policy outlines a method of assessment to increase safety during the postpartum period. Per evidence-based practice this document describes assessment timelines and techniques to meet patient satisfaction standards and follow hospital policies. Health care workers will be trained and patients will be educated to ensure the quality of care during the postpartum period of the patient’s hospital stay and self-care following.

**Definitions:**

* Postpartum period: The period directly after birth and the six weeks following (World Health Organization [WHO], 2013).
* Preeclampsia/eclampsia: high blood pressure and organ damage during pregnancy (Mayo Clinic, 2020a)
* Postpartum Hemorrhage: more bleeding than normal after delivery (usually greater than 500-1,000 mL) (Evensen, Anderson, & Fontaine, 2017)
* Heavy Bleeding: Pad is soaked with blood in less than 5 min, or 250mL blood loss per hour (WHO, 2015).
* Postpartum Depression: An intensely depressed mood beginning either during pregnancy, slightly after birth, or as much as a year after birth, which can interfere with the patient’s ability to care for their baby and accomplish everyday tasks (Mayo Clinic, 2019).
* Within normal limits vital signs per hospital policy: Blood pressure, HR, Respirations, temperature, and O2 saturation, pain.
* Lactation Ammenorrheal Method: A natural and temporary form of birth control that relies on the mother solely breastfeeding her newborn, and having no periods or spotting during the duration of her dependence on this form of birth control up to the first six months postpartum (U.S. Department of Health and Human Services, 2020).

**Goals and Objectives:**

1. Early detection and prevention of postpartum complications within hospital stay by using standardized measurements to detect complications.
2. Accurate and immediate documentation of patient assessments will occur after each patient interaction and will be referred to in order to improve patient care.
3. Patient will verbalize understanding of appropriate nutrition, family planning options, and signs and symptoms of risk factors for postpartum depression, breastfeeding considerations, and other risk factors pertinent to the patient prior to discharge.

**The goals and objectives of this process interrelate to the hospitals goals and objectives as follows:**

***Quality:*** *This policy integrates findings from current research with common medical practices in order to offer patients the highest quality of care.*

***Providing the Exceptional Experience:*** *Utilizing current research findings to influence the postpartum assessment will promote an exceptional experience for patients at Madison Memorial Hospital through the timely assessment and treatment of postpartum complications such as: postpartum depression, hemorrhage, and eclampsia, as well as promoting understanding of the steps patients should take should they have concerns.*

***Ensuring Our Future:*** *This policy will increase the prevalence of positive patient outcomes, increasing overall patient satisfaction, and providing Madison Memorial Hospital with a future influx of patients who are drawn to the facility because of its exemplary reputation for the postpartum treatment of its patients.*

**Equipment and Suitable Environment Needed:**

* Provide a calm, private environment as per patient’s wishes (WHO, 2015).
* Vital sign monitoring supplies such as blood pressure cuff, stethoscope, pulse oximeter thermometer, and a penlight (WHO, 2015).
* Gloves/Personal Protective equipment as needed (WHO, 2015).
* Pads, disposable mesh underwear, or adult diapers (WHO, 2015).
* Measuring tools: scale and disposable measuring tapes (WHO, 2015).
* Wipes or washcloth with a water basin (WHO, 2015).
* Blood sample test tube/blood draw kit (WHO, 2015).
* Ted hose, or compression stockings (WHO, 2015).

**Procedure:**

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| **Overview** | **Details** | **Quality Records** |
| Review of patient information | Step 1: Review patient electronic health record (EHR) after admission and prior to delivery. Note any risk factors related to the following:Postpartum depression: * Previous episodes of depression before or during pregnancy
* History with moderate to severe premenstrual syndrome (PMS)
* Negative attitudes about pregnancy (during or after)
* Recent major life events
* Disappointment in baby’s gender
* Low self-esteem
* Extreme stress about parenting
* Emergency cesarean section
* Postpartum complications
* Young age
* High blood glucose
* Nutritional deficiencies
* Out of range estrogen levels (Ghaedrahmati, Kazemi, Kheirabadi, Edbrahimi, & Bahrami, 2017; Mayo Clinic, 2019)

Postpartum hemorrhage:* Augmented labor (induced labor)
* Anemia
* Obesity
* Preeclampsia
* Primiparity (first birth)
* Prolonged labor
* Previous episodes of hemorrhage before pregnancy (Evensen, Anderson, & Fontaine, 2017)

Postpartum perineal and cervical scarring: * Third or fourth-degree tearing
* Asian or Pacific Islander background
* Nulliparity (first birth)
* High birth weight of baby
* Longer stage of second labor
* Young age
* Vacuum delivery
* Use of oxytocin
* Cerclage (cervical stitches) (Suzuki, 2015)

**If any of the above are present, refer to the coinciding hospital policy to continue treatment.** These policies include protocols for hemorrhage, preeclampsia, infection control, and postpartum depression. |  |
| Monitoring and Measuring | Step 2: Assess patient for heavy bleeding (see definitions).* More than 1 pad soaked in 5 minutes is indicative of heavy bleeding and should be reported.
* Uterus should be firm and well contracted.
* Blood pressure, pulse, and temperature should be within normal limits for patient.
* Hemoglobin should be >11g/dl.
* A temperature greater than 38 C along with any of the following symptoms must be reported to the health care provider: Extreme weakness, abdominal tenderness, foul-smelling lochia, profuse lochia, uterus not well contracted, lower abdominal pain, and history of heavy vaginal bleeding (WHO, 2015).
* When dealing with a postpartum mother, make sure to ask, check the patient’s medical record, look, listen, and feel. Doing these things can help to monitor and measure different things that may occur postpartum such as hemorrhage and depression.
* If any abnormal findings are present, the provider should be notified.

**Emergency signs**-**Hemorrhage:*** Uterus is soft, soaking a pad in 5 minutes or less, has bled more than 500 mL since birth (WHO, 2015; WHO 2020).

**Uterine Infection:*** Temp > 38 C, foul-smelling discharge, lower abdomen tenderness (WHO, 2015).

**Third Degree Tear:*** Tear extending to anus (WHO, 2015).

**Severe Preeclampsia:*** diastolic blood pressure is >110, or ≥90 mmHg and 2+ proteinuria with headache, or blurry vision, or epigastric pain (WHO, 2015).

**Severe Anemia:*** Severe pallor or Hemoglobin that is <7 g/dL (WHO, 2015).
 |   |
| Immediately after birth | Step 3: Care of the mother between birth of the baby, delivery of placenta, and immediate time following. After delivery of baby: Monitor for anemia, preeclampsia, third-degree tear, uterine infection, and hemorrhage. Assess the patient's mood and behavior noting any changes. Nurses remain clean by performing hand hygiene and using new, clean equipment. Therapeutic communication is used to address the patient and their needs (WHO, 2015). Begin head to toe examination of the mother. This assessment is immediately after birth. Continued assessments of the peritoneal area, breasts, bleeding, and pain will be done again in 15 minutes, every hour for the next four hours, and prior to discharge.* Hand hygiene
* Safety Survey
* Current Status, appearance
* Emotional state
* Check IV (solution, rate, pump and site)
* Inspect dressings, tubes, & drains

Vital signs:* Temperature, Pulse, Respirations
* Blood pressure
* Oxygen saturation, RA or O2
* Oxygen delivery method and amount
* Pain assessment and rating scale

Neurological:* Alert and Orientated x3 (person, place, and time)
* Communication (speech and hearing)
* PERRLA and pupil size
* Sensation in all limbs (numbness & tingling)
* Hand grips bilaterally equal
* Foot strength bilaterally equal

Respiratory:* Pattern, depth, and effort
* Auscultate breath sounds anteriorly, posteriorly

Cardiovascular:* Auscultate S1 S2 (rhythm, abnormal sounds)
* Apical pulse (rate & rhythm)
* Radial, dorsalis, & post tibial pulses (bilaterally equal, strength)
* Color & temperature of extremities X 4
* Capillary refill time X 4
* Edema

Gastrointestinal:* Assess for nausea, lightheadedness, and vomiting
* Ask about last meal, hunger, and ability to swallow
* Ask about bowel movements
* Inspect, auscultate bowel sounds, percuss, and palpate abdomen for unexpected masses or tenderness

Genitourinary:* Urine odor, color, amount, clarity
* Voiding regularly, continence
* Frequency, urgency, hesitancy, burning, discomfort
* Assess for any perineal tearing (WHO, 2015).
* Assess for swelling or distention of abdomen or bladder WHO, 2015).
* Assess the uterus to make sure it is contracted. Massage uterus for breakdown of any clotting.
* Check for any heavy or abnormal bleeding. Examine uvula, lower vagina, and perineum for tearing. Estimation of the amount and collection of blood loss is recorded in the patient's chart. Note if blood exceeds 500 mL to refer to hospital hemorrhage policy (WHO, 2020).
* Clean the mother and her perineal area. Place a clean chucks pad under her lower half to collect any blood or discharge. Assist in clothing or bedding changes if necessary (WHO, 2015).
* Remind and encourage the new mother to empty her bladder frequently. At least every 2 hours.

Skin:* Moisture, turgor
* Integrity (bony prominences)
* Skin risk

Breasts: * Inspect and palpate both breasts. Check for firmness, tenderness, also noting the shape.
* Assess both nipples. Check for redness, swelling, cracking, or bleeding (WHO, 2015).

 Inform the mother that continued assessment will take place again in 15 minutes, every hour for the next four hours, and teaching will be done prior to discharge. Continue to assess the amount of vaginal bleeding. Encourage the patient to eat and drink. Encourage the mother to pass urine. Continue IV fluids per agency policy. Massage the uterus until firm. If any abnormal findings are present, the provider should be notified. |  |
| 15 minutes after birth for the first hour.  | Step 4: Every 15 minutes after birth for the first hour after delivery of placenta perform the following:* If the nurse is entering the room, introduce yourself. Prior to touching the patient, perform hand hygiene, explain that you will now assess the patient’s vitals, bleeding, and overall status. Use therapeutic communication and ensure the patient has the privacy they desire. New mothers should not be left alone with neonate (Simpson, 2015; WHO, 2015).
* Quickly assess general appearance for emergency signs (see “monitoring and measuring” in step 2).
* Assess vitals and note any abnormalities. (WHO, 2015)

At least once in the first hour, perform the following:* Assess vaginal bleeding. Remove pad and weigh to determine blood loss in addition to subjectively measuring via visualization (WHO, 2015).
* Assess fundal height, pain.
* Encourage fluid intake and encourage the mother to void, measure intake and output as ordered (WHO, 2015).

After each assessment:* Each time an assessment is performed on the mother, document findings as appropriate in the patient's records.
* If any abnormal findings are present, the provider should be notified or the patient should report to the hospital. Refer to “Monitoring and Measuring” above (WHO, 2015).
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| Every hour for the first 4 hours. | Step 5: Every hour for first 4 hours, then every 4 hours for the first 24 hours perform the following: Beginning Assessment:Ensure Patient Comfort: * Introduce self.
* Prior to touching the patient, perform hand hygiene
* Ask for permission throughout
* Explain that you will now assess the patient’s vitals, bleeding, and overall status.
* Use therapeutic communication and ensure the patient has the privacy they desire. See definitions for clarifications (WHO, 2015).

Initial assessment:Assess overall status including:* Vitals, intake and output, neurologic status, sensory, bowels, cardiovascular, respiratory, urinary, skin, and conjunctiva for pallor.
* Every hour after the first hour perform a focused assessment as needed.
* Perform pain assessment determining severity. location, and quality especially of the perineum, breasts, vaginal canal, and abdomen (WHO, 2015).

Hemorrhage assessment:Assess the amount of bleeding:* Monitor how fast she is soaking a pad (See monitoring and measuring section in step 2 above).
* Check her chart to see if she has bled more than 500 mL, follow hospital protocol (WHO, 2020).
* Draw blood samples per hospital policy, and notify the doctor if increased blood loss is present (WHO, 2015).

Perineum Assessment:Examine the perineum: * Determine if a tear or cut is present, if not already assessed and documented (WHO 2015).
* If tear or cut is present, measure with a measuring tool. Examine perineum for redness, swelling and pus (WHO, 2015).

Abdomen Assessment:Feel and assess uterus:* Assess if it is hard and round.
* If it is soft then massage it and document any blood or blood clots that come out (Salam, Mansoor, Mallick, Lassi, Das, & Bhutta, 2014).
* Measure Abdomen/fundal height to determine if her uterus is firmly contracted and involuting as expected.
* Assess the abdomen for tenderness.
* Document her first bowel movement, or encourage a bowel movement. (Salam, Mansoor, Mallick, Lassi, Das, & Bhutta, 2014; Simpson, 2015).

Family Adjustment Assessment:Monitor risk factors:* How well is the mother and family adjusting to their new roles?
* Assess for risk factors of postpartum depression: as described in step one (Ghaedrahmati, Kazemi, Kheirabadi, Edbrahimi, & Bahrami, 2017).

During these assessments:* Reference monitoring and measuring section if you have questions about abnormal findings.
* If any complications listed in monitoring and measuring arise, follow relevant protocol (WHO, 2015).

Educate the patient and family:To watch for upon discharge:* Signs and symptoms to watch for, specifically, relevant to preeclampsia/eclampsia, postpartum depression, and heavy bleeding. (WHO, 2015).

Continue to Encourage oral intake of fluids and food. (WHO, 2015).  |  |
| Prior to discharge. | Step 6: If education has not been completed earlier, assess for the patient’s level of knowledge and confidence in the discussed topics. If possible, take the time to also address the knowledge and competency of the patient’s partner or primary support system (i.e. family, friend, roommate, etc.). For more information on specific education topics, refer to the Appendix.  |  |

**Internal References:**

* Educational information
* Pain scale
* Depression screening assessment
* Hospital policies and protocols for hemorrhage, preeclampsia, infection control, and postpartum depression
* Physician’s orders

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**Requirements:**

Idaho Department of Health and Welfare (2013), quality assurance of hospital policy and procedures.

*If the hospital offers maternity and newborn service, it shall be located in such a manner as to minimize traffic to and from other patient care areas. (10-14-88) 02. Delivery/Birthing Room Facilities. The delivery/birthing room shall be located in such a manner as to prevent traffic to and from other areas, and meet the following: (10-14-88) a. At least one (1) delivery room shall be provided; and (10-14-88) b. Scrub-up facilities shall be provided for the delivery room. Each sink shall have a soap dispenser, elbow, knee, or foot action water control, and gooseneck spout. Disposable brushes or brushes capable of withstanding sterilization shall be provided; and (10-14-88) c. A separate space shall be provided for the cleanup of non-sterile and contaminated material; and (10-14-88) d. Walls, ceilings and floors shall be of a waterproof, washable surface; and (10-14-88) e. Space shall be available for the storage of sterile and non-sterile supplies; and (10-14-88) f. A janitor’s closet shall be provided within or adjacent to the delivery suite and be used only for the delivery suite; and (10-14-88) g. There shall be provided a source of oxygen with a mechanism for controlling the concentration of oxygen and with a suitable device for administering oxygen to both infants and adults; and (10-14-88) h. There shall be provided a safe and suitable type of suction device for both infants and adults.*

**Quality Assurance and Sustainability:**

Upon hire or transfer to the labor and delivery unit, nurses will spend 2 weeks training and shadowing a previously certified nurse. Training will be completed by a hospital educator who is specialized in the labor and delivery unity. During this training there will be a 2-hour lecture portion where nurses will be educated on postpartum assessment and complications to be aware of. This will display competence in performing postpartum care and assessment. Certification of completion will be given as nurses can demonstrate and perform head to toe assessment on a postpartum patient.

Safety training and staff education renewal will happen annually. Safety will be promoted by educated and evaluated staff. During evaluation, to ensure quality control and compliance, administrators will review charting, compliance, and complications resulting from improper postpartum assessment. This evaluation will be done by an internal board member of the hospital.

Patient outcomes will be assessed during hospital stay and at discharge. Training and education will be specialized to meet patient outcomes to increase satisfaction. Staff orientation and instruction will be updated based on current evidence based practice research annually. Internal hospital board members will provide updated research for implementation.

**Disclaimer:** This policy is a resource to assist staff and not all circumstances may apply. The policy does not guarantee safety. Clinical situations may warrant adaption. Extenuating circumstances apply.

**Appendix:**

**Recommendation From World Health Organization**

“All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature, and heart rate (pulse) routinely during the first 24 hours starting from the first hour after birth. Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within six hours. Urine void should be documented within six hours” (WHO 2013).

**Education for the mother and partner prior to discharge:**

Nutrition:

Encourage mothers to:

* Eat a diverse selection of nutritional foods
* Consume food with high protein
* Consider adding Vitamin supplements to the patient's diet. This is particularly important if the mother is vegan (Mayo Clinic, 2020b).

Breastfeeding:

Encourage mothers to:

* Maintain 6-10 glasses of fluid intake. Amounts may vary based on patient size and infant feeding requirements. If the mother is thirsty, or her urine is dark yellow, they should drink more water.
* Avoid consuming large quantities of sugary liquids.
* Consult with the patient's doctor about continued prenatal vitamins.
* Increase daily calories by 330- 400 to sustain breastfeeding (Parent Help 123, 2015).

Things to avoid:

* Alcohol- Alcohol transfers into the breast milk and can be harmful to the child. It typically takes 2-3 hours for a single serving of alcohol to completely be cleared from the mother’s breast milk. Mother should consider pumping milk before ingesting any alcohol.
* Caffeine- Consumption of caffeine can lead to infant agitation or disrupted infant sleep cycles. Breastfeeding mothers should limit consumption to 16-24 ounces.
* Fish- Consumption of fish can lead to the accumulation of mercury in the breast milk that can be damaging to the infant's nervous system. Mothers should limit their seafood consumption, and should fully avoid swordfish, king mackerel, shark, and tilefish while breastfeeding.
* Smoking and Recreational Drug Use- Products used by the mother can transfer indirectly to the baby through the breast milk, causing gastrointestinal upset, changes in alertness, and addiction (Mayo Clinic, 2020b).

Breastfeeding Concerns:

* Engorgement- The breasts may become overly full, hindering the flow of lymphatic and venous drainage, resulting in feelings of being swollen, distended, painful, hot, and have impaired milk flow. The mother should express and drain both of her breasts to a comfortable level.
* Blocked Ducts- This is often the result of poorly managed engorgement. The mother may report that her breasts are tender, there is a palpable lump, and the skin is red and warm to the touch. The mother should feed from the affected side first, massage the area towards the nipple while feeding or expressing, and if the issue is not resolved the mother should contact her health care provider.
* Mastitis- Poor management of engorgement or blocked ducts may cause infection, leading to mastitis. Symptoms include pain, redness, and swelling in the breast, as well as flu like symptoms and fever. It is safe to continue breastfeeding. Mother should continue to massage towards the nipple while feeding or expressing milk. Ensure proper latching while feeding. If symptoms persist, patient’s should contact their health care provider. Antibiotics may be required.
* Nipple Thrush-Overgrowth of bacteria Candida albicans that results in a burning or stinging nipple pain that occurs during and after the feeding. The baby will show signs of oral thrush, and both mother and child will need to be prescribed oral and topical antibiotics (Doyle, 2018).
* Cracked or Bleeding Nipples- Identify if the baby is latching properly, and then proceed with treatment. It is safe to continue breastfeeding. If pain is too severe, the mother should feed the baby using expressed milk, and rest the nipple for 24 to 48 hours. The mother should practice breast hygiene, washing the affected area with soap and water. The mother might consider air drying her nipples after cleaning them. The mother should ensure that her bra is correctly fitted.

Warning: Mothers should not use over the counter medication to manage their breast pain. These are often ineffective and may be harmful to the baby. Mothers should consult with their doctor about pain management.

For any additional concerns, the mother should contact her health care provider, breastfeeding counsellor, or lactation consultant (Pregnancy Birth and Baby, 2018).

Safe sex and birth control:

There is no set time to wait before resuming sexual activities, but patients who experienced a damaging delivery should consult with their doctors about recommended healing times.

Birth control options include:

* Contraceptive implants
* Copper or hormonal intrauterine devices (IUD)
* Progestin-only contraceptives

Warning: Birth control pills containing both estrogen and progestin present an increased risk of blood clot formation shortly after child birth. Healthy women should not resume combined birth control pills until one month postpartum (Mayo Clinic, 2018).

Lactation Ammenorrheal Method: When done right, this offers 98% effectiveness against pregnancy up to the first six month postpartum. For Lactation Ammenorrheal Method (LAM) to be effective women must:

* Exclusively breast feed their babies every 4 hours during the day and every 6 hours during the night.
* Menstrual bleeding must be absent as of the second month postpartum (including spotting),
* Baby must be less than six months old (U.S. Department of Health and Human Services, 2017).

Mothers should resume alternative means of birth control in the event that:

* Breastfeeding is reduced
* Menstruation resumes
* The baby begins to feed from a bottle
* The baby reaches the age of six months old

(U.S. Department of Health and Human Services, 2017)

Cultural Assessments and Consideration:

Assess cultural barriers that may prevent appropriate nutrition of the neonate. Also, depending on who will be the primary caregiver to the child, be prepared to provide the father with education, or even a same sex partner depending on the sexual orientation of the patient.The patient may not be the intended primary nurturer, or may not adhere to traditional parenting styles (Livingston, 2014).

Check For Understanding and Provide Resources:

* Assess for patient understanding of signs and symptoms of complications related to: Hemorrhage, tearing/scarring, and depression
* Identify outside resources for the patient, including support groups and community help centers.
* Provide contact information for pressing concerns and emergency situations.
* Identify when and where the patient will go for follow-up assessments. (Ghaedrahmati, Kazemi, Kheirabadi, Edbrahimi, & Bahrami, 2017; Evensen, Anderson, & Fontaine, 2017; WHO, 2015).