The Graduate Nurse (gn) Is Caring For A Laboring Client With Epidural Anesthesia. After The Client Pushes

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Caring for a laboring client who has received epidural anesthesia presents unique challenges and responsibilities for the graduate nurse (GN). Once the client has completed the pushing phase, the nurse's role shifts focus toward monitoring the mother and newborn, preventing complications, and providing ongoing support. Understanding the physiological changes, recognizing potential issues, and implementing appropriate interventions are essential to ensure a safe and positive labor and delivery experience. This article explores the key responsibilities and considerations for GNs caring for a client post-pushing, highlighting best practices and critical assessments.

Post-Pushing Care: Immediate Priorities

Following the delivery of the fetus, the nurse's immediate priorities involve assessing maternal and neonatal status, managing the third stage of labor, and ensuring safety for both mother and baby.

Assessment of the Mother

The first step involves thorough assessment to identify any complications and to establish baseline postpartum status:

- **Vital Signs:** Blood pressure, pulse, respiratory rate, and temperature should be measured regularly to detect signs of hemorrhage, hypotension, or infection.

- **Uterine Tone and Fundal Location:** Palpate the uterine fundus to ensure it is firm and midline, indicating effective involution and control of bleeding.

- **Perineal Inspection:** Examine the perineal area for tears, lacerations, or hematomas. Check for excessive bleeding or unusual swelling.

- **Lochia Assessment:** Observe the amount, color, and consistency of lochia to monitor bleeding and uterine involution.

- **Pain Management:** Assess pain levels and provide appropriate comfort measures or medications as ordered.

Assessment of the Neonate

Simultaneously, the nurse should evaluate the newborn's condition:

- **Apgar Score:** Typically performed at 1 and 5 minutes after birth to assess respiratory effort, heart rate, muscle tone, reflex response, and skin coloration.

- **Temperature:** Keep the infant warm, especially if exposed to cold environments or if the mother received anesthesia.

- **Respiratory Status:** Observe for respiration rate, effort, and any signs of distress.

- **Bonding and Initiation of Breastfeeding:** Facilitate skin-to-skin contact if possible and support

early breastfeeding efforts.

Management of the Third Stage of Labor

The third stage involves delivering the placenta and preventing postpartum hemorrhage. Effective management includes:

Monitoring for Signs of Placental Separation

Signs include:

- Gush or trickle of blood
- Lengthening of the umbilical cord
- Uterine elevation or change in shape

Administration of Uterotonics

Medications such as oxytocin are administered as ordered to promote uterine contractions and minimize bleeding.

Controlled Cord Traction

Gently pulling on the umbilical cord while supporting the uterus helps facilitate placental delivery, ensuring minimal trauma.

Post-Delivery Nursing Interventions

Once the placenta is delivered, the nurse's role involves ongoing assessment, comfort measures, and preparation for postpartum care.

Monitoring for Hemorrhage

Signs to watch for include:

- Excessive or bright red bleeding
- Soft or boggy uterus indicating uterine atony
- Signs of hypovolemic shock such as tachycardia, hypotension, pallor, or dizziness

Interventions include uterine massage, ensuring bladder emptying, and administering medications as prescribed.

Managing Uterine Tone and Bleeding

A firm, contracted uterus indicates good involution. Uterine massage can help maintain tone, and pharmacologic agents can be administered to prevent atony.

Addressing Perineal Discomfort and Repair

If there are tears or episiotomies, monitor for bleeding and signs of hematoma. Provide analgesia and assist with perineal hygiene to prevent infection.

Complication Prevention and Recognition

Proactive monitoring is essential to identify and manage potential complications promptly.

Hemorrhage

Early signs include a boggy uterus and increased bleeding. Immediate interventions involve uterine massage, medication administration, and notifying the healthcare provider.

Hypotension

Can result from blood loss or epidural-related vasodilation. Positioning the client in lateral decubitus, administering IV fluids, and monitoring vitals are key steps.

Hematoma Formation

Symptoms include swelling, tenderness, and severe pain in the perineal area. Surgical intervention may be required if significant.

Infection Prevention

Maintain perineal hygiene, monitor for fever, and ensure sterile techniques during assessments and interventions.

Supporting the Client's Transition to Postpartum

The postpartum period involves emotional support, education, and preparation for discharge.

Emotional and Physical Support

Provide reassurance, facilitate bonding, and address concerns about pain, bleeding, or physical changes.

Patient Education

Inform the client about:

- Signs of postpartum hemorrhage

- Perineal care and hygiene
- Breastfeeding and infant care
- Follow-up appointments and postpartum recovery

Documentation

Accurate and thorough documentation of all assessments, interventions, and patient responses is vital for continuity of care and legal purposes.

Conclusion

Caring for a laboring client with epidural anesthesia after she pushes requires a comprehensive understanding of postpartum physiology, vigilant assessment skills, and prompt intervention. The graduate nurse plays a crucial role in preventing complications such as hemorrhage, hematoma, and infection while supporting the mother and newborn through this critical transition. By adhering to best practices, maintaining effective communication, and providing compassionate care, GNs can ensure a safe and positive birth experience for their clients.

Note: Always follow your facility's protocols and consult with experienced healthcare professionals when managing postpartum clients, especially those with epidural anesthesia, to ensure safe and effective care.

Frequently Asked Questions

What are the key assessments a graduate nurse should perform immediately after a laboring client has pushed and received epidural anesthesia?

The nurse should assess the client's vital signs, monitor the fetal heart rate, evaluate uterine contractions, check for signs of hypotension, assess the level of anesthesia, and observe for any signs of neurologic or respiratory compromise.

What are common signs of epidural-related hypotension that a graduate nurse should monitor for after the client pushes?

Signs include dizziness, nausea, blurred vision, pallor, a drop in blood pressure, and decreased fetal heart rate variability. The nurse should also monitor for decreased sensation or motor function below the epidural site.

How should the graduate nurse position the client after delivery of the placenta to optimize epidural effects and maternal comfort?

The client should be positioned in a lateral or semi-Fowler's position to reduce hypotension risk, ensure proper spinal drainage, and promote comfort. This position also helps facilitate uterine contraction and placental delivery.

What interventions are appropriate if the client exhibits signs of hypotension after pushing with an epidural?

Interventions include administering IV fluids as ordered, elevating the legs to improve venous return, administering vasopressors if prescribed, and notifying the healthcare provider promptly.

What are potential complications the graduate nurse should monitor for in the laboring client after epidural anesthesia and delivery?

Potential complications include post-dural puncture headache, urinary retention, hypotension, fetal distress, and neurologic symptoms such as numbness or weakness.

How can the graduate nurse support the client's comfort and safety post-push after epidural anesthesia?

The nurse can ensure proper positioning, monitor vital signs and fetal heart rate, assess pain levels, provide bladder care, and encourage early ambulation if appropriate, while maintaining safety precautions.

What documentation is essential after the client has pushed post-epidural for a laboring client?

Documentation should include the time and dose of epidural administration, assessments of vital signs, fetal heart rate, uterine activity, client's neurological status, comfort measures provided, and any complications observed.

What teaching should the graduate nurse provide to the client after delivery regarding epidural-related effects and recovery?

The nurse should instruct the client about possible post-epidural headache, signs of neurological issues, urinary retention, and when to report symptoms. Also, discuss activity restrictions, pain management, and the importance of hydration.

Additional Resources

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Introduction

Caring for a laboring client who has received epidural anesthesia is a complex and dynamic task, especially in the critical phase following childbirth when the client has just pushed. As a graduate nurse, understanding the physiological changes, potential complications, and appropriate nursing interventions is essential for ensuring maternal safety and fostering positive outcomes. This comprehensive review explores the key aspects of post-pushing care in a client with epidural anesthesia, emphasizing assessment, interventions, and considerations for optimal maternal and neonatal well-being.

Understanding Epidural Anesthesia in Labor

Definition and Purpose

Epidural anesthesia involves the administration of local anesthetic, often combined with opioids, into the epidural space of the lumbar spine. It provides effective pain relief during labor, allowing the client to remain alert and participate actively in childbirth.

Benefits

- Significant pain reduction
- Preservation of maternal consciousness
- Ability to facilitate mobility and position changes (with certain limitations)

Common Side Effects and Risks

- Hypotension

- Urinary retention
- Pruritus
- Fever
- Motor block (possible, with higher doses)
- Rarely, epidural hematoma or infection

Post-Pushing Phase: Key Nursing Considerations

Immediate Post-Delivery Assessment

Once the client has completed pushing and the baby is delivered, the nurse's initial focus includes:

- Assessing maternal vital signs: Blood pressure, pulse, respiratory rate, temperature
- Assessing uterine tone and position: Firmness, height, and any signs of bleeding
- Monitoring for postpartum bleeding: Lochia characteristics, amount, and clots
- Evaluating the perineum: For tears, episiotomy, swelling, or hematomas
- Monitoring for signs of complications: Hemorrhage, hypotension, or signs of epidural-related issues

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Specific Nursing Interventions After Pushing

1. Maternal Vital Signs and Hemodynamic Stability

- Frequency: Every 15 minutes for the first hour postpartum, then as per protocol
- Focus:
- Blood pressure: Watch for hypotension, which may be exacerbated by epidural-induced vasodilation
- Pulse rate: Bradycardia or tachycardia may indicate bleeding or hypovolemia
- Respiratory status: Ensure adequate oxygenation

- Temperature: Elevated temperature can suggest infection or dehydration

Interventions:

- Administer IV fluids if hypotension occurs
- Notify provider if abnormal vital signs persist
- Encourage deep breathing to prevent hypoventilation, especially if sedation is involved

2. Uterine Assessment and Lochia Monitoring

- Uterine Tone and Position:
- Ensure the uterus remains firm and contracted to prevent postpartum hemorrhage
- Fundal height should be midline and at the level of the umbilicus
- Lochia:
- Assess amount, color, consistency
- Moderate to heavy bleeding warrants further assessment
- Clots larger than a quarter or saturated pads within 15 minutes require intervention

Interventions:

- Gentle fundal massage if the uterus is boggy
- Ensure bladder is emptied to prevent uterine displacement
- Document findings meticulously

3. Perineal Care and Assessment

- Inspect for:
- Tears or episiotomy extension
- Hematomas: Swelling, discoloration, or increasing pain
- Edema or bruising

Interventions:

- Provide comfort measures, such as ice packs for swelling

- Perform perineal hygiene to prevent infection
- Educate the mother on signs of hematoma or infection

4. Monitoring for Hemorrhagic Complications

- Signs to Watch For:
- Excessive lochia (saturated pad within 15 minutes)
- Decreased blood pressure
- Increased pulse
- Pallor, dizziness, or weakness

Interventions:
- Notify provider immediately if bleeding is excessive
- Prepare for potential interventions such as medication administration or uterine massage

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Addressing Epidural-Specific Considerations

1. Monitoring for Epidural-Related Complications

- Hypotension:
- Common due to vasodilation
- Preventive measures include preloading with IV fluids before epidural placement
- Post-procedure, monitor blood pressure closely

- Motor Block:
- Assess lower extremity strength and sensation
- Encourage mobility as tolerated once the motor block subsides

- Urinary Retention:

- Frequent bladder assessments
- Encourage early ambulation or bladder emptying

- Pruritus or Nausea:
- Monitor for discomfort
- Administer antihistamines or antiemetics as ordered

2. Pain Management and Comfort

- Even after pushing, some discomfort or residual pain may persist
- Ensure effective communication regarding pain or discomfort
- Use non-pharmacologic comfort measures, such as positioning, cold packs, or relaxation techniques

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Neonatal Considerations Post-Delivery

- Initial Assessment:
- Apgar scoring at 1 and 5 minutes
- Assess for respiratory effort, tone, and activity
- Bonding and Skin-to-Skin Contact:
- Encourage early contact unless contraindicated
- Monitoring for Neonatal Effects of Maternal Anesthesia:
- Watch for respiratory depression or hypothermia
- Be prepared for neonatal resuscitation if necessary

Education and Support for the Client

- Postpartum Care Instructions:

- Recognize signs of postpartum hemorrhage, infection, or hematoma
- Proper perineal hygiene
- Importance of early ambulation to reduce thromboembolic risk
- Breastfeeding Support:
- Assist with positioning and latch
- Emotional Support:
- Assess for fatigue or emotional distress
- Provide reassurance and encourage rest

Documentation and Communication

- Detailed documentation of all assessments, interventions, and patient responses
- Clear communication with the healthcare team regarding any concerns or abnormal findings
- Hand-off reports to postpartum and nursing staff for continuity of care

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Summary of Key Points

- After the client pushes, vigilant assessment of vital signs, uterine tone, bleeding, and perineal status is crucial.
- Managing epidural-related effects, including hypotension, urinary retention, and motor block, is vital for safety.
- Early recognition of postpartum hemorrhage and hematomas can prevent serious complications.
- Supporting maternal comfort, facilitating bonding, and providing education enhances postpartum recovery.
- Effective documentation and interdisciplinary communication ensure comprehensive care.

Conclusion

Caring for a laboring client with epidural anesthesia after pushing requires a thorough understanding of the physiological changes, potential complications, and appropriate nursing interventions. As a graduate nurse, maintaining vigilance, providing compassionate care, and collaborating with the healthcare team are essential components in promoting maternal and neonatal health. Continuous assessment, timely interventions, and patient education empower the mother and foster a positive birth experience.

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