



Chapter 36

BIRTH BY CAESAREAN SECTION - PERIOPERATIVE CARE

1. Patient Teaching

- may be a planned or unexpected event
- the preoperative teaching will vary with the urgency of the situation and, on occasion, the teaching will need to be repeated and expanded upon postoperatively

2. NPO

- period of fasting as per hospital policy

3. Laboratory work

- CBC, Type and Screen or as per hospital policy

4. Antacid

- Given as ordered to neutralize stomach contents to prevent acid pneumonitis

5. Intravenous Infusion

- Use a large bore needle and a balanced solution

6. Empty Bladder

- Indwelling catheter connected to straight drainage

7. Abdominal/Perineal Shave Prep

- *Not* indicated because it increases the incidence of infection and causes maternal discomfort postpartum

8. Monitoring of Fetal Heart Rate

- Assessing fetal well being prior to c-section may be done by assessing the fetal heart rate either with intermittent auscultation or with electronic monitoring in consideration of the presence of obstetrical and/or intrapartum risk factors.

9. Monitoring of Contractions (if present)

- Assess uterine activity if contractions are present.

10. Positioning

- Supine position with wedge under right hip until after the birth relieves the pressure of the pregnant uterus on the vena cava and is shown in controlled trials to reduce the fall in BP that may occur with anaesthesia or surgery and to improve the oxygenation of the baby

SPECIAL CONSIDERATIONS

1. Dress the woman in a clean gown and cap
2. Ensure the woman's safety – with regional anaesthetic there is little or no leg movement
3. Explain procedures, sights, sounds, smells, and tastes, eg.
 - with general anaesthetic, there is a taste of "onions"
 - with epidural anaesthetic, there will be a feeling of "pressure" when the baby is born
4. Reassure the woman
5. Once the cord is clamped, the woman is to receive antibiotics (cephalosporins) 1gm Cefazolin IV ADC

POSTOPERATIVE CARE

1. Every 15 minutes until conscious and condition stable, assess:
 - BP, pulse, respirations (quality, quantity)
 - circulation
 - mentation
 - activity
2. Position – lateral or slight Trendelenburg
3. Check position of limbs
 - ensure circulation
 - relieve pressure points

- prevent brachial nerve damage
- 4. Ensure patent airway
 - check air entry – feel movement of abdomen
 - air movement felt by hand near nose and mouth
 - suction PRN
 - oxygen PRN
 - deep breathing and coughing following a general anaesthetic
- 5. Obtain instructions re: removal of endotracheal tube, usually when:
 - gag reflex present (cough)
 - can lift head
 - can respond to commands
 - patient has a strong hand grip
- 6. Obtain order for catheter removal
- 7. Relieve hypothermia
 - provide warm blanket
 - may require oxygen
 - shivering increases oxygen demand
 - temperature every 30 minutes
 - reassure shivering will cease
 - shaking, shivering and possibility peripheral cyanosis may be from exposure in the OR affecting the thermoregulatory system and if Halothane or epidural is used, shaking may be present
- 8. TPR and BP assessed upon transfer to postpartum every 4 hrs for 24 hrs, then q8h for 24 hours then once per the nurses shift (q 8 or 12 h) until discharge.
- 9. Every 15 minutes, assess for hemorrhage
 - Fundus
 - level
 - displacement
 - consistency
 - oxytocin 20 units in each litre of IV solution at 125 cc/hr
 - Lochia
 - amount (pad count)
 - character
 - presence of clots

- Incision (wound dressing)
 - outline bleeding on dressing
 - observe for hematoma formation
 - Bladder distention
 - may require recatheterization
 - in indwelling catheter, is tubing kinked?
10. The woman having Caesarean birth with regional anaesthetic will:
- have support of her choice present
 - be encouraged to hold her baby as soon as possible
 - be assisted to breastfeed as soon as possible

DAILY POST SURGICAL CARE

In addition to the care outlined in manual chapter 3, "Postpartum Nursing"

1. Assessment for signs and symptoms of infection
 - Wound healing
 - Odour of lochia
 - Fever and/or chills
 - Altered vital signs
2. Initial dressing off in 24 hours. No additional dressing needed after that
3. Can shower
4. Encourage early ambulation
5. Full diet as tolerated
6. Assess for distended abdomen/gas pain
 - May require stool softener or laxative
7. Analgesia as required
8. Assistance with breastfeeding
 - May breastfeed as soon as desired, encourage within 4 hours
 - Sit in straight chair, using a pillow to elevate the baby
 - Football hold

9. Encourage the woman to verbalize her feelings regarding the necessity of an operative birth.
- * The woman who has had a Caesarean section needs the uterine fundus checked gently postoperatively, as any other postpartum woman.**

DISCHARGE TEACHING

1. Wound healing – signs and symptoms of infection
2. Lochia – do not use tampons or douches
3. Sexual intercourse when comfortable and not bleeding
4. Activities – no heavy lifting, generally lift nothing heavier than the baby for approximately 6 weeks
5. Regular rest periods
6. Shower/tub bath PRN
7. Follow up appointments six weeks postpartum