Maternity Centre Recovery Following Caesarean Section

Site Applicability: SPH Maternity Centre, PACU, OR

Related Documents and Resources:

1. B-00-13-10071 – PACU: Discharge Criteria Post Anesthetic
2. B-00-13-10072 – PACU Care of the Patient Post C Section (General or Regional Anesthetic)

Skill Level: **Specialized**

Neonatal Resuscitation (NRP) Competency and Adult CPR required

Maternity Centre RNs who have completed the orientation to "Maternity Centre Recovery of Caesarean Section" education and orientation (MCR RN)

Anesthesiologists

Obstetricians

Family Practice Physicians

Midwives

Need to Know

- A caesarean section is considered major abdominal surgery
- Caesarean sections may be an elective (planned) or an emergency procedure

Definitions:
MCR RN • Maternity Centre RNs who have completed the orientation to "Recovery of Caesarean Section" education and orientation
Phase 1 • Immediate post anesthetic phase   • Commences once the patient is transferred from the OR to the assigned Maternity Centre recovery room

Safety:

- Staffing of the recovery of caesarean section will be based on the Maternity Centre's patient acuity, census and physical capability (see Appendix C)
- A MCR RN is present at all times to provide direct care and supervision at a ratio of

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- A second MCR RN is available at all times during the phase 1 level of care
- Patient meets criteria for Maternity Centre Caesarean Section Recovery (Appendix A)
- All monitoring equipment alarms must be operating and on at all times
- Only one designated support person (the person who accompanied the patient to the operating room) may accompany the patient and newborn in the Maternity Centre's recovery room.
- Post Caesarean Section patients can be recovered in Maternity Centre rooms 3601 to 3609
- See Appendix B for roles and responsibilities of team members

PRACTICE GUIDELINE

Phase 1 Care in the Maternity Centre

Admission Assessment & Vital Signs:

- Completed upon admission to the unit
- VS completed Q 15 minutes x 8 – if stable (VS within ±20% of pre-anesthetic level) then move to
    - Q 30 minutes x 4 –if stable (within ±20% of pre-anesthetic level) then move to
    - Q1H until discharged from Phase 1
- Assessment and findings are to be documented using the Providence Health Care St. Paul's Hospital PACU Patient Record and Medication Administration Record (MAR)

Assessments	Criteria and Directives
1. Physical Assessment a. Airway, b. Breathing c. Circulation d. Level of consciousness e. Oxygen saturation	a. Assess for airway patency, b. Assess chest expansion, rate and rhythm, and use of accessory muslces c. Measure BP, palpate pulse for rate & rhythm d. Assess level of consciousness, Glasgow Coma Scare (eye opening, verbal response, motor response), ability to move, and pupil size and reaction. e. Assess oxygen saturation via pulse oximetry –***CONTINUOUS*** • If room air SpO_2 is less than 93% administer oxygen either via nasal prongs or via

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f. Vital Signs g. Pain	facemask • Oxygen via facemask will be delivered at a flow rate greater than 6 L/min • Report findings to anesthesiologist responsible for patient f. Includes BP, HR, RR, Temperature, Pain g. Assess pain intensity using a rating scale appropriate to patient's cognitive and communication ability: • Ask patient to rate their pain using a numerical scale of 0 to 10 with 0 being no pain and 10 being the worst pain. • If patient is more comfortable using verbal descriptors such as no, mild, moderate, lots, intolerable, etc. use appropriate number rating associated with descriptor.
2. Postpartum Assessment a. Fundal tone and height b. Lochia colour and amount	a. Assess for firmness and central location b. Abnormal PV loss includes: • Saturated pad within the first 15 minutes • Numerous and/or large clots (greater than a loonie size) • Foul odour • Bright red blood
3. Abdominal Dressing • Dry and intact, nil/scant oozing	• Change wet/saturated dressing • If dressing NOT changed, mark boundaries of drainage on dressing (do not use felt pen – the ink is toxic and seeps through dressings) including date and time. Reassess in 15 minutes. Notify physician of excessive drainage. (Excessive Drainage may be defined as more than 100 mL blood loss in any 1 hour) • If dry recheck with each assessment of vital signs.
4. Fluid Balance Peripheral IV	• Location of intravenous lines, condition of intravenous sites including size and type (i.e. central vs. peripheral) and amount, type and rate of solution.

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Foley Catheter Blood loss	• Review and document OR fluid (crystalloid, PRBC, colloid, etc.) intake and OR output including estimate blood loss (EBL), urine output and any drainage output e.g. gastric. • Foley is insitu, secured to upper leg and draining • Urine output amount assessed on admission and Q1H until discharge. • Hematuria may be present due to microscopic bladder vessel tears • Notify physician if increase in hematuria. • Notify physician is urine output is less than 30 mL/hour for two hours • Drainage/blood loss.
5. Sensory dermatome levels, motor function and sedation scale	• Use ice to assess level of block • Patient is able to demonstrate symmetrical gross motor movement to lower limbs • Orientated to person, place and time, obeys commands
6. Nausea and vomiting	• Assess the need for antiemetic medication and administer as per orders
7. Emotional Status	• Assess readiness to initiate skin to skin and breastfeeding

Management of Reportable Conditions:

- **The MCR RN will report the following findings to the anesthesiologist responsible for the patient:**
  - Change in level of consciousness
  - Respiration rate less than 10/min and/or consistently irregular
  - Pulse consistently less than 50 bpm or greater than 100 bpm and/or irregular rate
  - Oxygen saturation consistently less than 93%
  - Temperature less than 35ºC or greater than 38ºC
  - Excessive bleeding on abdominal dressings
  - Change in BP greater than 20% of pre-anesthetic level
  - Urine output less than 30 mL/hour for 2 hours

- Persistent pain unrelieved by ordered analgesics
- Persistent nausea and/or vomiting unrelieved by ordered antiemetic

**If the responsible anesthesiologist is unavailable contact the anesthesiologist on call*

- **The MCR RN will report the following findings to the Obstetrician responsible for the patient:**
  - Excessive bleeding on abdominal dressing
  - Abnormal PV loss and/or clots
  - Persistent boggy fundus that has not responded to fundal massage
  - Persistent deviated fundus

❖ If the patient is identified as unstable by the responsible anesthesiologist or responsible obstetrician it is the physician's responsibility to arrange transfer to PACU

Newborn Care:

- The primary and secondary MCR RN will provide care for the newborn and complete the required newborn assessments
- Care of the newborn remains the same as any other post delivery care and does not influence the mother's discharge criteria
- Skin to skin and breastfeeding can be initiated when both mother and newborn are ready
- Only the designated support person may remain in the recovery area with the mother and newborn

Assessment and Phase 1 Discharge Criteria:

- Full discharge patient assessment is completed 5 minutes prior to discharge from Phase 1 Level of care
- Report must be given by the Primary MCR RN to the assigned postpartum nurse

ASSESSMENT	CRITERIA
Respiratory	• Patient has independently maintained airway for a minimum of 45 minutes • Respiratory rate 10 to 24/minute • Oxygen must be discontinued for a minimum of 15 minutes with a oxygen saturation level of 92% or greater on room air
CNS	• Orientated to person place and time • Obeys commands • May be drowsy, but rouses to verbal stimuli
Cardiovascular	• Stable Vital signs (within ±20% of pre-anesthetic level) • IV access is patent, site is satisfactory and IV solution is labelled and infusing as per orders • Patient independently maintaining a temperature of over 36ºC
Postpartum Assessment • Fundal tone and height • Lochia colour and amount	• Fundus is firm and midline • PV loss is appropriate
Abdominal Dressing	• Dry and intact or reinforced
Urine Output	• Foley catheter is secured to upper leg and draining • Output is greater than 30 mL/hour
Sensory dermatome levels and motor function	• Absence of orthostatic hypotension and is able to maintain BP in a 30 to 45º sitting position • Spinal – sensory block is at T10 or lower **and** has regressed at least 2 dermatomes from the intraoperative state. • Epidural – sensory block is appropriate to location i.e. lumbar, thoracic and operative site. • Patient has symmetrical gross motor movement to lower limbs and is able to reposition self (full limb sensation not required for discharge from Phase 1 care level) • Removal of epidural catheter as per orders

Nausea and vomiting	• Minimal nausea and vomiting
Pain management	• Pain management has been established for a minimum of 1 hour (stable vital signs and tolerable pain score)
Medications	• Oral medications –may be discharged from Phase 1 immediately following • IM medications –the patient must wait 30 minutes before discharge from Phase 1 Care • SUBCUT opioid (narcotic) -the patient must wait 60 minutes before discharge from Phase 1 Care • IV Direct (IV push) - the patient must wait 15 minutes before discharge from Phase 1 Care • IV minibag (initial dose) - the patient must wait 30 minutes following the initiation of the first dose before discharge from Phase 1 Care
Documentation	• All physicians orders and documentation and charting pertaining to both mother and newborn is completed • All nursing documentation pertaining to both the mother, newborn as well as labour and delivery is complete

Patient/Family Education:

Review with patient and support person:

- The reasons and frequency of assessments
- The role of equipment and supplies related to assessments
- Normal plan of care
- Only one designated support person (the person who accompanied the patient to the operating room) may accompany the patient and newborn in the Maternity Centre's Recovery room
- Education as per BC Maternal Postpartum Clinical Care Path and the BC Newborn Care Path

Documentation:

- Providence Health Care St. Paul's Hospital PACU Patient record
- Medication Administration Record (MAR)
- BC Maternal Postpartum Clinical Care Path

- BC Newborn Care Path

References:

1. American Society of PeriAnesthesia Nurses. (2014). *2015 - 2017 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements.* Cherry Hill, NJ: Author. British Columbia Perinatal Health Program (BCPHS). (2010) British Columbia Maternal Postpartum Clinical Care Path. Vancouver: BCPHS.
2. Providence Health Care. (January 2017). B-00-13-10071.pdf –PACU Post Anesthesia
3. Providence Health Care. (June 2015). B-00-13-10072.pdf –PACU- C-Section
4. Fraser Heath (2015) Clinical Policy Office: Nursing - Post-Anesthetic Care Unit ; Appendix I: Obstetrical and Gynecological Patients

Persons/Groups Consulted:

SCM Patient Care Manager, Maternity Centre

RN, Nurse Educator PACU

Maternity Safety and Quality Council

Revised By:

RN, Nurse Educator Maternity Centre

Approved By: Professional Practice Standards Committee

Date of Creation/Review/Revision:

June 2011

Revised: March 2017

Appendices:

Appendix A – Patient Criteria for Maternity Centre Caesarian Section Recovery

Appendix B – Roles and Responsibilities

Appendix C – Assessment of the Maternity Centre's Capacity to Recover Caesarian Sections

Appendix A: Patient Criteria for Maternity Centre Caesarean Section Recovery

- An appropriate Maternity Centre room and 2 MCR RNs are available
- Patient received regional anesthetic only, is stable and conscious
- Patient did not have additional surgical complications

Anesthesiologist and Maternity Team determines the patient is appropriate for recovery in the Maternity Centre

Patients Not Appropriate for Maternity Centre Caesarean Section Recovery

- Patients identified as “High Risk” (including twins and identified Cardiac patients)
- Patients who received General Anesthetic
- Patients requiring cardiac telemetry monitoring
- Patients who require intubation or have any airway concerns

Anesthesiologist and Maternity Team determines the patient is not appropriate for recovery in the Maternity Centre

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Appendix B: Roles and Responsibilities

MCR RN

- Maternal and newborn assessments
- Complete assigned recovery room safety check
- Ensure equipment is present and in working order in the assigned recovery room
- Ensure the OB Emergency cart has been checked and is located at the Nursing Station
- Ensure the Epidural cart has been checked and is located at the Nursing Station
- Ensure stabilette has be checked and set up

Maternity Centre CNL or CN

- Determines staffing of the recovery of caesarean section based on the Maternity Centre's patient acuity, census and physical capability
- Assigns a MCR RN to provide direct care and supervision at a ratio of 1:1
- Can be the second MCR RN, available at all times during Phase 1 level of care
- Ensures the OB Emergency cart has been checked and is located at the Nursing Station
- Ensures the Epidural cart has been checked and is located at the Nursing Station

Anesthesiologist

- Determines patient is stable and appropriate for Maternity Centre Recovery prior to transferring
- Transports the patient with the OR RN to the Maternity Centre
- Report given to MCR RN
- Orders for recovery are complete
- Responsible for arranging transfer to PACU if patient condition warrants
- Responsible for providing contact information

OR RN

- Transports the patient with the anesthesiologist to the Maternity Centre
- Report given to Primary MCR RN

Obstetrician/ Physician/ Midwife

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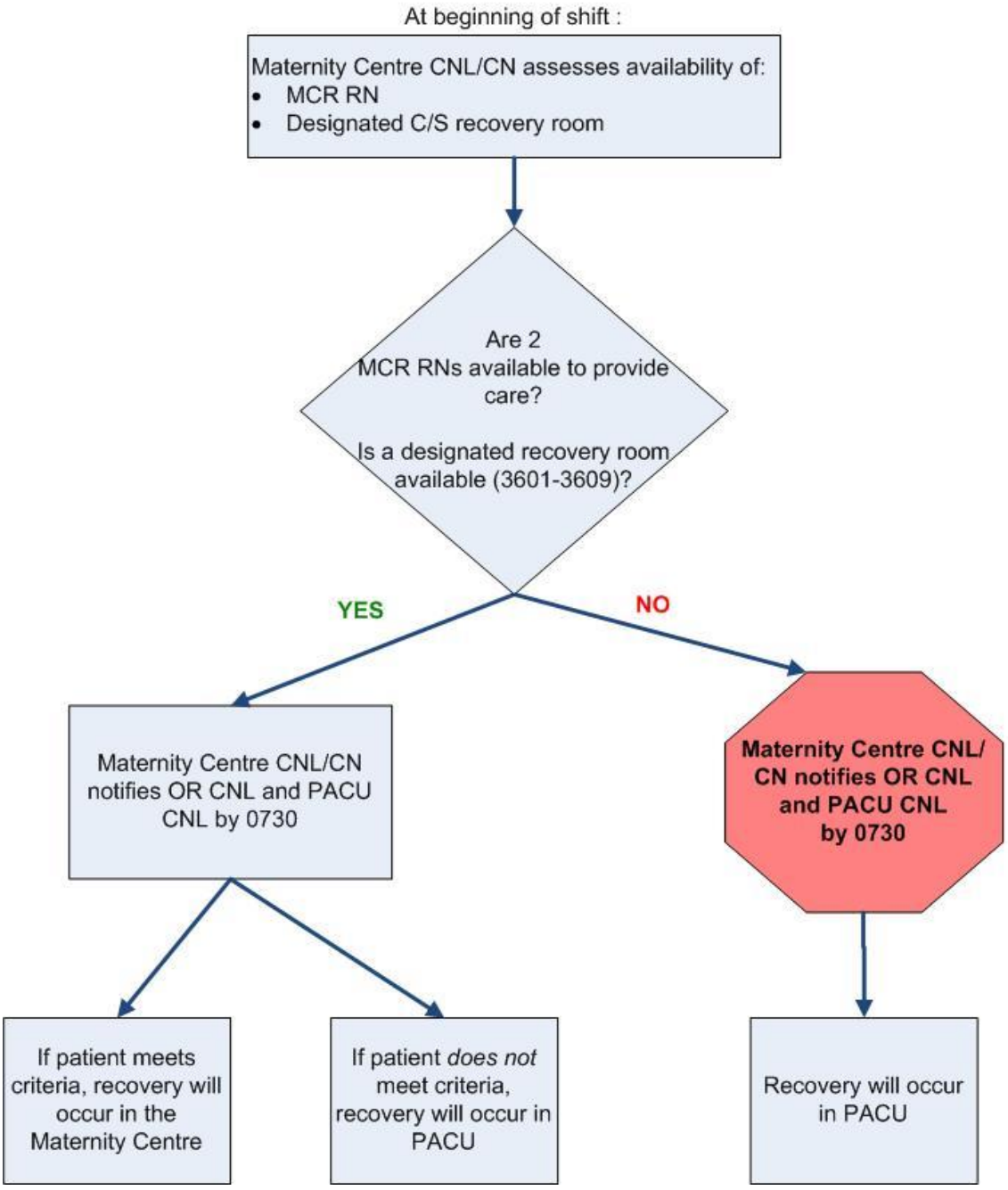
- Provide routine postpartum care
- Complete all documentation associated with delivery
- Complete all postpartum orders
- Responsible for arranging transfer to PACU if patient condition warrants

Pediatrician

- Complete all documentation associated with delivery
- Complete newborn assessment and orders

Appendix C:

ASSESSMENT OF MATERNITY UNIT CAPACITY TO RECOVER CAESARIAN SECTIONS



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