MATERNAL-NEWBORN · POSTPARTUM

Postpartum *Adaptation*

Physiologic involution, psychological transition, and the high-yield assessment framework for the first 6 weeks after birth.

NGN NCLEX 2026
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SOURCE DISCLOSURE
This topic is not contained in the user's uploaded personal notes. Content was synthesized from standard NCLEX preparation references: *Saunders Comprehensive Review for the NCLEX-RN 2026*, *ATI Maternal Newborn Nursing*, *Lippincott Manual of Nursing Practice*, and *AWHONN Postpartum Clinical Practice Guidelines*.

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DEFINITION · OVERVIEW

What is Postpartum?

- **Puerperium** = the 6-week period after birth during which reproductive organs return to a non-pregnant state.
- **Involution** = the process of the uterus returning to pre-pregnancy size, position, and tone.
- **Why it matters:** The leading causes of maternal mortality (hemorrhage, infection, VTE, depression) all peak in the first 6 weeks postpartum.

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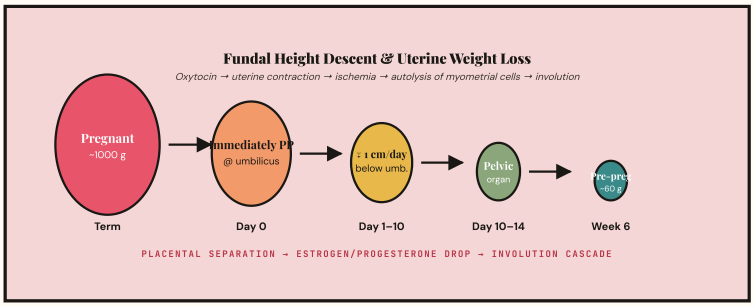
PATHOPHYSIOLOGY

Uterine Involution Pathway



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ASSESSMENT FRAMEWORK

BUBBLE-HE · The Postpartum Head-to-Toe

B — Breasts
Soft → filling → firm/engorged by day 3–5. Check for redness, cracking, mastitis. Colostrum first 2–3 days, then transitional, then mature milk.

U — Uterus (Fundus)
Firm, midline, at umbilicus on day 0. Descends 1 cm/day. **Boggy → MASSAGE FIRST.** Empty bladder if deviated to the right.

B — Bladder
Void within 4–6 hr of delivery. Full bladder = displaced fundus + ↑ bleeding risk. Watch for retention, UTI, diuresis 1500–3000 mL/day.

B — Bowel
BM by day 2–3. Fear of pain (perineum, hemorrhoids, C/S). Encourage fluids, fiber, ambulation, stool softeners (docusate).

L — Lochia
Rubra → Serosa → Alba. Saturating 1 pad/hour = HEMORRHAGE. Foul odor = infection. Clots > golf ball = report.

E — Episiotomy / Perineum
Assess with **REEDA**: Redness, Edema, Ecchymosis, Discharge, Approximation. Ice ×24 hr → then warm sitz bath.

H — Homans / Hemorrhoids
Assess legs for warmth, redness, edema, calf pain (DVT). Homans no longer sole indicator. Hemorrhoids → topical anesthetics, sitz baths.

E — Emotions / Bonding
Eye contact, en face, fingertip → palm → enfolding progression. Baby blues normal day 3–10. Screen for PPD with Edinburgh scale.

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LOCHIA STAGES

The Three-Phase Bleeding Timeline

Rubra	Serosa	Alba
DAYS 1-3	DAYS 4-10	DAYS 10-28 (up to 6 wk)
Dark red, bloody. Fleshy odor. Small clots OK. Contains blood, decidua, trophoblastic debris. **Heavy flow = first 2 hr.**	**Pink to brownish.** Serous, watery. Contains old blood, serum, leukocytes. Should NOT return to red — that signals retained tissue.	**Yellow to white.** Mostly leukocytes, decidual cells, mucus. No odor. Heralds endometrial healing.

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SIGNS & SYMPTOMS

Expected Findings vs. Red Flags

NORMAL / EXPECTED

- ✓ Fundus firm, midline, at umbilicus (day 0), descends 1 cm/day
- ✓ Lochia: rubra → serosa → alba, fleshy odor, small clots
- ✓ Afterpains (esp. multiparas, breastfeeding moms)
- ✓ Bradycardia 50–70 bpm (normal first 6–10 days)
- ✓ Diaphoresis & diuresis (↑ output, night sweats)
- ✓ Temp ≤ 100.4 °F (38 °C) in first 24 hr (dehydration)
- ✓ WBC up to 25,000–30,000/mm³ — physiologic leukocytosis
- ✓ Baby blues: tearful, mood swings day 3–10, self-limiting

RED FLAG · REPORT IMMEDIATELY

- Saturating > 1 perineal pad / hour = postpartum hemorrhage
- Boggy uterus that doesn't firm with massage
- Fundus deviated right + full bladder
- Lochia returns to RUBRA after serosa/alba
- Foul-smelling lochia + fever > 100.4 °F after 24 hr = endometritis
- Calf pain, redness, swelling, +Homans = DVT
- Sudden SOB, chest pain, hypoxia = PE
- BP > 140/90, headache, visual changes, RUQ pain = postpartum preeclampsia
- Thoughts of harming self or baby = postpartum psychosis (EMERGENCY)

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PRIORITY NURSING INTERVENTIONS

ABCs + Safety + Postpartum Priorities

A
Airway

- →Monitor for PE: sudden SOB, chest pain, ↓ SpO_2
- →Position semi-Fowler's for dyspnea
- →O_2 via NRB if respiratory distress

B
Bleeding

- →**MASSAGE the fundus first** if boggy
- →Empty bladder (uterus deviated R)
- →Quantify blood loss — weigh pads (1 g = 1 mL)
- →Two large-bore IVs, T&C, prep for oxytocin/methergine

C
Circulation

- →Vitals q15 min × first hour, then per protocol
- →Ambulate early to prevent VTE
- →SCDs/TEDs for at-risk clients
- →Monitor I&O — expect diuresis

S
Safety & Bonding

- →Fall precautions — orthostatic risk + epidural residual
- →Newborn ID bands matched before every handoff
- →Promote skin-to-skin in first hour
- →Edinburgh Postnatal Depression screen before discharge

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PHARMACOLOGY

Uterotonics, Vaccines, and Postpartum Drugs

DRUG	MECHANISM	SIDE EFFECTS	NURSING CONSIDERATIONS
Oxytocin Pitocin · 1st-line uterotonic	Stimulates uterine contraction → controls bleeding via mechanical compression of vessels	Water intoxication, hypotension, tachycardia (rapid IV)	10–40 units in 1 L LR/NS, titrate to firm fundus. Never IV push undiluted.
Methylergonovine Methergine · 2nd-line	Ergot alkaloid → smooth muscle contraction of uterus	↑↑ BP, headache, nausea, chest pain	**CONTRAINDICATED in HTN & preeclampsia.** Check BP before each dose.
Carboprost Hemabate · 3rd-line	Prostaglandin F2α analog → uterine contraction	Bronchospasm, diarrhea, fever, N/V	**CONTRAINDICATED in asthma.** Give antiemetic + antidiarrheal pre-dose.
Misoprostol Cytotec · prostaglandin E1	Stimulates uterine contraction, rectal/PO/SL routes	Shivering, fever, GI upset	Off-label PPH use. Cheap, stable, no refrigeration.
Rh_o(D) Immune Globulin RhoGAM	Prevents maternal Rh sensitization against fetal Rh+ RBCs	Local injection site reaction, mild fever	Give to **Rh-NEGATIVE mom** with Rh-POSITIVE baby within **72 hours** of delivery, IM.
Rubella (MMR) Vaccine Live attenuated	Active immunization in non-immune postpartum clients	Mild fever, rash, joint aches	Give before discharge. **Avoid pregnancy for 4 weeks.** Safe while breastfeeding.
Tdap Inactivated	Pertussis immunity for infant protection	Injection site soreness	Recommended each pregnancy at 27–36 wk; if missed, give postpartum before discharge.
Docusate Colace · stool softener	↑ water content of stool, softens passage	Mild cramping, diarrhea	Standard order to prevent straining over perineal repair / hemorrhoids.

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PSYCHOLOGICAL ADAPTATION

Rubin's Phases & Mood Continuum

PHASE 1

Taking-In

DAYS 1-2

Mom is **passive, dependent**. Focused on her own needs — food, sleep, recounting birth story. Reliant on others. **Teach later** — receptivity is low now.

PHASE 2

Taking-Hold

DAYS 2-10

Mom is **active, learning**. Most receptive to teaching. Concerned with body function and competence in baby care. **OPTIMAL teaching window.**

PHASE 3

Letting-Go

WEEK 2 +

Mom integrates new family role. Releases pre-baby self and idealized birth. Real attachment forms; relationship with partner re-negotiates.

Baby Blues

DAY 3-10 · ~80% of mothers

Tearfulness, mood swings, fatigue. **Self-limiting** within 2 weeks. Reassure & support. NOT a disorder.

Postpartum Depression

UP TO 1 YR · 10-15%

Persistent sadness, anhedonia, sleep/appetite changes, guilt. Lasts > 2 weeks. Screen with Edinburgh. Refer for SSRIs & therapy.

Postpartum Psychosis

FIRST 2-4 WK · 1-2 / 1,000 · EMERGENCY

Hallucinations, delusions (often about baby), disorganized thinking. **Risk of infanticide/suicide.** Hospitalize immediately.

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NCLEX TEST TRAPS

Wrong vs. Right · Watch For These

TRAP	CORRECT
Boggy fundus → call provider first.	**MASSAGE the fundus first.** Provider is notified only if massage + bladder emptying fail.
Fundus deviated to the right → reposition the mother.	**Empty the bladder.** A full bladder displaces the uterus & prevents contraction = bleeding risk.
Bradycardia 55 bpm on day 2 → notify HCP.	**Normal finding** in first 6–10 days postpartum. Document & continue routine monitoring.
Temp 100.2 °F at 12 hr postpartum = infection.	Temp ≤ **100.4 °F (38 °C) in first 24 hr is normal** (dehydration). Encourage fluids; recheck.
Give methylergonovine to a mom with BP 158/96.	**HOLD & notify.** Methergine is contraindicated in hypertension & preeclampsia.
Give carboprost to a mom with asthma during PPH.	**Contraindicated** — risk of bronchospasm. Use oxytocin or misoprostol instead.
Begin teaching infant care on day 1 while mom rests.	Day 1 = **taking-in phase**. Mom isn't receptive. Optimal teaching window is days 2–10 (taking-hold).
Mom tearful on day 4 → start SSRI & refer to psych.	Likely **baby blues** (normal day 3–10). Reassure & reassess. PPD requires symptoms > 2 weeks.
RhoGAM is given to a Rh-positive mom.	Given **only to Rh-negative mom with Rh-positive baby**, within 72 hours of delivery.

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PATIENT EDUCATION

Discharge Teaching Pearls

PERINEAL & HYGIENE CARE

- Peri-bottle with warm water front-to-back after every void/BM
- Ice pack first 24 hr, then warm sitz baths 2–3×/day
- Change perineal pads with every bathroom trip; no tampons until cleared
- Witch hazel pads & topical anesthetic for hemorrhoids

BREASTFEEDING & BREAST CARE

- Latch: chin-to-breast, wide mouth, areola in mouth, no clicking
- Nurse 8–12 ×/24 hr; switch sides; breast emptying prevents engorgement
- Air-dry nipples; lanolin for soreness; NO soap on nipples
- Cold cabbage leaves or ice for engorgement IF NOT nursing

ACTIVITY, REST & NUTRITION

- Rest when baby rests; accept help; limit visitors
- No heavy lifting > baby's weight × 4–6 weeks (esp. C/S)
- ↑ Protein, iron-rich foods, fluids (esp. while breastfeeding)
- Continue prenatal vitamins; +500 kcal/day if lactating

SEXUALITY & CONTRACEPTION

- Resume intercourse after lochia stops & perineum healed (~4–6 wk)
- Lubricant — estrogen drop causes vaginal dryness (esp. lactating)
- Ovulation may return before first menses — **use contraception immediately**
- Avoid combined OCPs first 6 wk (VTE risk) & if exclusively breastfeeding (↓ supply)

WARNING SIGNS · CALL PROVIDER

- Saturating a pad in <1 hr or passing clots larger than an egg
- Foul-smelling lochia or fever > 100.4 °F after 24 hr
- Calf pain, swelling, redness OR chest pain, SOB
- BP issues: severe headache, blurred vision, RUQ pain
- Thoughts of harming self or baby

EMOTIONAL & BONDING SUPPORT

- Baby blues = normal day 3–10; PPD if > 2 weeks or worsening
- Partner & family education on PPD/PPP warning signs
- Sleep deprivation worsens mood — share night feedings
- Postpartum check at 1–3 wk + comprehensive visit at 6 wk

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MEMORY BOOSTERS

Mnemonics & Pattern Recognition

BUBBLE-HE

The postpartum assessment

- **B** Breasts
- **U** Uterus
- **B** Bladder
- **B** Bowel
- **L** Lochia
- **E** Episiotomy/perineum
- **H** Homans & hemorrhoids
- **E** Emotions/bonding

REEDA

Perineal & episiotomy assessment

- **R** Redness
- **E** Edema
- **E** Ecchymosis
- **D** Discharge
- **A** Approximation of wound edges

"4 T's"

Causes of postpartum hemorrhage

- **T** one — uterine atony (#1, ~70%)
- **T** rauma — lacerations, hematoma
- **T** issue — retained placenta
- **T** hrombin — coagulopathy / DIC

RUBRA → SERO → ALBA

Lochia color progression

R ed → **P** ink/brown → **W** hite/yellow

Pattern: `1-3 → 4-10 → 10-28`

Backsliding to red = `retained placenta or subinvolution`

M-O-M

Fundus deviated to the right?

- **M** assage the fundus
- **O** ffload the bladder (have her void)
- **M** onitor — re-check fundus & bleeding

PHASES

Rubin's psychological phases

`Taking-In` = passive, dependent (days 1–2)

`Taking-Hold` = active, learner (days 2–10) ★ teach NOW

`Letting-Go` = role integration (week 2+)

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NCJMM · CLINICAL JUDGMENT SCENARIO

Six-Step Case Walkthrough

Case stem

A 28-year-old G2P2 is 2 hours post-vaginal delivery of a 4,200 g infant. She received epidural anesthesia and had a 2nd-degree midline episiotomy. Vital signs: T 99.1 °F, HR 96, RR 18, BP 108/64, SpO_2 98%. On assessment the nurse notes the fundus is boggy and palpated 2 cm above the umbilicus, deviated to the right. The peri-pad is saturated and there is a small pool of blood under her buttocks. The client states "I feel like I really need to pee but it hurts to move."

1 — RECOGNIZE CUES

Relevant: boggy fundus, displaced upward & right, saturated pad, pooled blood, urge to void + perineal pain, recent macrosomic delivery (PPH risk factor).

2 — ANALYZE CUES

Macrosomia → overstretched uterus → **atony**. Full bladder displaces uterus → prevents contraction → ongoing bleeding. Classic **"Tone" PPH** picture.

3 — PRIORITIZE HYPOTHESES

#1 Uterine atony with bladder distension. Lower priority: laceration, retained tissue, coagulopathy — consider if bleeding persists after corrective actions.

4 — GENERATE SOLUTIONS

Massage fundus → assist to void (or straight cath if unable) → reassess fundus & lochia → quantify blood loss → IV oxytocin per protocol → notify HCP if no response.

5 — TAKE ACTION

FIRST: Massage the fundus. **NEXT:** Empty bladder (assist to commode or straight cath). Re-assess fundal tone & bleeding within 5 min. Trend vitals q15 min.

6 — EVALUATE OUTCOMES

Effective: firm fundus, midline, at/below umbilicus, < 1 pad/hr, stable vitals.
Ineffective: persistent boggy uterus → escalate to uterotonics + provider notification.