

MATERNAL AND INFANT CARE:
A POSTPARTUM DISCHARGE MANUAL

by

Donna Mae Bristow

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Barbara Derwinski-robinson

Barbara Derwinski-robinson April 15, 1996
(Signature) Date

Approved for the Department of Nursing

Kathleen Chafey

Kathleen Chafey May 6, 1996
(Signature) Date

Approved for the College of Graduate Studies

Robert Brown

Robert Brown 7/30/96
(Signature) Date

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Signature Donna M. Bristow
Date June 26, 1996

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ABSTRACT

The length of hospital stay following an uncomplicated vaginal delivery has been steadily decreasing over the past 30 years. Currently new mothers and their infants are being discharged from the hospital within 12 to 48 hours of delivery. This presents a problem for postpartum nurses as they attempt to provide discharge teaching to these families at a time they may not be ready to learn. The purpose of this professional project was to design a postpartum discharge manual for a community hospital located in a south central Montana city with a population of approximately 25,000. The conceptual framework on which the manual was designed, consisted of principles from Roy's Theory of Adaptation, Rural Nursing Theory, and the process of patient education. The methodology for this project consists of a review of the literature to identify the history of early postpartum discharge in the United States, the educational needs of patients experiencing early postpartum discharge, a review of Reva Rubin's classic theory of maternal identity from a 1996 perspective, and examination of instructional design. In addition, three community hospitals located in Montana cities with populations of at least 12,000 sent copies of their discharge materials by request to be reviewed for content and format. Follow-up telephone calls were made to staff at the hospitals to determine perceptions of strengths and weaknesses of the materials. The initial draft of the manual was evaluated by expert reviewers and two learners from the target audience who provided feedback on content and format. The major findings of the project were that early postpartum patients are concerned about receiving specific information about care of themselves and their infants. In addition, written materials are one method of providing this information to these patients when they are most able to access and comprehend it.

CHAPTER 1

INTRODUCTION

Statement of the Problem

Many postpartum women, and their infants, are being discharged within 24 to 48 hours of an uncomplicated, vaginal delivery (Hiser, 1991; Stover & Marnejon, 1995; Harrison, 1990; & Sheil, et al, 1995). This phenomenon appears to be occurring on a national level, in both urban and rural areas. The characteristics of rural life, including the distance to services and the independent lifestyles of rural residents, make it difficult to provide follow up for these families (Bushy, 1991b). Knowledge of the trends, and the lack of a written discharge manual for postpartum families in a community hospital in south central Montana, established the rationale for this study.

Background

From the classic work of Reva Rubin (1961), it is known that there are two distinct periods of adjustment in the immediate postpartum period. The first, the "taking-in" phase, is said to last two to three days and is described as a period of maternal passivity and dependence. The new mother is preoccupied with food and sleep and hesitant to

make decisions or resume control of her life. She is very dependent on the staff and her family to assume control for her. The second phase, the "taking-hold" phase, begins some time during the next two to three days. In this phase, the new mother is able to begin to resume control of her life and make decisions for her new infant and her self. Also, this period is more conducive to learning how to care for herself and her infant. She is less dependent on staff and family for her care.

In 1984, Martell and Mitchell reexamined Rubin's (1961) research to see whether her tenants were still applicable. They looked at the timing and characteristics of both the "taking-in" and "taking-hold" phases. They found little evidence of a strong "taking-in" phase, but did discover strong evidence for the "taking-hold" phase. However, the "taking-hold" phase appeared to occur between the first and second post partum day rather than the second or third days as previously described by Rubin. Martell and Mitchell (1984) believed that the decrease in time between delivery and the "taking-hold" phase was related to both medical and societal changes that had taken effect during the 23 year interim. The authors believed mothers had less sedation for labor and so were more alert and tuned into their babies. The feminist movement has decreased dependent behaviors of women in general. The expansion in prenatal education better prepares women for what to expect in the postpartum period. In addition, new mothers have "earlier, more frequent, and longer contact with their infants than did mothers in the

1960s" (Martell & Mitchell, 1984, p. 146). This emphasis on early contact may have an impact on why women become focused on their infants earlier in the postpartum period (Martell & Mitchell, 1984).

With today's length of stay decreased even further than in 1984, the mother is discharged during the "taking-hold" phase and may be unable to assimilate the information being presented prior to discharge (Ament, 1990). This presents a challenge to the postpartum nurse who is responsible for assessing the need for, and providing, necessary information to this new family. A need exists for alternative methods of making the information available to the new family, when they are ready for it. Many alternative methods are considered for providing this information. These include having the families attend a prenatal course designed to provide this information prior to delivery or having them return for a postpartum class after delivery. These alternatives are difficult for rural families with limited time and resources. The distance from the health care facility may be a barrier to returning for education numerous times. Like many other groups, postpartum families may not be motivated to learn until they perceive the need for specific information to care for themselves or their infants (Redman, 1993).

Another method of providing discharge information is print form. In this way the families control the speed at which they read and comprehended the information. "Print partially relaxes time requirements and is more efficient

than oral language ..." (Redman, 1993, p. 140). Additional advantages of printed materials include: (1) they are readily available; (2) they provide consistent information; and (3) parents can read them multiple times to promote increased comprehension levels. They can be used any time, any place, and by relatives, friends and neighbors (Kramer and Perin, 1985).

Purpose

The purpose of this project was to develop a discharge manual for low risk, vaginally delivered, postpartum patients. The manual is directed at the needs of first time parents during the first two weeks postpartum and also serves as a review for all parents, regardless of parity.

CHAPTER 2

LITERATURE REVIEW

The review of the literature focused on three areas: the history of early postpartum discharge in the United States; the educational needs of families that are discharged earlier than the traditional 24-72 hours postpartum; and a review of Reva Rubin's (1961) classic theory of maternal identity. In addition, literature reviewed for the conceptual framework includes Roy's (1983) Adaptation Model, rurality and the process of patient education.

History of Early Postpartum Discharge

During the past 40 years, the length of stay following a vaginal delivery has steadily decreased (Beck, 1991). As early as 1943, early discharge was reported to be between two and five days, while the average length of stay, following a vaginal discharge, was 10 days (Beck, 1991). In 1962, the traditional postpartum stay, after a vaginal delivery, was five to six days. During this time, the need to relieve the overcrowding caused by the increased birth rate of the 'baby-boomers' increased the number of early discharges. These discharges occurred after a 72 hour stay (Rhodes, 1994). While the original reason for early discharge was to alleviate the hospital bed shortage, more

recent reasons are increasing costs for hospital care, consumer demand and family-centered maternity care (Beck, 1991).

Two recent solutions have been associated with the early postpartum discharge programs: an increased postpartum follow up period, in which home visits or telephone calls are provided to the short stay families; and the inclusion of postpartum teaching in prenatal education programs (Beck, 1991). Planning for early discharge includes antepartum classes and follow up home care to facilitate a safe and comprehensive transition from the hospital to home. This follow up home care can be extended to the third week postpartum (Beck, 1991).

Recent studies, in both the private and military sectors, have found early postpartum discharge to be safe and effective (Carty & Bradley, 1990; Berryman & Rhodes, 1991; Gonzalves & Hardin, 1993; Rhodes, 1994). In the majority of contemporary studies, early discharge is defined as discharge after 24 hours of observation following a vaginal delivery (Rhodes, 1994; Carty, 1990; Berryman & Rhodes, 1991), while others define early discharge as up to 48 hours post delivery (Gonzalves & Hardin, 1993).

Educational Needs for Early Postpartum Discharge

All early discharge programs, with successful outcomes, identify three common factors for program participants. Factors include: (1) meeting definitive inclusion criteria,

Factors include: (1) meeting definitive inclusion criteria, such as having a vaginal delivery with no adverse complications during labor, delivery, or postpartum; (2) participating in antepartal education with a postpartal component; and (3) agreeing to participate in postpartal follow-up, either by telephone call or home visit (Beck, 1991; Rhodes, 1994; Carty & Bradley, 1990; Berryman & Rhodes, 1991; Gonzalves & Hardin, 1993). According to Harrison (1990), assessment is necessary to provide individualized teaching. Common problems identified during home visits were "elevated bilirubin levels, questions about infant care and feeding, and breast engorgement" (p. 39).

Hiser (1991) found in her study, using card-sort and questionnaire tools, that maternal concerns could be grouped into three categories. Items included the 'worry' category, the 'interest' category, and the 'no concern' category (Hiser, 1991).

Items most frequently sorted into the worry category were family finances/having enough money, meeting the needs of everyone at home, and being a good mother. Items sorted most frequently into the interest category were knowing how babies grow and develop, knowing how babies act, and blood tests taken on the baby. Items of no concern to participants were my urinating, my sweating and my hemorrhoids (Hiser, 1991, p. 169)

According to Williams and Cooper (1993) "nursing care that historically included a focus on the adaptation of the mother, newborn and family no longer can be accomplished because of the decreased length of hospitalization" (p. 25). Further "mothers and newborns are being discharged from the

hospital without the majority of their post delivery health-care needs being met" (p. 25). A postpartum home care program was developed by Williams and Cooper, and nursing diagnoses monitored on 1,616 clients. The following concerns were identified by at least 10% of their clients:

- episiotomy/laceration pain (36%)
- ineffective breastfeeding (21%)
- diet concerns (21%)
- breast engorgement (19%)
- backache (16%)
- uterine cramping (14%)
- hyperbilirubinemia (14%)
- constipation (10%)
- bottle feeding problems (10%)

It is the responsibility of postpartum nurses to make accurate assessments of families' needs for follow-up and respond to the identified needs. With the growing number of women opting for early postpartum discharge, it is necessary to provide education for the families outside of the hospital. These educational needs may include a phone call or intensive in-home education (Hampson, 1989).

Lemmer (1987) states that with early discharge, conditions which normally do not manifest themselves until the second or third day of life may go unnoticed. She advises that postpartum teaching should include "written information on signs of illness, community resources, and care provider phone numbers" (p. 235). The written information should effectively provide instruction to the

audience for which it is being designed (Smith & Ragan, 1993).

Reva Rubin's Theory of Maternal Identity

In the late 1960's, Reva Rubin conducted her classic study of the needs of postpartum women. She identified two phases, "taking-in" and "taking-hold". "Taking-in" began at delivery and lasted for two to three days. During this period the mother was dependent on others to make decisions for her and to care for her and her infant. "Taking-hold" began after the second or third day after delivery. During this period the mother assumed more control for her self and her infant and was able to begin making independent decisions regarding their care.

In the last twelve years, several studies have tested Rubin's theories to determine if they are relevant to current maternity practice and care. The first of these studies was one by Martell and Mitchell (1984) that sought to answer two questions: "1) Do the subjects show 'Taking-in' and 'Taking-hold' behaviors and attitudes as described by Rubin? and 2) Do these behaviors and attitudes change during the course of hospitalization?"(p. 146). Using a similar population and setting, they determined that the traditional taking-in phase has decreased in time and the taking-hold phase occurs sooner (Martell & Mitchell, 1984).

The second study, conducted by Gay, Edgel & Douglas (1988), found that "much of the information on which Rubin

based her observations is obsolete today" (p. 398). Though the specific tenets may not be true, Gay and others credit Rubin with stimulating obstetric nurses "to look beyond the physical aspects of women who delivered infants" (p. 397). They caution that "classical writing of yesterday should not be discarded but should be viewed in the light of changes that may have an effect on what is known today" (Gay, Edgel & Douglas, 1988, p. 398). When a discrepancy exists between a study and current practice, further research is warranted.

Ament (1990) strived to evaluate how recent trends in maternity care impact Rubin's (1961) original theory of maternal identity. She found strong support for Rubin's theory based on the findings that behaviors and attitudes associated with "taking-in" and "taking-hold" do indeed change during the course of hospitalization. Her data supports "...Rubin's classic work in all respects, except that the time frames in which the changes are thought to occur must be altered" (p. 333). Ament's (1990) study found a strong taking-in phase lasted only 24 hours instead of the two to three days identified by Rubin. Ament (1990) is concerned about the current practice of encouraging women to be independent on their first postpartum day. She notes that "women are not ready to absorb the vast amount of information presented to them at that time because they are highly involved in the taking-in phenomenon" (p. 334). The independence expected of postpartum patients is unrealistic. Postpartum nurses need to reexamine their teaching role. Ament (1990) recommends that "instead of attempting to teach

these women in one day everything they need to know about caring for their newborns, perhaps outlining the necessary highlights may be more practical" (p. 334). She believes that follow up instruction 24 to 48 hours after discharge; in the 'taking-hold' phase; is more effective than providing necessary information to the families prior to an early discharge (Ament, 1990).

Conceptual Framework

Overview

During this time of decreased length of hospitalization after childbirth, the postpartum nurse's goal is to provide increased services to families within the constraints of decreased time and resources. One way of attaining this goal is by using an organizational framework (Logan, 1990).

"Implementation of a conceptual framework in practice offers an opportunity for designing a structured, organized approach to patient care delivery, with the potential for increased efficiency and effectiveness" (Weiss, Hastings, Holly & Craig, 1994, p. 80).

The conceptual framework for this project encompassed principles from Sister Calista Roy's Adaptation Model, the concept of rurality, and the process of patient education. Selected principles are described in the following paragraphs, giving special attention to the significance of each principle to postpartum families. The adaptation, education, and rurality principles provide the foundation

for development of a postpartum manual to provide information to postpartum patients on caring for themselves and their infants following discharge from the hospital.

Roy's Adaptation Model

The family is the system that most influences an individual's thoughts, beliefs, and attitudes. This relationship is reciprocal with the individual helping to shape and define the family. Any changes within the family can cause disruption of the system and adaptation is necessary for the survival of the family. Roy defined a system as "a set of parts connected to function as a whole for some purpose, and it does so by virtue of the interdependence of its parts" (Andrews & Roy, 1991, p. 7). This definition is very close to the definition of family found in Friedman (1992) that states a family is "a small open social system composed of a set of highly interdependent parts and affected by both its internal structure and external systems" (p.8). Roy's (1983) Adaptation Model was chosen as a component of the conceptual framework for developing a postpartum manual for families, because it focuses on "responses of the adaptive system in a constantly changing environment" (Fawcett, 1995, p. 445) with adaptation being "the central feature and a core concept of the model" (p. 445).

"Nursing interventions are the enhancing of stimuli [focal, contextual, and residual] to promote adaptation within the family system" (Roy, 1983, p. 275). The

integration of Roy with family is demonstrated in the following comment by Friedman (1992).

Whereas Roy suggests that nursing problems involve ineffective coping mechanisms, which cause ineffective responses, disrupting the integrity of the person, this notion could easily be broadened to the family unit, where ineffective family coping patterns lead to family functioning problems (p. 61).

Providing information to postpartum families at a time when they are best able to comprehend, enhances coping in a new situation.

Roy's Adaptation Model, as outlined by Jacqueline Fawcett (1995), is expanded in the following paragraphs by describing the model's relationship to family as client. This model follows nursing's metaparadigm as it contains the same basic components of person, environment, health, and nursing.

Person. The person in Roy's model, defined as the recipient of nursing care, can include an individual, a community, or as in this case, a postpartum family. The person is an adaptive system and has two major internal control processes, the regulator subsystem and the cognator subsystem. The regulator subsystem responds automatically through neural, chemical and endocrine pathways which produced automatic, unconscious effects on the family. The cognator subsystem responds to psychological, social, physical, and physiological factors that are then processed through four cognitive-emotive channels:

(a) perceptual/information processing, (b) learning,

(c) judgment, and (d) emotion (Fawcett, 1995).

The postpartum manual can have the most impact in the perceptual/information processing and learning channels. Regulator and cognator activity is demonstrated through coping behaviors in four adaptive, or response, modes: the physiological mode, the self-concept mode, the role function mode, and the interdependence mode (Fawcett, 1995).

Meeting the physiological needs is the primary function of families. The adaptive family provides for these needs at the most basic and most effective level. The family can not, and often does not, survive if these needs are not met.

The postpartum manual can be designed to provide information on how families can provide for the basic needs of newly delivered mothers and newborns.

The self-esteem of the family is inherent in each component of the self-concept mode. The family's level of self-esteem is a reflection of their self-concept and their related behaviors provide insight as to their adaptation in this mode (Fawcett, 1995). The postpartum manual provides factual information to the family, bringing the ideal self and reality closer together.

The role function mode is based on the need for social integrity. This mode contains both instrumental and expressive components. The instrumental component is goal-oriented and involves demonstrating role behaviors that meet societal expectations. The postpartum manual can provide insight into role behaviors associated with being a new parent. The expressive component deals with the feelings,

likes, dislikes and attitudes that the family has about the role or the performance of the role (Fawcett, 1995). The postpartum manual can provide information on feelings related to parenting and infant care. Resources can be included for parents to contact, should they need information and support.

The interdependence mode is based on the need for social integrity and the primary focus is on affectional adequacy. Families not only need affection from within their boundaries, but also from others outside the identified family unit. The postpartum manual can identify available community resources.

Environment. Roy (1983) describes environment as anything that has an effect on the development and behavior of the family. The environment is in a constant state of change and there are internal and external components. The model contains three classes of stimuli: (a) focal stimuli, the stimuli that most immediately attracts the family's attention, (b) contextual stimuli, all other stimuli that have an effect on the focal stimuli and impact how the family deals with the focal stimuli, and (c) residual stimuli, other environmental elements that may have unclear effects on the focal stimuli. The family may not be aware of these stimuli and the observer may not know that they were having an effect on the family (Fawcett, 1995). The postpartum manual can be written in a manner that focuses

primarily on focal stimuli, which is defined as the mother and infant's immediate needs.

Health. Within Roy's (1983) model, health is a dichotomy of adaptive and ineffective responses to the stimuli at hand, a state of being and a process of becoming integrated and whole. Adaptive responses promote the integrity of the family and ineffective responses do not promote the integrity of the family (Fawcett, 1995). The postpartum manual can assist the family in adjusting to their new roles in an adaptive, rather than a maladaptive manner.

Nursing. Nursing is a scientific body of knowledge that prescribes a process of assessment and interventions relating to ill or potentially ill families (Fawcett, 1995). Roy (1983) indicates that a nurse is necessary when the family is unable to cope effectively with, or adapt to, the ever changing environment, because of new or unusual stressors and/or weakened coping mechanisms. The goal of nursing is to increase adaptive responses and decrease ineffective responses by the family through promotion of adaptation in the physiological, self-concept, role function, and interdependent modes (Fawcett, 1995). The postpartum manual could address adaptive responses in the four modes.

Nursing Process. Roy's (1983) model includes a detailed nursing process consisting of six steps:

1. Assessment of behavior: Observable and non observable behaviors in each of the four adaptive modes.
2. Assessment of stimuli: Identification of internal and external stimuli influencing the behaviors of the family.
3. Nursing diagnoses: Three approaches to diagnosis with this model are: (a) the statement of behaviors within one mode with the most prominent influencing stimuli, (b) a summary label for behaviors in one mode with relevant stimuli, and (c) a label that summarizes behavioral patterns when more than one mode is being affected by the same stimuli.
4. Goal setting: Actively involving the family in identifying clear statements of the behavioral outcomes of nursing care of the family. Short term and long term behavioral outcomes are thought to promote adaptation by the family.
5. Intervention: Management of relevant focal and contextual stimuli to achieve stated goals for nursing care. Primarily, the focal stimuli are selected for management. If the focal stimuli can not be managed or changed, then management of the contextual stimuli is chosen as a way to increase the adaptation level of the family.
6. Evaluation: Effectiveness of nursing interventions are reviewed with the family, and defined by whether adaptation is occurring, through stimuli modification or by enhanced coping strategies.

The postpartum manual could be written using the nursing process to identify, and respond to, commonly identified needs of the families during the immediate postpartum period. Therefore, the discharge manual, according to Roy's (1983) model, would be a nursing intervention.

Rurality

Rurality, from the postpartum families perspective, is important to understand. Rurality impacts how parents view health and how and when they access health care services. When considering the needs of rural families, the issues of access to care and the characteristics of self-reliance and independence of rural dwellers are important (Bushy, 1991b).

Access to care is complicated by isolation as a result of distance and decreased population (Magilvy, Congdon, & Martinez, 1994), difficult terrain, inadequate or nonexistent public transportation, poor roads (Bushy, 1991a), extremes in weather, rural economy, long distances and paucity of services (Dietz, 1991). Postpartum families often find it difficult to obtain care and to have answers to their questions in a timely fashion, because of these constraints. While rural people do have a variety of health care resources available to them, (e.g., family, friends, neighbors and possibly nurses, physicians, nurse practitioners, physician's assistants, and others), they may be reluctant to use them (Doede, 1993). The physical barriers may lead to psychological barriers, perhaps

lowering health expectations (Doede, 1993). Bringing health care to them, in the form of a postpartum manual, could enhance adaptation and coping.

Self-reliance and independence, part of the theoretical dimension of person, have been demonstrated to be strong rural characteristics of rural dwellers in relation to health care. Rural persons have been found to manage on their own or turn to family and friends for assistance rather than formal agencies (Weinert and Long, 1991,p.29).

Bushy (1991b) concurs, stating that rural clients are more self-reliant and perform more services for themselves, rather than relying on health care providers. These characteristics support the need for postpartum families to be able to obtain health care information after they are discharged from the hospital. The postpartum manual needs to provide information in a manner congruent with their lifestyle and beliefs. Parents would not have to travel, make long distance calls for information, or seek information from others, if they had access to instructional materials in their homes.

Process of Patient Education

Redman (1993) describes a process model of patient education that closely follows the nursing process. The steps include assessment of patient needs and the readiness to learn, identification of learning needs and goals, and evaluation of the learning. Each of these steps are applied to postpartum families in the following section.

Assessment. Motivation is required for learning to occur (Redman, 1993). Motivation of postpartum patients may be their ability to care for themselves and their new infant. Readiness is described as "evidence of motivation at a particular time" (p. 16). Thus, parents asking questions regarding their infant or themselves demonstrate motivation to learn. Newly delivered mothers are in a "taking-in" mode (requiring assistance with care for themselves and their infants), and may not be as motivated to learn as mothers in the "taking-hold" phase.

Learning needs. The common learning needs of the postpartum patient are identified as specific skills necessary to care for themselves and their infants. From the review of the literature, it is known that postpartum patients are concerned with topics such as pain, engorgement, backache, cramping, diet, constipation, breast and bottle feeding, safety, and infant care (Williams & Cooper, 1993).

Goals. Redman (1993) describes individual and family development as one of the major goals of patient education. Within this domain, the focus of patient education is identified as "supporting and enhancing normal development" (p. 47). As noted in the nursing process, individual goals are developed in collaboration with the patient and can be stated as behavioral objectives. These objectives then determine what interventions are necessary in order to teach the postpartum patient to care for themselves and their

infants. The goals of postpartum patients, as identified in the literature, can be used when designing the postpartum discharge manual.

Teaching. Teaching encompasses interventions that promote learning for the postpartum family. Providing instruction involves trying to produce a change in behavior, "including change in thoughts, in feeling, and in the meaning of experience that will eventually yield observable behavior change" (Redman, 1993, p. 118).

Written materials. Written materials are the most common method for providing patient education. Advantages include their low cost to produce and duplicate , ease of distribution, ease of use and portability (Smith & Ragan, 1993). Written information has both strengths and weaknesses. Strengths are constant availability and efficiency. Weaknesses are that written materials are selective and discourage feedback (Redman, 1993). In order for written materials to be effective, it is important that reading comprehension and learning objectives be considered. The postpartum manual can be developed using consumer language to meet the previously identified learning needs of the postpartum family.

Format. When designing the postpartum discharge manual, many decisions need to be made regarding the format of the manual. Smith and Ragan (1993) recommend a systematic method in which written materials are developed using a "process

approach" (p. 362). The process consists of generating, critically evaluating, and revising the text.

The first step is to determine the "text structure" (Smith & Ragan, 1993, p. 362). Text structures are selected based on the type of learning outcome. When the goal of learning is concept oriented, the type of "text structure" used is description, whereas when the learning outcome is problem solving, the "text structure" is problem-solution (Smith & Ragan, 1993).

Guidelines for written materials recommended by Smith and Ragan (1993), include: keep the sentences short, simple, and concrete; make pronoun references direct and clear; and use the pronoun 'you' to direct the information to the learners. In addition use headings to break the text into sections, use transition words as appropriate (e.g., then, now, next, first, second, finally); and avoid gender bias (Smith & Ragan, 1993).

To ensure that the information presented in the manual is at approximately the sixth grade level, the SMOG formula can be used (Redman, 1993). To apply this formula, 30 sentences are identified from the written material, and the number of words containing three or more syllables are counted. A mathematical formula is then applied and the grade-level difficulty of the written material calculated.

Smith and Ragan's (1993) "text specifications" (p. 365) are important when designing written materials. They include consideration of font selection (style of type), leading (space between lines), and page breaks. "For instructional

texts, one should select a conservative and fairly common font, with an emphasis on clarity and legibility" (Smith & Ragan, 1993, p. 365). When determining the line spacing, recommendations from Montana State University College of Graduate Studies (1995) and the American Psychological Association (1994) were used. When establishing the "page breaks" for the sake of clarity, it is important not to separate a text unit into two separate pages (Smith & Ragan, 1993).

Evaluation. During the design process, evaluation of the instructional material is critical to identify weaknesses and the need for revisions. Smith & Ragan (1993) identified four evaluation phases. The first is the review by the author. During this phase, the author evaluates the information as it is written. The next phase consists of review by the experts. This phase involves examining the manual for accuracy, appropriateness, and completeness, by content and instructional design experts. The third phase consists of review by the learners. The best method of determining whether the instruction is effective is trying out the instructional materials with two or three members of the target audience. "Materials that have been tried out with only one or two representative students and then revised based upon the information gained are substantially more effective than the original instruction" (Smith & Ragan, 1993, p. 388). The purpose of having learner reviewers is to identify and revise gross problems with the

instructional materials (Smith & Ragan, 1993). The final phase involves ongoing evaluation of the written materials once they became available to the target population. This final phase is beyond the scope of this study.

Summary

The literature review indicates that early postpartum discharge (defined as within 24 to 48 hours of delivery) is occurring with increasing frequency in the United States. However, due to the recovery phase of the mother at the time of discharge, a need exists for additional instruction material for use in the home setting. Written materials can be provided either antepartally or postpartally.

Roy's Theory of Adaptation (1983), the concept of rurality, and the process of patient education were presented in the conceptual framework. Four important factors need consideration in the development of a postpartum manual:

- (a) postpartum families need timely assistance in adapting to new roles, (b) postpartum families need access to information to assist them in adapting to new roles,
- (c) rural postpartum families need support for self-reliance and independence in health seeking behaviors, and
- (d) written materials need to be appropriate to the learner in both content and format.

CHAPTER 3

METHODOLOGY

Design of the postpartum manual included a general review of the literature, contact with community hospitals, follow up telephone calls to staff, development of the manual, and evaluation of initial and final drafts by staff and postpartum families.

Step 1: Review of Literature

First, a literature search was conducted. This was completed by using the Montana State University computer system to log into the library and search in Cumulative Index of Nursing and Allied Health Literature and Carl/Uncover for the following terms: postpartum, infant/newborn care, patient education, home care services, length of stay, and Reva Rubin. Additionally, the community hospital medical librarian was contacted. Medline and/or other data base searches were requested for the same terms and conducted by the librarian.

Articles appropriate for the project were located, requested, and thoroughly reviewed for content. The reference list from each article was reviewed for resources, and additional articles requested, and reviewed for inclusion.

Step 2: Contact Five Community Hospitals

Five hospitals located in communities in Montana with populations of 12,000 or more were contacted by letter (See Appendix B) and asked to provide a copy of postpartum teaching manuals, or other information they sent home with patients. Hospitals that provided copies of their discharge information were offered a completed copy of the manual being designed.

Step 3: Follow-Up Telephone Calls

After reviewing the literature, and the postpartum information from other institutions, telephone calls were made to a staff member from each of the institutions returning information. Staff were asked two questions: What do you like about your hospital's discharge information? and What don't you like about your hospital's discharge information? The answers were incorporated into the design of the postpartum manual.

Step 4: Design of the Postpartum Discharge Manual

Information obtained using steps one through three was used to design the postpartum discharge manual. The literature review determined the outline for content. Educational materials from the community hospitals were used to identify format.

Step 5: Review and Approval of Manual

Once an initial draft of the manual was completed it was taken to a community hospital. Two staff members were invited to review the manual for content and format. In addition, two postpartum inpatients were asked to review the manual and provide feedback to the author. Based on their suggestions, as well as other maternal-infant experts, the final draft of the manual was completed.

The finished manual was submitted to a department head of obstetrics and approval was requested to have it printed in the graphics department and to make the manual available for distribution to postpartum patients. The manual will be used for patient teaching during their stay, and be available as a reference after they have been discharged from the hospital.

CHAPTER 4

PROJECT OUTCOME

ResultsStep 1: Review of Literature

Since the 1960s, the postpartum stay, following an uncomplicated vaginal delivery, has been decreasing at a steady rate to its current length of 24 to 48 hours. Reva Rubin's concepts on the "taking-in" and "taking-hold" phase remain true today, however, the time frame in which the phases occur have decreased. This information indicates a need for alternative methods of providing postpartum education to families discharged within 24 to 48 hours of delivery.

Next, the literature was reviewed to determine the educational needs of families. Families are concerned with day to day care of themselves and their infants. Maternal concerns were identified, including such items as breast care and what to do for discomfort. Identified infant concerns included bathing, safety issues, and how to know when the baby is ill (Lemmer, 1987; Hiser, 1991; Williams & Cooper, 1993).

A review of the literature on written materials was conducted to examine formatting recommendations. The

formatting suggestions include using the appropriate "text structure" for the identified learning needs; keeping sentences short and simple; using the pronoun 'you' to direct the information to the reader; avoiding gender bias; using transition words; and using expert and learner reviewers to evaluate the written materials (Smith & Ragan, 1993).

Step 2: Contact Five Community Hospitals

Letters were sent to five community hospitals in Montana requesting copies of postpartum discharge materials. Three hospitals responded and sent information.

Step 3: Follow-Up Telephone Calls

Phone calls were made to the three hospitals that provided information. A registered nurse at each of the institutions was asked what she liked/disliked about the manual used by that institution. One of the nurses indicated that while the manual was easy to understand, it contained only information on care of the mother, not the infant. That facility is currently working on a separate booklet for infant care. Another nurse at the second institution felt their manual was thorough and provided easy to understand information, but felt that illustrations would enhance the understanding, especially for those with low literacy levels. The nurse from the third institution, stated their manual was very comprehensive and well indexed. She could not think of anything she did not like about it.

Step 4: Design of the Postpartum Discharge Manual

The "You and Your Baby" postpartum discharge manual was constructed using information obtained from the review of the literature, from written information received from the three responding community hospitals, and from information received from the staff in follow-up telephone calls. (See Appendix B - The Manual). Revisions were made based on feedback in four categories: maternal care, infant care, community resources, and references. This feedback was obtained from masters prepared maternal-infant nurses, staff nurses and postpartum inpatients at the community hospital in south central Montana.

The staff nurses at the community hospital provided editorial comments, and clarified some of the information. Due to conflicting information in the literature, the author and the masters prepared maternal-infant nurses selected information that was congruent with the current instruction at the hospital. Examples of conflicting information included length of breastfeeding sessions and care of plastibell circumcisions.

The first postpartum inpatient to review the manual for content and clarity was a second time mother. She validated the information in the manual as congruent with her first postpartum experience. The mother indicated she had been told different things by different staff members and had become confused. The mother felt the draft of the postpartum discharge manual provided valuable information that she would have liked to have had available to her after

discharge following her first delivery. She did not feel the manual was as imperative with the second child, but did agree it would be a good review.

The second postpartum inpatient to review the manual was a new mother with her first baby. The mother reviewed the information and commented positively about the readability and format of the manual. The mother felt the text was easy to understand and was in an easy to use format. The mother especially appreciated the table of contents so she could look up the specific information she needed it. When asked about the content, she indicated it was all new to her and she appreciated any amount of instruction and information.

Step 5: Review and Approval of Manual

The last step involved submitting the manual to a supervisor of an obstetrics department. The supervisor is also the lactation specialist for the institution and provided additional feedback on the breastfeeding portion of the manual. Her comments were incorporated during further revision. Once approved, the manual will go to the graphics department of the hospital for printing. A copy will then be made available to the patients as part of their postpartum teaching. They can take the postpartum discharge manual home to be used as a resource during their first few weeks postpartum. In addition, a copy will be provided to each of the institutions that provided their postpartum discharge information to this author.

Implications and Recommendations for Further Study

Written information in the form of a postpartum discharge teaching manual is just one of an array of educational strategies that can be implemented to facilitate early postpartum discharge. Postpartum parents should have additional follow-up during the first few days after discharge. There are many ways of providing this service. They could receive follow up phone calls or visits from nurses. Parents could schedule visits with their health care providers within the first few days of discharge, rather than during the two to six week time span as is common today. Educational classes, both antenatally and postpartally, should be made available for these patients. Patients planning to go home soon after delivery may be ready for the information prenatally, as they will realize the postpartum stay may not be long enough to learn everything (Lemmer, 1986).

Another advantage of the postpartum discharge manual is it provides a framework. All health care providers, who come in contact with postpartum women, can use the manual to provide consistent information regarding the care of mothers and newborns during the postpartum period.

Nurses need to become involved with legislation which promotes the family. Currently, there is legislation pending in several states to require insurance companies to pay for a two day postpartum stay. Perhaps it would be more beneficial for nurses to encourage legislation that will pay

for some type of after hospital care, whether it be home visits, telephone calls, or some type of postpartum clinic service, where women can be seen within two or three days of discharge. Lemmer (1986) indicates that follow up contact needs to occur on the second day after discharge "as this is the time when maternal physical discomforts are greatest and when first responsibility for total care of the infant rests with the parents (p. 235). If women remain in the hospital until this period they may not experience full responsibility for infant care, as the hospital staff will continue to fulfill this role.

Recommendations for further study are to assess the needs of the clients in this rural community to see if the postpartum discharge manual actually meets their needs. It would be beneficial to research the impact of a discharge manual verses early postpartum visits (home or clinic based), postpartum telephone calls, or other combination of strategies.

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APPENDICES

APPENDIX A
LETTER OF REQUEST

Donna M. Bristow
c/o Montana State University
College of Nursing
Bozeman, MT 59717

July 25, 1995

Nurse Manager, RN
Obstetrics Department
Community Hospital
Address
City, State, Zip Code

Dear RN:

I am a graduate student in Montana State University's Family Nurse Practitioner program and am currently beginning work on my professional project. The purpose of my project is to research and construct a booklet to be given to patients at the community hospital at which I am currently employed. With the recent development of short stay maternity programs, I am concerned that the families are not ready to take in all of the information that the staff has to give them prior to discharge. I am planning to write a booklet that will be organized and indexed so that the patients can easily find the information they need once they are at home. It will focus on the care of newly delivered women and infants in the first two weeks post partum. At this time, I am interested in gathering samples of information that facilities in Montana are currently sending home with their patients and would be interested in finding out if your organization has any type of booklet you send home at discharge. If possible I would like to obtain a copy of it. In this day of short stays, it seems to be most important that patients have some way to access information when they need it, not just when we are able to provide it for them.

In return for your assistance, I will be happy to supply you with a copy of my finished product in the spring. I can be reached at 406-449-7628 (home). Bobbi Derwinski-robinson, MSN, RNC, chair of my professional project committee can be reached at 406-657-2912 after August 15th. Thank you for your assistance with this matter and I look forward to hearing from you in the near future.

Sincerely,

Donna M. Bristow, BSN, RNC
FNP Graduate Student

APPENDIX B
THE MANUAL

YOU AND YOUR BABY

by

Donna M. Bristow, BSN, RNC

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Congratulations on the birth of your child! With this new addition to your family, you may find yourselves with many questions and concerns about yourself and your infant. This manual is not designed to replace your regular health care provider, but rather is to be a resource for you during the first two weeks after your delivery.

YOUR CARE

Uterine Cramping

At first your uterus can be felt as a hard round ball with the top near your navel. It will get smaller over the next few weeks until you are no longer able to feel it. There may be some cramping as the uterus gets smaller in size. This means that it is returning to its normal size and is nothing to be alarmed about. If the discomfort from the cramping prevents you from doing the things you need to do, you may want to take something for the pain, such as Tylenol or Ibuprofen, to help ease your discomfort. The cramping may increase when you are breast feeding. If you discover that the cramping is uncomfortable while breastfeeding, you may find it helpful to take medication prior to nursing your baby. The cramping should gradually decrease over the first two or three days. If your cramping worsens you should contact your health care provider, as this may be a sign of infection.

Vaginal Discharge

You will notice a vaginal discharge, similar to a menstrual period, for the first two to six weeks after delivery. It will be a bright red at first, possibly containing some small (grape size) clots, and then should decrease in amount and turn to a pink and finally a white color. If you notice that the bright red discharge is increasing in amount, becoming bright red again after it has been the pink or white color, or you are passing larger (plum size) clots, these are signs you may be doing too much. You should immediately sit down, put your feet up and massage the top of your uterus. If this does not slow the discharge you should call your health care provider immediately.

Peri Care/Episiotomy

You are encouraged to continue to use your peri-bottle, filled with warm water, each time you void (urinate), until your flow has stopped. This will cleanse the irritated tissue around your vagina and help prevent infection, if you had a tear or episiotomy. You should also wipe from front to back after voiding and apply your peri-pad in a front-to-back motion to prevent infections. You can make your own sitz bath, by filling a clean tub with four to six inches of warm water, and sitting in it for 20 minutes. You may do this several times a day for comfort. If necessary, you may

take Tylenol or some other pain reliever prescribed by your health care provider for the discomfort.

Breast and Nipple Care

Breast Feeding

It is important that you wear a good supportive bra while you are breastfeeding. This will support the weight of the breasts as they fill with milk. Your bra does not have to be worn at night unless you feel the need.

Though you may find your nipples are slightly tender during the first 30 seconds of nursing, sore breasts and nipples are not a normal finding early in the postpartum period. If your baby is correctly latched onto your breast, nursing should not be painful. The entire nipple and most of the areola (the dark area surrounding your nipple) should be in the baby's mouth. It is important to break the suction by placing your fingertip in the corner of the baby's mouth before taking the baby off the breast. If your nipples do become sore, you can leave some breast milk on your nipples and expose them to air after the feeding to let them dry. You may also apply some purified lanolin to your nipples, if they become too dry and start cracking or bleeding. Some women find that using regular (not herbal) tea bags will help sore nipples. They steep them in warm water and apply them to the sore nipples until the tea bags have cooled. It is felt this will toughen the nipples, and the warmth is soothing and promotes healing. Another comfort measure is to

dry your nipples with your blow dryer, placing it on low heat and only using it for a couple of minutes.

Your breasts may become engorged as you begin to produce more milk on the second or third day after delivery. One way to alleviate the discomfort, associated with engorgement, is to put the baby to breast frequently to promote emptying the breasts. If this does not help, you may want to express some of the milk until you feel more comfortable, apply warm compresses to your breasts before nursing, or take a warm shower to decrease the discomfort.

Formula Feeding

You should also wear a good supportive bra, day and night. This will be more comfortable for you. You may experience engorgement as you begin to produce breast milk on the second or third day after delivery. If you are not planning to breast feed, it will be important to avoid stimulating your breasts by your baby, yourself, or your partner. Stimulation and warmth, as from a shower, will increase milk production. One way to ease the discomfort is to place ice packs on your breasts for ten minutes, three or four times per day. This will decrease the swelling associated with the increase in milk. Another option is to take Tylenol or Ibuprofen for the discomfort.

Diet and Activity

A well balanced diet should be followed whether you are formula feeding or breast feeding. A well balanced diet consists of at least two servings of meat or meat alternatives, two servings of dairy products, six servings of breads and cereals, and five servings of fruits or vegetables. If you are breast feeding you should continue your prenatal vitamins and always drink at least eight glasses of non-caffeinated beverages per day.

You should avoid excessive activity in the first couple of weeks. This includes stair climbing, lifting heavy objects, heavy housework, and vigorous exercise. You may want to do some stretching type exercise, or take long walks, but you should wait until after your first visit with your health care provider before starting more vigorous exercise programs. If at any time you notice that your flow or afterpains are increasing with activity, you should stop the activity until these symptoms disappear.

Elimination

You may notice increased voiding during the first 12 to 24 hours after delivery. This is because your body is eliminating the extra fluid from the pregnancy.

Many women are afraid that the first bowel movement after delivery will be painful. You should eat high fiber foods (whole grains, fruits and vegetables) and drink at least eight glasses of fluids per day to keep your stool

soft and decrease the discomfort associated with bowel movements. If you should become constipated, you should use natural type laxatives, such as prunes, prune juice or Metamucil, and support the area with tissue when attempting to have a bowel movement. Many medications used for constipation can be passed to your baby through breast milk. If you have worsening constipation despite the extra fluids and fiber, you should consult your health care provider.

Resumption of Intercourse/Contraception

Most health care providers advise waiting for three to four weeks after delivery before resuming intercourse as it can take up to six weeks for the inside of the uterus to heal, and this will help prevent infection. You should consider using some type of birth control method unless you are planning to become pregnant right away. If you feel comfortable and choose to have intercourse before the recommended waiting period, your partner should use a condom. Some new mothers report a lower sex drive after delivery and while breast feeding because of hormonal changes, fatigue, and vaginal discomfort. Because some women have vaginal dryness while breastfeeding, you may wish to use some type of water soluble lubricant, such as KY Jelly or Astroglide, during the first few months. Be patient and remember you will not feel this way forever. If intercourse remains uncomfortable after six months, you should contact your health care provider.

Sleep/Rest

It is important to get enough rest. You should take the time for at least two naps per day. Lay down when the baby does. Another suggestion is to remain in your gown and robe the first week home as a reminder to yourself to take it easy. This will also discourage visitors from staying too long and overtiring you.

Feelings

During the first few days after delivery, most new mothers are thrilled and excited about their new baby. However, some mothers respond to the hormonal changes, fatigue and the new responsibilities with mood swings. At one moment they may be very excited and the next they may be crying. This is termed the "baby blues" and is considered normal. These "baby blues" usually occur between the second day and fourth week after delivery. If these feelings last beyond this time or are accompanied by anxiety, inability to sleep, lack of appetite, feelings of hopelessness, or inability to care for yourself or your baby, you should contact your health care provider for assistance. These can be signs of postpartum depression.

Some fathers will often have many of the same feelings as the mother. They may feel increased responsibility for their family and possibly some anxiety about finances, especially if the mother was also bringing in a salary prior to delivery. They may also feel left out of the

relationship between the infant and the mother. Since many fathers have taken an active role in providing care for their babies, they report fewer feelings of being left out of the relationship. They are getting involved in the day to day care of their babies, and the babies are coming to depend on both parents for comfort. Fathers are often more playful and physically active with their infants, which the babies seem to enjoy.

Warning Signs

You should call your health care provider if you have any of the following symptoms:

- temperature over 100.4 degrees F.
- foul smelling vaginal discharge
- bleeding heavier than a normal period
- bright red bleeding or passing large clots (larger than a plum), after the first two to three days
- breast pain or redness
- leg pain or swelling (especially if in one leg and not the other)
- pain or burning when voiding
- redness, warmth or drainage around your vagina

BABY CARE

FeedingBreast

Breast milk is the most natural food for babies. It contains all the necessary nutrients for baby's early feedings and is easily digested. Breast milk is produced based on the law of supply and demand. This means that you will produce as much milk as your baby requires, based on the feeding patterns. For example, if your baby eats frequently, you will produce more milk. Feeding your baby a bottle of formula or water will disrupt this cycle and may cause you to have a decreased milk supply. Breast fed babies eat more often than formula fed babies, as the breast milk moves through the babies system more rapidly than formula. The early milk you produce after delivery is called colostrum. It is thicker and darker in color and contains many protective proteins to help your baby fight off infections.

It is important that you be relaxed, both physically and emotionally, when you nurse your baby, as these conditions may affect your milk let down and production. Proper positioning is important. One common position is sitting up with several pillows to support your back and arms. Babies should be on their side with the entire body facing toward you and held at the level of your breast so you do not have to lean toward them. Alternate positions

include lying down to nurse, and the football hold, where you tuck the baby's legs under your arm and cradle the head in your hand, using pillows to keep the baby at the level of your breast.

You should be sure that the baby is latched onto a good share of the areola (the dark area around the nipple) to help prevent soreness and promote adequate suckling. You should nurse at least 10 to 15 minutes per side as it often takes this long for your milk to let down. You should alternate which breast you start each feeding on, and encourage the baby to nurse on both breasts with each feeding. Many women use a safety pin on their bra strap to remind them on which side the baby should start feeding. If your baby does not release the nipple after feeding it is helpful to insert your little finger into the side of the baby's mouth to break the suction prior to removing the baby from your breast. Changing positions and breaking the suction will help decrease sore nipples. You should try burping your baby when switching breasts and after a feeding.

Many mothers are concerned as to whether their baby is getting enough to eat at the breast. Do not be concerned by the seemingly small amount of colostrum available during the first day or two. Your baby was born with fat and fluid stores to last until you are producing more milk. It is known that the more frequently the baby nurses, the sooner your milk will come in. Once your milk is in, you can count wet diapers. If your baby is having at least six to eight

wet diapers per day, you can be assured there is enough breast milk.

If you plan to spend some time away from your baby, you can pump breast milk either manually or by using an electric breast pump. Several different types of breast pumps are available, and each will come with instructions for its use. You can store your breast milk in the refrigerator for two to three days, or freeze it. It can be stored in a refrigerator-freezer for up to two weeks or in a deep freeze for up to two years. Be sure to label the milk with the date so you can use the milk in the order that you pumped it. Once thawed, breast milk should not be refrozen. You should not thaw frozen breast milk in a microwave because it will break down the proteins in the milk. You should thaw the milk quickly by running warm water over the container, rather than letting it sit at room temperature.

Formula

Formula is the food of choice if choosing not to breast feed. It is best not to feed your baby regular milk for the first year of life, as it is not as completely digested as formula. The formulas have been developed to be easily digested by infants. There are essentially two types of formula, milk-based and soy-based. Milk based is generally used unless there is a family history of milk allergy. If your baby seems fussy, or spits up frequently on one type of formula, you should contact your baby's health care provider and discuss the possibility of changing to another formula

to see if the symptoms are alleviated. Once you have found a formula that is agreeable with your baby, it is best to stick to one brand.

The baby should be held for each feeding in a position similar to a breast fed baby. Bottles should never be propped as your baby may choke during the feeding. Your baby will take the formula best, if it is at room temperature or just slightly warmed, but never hot. Once your baby has been fed from a bottle, the leftover formula should be discarded, within the next hour, to prevent germs from growing in the formula.

Formula fed babies need to be burped. If your baby slows down when sucking, it is a good time to remove the bottle, and sit the baby up to burp. This will help get excess air out of the stomach, which will make the baby less likely to spit up.

Bathing

Babies do not require a daily bath. Giving a sponge bath with a mild soap and paying special attention to the diaper area and creases should be enough . However, at some time after the cord falls off and the circumcision is healed, you may want to begin giving your baby a tub bath.

Tub Bath

For a tub bath you will need the following supplies: washcloth, mild soap, baby shampoo, towels and clothing, diaper, baby tub or basin, and a soft brush for hair. It is

best to bathe the baby in a warm, non drafty area. One procedure for a tub bath is as follows: The first or last step is to wash the baby's hair and dry it while your baby is still in a diaper and covered with a light towel or blanket to prevent your baby from getting cold. Next, wash the face with plain warm water using a separate clean corner of the washcloth for each eye, wiping from inside to out. Then dry the face. Next remove the diaper and light towel or blanket and place the baby in the tub in two to three inches of warm water, keeping the head supported above the water by cradling it in your hand, or holding the baby under the arms. You can now use soap on the wash cloth and wash the rest of the baby. Finish by rinsing the baby in the tub water, and wiping with a dry towel. Finally, diaper and dress the baby.

Umbilical Cord Care

The umbilical cord will dry up and fall off over the next week to 10 days. To assist in helping it to dry, you should clean it, each time you change the diaper, with an alcohol soaked cotton tip applicator. You should apply the alcohol to the site where the skin and the cord meet. Once the cord falls off you should continue applying the alcohol to the site for the next two days. You can keep this area exposed to air by fastening the diaper below the cord. This will hasten the drying of the cord. If this area becomes

reddened, or has a foul smell, you should contact the baby's health care provider.

Cradle Cap

Cradle cap is a crusting noted on the baby's scalp. While it will not hurt the baby in any way, it is rather unattractive. To remove this crust you can apply some type of oil (baby oil, Keri oil) to the baby's scalp and leave it in place for 20 minutes. You can then remove the oil and the crust by shampooing the baby's hair. You may need to use a soft bristle brush to assist in gently removing the crust.

Diapering

The baby's diaper should be changed any time the baby has voided or stoolled. After each void or stool you should clean the diaper area with a washcloth wet with water, prior to placing a new diaper on your baby. It is best to check your baby's diaper at least every couple of hours, whenever your baby is fussy, and before or after each feeding.

Voiding and Stooling

If you are breastfeeding, you may notice your baby only voids once or twice in the first 24 hours. Once your milk is in you should notice six to eight wet diapers per day. This will let you know the baby is getting enough fluids. Stools are more frequent in breast fed babies, often stooling occurs with each feeding. As your baby gets a little older, you may notice stools as rare as every three days. There is

a wide variation among babies. Formula fed babies should also have six to eight wet diapers per day, but may have fewer, more firm stools than breast fed infants. They are initially a black/green tarry substance called meconium and will gradually change over the next couple of days to a brown (if bottle feeding) or yellow (if breast feeding) color. If you notice blood in the stools or it is a bright green color, you should contact your baby's health care provider.

Circumcision

Gomco

If your baby's health care provider performed a gomco type circumcision, you will notice a dressing of gauze with vaseline placed over the head of the penis. This dressing should be changed with each diaper change for 48 hours. For comfort, you should place the diaper loosely over the circumcision during this period. You may notice a thin layer of yellow covering the head of the penis as it starts to heal. This is normal and will disappear as it heals completely. If the baby gets stool on the circumcision, you can cleanse this area by lathering a washcloth with a mild soap and wringing it out over the penis. You then should rinse it in the same manner. If you notice the gauze is stuck to the penis, you can soak it off as above.

Plastibell

If you notice a plastic ring on your baby's penis, then

your baby's health care provider has performed a plastibell circumcision. This plastic ring should be left in place. It will fall off as the edge of the circumcision heals, usually in about seven to ten days. You do not need to care for this type of circumcision in any special manner, except keeping the penis free of urine or stool.

Dressing

Generally, your baby will need to dress in as many layers as you do. If the weather is very warm, a diaper may be enough. If the weather is cool, you may need to add an extra blanket or layer of clothing, as babies may not move as much as adults and may not keep themselves as warm.

Safety

While it may seem that there are few things that can occur with a newborn during the first few weeks after delivery, there are actually several safety measures you can take to prevent accidents. Newborns can be quite active and it is important not to leave them unattended on a changing table or a couch as they may roll or fall off. Crib slats should be no more than 2 3/8 inches apart and protected with a bumper pad to prevent the baby from getting caught between the slats. Always leave the rails in the up position, whenever leaving the baby unattended in the crib. The American Academy of Pediatrics recommends that healthy babies be placed on their back or side to sleep in an effort

to reduce the risk of Sudden Infant Death Syndrome (SIDS). The side lying position is preferred during the first 30 minutes after eating, in case the baby should spit up.

Bulb Syringe

Because your baby may have increased mucous the first few days of life, it is important that you are able to clear this mucous out so your baby can breathe easily. Compress the bulb syringe and place the tip into the side of the baby's mouth. Then slowly release the bulb syringe and remove it from the baby's mouth. Repeat this process to clear the baby's nose by placing the tip of the bulb syringe into your baby's nose. This will draw up the excess mucous. You should avoid the roof of the baby's mouth and the back of the throat or you may cause the baby to gag. The bulb syringe should be washed after each use with warm soapy water.

Car Seats

State law requires that all infants under 20 pounds be placed in a rear facing car seat. They should be buckled into the carseat, and the carseat belted into your car. If you have front seat airbags, your carseat should be buckled into the back seat in the rear facing position. If the weather is cool it is preferred that extra blankets be placed over the infant once buckled into the car seat, rather than under the belts, as this may prevent the belts from being securely tightened. The baby's head should be supported by the car seat and it is best for newborns to be

in a reclining, rear-facing position to prevent injury in case of a car accident. Your baby should remain in a federally approved infant car set until reaching 40 pounds according to state law. This hospital rents infant and toddler car seats for a nominal fee.

Temperature Taking

There are several ways to check an infants temperature. One way to assess the temperature is under the arm. To do this, shake down the mercury in a glass thermometer and place the silver bulb into the baby's armpit and hold the arm securely to the chest. Hold the thermometer in place for five minutes. There are digital thermometers available for both axillary and ear temperatures. They are more costly than a glass thermometer, but work more rapidly. The ear thermometer works by scanning the temperature of the ear drum. Follow manufacturers instructions for their use. They will give you the baby's temperature within seconds. A normal temperature for a baby is 98.0 to 99.5 degrees F.

Jaundice

Jaundice is a term used to describe a yellow coloring of a baby's skin. This is normally caused by the immature liver of the baby. It often occurs after the second day of life and resolves after a week, often without treatment. You can help to speed the process by placing your baby near a sunny window, but out of direct sunlight, to protect against

sunburn. Providing frequent feedings will also improve the condition. If the jaundice lasts longer than a week, if the baby is too sleepy to eat, or if you notice the yellow color below the waist, you should notify your health care provider right away. If the jaundice becomes a problem, as identified with a simple lab test, it can be treated with specially designed lights. If the blood level is too high use of the lights may need to be done in the hospital. If the baby's health care provider feels it is at a safe level, the light treatment can be set up in your home.

Immunizations

Baby's are currently being immunized with the Hepatitis B vaccine while still in the hospital. It is a series of three shots that will prevent Hepatitis B infection in most people who are immunized. There are usually no side effects with the initial vaccine. The other two shots are given by your health care provider with the other childhood immunizations at two and six months of age. Your baby will not need any other immunizations until two months of age.

Feelings

Infants have unique personalities and behaviors from birth. You will come to know your baby best. Babies cannot talk to you or tell you their wants and needs. They communicate in other ways, such as crying when needing something, or snuggling into your arms when content or

comforted. If your baby is crying, it is often for one of the following reasons; wet diapers, gas, hunger, being uncomfortable, being overtired, or just bored and needing your attention.

Babies may have a consistent fussy time of the day where they just need to cry. It is often in the afternoon or evening and at the same time each day. There are many ways to deal with a fussy baby. Sometimes all you have to do is hold the baby close. Other suggestions are to take the baby for a drive in the car, take the baby into the tub with you, or rocking the baby in a rocking chair, or even putting the baby into a carrier and place it on top of the dryer. It is also helpful to enlist the help of others, such as a spouse or friend, who can assist you in trying to calm the infant. You can take turns with the fussy baby to decrease your stress. If your baby continues to cry despite all of your efforts to calm the baby, you can place the baby in a safe place, such as a crib, and walk away. This is a good way to calm yourself down, as the baby can sense your stress. After five or ten minutes you should check on your baby, and if the crying continues you can try the calming efforts again.

Siblings

If this is not your first baby you may be wondering how your older child will react. Siblings react in many ways, depending on their age. Younger children often begin to take on the baby's role, reverting to wetting their pants or

taking the baby's bottle or toys. Older children may throw temper tantrums or display anger toward the new baby. You can help your older child adjust to the new baby by allowing your child to help with the baby's care and activities. It will also help if you or your partner can spend some time alone with the older child and do some of the things they prefer, rather than focusing entirely on the baby.

Warning Signs

If any of the following occur you should call your baby's health care provider immediately:

- fever of 100.5 degrees F or higher
- sleepier than usual
- decreased wet diapers (four or less in 24 hours)
- nonstop or high pitched crying
- prolonged or forceful vomiting
- too tired to eat, poor appetite
- diarrhea or constipation
- yellow skin below the waist
- any other concerns you may have

COMMUNITY RESOURCES

La Leche League

An international organization with trained volunteers in most areas who answer questions and provide practical information and instruction to breastfeeding mothers. Headquarters are located in Franklin Park, Illinois and the number to call is 1-708-455-7730 between 9 AM and 3 PM central time. They will be able to locate a local La Leche League leader in your community.

Ask a Nurse

A nurse is on duty in St. Peter's Community Hospital emergency room, from 7 AM to 11PM daily, to answer health care related questions. The number to call is 447-2666 or 1-800-557-2666.

WIC

The Women, Infants & Children's program is located at the County Health Department. They offer nutritional counseling and food programs for pregnant and nursing women, infants and children who qualify for their program. Their number is 449-2935.

St. Peter's Community Hospital Obstetrics Dept.

Nurses are on duty 24 hours every day to answer questions about you and your baby. The number to call is 444-2208 or 444-2210.

Cooperative Health Center

The CHC is located in the County Health Department. They offer primary health care for all ages on a sliding fee scale. Their number is 443-2584.

Mother's Health Care Provider

Name & Number: _____

Infant's Health Care Provider

Name & Number: _____

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