**Postoperative care after caesarean section:**

**ا م د بان هادي , م د الاء ابراهيم 2018**

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**AIMS**

To be able to manage a case immediately after caesarean section.

To educate the women on strategies to prevent post-operative complications.

To diagnose early the post-operative complications and provide appropriate management should they occur.

**ROOM PREPARATION**

Check oxygen and suction.

Postoperative care (for low risk women with no medical problems):

Admission to the intensive care unit immediately after cs for close observation of:

1. **Recovery from anesthesia** (in general anesthesia cases)

 Check the consciousness level, pallor, breathing, cyanosis, dyspnea, any vaginal bleeding, patient position and an assistant for the woman in case of mobilization or baby feeding.

In cases of spinal anesthesia the patient is conscious and breaths normally, however it may take hours for the sensation to return so foley's catheter is kept to prevent urinary retention until return of normal sensation.

***2. Observations – vital signs:***

1.Observations to be checked include:

Respiratory rate, oxygen saturations, pulse and blood pressure, temperature and level of consciousness

Wound dressing ( if soaked with blood)

Tube drain (amount and whether bloody or serous).

Vaginal loss (postpartum hemorrhage)

Urinary output (oliguria in dehydration and shock)

Intravenous therapy (dextrose fluid , antibiotics, analgesia and thromboprophylaxis)

Pain score

Epidural site (if in situ) and dermatomes

2. Frequency of routine post-caesarean observations:

½ hourly for 2 hours

1 hourly for 2 hours

2 hourly for 2 hours

4 hourly for 24 hours

Three times daily unless maternal condition indicates more frequent

observations such as patients with preeclampsia and diabetes .

Four hourly observations must continue for the initial 24 hours following transfer to the postnatal ward.

***3.Maternal comfort and assistance***

1 Assist the woman to position herself comfortably and assist breastfeeding as required as soon as she can breast feed her baby.

2 Assist her to change her clothes.

***4 .Nutrition and Fluids***

1. **Fluids:**

Initially IV dextrose is given ( in winter 2 L while in hot weather 3 L )

Encourage oral fluids as required unless contraindicated by medical

Condition after bowel sounds became positive. Maternal hydration is a strategy to assist prevention of venous thromboembolism.

Consider removing the IV fluid when the woman is able to tolerate oral fluids

and diet. Note the amount of intravenous fluids the woman has already had and beware of fluid overload.

The intravenous cannula shall be left in situ when using epidural analgesia.

Syntocinon is an anti-diuretic and urinary output will improve once this

has been ceased. Increasing intravenous fluid intake based on concentrated urine output alone, can cause fluid over load and eventually pulmonary oedema.

2 **.Diet**

A full diet may commence as soon as the woman wishes unless

contradicted by medical condition. Early diet and fluids post Caesarean

section does not cause complications, and some evidence suggests that it

may speed bowel recovery.

 ***5 Pain Management***

1 .Monitor the woman’s pain score postoperatively by regular assessment.

A woman in pain will be less mobile, less likely to do deep breathing and

leg exercises, which increases the risk of venous thromboembolism.

***6. Wound Care***

1. Observation of the wound

Assess the wound for:

Bleeding / discharge

Signs of infection e.g. increasing pain, redness or discharge

Observe for signs of wound separation or dehiscence

Encourage the woman to look at her own wound

2 .Removal of the dressing

All women will have dressings which are water proof. Hydrocolloid

dressings are to be used only on subcuticular sutures (not over staples) and are to remain in situ for 3-5 days, Most women are to have their

dressings removed on day three.

Non-adhesive foam dressings are to remain in situ for at least 48 hours and should to be removed on day 3, unless otherwise ordered by medical staff2.

3. Removal of sutures/staples**:**

As per medical staff instructions (usually after 1 week in pfannenstiel incision).

***7. Bladder management***

Women are advised to notify the midwifery staff if they experience any

pain or voiding difficulties. Women with urinary symptoms should

be assessed for urinary tract infections, stress incontinence and urinary tract injury.

***8. Education and prevention of complications***

1. **Prevention of thromboembolic disease**

**Mobilization*:***

Encourage early mobilization when the woman’s sensation/movement

returns by:

Sitting the woman out of bed as soon as maternal condition allows

Advise the woman to have a midwife present when she first decides to ambulate

The midwife should ensure adequate sensation is present if the woman has an epidural in situ, and be available should the woman feel faint or

unsteady.

**Deep breathing exercises**

Encourage deep breathing exercises. A woman in pain is more likely to take

shallow breaths, so adequate analgesia is required and support of the abdomen with a pillow is helpful.

**Graduated Compression Stockings**

Encourage the woman to wear stockings until fully mobile

**Anticoagulant therapy**

* Such as heparin and warfarin is given according to the risk of thromboembolism

**Documentation**:

Discharge card on discharge from hospital which is usually after 2-3 days in low risk women while those with medical problems need extra care and longer hospitalization according to their condition.

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