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Conduct Postpartum Fundal Assessment

MAMABIRTHIE MATERNITY SKILLS CHECKLIST

Disclaimer: We recognize that some people who give birth do not identify as a woman. For the purpose of this practice tool, we use the term 'woman' inclusive of gender-diverse people.

Overview:

Nurses are responsible for assessing the woman and communicating with the healthcare team about any changes or deviations from expected findings. A main component of the postpartum assessment is a fundal assessment for firmness, size, shape and any associated bleeding. Any deviations from normal must be recognized early, to avoid complications for both the woman and her newborn baby

Learning objectives:

- Perform a postpartum fundal assessment.
- Recognize any abnormalities in mother and refer appropriately.
- Respectfully communicate evidenced based information when providing postpartum care.
- Educate the woman on ways they can help prevent bleeding complications.

Equipment:

- [ ] MamaBirthie on a student
- [ ] Bed
- [ ] Gloves
- [ ] Sanitary pad
- [ ] Weighing scale
- [ ] Paper and pen

Scenario:

You are caring for a woman that just gave birth 6 hours ago and is due for her postpartum fundal assessment.

Checklist:

	Done	Not Done	N/A
a. Inform the woman on steps of a fundal assessment, what to expect and obtain consent to begin.			
b. Perform hand hygiene, don clean gloves, and ensure privacy.			
c. Respectfully assist the woman to a lying position with their legs separated and expose the woman's stomach and lower parts.			
d. Observe the sanitary pad for lochia amount			
e. With non-dominant hand support the lower portion of the abdomen.			
f. Using your dominant hand palpate the woman's abdomen beginning two finger breadths above the umbilicus and moving lower on the abdomen one finger breadth distance at a time until locating the fundus.			
g. Upon location of the fundus apply gentle pressure with your fingertips to assess for firmness. At the same time, inspect and reassess sanitary pad for clots, or increased bleeding from initial assessment above.			
h. Assess the height of the fundus from the umbilicus, noting any deviations from expected measurements. Measurements are documented in number of finger breadths above or below the umbilicus.			
i. Ask the woman or support her to change the sanitary pad. Weigh and record amount as per protocol.			
j. Communicate with the woman the assessment findings and actions they can take to decrease bleeding complications.			
k. Document findings and inform the woman on the plan of care.			

Reflective questions:

Imagine that after explaining that you are here to check the woman's fundus and bleeding, she says, "I don't understand why you need to do this all the time, it hurts every time, and no one ever says if things are ok or not." Discuss how you would respond to her.

- What differences would there be in a fundal assessment of a woman who delivered 6 hours ago vs a woman who delivered 3 days ago?

Facilitator questions:

1.) If the assessment had revealed the woman fundus was boggy or not firm, how would you inform her and what actions might you consider?

2.) What could you discuss with the woman to educate them on ways to prevent bleeding complications?