Conduct Postpartum Fundal Massage

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 continuously assessing women after birth 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 abnormal finding of a boggy uterus and perform an appropriate fundal massage.
- Respectfully communicate evidenced based information when providing postpartum care.
- Inform the woman on assessment findings and explain why uterine contractions are important.

Equipment:

- [ ] MamaBirthie on a student
- [ ] Bed
- [ ] Gloves
- [ ] Sanitary pad
- [ ] Birthing gown
- [ ] Paper and pen

Scenario:

You are caring for a woman that just gave birth 4 hours ago and is due for her fundal assessment.

Checklist:

	Done	Not Done	N/A
a. Educate the woman on steps of a fundal assessment, what to expect and obtain consent to begin.			
b. Perform hand hygiene, don clean gloves, and provide privacy.			
c. Respectfully assist the woman to a lying position with their legs separated and expose the woman's stomach and lower parts.			
d. With non-dominant hand support the lower portion of the abdomen.			
e. Using your dominant hand palpate the woman's abdomen beginning two finger breadths above the abdomen and moving lower on the abdomen one finger breadth distance at a time until locating the fundus.			
f. Upon location of the fundus apply gentle pressure with your fingertips to assess for firmness, bleeding, or clots on the sanitary pad.			
g. Assess the height of the fundus above the symphysis pubis, noting any deviations from expected measurements.			
h. Apply gentle pressure with the palm of your hand, using a circular motion until fundus is firm.			
i. Ask the woman or support her to change the sanitary pad. Weigh and record amount as per protocol.			
j. Replace patient gown and educate patient on assessment findings			
k. Educate the woman on the importance of her emptying bladder, staying hydrated with fluids & promoting breastfeeding to help improve uterine contractility.			
l. Document findings and inform the woman on plan of care.			

Reflective questions:

Imagine you have just finished counseling the woman on ways to promote a firm fundus and she says "Ok, I will try to not drink so much water, so my bladder doesn't get full again and cause this problem." How would you correct her misunderstanding while maintaining respectful communication?

Facilitator questions:

1.) What antenatal, intrapartum and postpartum risk factors increase women's chances of having a postpartum hemorrhage?

2.) What are cultural or societal risk factors that may increase a women's risk of postpartum hemorrhage?

3.) Imagine that the women's fundus did not firm up with a fundal massage, after initial non-pharmacological interventions are followed what medications would you anticipate being needed?