



## CLINICAL PRACTICE GUIDELINE

Guideline coverage includes NICU KEMH, NICU PMH and NETS WA

# Postnatal Midwifery Care

This document should be read in conjunction with the [Disclaimer](#)

This policy is to be used in conjunction with the O&G Clinical Guidelines Section B - [Postnatal Care](#).

## 6B Admission Policy for Mothers

Ward 6B has 9 parent rooms attached to the ward. Mothers are accepted when medically able to be discharged from Maternity Hospital 4 hours post vaginal delivery and 24 - 72 hours post caesarean section. A postnatal assessment must be carried out at the referring hospital and the mother medically discharged prior to transfer. Discharge medication and analgesia are required to be prescribed and dispensed to the mother by the referring hospital.

Rooms have double beds so partners can stay. Due to the limited number of rooms admission priority is given as below:

1. Parents/carers of critically ill patients.
2. Rural parents/carers.
3. Breastfeeding Mothers.

Mothers are admitted as inpatients up to and including Day 5 postnatally. Admission during office hours is by the ward clerk, after hours by BAC Ext: 8632. Obtain Buff notes with mother's stickers

Commence post-partum observation chart, admission registration forms and inpatient progress sheet M822 and Discharge Summary form MR 806.

## Boarders

All fathers and mothers (if greater than 5 days post-delivery) are admitted as boarders. If there are no rooms available, alternative accommodation can be found by contacting the Social Worker.

## Meals

Meal vouchers are provided to mothers for first 5 days postnatal and when breastfeeding. Vouchers to have ward code and current date documented. Parents to be referred to Social Worker for further assistance re meals. Parents staying at Ronald Mac Donald House will receive meals there.

## Midwifery Assessment

On admission assess the mother. Document a medical history including allergies and current medications. Observations are carried out daily until Day 5:

- TPR, BP.
- Palpate the uterus to ensure involution is occurring.

- Observe the colour and amount of lochia as well as any odour.
- Observe bladder function, and normal placement of uterus (Displacement of the uterus, usually to the maternal right or swelling in the supra pubic region may indicate a full bladder).
- Encourage voiding 2-3 hourly, if dysuria occurs encourage increase hydration to 2-3 litres/24 hours and provide urinary alkalinisers.
- Observe the perineum and or abdominal wound. Follow post-operative orders for the removal of staples/sutures.
- Breasts - observe filling, presence of redness or lumps. Instruct on massaging of lumps whilst expressing or breast feeding. Contact the Womens Health Physio for ultrasound for inpatient's less than 5 days post-delivery (Ext 8503). Ultrasound treatment is done prior to expressing or a breastfeed. Refer back to obstetric hospital for medical review or ultrasound.
- Ensure the nipples are not sore and assess attachment when or if breastfeeding, correct positioning and pressure setting in use when expressing.
- Provide education and support regarding expressing and breastfeeding. Refer to Neonatology Clinical Guidelines.
- Check the calves for any redness/swelling/pain. TED stockings may be required. Ensure you have the inner thigh, lower calf and inside measurements to determine correct size.
- Bowels: Ensure bowel function is maintained - educate on adequate fluids, high fibre diet, assess the need for medication - aperients, softeners.
- Assess level of pain or discomfort and need for analgesia/ pain relieving measures. Refer to [Postnatal Midwifery Care: A Guide for Prescribing and Giving Medications to Mothers of 6B Infants](#).
- If the observations are within normal limits, repeat the assessment the next day and document.
- Report and treat deviations from the normal. If Obstetric treatment is required contact the Medical Officer at the referring Hospital. If the Mother is from a country hospital refer to KEMH Emergency Department (Phone:6458 1433). Arrange transport if required and /or nurse escort.
- In an emergency call SJOG Ambulance for transfer.
- If general medical treatment is required refer to local GP or Adult Accident and Emergency Department (I.e. SCGH phone: 9346 3333).

## Management of Pregnancy Induced Hypertension

Mothers' on Anti-hypertensive's - Assess and document BP daily as requested by the referring Doctor or until the BP is stable and within normal parameters. If the mother becomes symptomatic notify referring Obstetrician, or KEMH Emergency Department (country mothers and/or delivered at KEMH).

## Perineal Tears

Refer to [WNHS O&M Clinical Guidelines - Perineal Care](#). The woman is referred to the physiotherapist for assessment if ultrasound treatment is required in first 5 days postnatally and 6B inpatient Mother. Reiterate the importance of pelvic floor exercises.

## Analgesia

Level and type of pain is reviewed regularly, analgesia given as indicated and ordered as per NCCU Guideline. Refer WNHS Consumer medicine information “Medicines Used to Relieve Pain”

## Administration of Rh D Immunoglobulin

The administration of RhD-Ig to Rh (D) negative women with no immune anti-D antibodies reduces the risk of maternal sensitisation to foetal Rh (D) positive red blood cells. A sensitised woman may develop immune anti D which crosses the placenta destroying foetal Rh (D) positive cells. This can result in anaemia, foetal hydrops, and severe haemolytic disease on the newborn. When accepting an admission of a Post Natal Mother check for a negative blood group. If possible RhD Immunoglobulin should be given by the referring hospital prior to transfer.

## To give RhD Immunoglobulin

Also refer to WNHS Transfusion Medicine - [Rh D Negative Women: Rh D Immunoglobulin Products & Applications](#)

- Ensure the woman’s blood group is Rh (D) Negative and that she does not have confirmed immune anti-D.
- Check that the infant is Rh (D) positive.
- Check the Kleihauer test result and the dose of RhD-Ig required by the woman. The most common dose is CSL 625 IU. **RhD-Ig is to be administered within 72 hours of delivery.**
- Order RhD-Ig on a Transfusion Medicine request form and order from blood bank. The dose is ordered on Adult Medication Chart (MR810) by 6B Doctor.
- Ensure the woman is informed and appropriately counselled as to the reasons for requiring RhD-Ig. Inform the woman that RhD-Ig is a blood product and provide an Anti D patient. Provide Anti D pamphlet to mother.
- Information leaflet, ‘You & your baby’. Complete the verbal consent section on the RhD Immunoglobulin Record form, MR007.
- Check the vial of RhD-Ig with the naked eye. If it appears turbid or contains sediment it must not be used and returned to Transfusion Medicine.
- RhD-Ig must be brought up to room temperature before use.
- Administer the RhD-Ig **slowly by deep intramuscular injection only.**
- Following administration of RhD-Ig attach the peel off label to the RhD Immunoglobulin Record form (MR007) and complete all sections of the form and file in the woman’s medical record.
- Large doses (greater than 5 mL) should be administered in divided doses at different sites.
- Any adverse events relating to the use of RhD-Ig should be reported to Transfusion Medicine.

## General Care

Advice and support is provided to the postnatal Mothers with referral to appropriate agencies i.e. Social Workers, Clinical Psychology, Aboriginal Liaison Workers, Patient Advocate, Pastoral Care, Palliative Care Nurse, KEMH Breastfeeding Clinic,

Kilparrin Centre. Provide education in parent crafting skills, breastfeeding, postpartum period and what to expect, preparing for discharge.

## Discharge

If a mother is transferred back to her referring Hospital contact the on duty midwife and give a verbal handover. A copy of the postnatal observations and the progress notes are sent back with the mother.

If a mother is going home within 5 days the 6B midwife contacts the Visiting Midwife Service from the maternity hospital and organises a follow-up. Copies of the Postnatal Observations and Progress Notes are sent home with the mother.

## References

1. [Routine Postnatal Care on the Postnatal Ward](#) (King Edward Memorial Hospital. Clinical Guidelines, Section B: Obstetric and Midwifery Guidelines. Section 6: Routine postnatal care.
2. Transfusion Medicine - [Rh D Negative Women: Rh D Immunoglobulin Products & Applications](#)

## Related WNHS policies, procedures and guidelines

[O&M Clinical Guidelines Section B - Postnatal Care](#)

[WNHS O&M Clinical Guidelines - Perineal Care](#)

[Neonatal Clinical Guideline - Postnatal Midwifery Care: A Guide for Prescribing and Giving Medications to Mothers of 6B Infants](#)

[WNHSTransfusion Medicine - Rh D Negative Women: Rh D Immunoglobulin Products & Applications](#)

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