



## CLINICAL PRACTICE GUIDELINE

# Postnatal: Immediate Maternal Care in Labour and Birth Suite following Birth

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

## Aims

- The detection of any postpartum complications
- The promotion of early mother – baby interaction
- The initiation of breastfeeding

## Key Points

1. Observations should be performed as often as indicated by the woman's clinical status and recording to be commenced on MR 285.01.
2. Where indications for additional care are identified increase the frequency of the recommended observations as required and discuss consult and manage appropriately.
3. If blood loss is outside the expected range, or the placenta is retained, the woman shall not be given food or oral fluids and the medical officer informed immediately.

## Procedure

1. Assess and document the tone and position of the fundus and the amount of lochia following birth of the placenta
  - every 15 - 30 minutes for the first 2 hours
2. Inspect the perineum following birth of the placenta. Reassess if indicated e.g. increased lochia or pain.
3. Measure and document the woman's pulse, respiration, SaO<sub>2</sub>, blood pressure and temperature
  - Once within an hour of the birth of the placenta
4. Ensure the woman is warm, clean and dry.
5. Discuss, offer organise and administer analgesia as required.
6. Where the clinical status of the woman and her baby allows, encourage all women to maintain uninterrupted skin to skin contact following birth for at least 1 hour. See Clinical Guideline O&M: Newborn Feeding: [Skin to Skin Contact](#)
7. Encourage the woman to initiate infant suckling. See Clinical Guideline O&M: Newborn Feeding: [The First Feed](#)

8. If the woman has chosen not to breastfeed, organise a formula feed for the baby.
9. Encourage the woman to eat, drink and rest.
10. If the woman has received epidural analgesia, assess the woman's range of movement, leg sensation and weight bearing ability prior to ambulation. Perform a Bromage Score- refer to Clinical Guideline, Anaesthetics [4.6 Assessment of Motor Function](#)
11. Assist the woman to the shower and toilet. Offer a wash in bed where appropriate.
12. Encourage the woman to void. Ensure her bladder is emptied 4 hours post birth or removal of IDC. See Clinical Guideline Bladder Care
13. For bladder management with neuraxial blockage / an operative birth/ PPH with oxytocin or third or fourth degree tear see Bladder Care guideline
14. Discontinue any intravenous infusion if the woman's clinical condition allows. The cannula must remain in situ if an epidural is to continue.
15. The epidural catheter shall be removed if no longer required for analgesia.

## Prior to transferring to the postnatal ward

1. Assess and record:
  - The tone, height and position of the fundus.
  - The amount of lochia
  - The perineum
  - The bladder status
2. Once a bed is available transfer the woman, with the baby either in her arms or in a cot.
3. The woman shall be transferred by:
  - wheelchair
  - on the bed when she is unable to weight bear or her clinical status makes it inappropriate to use a wheelchair.
  - walking if the woman's condition permits or requests.

### Reference



Queensland Maternity and Neonatal Clinical Guideline: [Normal Birth](#) .2012

Related WNHS policies, procedures and guidelines

Postnatal Care (Routine)

Newborn Feeding

[Assessment of Motor Function](#)

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