GUIDELINE

Postnatal Midwifery Care for Mothers on 3B

Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Contents

Aim

Outlines the responsibilities and processes for the 3B midwives caring for the mothers of infants in the 3B NICU.

Risk

Inadequate postnatal care and support for the mother with an infant in the neonatal unit may lead to unrecognised acute deterioration in the mother's mental and physiological state.

Background

Neonatal inpatients on Ward 3B are predominantly newborns from peripheral and rural locations, i.e. admitted within the first 24 hours of birth. The 3B midwife is responsible for providing postnatal care **and** education to the mothers/birth parent of neonates who are admitted to 3B AND where the mother is admitted to the Ward 3B parent accommodation. The 3B midwife is not able to provide postnatal care to non-resident mothers including Ronald McDonald House.

Key Points

- Mothers can only be accepted when medically discharged from the referring maternity Hospital (6 hours post uncomplicated vaginal delivery and 48 - 72 hours post caesarean section) following a postnatal assessment (medical discharge for CS)
- Discharge medication and analgesia must be prescribed and dispensed to the mother by the referring hospital and she must be compliant with administration including Clexane.
- The 3B midwife is not able to provide postnatal care to non-resident mothers, including Ronald McDonald House

Parent Accommodation on Ward 3B

Rooms have double beds so partners/support person can stay. Accommodation is only for 2 adults. Due to the limited number of rooms, admission priority is given as below:

1. Parents/carers of critically ill infants.

2. Rural parents/carers (this is determined by PATS guidelines, usually 100km for CBD).
    - If no rooms are available for regional mothers the referral hospital contacts the PATS officer will organise accommodation. The midwife will also need to contact KEMH VMS to organise PN checks for the mother (note: this is the responsibility of the regional midwives).
3. Fully breastfeeding mothers.
4. Rooming out in preparation for discharge

- Mothers are admitted as inpatients for midwifery care up to and including Day 5 postnatally. Admission during office hours is by the ward clerk, after hours by BAC Ext: 65686. Obtain mother's stickers.
- Other mothers (greater than 5 days post-delivery) and parents/carers are admitted as boarders.

Midwifery Admission, Assessment and Referral

- On admission assess the mother and document a medical history including allergies and current medications. Observations are carried out daily until Day 5 (and/or as clinically indicated).
- Commence post-partum observation chart, admission registration forms and NaCS (Notifications & Clinical Summaries). DMR not progress notes.
- Provide routine postnatal observations, care, management and follow up as per WNHS Clinical Guideline Postnatal Care: Maternal.
- Report and treat deviations from the normal. If Obstetric treatment is required contact the Obstetric Medical Officer at the referring Hospital. If the Mother is from a country hospital refer to KEMH Emergency Department (Phone:6458 1433). Arrange transport via a cab if stable or via ambulance if unstable.
- Assess emotional wellbeing. If history of mental health concerns, ensure adequate supports in place. Refer to social work and clinical psychologist as appropriate. The following services are available for postnatal Mothers
    - Social Workers, Clinical Psychology, Aboriginal Liaison Workers, Patient Advocate, Pastoral Care, Palliative Care Nurse, KEMH Breastfeeding Clinic, Family Resource Centre. Please note EPDS is not attended in the NICU as comprehensive social work assessment is done for long stay patients, or care is handed back to the CHN.
- Provide education and support for initiating breastfeeding and/or expressing in conjunction with LC's and feeding team.
- Provide education in parent crafting skills and preparing for discharge.

Meals

- Meal vouchers are provided to inpatient mothers for first 5 days postnatal and when exclusively or fully breastfeeding.
- Vouchers must have the ward cost code and current date documented. (Expiry date)
- Parents can be referred to their Social Worker for further meal assistance. Meals can be arranged through PCH food services supervisor with social work approval in some circumstances.
- Parents staying at Ronald Mac Donald House (including Level 5) will receive meals and do not require meal vouchers.
- Parents have access to the parent lounge with snacks, tea and coffee.

Recognising and Responding to an acute deterioration

Unstable condition - Call Code Blue. It may be appropriate to call SJOG Ambulance to transfer the person. Do not transfer an unstable patient with only a nurse escort.

Stable condition - If non-urgent medical treatment is required promptly then transfer to Sir Charles Gardiner Hospital for review, or KEMH Emergency Centre for postnatal complications. The family can escort the Mother if she is able to walk unaided. If a wheelchair is required send an agility to organise a PCA and transfer with a nurse/midwife escort via the PCH/SCGH link bridge. If deterioration enroute there are 2 phones on the link bridge. Calling 55 on the phone at the PCH end, PCH Code Blue team will respond, SCGH Code Blue team if called from phone at the SCGH end.

For minor medical concerns it may also be appropriate to refer to a local GP. For mental state deterioration see below.

Management of Pregnancy Induced Hypertension

Mothers on Anti-hypertensives

Mothers are responsible for their own blood pressure monitoring and review. The midwife can perform a blood pressure check as requested, but mothers requiring ongoing BP assessment need to liaise with their health care provider.

If the mother becomes symptomatic notify referring Obstetrician, or KEMH Emergency Department (for country mothers and/or delivered at KEMH).

Perineal Tears

Refer to WNHS Guideline: Perineal care and repair (including perineal protection, assessment and management of trauma). Reiterate the importance of pelvic floor exercises for all postnatal women. Ice therapy is available.

Wound Review

Wound review for admitted mothers may be ordered for after day 5, including removal of staples or sutures, or removal of PICO dressing. Any abnormalities should be referred back to birthing hospital or KEMH as appropriate. Boarder mothers are advised to contact their birthing hospital.

Medications for Mothers

- NICU medical staff cannot prescribe medications for pre-existing conditions, postnatal complications. Mothers will need to be referred to their own doctor for ongoing treatment. The exception is Cabergoline for rapid suppression of breast milk for bereaved mothers only. See WNHS O&G Cabergoline.
- All medications (including analgesia) the mother will need during her stay should have been ordered and dispensed by the referring hospital. Mothers must self-administer medications provided on discharge including subcutaneous Clexane.
- There is no onsite pharmacy available to mothers.

Analgesia

Level and type of pain is to be reviewed regularly. Provide the mother with WNHS "Medicines Used to Manage Pain".

Medications containing codeine are not recommended for breastfeeding mothers.

Methadone

Mothers requiring Methadone must obtain this from the medical methadone clinic. This is organised by the referring doctor prior to the mother being transferred.

Domperidone

Domperidone is used to enhance breast milk production. Mothers must see their own GP to obtain a prescription for Domperidone. See Domperidone for Mothers of Infants with Insufficient Breastmilk Supply

Midwife Initiated Medications

- The non-prescription medications listed below may be provided to mothers of 3B patients by the 3B midwives and documented on the medication chart (MR 810).

  - Lactulose
  - Microlax enemas
  - Rectinol® cream and suppositories
  - Fibre supplements
  - Lanisoh
  - Paracetamol / Ibuprofen

Administration of Rh D Immunoglobulin

See WNHS Transfusion Medicine Use of RhD Immunoglobulin (RhD Ig) in pregnancy

Kleihauer Test - If not ordered by Maternity Hospital the 3B doctors may request a Kleihauer test to be performed at PathWest QEII on ground floor.

RhD-Ig is to be administered within 72 hours of delivery. Order RhD-Ig from the blood bank on a Transfusion Medicine request form. The dose (625iu) is ordered on the Adult Medication Chart (MR810) and a transfusion request form by a 3B Doctor. Anti-D can them be requested from Transfusion Medicine Unit and sent up in the chute for the 3B midwife to administer.

Maternal Secondary Postpartum Haemorrhage (PPH) on Ward 3B

Secondary Postpartum Haemorrhage is defined as abnormal or excessive bleeding from the birth canal between 24 hours and 6 weeks following the birth. See WNHS: Postpartum complications

Women at increased risk of a secondary PPH are those who have experienced:

- Antenatal haemorrhage and primary postpartum haemorrhage.
- Manual removal of placenta.
- Intrauterine infection.
- Multiple pregnancy

Initial Management

Refer to Appendix 1 for Quick Reference

1. Assess the patient, call for help, and commence resuscitation (DRSABCD) if required. **Dial 55 Code Blue**.
2. **Massage the fundus** (place your hand at umbilical level and apply pressure towards the mother's feet until the uterus contracts and feels firm under your fingers) and evacuate any vaginal clots. Continue to apply pressure to fundus while bleeding continues. Elevate feet, but not pelvis. (As this can allow the uterus to fill with blood and conceal bleeding).
3. Obtain management advice from the KEMH Obstetric Senior Registrar on page 3299 or via switch board. Give ISOBAR handover including mother's obstetric history and PPH status.
4. Obtain phone order from the KEMH Obstetric Senior Registrar for Uterotonic agents and administer, **i.e. Oxytocin 10 I.U. intramuscular injection (All medications must be prescribed by a medical officer)**.
    - Note: Oxytocin is kept in 3B ADM. (in the fridge – 4th shelf in plastic container "maternal oxytocin")

5. Insert 2 large bore intravenous cannula (16g) and commence IV fluid replacement normal saline or volume expander (Hartman's) 1000 mL/hr.
6. Intravenous Oxytocin infusion of 40 I.U. in 500 mL of normal saline at 240mL/h per hour may be ordered by KEMH Obstetric Registrar.
7. Insert IDC as full bladder will prevent the uterus from contracting (located in adult resus trolley).
8. Bimanual Compression may be required if ongoing uncontrollable bleeding. This should only be performed by staff competent in the procedure.
9. Keep all soiled perineal pads to estimate blood loss.
10. Ensure the next of kin are notified.
11. Arrange transfer by ambulance to KEMH Emergency Dept. as directed by the Obstetric Senior Registrar on page 3299

Perinatal & Parental Mental Health Clinic and Pathways

Neonatology 3B has a Clinical Psychologist (CP) allocated to provide perinatal and infant mental health support for parents of admitted infants. Referrals can be made by any member of the NICU team while the infant remains an inpatient.

Support includes:

- Routine perinatal/infant mental health support for parents coping with their infant's admission (low-risk situations).
- Support for parents (*without* associated immediate risk of self-harm, harm to baby or other) expressing worry or distress about meeting their infant needs as a new parent.
- Support for parents experiencing grief and loss.

Other mental health hospital services relevant for mothers/carers of 3B infants is via e-referral (Department of Clinical Psychology & Neuropsychology (dcpndutypsychologist@health.wa.gov.au / 96456 0261)

Referrals for Acute/High Risk situations

Parents/carers presenting with acute deteriorating mental state or immediate risk of harm to self, baby or other. i.e. current actions endangering self or other, e.g. overdose, suicide attempt or ideation with plan and intent, violence, possession of a weapon, aimless wandering, 'bizarre' behaviour given context, agitated, high risk ideas or behaviours associated with perceptual disturbance, thought disturbance, and/or delirium, significant distress. Or support person distress associated with concern about severe mental illness, absent insight, early warning signs of psychosis, obstructing care to the infant.

Urgent Referrals

- In-hours - can be made in collaboration with the 3B Clinical Psychologist and/or PCH Psychiatry In-reach Team (PPIRT) and the SCGH Acute Mental Health team Clinical Nurse Manager – 6383 1000 (8am-5pm).
- When the 3B Clinical Psychologists is not on duty referrals can be made to PCH Department of Clinical Psychology and Neuropsychology (DCPN) and/or PCH Psychiatric In-reach Team (PPIRT). This may be needed if the infant is transferred for ongoing care to another ward/team/hospital).
- The fastest access to urgent mental health care is via the Emergency Department at SCGH. Handover of concerns can be called through to the PLN (6457 3333). Patient escort is best supported by a family member if possible. For non-compliance patient transfer, arrange in coordination with St John Ambulance Service.

- PCH Psychiatry In-reach Team (PPIRT) (6456 0203)
- Advice for staff: Mental Health Emergency Response Line – 1300 555 788

Discharge

If postnatal women are transferred back to their referring birth hospital the midwife will contact the on-duty midwife and give a verbal handover. A copy of the postnatal observations and the progress notes will be sent back with the mother.

If a mother is going home within 5 days the 3B midwife will contact the Visiting Midwife Service from the maternity hospital and organise follow-up. Copies of the Postnatal Observations will be sent home with the mother. A verbal or emailed handover can be sent to the VMS midwife along with a copy or scanned copy of the Postnatal Care Pathway for Mothers on ward 3B (MR 399.00)

Routine postnatal observations are ceased after day 5 if all observations are within normal limits and there are no ongoing concerns requiring management. Women who have infants within the unit are provided with ongoing midwifery support as required for the duration of their stay.

Related CAHS internal policies, procedures and guidelines
Domperidone for Mothers of Infants with Insufficient Breast Milk Supply

References and related external legislation, policies, and guidelines
King Edward Memorial Hospital - Obstetrics and Gynaecology Guidelines • Postnatal ward Care: Quick reference guide

- Perineal care and repair (including perineal protection, assessment and management of trauma)

King Edward Memorial Hospital - Obstetrics and Gynaecology Medication Guidelines

KEMH: Use of RhD Immunoglobulin (RhD Ig) in pregnancy

Useful resources (including related forms)

Pain-management---Medicines-used-to-manage-pain.pdf

This document can be made available in alternative formats on request.

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Appendix 1: Maternal Secondary Post-Partum Haemorrhage

Initial Assessment:

- Call for help
- Assess for resuscitation (response, airway, breathing, circulation)
- Monitor vital signs (TPR, BP, SaO2) continuous monitoring
- Administer oxygen if required

Is the patient's condition stable?

YES

Clinical assessment

- Note uterus size, position & tone & any other signs & symptoms

Assess blood loss

- Commence fundal massage
- Insert large bore cannula. Take blood for G&H, FBC, Coags.
- Take a history: parity, intrapartum details & complications, birth & any relevant medical / family history, any obstetric risk factors

Commence

- IV fluids

Contact

- KEMH Senior Obstetric Registrar for advice via switchboard

Transfer

- Organise ambulance for transfer to KEMH EC or back to referring maternity hospital if clinically stable.

Document

NO

CALL CODE BLUE MEDICAL – DIAL 55

Clinical assessment

- Note uterus size, position & tone & any other signs or symptoms

Assess blood loss

- Commence resuscitation and fundal massage

Contact/Call

- KEMH Senior Ob Registrar for advice & oxytocic phone order
- Call an ambulance 000

Administer

- Oxytocin (Available in ADM).
- 1ST dose 10IU IM ASAP in the thigh.

Insert

- 2 x large bore cannulae. Take blood for G&H, FBC, Coags.

Commence

- IV Oxytocin infusion. 40IU in 500ml 0.9% NaCl or CSL at 125ml/hr
- Fluid resus with NaCl or CSL, rapid infusion

Insert IDC /Monitor maternal observations

Document