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

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Aim

This guideline outlines the responsibilities and processes for the midwives on ward 3B PCH caring for the mothers of infants in the NICU.

Risk

Inadequate postnatal care and support for the mother with an infant in the neonatal unit.

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 & 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.

Key Points

- Mothers can only be accepted when medically discharged from the referring maternity Hospital (4 hours post uncomplicated vaginal delivery and 48 - 72 hours post caesarean section) following a postnatal assessment
- Discharge medication and analgesia must be prescribed and dispensed to the mother by the referring hospital.
- Postnatal care is provided to birth mothers who are admitted to the Ward 3B parent accommodation.

Parent Accommodation on Ward 3B

Rooms have double beds so partners/support person 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 who are accommodated on the unit up to and including Day 5 postnatally are admitted as inpatients and care provided by the 3B midwives.
    - Admission during office hours is by the ward clerk, after hours by BAC Ext: 65686. Obtain Buff notes with mother's stickers.
- Other parents/carers (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 midwife on duty who will liaise with Ronald McDonald House.

Midwifery Admission, Assessment and Referral

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

- Commence post-partum observation chart, admission registration forms and inpatient progress sheet M822 and NaCS (Notifications & Clinical Summaries)
- Provide routine postnatal observations, care, management and follow up. Postnatal observations as per Postnatal Care: Maternal Clinical Guideline.
- This includes but is not limited to clinical observations such as Blood Pressure, Temperature, Heart Rate, Respiratory Rate, lochia & fundal position/tone, bladder & bowel care, perineal care, oedema.
- Assess emotional wellbeing. If history of mental health concerns, ensure adequate supports in place. Refer to social work and clinical psychologist as appropriate.
- Provide education and support regarding expressing and breastfeeding. Refer to Neonatology Clinical Guidelines.
- 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 it may be appropriate to call SJOG Ambulance for transfer.
- If general medical treatment is required refer to local GP or Adult Emergency Department (i.e. Sir Charles Gardiner Hospital phone: 9346 3333).
- Advice and support services are available for the postnatal Mothers
    - Social Workers, Clinical Psychology, Aboriginal Liaison Workers, Patient Advocate, Pastoral Care, Palliative Care Nurse, KEMH Breastfeeding Clinic, Family Resource Centre.
- Provide education in parent crafting skills, breastfeeding, postpartum period and what to expect, preparing for discharge.

Meals

- Meal vouchers are provided to inpatient mothers for first 5 days postnatal and when breastfeeding.
- Vouchers must have the ward cost code and current date documented.
- Parents can be referred to their Social Worker for further meal assistance.
- Parents staying at Ronald Mac Donald House will receive meals there and as such don’t require meal vouchers.
- Parents have access to the parent lounge with snacks, tea and coffee.

Management of Pregnancy Induced Hypertension

Mothers' on Anti-hypertensive's

Assess and document blood pressure daily as requested by the referring Doctor/Maternity Unit or until the blood pressure is stable and within normal parameters. 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.

Prescribing and Providing Medications for Mothers

- All medications the mother will need during her stay should be ordered and dispensed by the referring hospital.
- NICU medical staff cannot prescribe medications for pre-existing conditions or postnatal complications. Mothers will need to be referred to their own doctor for ongoing treatment.
- Country mothers and mothers delivered at KEMH with postnatal complications can be reviewed by the KEMH Emergency Department.
- Mothers must self-administer medications provided on discharge from maternity hospital including subcutaneous clexane

Analgesia

Level and type of pain is reviewed regularly. Analgesia needs to be prescribed by the discharging hospital. Refer WNHS Consumer medicine information "Medicines Used to Manage Pain".

Medications containing codeine are not recommended for breastfeeding mothers.

Cabergoline

Cabergoline is used for rapid suppression of breast milk. Refer to WNHS Obstetric and Gynaecology Medication Monograph Cabergoline.

Cabergoline can be prescribed by 3B Doctors for bereaved mothers only.

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 and is for the benefit of the inpatient neonate. We recommend mother see their own GP to obtain a prescription for Domperidone to ensure ongoing care. 3B medical staff will not prescribe domperidone. Refer to Domperidone for Mothers of Infants with Insufficient

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.

Rh D Negative Women: Rh D Immunoglobulin Products & Applications

Blood group management & clinically significant antibodies: Rh D negative & Rh D positive women

- 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.
    - If this has not be completed, 3B doctors may request Kleihauer which can be done at Pathwest 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 is ordered on the Adult Medication Chart (MR810) by a 3B Doctor.
- Ensure the woman is informed and appropriately counselled as to the reasons for requiring RhD-Ig.
- Check the vial of RhD-Ig. 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.

Nurse / Midwife Initiated Medications

Refer to WNHS Nurse / Midwife Initiated Medications and King Edward Memorial Hospital - Obstetrics and Gynaecology Medication Guidelines

- Nurse/Midwife initiated medications can be provided to mothers of 3B patients during their immediate postnatal period.
- The non-prescription drugs listed below may be administered by registered nurses and/or midwives without prior prescribing by medical staff.
- If the patient has received two doses of the medication, a medical officer MUST review the patient if a third dose is required.
- All nurse/ midwife initiated medication administered must be documented in the appropriate section of the medication chart (MR 810).
    - Liquid Parrafin (Agarol®).
    - Fibre supplements.
    - Glycerine suppositories.
    - Lactulose.
    - Microlax enemas.
    - Nicotine Replacement Therapy.
    - Paracetamol.
    - Ibuprofen.
    - Rectinol® cream and suppositories.
    - Any non-prescription (S2 and S3) topical preparations

Ward dispensing of any drugs other than nurse/midwife initiated medications, cabergoline and Anti-D is not permitted.

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. A secondary PPH occurs in 2% of postpartum women. Occurrence of secondary PPH is associated with a high maternal morbidity with approximately 85% requiring hospital admission. Approximately 15% of these women will require a blood transfusion and there is a 1% incidence of hysterectomy.

Risk Factors

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

Aetiology

In approximately one third of women the cause is unknown. The most common causes are:

- Sub involution of the uterus.
- Retained products in the uterus associated with bleeding early in the postpartum period.
- Endometriosis associated with bleeding later in the postpartum period.

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)**.
    a. Oxytocin is kept in 3B ADM under patient safe drawer.
5. Insert 2 large bore intravenous cannula (18 G) 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 125 mL 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.

Arrange transfer by ambulance to KEMH Emergency Dept. as directed by the Obstetric Senior Registrar on page 3299

Discharge

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

If a mother is going home within 5 days the 3B midwife may contact the Visiting Midwife Service from the maternity hospital and organises a follow-up. Copies of the Postnatal Observations and Progress Notes may be sent home with the mother.

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 till provided with 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
1. King Edward Memorial Hospital. (2011). “Emergency procedures, basic life support-adult”. Clinical Guidelines, Section A: Advanced life support 11.3. 2. King Edward Memorial Hospital. (May 2016). “Postpartum Haemorrhage”. Clinical Guidelines, Section B: Obstetric and Midwifery Guidelines 9.1.4 3. Princess Margaret Hospital. (2011). “Code Blue (55) and Emergency Resuscitation”. Paediatric Practice Manual, Section 4 Resuscitation Procedures 4.1.
King Edward Memorial Hospital - Obstetrics and Gynaecology Guidelines King Edward Memorial Hospital - Obstetrics and Gynaecology Medication Guidelines

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

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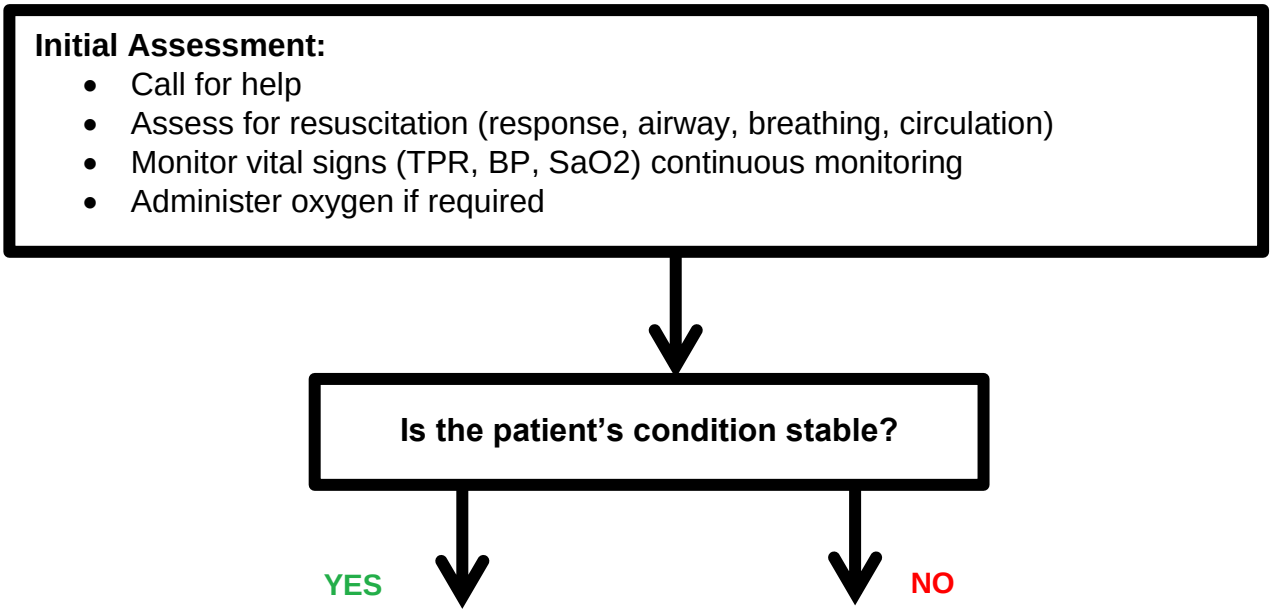
Appendix 1: Maternal Secondary Post-Partum Haemorrhage



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

If appropriate, organise ambulance for transfer to KEMH EC or back to referring maternity hospital if clinically stable enough to do so.

Document

Code Blue Medical – Code 55

Clinical assessment

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

Assess blood loss

Commence resuscitation and **fundal massage**

Call KEMH Senior Ob Registrar for advice & oxytocic phone order

Call an ambulance

Administer Oxytocin: 1ST dose **10IU IM ASAP** (thigh - Available in ADM.

Insert large bore cannula x 2. 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

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