



CLINICAL GUIDELINE	
Postnatal Midwifery Care for Mothers on 3B	
Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

This document should be read in conjunction with this [DISCLAIMER](#)

Contents

3B Admission for Mothers	2
Boarders.....	2
Meals	2
Midwifery Assessment.....	2
Discharge.....	3
Management of Pregnancy Induced Hypertension.....	3
Perineal Tears	3
Prescribing and Giving Medication to Mothers on 3B	3
Analgesia	3
Cabergoline.....	4
Methadone	4
Administration of Rh D Immunoglobulin.....	4
Nurse/Midwife Initiated Medication	4
Dispensing Medication	5
Maternal Secondary Post-Partum Haemorrhage.....	5
References	6

This policy is to be used in conjunction with the O&G Clinical Guidelines [Postnatal Care](#), [Postnatal Complications](#) and [Postnatal Quick Reference Guide](#)

3B Admission for Mothers

Ward 3B has 5 parent rooms attached to the ward. Mothers are accepted when medically able to be discharged from Maternity Hospital 4 hours post vaginal delivery and 48 - 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: 65686. 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 Ronald MacDonald House on Level 5.

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. Parents have access to the parent lounge with snacks, tea and coffee.

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.
- Ultrasound treatment is done prior to expressing or a breastfeed. 3B mothers following delivery are able to be referred to the Physiotherapy department for breast

and perineal ultrasound during the 5 day admission period. This is extended up to 7 days if treatment is still required over a weekend period. Once mothers reach boarder status we are unable to provide services and the mothers can then be referred back to their local delivering hospital or KEHM for ongoing management. Management of any other musculoskeletal issue should be referred to KEHM for follow up.

- Ensure the nipples are not sore and assess attachment when or if breastfeeding, correct positioning and pressure setting in use when expressing.
- 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.
- 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.
- 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).
- 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, Family Resource 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 3B 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.

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](#). Reiterate the importance of pelvic floor exercises.

Prescribing and Giving Medications to Mothers of 3B Infants

- 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.

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 Relieve Pain”. **Medications containing codeine are not recommended for breastfeeding mothers.**

Cabergoline

Cabergoline is used for rapid suppression of breast milk.

Dose: If lactation is not established give 2 x 500 microgram tablets in a single dose on day one. If lactation is established and suppression is required give half a tablet (250microgram) twice daily for 2 days, giving a total of 1mg. Cabergoline can be prescribed by 3B Doctors for bereaved 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 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.

Dose: 1 tablet (10 mg) 3 times daily for 2 to 4 weeks. If milk production does not improve a longer supply of Domperidone may be required.

For more information refer to Pharmacy and Medication Guidelines - [Domperidone](#) and Obstetrics and Gynaecology Guideline - [Breastfeeding: Increasing Breast Milk Supply](#).

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 3B 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.

Nurse / Midwife Initiated Medications

Refer to Pharmacy and Medication Guidelines - [Nurse / Midwife Initiated Medications](#).

- Nurses and midwives to administer Schedule 2 and Schedule 3 medications without a prescription by medical staff.
- 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 Paraffin (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.

Dispensing Drugs - Self Medication

Mothers receive a prescription supply of drugs which they can self-administer as directed. Medications should be prescribed by the doctor on the PBS discharge prescription with the mother's details (name, UR and DOB). This can be dispensed by the hospital Dispensary or a local Pharmacy. This can then be given directly to the mother after ensuring the mother understands the administration instructions.

Ward dispensing of any drugs other than cabergoline and Anti-D is not permitted.

Maternal Secondary Postpartum Haemorrhage (PPH) on Ward 3B

This guideline is specifically for mothers who are visiting and/or rooming in on 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:

- Primary postpartum haemorrhage.
- Manual removal of placenta.
- Intrauterine infection.

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

1. Initial Assessment: Assess the patient, call for help, commence resuscitation (DRSABCD). Assess blood loss and vital signs (pulse, respirations, oxygen saturation, blood pressure). Supply oxygen if required. If significant blood loss with haemodynamic compromise i.e. symptoms of pallor, rapid pulse, decrease in blood pressure, collapse or significant ongoing bleeding 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 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). 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.
11. Arrange transfer by ambulance to KEMH Emergency Dept. as directed by the Obstetric Senior Registrar on page 3299.


References

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

External related policies and guidelines

- WNHS O&M Clinical Guidelines – [Secondary Postpartum Haemorrhage](#)
- [WNHS O&M Clinical Guidelines - Perineal Care](#)
- WNHS Transfusion Medicine - [Rh D Negative Women: Rh D Immunoglobulin Products & Applications](#)
- KEMH Pharmacy and Medication Clinical Guidelines - [Cabergoline](#)
- KEMH Pharmacy and Medication Clinical Guidelines - [Nurse / Midwife Initiated Medications](#)
- WNHS: Obstetrics and Gynaecology Guideline - [Breastfeeding: Increasing Breast Milk Supply](#).

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