POSTNATAL CARE (ROUTINE)

MATERNAL POSTNATAL CARE

POSTNATAL: SUBSEQUENT CARE

Keywords: postnatal care, care after birth, maternal, postnatal check, postnatal education, postpartum

AIMS

- To promote recovery from labour and birth.
- To promote emotional/psychological and physical wellbeing.
- To provide educational support and advice to the woman which will promote:
  - Sound infant care,
  - Successful adaptation to motherhood
  - Effective mother-infant interaction.
- To monitor the progress of the postpartum woman
- To detect complications in a timely manner and make appropriate referrals for specialist care where required.
- To provide health education.

KEY POINTS

- While much research has been undertaken on specific aspects of patient observations, there is little research addressing the issues of the most effective and efficient way to monitor patient progress.
- **Observations should be performed as often as indicated by the patient's clinical status.**[1]
- Consistency and continuity of care are prerequisite for effective support for the postpartum woman.[2]
- All deviations from normal shall be referred to a Medical Officer. Documentation of the referral shall be made in the patient progress notes and Clinical Pathway MR 249.60/MR 249.61

	PROCEDURE	ADDITIONAL INFORMATION
1.	**Physical assessment**	
	The midwife is to introduce herself and confirm Patient identification.	
	Perform a postpartum physical assessment within four hours of birth.	For the first 12 to 24 hours after birth the woman is at high risk of haemorrhage and other complications.
	Obtain the woman's consent for performing a postpartum assessment	Frequent monitoring during this time,up to , and including day 5, is necessary to detect and act on any deviations from normal.

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Ensure comfort and privacy is maintained.	
Advise the woman of the signs and symptoms of potentially life threatening conditions and to call for help if any signs or symptoms occur[2]	
Repeat the assessment four hours later and then daily thereafter if it is within the normal range.	Following this initial postpartum period, the World Health Organization (WHO) recommends daily assessments until the end of the first week.[4] KEMH offers Visiting Midwifery Service (VMS) up to Day 5 post partum.
1.1 ***Vital signs***	Vital signs considered within a holistic assessment of the woman may be useful in identifying complications.[4]
• Respiratory rate • Oxygen saturations • Heart rate • Blood pressure • Temperature • Consciousness	
1.2 ***Uterine involution***	
• Prior to assessment, ask the woman to empty her bladder if she has not done so recently.	A full bladder displaces the uterus making it feel high and deviated to one side on palpation.
• Gently palpate the uterine fundus.	Palpation of the uterine fundus in the first hours following birth is necessary to determine that it is well contracted and is not filling with blood.[4]
• Note the tone, the height in finger breadths below the umbilicus and the position.	The value of subsequent assessments to identify subinvolution, due to retained products of conception (RPOC) and/or endometritis[5] remains unclear. Palpation and measurement of the uterus per se has not been confirmed by research[6,7] Therefore, in making a diagnosis of subinvolution, other factors such as fundal tenderness, pyrexia, offensive lochia and a change in the amount of lochia, need to be considered.
• Discuss the process of involution with the woman and teach her how to feel her own fundus.	Discussion of the process of involution informs the woman of what to expect and when to seek further advice

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	• Ensure the woman is provided with appropriate analgesia for involution pain. • Discuss the role of non-pharmacological measures (frequent bladder emptying, heat packs) in relieving pain.	
1.3	***Urinary elimination*** See Clinical Guideline Obstetrics & Midwifery: Postnatal Care (Routine): Subsequent Care: Bladder Care	Urinary problems in the early postpartum, in particular urinary retention and stress incontinence are common[8.] Vigilant surveillance of bladder functioning during this time, detection of problems and early intervention where they exist will minimise the risk of permanent bladder damage.[9]
	Record the frequency and volume of voids on the Vaginal Birth Clinical Pathway MR 249.60	150mL is regarded as an indication that bladder function has returned to a 'normal' state.
	Measure each amount voided until two consecutive voids of 150mL or greater are achieved prior to discharge from hospital.	
	Ask the woman if she is experiencing any discomfort or difficulty when voiding.	
	If the woman reports difficulty or discomfort, examine her abdomen for displacement of the uterus and swelling of the lower abdomen	Abdominal swelling may indicate bladder distention and the need for catheterisation.
	Palpate the bladder	
	Educate and encourage the woman to undertake pelvic floor muscle exercises.	There is evidence that pelvic floor muscle exercises are effective in reducing or resolving urinary incontinence after childbirth[16]

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1.4 *Lochia*	
• Ask the woman about the colour and amount of lochia, and whether it has any odour	Assessment of the lochia is done to detect abnormal bleeding, RPOC and uterine infection.
• Discuss with the woman the expected duration and the expected changes in amount and colour of the lochia. Inform her that:	A recent study has shown that the amount, colour and duration of lochia actually experienced by women varies widely and does not correlate with descriptors given in current textbooks[5.] Additionally, this study found that 4% of primiparous women were unaware that they would have any vaginal loss at all following birth[9].
➢ Regardless of parity, lochia lasts on average 24 days with a range in duration from 2 days to 86 days[10] and	
➢ If the lochia becomes heavy, bright red after the first week, offensive or if any clots are passed she should seek further advice from her GP.	Women therefore need to be informed so they know what to expect and what is normal.
1.5 ***Perineum and vulva***	
• Ask the woman whether she has any concerns about the healing process of any perineal wound; including perineal pain, discomfort, stinging, or offensive odour.	
• Offer to assess the woman perineum if the woman has pain or discomfort	Inspection of the perineum is done to ensure the area is clean and dry, bruising and oedema are reducing and that any trauma is healing appropriately.
• Discuss normal healing, hygiene and pain relief measures with the woman See Clinical Guidelines Obstetrics & Midwifery: Postnatal Care (Routine): Subsequent Care: Perineal Care	Appropriate hygiene reduces the risk of perineal infection and wound breakdown.
• Advise the woman of the importance of perineal hygiene, including frequent changing of sanitary pads, washing hands before and after doing this, and daily bathing/ showering to keep their perineum clean.[2]	

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1.6	***Breast care*** Ask the women if she has any discomfort or concerns. If she does • Inspect breasts for areas of redness. • Inspect the condition of the nipples and areola. • Palpate the breasts for areas of heat, hardness or pain.	Damaged nipples and/or areas on the breasts, which are red, hard and hot, may be due to poor attachment techniques. Identification of any problems or trauma indicates where breast feeds need to be supervised and instruction on correct attachment needs to be given. These signs may be an indication of blocked ducts or infection.
1.7	***Legs*** • All patients should have VTE risk assessed by a Medical Officer and documented on their National Inpatient Medication Chart 810.05. • The presence of any of the following should result in a full VTE risk assessment being performed and documented ➢ Previous VTE or thrombophilia ➢ Age > 35 ➢ Overweight (BMI ≥ 30) ➢ Prolonged immobility > 3 days • A VTE risk assessment sticker shall be placed across the page at the beginning of each ward admission. • Inform the woman's Medical Officer (MO) and document if there are any additional factors in the woman's history exacerbating her risk of VTE. • Inspect legs for any areas of redness, heat, tenderness or swelling. • Routine use of Homan's sign as a tool for evaluation of thromboembolism is not recommended	Where the possibility of VTE is increased prophylactic anticoagulant therapy may be considered.[11] These risk factors result in the greatest likelihood of VTE postnatally, even in women who have had a vaginal birth. This allows these risk factors to be documented and the entry to be signed and dated The presence of any of these risk factors or a history of thrombophilia or previous thrombosis requires a formal assessment of risk factors and the use of thromboprophylaxis where appropriate. Although the condition is rare, thromboembolism is a major cause of maternal mortality and morbidity[4, 11] If present, These signs may suggest a superficial or a deep vein thrombosis. Homan's Sign is regarded as generally unreliable, insensitive and non specific in

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	the diagnosis of thromboembolism [2] Obese women are at a higher risk of thromboembolism and should receive individualized care.[17]
• Provide the woman who is at increased risk of VTE with correctly fitted Graduated Compression Stockings (GCS)	When correctly fitted, GCS give venous support, which assists to prevent venous stasis in the legs
• Discuss preventative measures: ➢ early mobilisation, ➢ Attention to hydration ➢ elevation of legs and circulatory exercises (ankle circling and dorsiflexion of the feet) when sitting, ➢ avoidance of crossing legs, ➢ avoidance of long periods of sitting or standing and ➢ avoidance of smoking.	These measures promote venous return and minimise venous stasis thus minimising the risk of clot formation. Early mobilisation is said to be the major prophylaxis against VTE.[4]
1.8 ***Bowel elimination*** • Ask the woman if she is experiencing any discomfort or difficulty with defecation.	Refer to Clinical Guideline Obstetrics & Midwifery: Postnatal Care (Routine): Subsequent Care: Constipation Management in the Postnatal Woman which advises a stepwise choice of treatment according to the severity of constipation. A lack of dietary intake during labour or pain due to perineal trauma contribute to constipation.[5] Left untreated it may lead to the development of an acute anal fissure.[5]
• Reassure the woman that she will not damage any perineal repairs while defecating and that passing a motion may be made more comfortable by holding a clean pad against the perineum. • Ensure the woman has appropriate analgesia for perineal pain.	Anxieties about rupturing sutures or damaging repairs and of pain may prevent the woman from defecating thereby exacerbating constipation.

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• If complaining of constipation and discomfort, assess her diet and fluid intake and offer advice on how to improve her diet.	Education on the factors that maintain normal bowel function is an important aspect in the prevention of constipation.[6]
• Encourage the woman to eat a high fibre diet in conjunction with at least 6 to 8 glasses of clear fluids per day.[4]	Dietary fibre and adequate clear fluids stimulates peristalsis increasing bowel transit time and the frequency of bowel movements.[4]
• Explain to the woman that some medications (e.g. iron supplements and codeine) may cause constipation.	Knowledge of the constipating effects of medication allows informed decisions regarding the type of analgesia and iron supplements used.
• If, by the end of the third postpartum day, bowel function has not resumed, offer the woman a gentle laxative.	A gentle laxative may be recommended if dietary measures are not effective[2]
• If bowel function has not resumed within 4 to 5 days and the women does not have an anal fissure or haemorrhoids, offer a glycerine suppository. • Visiting midwives (VMS) can offer Microlax enemas or an alternative aperient. • If the woman feels that constipation has still not resolved after implementation of the above measures, inform the MO. • VMS to report this to the medical office in EC or refer the woman to her GP.	Glycerine suppositories promote faecal evacuation within 15 to 30 minutes through their osmotic laxative, lubricating and faecal softening and, local irritant effects. They are contraindicated in women with anal fissures and haemorrhoids.[13,14]
1.9 ***Haemorrhoids***	
• Ask the woman about the presence of haemorrhoids	Haemorrhoids are a common occurrence following childbirth. They usually resolve within a few days of giving birth but may cause considerable pain & discomfort in the mean time.[5]
• Explain to the woman that haemorrhoids: ➢ are common, ➢ usually resolve within a few days, ➢ usually only require	

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conservative management, ➢ May bleed following bowel movement &, if associated with pain, she should seek further advice. • Advise the woman to avoid constipation.	
• Offer the woman topical application of a haemorrhoid ointment (e.g. Rectinol) for pain relief. • Women with severe, swollen, or prolapsed haemorrhoids or any rectal bleeding should be referred to the medical officer.	Haemorrhoid ointments alleviate pain through their local anaesthetic and vasoconstriction effects.[14]
2. **Psychosocial assessment** Ask about the woman's emotional wellbeing. Encourage the woman and her family/partner to tell a healthcare professional about any changes in mood, emotional state and behaviour that are outside the woman's normal pattern.	The postpartum period is a vulnerable time for the development of emotional and psychological problems. The task of care-givers is to be vigilant to emerging problems and make appropriate and timely referrals for psychological or social work services.
2.1 ***Emotional*** Offer the woman the opportunity to talk about her: • birthing experience. If she has had an unexpected outcome (e.g. 3rd degree tear, instrumental delivery, PPH or Caesarean section),put a silver star against her name on the postnatal board to alert medical staff she may like a more detailed discussion of her birth events. • perception of how the birthing experience matched her expectations, • adjustment to the mothering role,	Allowing the woman to discuss her birth and postpartum experiences provides her with the opportunity to clarify events, gain specific information and resolve issues that may be causing concern. In addition, a discussion of both how the woman is feeling emotionally and of how she is adjusting to motherhood, provides the opportunity to assess her emotional and psychological health.

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• feelings toward her infant and Discuss with the woman the physical and emotional changes that occur after birth.	
2.2 ***Fatigue*** Assess the woman's level of fatigue: • Taking seriously any expression of fatigue and tiredness • Ask about her general well being and offer advice on diet, exercise and planning activites, including spending time with her baby • Refer the woman to the MO/GP for further assessment where there are any concerns.	Fatigue is both a common problem in the postpartum period[5] and a symptom of many psychological and medical conditions. It is important to identify its likely cause so the woman receives appropriate management.
2.3 ***Social circumstances and support*** Assess the woman's level of social support as well as her awareness of community resources and how to access these. Refer the woman for Social Work assessment where social problems and/or a lack of support are identified.	Support for the woman from her partner, relatives and friends is associated with better psychosocial outcomes and postpartum adjustment.[3,5]
2.4 Ensure the woman has a family doctor. A postpartum visit for mother and baby should be scheduled for 6-8 weeks. This may be earlier if there has been birth or postpartum complications.	The family doctor is an important element in the long term continuity of care for mother, baby and the family.

PROCEDURE	ADDITIONAL INFORMATION
3. **Postpartum Education** Should be completed and documented on Clinical Pathways MR 249.60/ Mr 349.61 Education is to include the following:	
• Breast care, breastfeeding and expressing.	See Obstetrics & Midwifery: Newborn Feeding
• Formula feeding for women who have chosen not to breastfeed.	See Obstetrics & Midwifery: Newborn Feeding
• Bladder care	See Clinical Guideline O&M: Postnatal Care: Subsequent Care: Bladder Care
• Hydration and nutrition	
• Sleep and rest including: ➢ the need for adequate rest; ➢ having at least one rest period during the day and ➢ Prioritising activities.	The postpartum period is a time of major psychological adjustment. Sufficient rest and sleep are essential for emotional and psychological wellbeing.
• Contraception, sexual health and sexual activity after childbirth especially: ➢ resumption of sexual activity ➢ potential problems including dyspareunia, vaginal dryness and loss of libido and ➢ Risks of sexually transmitted diseases.	High levels of sexual morbidity are associated with childbirth[15] It is important to discuss these issues with the woman so that she may respond appropriately to any difficulties.
4. **Administration of Anti D Immunoglobulin.** Offer RhD immunoglobulin to all non sensitized Rh-D negative women within 72 hours following the birth of an RhD-positive baby.	RhD immunoglobulin is used to prevent Rh immunisation. Refer to Clinical Guideline Obstetrics & Gynaecology, Standard Protocols, RhD Negative Blood Group Management, RhD Immunoglobulin: Administration.

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5.	**Administration of Measles, Mumps and Rubella Vaccine** Women found to be sero-negative on antenatal screening for rubella should be offered an MMR (measles, mumps, rubella) vaccination following birth and before discharge. Advise the woman that pregnancy should be avoided for 1 month after receiving MMR, but that breastfeeding may continue[2]	Infection during pregnancy is associated with a high risk of congenital abnormality in early pregnancy and with Expanded Rubella Syndrome in later pregnancy. Because the probability of a woman becoming pregnant within 30 days of giving birth is extremely small, the early postpartum period is an appropriate time to immunize.[4] Refer to Clinical Guidelines Obstetrics & Midwifery: Postnatal Care (Routine): Subsequent Care: Measles, Mumps and Rubella Vaccine Administration, Vaccine Administration: Contraindications and Precautions
6.	**Pertussis** This vaccine is recommended for parents planning pregnancy or as soon as possible after baby is born. The woman and her family are advised to attend her GP for this vaccination.	Immunisation greatly reduces the risk of infection, but protection wanes over time, and infection may still occur.

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National Standards – 1- Care provided by the clinical workforce is guided by current best practice
9- Recognising and Responding to Clinical Deterioration

Legislation - Nil

Related Policies - Nil

Other related documents – KEMH Clinical Guidelines Obstetrics & Midwifery:

- Postnatal Care (Routine);
- Newborn Feeding

RESPONSIBILITY	**OGCCU**
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