

## 6 ROUTINE POSTPARTUM CARE

Date Issued: March 2002  
Date Revised: September 2010  
Review Date: September 2013  
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Review Team: OGCCU

6.1 Immediate Care of Mother in Labour and Birth Suite Following Birth  
Section B  
Clinical Guidelines  
King Edward Memorial Hospital  
Perth Western Australia

### 6.1 IMMEDIATE CARE OF THE MOTHER IN LABOUR AND BIRTH SUITE FOLLOWING BIRTH

#### 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.
2. Deviations from normal will require more frequent checking.
3. If observations are outside the normal range or if the woman's condition gives rise to concern, the medical officer shall be informed immediately.
4. If blood loss is outside the expected range or the placenta is retained the woman shall not be given food or fluids.
5. The woman shall be kept in Labour and Birth Suite until she no longer requires frequent monitoring or medical review.
6. Each time the woman is checked and her physical condition assessed, the midwife shall perform a visual check of the neonate to ensure its condition remains within normal limits.

#### PROCEDURE

- Assess and document the tone and position of the fundus and the amount of lochia
  - every 15 minutes for the first hour after birth then
  - hourly for the second hour, then
  - four hourly
- Measure and document the woman's pulse and blood pressure and check the perineum
  - every 30 minutes for the first hour after birth and then
  - hourly for the second hour, then
  - four hourly

- Measure and document the woman's temperature once.
- Ensure the woman is warm, clean and dry.
- Assess the woman's level of pain and discomfort and initiate analgesia and comfort measures.
- 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 [B 8.1.4 Skin to Skin Contact](#)
- Encourage the woman to initiate infant suckling. See clinical guideline [B 8.1.5 The First Feed](#)
- If the woman has chosen not to breastfeed, organise a formula feed for the baby.
- Offer refreshments to the woman and her support person.
- Assess the woman's range of movement, leg sensation and weight bearing ability prior to ambulation.
- Assist the woman to the shower and toilet. Offer a wash in bed where appropriate.
- Encourage the woman to void. Ensure the bladder is emptied See clinical guideline [B 6.2.2.1 Bladder Care](#)
- If the woman has had an operative birth with an epidural or spinal top up, an indwelling catheter should remain in situ for at least 12 hours after birth.
- Discontinue any intravenous infusion if the woman's clinical condition allows. The cannula must remain in situ if an epidural is to continue.
- The epidural catheter shall be removed if no longer required for analgesia.

#### **PRIOR TO TRANSFERRING TO THE POSTNATAL WARD**

- Assess and record
  - The tone, height and position of the fundus.
  - The amount of lochia
  - The perineum
  - The pulse and blood pressure.
  - The bladder status
- Inform the respective postnatal ward of the transfer of the woman.
- Transfer the woman, with the baby either in her arms or in a cot.
- 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.