Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

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AUTHOR	C Byron (Clinical Midwifery Educator Postnatal Services)
SUMMARY	Guidance for the recognition, response and appropriate management of a postnatal woman's physical and/or mental state condition
Key words	Observations, postnatal deterioration

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Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The postnatal period is an important time for a woman and her neonate/s. It starts immediately after birth of the placenta and ends approximately at 6 weeks. Care of the woman during this time should be personalised and documented appropriately.

The aim of this CBR is to recognise, respond and appropriately manage a postnatal woman's deterioration in physical and/or mental state

Definitions:

A-I	A systematic physical assessment looking at:- Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose, Holistic, Infection
Behaviour change	Changes to the way a maternity woman interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and /or delirium
Bromage score	Scale of the intensity of the motor block, assessed by the woman's ability to move their lower extremities. Bromage 0 (none) = Full flexion of knees and feet 1 (Partial) = Just able to move knees and feet 2 (Almost Complete) = Just able to move feet only 3 (Complete) = Unable to move feet or knees
Clinical Emergency Response System (CERS)	A formalised system for staff, women, carers and families to obtain timely clinical assistance when a woman deteriorates (physiological and/or mental state)

2 RESPONSIBILITIES

2.1 Medical Staff – respond, assess/review and manage any changes in postnatal woman's observations

2.2 Midwifery and Nursing Staff - assess/review, escalate and follow-up any changes in observations

3 PROCEDURE

3.1 Clinical Practice

- Perform following observations in the first hour following birth:
  - Respiratory rate (RR), oxygen saturations (SpO^2), heart rate (HR), blood pressure (BP), temperature, uterine tone and PV loss, level of consciousness and/or behaviour changes
  - 15 minutely uterine tone and ongoing estimation of cumulative blood loss
- Perform full set of observations before leaving the birth environment including BP, HR, RR and temperature
- Assess bladder function, ensure woman has passed urine or has plan for indwelling catheter removal
- Activate CERS call if criteria met. Increase observations as per clinical condition. Observations can be increased by either midwifery/nursing or medical officer
- Complete Venous Thromboembolism (VTE) risk assessment within two hours of birth. Initiate appropriate prophylaxis as per Prevention of Venous Thromboembolism MoH PD2019_057
- Complete Waterlow scale
- Perform full set of observations within one hour of admission to the postnatal ward. Including a baseline A-I assessment and document in the medical record. Cease if within normal range
- Perform ongoing observations and clinical assessment as below and outlined in appendix 1
- Perform a full set of observations within one hour prior to discharge from hospital

Diabetes (pre-gestational or Gestational):

- Consult individualised advice plan for observation instruction. If there is no individualised plan:
  - diet controlled Gestational Diabetes Mellitus (GDM) woman to cease blood glucose level monitoring (BGL) at birth
  - woman with pharmacological controlled GDM (insulin and/or metformin) initiate postpartum BGL monitoring pre-meal and bedtime for 48 hours:
    - Escalate to endocrinology/obstetric medicine team if BGLs > 8.0 mmol/L

- BGLs < 8.0 mmol/L cease testing after 48 hours
- Follow-up 75g Oral Glucose Tolerance Test (OGTT) should be organised by her GP at 6-12 weeks postpartum or as directed by endocrinology/obstetric medicine team

Hypertension Disorders:

- Continue 4th hourly BP for 24hrs, then 6 hourly until advised by medical team

Febrile in labour or postnatally temperature ≥ 38.5°C:

- Suspect sepsis and follow Sepsis Pathway

Following postpartum haemorrhage and/or manual removal of placenta:

- Ensure continued close monitoring for the first hour, then 4th hourly observations with assessment of uterine tone, and assessment of PV loss for 24hrs

Third or Fourth degree tear

- Ensure 4th hourly observations and assessment of PV loss for 24hrs (as per Third or Fourth degree tear CBR)

Epidural (as per Epidural Analgesia):

- Ensure (as per CBR):
  - Bromage score prior to mobilisation
  - If residual epidural effects at 6 hours, organise anaesthetic review
  - Inspect epidural site at catheter removal and at 24 hours postpartum

Caesarean Birth:

- Ensure (as per CBR) hourly for the first 6 hours, then 4th hourly until 24hrs; then 6th hourly until discharge:
  - observations (BP, HR, RR, SpO2 and temperature)
  - sedation and pain score
  - uterine tone
  - wound
  - PV loss
  - bromage score

  (note: If neuraxial morphine, continue RR and bromage score 2nd hourly from 6-24 hours)

Pre-existing significant illness

- as directed by medical team

3.2 Documentation

- Medical Record

  - CERS (clinical review/rapid response)
  - Standard Maternity Observation Chart (SMOC)
- Neuraxial opioid observation chart (Adult)
- Obstetric epidural analgesia chart
- Postnatal clinical pathway for caesarean section
- Postnatal clinical pathway for vaginal birth
- Maternal sepsis pathway
- Wound chart

3.3 Education Notes

3.4 Implementation, communication and education plan

This revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

3.5 Related Policies/procedures

- Clinical Emergency Response system (CERS) – Management of the deteriorating patient
- Retained Placenta – Management
- Sepsis in Pregnancy and Postpartum
- Third and Fourth Degree Perineal Tears - Repair, Management and ward based postnatal care
- Epidural Analgesia
- Postpartum Haemorrhage – Prevention and Management
- Hypertension – Management in Pregnancy
- Bladder care during labour and the postpartum period
- Management of the deteriorating MATERNITY woman SESLHDPR/705
- Management of Gestational Diabetes Mellitus (GDM) SESLHDGL/117
- Management of Pre-Gestational Diabetes in Pregnancy SESLHDGL/116
- Postpartum Haemorrhage (PPH) NSW GL2021_017
- Prevention of Venous Thromboembolism NSW PD2019_057
- Recognition and management of patients who are deteriorating NSW PD2020_018

3.6 References

N/A

4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service. See NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters Working with Health Care Interpreters:

6 NATIONAL STANDARDS

Standard 3 – Preventing and Controlling Infections

Standard 5 – Comprehensive Care

Standard 6 – Communicating for Safety

Standard 8 – Recognising and Responding to Acute Deterioration

7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Amended August 2019 – PACE changed to CERS Change 777 to 2222 February 2019 Reviewed and endorsed Maternity Services LOPs group 10/10/17 "Observations for postnatal woman on the postnatal ward' - Approved Quality & Patient Safety Committee 19/5/11 Reviewed Obstetric Clinical Guidelines group April 2011 "General Observations – Postnatal Wards' – approved Quality Council 21/7/03		
11/06/2024	6	Maternity CBR Committee
1.7.24	6	Endorsed BRGC

Appendix 1

Postnatal Maternal Observations

Postnatal admission

MINIMUM SET OF OBSERVATIONS
1 SET OF OBSERVATIONS WITHIN HOUR OF ADMISSION
- Respiratory rate
- Oxygen saturation
- Heart rate
- Blood Pressure
- Temperature
- Uterine tone and PV loss
- Level of consciousness and/or behavioural changes

- Cease if within normal limits and pregnancy/birth was uncomplicated
- x1 Set observations within 1 hr of D/C home

Abnormal or deteriorating condition

CERS Call
Activate CERS 2222

Continue observations for the following maternal conditions

DIABETES	Consult individualised care plan (pharmacological GDM control) BGL pre-meal and bedtime for 48hrs) OR as directed by obstetric physician/endocrinology team
HYPERTENSIVE DISORDERS	4/24 BP for 24 hours → 6/24 until advised by medical team
FEBRILE IN LABOUR – TEMPERATURE ≥38.5°C – SUSPECT SEPSIS	FOLLOW SEPSIS PATHWAY
FOLLOWING PPH AND MROP	close monitoring of observations, uterine tone and PV loss for 1/24 (if stable) 4/24 observations with uterine tone and PV loss for 24hrs
3RD AND 4° TEAR	4/24 observations and PV loss assessment for 24 hrs
EPIDURAL in labour	Bromage score prior to mobilisation. If residual epidural effects at 6hrs, needs Anaesthetist Review Epidural site inspection at removal and 24 hrs
CAESAREAN BIRTH	1/24 observations, sedation, pain score, bromage, assessment of uterine tone, PV loss and wound for 6hrs THEN 4/24 observations until 24 hrs (**note:** neuraxial morphine continue 2/24 Respiratory Rate and bromage, score from 6-24hrs)
PRE-EXISTING MEDICAL Condition	As advised by medical team

ACTIVATE CERS IF CRITERIA MET
Increase observations as per clinical condition