MIDWIFERY GUIDELINES FOR COURSE OF POSTPARTUM CARE

These evidence-based guidelines are intended to support midwives in making assessments and exercising their judgment in the postpartum period, consistent with the Midwifery Standard for Postpartum Care. They include flexibility that acknowledges midwives are primary care providers capable of assessing individual clinical situations and exercising appropriate clinical judgments based on their assessments. Midwives are also encouraged to develop their own evidence-based guidelines for their practices.

Immediate postpartum: The midwife should remain in attendance until mother and newborn are stable in the immediate postpartum, or until care is transferred to a physician if required. Maternal and newborn stability are generally attained within two hours following birth, although this may occasionally take longer.

Recommendations for assessing postpartum stability for vaginal delivery:

Mother:

1. Vital signs (temperature, pulse, respirations and blood pressure) are in the normal range and stable;
2. Perineum is intact or repaired;
3. Bladder function is assessed as adequate; and
4. Vaginal blood loss is controlled and within normal limits and there are no complications requiring ongoing observation.

Newborn:

1. Respiratory rate is normal with no evidence of distress e.g. grunting or indrawing;
2. Body temperature and heart rate are normal and stable;
3. Physical exam has been completed, a birth weight recorded, and there is no evidence of significant congenital anomalies;
4. There is no evidence of sepsis; and
5. The baby has latched and sucked at the breast (or, if not, there is evidence of sucking/rooting and readiness to feed. The midwife will call within ten to twelve hours of birth to confirm that the baby has fed, and ensure appropriate follow-up if required.)

The mother should be reminded of conditions where she should contact the midwife immediately rather than waiting for the next visit. These include:

Newborn: temperature instability, failure to feed, lethargy and signs of sepsis; and

Mother: fever, constant or severe uterine pain, foul smelling lochia, excessive lochia, calf pain or inflammation, chest pain or dyspnea.

Postpartum visits in the first week:
The following visits are recommended as a basic schedule, with additional visits on an "as needed" basis. If mother and newborn are not in hospital, ideally these should be home visits.

First Visit: on Day 1 - within 24 to 36 hours of the birth;

Second Visit: on Day 3 or Day 4; and

Third Visit: between Day 5 and Day 7.

The following assessments are recommended during the first week postpartum:

First visit: In addition to basic assessments of mother and newborn (see below), the midwife should confirm that the newborn is not jaundiced and has successfully passed both urine and meconium. If the newborn is jaundiced within the first 24 hours or has not passed urine or meconium by 36 hours, a physician consultation is required[1].

Basic assessments of mother and newborn during the first week:
Mother: general physical and emotional well being; micturition and bowel function; involution; perineum; lochia; breasts and breastfeeding; s/s fatigue, backache, headache, pain/infection; and
Newborn: general wellbeing and behaviour (sleeping, waking, crying); colour; tone; respirations; heart; temperature; feeding, voiding and stools; hydration and weight loss/gain; resolution of moulding/ bruising/ cephalohematoma; and cord site healing/infection.
Newborn Screening for metabolic disorders should be done as soon as possible between 24-48 hours and no later than seven days after birth[2].

Postpartum visits after the first week and up to six-weeks postpartum:
After the first week postpartum, visits may take place either at the woman's home or the midwife's clinic.
It is recommended that subsequent visits occur close to the following schedule:

- at 10 days to 2 weeks postpartum; with repeat visits as needed, including at 3 weeks postpartum if the newborn has not regained birth weight by the previous visit. If the baby has not regained birth weight by 3 weeks postpartum, a physician consultation is required[3], (if the baby has regained birth weight, a 3 week visit is not required);
- at approximately 4 to 5 weeks postpartum; and
- at approximately 6 weeks. (The midwife may continue to provide care within her scope of practice and provide a final discharge visit up to three months postpartum.)

These visits should be timed to allow the midwife to properly assess the mother's recovery and adaptation, and that the baby is continuing to adapt, thrive and gain weight. It may be necessary for the midwife to conduct more frequent visits than those outlined above, either in person or by telephone, if there are concerns regarding either mother or baby.

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[1] CMBC *Indications for Discussion, Consultation and Transfer of Care*
[2] *Newborn Screening (Neonatal Guideline 9)*, Perinatal Services of BC (PSBC), 2010
[3] CMBC *Indications for Discussion, Consultation and Transfer of Care*

Postpartum Backup Coverage and Transfer of Care
A back-up plan should be in place with other appropriate health care providers (other midwives, local physicians, and/or the public health unit) to ensure that someone is available to assess a mother and/or newborn if the midwife is unable to attend a visit.

Occasionally distance or other circumstances may result in mother and newborn being unable to travel for postpartum midwifery clinic visits. If this is the case, and additional home visits are not possible, alternate care should be arranged. This can include requesting public health nursing support or transferring the balance of postpartum care to a local family physician.

If the midwife is unable to complete a full course of postpartum care with a mother and her newborn, care must be transferred to another primary care provider.

At the final postpartum visit the midwife formally transfers the care of mother and baby to another primary health care provider, usually the woman's family physician. A copy of the *Labour and Birth Summary* and *Newborn Summary* are provided to the mother or her care provider and the mother is informed of the community resources available for her and her baby.

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