

Observation of mother and baby in the immediate postnatal period: consensus statements guiding practice



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Introduction

This consensus guidance has been developed by members of the New Zealand College of Midwives and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists – New Zealand Committee, with the support of the Ministry of Health. This guidance has been reviewed by the Neonatal Encephalopathy working group of the Perinatal and Maternal Mortality Review Committee and is endorsed by the Ministry of Health and the National Maternity Guidelines Working Group.

Implementation of this guidance will be led by the relevant professional colleges, and included in every DHB's local Maternity Quality and Safety Programme. It is expected that all practitioners supporting mothers and babies in the immediate postnatal period will use this document to guide their practice.

Responsibilities of practitioners

- All mothers and their babies must receive active and ongoing assessment in the immediate postnatal period, regardless of the context around their birth. During this time, the mother and baby should not be left alone – even for a short time.
- Ongoing assessment is for a minimum of one hour. Assessment will be longer than one hour if the mother or baby has experienced factors that increase their risk of adverse outcomes.
- Care during this time supports the physiological processes of the mother's transition to motherhood and the baby's transition to independent life.
- To assist these transitions there is ongoing observation of both the mother and baby's wellbeing, promotion of skin-to-skin contact, and support and oversight of the first breastfeed. Supporting these processes promotes the psychological attachment essential to the baby's wellbeing within a safe and secure environment.
- Monitoring the baby's wellbeing includes ongoing assessment of the baby's colour, tone and respirations at all times, with particular care during periods of skin-to-skin contact. If there is any question about the baby's wellbeing a full assessment should be carried out.
- If there are any concerns regarding the baby's ability to transition to independent life, there must be follow up with a review by paediatric staff as soon as possible.
- All practitioners providing care in the immediate postnatal period must understand the importance of, and undertake, ongoing assessment of both the mother and baby, including situations where non-midwifery personnel are providing this care outside the delivery unit (eg, in a post-operative recovery unit). All staff must be educated and competent in recognising any departure from normal.
- All practitioners must be competent in providing emergency intervention for both the mother and the baby and how to obtain assistance from a midwife or doctor if there are concerns.

Involvement of family and whānau

- The principles of safe sleeping involve placing the baby to sleep so that they remain face up, with face clear and in a smoke-free environment at all times. Mother, father and family/whānau are provided with education and encouraged to follow safe sleeping practices during the immediate postnatal period and on an ongoing basis.
- It is recognised that the mother with her family/whānau may need a time of privacy after the birth. Observation of the baby may be transferred to family/whānau if this is deemed clinically appropriate. The baby must be well, the mother alert and the family/whānau be responsible for the time specified. During this time the mother and her family/whānau must understand that they are ensuring the baby's nose and mouth are clear and are able to observe the baby's colour and respirations. They must also be aware to note excess bleeding or a change in the mother's condition during this time. They must know when it is necessary to call for help and how to do so if they are concerned.

Responsibilities of district health boards or employers

- District health boards and employers must ensure sufficient staff are available to support Lead Maternity Carers and, if necessary, provide ongoing, active assessment of the mother and baby in the immediate postnatal period. There must be sufficient staff to enable ongoing assessment if the situation arises where the mother or baby requires observation for longer than one to two hours after the birth.

Rationale

Sudden Unexpected Early Neonatal Deaths (SUEND) is an increasingly recognised problem. Risk factors include unsupervised skin-to-skin contact, inexperienced mothers and mothers being left unsupervised in the immediate postnatal period.¹

Midwives comprise the main category of health professionals in the primary role of managing the care of mothers and their babies in the immediate postnatal period. At times, this responsibility is delegated to other health professionals or to family/whānau for short periods. Whoever is providing this care must be capable of carrying out this responsibility confidently, and have immediate access to additional support when required.

For the purposes of this document the 'immediate postnatal period' is defined as the first one to two hours after the birth, although this time may extend beyond this as required.

It is important to note that mothers are less able to ensure a safe environment for breastfeeding or sleeping when they have experienced a long or complicated labour and birth, are under the influence of medications, drugs or alcohol, or have some medical conditions.

Family/whānau are also less able to ensure a safe environment for mother and baby when they are tired after supporting the mother through a long or complicated labour and birth.

Babies are more at risk of respiratory difficulties from a compromised airway where their mother or family/whānau have been or are exposed to medications, drugs, alcohol and/or smoking.

All mothers and babies are at risk in the immediate postnatal and neonatal period regardless of whether additional risk factors are present.

¹ Becher JC, Bhushan SS, Lyon AJ. 2012. Unexpected collapse in apparently healthy newborns – a prospective national study of a missing cohort of neonatal deaths and near-death events. *Arch Dis Child Fetal Neonatal Ed* 97(1): 30–4.

Ongoing assessment of the baby includes, but is not limited to, assessing the baby's:

- colour, heart rate, respiratory rate, temperature, airway integrity and overall condition
- tone and activity
- ability to breastfeed/feed.

Ongoing assessment of the mother includes but is not limited to:

- assessing the mother's overall sense of wellbeing and mobility
- palpating uterine height, position and tone
- observing blood loss – whether known loss is consistent with maternal condition
- monitoring temperature, pulse, respirations, blood pressure and consciousness level following all births (frequency depends on context)
- urine output
- providing intravenous fluids if prescribed
- providing medications if required
- monitoring bleeding from lacerations, episiotomy or Caesarean section wound
- assessing pain relief requirements
- assessing block levels if epidural or spinal anaesthetic was used (the mother should not be transferred out of delivery suite if >T8, or home within four hours of last top up)
- facilitating and supervising early skin-to-skin contact and breastfeeding as soon as possible after birth, with particular emphasis on ensuring the baby's nose and mouth are not occluded and that parents also understand the importance of this
- assessing bonding of mother, father, family/whānau and baby.

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