HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Postnatal Caesarean Section: Surgical Care Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

The purpose of this guideline is to:-

- Provide safe and effective care for women post Caesarean section
- Establish a local approach to care, that is evidence based and consistent
- Inform good decision making

Scope

- Obstetric staff employed by the Hutt Valley DHB
- Midwifery staff employed by the Hutt Valley DHB
- Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff

Definitions

SCBU – special care baby unit
Hb – Haemoglobin
C/S – caesarean section
BP – Blood Pressure
IV - intravenous

In Theatre / Recovery

- A midwife should accompany the woman to theatre where possible to receive the baby, and assist in any neonatal resuscitation which may be required.
- If ward staffing does not allow for a midwife to accompany the woman to theatre, then they should endeavour to at a minimum be able to attend the woman in recovery to begin skin to skin and facilitate breastfeeding.
- Any student midwife must be accompanied at all times by a qualified member of staff.

Skin to Skin should be commenced as soon as the woman and baby are stable, preferably within 5 minutes, in theatre where possible, or on arrival in recovery.

- The baby should remain with its mother at all times, unless the baby needs to be cared for in SCBU
- If the mother is unable/unwell the baby remains with the support person either in recovery or in the postnatal ward.

Transfer to ward

Core midwife to collect women from recovery, it is not the responsibility of the LMC to accept the handover from the recovery nurse.

Prior to transfer to the ward, the midwife must ensure:

- Lochia loss is within normal limits
- Wound ooze nil/minimal
- IV site patent
- Urinary catheter draining.
- Pain relief adequate and drugs prescribed as appropriate.
- Level of consciousness is documented
- BP, Pulse, R and Temp are stable.
- Level of epidural block within normal limits(dermatome level at T4 and below)
- Epidural catheter is removed.
- Review medication chart and documentation including analgesia, fluids, anti-emetics, anti-pruritics and anti-embolics given in theatre and prescribed for ongoing care.
- Estimated blood loss should be charted
- Anti Thrombo emboli equipment in place and working.

Observations on ward

Respiration rate
Temperature
BP
Pulse
Wound
Lochia
Urinary output
Pain

Should be checked and documented at the following intervals:
½ hourly for 2 hours
Every hour for 4 hours
Every 4 hours for 24 hours
3 times daily for 48 hours
Daily until discharge

Temp should be checked on admission, and 4 hourly thereafter for 24 hours.

These guidelines are a minimum, and actual frequency will depend on the woman's condition and stability.

Women who have had intrathecal opioids (spinal morphine) should have a minimal hourly observation of RESPS, SEDATION and PAIN for 24 hours following morphine.

Analgesia

- Commence oral analgesia as charted from 4 hours post op.
- Regular analgesia is given as prescribed, as good pain management allows early mobility and baby cares.

Fluids

- Maintain fluid balance chart until normal input and output are achieved.
- IV fluids to run as charted via a Baxter pump.
- IV fluids to be discontinued once normal fluid intake is resumed and tolerated.
- IV luer can be plugged and flushed with 5ml normal saline (6-8 hourly) to maintain patency for 12-24 hours or until IV access no longer required. Phlebitis scale should be observed and noted each shift.
- Urine output should be at least 1ml/kg per hour.
- Urinary catheter can be removed once output is adequate, and the woman is mobile. This should be not sooner than 12 hours after the last epidural 'top-up' dose.
- Careful observations following removal to check that normal bladder function is returning. If not passed urine after 6 hours, with good fluid intake, consider recatheterising/in out catheter.

Eating and drinking

Women who are recovering well and who do not have complications after C/S can eat and drink whenever they feel hungry or thirsty.

Early eating and drinking is associated with reduced time to return of bowel sounds, and reduced post operative hospital stay. It is NOT associated with increased nausea, vomiting, and abdominal distension, time to bowel action, paralytic ileus or number of analgesic doses.

Wound care and hygiene

- Within 4-6 hours a full bed sponge and linen change as needed.
- Assist to shower within 12-24 hours, when able. Check integrity of wound dressing prior to shower – cover as appropriate if loose.
- Check epidural/ spinal site for sepsis.
- The wound dressing should be left in place for no longer than 48 hours. Any pressure dressing should be removed after 24 hours
- If the dressing becomes unsecure/ soiled then it needs to be changed because the protective barrier is broken. If this happens the wound should be cleaned with water and redressed using aseptic technique.
- If the wound or surrounding area is red, hot, swollen (mark area to observe if spreading), take a wound swab and send to the lab.
- If the wound is oozing copious amounts of blood or serous fluid refer to the obstetric team.
- Ongoing general C/S wound care advice should include encouraging woman to take prescribed analgesia, complete antibiotics if prescribed, wear loose comfortable cotton clothing, and underwear, bath or shower daily, gently clean and dry the wound well, and only apply dressings once discharged if advised by their midwife or doctor.

Prevention of DVT

- Encourage early mobilization.
- Provide TED stockings to be fitted correctly and applied **before** surgery - advise they are worn until discharge from hospital.
- Give Clexane if charted.

Prior to discharge back to LMC at 72 hours

- Check anti D status
- Check Hb on day 2, or earlier if symptomatic.
- Check instructions for sutures (usually dissolvable).
- Debriefing with woman and those present during labour and birth if possible.
- See physiotherapist for advice and leaflet regarding postnatal exercise.
- Ensure prescription for analgesia/antibiotics for discharge.

References

Mansegi L and Hofmeyer GJ. (2002) Early compared with delayed oral fluids and food after caesarean section. Cochrane Database of Systemic Reviews. Issue 4.

NICE (2008) Surgical Site Infection
http:/www.nice.org.uk/nicemedia/pdf/CG74FullGuideline.pdf

NICE (2004) Care of the woman after C/S
http://www.nice.org.uk/nicemedia/live/10940/29334/29334.pdf

Associated documents

Breastfeeding Policy
Guidelines for C/S analgesia – intraoperative and postoperative.
Thromboembolism prophylaxis for maternity care.

National Consensus Guidelines statement – in draft form due early 2012
'mother and baby observations in the immediate postnatal period'

Appendix 1
ACCEPTING CARE OF WOMAN POST CAESAREAN

In recovery:

Assess Dermatome level with recovery nurse. **Don't accept woman if level higher than T4.**

- Assess consciousness
- Wound ooze
- PV loss
- Has epidural catheter been removed
- IDC volume drained in recovery
- Check what medication has been given in theatre and recovery
- Woman must have adequate pain relief prior to transfer to ward
- Ensure adequate pain relief has been charted on medication chart
- BP, pulse, temp. RR and oxygen sats all within acceptable range

Whenever possible the baby should be kept skin to skin with mum in theatre and recovery.
Initiate breast feeding if baby shows feeding cues

On return to ward

- Record baseline T,P,R, BP and oxygen sats
- Temp, Pulse and Blood pressure need to be repeated ½ hourly for one hour, hourly for two hours, 4 hourly for 48 hours and 12 hourly until discharge
- If woman has had spinal or epidural morphine they need to have hourly resp rate, otherwise fit in with other observations.
- IV fluids running on pump.
- Catheter output (more than 30ml/hr)
- Teds on if not done prior to O.T.
- Facilitate or continue skin to skin and breastfeeding
- Check wound
- Check lochia
- Change pads and linen(if required)
- Iced water to sip and ice block
- Check placenta for completeness and give to parents or discard as per their wishes
- Enter details on electronic discharge

Continued post caesarean care

- Ensure Kleihauer taken for Rh negative mum
- Assist with mobilizing, this should be 6-8 hours post operatively. Help with showering depending on patient's condition, alternatively sponge bath.
- When clexane is charted, to be given daily until discharge
- Ensure adequate level of pain relief is maintained, offer regularly
- Catheter to be removed according to surgeons instructions
- Wound care according to surgeons note, replace opsite if "excessive" wound ooze otherwise to remain in place until 48hours postop
- Postnatal check each shift
- CBC on day 2 for Hb check unless alternate instructions from surgeon
- Fluid diet until bowel sounds heard or woman feels hungry
- Check and follow postnatal care plan in notes

Baby

- General condition of baby including skin colour, temperature (resps if requested by Paed) normal care for normal babies
- Weigh baby
- Vitamin k given with consent
- Check cord blood taken and sent if mum is Rh neg
- Cord clamp secure
- I.D labels x2
- Send baby admission form
- Administer Hep B immunoglobulin and vaccine if mum is Hep B positive
- Bath baby if mum is Hep B positive

- BCG and skin to skin forms completed
- Well child book birth page completed both sides and given to parents with birth registration
- Enter details on discharge summary

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).