**COMMUNITY MIDWIFERY PROGRAM**
**CLINICAL PRACTICE GUIDELINE**

# Preparation for leaving after the birth

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| **Scope (Staff):** | WNHS Community Midwifery Program (CMP) staff |
| **Scope (Area):** | Home birth sites |

**This document should be read in conjunction with this Disclaimer**

## Purpose

To provide CMP midwives with the role and responsibilities of the midwife when preparing to leave a mother and her baby at home following a normal birth.

## Pre-requisites

- The third stage of labour has been completed and haemostasis maintained.
- Perineal repair has been completed if required.
- The woman has voided at least once post birth (if not voided follow the WNHS Clinical Guideline, Obstetrics and Gynaecology: Bladder Management). Consult with the back-up hospital for further management).
- All maternal observations have been completed and are within normal limits as per Postnatal Observation and Response Chart.
- The initial neonatal assessment, observations and cephalocaudal examination have been completed and are within normal limits. Observations as per MR426 Newborn Observation and Response Chart (NORC).
- Contemporaneous records and documentation of the birth have all been completed.
- All equipment packed and waste products and sharps have been disposed of appropriately.
- The disclaimer for retaining placental tissue has been signed and the information on placental care and disposal has been given to the parents if required.
- The midwife must remain with the woman for a minimum of two hours following the completion of the 3rd stage of labour and monitor maternal and neonatal observations (neonatal observations for minimum three hours).

## Post birth care of the mother

- Ensure baseline observations of respiratory rate, pulse, BP, and temperature are within normal limits and recorded 30 minutes and 60 minutes post birth and prior to the midwife leaving the home.
- Check that the uterus is well contracted and that the vaginal loss is within normal limits.
    - Educate the women regarding normal blood loss, demonstrate rubbing up a contraction and advise when to call if concerned.
- Discuss perineal care and management of perineal pain or discomfort.
- Educate the woman regarding the signs and symptoms of venous thromboembolism (VTE) (deep vein thrombosis (DVT)) and encourage her to mobilise and walk around the house when she gets up to void.
- Discuss bladder function and the need to void regularly. Educate the woman regarding the management of vaginal, labial or perineal discomfort on micturition.
- Ensure appropriate education has been given during this time regarding neonatal feeding. The first feed and any subsequent feeds should be observed and documented in the neonatal notes. The woman should be confident with attachment at the breast or the giving of formula feeds.
- Commence and document postnatal education, regarding the care of the neonate, including:
    - Safe infant sleeping and Sudden Infant Death Syndrome (SIDS) prevention (ensure parents have been provided with written information)
    - Nappy changing
    - Bathing
    - Care of the cord and umbilicus
    - Temperature regulation
    - Feeding:
        - Feeding cues, frequency of feeds
        - Hand expressing (offer a demonstration)
        - For mothers who have chosen to formula feed – ensure they have been provided with information and a demonstration on the correct process for making up bottles

## Post birth care of the neonate

The first few hours of life should include assessing physiological adaption into extra-uterine life: colour, tone, breathing and heart rate. The neonate must be assessed in an appropriately lit environment.

When assessing the neonate after a homebirth provide education to the parents regarding the signs and symptoms of an unwell neonate (see section GBS: ‘Signs

and symptoms of GBS infection' in the WNHS patient booklet 'Pregnancy Birth and Your Baby' book).

- **Observations**: Ensure that all neonatal observations are within normal limits for colour, tone, respiratory rate, heart rate, temperature and positioning in a supine head neutral position enabling a patent airway. Refer to the NORC.
    - **Colour** - Skin, tongue and mucous membranes should be pink. Mild cyanosis is normal at birth and generally resolves after the first few minutes of life
    - **Tone** - The neonate should display good muscle tone, movement and flexion
    - Neonatal observations should be performed as per WNHS Obstetrics and Gynaecology guideline: Neonatal Care: 'Observations', or as clinically indicated. Record observations on NORC. Additional observations to be performed if Midwife still present.
    - Undertake **oxygen saturation monitoring** (as per WNHS guideline, Obstetrics and Gynaecology: Neonatal Care).
    - For **any deviations** from the 'normal observations', consultation with a paediatrician must occur. Refer to ACM Guidelines for Consultation and Referral (see About ACM- Guiding Documents- Midwifery Guidelines) and Department of Health WA: Public Home Birth Policy.

- **Cord**: Check that the cord clamp is secure and no bleeding or oozing from the cord stump is evident.
- **Output**: Monitor the passing of urine and/or meconium and document.
- **Vitamin K:** Discuss administration of Vitamin K and parental choice. For clients that accept Vitamin K for their babies, administer and document accordingly in the CMP Postnatal record – CMP MR 09
- **Examination** of the neonate as per WNHS Clinical Guideline Obstetrics and Gynaecology, Neonatal Care: Examination
- **Follow-up**: Ensure that the woman has the contact number for the CMP midwife and support hospital and knows when her next visit will take place.
    - The first postnatal visit should be arranged between 12 and 24 hours of the birth as indicated.

**Feeding**

- Ensure the neonate has been offered a feed and if not interested that the mother understands to keep offering feeds regularly.
- The mother should be advised about the importance of skin to skin contact with her baby to assist with the establishment of breastfeeding.
- If the neonate does not feed effectively (Refer to WNHS Obstetrics and Gynaecology: Newborn Feeding and Maternal Lactation: Breastfeeding guidelines):
    - Continue skin to skin contact

  - Facilitate hand expressing of colostrum within 2 hours of birth and give the colostrum by finger of cup feeding
  - Offer breast and/or express and give the colostrum via finger or cup feeding 8-12 times in 24hrs
- If the neonate does not feed effectively prior to the midwife leaving the house, a midwife must contact the mother by 6 hours of birth to determine the feeding status.
  - If at 6 hours after birth the neonate is still not effectively sucking at the breast or taking available EBM, contact the support hospital to assess the need for paediatric review.
- The mother must be advised that if her baby does not feed for a period of longer than 6 hours in the first 24 hours she should continue the above plan (skin to skin, hand express and give the expressed colostrum), and contact her midwife. Long periods without breast stimulation are not advisable when establishing breastfeeding.
- Additional WNHS feeding resources to assist the mother:
  - Patient booklet: 'Breastfeeding and Breast Care'
  - Videos (e.g. position and attachment, expressing, finger feeding)

## References

### Bibliography

Academy of Breastfeeding Medicine. Clinical Protocol #3: Supplementary feedings in the healthy term breastfed neonate. 2017.

Australian College of Midwives. National Guidelines for Consultation and Referral (4th ed.). 2021.

Department of Health WA. Public home birth program policy.

NICE guidelines NG194. Postnatal Care. 2021.

## Related legislation and policies

Department of Health Western Australia: Public Home Birth Policy

## Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines:

- Community Midwifery Program: Non-compliance of client with CMP midwifery standard of practice
- Obstetrics and Gynaecology:
  - Bladder Management
  - Neonatal Care
  - Postnatal Care

## Useful resources (including related forms)

- WNHS Patient booklets: 'Pregnancy Birth and Your Baby book' and 'Breastfeeding and Breast Care'
- The Breastfeeding Centre of WA including Video resources

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## Version history

| Date | Summary |
|---|---|
| Prior to June 2016 | Archived- contact OGD Guideline Coordinator for previous versions. Note- versions prior to 2015, maintained by CMP. Original titled as: 'Preparation for Leaving Mother and Baby After Birth'. |
| June 2016 | • Ensure baseline observations of respiratory rate, pulse, BP, and temperature are within normal limits and recorded 30 minutes and 60 minutes post birth and prior to the midwife leaving the home<br>• Hand expressing (offer a demonstration)<br>• Ensure that all neonatal observations are within normal limits for colour, tone, respiratory rate, heart rate, temperature and positioning in a supine head neutral position enabling a patent airway.<br>• Neonatal observations should be performed as clinically indicated but at a minimum of 30 minutes and 60 minutes after birth and again prior to leaving the house.<br>• The mother must be advised that if her baby does not feed for a period of longer than 6 hours in the first 24 hours she must increase the length of skin to skin time, hand express and give the expressed colostrum via a spoon and contact her midwife. |
| April 2020 | • Reviewed and made more concise<br>• Neonatal observations updated; added reference to NORC |
| Oct 2023 | • Specified that neonatal observations are for minimum 3 hours<br>• Document on relevant Observation and Response Chart<br>• Updated guidance if neonate does not feed effectively, including aligning with WNHS Newborn Feeding guideline- if not feeding effectively or taking EBM by 6 hours- to assess the need to contact the support hospital for paediatric review |