Clinical Guideline For Care Following Operative Procedures in Maternity Services

A Clinical Guideline for care following operative procedures in maternity services

For Use in:	Maternity Services
By:	Maternity and Neonatal staff
For:	Neonates
Division responsible for document:	Women and Children
Key words:	Postnatal, Operative, procedures, Caesarean section
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Date of approval:	23/10/2020
Ratified by or reported as approved to (if applicable)**:**	Maternity Services Committee
To be reviewed before: This document remains current after this date but will be under review	Authors
To be reviewed by:	Practice Development Midwives
Reference and / or Trust Docs ID No:	812
Version No:	5
Compliance links:	National Institute for Health and Care Excellence (2014) CG179. NICE guidelines [CG192] NICE (2011) Caesarean Section, Clinical guideline [CG132]
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No deviation

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Version and Document Control:

Version Number	Date of Update	Change Description	Author
5	23/10/2020	Addition of Midwifery Facilitated Discharge, updated Bladder Care guidance and wording updated for clarity	Debbie Walker, Cathy Taylor, Rosie Goodall

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

Overview

An operative Procedure includes the following

- All Caesarean sections
- Forceps/vaccum/kiwi delivery under regional anaesthesia
- Manual removal of placenta
- Repair of 3rd and 4th degree tears
- Examination under anaesthesia
- All regional anasthetic procedures in theatre

This is a guideline for midwives and maternity care assistants involved in the continuing care of women when they have been discharged from the recovery area.

Please use this guideline with

- **Clinical Guideline for: the Management of Postnatal Care** Trustdocs Id: 8613,
- **Clinical Guideline for: The Management of Women requiring Emergency Caesarean Section (CS)** Trustdocs Id: 841
- **Trust Guideline for Midwifery Facilitated Discharge (MFD)** Trustdocs Id: 15910

Objectives

To ensure safe recovery and consistent care for all women following elective and emergency caesarean section or other operative procedure.

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To maintain physical stability, detect any deterioration of condition and ensure comfort for women following an operative procedure.

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Rationale

Women, who have undergone an operative procedure under regional or general anaesthetic, will have a range of immediate, short and longer-term health needs. These will include post- operative observations, wound care, bladder care and pain relief. In addition, women having undergone an operative procedure may require additional physical and emotional support as well as help with feeding and caring for their baby. The information set out should be shared with women, so they can be fully informed and involved in decisions about their own care.

Broad recommendations

That all women should receive routine observations and a consistent standard of care following any operative procedure in accordance with the NICE guidelines. (NICE Caesarean Section 2011).

Following an operative procedure all women should have spent a minimum of 20 minutes in the recovery area, where they will have been cared for by a recovery nurse. During this time the midwife assigned to each woman will be responsible for encouraging skin to skin contact between mother and baby and helping the woman to initiate feeding as soon as she is ready. The midwife will maintain responsibility for the baby.

This guideline is concerned with the care of the woman from the time she is discharged from the recovery area until she is discharged from the postnatal ward.

Before transfer back to midwifery care following her time in recovery, the
Women should be in a stable condition, have regained airway control, cardio -respiratory stability, be conscious and alert and able to communicate as well as having satisfactory control of emesis and postoperative pain. (See Emergency Caesarean Section (Appendix1)). Trustdocs Id: 841

The recovery ward handover tool should be signed by the receiving midwife and the risk factors identified. MEOWS score should be recorded prior to the woman leaving recovery.

Routine Regular Observations

It is essential that staff read the surgical notes for specific instructions for the care of individual women on return from theatre.
It is important that the person carrying out the observations understands the implications of deviation from the norm and either takes appropriate action or refers the problem to the appropriate member of the team. The frequency of recordings will depend on the stage of recovery and clinical condition of the patient.

Observations to be recorded:

- Temperature

- Pulse
- Respirations
- Blood pressure
- Urine output
- AVPU
- Condition of fundus
- Wound leakage
- Lochia
- Wound drain if applicable

Minimum Frequency of observations for post-operative procedures:

- Half hourly for the first 2 hours
- Hourly for the following 2 hours
- Two hourly for the next 2 hours
- Four hourly for remainder of the first 24 hour period
- Following a caesarean section, 4hrly observations for the second 24 hour period if remaining in hospital
- Twice daily observations for the rest of the woman's' stay in hospital providing she is well.

MEOWS score should be attributed to each set of observations and acted upon accordingly (see Modified Early Obstetric Warning Score (MEOWS) Trustdocs Id: 817

Pain Relief

It is important for women to be given regular analgesia following their operation. Regular analgesia is associated with earlier mobility, earlier discharge home and will help to improve the woman's perception of her recovery. She will most likely find infant feeding and caring for her baby easier if her pain is well controlled. Therefore it is important that analgesia be administered on a regular basis as prescribed.
Women should be transferred following their operative procedure with a prescription for pain relief, antiemetic's, IV fluids (if required) and medication to take home.

Guidance on care of women who have had spinal opiates in theatre should be given by the anaesthetist. For women with Epidural or PCA analgesia, (please see Patient Controlled Analgesia Trustdocs Id: 1205 **, respirations** should be observed and documented bearing in mind the risk of respiratory distress following administration of opiates. These women will need to progress on to oral analgesia as soon as possible for administration on a regular basis as per prescription. Women receiving an epidural infusion for analgesia should be cared for on delivery suite.

Epidural catheters should not be removed until 12 hours has elapsed since the administration of prophylactic low molecular weight heparin (LMWH) or within 4 hours before the next dose. (Refer to Regional Anaesthesia Patients Venous Thromboprophylaxis with Anticoagulant and Antiplatelet Drugs Trustdocs Id: 1193

Hygiene and comfort

All women to be offered a wash or 'bed bath' within six hours after their procedure and encouraged out of bed and into a chair while the bed linen is changed if appropriate The bed must be kept clean and dry and sanitary towels and protective pads must be changed regularly while the woman is unable to get out of bed unaided.

The midwife is responsible but may delegate this aspect of care to the Maternity Care Assistant (MCA).

Pressure area care

Please read the **Trust Policy for the Prevention and Assessment of Pressure Ulcers** Trustdocs Id: 1063

Evidence suggests grade 1 pressure ulcers are under reported in individuals with darkly pigmented skin because areas of redness are not easily seen. Inspect the skin regularly for signs of redness in individuals identified as being at risk.

The Waterlow score should be completed on transfer of the woman and as applicable thereafter. It should also be attributed on discharge home. In hospital women should be encouraged to be mobile as soon as possible. Whilst they are unable to reposition independently they should be assisted to do so every 2 hours and encouraged to continue this once independent to avoid pressure injury and promote good circulation.

The repositioning/ skin inspection chart should be used to document position change and that pressure areas have been inspected. This can be found on the Patient Positioning / Turning Chart Trustdocs Id: 7397.

The patient should be asked if they have any areas of discomfort or pain that could be attributed to skin damage. A number of studies have identified pain as a major factor for individuals with pressure ulcers. Pain over the site may be a precursor to tissue breakdown.

Wound care

Routine wound dressings should not be removed for at least 2 days and can be left for up to 7 days following a caesarean section depending on the sutures to skin. Pressure dressings should be removed at 4 hours post operatively to avoid damage to underlying skin. Regular observation of the area around the wound is essential to detect signs of infection. This may be inflammation, leakage of fluid, reports of pain or swelling or an offensive smell or discharge from the wound. These should be acted upon and documented in the records. If oozing migrates beyond the dressing this should be changed using an Aseptic Non Touch Technique (ANTT).

Women can be advised that the dressings are splash proof and can therefore shower.

Wound drains to be removed on the direction of the obstetric team.

Bladder care

All post-operative women should have an up to date fluid balance completed. All bladder care should be in accordance with **Bladder Care in Labour and Postnatally** Trustdocs Id: 12617

Removal of the urinary bladder catheter should be carried out once a woman is mobile following a regional anaesthetic. This will usually be on the day of the operation 6-12 hours post-operatively/post-procedure or by 0800 the following day if the patient declines removal on the day; unless a longer period of catheterisation is indicated

Following removal of catheter it is essential to ensure adequate voiding with normal sensation. Women should be asked to report is unable to void after 4 hours. A fluid balance chart should be kept up to date and the woman advised to take adequate but not excessive oral fluids. Post void residuals should be performed if indicated. As per guideline

Food and fluids

Women who are recovering well following operative procedure and who do not have complications can eat and drink as soon as they feel hungry or thirsty. (NICE Caesarean Section 2011).

Skin to skin contact and early breastfeeding

Early skin-to-skin contact between the woman and her baby should be encouraged and facilitated, if possible while the woman is still in theatre or the recovery room. Ensure optimal positioning of the baby whilst skin to skin with the baby's head supported and airway unobstructed. This will improve maternal perceptions of their infant, mothering skills, maternal behaviour, breastfeeding outcomes, and reduces infant crying. (NICE Caesarean Section 2011)

Women who have had a CS should be offered additional support to help them initiate breastfeeding as soon possible after the birth of their baby. It has been shown that women who have had a CS are less likely to start breastfeeding in the first few hours after the birth, but when breastfeeding is established, they are as likely to continue as women who have had a vaginal birth.

Thromboprophylaxis

See Guideline Preventing blood clots in pregnancy and after birth M73

http://nnvmwebapps01/TrustDocs/ViewDoc.aspx?id=4070
Early mobilisation, ankle and leg exercises and good hydration are recommended for all women who have undergone an operative procedure.

Midwifery Facilitated Discharge

The Midwifery Facilitated Discharge concept has become the norm on the postnatal ward and is now well engrained, allowing midwives to take autonomy for the discharge of high-risk post-operative and post-procedure cases that would historically have required a medical doctor review. This facilitates better continuity of care and a more robust and timely discharge process to avoid delays and length of stay. Please see below in the yellow box, the agreed criteria for cases suitable for midwifery facilitated discharge. Each operation and procedure has a strict agreed pathway for midwifery autonomy.

For details, checklists and updated guidance refer to Trust Guideline for Midwifery Facilitated Discharge (MFD) Trustdocs Id: 15910

Agreed Cases	
Midwifery Facilitated Discharge	**Doctor Review for Discharge**

• **ALL** Caesarean Sections
• **ALL** Operative Births
  - Forceps
  - Kiwi
  - Ventouse
• PPH <1500ml
• MROP
• 3rd Degree Tear
• NVD (MW protocol)
	• PPH >1500ml
	• Re-admission to Postnatal
	• Sepsis in labour or postpartum
	• 4th Degree Tear
	• PET/Hypertensive disease
	• Complicated delivery as indicated only by delivering doctor on E3
	• Antenatal Outliers
	• At midwife verbal request

Information

Women undergoing elective CS should have been given Trust information leaflets outlining the care they can expect following their operation. For women undergoing emergency or unexpected procedures there are a range of leaflets available on the Trust intranet which will be included in the discharge pack.

Clinical audit standards

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of the monthly departmental Clinical Governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

Distribution list / dissemination method

Head of midwifery
Clinical midwifery managers
Trust Intranet
Community team leaders
School of Nursing/midwifery
Risk manager (Division 3)

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References/ source documents

NICE (2011) Caesarean Section .Clinical guideline [CG132] Published date: November 2011 Last updated: September 2019

National Institute for Health and Care Excellence (2014) *Pressure ulcers: prevention and management of pressure ulcers.* CG179. [online]. London: NICE. Available from: http://guidance.nice.org.uk/CG179 [Accessed 4th June 2014] Waterlow, J (2005)

http://nhs.stopthepressure.co.uk/Path/path.htm