HACKETTSTOWN COMMUNITY HOSPITAL

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MATERNAL SERVICES
(Scope)

TITLE: TRANSFER OF PATIENT FROM MATERNAL SERVICES

PURPOSE: To outline process to provide continuity of care for maternity patients transferred from Maternal Services. This is a summary of the postpartum care on the CFC.

LEVEL: Interdependent

SUPPORTIVE DATA: To be provided by RNs or LPNs.

CONTENT:	PROCEDURE	KEY POINTS
		All care is to be documented in the patient record.
	1. Assess patient's VS, check fundus firmness and location in relation to umbilicus, lochia and IV status.	When fundus is massaged, some clots may be expressed but a steady stream of bright red bleeding may be excessive. Physician should be notified at once if this occurs.
	2. Check location of fundus. If it is above the umbilicus or higher on one side than the other, the bladder may be full. If patient is unable to void, she may need to be catheterized. If the patient needs catheterization the second time, OB should be notified as provider may order a Foley insertion.	Check the provider orders for catheterization order.
	3. Assess amount of feeling patient has in legs as pudendal blocks may cause feeling not to return for several hours. Patient may be unable to ambulate.	Explain to the patient that she should not attempt to get out of bed without assistance. Leave the nurse call light in reach.
	4. Check patient's fundus every hour for first 4 hours after delivery, then every 4 hours x24 hours then every shift and massage fundus to keep it firm. To massage fundus, one hand is placed above the symphysis (to prevent the descent of uterus) and the other hand is placed on top of the fundus and massaged in a circular motion until it is firm.	Assess fundus firmness more frequently if patient had general anesthesia as bogginess is more common after general anesthesia. Check every hour for first four hours after delivery; q4 hr x 24 hr; then q. shift.
	5. Assist patient when getting her OOB for the first time. Many patients are very weak and may faint. Have spirits of ammonia available for the first excursion and be aware that it is normal for lochia to run down patient's legs due to uterine pooling when upright for first time.	Explain to the patient the criteria for assisting the patient out of bed.
	6. If patient had a vaginal delivery, assist her to the bathroom to void within three hours after delivery. Instruct in use of peri-bottle. Measure and	Measure and record first 3 post-partum voids. After voiding, squirt warm water over perineal area and pat dry with toilet

record 1st 3 post-partum voids.	tissue.
7. If patient had a C/S, wash perineal area with wash cloth until Foley catheter is removed, then instruct her in same peri-care as per vaginal delivery. Peri-care should be continued by patient until all traces of lochia have subsided.	Patients are to be instructed to continue peri-care at home.
8. Assess patient's level of perineal discomfort. Ice packs may be applied to perineal area for episiotomy or hemorrhoid discomfort for first 24 hours after delivery. Sitz baths may be used after first 24 hours. Sitz baths are to be done to relieve hemorrhoids or episiotomy discomfort and should be done at least two times per day, 10-15 minutes each time. Instruct patient to fill basin with very warm water, raise top of toilet and set basin in toilet bowl.	Refer to “Sitz Bath Procedure.”
9. Check obstetrician's postpartum routine orders. Topical medications are ordered prn to be left with patient for episiotomy and hemorrhoid discomfort.	Instruct the patient in use of topical medications and criteria for use.
10. Many postpartum patients (especially multiparas) will have after pains. Sometimes an IV with pitocin is causing the cramping. The routine Tylenol with codeine prn order is usually sufficient to relieve these cramps. Anaprox also helps in relieving the pain.	Advise breast-feeding mothers that after-pains might be most apparent when the baby is nursing. Explain the reason why.
11. Check patients to see that they are wearing a bra at all times.	
12. If patient is breast feeding, call the OB nurses to instruct in breast care.	
13. Assess if patient needs emotional support and observe for signs of postpartum depression.	Advise of grief support group if transfer was because of fetal demise or adoption reasons. Home visit may be ordered if indicated.
14. If patient had a tubal or C/S, observe routine surgical care, but do perineal care also.	May not shower until orders from provider to do so.