POSTPARTUM CARE

IMMEDIATE CONCERNS:

- Continue management of previous labor related problems (see postpartum hemorrhage, preeclampsia, chorioamnionitis, PE, AF embolism, DVT, GDM)
- Feel for firm fundus and monitor bleeding (watch for late postpartum bleeding)
- Monitor vital signs for new or not previously detected infection, preeclampsia, hemorrhage and DVT
- Pain management. Ibuprofen, Tylenol ES, Tylenol #3
- Determine the need for continuing or starting intravenous fluids (enter order D/C IV when appropriate-tolerating PO/stable Hgb)
- Breastfeeding initiation (emphasize no formula or bottles)
- Hgb ordered for postpartum day #1

NEXT DAY PLANNING:

- Notify HCMC OB/GYN for preop if postpartum tubal ligation desired
- Confirm tubal ligation consent previously signed and patient has a normal pap smear
- Clarify desire for male baby's circumcision and plan for day 1 of life
- Remember to get consent for circumcision (form)
- If there is time following delivery, begin discharge paperwork including infant's prenatal and maternal history (start newborn form)

POSTPARTUM DAY 2:

- Check vital signs for signs of hypotension and infection
- Interview patient for signs and symptoms of above, for amount of lochia and pain level and control
- Examine patient, especially assessing fundal firmness and location
- Examine for Homan's sign
- Vaginal inspection of repaired episiotomy or laceration (chaperone if male doc)
- Check postpartum Hgb and compare with predelivery
- Start Fe Gluc 300mg PO TID of Ferrious Sulfate 325mg PO TID if Hbg below 10
- Assess how breastfeeding is going and need for lactation consult
- Assess birth control needs if plan not already made. May use Depo Provera or progestin only BCP. (Micronor or Nordette). BCP less likely to affect breast milk production if delayed until 1 month postpartum. Delay start of combined OCP's or Ortho Evra patch until 4 weeks postpartum.
- Order public health nurse to see patient day after discharge and as needed.
- Order discharge medications night before discharge (select HCMC as pharmacy)
  (check to see if INH needed, check baseline LFT's)

DISCHARGE (all need to be completed NO LATER than 11 AM):

- Repeat as needed from above all that is relevant
- Complete EPIC discharge order set
- Fill out green stat sheet (paper form)
- Confirm patient has all needed medications including pain pills, vitamins, iron, birth control, stool softeners and bulking agents, and any of patient's regular medications
- Order breast pump if indicated by lactation consultant. Requires faculty signature. If breast pump is needed only for return to work, it should be ordered at clinic at postpartum visit.
- Recommend 6 weeks of pelvic rest with pain and amount of bleeding as guide of final duration (no sex, no tampons, no douching)
- Schedule for 6 week postpartum check up with PCP
- Return earlier if excessive bleeding, fever, abdominal pain, signs of postpartum depression, etc.

JCAHO DISCHARGE CRITERIA:

Contraception choice

- Average return to ovulation is 46 days for non breastfeeding women and up to 6 months for who are exclusively breastfeeding (lactational amenorrhea)
- Nonhormonal methods include IUD, condoms, cervical caps and diaphragms
- Postpartum women are hypercoaguable until about 3 weeks postpartum, so estrogen containing contraception should not be started until baby is 3- 4 weeks old
- Estrogen containing contraceptives can also interfere with the establishment of breastfeeding by decreasing milk supply (see below)

- **ACOG recommendations for initiating hormonal contraception postpartum**
  - Progestin only pills (Micronor, Nordette) to be started when baby is 3 weeks old
  - Depo Provera can be initiated 6 weeks postpartum
  - Combined OCP's should not be started until at least 6 weeks postpartum if breastfeeding is well established and baby is gaining weight appropriately

- Ortho Evra-wait 4-6 weeks postpartum to start due to estrogen content.
- Nuva Ring-wait 4-6 weeks postpartum due to estrogen content.
- Can send patient home from hospital with progestin only pills, combined OCP's or estrogen containing patches/devices with instructions about when to start medication
- IUD – is placed at 6 weeks postpartum visit, schedule patient with PCP visit at 5 weeks postpartum for IUD education and check for vaginal infections.

Other discharge meds to consider:

- If breastfeeding, order prenatal vitamins for mom with discharge meds and order Polyvisol 1 cc PO daily for baby because of concern about vitamin D deficiency rickets (especially in winter months as decreased amount of sunlight available)
- Docusate (stool softener) for those on iron or with perineal tearing
- Ibuprofen or Tylenol ES prn pain (narcotics not routinely needed for vaginal delivery
- C-section patients can also be discharged with narcotic medication if needed
- Check Hgb, if $\leq$10 send patient home with iron and check Hgb at postpartum visit

For C-section patients: (Patient followed and orders written by OB service)

- Pelvic rest for 2 weeks
- Do not drive for 2 weeks (until able to slam on brakes)
- No lifting >20 lbs. for 6 weeks (a baby car seat or a bag of groceries = 20 lbs.)
- Most will be discharged with Tylenol #3
- Remove dressing POD #1
- D/C Foley POD #1
- D/C PCA when appropriate
- Staples removed POD #3 only transverse incision, POD #5-7 for vertical incision
- FMS to follow FM patients who had c-sections. Be sure previously identified problems are addressed (i.e., pp INH) and it is clear where patient is to follow up.

ACOG Clinical Review Jan-Feb 2007