HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Departmental Policy and Procedure		
Title:	Immediate Post-Partum Care		
Applies To:	All Obstetrics and Gynecology Staff		
Preparation Date:	January 08, 2025	**Index No:**	L&D-DPP-034
Approval Date:	January 22, 2025	**Version :**	2
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1. PURPOSE:

1.1 To observe the patient following vaginal delivery to avoid post-natal complication.
1.2 To identify patients at risk for postpartum complication and the institution of prophylactic measures to minimize the possibility of maternal mortality.
1.3 To facilitate immediate medical and nursing management for any complication that may arise.
1.4 To provide maternal optimal comfort for the restoration of usual body functions.

2. DEFINITIONS:

2.1 **Postpartum**- immediate care of the mother and the newborn during the first 2 hours post-delivery.

3. POLICY:

3.1 The patient must remain in the delivery room for 2 hours following delivery for close observation.
3.2 The qualified nurse or midwife must assess the fundus and must observe the amount of vaginal bleeding.
3.3 Notify the physician if noted increased respiration and pulse, decreased blood pressure and orthostatic changes which may indicate hemorrhage.

4. PROCEDURE:

4.1 Hand hygiene is a must.
4.2 PV examination by the Physician before shifting.
4.3 Inform post-natal ward of impending transfer.
4.4 IV cannula to be kept at least 8hrs if patient still in DR.
4.5 Transfer mother and child to post-natal ward, by wheel chair, after reassessment and order by obstetrician with complete notes and belongings.
4.6 Endorse to ward staff summarizing delivery and subsequent care and management.
4.7 After receiving endorsement from the delivery room nurse, assessment and evaluation must be done.
  4.7.1 Monitor vital signs.
  4.7.2 Palpate uterus to ensure contraction.
  4.7.3 Observe lochia for volume and consistency.
4.8 Observe whether patient has any pain or discomfort.
4.9 Ensure the patient is comfortable, may offer milk or tea if no further complication.
4.10 Encourage mother to cuddle her baby and assist breastfeeding.
4.11 Keep the newborn with the patient, however if newborn requires admission to the NICU, an explanation must be given.
4.12 Assist patient to bathroom and encourage micturation. Document if patient passed urine or not.
4.13 Document all relevant details in patient's file, birth register and kardex.

5. MATERIALS AND EQUIPMENT:

5.1 Vaginal Pad
5.2 Linen saver pad
5.3 Patient's gown

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses
6.3 Midwives

7. APPENDICES:

7.1 Newborn assessment form

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration, Functions and Duties Policies and Procedure

9. APPROVALS:

	Name	Title	Signature	Date
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KINGDOM OF SAUDI ARABIA

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Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

NEWBORN NURSING INITIAL/ ADMISSION ASSESSMENT FORM

I. ADMISSION SOURCE:

☐ ER ☐ LR ☐ OR ☐ OTHERS.....

II. ADMISSION DIAGNOSIS

.....

III. BIRTH HISTORY:

BIRTH DATE: / TIME:	V. ADMISSION DATE/ TIME:	APGAR: 1minute	APGAR: 1minute	ID BRACELET #:

TYPE OF DELIVERY:
VAGINAL..... C-SECTION .....
OTHERS .....

WEEKS OF GESTATION: .....

BLOOD TYPE / Rh .....

PARAMETERS:
BIRTHWEIGHT..... gm (kg) / LENGTH .....cm / HEAD CIRCUMFERENCE .....cm / CHEST CIRCUMFERENCE.....cm

RESUSCITATION:
NONE ..... OXYGEN ..... BAG / MASK ..... INTUBATION ..... CPR .....

HEP «B» VACC:
SITE..... DATE:.....
TIME:.....

VIT K:
SITE ..... TIME
..... INT.....

ERYTHROMYCIN (PROPHYLACTIC EYE TREATMENT)
DATE/TIME:..... INT.....

IV. MATERNAL HISTORY:

MATERNAL AGE:	MAT BLOOD TYPE:	G /Para:	GBS:	PROM ..... HRS	MAT TEMP:	OTHER: .....

III. PHYSICIAN NOTIFIED ☐ YES ☐ NO | **PHYSICIAN NAME:** | **TIME:**

V. TRANSITION NOTE:

DATE/TIME	TEMP	HR	RR	SPO2	BP	BLOOD GLUCOSE	ACTIVITY	COLOR	URINE	STOOL	OTHER	INITIAL

ACTIVITY OBSERVATIONS ++= SPONTANEOUS +=WITH STIMULATION L=LMP

VI. PHYSICAL ASSESSMENT:

CATEGORY	OBSERVATIONS	COMMENTS (Finding Indicated by * require notes)
General Appearance	COLOR: ☐pink ☐pale ☐acrocyanosis* ☐jaundice*	
	CRY: ☐strong ☐weak ☐high-pitched*	
	TONE: ☐good tone ☐hypotonic* ☐hypertonic*	
	MATURITY: ☐term ☐pre-term ☐post-term	
Skin	☐Clear ☐Peeling ☐Rash* ☐Bruising*	
	☐Vernix ☐Petechiae * ☐Mongolian spot	
Head	☐intact ☐Molding ☐Caput ☐Bruising*	
	☐Open Flat Fontanels ☐Cephalohematoma	
Eyes	☐Clear ☐Discharge* ☐Jaundice* ☐Hemorrhage	
ENT	☐Intact ☐Palate ☐Normal Ear Setting	
	☐Patent Nares ☐Nasal Flaring	

Name: _____ الاسم:	MRN: | | | | | | | | | | رقم الملف الطبي:

Thorax	❑Symmetrical ❑Clavicle (intact / fractured)	
Lungs	❑Clear ❑Equal Expansion Bilaterally ❑Retractions*	
	❑Grunting* ❑Coarse ❑Breath Sounds*Abd. ____cms ❑Abdomen Soft / Distended* ____	
Heart	❑Regular Rate ❑Peripheral Pulses Bilaterally (Y/N)	
Abdomen	Abd. ____cms Abdomen ❑Soft / Distended* ____	
	Umbilical cord ❑Bowel Sounds (present / diminished*/ absent*)	
Genitalia	❑Male ❑Female ❑Ambiguous*	
	Testes: L ____ R ____ Discharge*	
Anus	Patent ❑Meconium (present* / absent*)	
Trunk – Spine	Gluteal Folds (equal/unequal*) ❑Hip Click (R/L)	
Extremities	Symmetrical ❑Extra Digits* ❑Syndactyly	
Reflexes (noted)	Moro ❑ Grasp ❑Suck ❑Swallow	

VII. NUTRITIONAL ASSESSMENT:

FIRST FEED: ❑Breast Feed ❑Bottle Feed: Time ____ Type ____ Amount ____

VIII.PAIN ASSESSMENT: CRIES NEONATAL PAIN SCALE

- Any score above 4 indicates pain and infant should receive pain management intervention.

CATEGORY	PARAMETERS	SCORE	PATIENT'S SCORE
Crying	No	0	
	High Pitched (Consolable)	1	
	Inconsolable	2	
Requires 0_2 for Sat greater than 95%	No	0	
	Less than 30%	1	
	greater than 30%	2	
Increased vital signs	HR, BP within 10% of Pre-Op value	0	
	11% to 20% greater than Pre-Op values	1	
	greater than 21% of Pre-Op values	2	
Expression	None	0	
	Grimace	1	
	Grimace/Grunt	2	
Sleeplessness	No	0	
	Wakes at frequent intervals	1	
	Constantly awake	2	
	TOTAL PATIENT'S PAIN SCORE		

SCORING: ❑0- 3 No pain ❑4- 6 Moderate pain ❑7- 10 Severe pain

Note: Grimace consists of lowered brow, eyes squeezed shut, deepening nasolabial furrow, and open eyelids.
Non-audible grunt - only heard with a stethoscope

IX."HUMPTY DUMPTY"FALL RISK ASSESSMENT: (Write & sum up the appropriate answer from "a" to 'g' to get the total)
SCORE: ____ (If score is 12 or above at risk for falls) Minimum Score = 7 Maximum Score = 23

Parameters	Criteria	Score	Patient's Score
a) Age	Less than 3 years old	4	
	3 to less than 7 years old	3	
	7 to less than 13 years old	2	
	13 years and above	1	
b) Gender	Male	2	
	Female	1	
c) Diagnosis	Neurological Diagnosis	4	
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3	
	Psychological/Behavioral Disorders	2	
	Other Diagnosis	1	
d) Cognitive Impairments	Not aware of Limitation	3	
	Forgets Limitations	2	
	Oriented to own ability	1	

Name:_____ الاسم:	MRN: _____ رقم الملف الطبي:

e)Environmental Factors	History of falls or Infant-Toddler placed in bed	4	
	Patient uses assistive devices or Infant-Toddler in crib or Furniture/Lighting (Tripled room)	3	
	Patient placed in bed	2	
	Outpatient Area	1	
f) Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3	
	Within 48 hours	2	
	More than 48 hours/None	1	
g) Medication Usage	Multiple usage of : Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics, Barbiturates, Phenothiazines, Antidepressants, Laxatives/Diuretics, Narcotics	3	
	One of the medication listed above	2	
	Other medications/None	1	
	TOTAL PATIENT›S FALL RISK SCORE		

X. SKIN RISK ASSESSMENT: NEONATAL / INFANT BRADEN Q SCALE (NIBQS)
(Write number adjacent to descriptor; add for total score)

Parameters	Criteria	Score	Patient's Score
a) Gestational age	Less than 28 wks.	1	
	greater than 28- Less than 33 wks.	2	
	greater than 33- Less than 38 wks.	3	
	greater than 38wks.	4	
b) Mobility	Completely immobile	1	
	Very limited	2	
	Slightly limited	3	
	No limitation	4	
c) Activity	Bedfast	1	
	Very limited	2	
	Slightly limited	3	
	No limitation	4	
d) Sensory perception	Completely limited	1	
	Very limited	2	
	Slightly limited	3	
	No impairment	4	
e) Moisture	Constantly moist	1	
	Very moist	2	
	Occasionally moist	3	
	Rarely moist	4	
f) Friction/ Shear	Significant problem	1	
	Problem	2	
	Potential problem	3	
	No apparent problem	4	
g) Nutrition	Very poor	1	
	Inadequate	2	
	Adequate	3	
	Excellent	4	
h) Tissue perfusion & oxygenation	Extremely compromised	1	
	Compromised	2	
	Adequate	3	
	Excellent	4	
	TOTAL PATIENT ‹S SKIN RISK SCORE		

Score:..... If Less than 20At risk for skin breakdown

Diaper Dermatitis risk:* (identification of one or more risk factors+ enteral feeding = dermatitis risk.)

❑Frequent stool ❑ Bowel surgery ❑ Short gut ❑hyper-caloric feeding ❑PGEs ❑On Antibiotics ❑ Prolonged NPO status

Name:..... الاسم:	MRN: رقم الملف الطبي:

Interventions: ❑Skin cleansing/protection ❑Gel pillow ❑Sheepskin ❑Scheduled turning ❑Tegaderm
❑Reduce friction /shear ❑Petroleum jelly ointment ❑Desitin ointment ❑Citric acid ointment ❑Other:.....
Comments:.....

XI.OTHERS: (oral and nasogastric tubes, dressing, restraint (splint), umbilical catheter)

.....

XII.SAFETY:

❑Cardio-respiratory audible alarms at 70% volume ❑Oximeter alarm settings: Low..... High.....
❑Bag/mask/suction@ bedside: FiO2..... ❑ IV fluids/rate verified ❑High risk medication infusion dose/rate verified
❑Bed appropriate for developmental level
❑Radiant warmer ❑Incubator; NTE..... ❑Bassinette ❑NICU Crib ❑Pedi Crib
❑I.D Band x 2 ❑I.D. band location:1..... 2..... MR#.....

XIII. PSYCHOSOCIAL :

Patient / family express or demonstrate coping: ❑Yes ❑No
Family active in care: ❑Yes ❑No Detail:.....
Support needs identified:
❑Emotional support ❑Interpreter ❑Social worker ❑Chaplain ❑Lactation consultant

XIV. DISCHARGE PLANNING

SOCIOECONOMIC NEEDS:		
Lack of needed caregiver; family support	❑Yes	❑No
At risk of abuse or neglect	❑Yes	❑No
Inadequate resources: insurance, financial	❑Yes	❑ No
Foster parent, guardian etc.	❑Yes	❑No
PHYSICAL NEEDS:		
Metabolic Screening	❑Yes	❑No
ENVIRONMENTAL NEEDS:		
Change in living arrangements	❑Yes	❑No
In-home care or equipment	❑Yes	❑No
REFERRAL INDICATED:		
Referral sent to:		
Social Services	❑Yes	❑No
Home Care	❑Yes	❑No
Others.....	❑Yes	❑No
High risk indicated but no referral sent, why?	❑Yes	❑No

XIII. EDUCATIONAL / GENERAL NEEDS:

Repeated, unscheduled admissions	❑Yes	❑No
Newly diagnosed chronic/ terminal illness	❑Yes	❑No
Family education needed for in-home care	❑Yes	❑No
Immunization awareness	❑Yes	❑No

PHYSICAL DEFICITS

Cardiovascular	❑Yes	❑No
example		
Respiratory	❑Yes	❑No
example		
Neurological	❑Yes	❑No
example		
Sensory/Speech	❑Yes	❑No
example		
Gastrointestinal/Nutritional	❑Yes	❑No
example		
Genitourinary	❑Yes	❑No
example		
Musculoskeletal/Mobility	❑Yes	❑No
example		
Skin/Wound	❑Yes	❑No
example		
Cognitive/Mental	❑Yes	❑No
example		
Endocrine	❑Yes	❑No
example		
Language Barrier	❑Yes	❑No
example		
Other Concerns:		

....

RN NAME (Assessor) Signature Designation Job number Date & Time

Note: Please fill-up the data required completely and legibly. Put check ( ) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.

Name:_____ الاسم:	MRN: _____ رقم الملف الطبي:

XV. PROBLEM SUMMARY LIST
"ACTION : REFER TO MULTIDISCIPLINARY PLAN OF CARE FORM"

SERIAL NUMBER	ASSESSMENT / PATIENT NEEDS FINDINGS

RN NAME _____ Signature _____ Designation _____

Job number _____ Date (dd/mm/yy) _____ Time _____

NOTE: Please fill-up the data required completely and legibly. Put check (√) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.

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Hospital: _____ مستشفى:

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Dept./Unit: _____ القسم/الوحده:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنه Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____/____/ 14____H ____/____/ 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PHYSICIAN NEWBORN ASSESSMENT FORM

Date: ___/___/___	Time:
Gestational age:	Chronological age:
Birth weight: ☐ Inborn ☐ Out born	

Reason for admission:

.....

.....

.....

Maternal History:	Age:	Gravida:	Parity:	Abortion:	Term:	Living:

Chronic disease and previous obestetrical history (diabetes, hypertension, neonatal death, Rh ISO, infant death, etc.....)

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.....

Current pregnancy related illness (hypertension, diabetes, oligohydramnios, bleeding, infection, etc.....)

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.....

Antenatal ultrasound findings:

.....

.....

.....

Medications during pregnancy (tocolysis, steroids, antibiotics, etc.....)

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.....

.....

Family history (Consanguinity, congenital anomalies, metabolic disease, etc.....)

.....

.....

Name:_____ الاسم:	MRN: رقم الملف الطبي:

(Psychosocial history) (home environment, occupation of father anf mother, problems, family support system, etc.....)

(Labor) (spontaneous, induced, PROM, fetal distress, etc.....)

☐ *Infant* ☐ Apgar score: ☐ 1 min. ☐ 5 mins. ☐ 10 mins.

☐ Delivery: ☐ SVD ☐ C/S ☐ Forceps ☐ Vacuum

Resuscitation (initial steps, IPPV, intubation, cardiac massage, medications,, volume, surfactant)

Physical examination: Weight _____/_____ % Length _____/____ % HC _____/_____%

Ballard assessment: Dates: ___/___/___Exam _____

Temperature: _____ PR: _____ RR: _____ BP: _____

General: Color: _____ O^2 saturation: _____ Posture: _____

Skin:

Head, face dysmorphism:

Eye, red reflex:

ENT:

Neck:

Chest/ Lungs:

CVS:

Abdomen and genetalia:

CNS (TONE, POWER, DTR, etc.....)

Name: _____ الاسم:	MRN: | | | | | | | | | | رقم الملف الطبي:

Musculoskeletal:

Hips

Assessment/Diagnosis

Investigation

Procudures: Intubation, umbilical line catheterization, ect....)

Plan of care

Patient care (lab, consults, ect...)

Communication with family (reason for admission, medical or surgical management, education ect...)

Name: ..... *Stamp&Signature:* ..... *Date:*____/____/____

Comments: Specialist/consultant

Name: ..... *Stamp&Signature:* ..... *Date:*____/____/____