Affix label here

Salisbury

NHS Foundation Trust

Telephone number ............................................

**ELECTIVE CAESAREAN**

Postnatal notes MOTHER

to be commenced by Community midwife in AN period

**How to contact your midwife**

Named Midwife ............................................................ Team name .............................................

**Non Urgent** 01722 425185 (Mon - Fri 9am - 6pm) **Urgent** 01722 425184 (Postnatal Ward)

**If you have not heard from your community midwife by 4pm on your first day home**

**please contact the non urgent number above**

Partner’s name ........................................................................... Parity .......................................

**Name and specimen signatures of staff giving care**

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| --- | --- | --- | --- | --- |
| Date | Name | Grade | Signature | Initials |
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Name Hospital No DOB

Consultant

Consultant ............................................................. Reasons for LSCS ............................................... Parity ..................................................................... ............................................................................. Gestation ............................................................... Risk Factors ........................................................ BMI ....................................................................... ............................................................................. Booking BP............................................................ Allergies ...............................................................

**Pre-Operative Bloods**

Hb: ........................................................... Platelets: ............................ Blood Group:............................

|  |  |  |  |
| --- | --- | --- | --- |
| **Pre-Operative Check** |  | | |
| Omeprazole 10.00pm | Y | N | Placental position: ................................................ |
| Omeprazole 06.30am | Y | N | Last ate: ............................................................... |
| Cord Rhesus blood needed: | Y | N | Last drank: ........................................................... |
| Paediatrician needed: | Y | N | If breastfeeding, have they  expressed antenatally? ........................................ |
| NICU informed: | Y | N |  |

Blood group

Anti D Required Yes  No  Anti D given Yes  No  Batch no Date and time

Given by

**Other Vaccinations or Investigations required**

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| --- | --- | --- | --- | --- |
| Date | Investigation required | Consent | Result | Signature |
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**Other agencies involved with the family** 2

Name Hospital No DOB

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| Date & time | Postnatal Care Plan | Signature |
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**Risks / Concerns**

Smoker Yes  No  Referral to smoking cessation sent postnatally? Yes  No 

**Risk Assessment including the following to be added to management plan as necessary**

|  |  |
| --- | --- |
| Concern | Reason |
| Primary PPH |  |
| Urinary Problems (Catheter care) |  |
| Infection |  |
| Hypertension |  |
| Tissue Viability (risk scoring) |  |
| Psychological well being |  |
| Anaemia |  |

**Postnatal venous thrombophrophylaxis (VTE) risk assessment and management**

**- to be assessed on delivery suite**

❒ Any previous VTE

❒ Any Antenatal LMWH throughout A/N period

❒ Low-risk thrombophilia

❒ High-risk risk thrombophilia + FHX of oestrogen related VTE

❒ Caesarean section in labour

❒ BMI>- 40kg/m2

❒ Readmission or prolonged admission ( 3 days)

❒ Any surgical procedure in the puerperium except

immediate repair of the perineum

❒ Medical comorbidities e.g. cancer, heart failure,

active SLE, IBD or inflammatory polyarthopathy,

nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU

❒ Age Obesity >35 years

❒ Obesity (BMI greater or equal to 30 Kg/m2)

❒ Parity Greater or equal to 3

❒ Smoker

❒ Elective caesarean section

❒ Family history of VTE

❒ Low-risk thrombophilia

❒ Current systemic infection

❒ Immobility, e.g. paraplegia, PGP, long distance travel

❒ Multiple pregnancy

❒ Preterm delivery in this pregnancy (<37+0 weeks)

❒ Stillbirth in this pregnancy

❒ Mid-cavity rotational or operative delivery

❒ Prolonged labout (>24 hours)

❒ PPH > 1 litre or blood transfusion

❒ **High Risk**

Consider 6 weeks postnatal prophylactic

LMWH

❒ **Intermediate Risk**

Consider 10 days postnatal prophylactic

LMWH

NB if persisting or > 3 risk with factors consider extending prophylaxis with LMWH

Two or more risk factors

Fewer than two risk factors

❒ **Lower Risk**

Mobilisation and avoidance of dehydration

**Bleeding risks/ exclusion criteria Thrombophilias**

**Patient related**

Active bleeding

Acquired bleeding disorders (e.g. acute liver failure)

Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR >2)

Acute stroke

Thrombocytopenia (platelets <75 x 109/L)

Uncontrolled systolic hypertension (200 mmgHg or >120 mmgHg diastolic)

Untreated inherited bleeding disorders (such as haemophilia and von Willebrand’s disease)

Severe renal disease (CrCI <30ml/min)

Severe liver disease (prothrombin time above normal range or known varices)

Surgical procedure with a high bleeding risk

Lumbar puncture/epidural/ spinal anaesthesia with in the previous 4 hours

**Low risk (+ no previous VTE)**

Heterozyqous

Prothrombin gene mutation / Factor V Leiden

Protein C deficiency

Protein S deficiency

**High risk (+ no previous VTE)**

Homozygous FVL/PGM or compound abnormalities Anti-thrombin deficiency: Anti-phospholipid syndrome Anticardiolipin antibodies / Lupus anticoagulant

**Postnatal venous thromboprophylaxis risk (VTE) assessment sheet**

Assess woman postnatally and if re-admitted postnatally.

All women must be given verbal and written information on VTE Information given ❒

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Gestation | Risk category | | action | comments | signature/designation |
|  |  | High | ❒ | LMWH\* ANC |  |  |
| Intermediate | ❒ | LMWH\* ANC |
| Low | ❒ | Advice only |

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| Date | Gestation | Risk category | | action | comments | signature/designation |
|  |  | High | ❒ | LMWH\* ANC |  |  |
| Intermediate | ❒ | LMWH\* ANC |
| Low | ❒ | Advice only |

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|  |  | High | ❒ | LMWH\* ANC |  |  |
| Intermediate | ❒ | LMWH\* ANC |
| Low | ❒ | Advice only |

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| Date | Gestation | Risk category | | action | comments | signature/designation |
|  |  | High | ❒ | LMWH\* ANC |  |  |
| Intermediate | ❒ | LMWH\* ANC |
| Low | ❒ | Advice only |

\*Balance risk of bleeding against risk of VTE. Women at high risk of hemorrhage with risk factors including major antepartum hemorrhage, coagulopathy, progressive wound hematoma, suspected intra-abdominal bleeding and postpartum hemorrhage may be managed with foot impulse devices, intermittent pneumatic compression devices or Anti- embolic stocking.

**Postnatal prophylactic dose of Low Molecular Weight Heparin (LMWH)**

Once daily dosing for postnatal prophylaxis.

|  |  |
| --- | --- |
| Booking weight | Once daily dosing |
| < 50 kg | 2500 units once daily |
| 50 - 90 kg | 5000 units once daily |
| 91-130kg | 7500 units once daily |
| 131-170 kg | 10000 units once daily |
| 170 kg | Discuss with Consultant Haematologist |

For obstetric use dalteparin is a red (hospital only) drug and ongoing supplies should be prescribed by the hospital clinician.

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| **Day 0 Midwife Check**  IV fluids down in recovery: | 9 |  |
| Chewing gum in recovery: | 9 |
| Sit out of bed 6 hours post op: | 9 |
| Dalteparin prescribed: | Y | N |
| Catheter Removed at midnight: | Y | N |

...If not, why not: ......................................................................................................................................

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| **Day 1 Midwife Check**  Is EBL > 500mls: | Y | N |
| If yes, FBC at 0600: Time of first void: Volume of first void: | Y | N |
| Pain well controlled: Discharge today: | Y Y | N N |

...If not, why not: ......................................................................................................................................

**Day 1 Post Caesarean Section Review**

Salisbury

NHS Foundation Trust

|  |  |
| --- | --- |
| Date: Time: Dr: Grade: Bleep: |  |
| Category of C/S | Elective/ Emergency I Not Documented |
| Indication for C/S |  |
| Observations | Temp: BP: HR: RR: |
| Blood loss/ Anaemia | Pre op HB: EBL: Post op HB:  Asymptomatic/ Dizzy / Faint / SOB / Chest pain / palpitations |
| Bladder Care | Catheter in Situ/ TWOC  Catheter Draining / PU’d / Not PU’d |
| Thromboprophylaxis | Mobilising: Yes/ No  TEDS / LMWH / None |
| Sutures | Absorbable / Remove on day: |
| Lochia | Light/ Moderate/ Heavy |
| General Wellbeing | Drinking: Yes / No  Pain controlled: Yes / No  No Flatus yet / BNO / Passing Flatus |
| Examination | Fundus:  Uterus well / poorly contested Dressing: Minimal ooze / Dry BS: Absent / Sluggish / Normal Calves: symmetrical: Yes / No |
| Pt Advice and Information | Plan for future deliveries discussed  VBAC / Repeat caesarean section  Contraception advice given / declined / not given  Breastfeeding advice given / not given / declined  No recovery advice given / avoid strenuous activity for 6 weeks  Other recovery advice given please specify -1  No driving advice given / No driving for 6 weeks  Other driving advice please specify  Wound care discussed/ Not discussed |
| Post Op Plan |  |

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| **Date** |  | |  | |  | |  | |  | |  | |
| **Day** | Am Pm | | Am Pm | | Am Pm | | Am Pm | | Am Pm | | Am Pm | |
| Temperature |  |  |  |  |  |  |  |  |  |  |  |  |
| Pulse |  |  |  |  |  |  |  |  |  |  |  |  |
| Blood Pressure |  |  |  |  |  |  |  |  |  |  |  |  |
| Respiratory Rate |  |  |  |  |  |  |  |  |  |  |  |  |
| Feeding method |  | |  | |  | |  | |  | |  | |
| Breasts |  | |  | |  | |  | |  | |  | |
| Uterus |  | |  | |  | |  | |  | |  | |
| Lochia |  | |  | |  | |  | |  | |  | |
| Legs |  | |  | |  | |  | |  | |  | |
| Bladder |  | |  | |  | |  | |  | |  | |
| Bowels |  | |  | |  | |  | |  | |  | |
| Wound |  | |  | |  | |  | |  | |  | |
| Pain |  | |  | |  | |  | |  | |  | |
| Emotions |  | |  | |  | |  | |  | |  | |
| PN Exercises |  | |  | |  | |  | |  | |  | |
| Management  Plan review |  | |  | |  | |  | |  | |  | |
| Emergency contact details reaffirmed at each visit |  | |  | |  | |  | |  | |  | |
| Signature |  | |  | |  | |  | |  | |  | |

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| Temperature |  |  |  |  |  |  |  |  |  |  |  |  |
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| Respiratory Rate |  |  |  |  |  |  |  |  |  |  |  |  |
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Abdominal Wound care

**Do:**

• Do keep your wound clean and dry

• Do have a daily shower or bath using unperfumed soap. However, do not use soap directly on the wound. Wash your wound with water only and gently pat the area dry with a clean towel.

• Do try to find time each day to lie down and loosen all clothing from the skin around the wound.

Fresh air will dry your wound and help it heal. This is especially important during warmer weather and if you are overweight.

• If you need to touch your wound, wash your hands with soap and water before and after.

**Do not:**

• Do not touch your wound unnecessarily

• Do not place a dressing on your wound, unless advised by your midwife or GP

• Do not use antiseptic creams, washes or sprays on the wound

• Do not use other products on the wound unless advised by your doctor. This includes moisturiser, tea tree oil, honey, arnica and essential oils. When your wound is fully healed which may take 2-6 weeks, these products are safe to use then.

• Do not use swimming pools, saunas or hot tubs until your wound is completely healed.

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**Information pack received**

Bounty Pack (includes child benet forms)  Postnatal exercises re-inforced 

Community Midwife Visiting cards  Other (please list) Going home leaet  

**Transfer from unit to community checklist**

|  |  |  |  |
| --- | --- | --- | --- |
|  | ✓ |  | ✓ |
| Discharge address checked |  | Registration of birth explained |  |
| Outpatient appointment made (if necessary) |  | Advised registration with GP |  |
| 6/52 Postnatal appointment explained |  |  |  |
| TTO's given (if necessary) |  |  |  |
| Support at home? | | | |

Code A Yes  No 

Date of transfer

Brief details of information passed to Community Midwife if Code A

Signature of Midwife

**Discharge form Midwifery Care / Transfer to Health Visitor**

Brief details of information passed to Health Visitor (including any issues identied)

AN Mental health issues identied Yes  No 

Other agencies involved in care Yes  No 

Method of feeding at transfer to HV Signature Date