Reference Number: UHBOBS105 **Version Number: 6**	**Date of Next Review:** **Previous Trust/LHB Reference Number:**

Postnatal Care

Introduction and Aim

Healthcare professionals have the responsibility to help families adjust to their new life, and be able to identify and care for the families in which complications arise (NICE 2021).

This document aims to provide guidance for use by the obstetric and midwifery team to provide evidence-based best practice care for women and their families in the postnatal period. Our key values are to treat Women and their families with kindness, dignity and respect; and to consider their views, values, and beliefs. Good communication is essential, and all information should be provided in a form that is accessible to the woman and her family, accommodating any disabilities and language barriers.

We aim to provide a supportive environment in which new families will be aided by professionals in learning to care for their baby and themselves, and educate them to recognise and act upon any deviation from the norm. Any individualised plans or concerns should be communicated to the relevant professional groups or individuals of the multi-disciplinary team. These may include neonatologists, obstetricians, anaesthetists, general practitioners, health visitors and maternity support workers.

The words woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity'

Scope
Local guideline for all midwives working in Cardiff and Vale University Health Board

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	*Admission of mother and babies to first floor; Anti-D administration; Babies don't bounce leaflet; Born before arrival (BBA); Bedsharing; Bladder care; Breastfeeding; Guidelines for obstetric anaesthesia; Hypertension disorders in pregnancy; Identification of babies; Management of babies requiring transitional care; Management of hypoglycaemia on the postnatal ward; Maternity TTH procedure; Neonatal Jaundice; Obstetric haemorrhage; Perineal care; Postnatal contraception; Sepsis in maternity services; Sticky eyes in babies; Tongue tie; Vitamin K; VTE in pregnancy and puerperium.*
Approved by	*Maternity Professional Forum*

Accountable Executive or Clinical Board Director	*Jason Roberts, Executive Nurse Director*
Author(s)	*Jasmine Deere*

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Aug 2006	Aug 2006	
2	Aug 2009	Aug 2009	Reviewed and Updated by Anne Morgans
3	Sep 2011	Sep 2011	Reviewed and Updated by Anne Morgans /Sarah Andrews
4	Jun 2012	Jul 2012	Reviewed and updated by Angela Massey /Su Karren/Abi Holmes
5	?	?	Reviewed and updated by Angela Massey /Liddy Sheppard
6	December 2022	20/3/23	Reviewed and updated by Aamna Ali

1 Table of Contents

Contents

2 Introduction

"Postnatal care is the individualised care provided to meet the needs of a mother and her and babies, care during this period needs to address any variation from expected recovery after birth. Postnatal care should be a continuation of the care the woman received during pregnancy, labour and birth and involve planning and regularly reviewing the content and timing of care that women and their babies should receive for 6-8 weeks after the birth" (NICE 2015).

The Key Principles of Good Postnatal Care:

Each postnatal contact should be provided in accordance with the principles of individualized Care.
The provision of care should be culturally appropriate. Practices of women from ethnic minority groups should be incorporated into their postnatal care plans.
Appropriate support should be provided, as needed or requested, for women with additional physical, cognitive or sensory needs, and women whose first language is not English.
Care should support the developing relationships between all family members.
Women should be involved in planning their postnatal care, with consideration given to their cultural needs, risk factors that presented in the antepartum and intrapartum period, pre-existing medical, social or psychological conditions, and any complications with the health of the baby.
Planning for postnatal care should being in the antenatal period, in discussion with the named midwife. The midwife responsible for the birth should adjust the postnatal care plan, in discussion with the woman and her family, accounting for the nature and type of birth and the postnatal care that is required.
There should be effective written and verbal communication between all health professional involved in providing care.

*' *The words woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity'*

Back to Contents

2.1 Principles of care

The woman and her family are the centre of postnatal care planning, and their needs and preferences should be elicited and responded to. A woman may be supported by their partner during this time and their involvement should be in accordance with women's wishes. When caring for a baby, those with parental responsibility have a right to be involved if they choose.

When giving information about postnatal care, language should be clear and the content, timing and delivery of information should be tailored to the woman's needs. Shared decision

making is a central principle, ensuring information provided is individualized, sensitive to the woman's needs, supportive, respectful and evidence based. If possible, information should be supplemented with digital or written information and translated by an appropriate interpreter to overcome language barriers.

There should be regular opportunities for women to ask questions and to check understanding of information given.

Back to Contents

3 Immediate Care of the Mother

3.1 Documentation

Immediate postnatal care on the delivery suite and midwifery led unit should continue on the yellow partogram or the low risk all wales care pathway (use continuation sheets as needed). Once on the postnatal ward all documentation should be written on continuation sheets and filed in the patient folder. Once the patient is discharged these will be filed into the green notes and the postnatal care pathway will be used on transfer to the community.

Back to Contents

3.2 Observations

Immediately after birth a full set of maternal observations should be undertaken with a MEOW (Modified Early Obstetric Warning) score. This should include blood pressure, pulse, temperature, respiration rate and pain score. Any abnormal findings should be acted upon. See the following guidelines if applicable;

- Infection and Sepsis in Pregnancy,
-All Wales Post Partum Haemorrhage
-Hypertensive Disorders in Pregnancy.

The frequency of observations for women on the postnatal ward will be decided by the medical and midwifery staff on transfer to the postnatal ward. (SBAR/Transfer sheet Appendix 1). As a general guide the minimum frequency of observations for women with a consultant led delivery is 4 hourly and midwifery led is twice daily.

Back to Contents

4 Immediate care of the newborn

4.1 Immediate postnatal care (golden hour)

The Golden Hour encompasses a set of evidence-based practices which are outlined in the recommendations below that contribute to the physiological stabilisation of the mother and infant after birth[43].

Recommendations

- There should be optimal cord clamping after at least 1 minute- up to 5 minutes may provide further benefits.
- Skin-to-skin contact should be recommended for at least an hour, regardless of intended method of infant feeding.
- Perform newborn assessments whilst the baby is held safely in skin-to-skin contact to avoid mother - infant separation.
- Non-urgent tasks should be delayed (e.g. weighing) for at least 60 minutes.
- First feed should be given in skin to skin regardless of feeding method[42].
- Early initiation of infant feeding[42,43].
- Newborn feeding behaviours should be acknowledged and supported via bio-nurturing methods where possible[42].
- These practices should be encouraged, and midwives, women and families should be aware of supporting safe skin to skin practices in all environments.

Back to Contents

4.2 Ongoing postnatal care

At each postnatal contact the healthcare professional should encourage discussion with the woman about her health and wellbeing and any additional needs the woman and family may have topics to consider are:

Diet, nutrition and physical exercise
Contraception and sexual intercourse
Fatigue
What to expect in the postnatal period

Signs and symptoms of physical problems
Signs and symptoms of mental health problems
Importance of pelvic floor exercises
Smoking, alcohol consumption and recreational drug use
How to seek help
Safeguarding and domestic abuse

A full clinical assessment of physical and mental wellbeing should be completed using the 'Postnatal Care Sticker or pathway' as a guide through subjects to discuss and review at each appointment.

Pain
Signs and symptoms of infection
Signs and symptoms of • Anaemia • Pre-eclampsia • thromboembolism
Vaginal discharge and bleeding
Bladder and bowel function
Wound healing
Nipples and breast discomfort

Back to Contents

5 Ongoing Care of the Mother

5.1 Postnatal Bleeding

An assessment of lochia and uterine involution should be ongoing following birth and then assessed at each postnatal examination. Any abnormalities should be evaluated and medical review considered. In the event of sudden or profuse blood loss, emergency help should be summoned. See 'Postpartum Haemorrhage guideline. Women should be reviewed if they have a sudden increase in their vaginal bleeding, they pass clots, tissue or membranes, they have concerns about their bleeding or they show signs or symptoms of infection such as abdominal pain, fever or offensive lochia. It is important to be aware that a maternal weight below 50kg and the presence of anaemia will worsen the consequences of secondary post partum haemorrhage and therefore medical review should be sought earlier if these risk factors are present.

Back to Contents

5.2 Perineal Care

Following initial perineal care after birth and potential suturing, care of the perineum should be discussed with the woman. Risk factors for persistent postnatal perineal pain are episiotomy or perineal/labial tear, assisted vaginal birth, wound infection or breakdown and traumatic birth experience. Analgesia should be offered.

A perineal examination should be offered daily as an inpatient or at each postnatal contact in the community. At each postnatal contact perineal health should be discussed. The woman should be asked if she has any concerns regarding perineal pain not resolving or requiring more analgesia, unpleasant smelling discharge, swelling or wound breakdown. The 'Perineal wound care' leaflet should be provided to all women who have experienced perineal trauma.

See Perineal Trauma guideline for further information.

Women should be advised about the importance of good perineal hygiene including cleaning of the perineum, frequency of changing sanitary pads and handwashing.
In the event of poor healing, wound breakdown or signs of infection or haematoma, medical review by an obstetrician or experienced midwife should be sought. If the referral for wound breakdown is from the community the women should be seen the same day.
The physiotherapy team will visit women on the postnatal ward. Women who have sustained 3rd or 4th degree tears will be offered additional input from the physiotherapy team.
Back to Contents

5.3 Caesarean section.

Analgesia and thromboprophylaxis should be prescribed by an anaesthetist or surgical team once the woman is transferred out of theatre.

Information link for pain relief Going Home Following Your Birth - Cardiff and Vale University Health Board (nhs.wales)

The operation note should be printed, signed and placed in the patient notes. A summary of the operation should be put into the discharge summary on the Welsh Clinical Portal (WCP). The postnatal midwife should be in theatre for the WHO surgical checklist sign out and be made aware of any obstetric and anaesthetic concerns. Maternal observations and monitoring following caesarean section should follow the caesarean section guideline. HDU care should be provided as indicated. Following a caesarean section, the wound should be assessed regularly to look for signs of infection, separation or dehiscence. Women with a suspected complication should be referred to an obstetrician or the Obstetric Assessment Unit (OAU) for review. Wound care should be discussed with each woman and dressings, sutures or clips removed as documented in the operation note and should be decided by the operating surgeon. Timing will be decided according to what dressing type is applied.

Back to Contents

5.4 Bladder care.

See - Bladder Care in Labour and Postpartum.pdf

Back to Contents

5.5 Bowel care

Women should be asked if they have had their bowels opened at each postnatal contact. If the woman is suffering with haemorrhoids, constipation, anal fissure or faecal incontinence the ongoing plan should be discussed with the medical team. Third and fourth degree tears should be examined regularly for signs of healing and infection. Ensure referral to relevant postnatal obstetric clinic and obstetric physiotherapist has been completed. Stress importance of perineal hygiene and regular analgesia for pain.

Back to Contents

5.6 Anaemia.

If there is significant blood loss following birth (>500mls) a repeat full blood count is recommended prior to discharge from hospital. The frequency and timing of this will be determined by the clinical picture and on the advice of medical staff and should be documented clearly in the notes and handover paperwork. A checking of full blood count following a caesarean section is dependent on the clinical picture and pre delivery Haemoglobin but should be undertaken prior to discharge.

Back to Contents

5.7 Handover

On admission to the postnatal ward an SBAR from midwifery staff and the postnatal transfer sheet should be completed. An SBAR should be completed in the postnatal notes if the women is transferred to another ward area.

Prior to transfer to the postnatal ward, all women who have birth on the consultant unit must have a discharge sticker completed to identify which type of dischsrge they require. It is

important to consider any emerging risk factors that may change this during the postnatal stay.

Postnatal Discharge Sticker

Criteria	Date & Time	Signature	Grade
Suitable for Midwife Led Discharge			
Suitable for Midwife Led Discharge if following criteria met: …… …… …… …… ……			
Requires obstetric review prior to discharge			

Suitability for midwifery led discharge may change should the clinical condition of the patient deteriorate.

5.8 Venous Thromboembolism (VTE)

See the 'VTE in pregnancy and the puerperium' guideline for further guidance on assessment and management of VTE.

If a woman is re-admitted in the postnatal period, a VTE risk assessment should be completed at every admission and thromboprophylaxis prescribed as indicated.

Back to Contents

5.9 Mobilisation.

Women should be encouraged to mobilise as soon as possible following the birth and this can occur before catheter removal as long as this is safe to do so. Pressure areas should be checked and waterlow chart completed every two hours until the woman is mobile to prevent pressure ulcer formation. If there is a concern regarding pressure ulcer development medical photography and the tissue viability team should be contacted.

Back to Contents

5.10 Rhesus Negative status

All women with rhesus negative status should be offered a Kleihauer test. Any outstanding results should be obtained and action taken as appropriate. See the 'Anti-D Prophylaxis ' guideline for further guidance.

Anti-D Administration.pdf

Back to Contents

5.11 Security

Security of mothers and babies should be ensured at all times. See the 'Identification of babies' guideline for further guidance. ID bands and security tags should be recommended for all babies on the postnatal ward. The 'Babies don't bounce' risk assessment should be completed and the policy discussed with all mothers and/or accompanying birth partners. Babies must be cared for by the parent/s in the bed space. Should a woman be unable to provide safe care for her baby/babies or be required to leave the ward for any reason, her baby/babies should be admitted to NICU or a clinical member of staff should be allocated to babysit 1:1 until the mother and/or her partner returns.

Back to Contents

5.12 Infant feeding

Support should be provided to initiate feeding regardless of method. Parents' emotional, social, financial and environmental concerns about feeding methods should be acknowledged and choices respected.

Back to Contents

5.13 Contraception

Contraception options should be discussed with all women in the postnatal period. All women should be offered contraception prior to discharge (methods available include the Progestogen Only Pill (POP), the contraceptive injection or a contraceptive implant (if a skilled practitioner is available). Women who have had contraception inserted at the time of birth should be informed that this can be checked with their GP at their posnatal follow up at 6-8 weeks post partum. They should also be reminded about the time period that their chosen coil will provide adequate contraception
See - Postnatal contraception.pdf

Women should be made aware that it is possible to become pregnant very soon after giving birth, even if they are breastfeeding and their period has not returned. GPs and family planning clinics can provide ongoing advice and treatment.

Back to Contents

5.14 Medical review and Postnatal huddle

The postnatal 'huddle' takes place from 10:30 am daily on East and then West wards. This is led by the senior registrar or consultant allocated to the ward round or the consultant on call during weekends. At weekends this may occur at a later time. The Huddle will involve the midwives on duty on the ward, the first flow junior doctor, the ward round senior or consultant and anyone else looking after the patient. All patient's needing review that day (as per the doctor job's list or midwifery handover sheet) will be discussed.

The following women need to be discussed and a senior plan made on the huddle:

- Any woman on the sepsis pathway
- Any woman on antihypertensives
- Severe perinatal mental health concerns
- Any woman with obstetric complication such as major postpartum haemorrhage, return to theatre, shoulder dystocia, preterm birth
- Anyone else whom requires senior input

The following women need an in person review by the consultant:

- All postnatal readmissions for maternal reasons, within 24 hours of admission and every 24 hours thereafter at a minimum.
- Any woman on the sepsis pathway who is still pyrexial or unwell despite 24 hours of antibiotics.
- Any woman who the junior medical staff or midwives are concerned about with regards to mental or physical health

Back to Contents

5.14.1 Postnatal readmissions

All postnatal women readmitted to the hospital for maternal indications need a senior review (ST6 or above) within 24 hours of admission. This review ensures full assessment and management plans are made.

Back to Contents

6 Management of Common Postnatal Problems

6.1 Perineal pain and perineal wound breakdown

See – Perineal Trauma guideline

Women with ongoing perineal pain or wound breakdown should be reviewed by experienced midwifery or medical staff.
Initial assessment should include maternal observations and inspection of the perineum with regards to the extent of trauma, bruising and signs of infection.

Back to Contents

6.2 Post partum Infection

It is important to be aware of the possibility of mastitis, wound infection, urinary tract infection (UTI) and uterine infection. If there is evidence of infection a full set of maternal observations should be taken and plotted on the MEOWs chart.

If the woman presents with urinary symptoms, consider the possible diagnosis of UTI, stress incontinence (occurs in about 4% of women after caesarean section) or urinary tract injury (occurs in about 1 per 1000 after caesarean section).

The caesarean or perineal wound should be assessed regularly to look for signs of infection, separation or dehiscence. If there are any concerns of separation of the wound edges, tenderness, increasing pain, discharge (pus/serous), redness from incision line, localised heat or swelling, or offensive odour a wound swab should be sent.

The uterus should be palpated during each postnatal examination and should be well contracted, not tender and central. If the uterus is tender, high or there is evidence of a change or offensive lochia uterine infection should be considered.

Women who are unwell with signs and symptoms of postnatal infection should be referred for an obstetric review and a full physical assessment and management plan. If the woman is in the community she should be referred to the Obstetric Assessment Unit (OAU) for review.

Back to Contents

6.3 Headache

Women should be advised to report a severe headache, particularly one which occurs when standing or sitting. A full set of maternal observations should be taken and plotted on the MEOWs chart.

Women who have received and epidural or spinal anaesthesia for labour and birth will need a review by an anaesthetist. All women reporting a severe headache despite analgesia should be reviewed by an obstetric doctor and hypertension and other causes excluded.

Back to Contents

6.4 Urinary problems

See - Bladder Care in Labour and Postpartum.pdf

Back to Contents

6.5 Breasts and nipples

An assessment of the condition of the breasts and nipples should be included during each postnatal examination. Women should be advised of the natural process of lactation and made aware of any symptoms that may occur (blocked milk ducts/engorgement/mastitis etc). They should be encouraged to self-refer if they have any concerns. If nipples are sore or cracked, they should be advised on correct positioning and attachment.

Natural suppression of lactation should be discussed with women who choose not to breastfeed.

Back to Contents

6.6 Bowel problems including constipation

Constipation is common during pregnancy and in the postpartum period. On initial discussion women should be advised about dietary and lifestyle measures such as increasing dietary fibre, hydration and activity levels in the first instance.

If these measures are ineffective, or symptoms do not respond adequately, offer short-term treatment with oral laxatives. Adjust the dose, choice, and combination of laxatives used, depending on the woman's symptoms, the desired speed of symptom relief, the response to treatment, and their personal preference. Offer a bulk-forming laxative first-line, such as ispaghula (Fybogel). If stools remain hard or difficult to pass, add or switch to an osmotic laxative such as Lactulose. If stools are soft but difficult to pass or there is a sensation of inadequate emptying, consider a short course of a stimulant laxative such as Bisacodyl or Senna. If the response to treatment is still inadequate, consider prescribing a glycerol suppository.

Special consideration should be taken particularly in women who have a history of bowel problems including but not limited to chronic constipation, inflammatory bowel disease, irritable bowel disease or previous bowel surgery.

All women who have had a caesarean should be specifically asked about the passing of flatus and stool post operatively. Women who report abdominal pain and distension post caesarean with no flatus or bowel disruption should be discussed with a senior obstetrician to exclude bowel obstruction and/ or bowel perforation. Women with these symptoms should have a full set of maternal observations, blood tests for full blood count, U&Es and lactate and a consideration for imaging after discussion.

Back to Contents

7 The Unwell Postnatal Woman

The following symptoms and signs are suggestive of potentially life-threatening physical conditions of the woman:

- Sudden and profuse blood loss or persistent increased blood loss
- Abdominal, pelvic or perineal pain not responding to analgesia
- Faintness, dizziness, palpitations or tachycardia
- Fever, shivering (rigors), abdominal pain – especially if combined with offensive lochia or a slow-healing perineal wound
- Persistent or severe headaches accompanied by visual disturbances and/or nausea and vomiting
- Leg pain, associated with redness or swelling
- Shortness of breath or chest pain
- Worsening reddening and swelling of breasts that persist for more than 2 days despite self management
- Signs and symptoms of potentially serious conditions that do not respond to treatment

Women with any of the above symptoms require urgent medical attention and should be referred to the obstetric team and to OAU if in the community.

Potential life-threatening conditions include:

- Preeclampsia/Eclampsia
- Postpartum haemorrhage
- Sepsis/Genital tract sepsis
- Deep vein thrombosis/Pulmonary embolism

See 'Hypertensive disorders in pregnancy', 'Prevention and Management of Postpartum Haemorrhage', 'Infection and Sepsis in Pregnancy' and ' Venous Thromboembolism (VTE) In

Pregnancy and the Puerperium: Risk assessment, Diagnosis and Management.' guidelines for further guidance.

Providing women with information about the symptoms and signs that may indicate a serious physical illness or mental health condition may prompt them to access immediate emergency treatment if needed. Women should be advised within 24 hours of the birth of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Back to Contents

8 Emotional Wellbeing

At each postnatal contact women should be asked about their emotional wellbeing and the family and social support that is available to them. They should be given the opportunity to talk about their birth experience and be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside the woman's normal pattern.

Women should also be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, time to rest, getting help with their baby, talking about their feelings and ensuring they can access social support networks.

Some women, particularly those with underlying mental health conditions may experience difficulties with the mother–baby relationship. Assessment of the nature of this relationship, including verbal interaction, emotional sensitivity and physical care should be made at all postnatal contacts.

All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after birth.

Back to Contents

8.1 Postnatal Depression and postpartum PTSD

Mental health conditions such as postnatal depression (PND) and postpartum PTSD can develop in the postnatal period (see below for symptoms). Formal debriefing of the birth experience is not recommended for all women (NICE 2006) however if the woman feels traumatised or would like to discuss her birth experience a referral to the 'Birth After Thoughts' service should be offered. Women can self refer here Birth Afterthoughts Self-referral Form (office.com)

Prior to discharge from maternity services, explore the woman's mental health and resolution of symptoms of baby blues (for example tearfulness, anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal

depression and referred to GP if symptomatic. Liaison with the health visitor is also crucial to ensure relevant information sharing within the MDT.

Back to Contents

8.2 Life-threatening mental health conditions

The following signs and symptoms are suggestive of potentially life-threatening mental health conditions in the woman:

- Severe depression, such as feeling extreme unnecessary worry, being unable to concentrate due to distraction from depressive feelings
- Severe anxiety, such as uncontrollable feeling of panic, being unable to cope or becoming obsessive
- The desire to hurt others or themselves, including thoughts about taking their own life
- Confused and disturbed thoughts, hallucinations and delusions

Urgent medical care (liaison psychiatric team, GP or A&E) should be sought if any of the above signs are evident and an urgent referral to the perinatal mental health team completed.

See Postpartum Psychosis guidance.

Back to Contents

9 Maternal discharge process

- On discharge from hospital (or following a homebirth) women should have a thorough postnatal examination.
- E3 should be checked for ant safeguarding alerts and plans.
- This should be recorded in the 'Postnatal Care Pathway' and on Euroking (E3). Printed copies of the E3 documents should be filed in the maternal notes and a copy sent to the GP. A copy should be provided for the woman to take home for use by the community midwife and health visitor.
- An additional GP communication letter should be completed for any women with significant or complex issues during or following the birth (new regular medication etc).
- The woman will take her 'Postnatal Care Pathway' home with her for the community midwife to use until she is discharged from maternity care.
- It is the responsibility of the midwife discharging the woman to ensure that women who have specific needs such as child protection, substance misuse and mental health issues have suitable plans in place and that the appropriate professionals are informed of the discharge.
- All relevant take home medicines should be documented on the discharge record. The woman should be familiarised with each medication and how to safely administer it at home.
- MEOWS charts to accompany women home if any underlying medical or new conditions are identified which require review throughout the postnatal period (e.g., hypertension).
- VTE prophylaxis medication (i.e., Clexane) requires an administration assessment which is to be completed for the woman or a nominated carer prior to discharge. Medication charts are to accompany women home so that an accurate record of prophylactic thromboembolic therapy is recorded.
- Where there has been a complex postnatal course, the original medication chart should stay with the medical records and a fresh one be provided to take home.
- The following topics should be discussed with every woman:

  - Potential life-threatening signs and symptoms
  - Contact numbers
  - Normal patterns of emotional changes
  - Cervical screening
  - Contraception
  - Pelvic floor exercises
  - Pattern of home visits

Back to Contents

10 Community postnatal care

- Community midwives will be informed of the discharge via the ediary.
- All women will receive the first community postnatal visit by a midwife at home the day after discharge or homebirth.
- Subsequent visits will be individualised and determined by any ongoing maternal issues while also coinciding with ongoing care of the infant.
- Discharge from maternity services should occur around 28 days postnatal. A midwife can use her professional judgement to bring forward or delay the discharge where appropriate.
- Each woman should be aware of and be provided with the contact details for the MLU and the community midwives' office.
- Where possible the provision of postnatal care should be delivered by the named midwife or by a small team of midwives and maternity care assistants (MCA's) to facilitate communication and ensure continuity and consistency of care.
- The community midwife should liaise with the GP, health visitor and other relevant health care professionals as required.

Back to Contents

11 Domestic Abuse

- All healthcare professionals should be aware of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management.
- Please see and complete 'Cardiff and Vale UHB 'Ask & Act' Domestic Abuse Assessment Form' if concerns raised and liaise with specialist safeguarding midwife or GP if further guidance required.

Back to Contents

Back to Contents

12 Appendices

12.1 Postnatal handover of care after delivery

Patient Addressograph

Date and Time of Delivery: Type of Delivery:

MBL: Baby weight:

Risk Factors:

PPH	Mental Health	HDU
PET	Social Concerns	Diabetes
SGA	Sepsis	Cardiac
3/4th degree tear	Other:	

Handover of care:

Maternal:

- Observations: 4 hourly TDS BD
- Bloods required?

Date and time	FBC	LFT	Clotting
	U+E	CRP	Other

- VTE prophylaxis required? Y N
- E-Discharge needed? Y N
- Review needed: Midwife led discharge Obstetric review
  Senior obstetric review
- Follow up required? Y N
  Details of follow up:……..

Baby:

- Observations: Infection BMs NAS
  - Timing
- Feeding: Breast Bottle Mixed
  - Last feed: / / / ….:….
- Medication: