Aneurin Bevan University Health Board

Postnatal Care of Mother and Baby Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Executive Summary

The purpose of this guideline is to provide clinicians working within maternity services evidence based guidance in the postnatal care of the mother and baby.

The post-natal period extends from the birth of the baby to not less than 10 days and may be extended to 6 to 8 weeks (NMC 2012, NICE 2015). This is a time of physiological and psychological adaptation for the mother, baby and family and every opportunity should be taken to provide the family unit with information and support during this important period.

Although for most mothers and babies the postnatal period is uncomplicated, with the increase of mothers with multiple morbidities and social challenges, reports from MBBRACE, RCOG and NICE all highlight the immediacy required for responsive care to address potential maternal morbidity and mortality.

1.1 Scope of policy

This policy applies to all clinicians working within maternity services.

2 Aims

To support safe practice -

- To ensure all mothers and babies receive appropriate care
- To ensure mothers and partners feel confident to care for their baby being responsive to his/her needs
- To ensure prompt assessment of women who require urgent medical/mental health/obstetric/surgical review.
- To ensure that all mothers and their babies are supported in their choice of method of feeding
- To ensure the care of the mother and baby are transferred to the primary health care team in a timely manner.
- To provide such support and care that increasing numbers of mothers and their partners state that they were treated well by maternity services.
- To guide referral to other agencies where indicated

3 Responsibilities

The maternity team will be responsible for –

- Acting in accordance with the NMC and within his/her sphere of practice
- Being accountable and autonomous for his/her practice

- Ensuring women and their partners are treated with courtesy, dignity and respect at all time.

4 Monitoring and Effectiveness

Performance outcomes will be reviewed internally through clinical audit and clinical risk management systems.

The maternity service will continue to participate in independent audit review by welsh Government and UNICEF.

The care of the mother and baby during the postnatal period will be audited on a regular basis.

This policy has undergone an equality impact assessment screening process using the toolkit designed by the NHS Centre Equality & Human Rights. Details of the screening process for this policy are available from the policy owner.

5 Further information

Women and their families should be treated with kindness, respect and dignity at all times, with consideration given to privacy, and where care is provided in a maternity unit to create a clean warm and welcoming environment. The views, beliefs and values of the woman her partner and her family in relation to her care and that of the babies care should be sought and respected at all times. The woman should be fully involved in planning the timing and content of each postnatal contact so that care is flexible and tailored to meet her social, clinical and emotional needs and those of her baby and family (NICE 2016)

Physical Assessment

A full set of observations must be taken and charted using a MEOWS chart as a minimum for the first 3 days following delivery (Day 1 will be day of delivery) either by hospital or community midwives. This will include monitoring of blood pressure, temperature, pulse, respiratory rate, and assessment of pain score.

Key physical signs that may suggest serious illness. And that warrant immediate medical referral
• **A heart rate over 100 beats per minute (bpm)** • **A systolic blood pressure over 160 mm/Hg or under 90 mm/Hg and/or a diastolic blood pressure over 80 mm/Hg**

- **A temperature over 38 degrees centigrade and/or**
- **A respiratory rate over 21 breaths per minute. The respiratory rate is often overlooked but rates over 30 per minute are indicative of a serious problem**

*See also Physiological Observations in Maternity Service Guideline ABHB 0507

At the first postnatal contact women should be advised of potentially of life threatening conditions and to contact their health care professional immediately or call for emergency if any of the following signs and symptoms occur.

Signs and symptoms	**Condition**
Sudden and profuse blood loss or persistent increased blood loss Faintness, dizziness or palpitations/tachycardia	Postpartum haemorrhage
Fever, shivering, abdominal pain and/or offensive vaginal loss	Infection
Headaches accompanied by one or more of the following symptoms within the first 72 hours after birth: visual disturbances nausea, vomiting	Pre-eclampsia/ eclampsia
Unilateral calf pain, redness or swelling Shortness of breath or chest pain	

Women should be encouraged to mobilise as soon as appropriate following the birth. Women with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis

Women experiencing shortness of breath or chest pain should be evaluated for pulmonary thromboembolism (emergency action).

Obese women are at higher risk of thromboembolism and should receive individualised care

Uterine Involution

Assessment of vaginal loss and uterine involution should be undertaken if a woman has excessive or offensive vaginal loss, abdominal tenderness or fever. Midwives should offer women advice regarding normal lochia and encourage them to seek further advice if any concerns are raised.

Perineum/caesarean section wound site.

The midwife will enquire whether the woman has any concerns about the healing process of her perineum/wound at each visit. This will include her experience of perineal pain, discomfort, dyspareunia or offensive odour. Signs and symptoms of infection, inadequate repair, wound breakdown or non healing should be investigated and the appropriate referrals made as necessary.

The midwife will give advice regarding personal hygiene, wound care, contraception and resumption of sexual intercourse on an individualised basis.

The midwife will ensure that surgical site infections are recorded on the maternity data system CSC.

Bladder and Bowel Function

All women following birth should void urine within 6 hrs of birth and the amount should be recorded. If women experience problems with the first void of urine then the Health Boards' guideline for Postnatal Retention of Urine should be followed.

The midwife will provide advice on diet and fluid intake, to ensure the mother's bowel habits return to normal. The midwife will ask about signs of constipation within 3 days of birth.

The midwife will advise, teach and stress the importance of pelvic floor exercises to women. If there are any signs of incontinence or perceived problems, the midwife will refer the mother for an assessment using the Health Board's Pelvic Floor Guideline.

Haematological Investigations

Full Blood Count, Rhesus and Rubella status are routinely taken during the ante natal period. If the mother is un-booked, these investigations need to be taken as soon as possible as a matter of urgency. All outstanding investigations need to be followed up as soon as possible so that appropriate care is given in a timely manner.
Midwives should assess the necessity of any other haematological investigations required in the postnatal period taking into consideration the mother's medical history, pertinent risk factors, blood loss at birth and clinical observations.

Emotional Wellbeing

The midwife will observe the emotional health and wellbeing of the women including their coping strategies and the support network available to them. Midwives will encourage women and their families to report any concerns. Midwives will be alert to any signs and symptoms of maternal health problems and refer for expert medical consultation if necessary. Care pathways will inform appropriate referrals for support.

Feeding

Midwives follow UNICEF Baby Friendly Initiative guidelines, to promote and encourage breastfeeding. Women will be advised of the signs of successful feeding including correct positioning and attachment. Women must be offered support and advice to ensure they gain confidence in breastfeeding. The midwife will ensure that the woman knows how to hand express her breasts.
Midwives will encourage unrestricted breastfeeding duration and frequency and assist with establishing infant feeding.

During the first hour of life the mother and the baby should not be separated, skin to skin contact should be encouraged and feeding initiated. Where postnatal care is provided in a clinical setting round the clock rooming-in and continuing skin to baby's skin contact when possible should be encouraged.

A women who chooses to feed her baby formula milk should be taught how to make feeds using the correct measured quantities of formula as based on manufacturer's instructions, and how to clean sterilise feeding bottles and teats and the storage of formula milk.
All women and carers who are giving their babies formula feed should be offered appropriate and tailored advice to ensure this is undertaken as safely as possible and optimises infant development.

Feeding progress should be assessed and documented in the care plan at each postnatal contact.

Social Needs

The midwife will assess the mother's needs and refer to the appropriate multiagency partners e.g. social services, seeking advice from specialist midwives as required.

Domestic Abuse

The midwife will check that the routine enquiry for domestic violence has been achieved in the ante natal period, and complete if necessary in the postnatal period. Routine enquiry for domestic abuse should only take place if the mother is alone.

3.1 ASSESSMENT OF INFANT

A complete physical examination of the newborn is undertaken within 72 hours of birth. Consent must be obtained from the mother or both parents prior to performing any neonatal examinations or treatments. This will include the aims of any physical examination and or treatment by the Healthcare Professional. All findings are recorded in the postnatal plan.

- **Handling / infant behaviour**

The infant should be stripped and examined on the first home postnatal visit, in order to observe the infant's appearance, respiration, behaviour, activity and posture. This examination along with any findings must be documented in the postnatal notes. Referrals to the appropriate healthcare professional should be made as necessary.

- **Feeding**

Midwives will encourage skin to skin contact and initiation of feeding within the first hour of birth. Women who choose to breastfeed their babies are provided with appropriate advice and support to initiate and sustain breast feeding. Formula milk should not be given to breastfed babies unless medically indicated. If the mother chooses to bottle feed the midwife should provide the necessary information and advice on the sterilisation of equipment and making up artificial feeds, to ensure the correct technique is used. All mothers are given help-line contact numbers for breastfeeding advice and support in the early postnatal period.

Evaluation for ankyloglossia (tongue tie) should be made if breast feeding problems persist after a review of positioning and attachment by a skilled healthcare professional or peer counsellor. Babies who appear to have ankyloglossia should be evaluated further (non-urgent action)

- **Eyes / mouth / cord / skin**

The midwife will assess skin condition, colour, rashes, and abrasions' bruises, signs of infection and note separation of the cord. The midwife will take any necessary action required and refer to the appropriate healthcare professional as required.

- **Jaundice**

The midwife will assess the presence / absence and degree of jaundice in the context of the infant's age. Infants who develop jaundice within the first 24 hours should be urgently investigated. The midwife will also assess the adequacy of feeding pattern, tone, presence of pale stools, hydration, alertness and infant's overall well being. The bilirubin levels will be checked and subsequent appropriate action taken as necessary.

- **Bladder function**

To assess the amount and nature of urine passed by infant and identify signs of inadequate nutrition and give appropriate advice and /or refer to the appropriate healthcare professional.

- **Bowel function**

The midwife will record that the infant has passed meconium within the first 24hours of birth and then ensure that the baby has a normal changing stool pattern. The midwife will take appropriate action if there is any delay in this process and where there is any deviation from normal.

- **Weight**

Weighing forms part of the overall neonatal assessment. It is normal for infants to lose up to 10% of their body weight initially but they should regain it by 2 weeks of age. If the midwife has any concerns regarding weight gain or a suspicion/detection of an identified problem relating to the wellbeing of the baby, a full assessment of the infant's feeding pattern and behaviour should be undertaken. This should include weighing of the baby and a referral to the appropriate professional for an opinion. All infants should be weighed at birth, at 5 days (either by the midwife or health visitor) and on discharge from maternity services. In addition all breast fed babies are to be weighed at 72 hours.

Vitamin K administration

Vitamin K should be administered as a single dose of 1mg I.M. at birth. This is the most clinically effective method of administration. If parents decline I.M. vitamin K for their baby, oral vitamin K should be offered as an alternative, and will require multiple doses.

Newborn Blood Spot Test

The Newborn blood spot test should be offered to all parents when their infants are 5-8 days of age. Informed consent should be obtained

♦ **Newborn hearing screening**

All infants should have their hearing screened prior to discharge or by week 4 in the hospital programme or by week 5 in the community programme.

Frequency of postnatal visits
The frequency and time of post natal visits in the community is agreed between the woman and midwife. This is based on the clinical, social and emotional needs of the mother and infant. During this period, referrals to other health professionals/agencies may be necessary. The following are guidelines for a minimum visiting schedule:

- The first day following birth/hospital discharge in order to review appropriate care plan dependant on the needs of the mother and infant

- Between days 5 – 8 following birth in order to offer newborn metabolic screening and administer the second dose of oral Vitamin K if required.

- A final visit 28 days following birth for a full evaluation of the mother and infant. Areas to be assessed include:

  Public health issues
  Parenting abilities
  Development and feeding of the infant
  Social, psychological and physical wellbeing of mother and infant.
  Administration of the third dose of oral Vitamin K to fully breast-fed infants.

Documentation

It is the midwives responsibility to maintain accurate records (NMC 2004)
Documented evidence of the care provided to woman and infant is to be recorded in the woman's personal postnatal care pathway record, which is reunited with the woman's medical notes at discharge from midwifery care.

Appendix 1 Ankyloglossia (Tongue tie)

Some babies are born with the condition tongue-tie, which has the medical name ankyloglossia. The fold of skin under the tongue that connects to the tongue to the bottom of the mouth is shorter than usual, and this restricts the movement of the tongue. The condition may be mild, or it can be severe, with the tongue joined to the bottom of the mouth. Tongue-tie can cause problems with breastfeeding, such as problems 'latching on' (getting in the right position to feed efficiently) and sore nipples. If the baby isn't feeding efficiently, he or she may not gain weight at the normal rate. The procedure NICE has looked at involves cutting through the fold of skin using sharp, blunt-ended scissors.
Aneurin Bevan University Health Board makes sure all parents who are worried about their baby's breast feeding within the first 6 weeks of birth will be seen by a Lactation Consultant and have a detailed assessment of their baby's feeding. The Lactation Consultant will arrange the baby's care. This may be feeding reviews every week or the Lactation Consultant may suggest the tongue tie should have a tongue tie procedure. For a very young baby, this is usually done without an anaesthetic or using a local anaesthetic. The baby should be able to feed straight after having the procedure. The Lactation Consultant will not be able to offer the procedure on babies older than 6 weeks.

Division of ankyloglossia (tongue-tie) for breastfeeding How well the procedure works
Information about NICE Interventional Procedure Guidance 1496
One study compared what happened in babies who had the tongue tie procedure with babies whose mother had 48 hours of intensive support from a breastfeeding specialist. Nearly all the mothers of babies who had the procedure said that breastfeeding had improved 24 hours afterwards (it improved in 19 out of 20 babies). As a comparison, only 1 mother out of 20 who had support from the breastfeeding specialist said that breastfeeding improved afterwards. In one study that followed what happened in 215 babies who had the tongue-tie procedure, 173 mothers said breastfeeding improved afterwards. In another study, all 70 mothers said that their babies could latch on better after having the procedure. And the 53 mothers who had felt nipple pain said that this improved after their babies had the procedure. In a third study, all 36 babies in the study who had the tongue-tie procedure could move their tongues normally 3 months later.

What the experts said
The experts did not agree about how well the tongue-tie procedure worked. Some said that it was difficult to tell whether the

improvement in breastfeeding happened as a result of the procedure or improved management of breast feeding.

Division of ankyloglossia (tongue-tie) for breastfeeding
Risks and possible problems
What the studies said

The studies did not report many problems after the tongue-tie procedure. In one study, 4 out of 215 babies had an ulcer under their tongue that lasted more than 48 hours. Two studies that included a total of 159 babies found no problems after the procedure. In one study, 3 out of 36 babies slept through the procedure, and 39 out of 215 babies slept through it in another study.

What the experts said
The experts said that problems were likely to be very rare. The following were possible, though: bleeding, infection, ulcers, pain, and damage to the tongue and surrounding area. It was also possible that the tongue-tie might return.

Your appointment with the lactation consultant for your baby's feeding assessment

IS AT

DATE

TIME

Your lactation consultant's name is

If you are unable to make this appointment please contact

Appendix 2 Mastitis and breast abscess

Mastitis is a painful inflammatory condition of the breast which may or may not be accompanied by infection. It is usually associated with lactation ('lactational' or 'puerperal mastitis'), but it can also occur in non-lactating women ('non-lactational mastitis').

- A breast abscess is a localized collection of pus within the breast. It is a severe complication of mastitis, although it may occur without apparent preceding mastitis. Other complications include sepsis, scarring, and recurrent mastitis.
- In lactating women, milk stasis is usually the primary cause of mastitis.
  - The accumulated milk causes an inflammatory response which may or may not progress to infection.
  - The most common organism associated with infectious mastitis in lactating women is *Staphylococcus aureus*.
- In non-lactating women, mastitis is usually accompanied by infection, which can be categorized as either central/subareolar or peripheral.
  - Central/subareolar infection is usually secondary to periductal mastitis (a condition where the subareolar ducts are damaged and become infected).
  - Peripheral infection (less common) is associated with diabetes mellitus, rheumatoid arthritis, trauma, corticosteroid treatment, and granulomatous lobular mastitis (a rare inflammatory disease of the breast), but often there is no underlying cause.
  - The most common organisms associated with infectious mastitis in non-lactating women are *S. aureus*, enterococci, and anaerobic bacteria (such as *Bacteroides* spp and anaerobic streptococci).
- Mastitis should be suspected if a woman has:
  - A painful breast.
  - Fever and/or general malaise.
  - A tender, red, swollen, and hard area of the breast, usually in a wedge-shaped distribution.
- It is not possible to distinguish clinically between infectious and non-infectious mastitis. Infection is more likely if the

woman has a nipple fissure that is infected, or if in a lactating woman:
  - Symptoms do not improve, or are worsening, after 12–24 hours despite effective milk removal.
  - Bacterial culture in breast milk is positive.
- A breast abscess should be suspected if the woman has:
  - A history of recent mastitis.
  - A painful, swollen lump in the breast, with redness, heat, and swelling of the overlying skin.
  - Fever and/or general malaise.
- If a breast abscess is suspected, the woman should be referred urgently to a general surgeon for confirmation of the diagnosis and management.
- If there is an underlying mass or breast cancer is suspected, an urgent 2-week wait referral should be arranged.
- First-line management of a woman with mastitis not requiring urgent admission or referral includes:
  - Offering reassurance that the breast should return to normal following appropriate treatment.
  - Advising on measures to relieve pain and discomfort, such as the use of simple analgesics and applying a warm compress to the breast.
  - Encouraging breastfeeding women to continue feeding if possible, including from the affected breast.
  - Identifying and managing predisposing factors for mastitis, where possible, including poor infant attachment to the breast, nipple damage, smoking, and/or an underlying breast abnormality.
  - Prescribing oral antibiotics if indicated.
  - Offering appropriate advice on measures to prevent recurrence, such as encouraging good breastfeeding technique and maintaining good hygiene.

Acute Breast Sepsis

Definition
Cellulitis affecting the interlobular tissue of the breast, usually caused by an acute bacterial infection.

Clinical presentation includes:

- short duration of skin erythema
- tenderness
- indurated tissue

Refer immediately if *(considering acute surgical team if systemically unwell)*

- Systemically unwell
- Obvious abscess
- Necrotic/compromised skin

Initial Primary Care Management

- Lactational - High dose Flucloxacillin or Clarithromycin for 10-14 days
- Non lactational - Augmentin or clarithromycin for 10-14 days
- Review at 48 hours
- If improving, complete course
- If deteriorating refer

- If referral criteria are not met, but resolution of symptoms are slow or recurrent, refer for full triple assessment via 2-week wait proforma.

Management of **a woman with a breast abscess**

- **Refer the woman urgently to a general surgeon for:**
  - Confirmation of the diagnosis (by ultrasound).
  - Drainage of the abscess (by ultrasound-guided needle aspiration or surgical drainage).
  - Culture of fluid from the abscess (which will be used to guide the choice of antibiotic).
- **Advise lactating women to continue breastfeeding if possible (including from the affected breast).**
  - If this is too painful, or the infant refuses to breastfeed from the affected breast, advise the woman to express the milk (by hand or with a breast pump) until she is able to resume breastfeeding from that breast.
    - For detailed information on how breast milk should be expressed, see ABUHB information on How to express breast milk.
    - A breast pump may be obtained from Bluebell ward in RGH and the maternity ward 2:1 in NHH.

Breastfeeding advice

- Because milk stasis is often the initiating factor in lactational mastitis, the most important management step is frequent and effective milk removal. **Sudden cessation of breastfeeding in women with lactational mastitis increases the risk of abscess formation**

Pathways of Care Mastitis
Assess to Maternity Advice

Women should be encouraged to contact their community midwife for advice on attachment and mastitis in the first instance via designated single point of contact for their Borough. Day Assessment Facilities are available for women to attend for midwifery review at YYF, County, YAB, these community based facilities do not have attending obstetricians.

Professionals should be advised to contact the Admissions Triage Unit if they are experiencing any breast abscess related problem that requires an obstetric or surgical review.

The GP should make a referral to the on call surgical team for women with a breast abscess after the 28th post-natal day.

Referral Process ABUHB

Mothers have the interest of their baby at heart. It is important that mothers perceive all staff are aware of this and are responsive to the mother / baby's needs.

Should the mother require admission to hospital, provision will be made for the accompanying baby / babies. The baby / babies are the responsibility of the mother and family. Baby cots can be obtained through the maternity unit.

Mothers who are within 6 weeks of birth will be accommodated on the maternity unit with close liaison with the surgical team.

Mothers and babies who have been discharged from midwifery care will be cared for in a single cubicle. There is no requirement for additional security in regard to the baby.

All mothers with acute breast abscess are admitted through acute surgical admission, the mother will be assessed within 24 hours by the breast surgical team.

If imaging demonstrates a pus collection, then depending on abscess, size, location and skin integrity, as well as the mother's preference, it will be drained by incision and drainage or repeated aspiration.

If imaging does not show a collection the mother will be returned to the care of her GP. If previous breast disease, patient family history or clinical presentation warrants a higher index of suspicion for underlying malignancy, then the mother will undergo formal triple assessment and the GP will receive correspondence regarding this.

If out of office hours or the patient is unwell, contact the on call surgical team to arrange assessment and onward referral to the breast team.

ABUHB, Breast surgeons

Mr Holland	RGH
Dr Gately	RGH
Mr Gomez	NHH

These surgeons are all contactable through their secretaries for discussion on individual care needs.

In order that the baby's ongoing nutrition needs can be met, the breast feeding lead midwife must be kept informed of any mother who has been admitted to ABUHB for treatment.

Record Keeping

Care provided will be documented and recorded in accordance with the NMC Guidance for Record Keeping, Aneurin Bevan Record Keeping Policy and Health Care Standards.

Observations to be completed on admission:-

All women should have their post-natal hand held records reviewed and a full history of the current presenting complaint. Initial assessment must include:-

- **S – (Situation)**
  Reason for attendance
  Description of Symptoms

- **B – (Background)**
  Feeding patterns / history

- **A – (Assessment)**

  -Postnatal women
  -BP, Pulse, Temperature, Respiratory Rate, Urinalysis, uterus, lochia,
  - perineum wound, VTE.
  - Assessment of breasts
  - Consider culture and sensitivity of breast milk
  - Consider sepsis

- **R – (Recommendations)**
  Differential Diagnosis
  Management Plan
  Medical Review

Biochemical / haematological tests should be taken in accordance with the woman's condition. Any blood tests ordered must have the results followed up before discharging the woman home and referring GP informed.

References

NICE Division of ankyloglossia (tongue-tie) for breastfeeding NICE 2005

Reference: pathway author English R BMJ 2011; 342:d396

World Health Organization (WHO) guideline Mastitis. Causes and management WHO 2000

The Academy of Breastfeeding Medicine (ABM) guideline ABM Clinical protocol number 4: mastitis 2014

World Health Organization 2000 Academy of Breastfeeding Medicine 2014 Sudden cessation of breastfeeding in women with lactational mastitis increases the risk of abscess formation.

The Academy of Breastfeeding Medicine (ABM) guideline *ABM Clinical protocol number 4: mastitis 2014*

*Th*e National Institute for Health and Care Excellence (NICE) guideline *Postnatal care 2015*].

ABUHB Pelvic Floor guidelines
ABUHB Breast Abscess guideline
ABUHB Guideline Physiological observation in maternity service
ABUHB Bladder and Bowel care guideline
ABUHB Infant feeding policy for hospital and community
MBBRACE Saving mothers Lives improving mothers care 2015
NICE Postnatal care 2015
WHO UNICEF BFI 2015