

Enhanced Postnatal Care

Standard Operating Procedure (SOP)

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AUTHORSHIP, RESPONSIBILITY AND REVIEW

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Disclaimer

When using this document please ensure that the version is the most up to date by checking the Obstetrics & Gynaecology Guidelines on WISDOM

PRINTED DOCUMENTS MUST NOT BE RELIED ON

Enhanced Postnatal Care Standard Operating Procedure

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Staffing Standards and Oversight

A band 6 or above midwife should be allocated the enhanced care bay at the start of each shift.

Due to the high-risk nature of the service users requiring enhanced care, the allocated midwife should be based in the enhanced care bay at all times.

If the midwife allocated to enhanced care needs to leave the bay for any reason whatsoever, another midwife should be allocated to remain in the bay during their absence. The enhanced care bay should never be left unattended by a midwife under **any** circumstances.

The transferring midwife should remain in the enhanced care bay for handover and to provide clinical care for a minimum of one hour following transfer.

During periods of increased patient complexity or acuity, consideration should be given to the allocation of a Health care Support Worker (HCSW) to assist with clinical activities. This support aims to enhance the capacity of the clinical team, ensuring timely and effective patient care while maintaining safety and quality standards. The deployment of HCSWs in such circumstances should be guided by clinical judgement, workload assessment, and woman's needs, and should align with the organisation's staffing protocols and escalation procedures.

The band 7 midwife co-ordinator will be responsible for overseeing the midwifery/nursing management of high-risk women, although not directly responsible for care provided. The band 7 midwife co-ordinator should be kept informed of the acuity in the enhanced care bay so staff can be allocated and supported accordingly. It is the responsibility of the labour ward coordinator to review the enhanced care acuity regularly throughout the shift. This should be a minimum of every 4 hours. Enhanced care acuity should also be recorded on the daily acuity sheet.

Criteria for admission to Enhanced care

Women meeting the following criteria should routinely be cared for in the enhanced care bay in the immediate postnatal period:

- Postpartum haemorrhage 1500ml or more, or where there is significant clinical concern following a postpartum haemorrhage
- Caesarean birth
- Assisted birth in theatre
- Manual removal of placenta
- Repair of 3rd or 4th degree tear
- Transfer back to maternity from intensive care unit (ITU)
- Cervical cerclage

- Any postnatal woman with a clinical concern requiring close observation or monitoring via a High Dependency Unit (HDU) chart

NB. The above list is not exhaustive and clinical judgment should always be used when planning postnatal care.

Care planning prior to transfer to Enhanced care

In the case of an elective procedure, such as a planned caesarean birth, the availability of an enhanced care bay bed should be confirmed before starting the procedure. If a bed is not available in enhanced care, the procedure should not go ahead until one becomes available, or an alternative plan for appropriate close monitoring is made. If a delay is necessary, this should be discussed and agreed by the MDT.

When transferring women to the enhanced care bay, care must be handed over at the bedside by a registered midwife. The transferring midwife should remain in the enhanced care bay for handover and to provide clinical care for a minimum of one hour following transfer.

Documentation in the case notes must clearly identify the midwife who is transferring the care and the midwife who is taking over care.

Women must not be transferred during changeover of shifts.

Care and Observations required

All observations for women post theatre should be carried out as per appendix three unless otherwise indicated. If the frequency or type of observations required deviate from standard care pathways, this should be clearly documented in the notes, along with the plan for observations. A plan for review and/ or discharge should be clearly documented in the maternity record prior to transfer to the enhanced care bay. The clinical conditions that should be met prior to transfer to the ward or discharge home should also be clearly documented. This is to aid timely transfer or discharge from enhanced care.

i. Planned Caesarean Birth

Care should be provided as per the Planned Caesarean birth pathway:

[search-](#)

<ms:displayname=Search%20Results%20in%20Maternity&crumb=System.Generic.String%3AERAS&crumb=location:X%3A%5C%20Maternity> unless otherwise clinically indicated.

ii. Unplanned Caesarean Section

In the case of an unplanned (categories 1, 2 & 3) caesarean birth, the Unplanned Caesarean Birth Pathway should be followed: [Unplanned C Birth.pdf](#) unless otherwise clinically indicated.



iii. Postpartum haemorrhage

Care should be provided as per the All-Wales Maternity & Neonatal Network Guidelines Prevention and Management of Postpartum Haemorrhage (section 7 Care Following PPH): wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-pph-guideline-management-and-prevention/

iv. Assisted vaginal birth in theatre

Care should be provided as per the Operative Vaginal Birth guideline: [Guideline for operative Vaginal Deliveries \(nhs.wales\)](#) Section 16 postnatal care.

v. Manual removal of placenta

Care should be provided as per the Management of the Third Stage of Labour including Retained Placenta Guideline: [Guidelines Template March 2011 \(nhs.wales\)](#)

vi. Repair of 3rd or 4th degree tear

Care should be provided as per Repair of third or fourth degree perineal tear guideline: [Guidelines Template March 2011 \(nhs.wales\)](#)

vii. Guideline for Neurological Monitoring Associated With Obstetric Neuraxial Block

wisdom.nhs.wales/a-z-guidelines/n/neuraxial-monitoring-guideline-v4-1-003-pdf/

NB. In any of the above cases, if it is anticipated that additional care and observations are required, this should be clearly documented by the Obstetrician and/ or anaesthetist in the postnatal section of the maternity record.

viii. Minimum stay on enhanced care

Any woman receiving routine post operative care should remain on the enhanced care bay for a minimum of 2 hours.

If a Syntocinon infusion is ongoing, the woman should remain on the enhanced care bay until the infusion is complete, which will usually be 4 hours.

Due to the anticipated demand for enhanced care beds, every effort should be made to transfer or discharge the woman from enhanced care as soon as clinically appropriate.

In some circumstances, such as a bed not being available on the ward, the woman can remain on enhanced care, but does not require enhanced monitoring. Care should be provided as clinically indicated, and should not be guided by place of care.

When being transferred to enhanced care, the Obstetrician and/ or anaesthetist should clearly document which care pathway should be followed, including frequency of observations.

Escalation

I. If enhanced care is full

If enhanced care is full and a bed is needed, review by an obstetrician and/ or anaesthetist should be urgently requested to review the women in enhanced care in order to assess who may be suitable for transfer to the main maternity ward. If the enhanced care bay remains full, the woman must remain on labour ward/ in theatre for ongoing care and the Escalation Policy should be followed.

II. If 1:1 care becomes clinically indicated

If following an Anaesthetic or Obstetric review it is decided that 1:1 care is necessary, an additional midwife should be allocated to care for the woman requiring 1:1 care in the enhanced care bay. This is to ensure bed capacity is maintained on labour ward for women in labour. The enhanced care bay midwife should not be expected to provide 1:1 care unless there are no other women in the enhanced care bay.

III. Escalating clinical concerns

If the midwife has any clinical concerns, these should be escalated to the midwife in charge of labour ward as per access to advice guideline: wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/jump-call-guideline-for-clinical-staff/

Visiting

Only the woman's partner/ birth companion is permitted to visit the enhanced care bay. As most women will be transferred to the ward within a few hours, visiting can take place on the maternity ward once transferred.

Discharge from Enhanced care: Transfer to Maternity Ward or home

I. Transfer to the Maternity Ward

A plan for when the woman can be transferred to the maternity ward should be clearly documented when the woman is admitted to the enhanced care bay. Unless otherwise clinically indicated, efficient transfer should be made as early as possible.

If a plan has not been documented, or the clinical situation has changed, review by a Senior Obstetrician should be undertaken prior to transfer, with a clearly documented plan for ongoing care.

Any woman who has required HDU monitoring for any reason should have a documented MDT review prior to transfer from Enhanced care.

If care in the enhanced care bay is still required after 6 hours, a formal structured MDT review should be undertaken using the Maternal Critical Care Structured Review pro forma in

Appendix 4 for any woman who requires ongoing enhanced maternal care (or not suitable for ward discharge) at 6 hours.

II. Discharge Home

In some circumstances, a discharge may be made directly to home from the Enhanced care Bay. For example, if the woman is more than 24 hours post uncomplicated caesarean section and has been reviewed as fit for discharge.

In this case, the usual discharge home processes should be followed in full. More details can be found in the postnatal care guideline.

wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/postnatal-care-including-discharge-from-hospital/



Appendix One: Minimum Equipment Stock Levels

Resources, including equipment

The enhanced care bay should have the following equipment available within the bay at all times:

- A resuscitaire
- Glucometer and hypoglycaemia box
- MediWell medication cupboard in PCH, stocked and checked by pharmacy
- Oxygen and suction
- A working telephone
- Computer and printer
- A buzzer that can be heard on labour ward
- IV pump for each bed
- Bedside locker
- Bed table
- HDU monitoring board for each bed
- A cot for each bed space, which includes a pressure mattress alarm system
- Stock of Linen - bedding and towels for adults and neonates
- Bed pans
- Sanitary pads
- Kidney dishes
- Incontinence sheets
- Dressing pads
- Mid-Stream Urine pots
- Hourly catheter pack
- Giving sets (standard and blood giving)
- Pressure dressing
- Formula milk and teats
- Sterile water for babies
- Nappies
- Hats
- Equipment trolley, including for blood taking/ cannulation
- PROMPT Emergency boxes (PPH, Sepsis, Eclampsia)
- Baby trolley
- Baby weighing scales
- Adult weighing scales

Appendix Two: Paperwork Stock

- Enhanced care Handover sheet
- MEWS charts
- High Dependency Care Charts (HDU)
- History sheets
- Medication chart
- Purpose T chart
- Maternal Critical Care Structured Review pro forma
- Visual Infusion Phlebitis chart (VIP)
- Fluid balance chart
- Group and Save forms
- Postnatal care pathway
- Infant feeding chart
- Neonatal Early Warning Track and Trigger Tool (NEWTT)
- Neonatal medication chart



Appendix Three: Observations Following Theatre

To be documented on the MEWS chart along with pain and sedation score.

Type of Anaesthesia	Frequency
Spinal/epidural Opiates:	Every 5 minutes for 15 minutes 1 x 15 minutes Every 30 minutes until 2 hours 2 hourly until completed 12 hours 8 Hourly until discharge home.
GA & PCA:	Every 5 minutes for 30 minutes (recovery) Every 30 mins until 2 hours. 2 hourly until PCA discontinued. Then 2 hourly for 4 hours post disconnection. 8 Hourly until discharge home.
<p>These are minimum standards. Please increase frequency of observations if there are any concerns and use a HDU Chart</p>	
Potential Postoperative Risks:	Respiratory depression Hypothermia Reduced conscious level Haemorrhage / Fluid balance issues
Wound care:	Remove pressure dressing after 2 hours Aquacel dressing to remain in situ for 7 days



Appendix Four: Maternal Critical Care Structured Review

Maternal Critical Care Structured review

This is designed to be used during the multi-professional review of a critically ill pregnant or postpartum woman.

It does not replace, nor should repeat the observations and information recorded on the Maternal Critical Care chart.

Relevant notes can be made as each item is considered either directly into the woman's notes or by annotating the work sheet which should be dated, signed and filed in the woman's maternity notes at the end of the review.

Patient ID (addressograph)

Date..... Time.....

	Items to be considered	Notes:
A	Airway	
B	Breathing (Respiratory Rate, SpO ₂ , FiO ₂ , chest examination findings)	
C	Circulation (Heart rate, BP, capillary refill time, vasopressors)	
D	Disability (level of consciousness, pain, epidural or spinal block)	
E	Electrolytes (Mg ²⁺ , Na ⁺ , K ⁺ levels and eGFR/creatinine)	
F	Fluids – Review of fluid balance (input, output, blood loss, drains)	
G	GI & glucose control (bowel function and gastro-protection measures)	
H	Haematology (FBC, clotting profile, VTE prophylaxis)	
I	Infection (temperature, Sepsis Six, inflammatory markers, cultures, antibiotics)	
L	Lines (cannulae, arterial line, central line, urinary catheter, wound drains)	
M	Maternal Co-Morbidities (diabetes, hypertension, asthma, epilepsy)	
N	Neonatal considerations	
O	Obstetric: antenatal, intrapartum/postpartum related	
P	Pharmacology (review drug chart)	
Q	Questions	
R	Recommendations	
S	Summary	
	Signature	Print Date

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