Guideline for Postnatal Care Including Discharge from Hospital

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Target Audience:

People who need to know about this document in detail	All obstetric and midwifery staff including locum and agency staff working in CTM UHB
People who need to have a broad understanding of this document	As Above
People who need to know that this document exists	All Midwifery and Obstetric Staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** March 2026
	Outcome: no negative impact
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)

Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

Definition and Background

The postnatal period is a critical phase for women and newborns, during which the provision of safe, equitable, and responsive care is essential to prevent avoidable harm and optimise health outcomes.

The National Institute for Health and Care Excellence guideline NICE NG194 Postnatal Care outlines evidence-based standards for routine postnatal care during the first eight weeks following birth. These standards emphasise early identification of maternal and neonatal complications, individualised care planning, support for infant feeding, and the delivery of clear, inclusive, and accessible communication.

The MBRRACE-UK *Saving Lives, Improving Mothers' Care* report (2025) further reinforces the importance of high-quality, personalised postnatal care. It highlights the need for vigilant monitoring of physical and mental health, effective breastfeeding and infant care support, and robust escalation and follow-up pathways when concerns are identified. Collectively, these recommendations aim to reduce maternal and neonatal morbidity and mortality while improving the overall experience of care for women and families.

Rationale

The aim of postnatal care is to promote and maintain the physical, psychological, and social wellbeing of the woman and her baby through the provision of integrated clinical care, health education, parenting support, and early detection of complications.

Postnatal services should be planned to ensure safe, efficient, and effective care delivery, with all contacts underpinned by the principles of individualised, woman-centred care. Care must be culturally appropriate and responsive to diversity, with recognition and inclusion of practices relevant to women from ethnic minority backgrounds within their care planning.

Additional consideration should be given to women with complex or additional needs, including those who:

- Misuse substances
- Are recent migrants, asylum seekers, or refugees, or have limited English proficiency
- Are aged under 20 years
- Experience domestic abuse or safeguarding concerns
- Have physical, cognitive, sensory, or communication difficulties

Postnatal care should support the development of relationships between the woman, her baby, and family members, where appropriate.

Care planning should be undertaken collaboratively with the woman and should begin in the antenatal period, incorporating individual needs, cultural considerations, antenatal and intrapartum risk factors, pre-existing medical, psychological, or social conditions, and any neonatal health concerns.

The named midwife or consultant should initiate and discuss the postnatal care plan antenatally, with subsequent review and adjustment by the responsible midwife or obstetric team in response to the mode of birth and evolving clinical needs.

Effective communication across all healthcare professionals is essential to ensure continuity and safety of care. Information provided to women should be clear, consistent, and tailored to individual needs and preferences, and should support shared decision-making.

Information should be:

- Delivered face-to-face wherever possible and supported by written, digital, or alternative accessible formats (including translated materials, Braille, and Easy Read)
- Provided throughout the continuum of postnatal care
- Individualised, respectful, and sensitive to personal circumstances
- Evidence-based and consistent across services
- Supported by qualified interpretation services where language barriers exist

Transfer to the Postnatal Ward

Timing & Safe Transfer

- Do not transfer mother and baby within 1 hour of handover or during handover period.
- Transfer should only occur when safe and staffing allows.

Handover Process

- Must be a face-to-face handover from labour ward midwife → postnatal ward midwife.
- Labour ward midwife must:
    - Identify and document antenatal, intrapartum, and neonatal risk factors
    - Include results of BAPM NEWTT2 Risk Assessment Tool (within 2 hours of birth)
    - Record name of receiving midwife
- Postnatal midwife must:
    - Be introduced by name to the woman
    - Receive clear verbal + written handover (postnatal care pathway)

Orientation & Comfort

- Explain call bell system
- Orientate to ward (bathroom, midwives' station, facilities)
- Provide water (jug and glass)
- Discuss NNU visiting (if baby admitted)

Infant Safety

- Check infant ID bands and security tag (per local policy)
- Follow Security of Infant guideline
- Photos of baby in NNU only taken with parental consent by NNU staff

Postnatal Midwife Assessment (on arrival)

Document all of the following:

Maternal physical assessment

- Blood loss
- Uterine tone/contracting
- Perineum or wound condition
- Urine output:
    - Within 6 hours after vaginal birth (NICE 2021)
    - Or within 6 hours of catheter removal

Bladder care

- Catheter plan (if applicable)
- Complete catheter care bundle (CTMUHB / NICE guideline) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/postnatal-bladder-care/

Pain & comfort

- Pain assessment
- Ensure analgesia given before transfer if needed

Mother–baby interaction

- Skin-to-skin preference/continuation
- Feeding plan and early feeding assessment
- Start/continue feeding chart
- If baby in NNU: support hand expression of colostrum early

Neonatal observations

- Baby temperature recorded before transfer

- Document on postnatal pathway or neonatal notes
- Pre- and post-ductal oxygen saturations (O_2 sats) must be recorded between 4 hours after birth and before 24 hours of age.

Maternal observations

- MEWS: temperature, pulse, BP, respiratory rate, oxygen saturation

Risk assessments

- VTE risk assessment + encourage early mobilisation
- IV cannula monitoring (VIP score if present)
- Moving & handling assessment
- Smoking status + CO^2 monitoring if available
    - Offer referral to MAMSS (Maternal Smoking Cessation Service)
- "Purpose T" risk assessment + skin bundles updated

Documentation

- Clear documentation of:
    - Handover details
    - Risk factors
    - Care plan updates
    - All assessments and observations

Continuing Postnatal Care Whilst in Hospital

Whilst on the postnatal ward, women and babies should receive care in accordance with the postnatal care section of the guideline, with ongoing assessment, documentation, and individualised care planning.

Maternal Mental Health

Any concerns regarding maternal mental health during the inpatient stay must be escalated to the Mental Health Liaison Team (Appendix 4).

Where a woman has a pre-existing wellbeing or safety plan, this must be:

- Reviewed on admission
- Followed during the inpatient stay
- Used to guide escalation in the event of deterioration

On discharge, the Perinatal Mental Health Service must be informed to ensure appropriate ongoing follow-up and continuity of care.

Further guidance should be referred to in the:

- CTMUHB Antenatal and Postnatal Maternal Mental Health Guideline

Care following Pregnancy Loss

Families experiencing pregnancy loss should, where possible, be cared for in a designated bereavement room.

The appropriate gestational age-specific bereavement checklists must be completed.

Staff must ensure care is delivered sensitively and in accordance with the:

- **CTMUHB Stillbirth Guideline**

Discharge Care Following Pregnancy Loss

Prior to discharge, the midwife must ensure the following:

- Any required take-home medication is prescribed, dispensed, and available
- The family are offered community midwife home visits, even if declined
- The community midwifery team is informed of delivery and discharge in all cases
- For pregnancy loss under 24 weeks gestation, the event must be:
    - Clearly documented
    - Emailed to the community midwifery team

The family must be provided with:

- Contact details for the bereavement midwife
- Information regarding follow-up support
- Consent for ongoing bereavement contact must be documented

Where appropriate, families should be offered support to leave the hospital environment, including being accompanied from the ward.

Midwifery-Led Discharge of Women Following Operative Births

In principle, the discharge of women experiencing pregnancy or childbirth complications remains the responsibility of the Consultant overseeing the woman's care. However, this responsibility may be delegated to another appropriately trained healthcare professional, provided that clear guidance and protocols are in place to ensure the safety and wellbeing of women.

Midwife-facilitated discharge is a process in which midwives take an active role in planning and coordinating hospital discharge. This involves collaboration with the multidisciplinary team to ensure women are discharged in a timely and appropriate manner once they are clinically stable and deemed fit for discharge.

Midwives are fully responsible and accountable for the discharge of healthy pregnant women. They may also take a delegated lead role in the discharge of women who have experienced pregnancy or childbirth complications, where appropriate governance arrangements are in place.

The benefits of midwife-led discharge include improved timing of discharge, enhanced women's experience and satisfaction, and more efficient patient flow. This approach supports better capacity management on Ward 12 at Princess of Wales Hospital and Ward 21 at Prince Charles Hospital, enabling more effective use of resources.

Guidance to Support Midwife-Facilitated Discharge

Following a caesarean section or instrumental birth, the operating surgeon is responsible for documenting on the electronic operation record whether the woman is considered suitable for midwife-facilitated discharge.

Women must not have required any additional obstetric or anaesthetic review following birth. All postoperative observations and recovery parameters must be within recognised normal limits. In addition, the woman should feel well, clinically stable, and able to care for herself and her baby.

A discharge checklist must be completed by the discharging midwife and filed in the maternal health record. This provides evidence that all aspects of postoperative care have been assessed and found to be within expected safe and normal parameters, and that any required management has been reviewed, actioned, and completed prior to discharge. Please refer to the Appendix for the checklist.

Discharge from Hospital or Birth Centre

Discharge should be planned according to the needs, preferences, and safety of the woman and baby, including safeguarding requirements and available support. The estimated length of stay should be discussed antenatally and agreed postnatally, based on maternal and neonatal wellbeing and home support. Early discharge should be considered where appropriate, and women requesting this should remain in the Birth Centre or ward initially to support continuity of care.

Before discharge, women should be offered a discussion of labour and birth (where appropriate) and information about the Afterthoughts clinic.

Pre-discharge assessment (mother and baby)

Before transfer to community care or after home birth, the midwife must complete and document:

- Maternal health assessment, including bladder function (per CTM guideline)

- Neonatal assessment (physical exam and observation), including body map with parental signature
- Feeding plan, including at least one observed effective feed
- Advice that if no meconium is passed within 24 hours, medical advice should be sought

Information to be given before discharge

Women should receive verbal and written information on:

- Postnatal recovery and what to expect
- Pelvic floor exercises and bladder health
- Infant feeding support and contacts (including voluntary services and helplines)
- Safe sleep and SIDS prevention
- Signs of serious postnatal illness and emergency contacts
- Newborn screening and follow-up appointments
- Wound/perineal care, driving, lifting, and post-op advice
- Car seat safety and responsive feeding
- Support services and when/how to seek help

Bottle-feeding mothers should receive a demonstration and written guidance on sterilisation and formula preparation.

Safeguarding

If a safeguarding plan is in place, required pre-discharge meetings must occur and handover to community teams completed. Where foster/adoption care is involved, sensitive and empathetic support must be provided, with appropriate information given.

Clinical and professional responsibilities

- Medical team must document suitability for midwifery-led discharge
- Complex operative births should be reviewed by obstetric team before discharge
- Midwives must escalate any concerns before discharge approval
- Women with 3rd/4th degree tears or complications require appropriate follow-up referrals
- Physiotherapy referral and pelvic floor advice should be considered for all women, especially high-risk groups
- Women experiencing traumatic birth should be offered debrief and Afterthoughts clinic information

Prescriptions and follow-up

- Discharge prescriptions should be completed early where possible; women advised to obtain simple analgesia OTC
- Ensure all follow-up appointments (e.g. hip scans, blood tests) are explained and arranged

- Relevant referrals (e.g., gynaecology, physiotherapy) must be completed before discharge

Specialist follow-up

- Gestational diabetes: postpartum diabetes screening arranged in primary care
- Pre-existing diabetes: diabetes team informed and review arranged
- Out-of-area discharges must be communicated to the appropriate community midwifery team
- Address at discharge must be confirmed and correctly recorded

Communication and documentation

- Community midwife notified via electronic system (e.g., GRIDViewer)
- All discharge information must be clearly documented and transferred
- Neonatal unit discharges must be communicated to community teams
- Other professionals (health visitor, social worker) informed where appropriate
- If no community visit by 3pm next day, woman should contact postnatal ward
- Incident report completed if discharge communication fails

Newborn Infant Examination (NIPE)

All babies require a Newborn Infant Physical Examination (NIPE) within 72 hours of birth. This is a systematic clinical assessment of the newborn and is usually performed by a paediatrician after 6 hours of age, ideally after 24 hours in a well-baby. If a baby shows any signs or symptoms of ill health, they should be assessed promptly by a paediatrician independently of the routine neonatal examination.

The NIPE may also be undertaken by a midwife who has been deemed competent to perform the examination, in line with relevant CTM UHB guidelines (ADD GUIDELINE). This assessment can take place either in hospital or at home for infants who meet the appropriate eligibility criteria.

Well, term babies with no clinical concerns who meet the criteria may be transferred home, with arrangements in place for the NIPE to be completed by an appropriately trained community midwife. Alternatively, the examination may be completed if the baby returns to the postnatal ward or Tirion Birth Centre. Parents should be informed of these arrangements prior to discharge from hospital.

Where the NIPE is to be completed in the community, pre- and post-ductal oxygen saturations must be performed and documented prior to discharge, or there must be clear arrangements for these to be undertaken in the community setting. The neonatal notes should accompany the baby home to ensure the NIPE findings are accurately documented in the clinical record.

Postnatal Care in the Community

All women and babies should receive a minimum of two early postnatal contacts:

- Within 24 hours of discharge/birth – full assessment of mother and baby
- 48–72 hours post birth – focused review of:
    - Infant feeding (breast or bottle)
    - Baby's weight, hydration, and jaundice
    - Maternal physical and mental health

Further community visits should be individualised according to need, particularly within the first 10–14 days, including support with feeding, neonatal checks, jaundice monitoring, and maternal wellbeing.

First community visit

The midwife must:

- Complete and document full maternal and neonatal observations (MEWS for mother)
- Escalate any MEWS score ≥1 as per guideline
- Reinforce information on urgent maternal and neonatal warning signs and who to contact

Information to be provided

Women should be given:

- Feeding advice and written information
- Emergency and community midwife contact numbers
- Postnatal contraception and pelvic floor advice
- Safe sleep and SIDS prevention guidance
- Newborn screening and health visitor information
- Breastfeeding support services
- Smoking cessation advice and CO monitoring, with referral if required

Baby checks

- All babies must be fully undressed and examined at key community visits

- Increased frequency of checks is required for safeguarding concerns

Health visitor handover

- Formal handover to Health Visitor is essential for continuity of care
- Health Visitor contact usually occurs between day 7–14, with earlier contact if needed
- Early or joint midwife–health visitor visits may be arranged for complex cases
- Clear communication is essential, especially for safeguarding or domestic abuse cases

Ongoing care and discharge

- Discharge from midwifery care is usually no earlier than day 10 postnatal, depending on need
- Care plans must be completed, returned, and records amalgamated within one week
- Community visits may be undertaken by midwives or appropriately supervised Maternity Support Workers

Postnatal Care of Women

At each postnatal contact, assess the woman's physical and emotional wellbeing and provide information, reassurance, and escalation of care where needed.

General wellbeing

Discuss:

- Postnatal recovery and what to expect
- Physical and mental health symptoms and when to seek help
- Pelvic floor exercises
- Fatigue, nutrition, activity, smoking, alcohol, and drugs
- Contraception and sexual health
- Safeguarding and domestic abuse

Mental health

- Ask about mood, coping, and support networks at each contact
- Encourage women and families to report changes in mood or behaviour
- At 10–14 days, assess for baby blues; if symptoms persist, assess for postnatal depression
- Promote self-care, rest, support, and social connection

Physical health

Assess for:

- Infection, pain, bleeding, and discharge
- Bladder and bowel function
- Breast/nipple problems
- Anaemia, thromboembolism, and pre-eclampsia symptoms
- Perineal healing (vaginal birth)
- Wound healing and infection (C-section)

Red flag symptoms (urgent review)

Women should be advised to seek help urgently for:

- Heavy or persistent bleeding
- Severe abdominal/pelvic pain or foul discharge
- Fever or systemic illness
- Leg swelling or chest pain (VTE signs)
- Severe headache or visual symptoms
- Breast redness/pain not improving (mastitis)
- Any worsening or persistent concerning symptoms

Observations and escalation

- Minimum one blood pressure within 6 hours post-birth
- Repeat and escalate raised BP per MEOWS pathway
- Monitor for sepsis signs and escalate promptly using MEOWS and sepsis guidance

Perineal Care and Dyspareunia

- Inspect perineum at least once post-birth or if pain is reported
- Advise on hygiene (handwashing, frequent pad changes, daily washing/showering)
- Ask at each contact about pain, odour, wound issues, or dyspareunia and assess if present
- Offer lubricant (water-based), especially if breastfeeding
- Pain relief: cold therapy and paracetamol first line; consider NSAIDs if needed
- Urgently assess for infection, breakdown, or poor healing and refer if needed
- Persistent pain may be linked to trauma, infection, or psychological effects
- Risk factors: tears/episiotomy, assisted birth, infection, traumatic birth

Wound Care

- PICO dressings removed at ~7 days (MDAU/community midwife)
- Remove skin closure materials as per surgical plan
- Refer urgently to obstetric team if wound concerns or infection suspected

Headache

- Ask at each contact
- Urgent review if severe headache (especially post-epidural/spinal or with pre-eclampsia symptoms)
- Support tension/migraine management with advice and avoidance of triggers

Bowel Care

- Ensure bowel opening within 3 days
- Manage constipation with diet, fluids, ± laxatives
- Haemorrhoids: dietary advice; urgent review if severe, prolapsed, or bleeding
- Urgent assessment for faecal incontinence

Bladder Care

- Encourage voiding within 6 hours post-birth
- Assess if no void: hydration and retention signs; follow bladder care guidance
- Escalate urinary retention
- Teach pelvic floor exercises for minor leakage; assess persistent symptoms

Contraception

- Discuss within first week post-birth
- Provide advice, options, and support access (see CTM guidance)

Immunisation

- Anti-D within 72 hours if Rh-negative mother with Rh-positive baby
- Offer MMR before discharge if rubella non-immune
- Avoid pregnancy for 1 month after MMR (breastfeeding safe)

Safety – Domestic Abuse

- Be aware of signs and risks
- Follow safeguarding procedures and escalate appropriately

Postnatal Care of the Newborn

Newborn Examination (NIPE)

- Complete examination within **72 hours of birth** to assess eyes, heart, hips, testes (boys), and overall physical health
- Explain purpose to parents and document findings in the postnatal record
- Include review of medical, antenatal, birth history, and feeding/urine/meconium output
- Parents' concerns should be considered and addressed

Examination includes

- General appearance, tone, activity, and cry
- Head, face, palate, neck, clavicles, limbs, spine, skin
- Heart, lungs, abdomen
- Genitalia and anus (incl. undescended testes in boys)
- Hips (Barlow/Ortolani)
- Neurological tone and reflexes if indicated

Screening

- **Newborn blood spot test:** day 5–8
- **Hearing screen:** before discharge or by week 4–5 depending on pathway

Healthy newborn signs

- Normal colour, feeding well, regular urine/stools
- Stable temperature and settling between feeds
- No excessive irritability, lethargy, or floppiness
- Vital signs within NEWTTs2 parameters (escalate if abnormal)

Parental information

Provide advice on:

- Umbilical cord care, bathing, skin care
- Feeding and bonding/attachment
- Signs of illness and when to seek help (including emergency services if needed)
- Safe sleep, smoke-free environment, and vitamin D
- Immunisation's schedule
- Baby Check tool (if appropriate)

Red flags (urgent action required)

- Lethargy, unresponsiveness, or poor colour (pale/blue/mottled)
- Abnormal breathing (grunting, >60/min, chest indrawing)
- Temperature <36°C or ≥38°C

- Non-blanching rash or bulging fontanelle
- Seizures or neurological signs
- Bilious or projectile vomiting
- Signs of dehydration or severe diarrhoea
- Focal neurological signs or neck stiffness

If any red flag is present: **urgent medical assessment or call 999 if life-threatening**

Early support and information

- Promote parent–baby bonding and reassure about newborn behaviour
- Provide information on local postnatal support services and groups (2–8 weeks)

Feeding

- Support feeding as per CTMUHB Infant Feeding Policy http://cthbintranet/Docs/Clinical/Maternity%20Policies%20and%20Proced ures/Infant%20Feeding%20Policy.doc
- Document feeding plan and provide ongoing support

Weight

- Weigh baby at or soon after **72 hours**
- If weight loss **>8%**, complete feeding support plan and document using Breastfeeding Assessment Record (refer to weight loss guidance)

Lactation suppression

Discuss if breastfeeding is not initiated, stopped, contraindicated, or following neonatal death:

- Milk production and suppression process
- Self-care (avoid stimulation, supportive bra, cold packs, analgesia, minimal expression if needed)
- When to seek help
- Medication options if required
- Donor milk consideration

Jaundice

- Advise parents to report jaundice or pale stools
- <24 hours old: **urgent review**
- ≥24 hours: measure bilirubin (or refer for assessment if unavailable)
- Encourage frequent breastfeeding; avoid routine formula/water supplementation

- Investigate significant or prolonged jaundice (>7 days onset or >14 days persistence)

Skin & Cord care

- No bath additives, lotions, or medicated wipes
- Keep umbilical cord clean and dry; no antiseptics routinely

Thrush

- Treat breastfeeding dyad if symptomatic or affecting feeding
- No treatment needed if asymptomatic
- Provide hygiene advice

Nappy rash

- Assess hygiene, irritants, and infection
- If persistent/painful, treat as likely thrush
- Escalate if not resolving after treatment

Bowel movements

- No meconium by 24 hours: assess urgently
- Formula-fed constipation: review feed prep, intake, and frequency
- Breastfed: expected ≥2 stools/day; deviation needs feeding assessment
- Increased loose stools: assess

Excessive/inconsolable crying

Assess:

- General health and history
- Feeding and stools
- Cry pattern (onset, duration, triggers)
- Family history of allergy
- Parental coping and response
- Factors improving/worsening symptoms

Fever

- Routine temperature checks not required unless risk factors present
- If baby unwell, use calibrated thermometer
- **≥38°C is abnormal** → urgent full assessment and escalation

Parenting & Emotional Attachment

- Encourage both parents to attend examinations and participate in care
- Assess bonding at each contact and support attachment during home visits
- Provide extra support where psychosocial risk factors exist (e.g. trauma, care experience, complex needs)

Safety (Home Visits)

- Use visits to assess home safety and promote safe practices for all family members

Co-sleeping & SIDS

- Discuss safe sleep guidance with all parents
- Advise:
    - Baby sleeps on firm, flat surface, on back
    - Avoid sofas/chairs for sleep
    - No pillows/duvets near baby
    - No pets or other children in bed
- **Avoid co-sleeping if:**
    - Baby is premature or low birth weight
    - Parents smoke, have taken alcohol (≥2 units), sedatives, or recreational drugs

Safeguarding / Child Protection

- Be alert to signs and risk factors of abuse
- Follow safeguarding procedures and escalate concerns immediately

Postnatal Readmission of Woman and/or Baby

Principles of care

- Timely, person-centred assessment for all postnatal concerns
- Clear communication between community and hospital teams
- Early intervention to prevent deterioration and avoid admission where possible
- Shared decision-making with women and families
- Equitable access to urgent postnatal care

Indications for readmission

Maternal:

- Infection (e.g., endometritis, wound infection, mastitis not responding to treatment)
- Secondary postpartum haemorrhage

- Hypertension or concerning BP
- Thromboembolism symptoms
- Severe unrelieved pain
- Acute mental health concerns

Neonatal:

- Jaundice requiring treatment
- Feeding difficulties, dehydration, or excessive weight loss
- Hypoglycaemia
- Suspected infection
- Respiratory concerns
- Temperature instability

Referral and assessment

- Referral via midwife, HV, GP, MPU, ED, or urgent lines
- Prompt triage using CTM UHB tools
- Full clinical assessment by trained clinician and documentation of findings
- Consider safeguarding and escalate if needed
- Joint midwifery/medical decision for admission with clear explanation to family

Care during readmission

- Individualised care plan addressing cause of admission
- Regular review by relevant clinical team
- Support feeding, maternal wellbeing, and family involvement
- Inform community teams of admission and expected discharge

Discharge planning

- Discharge when clinically stable with a safe ongoing plan
- Provide clear written/verbal advice, red flags, and follow-up arrangements
- Notify community midwifery and health visiting teams promptly

Documentation & Governance

- Document all assessments and decisions in line with CTM UHB standards
- All readmissions must be escalated via Datix in accordance with the incident reporting policy
- Cases should be reviewed for learning and service improvement

Auditable Standards

- Clear evidence of planning of care
- Clear evidence of handover of care
- Amalgamation of Postnatal Care Plan into Maternity Case Notes
- Compliance with Postnatal Care Pathway
- Assessment of feeding at each visit using appropriate tool

References

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World Health Organisation (2013) Postnatal Care of the Mother & Newborn.

RCOG (2020) Assisted Vaginal Birth Green-top guideline No.26

NICE (2010) (updated 31st October 2023) Jaundice in Newborn Babies under 28 Days.

Appendix 1

Addressograph

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Maternity Risk Assessment for Venous Thromboembolism (VTE)

Pre-existing risk factors for VTE	Tick	Score
Previous VTE *(except a single event related to major surgery)* ***Refer to Consultant Obstetrician at diagnosis of current pregnancy***		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia *(Antithrombin deficiency, APLS, Homozygous factor V Leiden)*		3
Medical co morbidities *e.g. cancer, heart failure; active SLE, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user*		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia *(Heterozygous factor V Leiden, Prothrombin gene mutation)*		1
Age *(> 35 years)*		1
Obesity **BMI kg/m²** *≥ 30 = 1;* *≥ 40 = 2;* *≥ 50 = 3*		1 / 2 / 3
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric risk factors in current pregnancy	**Tick**	**Score**
Pre-eclampsia in current pregnancy		1
ART/IVF *(antenatal only)*		1
Multiple pregnancy		1
Transient risk factors in current pregnancy	**Tick**	**Score**
Any surgical procedure in pregnancy or puerperium *except immediate repair of the perineum e.g. appendicectomy*		3
Hyperemesis/ Dehydration		3
Ovarian Hyper Stimulation Syndrome *(first trimester only)*		4
Current systemic infection		1
Immobility *(PGP)*		1
If admitted to hospital during antenatal period, consider thromboprophylaxis.		
Postnatal risk factors	**Tick**	**Score**
Caesarean section – *elective score 1, in labour score 2*		1 / 2
Mid-cavity or rotational operative delivery		1
Prolonged labour *(> 24 hours)*		1
PPH *(> 1 litre or transfusion)*		1
Preterm birth < 37+0 weeks in current pregnancy		1
Stillbirth in current pregnancy		1
If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium, consider thromboprophylaxis.		
Total VTE Risk Score		

Thromboprophylaxis needed?	Duration	Prescribed?
❑ No ❑ LMWH ❑ TEDS	Antenatal ❑ From first trimester ❑ From 28 weeks Postnatal ❑ 10 days ❑ 6 weeks	❑ Yes ❑ No

Date of Risk Assessment:	Name:	Designation:
_____	_____	_____

- **If total score ≥ 4 antenatal, consider thromboprophylaxis from first trimester and 6 weeks post natal**
- **If total score 3 antenatal, consider thromboprophylaxis from 28 weeks and 6 weeks post natal**
- **If total score ≥ 2 postnatal, consider thromboprophylaxis for at least 10 days postnatal and during any hospital admission**
- **If total score ≥ 3 postnatal. consider thromboprophylaxis for 6 weeks**

For patients with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

Addressograph

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Maternity Risk Assessment for Venous Thromboembolism (VTE)

Thrombo-prophylactic doses for antenatal and postnatal LMWH: Table 3

Prescribe according to booking weight unless there has been a significant weight gain (>12 kg) during pregnancy. Lower doses of LMWH should be employed if the creatinine clearance is less than 30 ml/minute with enoxaparin or less than 20 ml/minute with tinzaparin.

Table 3: Suggested prophylactic doses of LMWH in pregnancy

WEIGHT (KG)	ENOXAPARIN	TINZAPARIN
< 50	20 mg daily	3500 units daily
50 - 90	40 mg daily	4500 units daily
91 - 130	60 mg daily*	7000 units daily*
131 - 170	80 mg daily*	9000 units daily*
>170	0.6 mg/kg/day*	75 units/kg/day*
HIGH PROPHYLACTIC DOSE FOR WOMEN WEIGHING 50 – 90 KG	40 mg 12 hourly	4500 units 12 hourly

* Can be prescribed in divided dose twice a day
* Single daily dose advised in women with needle-phobia, and/or if administered by community midwife.

Contraindications/cautions to LMWH use

- Allergy to LMWH – discuss with Haematology for alternatives
- Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)
- Active antenatal or postpartum bleeding
- Women considered at increased risk of major haemorrhage (e.g. placenta praevia)
- Thrombocytopenia (platelet count < 75×10^9/l)
- Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)
- Severe renal disease (glomerular filtration rate [GFR] < 30 ml/minute/1.73 m^2)
- Severe liver disease (prothrombin time above normal range or known varices)
- Uncontrolled hypertension (blood pressure > 200 mmHg systolic or > 120 mmHg diastolic)

Consider below knee anti-embolic stockings alone if LMWH is contraindicated and thromboprophylaxis needed.

Avoid stockings if pedal pulses are impalpable, peripheral vascular disease, severe dermatitis, peripheral neuropathy or recent skin graft.

Appendix 2

Postnatal Referral form.

To be completed by the person making the referral. Please inform the secretary and forward the form to the appropriate secretary with the maternity notes.

Addressograph

Date: of referral
……..

Named Consultant:
……

Date of Delivery:
……..

Reason for postnatal review:

Referral made by: …….

Woman contact details: …….

Appointment date and time: …….

Date woman informed:…… Person informing woman: …….

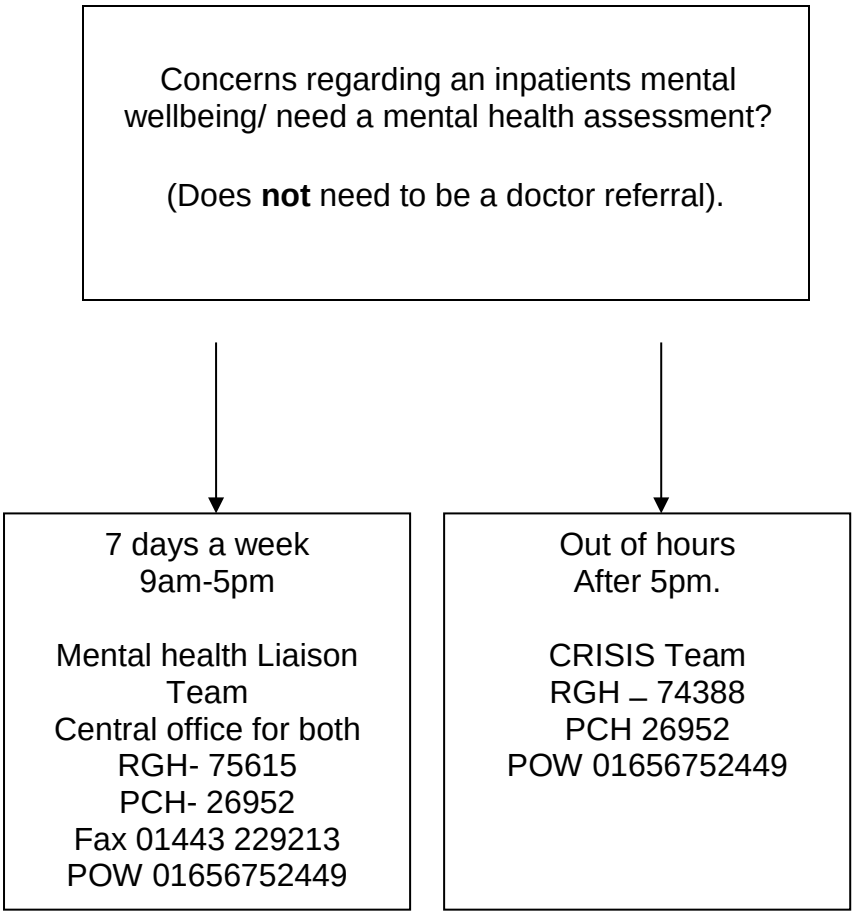
Consultants Secretaries and Telephone Numbers

RGH	PCH	POW
N Bhal, A. Doherty Amy Griffiths 01443 443528 -J Pembridge, M ElNasharty Maria Bevan 01443443179 -N Swamy Tammy Maguire 01443 443526 -M Khalifa Elizabeth Green 01443 443491	S Vine, H Marks, P White (Temp) Tammy Wickens 01685728802 -A Sivasuriam, F Moore Denise Dummett 01685 728369 -S Chawathe, J Rogers Bev Duncan 01685728356 - S Ambika, G Haroun Carolynne Phillips 01685728125	L. Mukhopadhyay Belinda Lucini 01656 752970 -S Hemmadi, A. Miskin Julie Jenkins 01656 752308 -K Emmanuel, P. Munjal Rebecca McCormack 01656 752465 -R Patel-Gadhia, A. Allman, K. Bisseling Lynne Evans 01656 752466 -C Igbenehi, R. Nagrani, F Hodge Nicola Rees 01656 752441

Appendix 3

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Flow Chart for Inpatient Mental Health Concerns



Also consider 111 and option 2 for advice.

The Mental Health Liaison Team can refer women to the appropriate services.

Complete a Perinatal Mental health referral form to ensure client is followed up by the Perinatal Mental Health Team.

Appendix 4

Support for parents going through Fostering Process from birth

We understand this can be a very stressful and difficult time. The Community Midwifery Service will provide you with support in the early postnatal period. There are services who can offer you and your family support.

Your GP can refer you to the Primary Care Mental Health team. Counselling is available from your GP. If you are under 25 counselling is available via Eye to Eye
info@eyetoeye.wales

Barnardo's are able to offer support during this process
www.barnardos.org.uk
Citizens Advice can offer practical support
Legal advice can be obtained, from your solicitor.

If you would like to talk to somebody urgently

CRISIS 01443 443443 or 01656 752150 ask for CRISIS

SAMARITANS Call Helpline 0800132737 or text help to 81066
C.A.L.L. Helpline 0800132 737 or text HELP: 1081066

Appendix 5

Midwife Facilitated Discharge Checklist for transfer home or to Birth Centre following Caesarean birth /Assisted birth

	Yes	No
Suitable for midwife facilitated discharge as recorded on operation sheet?		

Has the woman required a medical review, complication or a PPH since completion of operation?		
If you have answered **yes** the woman must be reviewed by Registrar to re-access suitability for midwife led discharge		

If Haemoglobin check requested >100g/dl	Hb=

If Suitable for midwifery led discharge

	Yes	No	NA
Temperature, blood pressure, pulse, respiratory rate, and oxygen saturation within normal limits on MEOWS chart			
Pain acceptable/manageable for woman with over counter analgesia			
Tolerating fluids and diet			
Wound dressing/site/perineum reviewed			
Evidence of good urinary output (following removal of catheter)			
Lochia			
VTE risk assessment completed			
Any signs of potential DVT			
Mobilising and self-caring			
Venflon removed			
Is Anti D required			
Take home medication dispensed			
Discharge completed in maternity records & GRIDVIEWER			
Contraception discussed			
Surgical Site Surveillance completed			
Discharge information pack provided			
Debrief offered			

Signature…… Date of Discharge……

Print name……Designation……

Appendix 6 Midwife to Health Visitor- Handover document.

Basic details	
Midwife completing form	MW Team
Contact number Midwife	Date
Name of Parent/Carer	Parent/Carer D.O.B.
Contact number	Discharge of care address
Name of infant	Infant D.O.B.
GP	Family HV
Please state role, name and contact number of all professionals involved if: CP/CASP/CLA/Vulnerable Other	Birthweight Weight today Feeding status
Please comment on the following	
Complications during labour	
Maternal Mental health	
Maternal Smoker Yes No	
Weight Management in Pregnancy Yes No	

Problems with feeding

Infant health

Hospital re-admission? If so, reason?

Jaundice

Dates of PKU and Hearing test and PKU reference number

Other issues identified

Birth marks/birth injuries

Please describe in detail any birth marks or birth injuries and where they are located on the baby's body.

If there were any safeguarding concerns with the birth mark/birth injury, have safeguarding procedures been followed? YES NO

Have any safeguarding concerns been followed up by a SIP3 and a telephone call to the health visitor? YES NO

Please email this form to CTM.MidwiferyHealthVisitorComms@wales.nhs.uk and it will be sent to the relevant Health Visitor.