Postnatal Care Guideline
Including Discharge from Hospital

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Guidelines Definition
Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.Minor Amendments
If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person

Equality Impact Assessment Statement
This Procedure has been subject to a full equality assessment and no impact has been identified.

Related Guidelines

- Identification of the Newborn & Security of the Infant
- Anti D
- Infant Feeding
- Transfer to Health Visitor
- All Wales Domestic Abuse Pathway/ Domestic Abuse
- Child Protection Procedures
- Vulnerable Adult Policy and Procedure
- Substance Misuse
- All Wales Midwifery Led Care
- Transcutaneous Bilirubin Policy

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Definition and Background

The days and weeks following childbirth – the postnatal period – is a critical phase in the lives of mothers and new-born babies. Major changes occur during this period, which determine the well-being of mothers and new-borns. Lack of appropriate care during this period could result in significant ill health and even death, with most maternal and infant deaths occurring during this period (WHO 2013).

Postnatal care should be individualised according to the woman and new-born's needs. The minimum recommended number of contacts is three, at day 1, day 5 and day 10. Midwives have a statutory duty to attend a woman in hospital or in her own home until such time that the midwife considers referral to a Health Visitor is appropriate.

Rationale

The aim of postnatal care is to promote and maintain optimal health and well-being in the woman and her baby. Postnatal care incorporates consistent health advice, parenting skills, clinical care, and the detection of ill health, both mental and physical. Postnatal services should be planned to achieve the most efficient and effective service for women and their babies, and each postnatal contact should be provided in accordance with the principles of individualised care. The provision of care should be culturally appropriate, and the various practises of women from ethnic minority groups incorporated into their postnatal care plans. Consideration should also be given to women with additional physical, cognitive or sensory needs, and women whose first language is not English.

Postnatal care should support the developing relationships between all family members. Postnatal care should be planned together with the woman giving consideration to the woman's individual needs, including cultural needs, risk factors that presented in the antenatal and intrapartum period, pre-existing medical, social or psychological conditions and any

complications with the health of the baby. The named midwife should discuss postnatal care with the woman prior to birth and begin to develop the postnatal care plan in the antenatal period.
The midwife responsible for the birth will adjust the postnatal care plan taking account of the nature and type of birth and care that is required.

Every effort should be made to ensure there is effective written and verbal communication between all health professionals involved in providing care.

Transfer to the Postnatal Ward

- Transfer must not take place during handover periods. Transfer must not take place an hour before handover to ensure safety.
- The midwife responsible for care during the birth must identify any antenatal or intrapartum risk factors and record these in the case notes, computer records and postnatal care plan.
- A face to face hand over from the midwife responsible for the care of the woman on labour ward to the midwife who will be responsible for the care of the woman on the postnatal ward, should take place when the woman and her baby are transferred to the postnatal ward. The delivering midwife must document the name of the midwife assuming responsibility of care on the postnatal ward.
- The postnatal midwife must be introduced by name. The 'handover' must include any relevant history and proposed plan of care and documented clearly on the postnatal care pathway.
- The woman should be informed of how to use the patient call system and orientated to the ward area, including bathroom facilities and midwives' station as well as given a glass and jug of water.
- The infant armbands and security tag should be checked in accordance with the 'Security of Infant' guideline.
- Women whose infants are in the Neonatal Unit (NNU) unit should be informed that they can visit the NNU whenever they want.

Photographs of the baby for parental use can be taken by NNU staff only after consent from the parents has been given, in accordance with the Cwm Taf Morgannwg University Health Board guideline.

- The postnatal midwife should assess and document the following:-

  - ✓ Blood loss
  - ✓ Contraction of the uterus
  - ✓ Condition of perineum or wound site
  - ✓ If the woman has passed urine following birth. This should occur within 6 hours of a spontaneous vaginal birth (NICE 2014).
  - ✓ If a catheter is in situ, midwife to note plan of care for removal and woman to pass urine within 6 hours of removal (Postnatal Bladder Care Guideline – CTMUHB / NICE)
  - ✓ The need for pain relief should be assessed and any analgesia given by the delivering midwife prior to transfer to the postnatal ward.
  - ✓ Whether the mother wishes to continue or initiate skin-to-skin contact
  - ✓ Infant feeding choices and needs, including an assessment of any feeds so far. Baby's feeding chart commenced in the baby's postnatal care pathway, or in the Neonatal Notes. Breastfeeding mothers whose babies are in the NNU should be helped to hand express colostrum as soon as possible, if this has not already been initiated on Labour Ward.
  - ✓ All babies should have their temperature taken and documented on the Postnatal Care pathway prior to transfer to ward, NNU or home.
  - ✓ Baseline observations of temperature, pulse, blood pressure oxygen saturation and respirations (documented on MEWS chart).
  - ✓ DVT risk assessment. This should be documented on the mother's care pathway and on the computer records. Women should be encouraged to mobilise as soon as possible following birth.
  - ✓ IV cannula monitoring (VIP) if appropriate

- ✓ Moving and handling assessment
- ✓ Smoking status to be established and Carbon Monoxide (Co) monitoring performed. Discussion on dangers of smoking and passive smoking and offer immediate referral to our MAMSs (Maternal Smoking Cessation) team.
- ✓ Waterlow score
- ✓ Clear documentation of postnatal handover

Continuing Postnatal Care Whilst in Hospital

Whilst on the postnatal ward, women and babies should be cared for as described in Appendix One.

Regarding Maternal Mental Health, whilst an inpatient, if there are any concerns, refer to mental health liaison team (Appendix 4). Some women especially if seriously mentally ill will have a wellbeing plan with trigger factors etc. Please inform the perinatal service on discharge so the appropriate follow up support can be provided. For further information please refer to CTMUHB Antenatal and Postnatal Maternal Mental Health.

Families admitted with a pregnancy loss should, if at all possible, be cared for in the designated bereavement rooms and the relevant gestational age checklists completed (for further information please refer to CTMUHB Stillbirth guideline)

When families who have suffered a pregnancy loss are discharged from hospital midwife to ensure that

- Any take home medication is available
- The family should be offered home visits by the community midwife even if these are declined the community midwives need to be informed of the delivery and discharge. If the pregnancy loss is under 24 weeks this information will need to be documented and telephoned through to the community midwives.

- The family have the contact information for the bereavement midwife and have agreed that contact can be made.
- Offer to walk the family out of the hospital

Discharge from Hospital or Birth Centre

Discharge from hospital must be timed according to the needs of the woman and her baby. Prior to discharge the woman should be offered the opportunity for a discussion of labour and birth.

If there is a Safeguarding plan (Appendix 5) and it states a need for a pre discharge planning meeting this needs to be convened prior to discharge and plan for care in the community handed over to the community midwifery team If the plan is for baby to be placed in foster care, this is an emotional period for the parents and understanding and empathy is paramount .Support and advice to be given (See Appendix 6 - leaflet).
In the antenatal period, the midwife should discuss options for discharge following the birth of the baby and assess if early discharge is an option if mother and baby are well following the birth. The estimated length of stay in hospital will be agreed after birth. Before this discussion the midwife should consider the health of both the woman and her baby and the level of support available to her following discharge home.

If the woman requests an early discharge then she should, **if possible,** remain on the labour ward or Birth Centre (depending on where care was given) after birth to enable continuity of carer and minimum disruption.

The discharge process may be delayed for a number of reasons. By taking a proactive approach to discharge planning this will have a positive effect on the patient experience and ensure the best use of resources. The discharge of patients is a multidisciplinary process and the woman must be fully involved in the procedure.

The following medications may be dispensed directly from the ward TTH facility;

- Clexane
- Ferrous Sulphate

All other Take Home prescriptions should be written and sent to pharmacy prior to transfer to the postnatal ward wherever possible. Women and families are advised to source their own paracetamol and Ibuprofen which can be bought over the counter.

We are moving towards midwifery led discharge for caesarean section and assisted vaginal births. It is the responsibility of the medical team, conducting the delivery, to clearly document if the patient is suitable for a midwifery led discharge. It is recommended woman should be reviewed prior to hospital discharge to discuss the indication for operative delivery, management of any complications and the prognosis for future deliveries. Best practice would be a review by the Obstetrician who conducted the delivery. Following a review, if the woman is considered well, she may be discharged home by the Midwife when appropriate. If during the period of medical review and discharge, the midwife has identified any concerns, she must request a further medical assessment, e.g. a rise in blood pressure or increase in lochia.

- All women should be offered physiotherapy-directed strategies to prevent urinary incontinence especially high risk women – See Postnatal Bladder Care guideline

- Offer advice and support to women who have had a traumatic birth and wish to talk about their experience. The effect on the birth partner should also be considered.

- When discharge from hospital is anticipated the woman should be provided with the following information:-

· Written information regarding her chosen method of feeding
· Contact numbers for the community midwife and information about when to expect the first postnatal visit at home.
· How to get ongoing support for breastfeeding. This should include contact details for voluntary organisations including the 24 hour Breastfeeding Helpline, for the CTMU Infant Feeding Specialist service, and for Breastfeeding Peer Support via social media.
· Emergency contact numbers
· Information re wound care or perineal care
· Advice re driving and lifting post operatively
· Information on postnatal exercises, particularly pelvic floor exercises.
· Information on reducing the risk of Sudden Infant Death and Safe Sleeping for Babies.
· New-born Bloodspot Screening Information
· Debriefing information
· Use of appropriate car seats
· NAHI Non Accidental Head Injury DVD offered

- Women choosing to bottle feed their babies should, prior to discharge home, be offered a 'one to one' discussion/ demonstration of how to sterilise feeding equipment and make up formula feeds and should also be given written information on this important topic. The midwife responsible for the discharge must ensure the parents know the details of the follow up appointments or investigations such as hip scans, blood tests etc.

- On discharge from hospital, the midwife responsible must ensure that for any women requiring follow up the notes are to be sent to the gynaecology secretaries for an appointment to be arranged, and the postnatal referral form completed (see appendix). A hospital

appointment is made for those women who require one. These may include women who have had a 3rd or 4th degree perineal tear (refer to OASI guideline) and women who have had complicated births.

- Women diagnosed with Gestational Diabetes in pregnancy will require screening for Type 2 diabetes following birth, in primary care (GP) setting, consisting of:

  - Glycated Haemoglobin (HbA1c) at 13 weeks postnatal (preferred method at PCH and RGH)
  - Oral Glucose Tolerance Test (OGTT) at 6 weeks postnatal OR Fasting Plasma Glucose (FPG) at 6-13 weeks postnatal (preferred method at POW).

  Additionally, women are advised to continue screening for type 2 diabetes in primary care on an annual basis.

  Women with pre-existing diabetes Type 1 or Type 2, or other rarer forms, should resume usual diabetes care, Diabetes teams should be informed of delivery and review women prior to discharge.

- All out of area discharges, including PoW women, must be recorded in the community discharge book and this information must be passed on to the community midwifery teams (as below).

- The discharging midwife must confirm with the woman the address she is being discharged to. If a woman lives out of the CTMHB geographical area it is the responsibility of the discharging midwife to contact the midwife in the appropriate area via the local hospital.

- If the baby is being discharged to a different address from the mother e.g. foster placement or adoption, this address and all details should be recorded in the mother's case notes. It is the responsibility of the

discharging midwife to confirm the address the baby is being discharged to. If this is outside CTMUHB geographical area it is the responsibility of the discharging midwife to contact the midwife in the appropriate area via the local hospital.

- The Community Midwife will be notified electronically of the discharge via GRIDVIEWER when the post-natal discharge summary is completed by the midwife prior to the mother leaving hospital (PCH & Trion Birth Centre only).

- Following discharge from POW hospital, a hospital midwife must ensure that the community midwifery team has been informed of the woman's discharge home. The community midwife requests discharges at 09.00 hrs on the day following discharge.

- For any out of area discharges including PoW the hospital midwife must document who she has given the discharge to in the discharge book. All relevant information relating to the individual woman and her baby should be given to the community midwife.

- At an appropriate time the midwife in charge of the postnatal ward will ensure that all postnatal women discharged the previous day have been communicated to the relevant community midwifery team.

- Information regarding babies discharged from the Neonatal unit (NNU) directly into the community must be documented in the Postnatal discharge book by the Neonatal unit staff for all babies

- Consideration needs to be given of other health professionals who may need to be informed of a discharge home e.g. health visitor, social worker etc.

- The woman should be informed that if she has not received a visit from a community midwife by 3pm the day after discharge, she should contact the postnatal ward, who will then communicate with the relevant community team to ensure a visit is made.

- An incident form should be generated in the event of a discharge not being given out to the community midwives.

Neonatal Discharges

- All babies require one neonatal examination prior to discharge home, which should be carried out as near to discharge as possible, preferably after 24 hours of age in a well-baby.
  This allows time for the ductus to close and pulmonary vascular resistance to fall, thus increasing the chances of diagnosing congenital heart disease. If a baby is showing signs and or symptoms of ill health, he/she should be assessed promptly by a paediatrician independently of the neonatal examination. A neonatal examination (if this is the only examination the baby will be given) should not be carried out before 6 hours of age.

- Paediatricians and midwives who have received training can carry out neonatal examination and discharge a baby on its completion.

- Neonatal examination can be carried out by a paediatrician or a midwife who has received specific training, as long as informed consent is provided by an individual with parental responsibility.

Neonatal examinations may be performed by a trained midwife in the following cases;

- Babies born following uncomplicated pregnancies

- Babies who show signs and symptoms of well being
- Babies born after 36 completed gestational weeks
- Babies delivered by spontaneous normal vaginal birth, or following operative or instrumental delivery if no other complications exist

Neonatal Examination by a Community Midwife

When the maternity unit is working at full bed and/or cot capacity, well, term babies with no clinical concerns may be transferred home and the neonatal examination can be carried out by an appropriately trained community midwife. Alternatively, arrangements should be made for the baby to return to the postnatal ward for the examination. Parents should be informed of the arrangements prior to leaving the hospital.
The community midwife needs to ensure that the baby has oxygen saturations performed before going home and that the neonatal notes are tracked home.

Neonatal examination should be performed by a paediatrician in the following cases;

- Babies with a known abnormality
- Babies with intrauterine growth restriction
- Babies who have been admitted to the Neonatal Unit
- Babies with maternal or peri-natal risk factors for infection
- Babies who show signs and symptoms of ill health
- Babies born in the presence of significant meconium stained liquor

Postnatal Care in the Community

- The community midwife receiving the discharge information will ensure a community visit will be undertaken on the day following discharge.

- At the first Community Visit the midwife should reiterate the information regarding the signs and symptoms of potential life threatening conditions and who to contact if these occur.
- The community midwife should ensure the woman has the following information:-
  - Written information regarding her chosen method of feeding
  - Contact numbers for the community midwife and ward
  - Telephone numbers and details for additional ongoing breastfeeding support
  - Emergency contact numbers
  - Information on postnatal contraception
  - Information on postnatal exercises, particularly pelvic floor exercises.
  - Information on reducing the risk of Sudden Infant Death and Safe Sleeping for Babies
  - Smoking status to be established and Carbon Monoxide (Co) monitoring performed. Discussion on dangers of smoking and passive smoking and offer immediate referral to our MAMSs (Maternal Smoking Cessation) team
  - Information on the Newborn Bloodspot Screening
  - Information on the Health Visitors birth visit at approximately 10 days post delivery

Postnatal care shall be provided as described in Appendix One

In addition to the postnatal care guidance outlined in Appendix One, the community midwife should ensure that; all babies should be undressed and examined on the first postnatal visit, the neonatal screening visit, and the discharge visit. Babies from families with identified child protection risk factors should be undressed and examined on each visit by the community midwife.

Hand over to Health Visitor

- Formal handover of care to the Health Visitor is crucial for continuity and consistency of advice and care given to the mother and the family. Formal handover of care to Health Visitors is important for a seamless service. The Nursing and Midwifery Council (2015) state that we to achieve co-operative working, we must:
- '8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other healthcare professionals and staff'.

Health professionals and the mother and her family must ensure they have effective communication in the care they give.
In cases where there are concerns, the health visitor should be involved as early as possible in the antenatal period by communication with the named midwife. In some cases, joint visits by the midwife and health visitor and midwife may be appropriate; this may be accommodated in the antenatal clinic, or the woman's home. Good communication and sharing of information is crucial for joint planning of care. The health visitor and the midwife should also liaise with other members of the multidisciplinary team, such as Flying Start. In certain cases, the named or delegate midwife may wish to inform a health visitor personally when a woman has given birth.

On discharge from hospital where the Domestic Abuse Pathway is active (part 2 DA2), the midwife discharging the woman should contact the health visitor either verbally or in person. A detailed handover should take place, which should be documented in the case notes.
Formal handover of care to the health visitor should be documented using Appendix Two. This can be supplemented with verbal communication if required.

The named midwife shall assume overall responsibility for formal handover to the health visitor when the mother and baby are discharged.

- The mother and baby should be discharged from maternity services according to individual needs, but no earlier than 10 days postnatal by a midwife who has provided all or part of the postnatal care.
- The discharging community midwife is responsible for returning the clients postnatal care plan to facilitate amalgamation of maternity records within one week of discharge. All audit data/forms must be completed at discharge and returned with the care plan.
- Community visits following birth may be carried out by a community midwife, or where appropriate a Maternity Support Worker working under the indirect supervision of a midwife.

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

All Wales Midwife-led Care Guidelines, December 2015. Accessed May 2016
http://cthbintranet/Docs/Clinical/Maternity%20Policies%20and%20Procedures/Midwifery%20Led%20Care%20Guidelines,%20All%20Wales.pdf

MBRRACE 2015 Reports | MBRRACE-UK | NPEU Accessed January 2016

NICE Clinical Guideline CG37, Postnatal Care Up to 8 Weeks After Birth, 2006. Updated 2015. Accessed May 2016.

Nursing & Midwifery Council (2015) *The Code, Professional Standards of Practice and Behaviour for Nurses and Midwives*, NMC, London

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

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

NICE (2010) updated (2016) Jaundice in Newborn Babies under 28 Days

Appendix One

Postnatal Care Guidance

Each time a midwife reviews the physical and psychological condition of a mother and baby, an evaluation of their needs will be performed and appropriate action taken. At each contact, the midwife should;

- Ask the woman about her health and wellbeing and that of her baby, and should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed.
- Offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion
- Encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions
- Document in the Postnatal Pathway any specific problems and follow-up. Postnatal visits should be planned according to the individual needs of the mother and baby. Continuity of carer should be maintained during the postnatal period whenever possible. At least three postnatal contacts are recommended for all mothers and new-borns (WHO 2013).

Postnatal Care of Women

Mental health and wellbeing

At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.

Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern. Formal debriefing of the birth experience is not recommended.

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 the birth.

At around 10–14 days after birth, women should be asked about symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further.

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

Information

Women should be made aware of the signs and symptoms of potentially life threatening conditions and asked to inform a health professional if these occur. This information should be reinforced on discharge from hospital by the discharging midwife. These should include;

- ✓ *Signs and symptoms of PPH:* sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations/tachycardia.
- ✓ *Signs and symptoms of pre-eclampsia/eclampsia:* headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric pain, feeling faint, convulsions (*in the first few days after birth*).
- ✓ *Signs and symptoms of infection:* fever, shivering, abdominal pain and/or offensive vaginal loss.

- ✓ *Signs and symptoms of thromboembolism:* unilateral calf pain, redness or swelling of calves, shortness of breath or chest pain.

Physical health and wellbeing

Observations

Maternal observations should be performed as the woman's clinical condition indicates. A minimum of one blood pressure recording should be performed within six hours of the birth. If the diastolic blood pressure is greater than 90mmHg, it should be repeated within 4 hours. If this first recording is accompanied by symptoms of pre-eclampsia this should be investigated. If there are no symptoms of pre-eclampsia and the blood pressure remains greater than 90mmHg after four hours then investigations of pre-eclampsia should be initiated and a Senior Obstetrician informed.

Midwives should be aware of the variety of signs and symptoms associated with sepsis in the pueperium which can be insidious with rapid clinical deterioration. **Symptoms such as vomiting diarrhoea, abdominal pain, tachycardia, tachypnoea and pyrexia greater than 37.5c. Any concerns should be discussed with the woman's GP or a Senior Obstetrician. For further guidance, please see CTMUHB Sepsis Guideline**.

Perineal care and Dyspareunia

Following a vaginal birth, the perineum should be inspected on at least one occasion, regardless of the perineal outcome at birth, or if a woman complains of perineal pain.

Women should be advised of importance of perineal hygiene, including frequent changing of sanitary pads, washing hands before and after doing this, and daily bathing or showering to keep their perineum clean.

At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound; this might

include reporting perineal pain, discomfort or stinging, offensive odour or dyspareunia. The midwife should offer to assess the perineum if the woman reports any of these symptoms.

Women with perineal trauma and dyspareunia should be offered an assessment of the perineum. A water-based lubricant gel to help ease discomfort can be advised, especially if breast-feeding.

Women should be advised that topical cold therapy, for example crushed ice or gel pads, are effective methods of pain relief for perineal pain. If oral analgesia is required, paracetamol should be used in the first instance unless contraindicated. If cold therapy or paracetamol is not effective a prescription for oral or rectal non-steroidal anti-inflammatory (NSAID) medication should be considered in the absence of any contraindications.

Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated urgently.

Wound Care

Wound dressings should be removed 48 hours following birth.

Any woman with a PICO dressing in situ should have an appointment to return to MDAU or for community midwife for removal at 7 days.

Skin closure material should be removed if necessary according to the instructions of the operating doctor. This is usually around 7 days.

If there are any concerns with wound healing, the woman should be referred directly to MDAU for assessment.

Headache

Women should be asked about headache symptoms at each postnatal contact.

Women who have had epidural or spinal anaesthesia should be advised to report any severe headache, particularly one which occurs while sitting or

standing. For severe headache, it may also be appropriate to investigate for pre-eclampsia

Women with tension or migraine headaches should be offered advice on relaxation and how to avoid factors associated with the onset of headaches.

Bowel Movements

Women should be asked if they have opened their bowels within 3 days of the birth.

Women who are constipated and uncomfortable should have their diet and fluid intake assessed and offered advice on how to improve their diet. A gentle laxative may be recommended if dietary measures are not effective.

Women with haemorrhoids should be advised to take dietary measures to avoid constipation. Women with a severe, swollen or prolapsed haemorrhoid or any rectal bleeding should be evaluated urgently.

Women with faecal incontinence should be assessed for severity, duration and frequency of symptoms and reviewed urgently.

Bladder Care

Women should be informed of the importance of voiding urine within 6 hours following birth. It should be documented in the Care Plan once the woman has passed urine. If a woman has not voided urine within six hours of birth, her level of hydration should be assessed along with clinical signs of retention of urine. She should be encouraged to pass urine by taking a warm shower or bath. The midwife should inform the doctor of any problems voiding urine. If urinary retention persists catheterisation should be offered and refer to the CTMUHB **Post Natal Bladder Care** guideline for further management.

Women with involuntary leakage of a small volume of urine should be taught pelvic floor exercises. Women with involuntary leakage of urine which does not resolve or becomes worse should be evaluated.

Contraception

Methods and timing of resumption of contraception should be discussed within the first week of the birth.

The midwife should provide proactive assistance to women who may have difficulty accessing contraceptive care. This includes providing contact details for expert contraceptive advice (refer to CTMUHB Postnatal Contraception Guideline).

Immunisation

Anti-D immunoglobulin should be offered to every non-sensitised Rh-D-negative woman within 72 hours following the birth of a RhD-positive baby. See also CTMUHB Anti D Guideline.

Women found to be sero-negative on antenatal screening for rubella should be offered an MMR (measles, mumps, rubella) vaccination following birth and before discharge from the maternity unit if they are in hospital.

See the Public Health England/Department of Health guidance, Immunisation against infectious disease (2013) (the Green Book) for guidance on the timing of MMR vaccination in women who are sero-negative for rubella who also require anti-D immunoglobulin injection

Women should be advised that pregnancy should be avoided for 1 month after receiving MMR, but that breastfeeding may continue.

Safety: 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.

Postnatal Care of the Newborn

Physical Examination and Screening of the Newborn

The aims of any physical examination should be fully explained and the results shared with the parents and recorded in the postnatal care plan.

A complete examination of the baby should take place within 72 hours of birth. This examination should incorporate a review of parental concerns and the baby's medical history should also be reviewed including: family, maternal, antenatal and perinatal history; fetal, neonatal and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine.

The newborn blood spot test should be offered to parents when their baby is 5-8 days old.
A hearing screen should be completed before discharge from hospital or by week 4 in the hospital programme or by week 5 in the community programme.

Healthy babies should have normal colour for their ethnicity, maintain a stable body temperature, and pass urine and stools at regular intervals. They initiate feeds, suck well at the breast (or bottle) and settle between feeds. They are not excessively irritable, tense, sleepy or floppy. The vital signs of a healthy baby should fall within the following ranges:

- respiratory rate 30−60 breaths per minute
- heart rate between 100 and 160 beats per minute in a newborn
- temperature in a normal room environment of around 37°C (if measured).

At each postnatal contact, parents should be offered information and advice to enable them to:

- assess their baby's general condition

- identify signs and symptoms of common health problems seen in babies
- contact a healthcare professional or emergency service if required.

Parents, family members and carers should be offered information and reassurance on:

- their baby's social capabilities as this can promote parent–baby attachment (in the first 24 hours)
- the availability, access and aims of all postnatal peer, statutory and voluntary groups and organisations in their local community (within 2–8 weeks).

Feeding

Feeding should be supported and managed as per CTUHB Infant Feeding Policy

http://cthbintranet/Docs/Clinical/Maternity%20Policies%20and%20Procedures/Infant%20Feeding%20Policy.doc

Weight

All breastfed babies should be weighed at or soon after 72 hours of age. Any weight loss of ≥ 10% should have a clear plan of care for supporting feeding documented in the 'Breastfeeding Assessment Record' with reference to the 'Weight Loss Guidance for Breastfed Babies'.

Bottle fed babies should be weighed according to individual need.

Jaundice

Parents should be advised to contact their midwife if their baby is jaundiced, their jaundice is worsening, or their baby is passing pale stools.

If jaundice develops in a baby under 24 hours old, urgent review should be sought.

If jaundice develops in babies aged 24 hours and older, All babies with suspected jaundice should have their bilirubin level measured using a

Transcutaneous Bilirubin monitor NICE 2016 In the absence of a bilirubin monitor the baby MUST be referred to the post-natal ward to have performed, monitored and systematically recorded along with the baby's overall wellbeing with particular regard to hydration and alertness.

The mother of a breastfed baby who has signs of jaundice should be actively encouraged to breastfeed frequently, and the baby awakened to feed if necessary. Breastfed babies with jaundice should not be routinely supplemented with formula, water or dextrose water.

If a baby is significantly jaundiced or appears unwell, evaluation of the serum bilirubin level should be carried out.

If jaundice first develops after 7 days or jaundice remains after 14 days in an otherwise healthy baby and a cause has not already been identified, it should be evaluated urgently.

Skin

Parents should be advised that cleansing agents should not be added to a baby's bath water nor should lotions or medicated wipes be used.

Parents should be advised how to keep the umbilical cord clean and dry and that antiseptics should not be used routinely.

Thrush

If thrush is identified in the baby, the mother should be offered information and guidance about relevant hygiene practices.

Thrush in a breastfeeding woman should be treated with an appropriate antifungal medication if the symptoms are causing pain to the woman or the baby or feeding concerns to either. If thrush is non-symptomatic, women should be advised that antifungal treatment is not required.

Nappy Rash

For babies with nappy rash the following possible causes should be considered:

- hygiene and skin care
- sensitivity to detergents, fabric softeners or external products that have contact with the skin
- presence of infection.

If painful nappy rash persists it is usually caused by thrush, and treatment with antifungal treatment should be considered. If after a course of treatment the rash does not resolve, it should be evaluated further.

Bowel Movements

If a baby has not passed meconium within 24 hours, the baby should be evaluated to determine the cause, which may be related to feeding patterns or underlying pathology.

If a baby is constipated and is formula fed the following should be evaluated:

- feed preparation technique
- quantity of fluid taken
- frequency of feeding
- composition of feed.

A baby who is experiencing increased frequency and/or looser stools than usual should be evaluated.

Excessive/ Inconsolable Crying

Assessment of excessive and inconsolable crying should include:

- general health of the baby
- antenatal and perinatal history
- onset and length of crying

- nature of the stools
- feeding assessment
- family history of allergy
- parent's response to the baby's crying
- any factors which lessen or worsen the crying.

Fever

The temperature of a baby does not need to be taken during routine postnatal visits, unless there are specific risk factors, for example maternal pyrexia during labour. When a baby is suspected of being unwell, the temperature should be measured using electronic devices that have been properly calibrated. A temperature of 38°C or more is abnormal and the cause should be evaluated urgently. A full assessment, including physical examination, should be undertaken.

Parenting and Emotional Attachment

Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both parents in the care of their baby and enable them to learn more about their baby's needs.

Assessment for emotional attachment should be carried out at each postnatal contact. Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment.

Safety

All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment and promote safety education.

Co-sleeping and sudden infant death syndrome (SIDS)

Recognise that co-sleeping can be intentional or unintentional. Discuss the 'Safe Sleeping for your Baby' page in the 'Caring for Your New Baby' booklet with parents and carers and inform them that there is an association between co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) and SIDS.

Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS is likely to be greater when they, or their partner, smoke.

Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS may be greater with:

- parental or carer recent alcohol consumption, or
- parental or carer drug use, or
- low birth weight or premature infants.

Child abuse

Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse. If there is raised concern, the healthcare professional should follow local child protection policies.

Postnatal thromboprophylaxis risk assessment and management

Addressograph

to be assessed on delivery suite:

- Any previous VTE
- Anyone requiring antenatal LMWH
- High-risk thrombophilia
- Low-risk thrombophilia + FHx

→ **HIGH**
At least 6 weeks

- C-section in labour
- BMI >40
- Readmission or prolonged admission (>3days) in the puerperium
- Any surgical procedure in the puerperium except immediate repair of the perineum
- Medical comorbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU

→ **INTERMEDIATE RISK**
At least 10 days' postnatal prophylactic LMW
NB If persisting or >3 risk factors, consider extending thromboprophylaxis with LMWH

- Obesity (BMI >30)
- Age >35
- Parity≥3
- Smoker
- Elective C-section
- Family history of VTE
- Low-risk thrombophilia
- Gross varicose veins
- Current systemic infection
- Current pre-eclampsia
- Immobility e.g. Paraplegia, PGP, long-distance travel
- Multiple pregnancy
- Preterm delivery in this pregnancy (<37weeks)
- Stillbirth in this pregnancy
- Mid-cavity rotational or operative delivery
- Prolonged labour (>24 hours)
- PPH >1 litre or blood transfusion

→ **Two or more risk factors**

→ **Fewer than two risk factors:**
LOWER
Early mobilisation and avoidance of dehydration

Postnatal assessment and management

Name: ..... Signature: ..... date: ..... time: .....

For prescribing guidance please see over page

Adapted from: Royal College of Obstetricians and Gynaecologists. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. Green-top Guideline No.37a. April 2015.

IP6604(k)CT

Antenatal and postnatal prophylactic dose of LMWH:

Weight	Enoxaparin	Dalteparin	Tinzaparin (75units / kg / day)
<50kg	20mg daily	2500 units daily	3500 units daily
50-90kg	40mg daily	5000 units daily	4500 units daily
91-130kg	60mgdaily*	7500 units daily	7000 units daily*
131-170kg	80mg daily*	10,000 units daily	9000 units daily*
>170kg	0.6mg/kg/day*	75 units/kg/day	75 units/kg/day*
High prophylactic dose for women weighing 50-90kg	40mg twice daily	5000 units twice daily	4500 units twice daily

*may be given in 2 divided doses

Contraindications / cautions to LMWH use:

- 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 x 109/1)
- Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)
- Severe renal disease (glomerular filtration rate [GFR] < 30 ml/minute/1.73m2)
- Severe liver disease (prothrombin time above normal range or known varices)
- Uncontrolled hypertension (blood pressure> 200 mm Hg systolic or> 120 mm Hg diastolic)

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University Health Board

ADDRESSOGRAPH

Postnatal Discharge Management

Discharge Address (if different from addressograph): ……
……
Contact telephone number……

Antenatal Risk Factors- circle as appropriate

Complication	Action	Follow Up
Diabetes	GTT Appointment	Requested for 6/5 ☐
Hypertension on labetalol	GP follow up within 48-72 hours	Woman to arrange
Obstetric cholestasis	Day 10 bloods	Arrange with community midwife/ GP

Caesarean Section

Dressing removed at 48 hours ☐ Wound Care Leaflet Given ☐

PICO Dressing in situ on dischrge ☐ To be removed on day 7

Birth Complications

Discharge Information

Baby going home with mother	YES/ NO	Did baby receive Transitional Care	YES/ NO
Postnatal MITTS Complete	YES/ NO	Baby in SCBU	YES/ NO
Safeguarding Birth Plan	YES/ NO		

Discharge completed by……Designation……Print……

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: ……..

Patient contact details: ……..

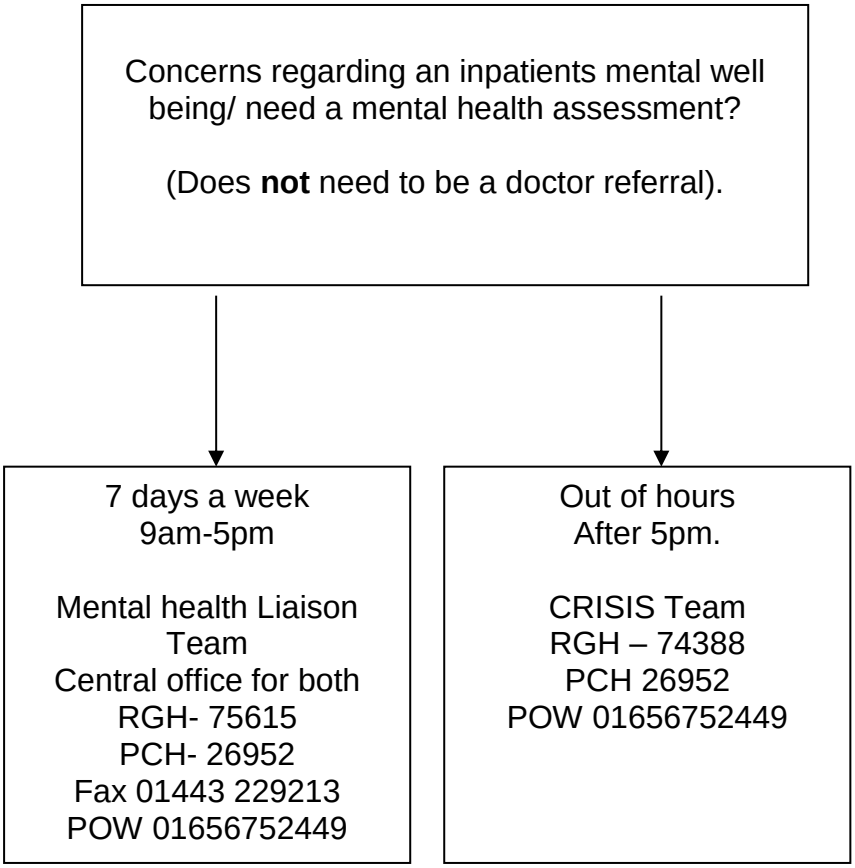
Appointment date and time: ……..

Date patient informed:…… Person informing patient: ……..

Consultants Secretaries and Telephone Numbers

RGH	PCH	POW
-N Bhal, N Swamy Tammy Maguire 01443443528 - I Abbasi Carlene Tucker 01443443526 -J Pembridge, M El-Nasharty Maria Bevan 01443443179	-S Vine, Helen Bayliss Tammy Wickens 01685728802 -A Sivasuriam, Helen Marx Denise Dummett 01685 728369 -S Chawathe, J Rogers Bev Duncan 01685728356 - S Ambika, G Haroun Carolynne Phillips 01685728125	-L Margarit, A Allman Belinda Lucini 01656 752970 -S Hemmadi, T Riaz Julie Jenkins 01656 752308 -K Emmanuel, J Hilborne, R Nagrani Lorraine Field 01656 752882 -R Patel-Gahdia, A Miskin Christine Nicholas 01656 754067 -M Zaki Rebecca McCormack 01656 752465 -C Igbenehi, K Bisseling, F Hodge, S Yisa Nicola Horsfield 01656 752441

Flow Chart for Inpatient Mental Health Concerns



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.

Safeguarding Care Plan

Specialist Safeguarding Midwife: Fiona James 07388950232

Delivering Midwife to contact Children's services
RCT 01443 425006
MERTHYR 01685 725000
OUT OF HOURS 01443 743665
POW

IF CALL MADE TO DUTY TEAM THEN MIDWIFE TO CALL NAMED SW AT 9AM FOLLOWING MORNING.

Date/Time of call

Likely time mother and baby fit for discharge? Inform children's services

Who was spoken to and plan

Discussions with safeguarding professionals:

DATE/ TIME	DISCUSSION	SIGN

Discharge Planning Meeting:

Names of Team Present:

Hospital Midwife:……..……..

Community Midwife:…….

Health Visitor: ……..……..

Social Worker: ……..……..

Parents: ……..……..…..

Other: ……

DATE	**Discussion Notes:**

PLAN:

Address of foster cares or mother and baby unit :

Please retain in maternity notes not to go home with mother

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 post-natal 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

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Midwife to Health Visitor- Information Sharing Form

Cause for concern at *any* contact - Please complete and send to the HV HUB

Name of midwife (completing handover form: **MW Team (Cynon, Rhondda, Taf, Merthyr, Bridgend)**

Contact number of Midwife completing this form: **Home visit (H) or Telephone contact (T/C):**

Date: **Time of contact:** **Name of Mother:** **Mother D.O.B:** **Address:**

Contact Number:

Name of Infant (if known): **Infant D.O.B:** **G.P.** **Family H.V. if known:**

COVID-19 **(state if risks identified)** **Mother**Click here to enter text. **Infant**Click here to enter text.	Please state role and name of all professionals involved if: **CP/CASP/CLA/Vulnerable** Click here to enter text. **Flying Start** Click here to enter text. **Other** Click here to enter text.	**Birthweight** Click here to enter text. **Weight today** Click here to enter text.
Reason for contact: Click here to enter text.		
Issues identified: Click here to enter text.		
Plan: Click here to enter text.		
Professionals notified of Plan: HV HUB, Midwife Team MWT, Social Worker SW, Flying Start Midwife FSMW,		
Date & time form completed:		
Please send this form to: **This form will then be sent to the relevant HUB Health Visitor**. The form will be be filed in the relevant section of the child's record.		