Reference Number: UHBOBS105 **Version Number: 7**	**Date of Next Review: 1/9/2027** **Previous Trust/LHB Reference Number:**

Postnatal Care

Introduction and Aim

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

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

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

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

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

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

Accountable Executive or Clinical Board Director	*Jason Roberts, Executive Nurse Director*
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Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	Aug 2006	Aug 2006	
2	Aug 2009	Aug 2009	Reviewed and Updated by Anne Morgans
3	Sep 2011	Sep 2011	Reviewed and Updated by Anne Morgans /Sarah Andrews
4	Jun 2012	Jul 2012	Reviewed and updated by Angela Massey /Su Karren/Abi Holmes
5	?	?	Reviewed and updated by Angela Massey /Liddy Sheppard
6	December 2022	20/3/23	Reviewed and updated by Aamna Ali
7	Sept 2024		Following guidelines incorporated - Guidance for Mothers Sharing a Bed With their Babies for Feeding While in Hospital/ Safe sleeping- UHBOBS374 - Management of Relatives Who Wish to Remain Overnight Within the Maternity Unit – UHBOBS117 -Bladder Care in Labour and the Postpartum period

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2 Introduction

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

The Key Principles of Good Postnatal Care:

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

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

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2.1 Principles of care

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

When giving information about postnatal care, language should be clear and the content, timing and delivery of information should be tailored to the woman's needs. Shared decision making is a central principle, ensuring information provided is individualized, sensitive to the woman's needs, supportive, respectful and evidence based. If possible, information should be supplemented with digital or written information and translated by an appropriate interpreter to overcome language barriers.

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

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3 Immediate Care of the Mother

3.1 Documentation

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

3.2 Observations

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

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

The frequency of observations for women on the postnatal ward will be decided by the medical and midwifery staff on transfer to the postnatal ward. (SBAR/Transfer sheet Appendix 1). As a general guide for midwifery led patients is twice daily. For CLC the guidance is below-

Minimum observation frequency (unless clinical concern on MEWS or other clinical specification of frequency (e.g. sepsis)	
All inpatients	12 hourly
Inpatient induction of labour	Low risk: 12 hourly High risk: 4 hourly If pethidine given: 30 mins after dose and 2 hourly for the following 4 hours
Intrapartum	Low risk: 4 hourly (HR hourly) High risk: hourly
Patient controlled analgesia (PCA)	Morphine/fentanyl/remifentanyl: 2 hourly (NB: remifentanil: ½ hourly RR and O2 sats)
Recovery area	General anaesthetic (GA): 5 mins for 1st ½ hour Regional anaesthetic (RA): 15 mins for 1st ½ hour GA and RA (after 1st ½ hour): 15 min for following ½ hour and then every 30 mins until discharge criteria met
Postnatal ward (after operative birth)	If RA with opiate: 2 hourly until 14 hours after birth, plus hourly straight leg raises (SLR) for 6 hours. If unable to SLR by 6 hours, needs anaesthetic review All patients: 4 hourly for at least 24 hours

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4 Immediate care of the newborn

4.1 Immediate postnatal care (golden hour)

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

Recommendations

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

5. Ongoing Care of the Mother

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

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Diet, nutrition and physical exercise
Contraception and sexual intercourse
Fatigue
What to expect in the postnatal period Signs and symptoms of physical problems
Signs and symptoms of mental health problems
Importance of pelvic floor exercises
Smoking, alcohol consumption and recreational drug use
How to seek help
Safeguarding and domestic abuse

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

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

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Pressure Area Care in Maternity uses the Purpose T Bundle **(See Appendix 7.1)**

5.1 Postnatal Bleeding

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

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5.2 Perineal Care

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

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

See Perineal Trauma guideline for further information.

Women should be advised about the importance of good perineal hygiene including cleaning of the perineum, frequency of changing sanitary pads and handwashing.
In the event of poor healing, wound breakdown or signs of infection or haematoma, medical review by an obstetrician or experienced midwife should be sought. If the referral for wound breakdown is from the community the women should be seen the same day.

The physiotherapy team will visit women on the postnatal ward. Women who have sustained 3rd or 4th degree tears will be offered additional input from the physiotherapy team.

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5.3 Caesarean section.

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

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

The operation note should be printed, signed, and placed in the patient notes. A summary of the operation should be put into the discharge summary on the Welsh Clinical Portal (WCP). The postnatal midwife should be in theatre for the WHO surgical checklist sign out and be made aware of any obstetric and anaesthetic concerns. Maternal observations and monitoring following caesarean section should follow the latest Planned OR Unplanned caesarean section pathway guidance. HDU care should be provided as indicated. Following a caesarean section, the wound should be assessed regularly to look for signs of infection, separation, or dehiscence. Women with a suspected complication should be referred to an obstetrician or the Obstetric Assessment Unit (OAU) for review. Wound care should be discussed with each woman and dressings, sutures or clips removed as documented in the operation note and should be decided by the operating surgeon. Timing will be decided according to what dressing type is applied. The Standard Dressing used following Caesarean Section is Leukomed Sorbact. Manufacturer guidance states the dressing can remain on for 7 days, if the dressing becomes saturated it should be changed more frequently.

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5.4 Bladder care.

Consider (re-)inserting a urinary catheter postnatally in women after:
Regional anaesthesia and prolonged labour
Any type of instrumental delivery
Urethral trauma
Severe perineal trauma

All women who have delivered in theatre will have an indwelling urinary catheter sited. This should remain in place for a minimum of 8 hours or until complete recovery of any residual anaesthesia block. Regional anaesthesia can affect bladder sensation and therefore the indwelling catheter should not be removed until the woman is mobile as a minimum unless specified otherwise in the operation note. It may be appropriate to leave an indwelling catheter in place for a longer period for example if there is significant perineal trauma/oedema or there is a need for accurate measurement of the urine output e.g. high dependency care. Following removal of the urinary catheter, women should be encouraged to pass urine after 4 hours – this allows time for conservative measures to be tried (analgesia, mobilisation, bath or shower, privacy) before 6 hours has passed.

All women should void within 6 hours of delivery or removal of indwelling catheter.
The Royal College of Obstetricians and Gynaecologists (RCOG) study group on incontinence recommends that no woman should be allowed to go longer than 6 hours without voiding or catheterisation postpartum.

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- Document time and volume of first void after delivery or after removal of the indwelling catheter on the postnatal pathway. It is important to ask the woman about her voiding pattern as this could point towards voiding dysfunction
- In women with indwelling catheter, time of removal of the catheter must also be documented.
- Early mobilisation is encouraged even with catheter in situ. Pressure Area care following Purpose T guidance continues 4 hourly while immobile including 2 hourly position changes and skin checks. Once mobilisation achieved Purpose T Pressure Area monitoring can be discontinued.

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5.5 Home Birth

Following a homebirth, the woman should be instructed to make a note of the time of the first void and contact the Midwife Led Unit (MLU) if

- this has not occurred within 6 hours
- there are any symptoms of voiding dysfunction

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6. Management of Postpartum Voiding Dysfunction

6.1 Symptoms of Postpartum Voiding Dysfunction

Signs and symptoms that should raise the alert to voiding dysfunction are listed. It is important to recognise that acute retention can be **painless** in the postpartum period especially following regional analgesia.

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Signs or Symptom	Comment
An inability to pass urine within 6 hours of delivery or removal of indwelling catheter.	
Slow urinary stream	
Frequent voids of less than 150mls	
Incomplete bladder emptying	Woman will report the sensation of this.
Urinary incontinence	Including episodes of overflow leakage i.e. a large leak without the urge to void or constant dripping.
Discomfort due to bladder distension	
Lack of bladder filling sensation	

Table 1 Signs and Symptoms of Postpartum Voiding Dysfunction Diagnosis and Initial Management

6.2.1 Diagnosis and initial management of postpartum voiding dysfunction

1. Midwifery assessment on the postnatal ward should include questions regarding normal bladder control and sensation, feeling of complete bladder emptying and urinary incontinence.

2. Insert an in/out catheter for post void residual volume (PVRV) if any of the above symptoms are experienced, to exclude bladder dysfunction. Clearly document time and volume drained. A bladder scan may not give accurate readings in patients with a high BMI or with the presence of clots in the uterus.

3a. If PVRV 100-500ml, measure the next voided volume (within 3-4 hours) and PVRV:

- If the subsequent PVRV <150mls: no further intervention is needed in an asymptomatic woman.
- If the subsequent PVRV is 150 ml or more: insert an indwelling catheter for 24 hours followed by trial without catheter (TWOC). This can be done as an outpatient.

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3b. If PVRV > 500ml or more: insert an indwelling catheter for 24 hours followed by TWOC – this can be done as an outpatient. The obstetric team should be informed. All patients with postpartum bladder dysfunction should have a Datix form completed.

6.2.Investigations following the diagnosis of postpartum voiding dysfunction

Further management aims to identify any factors contributing to delayed bladder emptying and to ensure adequate bladder drainage while waiting for normal function to return. Following the diagnosis of urinary retention or voiding dysfunction, the following actions should be taken and documented in the hospital notes:

- Perform urinalysis and sent for MC&S as the presence of infection is an important contributory factor to prolonged voiding dysfunction.
- If a urinary tract infection is suspected, prompt antibiotic therapy should be initiated as per Hospital Microguide.
- The perineum should be examined and if swollen or painful, a catheter should be sited until the swelling and pain have settled.
- Ensure and provide adequate analgesia, as perineal pain is a significant factor in development of retention.
- Avoid and treat constipation if required.

All women experiencing voiding dysfunction must have follow up after discussion with the responsible consultant or senior registrar. It is the responsibility of the midwife who discharges the woman from the postnatal area to ensure that this appointment for the perineal trauma clinic has been arranged

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6.3 Management of Trial Without Catheter (TWOC)

1. If at TWOC the woman is either unable to void within 6 hours or has a PVRV > 500mls, re-catheterise. If PVRV is 150mL – 500mls: record the next 2 voids. If PVRV is ≥ 150mL after the 2nd void then re-catheterise the woman for 1 week. Leave the catheter on free drainage. TWOC should be attempted after

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1 week. (This can be done as an outpatient

2. At 2nd TWOC record 2 voids and if the woman is either unable to void within six hours or has a PVRV > 150mL after 2nd void; re-catheterise for 10 days. Fit a flip-flo valve for daytime use and keep the catheter on free drainage at night. After 10 days a TWOC is attempted (as an outpatient).

3. If at 3rd TWOC the woman is either unable to void within 6 hours or has a PVRV > 150mL after 2nd void; re-catheterise and refer to Mrs Jo Jones, urogynaecology Nurse Practitioner using attached referral form.

In all of these cases, the time and volume of voiding must be documented in the hospital notes. The voided volumes and the PVRV must also be recorded. Measurement of intake and output volumes needs to be recorded on a fluid balance chart in these cases.

- 6.4 Bowel care

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

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6.5 Anaemia.

If there is significant blood loss following birth (>500mls) a repeat full blood count is recommended prior to discharge from hospital.

6.6 Handover

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

Prior to transfer to the postnatal ward, all women who have birth on the consultant unit must have a discharge sticker completed to identify which type of discharge they require. It is important to consider any emerging risk factors that may change this during the postnatal stay.

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Postnatal Discharge Sticker

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

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

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6.7 Venous Thromboembolism (VTE)

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

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

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6.8 Mobilisation.

Women should be encouraged to mobilise as soon as possible following the birth and this can occur before catheter removal if this is safe to do so. Pressure areas should be checked two hours alongside position changes until the woman is mobile to prevent pressure ulcer formation.

If there is a concern regarding pressure ulcer ddevelopment medical photography and the tissue viability team should be contacted. See Purpose T Bundle in Appendix B

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7. Neurological Injury

Most postnatal neurological complications are due to compressive neuropathy because of prolonged labour, patient positioning or mode of delivery, although anaesthetic review may be required to exclude complications of neuraxial anaesthesia. The anaesthetist should be called to review any patient who has any signs suggestive of a nerve injury e.g. persistent leg weakness or altered sensation, abnormal bladder or bowel function, if they have received a spinal, epidural or CSE at any stage during their labour and delivery and their findings must be documented in the notes. Severe back pain or any signs of infection at the site of spinal/epidural placement should also be urgently reviewed by the anaesthetist, as imaging of the lumber spine may be considered appropriate. Further information on the presentation of compressive neuropathies and injuries related to anaesthesia and a proforma for documentation of findings are summarised in the Obstetric Anaesthetic Guidelines below.
Guidelines for Obstetric Anaesthesia Aug 2024.pdf

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8. Rhesus Negative status

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

wisdom.nhs.wales/health-board-guidelines/c-vmantenatalcarefile/anti-d-prophylaxis-for-women-who-are-rhesus-d-rhd-negative/

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9. Security

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

10. Identification of babies

The Midwife in charge of the delivery is accountable for ensuring that the baby is correctly identified (Amended Rules NMC, 2007)
As soon as possible after the birth two bands should be attached to the baby 1 around wrist and 1 around ankle, giving the following information: -

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- Mother's surname and forenames
- Mother's Unit Number, if allocated.
- Date and time of birth of baby
- Sex of the baby, recorded as boy or girl (not male or female since these terms are more likely to be misread).

The band placed on the mother's wrist only has the band number on it. The information on the three bands must be checked by: -

- the midwife and another responsible person who is usually one of the parents verifying the details or
- the delivering midwife and another member of staff in the presence of the mother

The band number is recorded on the front sheet of the baby's notes and in the postnatal pathway by the midwife and second member of staff who will sign the baby's notes that all identification details are correct. The mother must also be advised about her responsibility for regularly checking the bracelets, particularly following separation from her baby.

- A baby is issued with their own NHS Number and Hospital identification number as the delivery details are entered onto the Maternity Information system. The Hospital number must be used for labelling any samples or correspondence regarding the baby.

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11. Transfer to the Neonatal Unit

- Babies transferred to the Neonatal Unit should be identified as above before leaving the delivery area. If the delivery area is at the Consultant Led Unit and this is not possible, a midwife should accompany the baby to the Unit. **A neonatal nurse checks identification bands with the midwife who transfers the baby and signs on baby notes that bands are correct.** Babies requiring transfer from the Midwifery Led Unit will be escorted by a midwife, and the identification bands will be in place.
- The Midwife/Nurse who receives the baby is responsible for checking the bands, as soon as possible.

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- If an identification band must be cut off, all 3 bands should be renewed following the usual procedure. These bands should be checked by two midwives or nurses if the mother is unfit to visit the Unit or has been discharged home. The third band should be attached to the mother or placed in the baby's notes

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12. On Admission to the Ward

- The Midwife/Nurse who admits the baby to the ward is responsible for checking with the midwife who is transferring the baby to the ward that the identification bands are in place and that the information corresponds with the case notes. **She/he must then sign the baby's records to ensure that these details are correct**. It is the midwife's responsibility to ensure that every baby has an electronic security tag secured to their ankle on admission to the ward.

- If a baby is admitted from another hospital or from home, the details should be checked with the Midwife/Nurse or relative escorting the baby, and the identification bands completed and attached in their presence following procedure as for following the birth.

- When taking the baby to the mother for the first time after separation, the Midwife/Nurse must ask the mother to check that the information on both bands is correct and the mother should then be advised about her responsibility for regularly checking the bands.

- It is the mother's responsibility to ensure the safety of her baby. Every mother admitted to the ward or Neonatal Unit will be given a Guidance on Security Leaflet outlining these responsibilities.

- **Daily checks** of identification bands should be carried out and **signed as correct in the infant's records and postnatal pathway.**

- If a band is missing, the Midwife/Nurse in charge of the ward must be informed. The Midwife/Nurse in Charge together with the person discovering that the band is missing must then check the remaining band against the mother's case notes. If they correspond, a new set of 3 bands should be completed following the procedure as for Delivery Suite. The mother should be present during this procedure to check the details and witness the new bands attached to the baby's ankle/wrist. Every effort should be made to locate the missing identification band, which should then be destroyed.

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- The Midwife/Nurse in Charge of the ward **must always** be informed if a baby

- is found to have both bands missing. New bands must not be issued until it is certain that there can be no doubt about the baby's identity. If any doubt exists, the Midwife/Nurse Manager or Acting Midwife/Nurse Manager and the Midwife/Nurse in charge of the ward should check the presence of all other babies' notes. When these midwives/nurses are satisfied that there is no possibility of a mistake in identity, three new identification bands should be made out, using information in the Midwifery Infant Record and the mother's case notes following the procedure as for Delivery Suite. If the midwives/nurses are not completely satisfied with the baby's identity, the Ward Manager/Midwifery Unit Manger should be contacted, who will decide upon appropriate action.

- The Midwife in Charge and the midwife should record the incident in the infant case notes, giving the date and time of the incident and specifying their names and job titles. The notes should then be signed by them. **An incident form should be completed.**

- A separate identification band should be placed on the baby with name, date and time of birth and hospital number if he/she requires any medication/investigations.

    - The identification bands must be checked immediately prior to transfer home in the mother's presence. The mother and midwife/nurse must sign that the 3 identification bands are correctly labelled on transfer from hospital. The midwife/Nurse and the mother must sign the record book kept at the reception book after checking that all bands are present and correct immediately prior to leaving the ward on discharge home.

    - At the first visit by the Midwife/Outreach nurse in the community, the identification bands will be removed and given to the mother and the same documented in the community notes.

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13. Infant feeding

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

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14. Contraception

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

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

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15. Medical review and Postnatal huddle

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

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

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

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

- All postnatal readmissions for maternal reasons require a documented Consultant Obstetric review within 24 hours of admission and every 24 hours thereafter at a minimum.
- Any woman on the sepsis pathway who is still pyrexical or unwell despite 24 hours of antibiotics.

- Any woman who the junior medical staff or midwives are concerned about with regards to mental or physical health

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16. Management of Common Postnatal Problems

16.1 Perineal pain and perineal wound breakdown

See – Perineal Trauma guideline

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

16.2 Postpartum Infection

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

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

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

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

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

16.3 Headache

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

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

16.4 Urinary problems and bladder care

- See bladder care section

16.5 Breasts and nipples

An assessment of the condition of the breasts and nipples should be included during each postnatal examination. Women should be advised of the natural process of lactation and made aware of any symptoms that may occur (blocked milk ducts/engorgement/mastitis etc). They should be encouraged to self-refer if they have any concerns. If nipples are sore or cracked, they should be advised on correct positioning and attachment.
Natural suppression of lactation should be discussed with women who choose not to breastfeed.

16.6. Bowel problems including constipation

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

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

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

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

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17. The Unwell Postnatal Woman

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

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

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

Potential life-threatening conditions include:

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

See 'Hypertensive disorders in pregnancy', 'Prevention and Management of Postpartum Haemorrhage', 'Infection and Sepsis in Pregnancy' and ' Venous Thromboembolism (VTE) In Pregnancy and the Puerperium: Risk assessment, Diagnosis and Management.' guidelines for further guidance.

Also use the MEOWS scoring system and escalate according to the instructions on the reverse of the MEOWS Chart.

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

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18 Emotional Wellbeing

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

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

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

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

18.1 Postnatal Depression and postpartum PTSD

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

Prior to discharge from maternity services, explore the woman's mental health and resolution of symptoms of baby blues (for example tearfulness, anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression and referred to GP if symptomatic. Liaison with the health visitor is also crucial to ensure relevant information sharing within the MDT.

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19. Life-threatening mental health conditions

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

- Severe depression, such as feeling extreme unnecessary worry, being unable to concentrate due to distraction from depressive feelings

- Severe anxiety, such as uncontrollable feeling of panic, being unable to cope or becoming obsessive
- The desire to hurt others or themselves, including thoughts about taking their own life
- Confused and disturbed thoughts, hallucinations and delusions

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

See Postpartum Psychosis guidance.

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20. Maternal discharge process

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

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

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21 Community postnatal care

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

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22. Domestic Abuse

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

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23. Guidance for mothers on co-sleeping with their babies while in hospital

Bed-sharing is taking a baby into a bed with one or both parents. Although the safest place for a baby to sleep, after a baby has been fed is in the cot by the side of the parents' bed, research found that in the first 4 months of life, 70% of breastfeeding mothers repeatedly bed share or co-sleep (1). There is some evidence to suggest that bed-sharing may be associated with Sudden Infant Death (SIDS) (2). However, the evidence suggests associated risk factors, particularly smoking, rather than bed-sharing, may lead to problems (2,4). Bed-sharing is strongly associated with successful breastfeeding (5). Therefore, it is important that new parents are given

information about how to avoid risks associated with bed-sharing and co-sleeping with their babies (4,8). Co-sleeping is unsafe in hospital beds.

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23.1 Definitions

Bed-sharing: - A mother sharing her bed with her baby to provide warmth and comfort during feeding.
Co-sleeping: - A mother who sleeps whilst sharing a bed with her baby; whether intentional or not.

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23.2 Objectives

1. To encourage successful baby feeding and a close mother and baby bond within a safe environment. DOH advises exclusively breastfeeding for 6 months and evidence shows that breastfeeding for at least two months halves the risk of SIDS – but the longer you can continue the more protection it can give your baby.
2. To discuss with mothers about risk factors associated with bed-sharing so that they can make an informed choice about where to feed their baby. Maternity staff should also ensure that parents are given information about the serious risks of co-sleeping with their babies in a hospital environment, as this is unsafe practice.
3. To reinforce the information regarding safe bed-sharing and co-sleeping in the community, following hospital discharge, to enable mothers to make informed decisions about safe practice. The responsibility for that decision belongs to the mother, and her decision should be respected.

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23.3 Contraindications to bed-sharing –Risk factors

The safest place for a baby to sleep is in a *cot by the side of the mother's bed. Mothers should be informed of the following risk factors, which increase the risk of SIDS. It is not uncommon for a mother to fall asleep in her hospital bed while feeding her newborn. This situation increases risk of adverse outcomes such as sudden unexpected postnatal collapse and near-miss events or deaths related to sleep, suffocation (‘overlaying) and falls from the mother's hospital bed reports typical infant risk-to-fall maternal indicators including breastfeeding, cesarean birth, use of opioid pain relief within the last 4 hours, and the phenomenon of emotional/physiological maternal exhaustion second or third night postpartum (especially between midnight and early morning [9:00 a.m.])

Hospital beds are not designed for co-sleeping, and therefore parents should be aware that babies should always be put back into their cots following skin-to-skin contact and feeding.

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1. Do not sleep in a hospital bed with your baby as these beds are not designed for co-sleeping even with the cot-sides up.
2. Do not sleep with your baby if you or anyone else in the bed is a smoker.
3. Do not sleep with your baby when you have been drinking any alcohol or taking drugs (legal or illegal)
4. Do not put yourself in a position where you could doze off to sleep with your baby in a sofa or armchair as this can increase the risk up to 50 times.
5. Keep your baby away from pillows or duvets and make sure bedclothes do not cover your baby's face.
6. Make sure your baby cannot fall out of bed or become trapped between the mattress and the wall.
7. Do not bed-share if your baby was born prematurely or had a low birthweight (below 2.5Kg)
8. Do not leave your baby alone in bed.
9. Do not bed-share with your baby, if you, your baby, or anyone else in the bed are unwell or have a condition which may cause a temporary lapse of consciousness e.g., unstable diabetic or epileptic.
10. Do not bed-share if you are excessively tired as it may affect the ability to respond to your baby.
11. Do not bed-share if you are obese (BM1 = >35).
12. Do not bed-share with your baby if you have any condition that affects mobility, sensory or spatial awareness e.g., multiple sclerosis, paralysis, or blindness.

In hospital additional risk factors where it is advisable not to **bed-share** are:

1. Mother under the effect of general anaesthetic.
2. Immobile due to spinal anaesthetic.
3. Mother unwell following conditions such postpartum haemorrhage or severe hypertension.

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23.4 Guidelines for implementation in hospital if a mother chooses to bedshare:

1. After a feed and once the baby is settled, ask the mother's permission to place the baby in the cot.
   If a mother chooses to bed-share, discuss the benefits, risk factors and steps to increase safety. Parents should be fully responsible for their decisions regarding bed-sharing and have access to evidence-based information by accessing www.lullabytrust.org.uk – "Safe Sleeping Advice" (which should be given on discharge from the hospital with access to the QR code www.unicef.org.uk/caringatnight

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2. A risk assessment should be completed prior to bed-sharing. Risk assessments should be reviewed if circumstances change. Document any risk factors in the maternal postnatal notes.
3. Supervision is required if a mother chooses to bed-share. Curtains should be left open so staff can check both the mother and baby regularly.

4. To minimize accidents:
    a. Keep pillows, sheets, blankets away from your baby, or any other items that could obstruct your baby's breathing or cause them to overheat.
    b. To protect the baby from falling out of bed, tuck light bed clothes around the mother, lower the bed as far as possible and ensure bed-guards are up.
    c. Ensure there is not gap between the bed guard and bed which could cause a danger of entrapment. Maternity unit bed rails are not designed to prevent babies falling out of bed and could result in entrapment.
    d. Ensure the mother has easy access to the call system.
    e. Sleep baby on their back, flat, feet to the bottom of the cot and allow a clear safer sleep space.
    f.
5. On discharge, ensure all mothers have discussed safe bed sharing. Document discussion in the maternal postnatal notes.

6. Ensure the mother has the Public Health Wales Bump Baby and Beyond book "Getting a good night's sleep" section for safe bedsharing. Mothers may wish to download a free information leaflet "*Caring for your baby at night*" from www.unicef.org.uk/caringatnight

*A cot should conform to British Safety Standards

24. References

Ball HL (2002) Reasons to bed-share: why parents sleep with their infants. Journal of Reproductive and Infant Psychology 20:4, 207-221

FSID.org.uk

"Bump Baby and Beyond" Book. Public Health Wales April 2014 Also available as an e-book from www.bumpbabyandbeyond@wales.nhs,uk

UNICEF Baby Friendly Initiative (2014) Caring for your baby at night. www.unicef.org.uk/caringatnight

Mc Kenna JJ, Mosco SS, Richards CA (1997) Bed-sharing promotes breastfeeding. Paediatrics 100:214-9

Safe use of bed rails December 2013 Medicines and Healthcare Products regulatory Agency (MHRA)

UNICEF Baby Friendly Initiative Hospital Standards (2014) www.babyfriendly.org.uk

Ball, H. L. et al (2016). Bed-sharing by breastfeeding mothers: who bed-shares and what is the relationship with breastfeeding duration? Acta Paediatrica, DOI: 10.1111/apa.13354.

Lullabytrust.org.uk. 2022. *The Lullaby Trust Home Page*. [online] Available at: www.lullabytrust.org.uk

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25. Guidance for partner who stay in hospital over night

The woman's partner or a relative may request to stay with her within the Maternity Unit to provide additional support to the woman during the initial stages of labour/induction of labour or during the early postnatal period. The following guideline is designed to provide a consistent approach to provide the best service for the woman and her family and also to safeguard staff from aggressive behaviour from relatives.

25.1 Guidance

It is important that continuity in managing overnight visitors is maintained by all staff. The following points are to be applied in all cases: -

The allocation of side rooms is on a clinical need basis and should be reviewed daily by the Midwife in Charge.
Women/ partners who request and/or require side rooms should inform the Midwife in Charge on arrival to the ward or as soon as possible. All requests are to be considered, but women/ partners are to be advised that it may not be guaranteed.

The facilitation of Relatives/Partners staying overnight should be considered individually. If a woman requests support from her relative/partner in the early postnatal period when she requires to be cared for in a bay consideration must be given to other women in the bay.

If other women are not comfortable with relatives/partners staying in the bay every effort should be made to accommodate the request by moving the woman into another bay or side room if available to support, her choice.

If there are no side rooms available and other women in the multi-bedded bays do not give their consent for the partners to stay overnight then unfortunately, in this instance, partners will not be supported to stay overnight. It is important to always respect the wishes and dignity of the other women.

All women/ partners requesting the overnight facility should be given the written information 'Staying overnight - Information for your partner or relative,' to inform them of the Maternity Unit guidelines regarding overnight guests which includes a signed agreement regarding expected behaviour.

Women and their partner/ relative are to be informed that there may be occasions when we have to withdraw the overnight guest privilege, if ward security may be compromised, or clinical needs change.

Important

Please check on the Maternity system if there are any 'alerts' highlighted which may result

in the overnight support from Relatives / Partners not being appropriate at any time.

Consideration must always be given to the safety and dignity of other women on the ward.

Criteria for Relatives/Partners staying overnight

1. Overnight support for a woman in early labour or induction of labour on the maternity wards.
2. Overnight additional support for a woman and baby in the early postnatal period.

- One person may accompany the woman
- The partner/relative will be asked to remain in the room/ bedside as much as possible (to ensure privacy and security to other women and babies) unless they need to leave the room for food or personal hygiene.
- Midwifery support for these women is provided by ward staff until transfer to delivery suite/discharge from hospital.

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25.2 Support for women on Delivery Suite

During the pregnancy community midwives should ask the woman to inform her relatives to refrain from ringing the maternity unit or visit whilst she is in labour. A notice is to be displayed in the hospital ANC advising this. However, we recognize that birth is a family event and consideration should be given to family members wishing to visit the new family once the baby is born.

- Ask the woman to identify a maximum of TWO named birth partners to remain with her on delivery suite.
- Arrangements can be made for short visits of 5 – 10 minutes after delivery on the Delivery Suite, if clinical care is not compromised, and it is not too frequent.
- Discretion must be used for women who are receiving antenatal or postnatal high dependency care and are being nursed on the delivery suite. Each case must be assessed individually as circumstances will vary. It is the senior midwife's responsibility to ensure that the woman and her family's wishes are taken into consideration.

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25.3 Overnight support within the Maternity Unit

This needs to be discussed with women during the ante natal period, supported with written information. This will ensure women can advise their partners/relatives in advance of the guidelines related to overnight support.

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The partner / relative may remain with the woman in a recliner chair provided if possible.

- The partner/relative will be asked to remain in the room/bedside as much as possible (to ensure privacy and security to other women and babies) unless they need to leave the room for food or personal hygiene.
- The midwife in charge of each shift would review the allocation of side rooms.
- Double/ side rooms should be allocated based on clinical need, taking into consideration women who may require additional support.
- Offer side rooms to a woman whose baby is expected to have a prolonged inpatient stay, e.g.: prematurity <36/40, birthweight < 2kg, antibiotic therapy > 48 hours (about 2 days), phototherapy > 48 hours, multiple birth etc.

The security of mothers and babies in hospital is paramount. However, all staff are reminded that relatives may be anxious and distressed due to emotional circumstances and should be treated with understanding and compassion.

Staff should aim to accommodate relatives, when possible, especially for women in early labour when supportive care from birth companions has a significant effect on the course of their labour, enhances normality and reduces the need for obstetric intervention (Hodnett ED et al 2007).

As a member of staff, your safety is also important. If you feel either ward security or your own safety is compromised by the presence of an individual on the ward overnight, discuss your concerns with Delivery Suite Band 7.

25.4 Reference

Ellen D Hodnett, Simon Gates, G Justus Hofmeyer, Carol Sakala. Continuous Support for Women During Childbirth. Article first published online: 18 July 2007 DOI: 10.1002/14651858.CD003766.pub2

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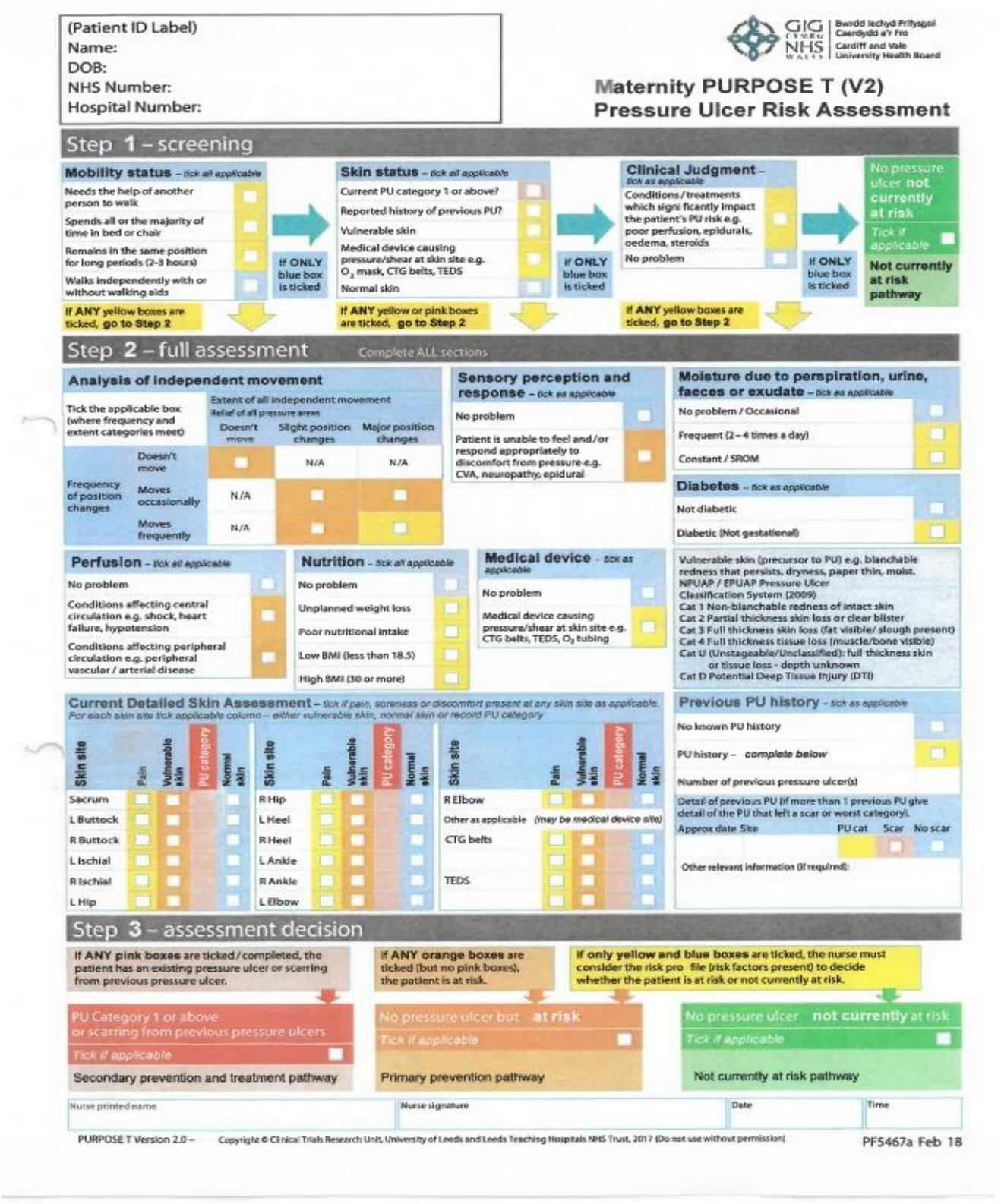
26 Appendix

26.1


(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board
Maternity PURPOSE T (V2)
Pressure Ulcer Risk Assessment
Step 1 – screening
Mobility status – tick all applicable
Needs the help of another person to walk
Spends all or the majority of time in bed or chair
Remains in the same position for long periods (2–3 hours)
Walks independently with or without walking aids
If ONLY blue box is ticked
If ANY yellow boxes are ticked, go to Step 2
Skin status – tick all applicable
Current PU category 1 or above?
Reported history of previous PU?
Vulnerable skin
Medical device causing pressure/shear at skin site e.g. O2 mask, CTG belts, TEDS
Normal skin
If ONLY blue box is ticked
If ANY yellow or pink boxes are ticked, go to Step 2
Clinical Judgment – tick as applicable
Conditions / treatments which signi ficantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
No problem
If ONLY blue box is ticked
If ANY yellow boxes are ticked, go to Step 2
No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway
Step 2 – full assessment
Complete ALL sections
Analysis of independent movement
Tick the applicable box (where frequency and extent categories meet)
Extent of all independent movement
Relief of all pressure areas
Doesn't move
Slight position changes
Major position changes
Frequency of position changes
Doesn't move
Moves occasionally
Moves frequently
N/A
Sensory perception and response – tick as applicable
No problem
Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural
Moisture due to perspiration, urine, faeces or exudate – tick as applicable
No problem / Occasional
Frequent (2 – 4 times a day)
Constant / SROM
Diabetes – tick as applicable
Not diabetic
Diabetic (Not gestational)
Perfusion – tick all applicable
No problem
Conditions affecting central circulation e.g. shock, heart failure, hypotension
Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease
Nutrition – tick all applicable
No problem
Unplanned weight loss
Poor nutritional intake
Low BMI (less than 18.5)
High BMI (30 or more)
Medical device – tick as applicable
No problem
Medical device causing pressure/shear at skin site e.g. CTG belts, TEDS, O2 tubing
Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Cat D Potential Deep Tissue Injury (DTI)
Current Detailed Skin Assessment – tick if pain, soreness or discomfort present at any skin site as applicable.
For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category
Skin site
Pain
Vulnerable skin
PU category
Normal skin
Sacrum
L Buttock
R Buttock
L Ischial
R Ischial
L Hip
R Hip
L Heel
R Heel
L Ankle
R Ankle
L Elbow
R Elbow
Other as applicable (may be medical device site)
CTG belts
TEDS
Previous PU history – tick as applicable
No known PU history
PU history – complete below
Number of previous pressure ulcer(s)
Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).
Approx date
Site
PU cat
Scar
No scar
Other relevant information (if required):
Step 3 – assessment decision
If ANY pink boxes are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.
If ANY orange boxes are ticked (but no pink boxes), the patient is at risk.
If only yellow and blue boxes are ticked, the nurse must consider the risk pro file (risk factors present) to decide whether the patient is at risk or not currently at risk.
PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable
Secondary prevention and treatment pathway
No pressure ulcer but at risk
Tick if applicable
Primary prevention pathway
No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway
Nurse printed name
Nurse signature
Date
Time
PURPOSE T Version 2.0 –
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PF5467a Feb 18

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

Body Map

Guidance for completion.

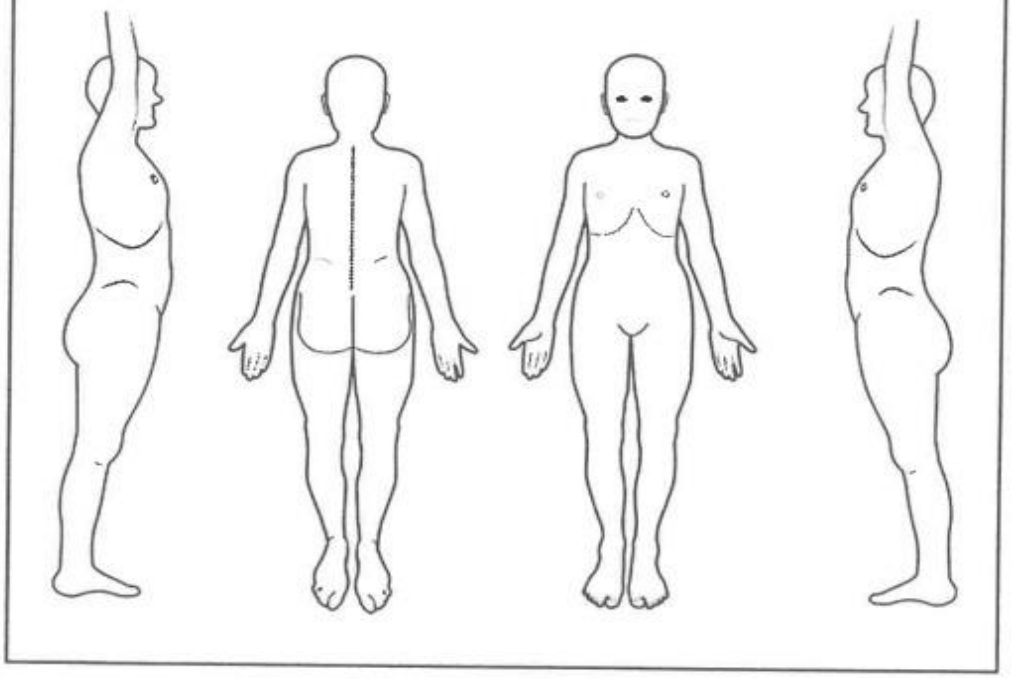
Use to document and illustrate visible signs of physical injury or harm.

The table is to be completed and recorded even if no injury/damage is present (see example) Draw on the body map in black ink, using the key to indicate the different types of injury (shading or alphabetic code).

Use the table to provide details for each injury, eg. measurements of wound, colour of bruise, widespread/localised etc.

Key

- ☐ A - Pressure ulcer
- ☐ B - Moisture lesion
- ☐ C - Wounds, cuts, abrasions
- ☐ D - Surgical wound
- ☐ E - Rash
- ☐ F - Bruising
- ☐ G - Other



(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

Orange Pressure Ulcer Prevention and Management Care Plan for Antenatal Women

Refer to the care plan:

- 2 hourly if independent movement is restricted
- 12 hourly if independent movement is not restricted

Action to be completed	Date, time and initals	Date, time and initials	Date, time and initials	Date, time and initials	Date, time and initials
Example action	*12/1/23 @ 1800 J Bloggs*				
Highlight maternity skin safety card if appropriate					
Encourage and assist with frequent position changes (minimum of two hourly) if independent movement is restricted.					
Apply Med-S cream to areas exposed to potential moisture damage e.g. buttocks, sacrum and thighs, following SROM or any urinary incontinence. Re-apply every 12 hours or after every third cleanse					
Change inco pads and linen as required					
Perform current detailed skin assessment (2 hourly if independent movement is restricted, 12 hourly otherwise)					
Inspect any skin areas that are in contact with a medical device such as catheter tubing, fetal scalp electrode or pulse oximeter.					
If vulnerable skin is noted, please refer to Pink Pressure Ulcer Prevention and Management Care Plan					

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

Pink Pressure Ulcer Prevention and Management Care Plan

Refer to care plan at a minimum of every two hours

Action to be completed	Date, time and initals	Date, time and initials	Date, time and initials	Date, time and initials
Example action	*12/1/23 @ 1800 J Bloggs*			
Highlight maternity skin safety card if appropriate				
Perform skin assessments every two hours if the woman is in recovery or receiving 1:1 care and 4 hourly if the woman is on the ward or until independently mobilising				
Encourage and assist with frequent position changes (minimum of 2 hourly) if independent movement is restricted. Position the affected person to relieve pressure from the vulnerable area of skin				
Ensure adequate analgesia is given if pain is experienced due to vulnerable skin or a pressure ulcer				
Change inco pads and linen as required to help prevent any or additional moisture damage to skin				
Apply Medi-S cream to areas exposed to potential moisture damage e.g. buttocks, sacrum and thighs, following SROM or any urinary incontinence. Reapply every 12 hours or after every third cleanse. Do not apply Medi-S to any areas of broken skin.				
Inspect all skin areas that are in contact with a medical device such as catheter tubing and fetal scalp electrodes.				
Encourage early mobilisation where appropriate. Following an epidural or spinal, women should be assessed as safe to mobilise before first getting out of bed. The person				

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

Orange Pressure Ulcer Prevention and Management Care Plan for Postnatal Women

Refer to care plan at a minimum of every two hours whilst providing 1:1 care or in recovery, and four hourly following until woman is independently mobilising

Action to be completed	Date, time and initals	Date, time and initials	Date, time and initials	Date, time and initials
Example action	*12/1/23 @ 1800 J Bloggs*			
Highlight maternity skin safety card if appropriate				
Encourage and assist with frequent position changes (minimum of two hourly) if independent movement is restricted.				
Perform current detailed skin assessment every two hours whilst the woman is receiving 1:1 care (e.g. recovery) and 4 hourly once transferred to the ward.				
Inspect any skin areas that are in contact with a medical device such as catheter tubing, oxygen masks or flowtron boot tubing.				
Ensure that appropriate analgesia is being given and is effective to support and encourage mobilisation				
Change inco pads and linen as required to help prevent moisture damage to skin				
Encourage early mobilisation where appropriate. Following an epidural or spinal, women should be assessed as safe to mobilise before getting out of bed. The person should be able to perform a bilateral straight leg raise with normal feel of strength in legs. Assistance should be given when first getting out of bed until the woman is confidently able to independently mobilise.				

should be able to perform a bilateral straight leg raise with normal feel of strength in legs. Assistance should be given when first getting out of bed until the women or birthing person is confident to independently mobilise.				
Consider using a pump with the Aria Flex mattress for those women and birthing people who have a vulnerable area of skin and may be unwell or immobile for a prolonged period e.g requiring HDU monitoring or are unwell.				
If vulnerable skin or a pressure ulcer is identified in office hours, arrange for medical illustration to photograph area of vulnerable skin (see 6.1 in SOP for further details)				
Refer to the Tissue Viability Specialist Nurse in office hours (see 6.1 in SOP for further details)				
If vulnerable skin is identified out of office hours, please ensure good documentation describing the area of vulnerable skin (see 0.0 for further details)				

(Patient ID Label)
Name:
DOB:
NHS Number:
Hospital Number:

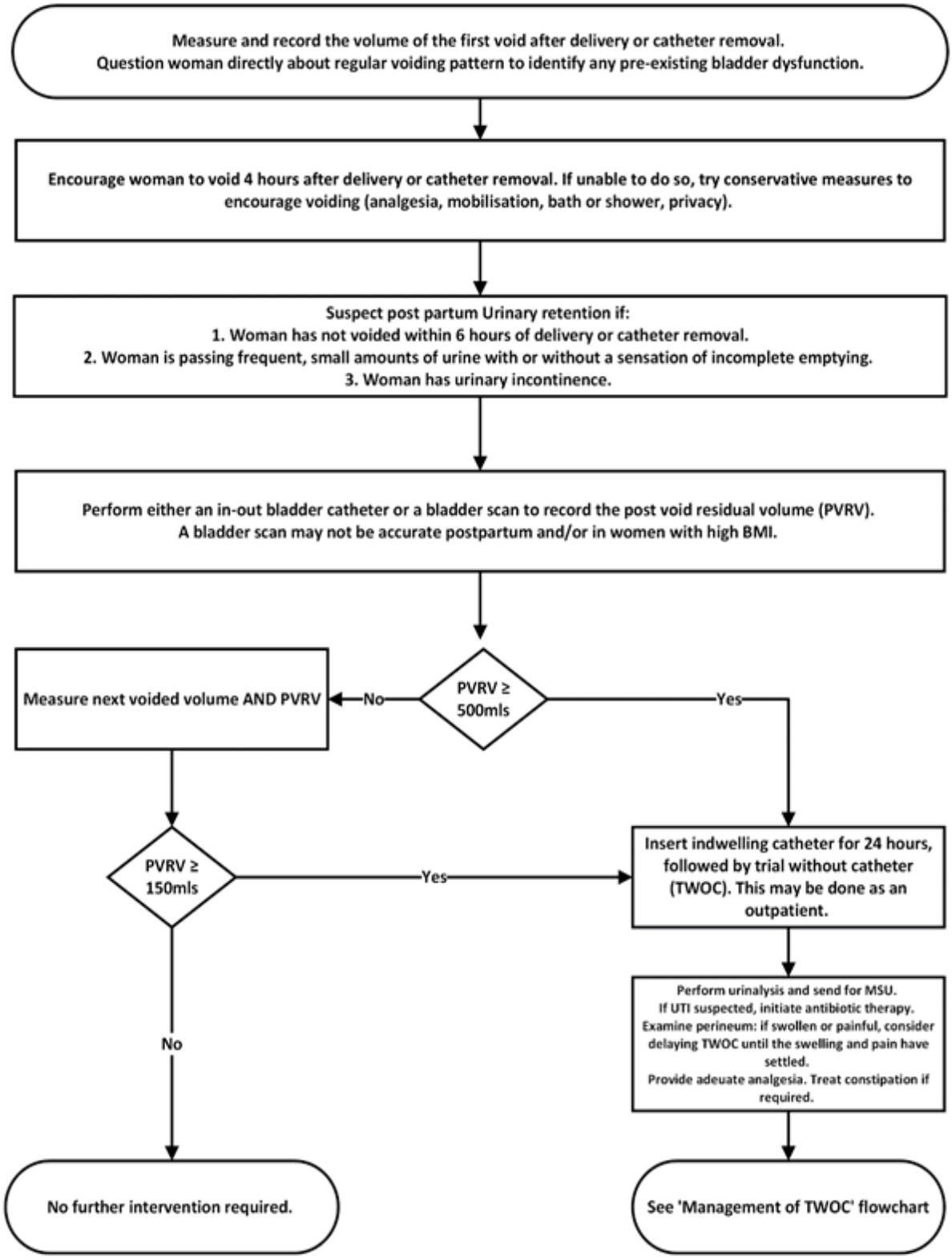
Pink Pressure Ulcer Prevention and Management Care Plan

Refer to care plan at a minimum of every two hours

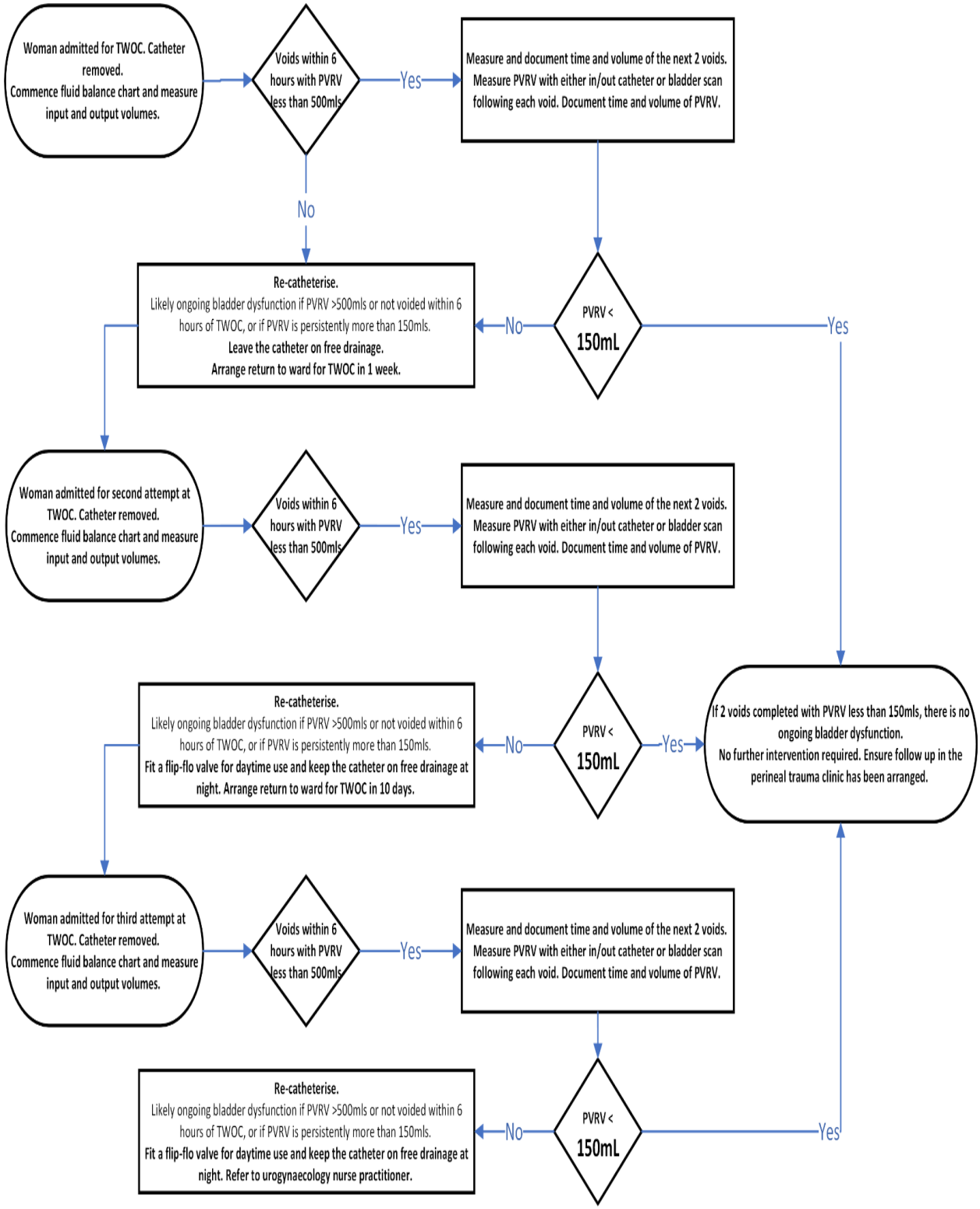
Action to be completed	Date, time and initals	Date, time and initials	Date, time and initials	Date, time and initials
Example action	*12/1/23 @ 1800 J Bloggs*			
Highlight maternity skin safety card if appropriate				
Perform skin assessments every two hours if the woman is in recovery or receiving 1:1 care and 4 hourly if the woman is on the ward or until independently mobilising				
Encourage and assist with frequent position changes (minimum of 2 hourly) if independent movement is restricted. Position the affected person to relieve pressure from the vulnerable area of skin				
Ensure adequate analgesia is given if pain is experienced due to vulnerable skin or a pressure ulcer				
Change inco pads and linen as required to help prevent any or additional moisture damage to skin				
Apply Medi-S cream to areas exposed to potential moisture damage e.g. buttocks, sacrum and thighs, following SROM or any urinary incontinence. Reapply every 12 hours or after every third cleanse. Do not apply Medi-S to any areas of broken skin.				
Inspect all skin areas that are in contact with a medical device such as catheter tubing and fetal scalp electrodes.				
Encourage early mobilisation where appropriate. Following an epidural or spinal, women should be assessed as safe to mobilise before first getting out of bed. The person				

Consider using a pump with the Aria Flex mattress for those women or birthing people who are unwell e.g. HDU monitoring and may be immobile for a prolonged period of time.				
If vulnerable skin is noted, please refer to Pink Pressure Ulcer Prevention and Management Care Plan				

26.2 Flowchart for Diagnosis and Initial Management of Postpartum Voiding Dysfunction



26.3 Flowchart for the Management of Trial Without Catheter (TWOC)



26.4 Referral to Urogynaecology Nurse Practitioner

Please print and complete the following referral form (starts on next page).

POST NATAL VOIDING DYSFUNCTION
REFERRAL FORM

Pt sticker Referral date…….

Consultant……

Patient's tel no…….

Date of delivery: …… BMI: ……. Parity: …… Baby Weight: …… g
SVD Forceps Ventouse Epidural Caesarean 3rd/4th Degree Tear

History of presenting complaint:
……

……

……

……

……

……

Date of initial catheterisation……..

Date of 1st TWOC …… Re-catheterised

Date of 2nd TWOC ……. Re-catheterised Flip-Flo attached: Y / N

Date of 3rd TWOC ..... Re-catheterised Flip-Flo attached: Y / N

Signature of Person Referring:
……

PRINT NAME & Designation:
……

Ext/Contact No:
……

PLEASE FORWARD THIS FORM TO JO JONES, UROGYNAECOLOGY NURSE PRACTITIONER, ROOM 225, WOMEN'S UNIT, UPPER GROUND FLOOR, UHW, EXT 418