Postnatal Care - Full Clinical Guideline

Reference no.: UHDB/PN/07:23/P2

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1. Introduction:

Postnatal care should be structured to meet the requirements of each individual mother and baby to promote long term physical and emotional wellbeing for both. Communication is a cornerstone of good clinical practice, underpinned by effective systems of communication between all team members and each discipline, as well as with the parent(s) and their families.

This guideline covers the routine postnatal care that women and their babies should receive in the first 8 weeks after the birth. It includes the organisation and delivery of postnatal care, identifying and managing common and serious health problems in women and their babies and how to help parents form strong relationships with their baby. The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Women having routine postnatal care, and their families

2. Abbreviations

NEWTT	-	Neonatal early Warning Trigger and Track
PAU	-	Pregnancy Assessment Unit
PET	-	Pre-Eclampsia
PIH	-	Pregnancy Induced Hypertension
PPH	-	Postpartum Haemorrhage

3. Organisation and delivery of postnatal care

Principles of Care

When caring for a woman who has recently given birth, listen to her and be responsive to her needs and preferences. The implementation of personalised care and support plans (PCSP) should aid the planning of women's antenatal and postnatal care and provide a platform for discussions of preferences.

Be aware that the 2020 MBRRACE-UK reports on maternal and perinatal mortality showed that women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring.

The reports showed that:

- compared with white women (8 per 100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is:
  – 4 times higher in black women (34 per 100,000)
  – 3 times higher in mixed ethnicity women (25 per 100,000)
  – 2 times higher in Asian women (15 per 100,000; does not include Chinese women)
- the neonatal mortality rate is around 50% higher in black and Asian babies compared with white babies (17 compared with 25 per 10,000)
- women living in the most deprived areas are more than 2.5 times more likely to die compared with women living in the least deprived areas (6 compared with 15 per 100,000)
- the neonatal mortality rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many babies dying in the most deprived areas compared with the least deprived areas (12 compared with 22 per 10,000).

When caring for a baby, remember that those with parental responsibility have the right be involved in the baby's care, if they choose.

When giving information about postnatal care, use clear language and tailor the timing, content, and delivery of information to the woman's needs and preferences.
Information should support shared decision making and be:

- provided face-to-face and supplemented by virtual and written formats, for example, digital/printed.
- offered throughout the woman's care
- individualised and sensitive
- supportive and respectful
- evidence based and consistent
- translated by an appropriate interpreter to overcome language barriers

Check that the woman understands the information she has been given, and how it relates to her. Provide regular opportunities for her to ask questions and set aside enough time to discuss any concerns.

Consider offering additional support to women who have complex social factors, such as:

- women who misuse substances
- recent migrants
- asylum seekers or refugees
- women who have difficulty reading or speaking English
- young women aged under 20
- women who experience domestic abuse.

Schedule of Postnatal care
Hospital:
Women and their babies should have as a minimum daily check for the first 5 days unless identified more frequent observations through their personal care plans. After this time a mother and baby postnatal check should be undertaken daily if a clinical indication.

Community (routine):
1st visit the day after discharge from hospital
Day 5 visit
Day 10-14 Visit

Additional visits can also be undertaken where additional support is required or there are potential concerns regarding the mother or babies' wellbeing, including;

- Breast feeding
- Babies may require a day 3 weight review (<37 weeks/tongue tie/HB<90 gL/PPH/low birthweight <2.5kg/breast surgery/previous mastitis/pre-eclampsia)
- Babies that required a weight review after 48-72hrs
- Women requiring more frequent observations, such as PIH/PET
- Women who have complex social factors and/or safeguarding

4. Communication between healthcare professionals at transfer of care

Ensure that there is effective and prompt communication between healthcare professionals when women transfer between services, for example, from secondary to primary care, hospital to hospital and from midwifery to health visitor care. This should include sharing relevant information about:

- the pregnancy, birth, postnatal period, and any complications
- the plan of ongoing care, including any condition that need long-term management
- problems related to previous pregnancies that may be relevant to current care
- previous or current mental health concerns
- FGM (mother or previous child)
- who has parental responsibility for the baby, if known
- the woman's next of kin
- safeguarding issues
- concerns about the woman's health and care, raised by her, her partner or a healthcare professional
- concerns about the baby's health and care, raised by the parents or a healthcare professional
- the baby's feeding

Any safeguarding concerns should be recorded on the maternity system and acknowledged within the discharge handover of care so Community Midwifes are aware of relevant information regarding the family.

Midwifery services should ensure that:

- the transfer of care from midwife to health visitor is clearly documented through completion of the midwife to health visitor form and verbal discussion if appropriate
- women or the parents are informed about the transfer of care from midwife to health visitor.

4.1 Transfer to Community Setting

Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth:

- assess the woman's health
- assess the woman's bladder function by measuring the volume of the first void after giving birth
- assess the baby's health (including physical inspection and observation)
- if the baby has not passed meconium, advise the parents that if the baby does not do so within 24 hours of birth, they should seek advice from a healthcare professional
- make sure there is a plan for feeding the baby, which should include observing at least 1 effective feed.
- Provide parents with information about the Baby Check scoring system on the Lullaby Trust Website, and how it may help them to decide whether to seek advice from a healthcare professional if they think their baby might be unwell.

Discuss the timing of transfer to community care with the woman, and ask her about her needs, preferences and support available. Consider the woman's preferences, the mother and babies health and any identified concerns, including any safeguarding issues.

Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth, give women information about:

- the postnatal period and what to expect
- the importance of pelvic floor exercises
- what support is available (statutory and voluntary services)
- who to contact if any concerns arise at different stages.

4.2 First midwife visits after transfer of care from the place of birth or after a home birth

Ensure that the first postnatal visit by a midwife takes place within 36 hours after transfer of care from the place of birth or after a home birth. The visit should be face-to-face and usually at the woman's home, depending on her circumstances and preferences. Refer to first visit of transfer of care in MHHR. (See Appendix A)

For more detailed information on transferring care, see Transfer of Care - Maternity - Full Clinical Guideline.

4.3 First health visitor visit

Midwifery services should ensure that the transfer of care from midwife to health visitor is clearly communicated between healthcare professionals so that safe, personalised and effective care can be provided. The woman or the parents need to be informed about the transfer of care from midwife to health visitor.

The first postnatal health visitor home visit to take place between 10 to 14 days after transfer of care from midwifery care so that the timing of postnatal contacts is evenly spread out. If a woman did not receive an antenatal health visitor visit, consider arranging an additional early postnatal health visitor visit.

5. Postnatal care of the woman

5.1 Assessment and care of the woman

At each postnatal contact, ask the woman about her general health and whether she has any concerns, and assess her general wellbeing. Discuss topics that may be affecting her daily life, and provide information, reassurance, and further care as appropriate.

Topics to discuss may include:

- the postnatal period and what to expect
- symptoms and signs of potential postnatal mental health problems and how to seek help
- symptoms and signs of potential postnatal physical problems and how to seek help
- the importance of pelvic floor exercises, how to do them and when to seek help
- fatigue

- factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use
- contraception
- sexual intercourse
- safeguarding concerns, including domestic abuse

At each postnatal contact by a midwife, assess the woman's psychological/emotional wellbeing as well as her physical health, including the following:

- for all women:
  - symptoms and signs of infection
  - pain
  - vaginal discharge and bleeding (see the section on postpartum bleeding)
  - bladder function
  - bowel function
  - nipple and breast discomfort and symptoms of inflammation
  - symptoms and signs of thromboembolism
  - symptoms and signs of anaemia
  - symptoms and signs of pre-eclampsia

- for women who have had a vaginal birth:
  - perineal healing should be discussed and in cases of trauma, perineal examinations should be offered to confirm healing and documented clearly

- for women who have had a caesarean section
  - wound healing- the dressing should be removed at the first community visit to allow inspection unless PICO dressing in situ
  - symptoms of wound infection

5.2 Signs and symptoms of postnatal complications

At the first postnatal midwife contact, inform the woman that the following are symptoms or signs of potentially serious conditions, and she should seek medical advice without delay if any of these occur:

- sudden or very heavy vaginal bleeding, or persistent or increased vaginal bleeding, which could indicate retained placental tissue or endometritis
- abdominal, pelvic, or perineal pain, fever, shivering, or vaginal discharge with an unpleasant smell, which could indicate infection
- leg swelling and tenderness, or shortness of breath, which could indicate venous thromboembolism
- chest pain, which could indicate venous thromboembolism or cardiac problems
- persistent or severe headache, which could indicate hypertension, pre-eclampsia, postdural-puncture headache, migraine, intracranial pathology, or infection
- worsening reddening and swelling of breasts persisting for more than 24 hours despite self-management, which could indicate mastitis
- symptoms or signs of potentially serious conditions that do not respond to treatment.

At each postnatal contact, give the woman the opportunity to talk about her birth experience, and provide information about relevant support and birth reflection services, if appropriate.

All healthcare professionals should ensure appropriate referral if there are concerns about the woman's health.

5.3 Managing maternal health concerns in postnatal period

Hospital: Request a medical review as soon as possible.

Community: The suitable pathway in the postnatal period for managing health concerns of a woman is GP and out of hours 111. This would be for the management of infections, analgesia, or women experiencing mental health concerns. However, if the health professional has significant concerns, such as heavy bleeding/sepsis/hypertension, then it would be appropriate to discuss the concern with the Obstetric Registrar/review the discharge management plan and refer in PAU

(Derby) or A and E (Burton).

For guidance on care for women with symptoms or signs of sepsis, see Maternal Infections and Sepsis in Pregnancy and the Postpartum Period Full Clinical Guideline. If the woman has confirmed or suspected puerperal sepsis, assess the baby for symptoms or signs of infection.

For postnatal care of women who have had hypertension or pre-eclampsia in pregnancy, see Postpartum Hypertension Full Clinical Guideline.

- postnatal investigation, monitoring and treatment:
  - for women with chronic hypertension
  - for women with gestational hypertension
  - for women with pre-eclampsia
- antihypertensive treatment during the postnatal period, including when breastfeeding.
- advice and follow-up at transfer to community care.

For postnatal care of women with pre-existing diabetes or who had gestational diabetes, see Diabetes in Pregnancy- Full Clinical Guideline.

For guidance on assessing the risk and preventing venous thromboembolism in women who have given birth, see Thromboprophylaxis during and up to 6 weeks after pregnancy – Maternity and Gynaecology - Full Clinical Guideline.

For guidance on assessing and managing urinary incontinence and pelvic organ prolapse in women who have given birth, see Bladder Care - Early Labour and Postnatal – Full Clinical Guideline.

5.4 Postpartum Bleeding

Discuss with women what vaginal bleeding to expect after the birth (lochia), and advise women to seek medical advice if:

- the vaginal bleeding is sudden or very heavy
- the bleeding increases
- they pass clots, placental tissue, or membranes
- they have symptoms of possible infection, such as abdominal, pelvic, or perineal pain, fever, shivering, or vaginal bleeding or discharge has an unpleasant smell
- they have concerns about vaginal bleeding after the birth.

If a woman seeks medical advice about vaginal bleeding after the birth, assess the severity, and be aware of the risk factors for postpartum haemorrhage. Also be aware of the following factors, which may worsen the consequences of secondary postpartum haemorrhage:

- anaemia
- weight of less than 50 kg at the first appointment with the midwife during pregnancy (Booking appointment)

5.5 Perineal Health

At each postnatal contact, as part of assessing perineal wound healing, ask the woman if she has any concerns and ask about:

- pain not resolving or worsening
- increasing need for pain relief
- discharge that has a strong or unpleasant smell
- swelling
- wound breakdown.

Advise the woman about the importance of good perineal hygiene, including daily showering of the perineum, frequent changing of sanitary pads, and hand washing before and after doing this.

Offer an examination of the perineum by a midwife at postnatal checks to confirm perineal wound healing. If needed, discuss available pain relief options, considering if the woman is breastfeeding.

If the perineal wound breaks down or there are ongoing healing concerns, request prophylactic antibiotics and medical review for the woman urgently.

Be aware that perineal pain that persists or gets worse within the first few weeks after the birth may be associated with symptoms of depression, long-term perineal pain, problems with daily functioning and psychosexual difficulties.

The following are risk factors for persistent postnatal perineal pain:
- episiotomy, or labial or perineal tear
- assisted vaginal birth
- wound infection or breakdown
- birth experienced as traumatic.

6. Postnatal care of the baby

6.1 Assessment and care of the baby

At each postnatal contact, ask parents if they have any concerns about their baby's general wellbeing, feeding or development. Review the history and assess the baby's health, including physical inspection and observation. If there are any concerns, take appropriate further action.

Be aware that if the baby has not passed meconium within 24 hours of birth, this may indicate a serious disorder and requires medical advice and/or review.

Conduct a complete examination of the baby within 72 hours of the birth and at 6 to 8 weeks after the birth. See NIPE - Newborn and Infant Physical Examination - Clinical Guideline.

For advice on identifying and managing jaundice, see Early Neonatal Jaundice – Maternity & Neonatal/Paediatric Full Clinical Guideline.

If there are concerns about the baby's growth, see Infant Feeding Policy.

Offer out newborn hearing screening in line with the NHS Newborn Hearing Screening Program. For more information see New-born Blood Spot Screening - Clinical Guidelines

Give parents information about:
- how to bathe their baby and care for their skin
- care of the umbilical stump
- feeding (see recommendations on planning and supporting babies' feeding)
- bonding and emotional attachment (see recommendations on promoting emotional attachment)
- how to recognise if the baby is unwell, and how to seek help (see recommendations on symptoms and signs of illness in babies)
- established guidance on safer sleeping (including recommendations on bed sharing)
- maintaining a smoke-free environment for the baby (see also the NICE guideline on smoking: stopping in pregnancy and after childbirth)
- vitamin D supplements for babies in line with the NICE guideline on vitamin D

Advise parents to seek advice from a healthcare professional if they think their baby is unwell, and to contact emergency services (call 999) if they think their baby is seriously ill.

6.2 Bed Sharing

Complete sleep safe at first community visit (unless baby not present, such as in NICU) and discuss with parent's safer practices for bed sharing.

For further information see Keeping Babies Safe - Babies Sharing their Mothers' Bed / Co-Sleeping and SIDS- Full Clinical Guideline.

6.3 Promoting emotional attachment

Before and after the birth, discuss the importance of bonding and emotional attachment with parents, and the approaches that can help them to bond with their baby.

Encourage parents to value the time they spend with their baby as a way of promoting emotional attachment, including:

- face-to-face interaction
- skin-to-skin contact
- responding appropriately to the baby's cues.

Discuss with parents the potentially challenging aspects of the postnatal period that may affect bonding and emotional attachment, including:

- the woman's physical and emotional recovery from birth
- experience of a traumatic birth or birth complications
- fatigue and sleep deprivation
- feeding concerns
- demands of parenthood.

Recognise that additional support in bonding and emotional attachment may be needed by some parents who, for example:

- have been through the care system
- have experienced adverse childhood events
- have experienced a traumatic birth
- have complex psychosocial needs.

7. Symptoms and Signs of Illness in Babies

Listen carefully to parents' concerns about their baby's health and treat their concerns as an important indicator of possible serious illness in their baby.

Follow the recommendations in the Management of Early Onset Neonatal Sepsis Full Clinical Guideline to assess and manage the risk of early-onset neonatal infection after birth (within 72 hours of the birth). As well as be aware of risk factors for and clinical indicators of possible late-onset neonatal infection (more than 72 hours after the birth).

Be aware that fever may not be present in young babies with a serious infection. If the baby has a fever, refer the baby for a medical review urgently, via GP or 111/Children's emergency department out of hours.

Be aware of the possible significance of a change in the baby's behaviour or symptoms, such as refusing feeds or a change in the level of responsiveness.

Be aware that the presence or absence of individual symptoms or signs may be of limited value in identifying or ruling out serious illness in a young baby.
Recognise the following as 'red flags' for serious illness in young babies:

- appearing ill to a healthcare professional
- appearing pale, ashen, mottled, or blue (cyanosis)
- unresponsive or unrousable
- having a weak, abnormally high-pitched, or continuous cry
- abnormal breathing pattern, such as:
  - grunting respirations
  - increased respiratory rate (over 60 breaths/minute)
  - chest indrawing
- temperature of 38°C or over or under 36°C
- non-blanching rash
- bulging fontanelle
- neck stiffness
- seizures
- focal neurological signs
- diarrhoea associated with dehydration
- frequent forceful (projectile) vomiting
- bilious vomiting (green or yellow-green vomit).

If a baby is thought to be seriously unwell based on a 'red flag' or on an overall assessment of their condition, arrange an immediate assessment with an appropriate emergency service. If the baby's

condition is immediately life threatening, ring 999 and ask for a category 1 transfer via Ambulance.

7.1 Managing a baby's health concerns in postnatal period

Hospital: If the baby is suspected of being unwell commence a NEWTT chart and request an urgent neonatal review by bleeping the Neonatologist in Children's Emergency Department.

Community: If a baby is suspected of being unwell then the health professional should refer to GP for an urgent same day review. However, if the concerns are significant or out of hours, then the baby should be referred to the Children's Emergency Department and the on call Neonatologist informed of the transfer.

When transferring a baby in from a home birth mother and baby should be admitted to labour ward in the first instance so that appropriate care can be given to mother also.

8. Planning and Supporting Babies' Feeding

8.1 General principles about babies' feeding

When discussing babies' feeding, follow the recommendations in the section on principles of care, and:

- acknowledge the parents' emotional, social, financial and environmental concerns about feeding options
- be respectful of parents' choices.

8.2 Giving information about breastfeeding

Before and after the birth, discuss breastfeeding and provide information and breastfeeding support (see Infant Feeding-Trust policy and Procedure).
Topics to discuss may include:

- nutritional benefits for the baby
- health benefits for both the baby and the woman
- how it can have benefits even if only done for a short time
- how it can soothe and comfort the baby.

Give information about how the partner can support the woman to breastfeed, including:

- the value of their involvement and support
- how they can comfort and bond with the baby.

Inform women that vitamin D supplements (10 mcg) are recommended for all breastfeeding women.

Inform women and their partners that under the Equality Act 2010, women have the right to breastfeed in 'any public space'.

8.3 Role of the healthcare professional supporting breastfeeding

Healthcare professionals caring for women and babies in the postnatal period should know about:

- breast milk production
- signs of good positioning and attachment at the breast
- effective milk transfer
- how to encourage and support women with common breastfeeding problems
- appropriate resources for safe medicine use and prescribing for breastfeeding women.

Encourage the woman to have early skin-to-skin contact with her baby so that breastfeeding can start when the baby and mother are ready. Those providing breastfeeding support should:

- be respectful of women's personal space, cultural influences, preferences and previous experience of infant feeding
- balance the woman's preference for privacy to breastfeed and express milk in hospital with the need to carry out routine observations
- obtain consent before offering physical assistance with breastfeeding
- recognize the emotional impact of breastfeeding

- give women the time, reassurance, and encouragement they need to gain confidence in breastfeeding.

For more detailed information about supporting Infant feeding, see Infant Feeding Policy.

8.4 Maternity Support Workers role in the postnatal period

Maternity support workers within the Hospital or Community setting play a vital role in assisting Midwives in providing routine postnatal care. For more detailed information regarding a Maternity Support Worker role, please see MSW Roles and Responsibilities within Community Care.

9. Monitoring Compliance and Effectiveness

As per Business Unit Audit Forward programme

10. References

NICE guideline [NG194] Published: 20 April 2021

Appendix A

First visit in primary care	Yes	N/A	Initial
Personalised Care and Support plan reviewed			
Postnatal examination			
Postnatal exercise discussed			
Perineal / wound care discussed			
Psychological and social support discussed			
Home environment assessed			
Next appointment arranged (inform family if midwife or support worker visit)			
Book interpreter if appropriate for next visit			
Day 5 visit in primary care	**Yes**	**N/A**	**Initial**
To be completed by midwife or support worker			
Maternal wellbeing discussed			
Next appointment arranged			
Book interpreter if appropriate for next visit			
To be completed by midwife			
Postnatal examination			
Discharge visit in primary care at 10+ days postnatal	**Yes**	**N/A**	**Initial**
To be completed by midwife			
Personalised Care and Support plan reviewed			
Postnatal examination			
General discussion: ☐ Sexual health ☐ Menstrual cycle ☐ Contact numbers ☐ Postnatal examination at 6 weeks			
Contraception discussed and signposted			
Review social circumstances			
Clear documentation of RE question asked			
Review smoking status and advise as necessary			

Documentation Control

Reference Number: **UHDB/PN/07:23/P2**	**Version: 1.1**		**Status: FINAL**	
Version / Amendment	Version	Date	Author	Reason
	1	Feb 2023	Jenni White Senior Midwife - Primary Care	New
	1.1	Nov 2023	Joanna Harrison-Engwell - Lead Senior Midwife for Guidelines, Audit and QI	To ensure full compliance with Baseline Assessment Tool
Intended Recipients:				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;				
To be read in conjunction with: Transfer of Care/Postnatal Hypertension/ Diabetes/ Perinatal Mental Health/Safeguarding/Haemorrhage/Jaundice/Infant Feeding/Smoking/Vitamin K/Safe Sleeping/Bed Sharing				
Consultation with:	Maternity Staff			
Business Unit sign off:	02/05/2023: Maternity Guidelines Group: Miss S Rajendran – Chair 24/11/2023: V1.1 - Miss A Joshi 19/06/2023: Maternity Governance Group – Mr R Deveraj 04/12/2023: V1.1			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/06/2023, V1.1 19/12/2023				
Implementation date:	28 /12/2023			
Review Date:	July 2026			
Key Contact:	Joanna Harrison-Engwell			