Frimley Health
NHS Foundation Trust

Postnatal care of the mother and baby including transfer/discharge of the mother when her baby is requiring transfer to another hospital

Key Points

- At each postnatal contact, all women should be asked about their general health and well-being and if they have any concerns.
- At each postnatal contact, all mothers should be asked if they have any concerns about their baby and an assessment of baby's well-being performed.
- Consent must be given by a parent prior to starting any assessment.
- Prior to discharge or the midwife leaving the home, mothers should be advised how and who to contact if they have any concerns with themselves or their baby.
- All mothers should be given/signposted to postnatal information which enable them to care for themselves and their baby safely and recognise when to seek advice/help.

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Abbreviations

AES	Anti Embolic Stockings
NIPE	Newborn infant physical examination
NSAID	Non-steroidal Anti-inflammatory Drug
PN	Postnatal
SIDS	Sudden infant death syndrome
VTE	Venous thromboembolism

Contents

1. POSTNATAL CARE OF THE MOTHER AND BABY

1.1 Postnatal care of the newly delivered mother and her baby should be individualised and represent the choices she has made. Care should be undertaken in partnership between the mother, her family and her healthcare providers.

Postnatal care is about empowering women to care for herself and her baby, promoting the physical and emotional well-being of both, that is supportive of them establishing the mother and baby bond. Advice and information must be provided in a timely manner to all mothers on how to care for herself and her baby and what to expect/is normal in the early postnatal period[1][2].

Whilst in the hospital and at each routine community appointment a full examination should be performed with consent, ensuring privacy and dignity are maintained, referring any concerns with either the mother or baby to the appropriate professionals and fully documenting the care and advice provided on the mother/baby's EPIC record.

1.2 Postnatal contact

At each postnatal contact the mother should be advised of the signs and symptoms of potentially life-threatening conditions for both her and her baby (please refer to tables on page 9) and then a discussion should be undertaken that includes:

- Emotional wellbeing
- Domestic abuse
- Family and social support
- Coping strategies for dealing with day-to-day matters/crying baby
- Advice and information to assess their baby's general condition
- How to identify signs and symptoms of common health problems seen in babies.

Women, their families and partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside the women's normal pattern.

Women and their partner or the main carer should be given information on common baby concerns at each postnatal contact: this should include jaundice; the association between co-sleeping and sudden infant death syndrome (SIDS); reducing the risk of SIDS; Infant Feeding; and signs and symptoms of the baby being unwell.

Women should also be educated on the physiological process following birth and common health concerns requiring midwifery/medical advice[1]. This should include management of common breastfeeding challenges like preventing nipple pain, blocked ducts, engorgement and mastitis, perineal pain; urinary retention; incontinence; constipation; "baby blues"; tiredness; and signs and symptoms of venous thromboembolism (VTE).

1.3 Transfer to postnatal ward.

Follow the standard for transfer of women and babies to the postnatal ward, fully document on the SBAR maternity handover note on the Epic patient record. This must be completed prior to transfer and be followed by a face-to-face midwife handover. The transferring midwife should also ensure the Epic whiteboard is updated and the transfer is ordered on Epic.

- Perform and document on EPIC a full MEOWS assessment on the mother, check fluid balance and the MAR chart are up to date.
- Admission observations must be carried out on all babies on transfer to the ward and be documented on the NEWTT2 Chart[3] on Epic.
- A review/plan for pain relief and other medications should be made and be prescribed on the MAR prior to transfer to the postnatal ward.
- Carry out an infant feeding assessment and discuss the feeding method/plan in partnership with the mother, indicate time /quality of last feed on transfer. Discuss observing for early feeding cues and responsive feeding.
- Ensure maternal orientation on arrival to the postnatal ward, call bell given, and water provided, introduction of the midwife who will be taking over care.
- The current VTE assessment must be completed prior to transfer and if indicated thromboprophylaxis should be prescribed on the MAR prior to transfer to the postnatal ward. This prophylactic medication should be administered within 4 hours of delivery unless contraindicated.
- Any safeguarding plans must be read and plans followed and handed over.
- NIPE can be completed at any point, prior to 72 hours and does not have a minimum time for achieving[4]. This can be part of the initial newborn check after delivery. Pulse Oximetry which is performed alongside the NIPE should be performed after 4hrs post-delivery as per guideline 'Neonatal Pulse Oximetry'.
- Hearing can be completed at any point from birth and up to four weeks of age. This would ideally be completed prior to discharge from the hospital, where this is not possible, a community hearing clinic appointment must be scheduled with the hearing screening team.
- Where early discharge home is being considered/requested, NIPE and hearing should be completed where possible, where this is not possible arrangements must be made for the NIPE and hearing to be completed in the community, ensuring this is communicated with the community teams.
- Signpost all mothers to accessible postnatal information via the My Frimley Health App/leaflets/online prior to discharge.
- Prior to discharge from the hospital or leaving the mothers home after a homebirth, contact detail must be provided on how to contact a midwife/health professional for further advice/support. Mothers should be advised to call 999 if they have immediate life-threatening concerns for either themself or their baby.

1.4 Frequency of postnatal examinations

Whilst in hospital these will be daily:

Baby

- Posture and tone - on handling the baby should not be excessively irritable, tense, sleepy or floppy[1]. Parents should be made aware of normal tone.
- Temperature – should be between 36.5 – 37.5 °C axilla.
- Respirations – should be between 30 – 60 breaths per minute. Irregular breathing patterns are not uncommon in the newborn.
- Heart rate – should be between 100 – 160 beats per minute.
- Fontanelles – these may vary in size, they should not be raised or sunken. A raised fontanelle indicates signs of increased intra-cranial pressure. A sunken fontanelle indicates dehydration.
- Skin – observe for bruising, swelling or spots. Document any marks on the EPIC body map. Refer to the paediatrician if any concerns.

- **ID Labels – Ensure all babies has 2x labels, one should have the mother's details and the other the baby's.**
- Security tag (WPH) /Cot Alarm (FPH) - Ensure present and check each shift they are in working order. Ensure the parents know what they are for and how they work.

Eyes:

- Sclera – this should be white, although bloodshot sclera is not unusual; if they are bloodshot, re-assure parents and inform them it should resolve by ten days of age, referral to a paediatrician is required if it doesn't resolve. Sclera may be yellowish in colour if the baby is jaundiced (see later re skin).
- Referral should also be made if the baby has a red eye / eyelids.
- Tear ducts – it is not unusual for tear ducts to be blocked, resulting in a clear creamy discharge. Parents should be advised this is normal, pathway of care - cleaning of the eyes using cooled boiled water (or sterile saline if in hospital) or breast milk, observe that the discharge does not change colour or significantly worsens [5].
- Potential infection – if there is purulent yellow / green discharge, the eye should be swabbed and sent to microbiology for MC&S, cleaned as above, and referral made to the paediatrician or GP for treatment.

Mouth:

- Should be clean and moist, if there are signs that the baby may have oral thrush (adherent white areas) referral should be made to the paediatrician or GP for on-going treatment.
- Suspected Tongue tie (presence of an obvious frenulum) – Offer basic information on tongue tie to parents and refer to the infant feeding team for a full oral and feeding assessment to confirm whether a tongue is present and whether this requires division.
- Pre-natal teeth – refer to paediatrician.

Skin:

- Colour - the overall colour should be assessed, according to the baby's ethnicity, the colour should not be excessively pale or ruddy.
- The whole of the baby's skin should be observed for rashes, spots and dryness, parents should be reassured if the rash is neonatal erythema. The buttock / groin area should be free from spots, a thin covering of petroleum based emollient can be used for 'nappy rash'. Any unusual skin conditions / possible thrush should be referred to the paediatrician for review / treatment. Document any marks on the body map.
- Physiological jaundice – Approximately 60% of term and 80% of preterm babies develop jaundice in the first week of life, and about 10% of breastfed babies are still jaundiced at 1 month.[6] If jaundice is noted within the first 24hrs or appears excessive at any age, local guidelines should be followed with paediatric input. Please refer to 'Neonatal Jaundice' guideline. All mothers should be provied with information prior to discharge regarding neonatal jaundice and when to refer to MAMAS line or speak to their community midwife. The opportunity will arise when observing skin to discuss general care of the skin – bathing, the use of creams / bath products are not recommended for the first 6 weeks following birth.

Cord:

Care – the area around the cord should be kept clean and dry, if cleaning is necessary this should be done with water and dried. As a general rule no antiseptics ointments should be used on the cord area as this delays cord separation.

- Separation – this occurs by the process of dry gangrene, around 7 – 10 days, although it can take longer.[7]

- Infection – signs of redness, umbilical flare should be observed closely and referred to the paediatrician / MAMAS Line / GP for treatment if necessary.

Urine:

- All babies should pass urine within 24hrs - refer to the paediatrician if any doubt
- Urine should be pale and odourless.
- Parents should be advised to contact MAMAS Line if any concerns that their baby is not having many wet nappies, in particular those parents who have been discharged within 24 hours of birth.
- Immature kidneys mean babies may pass urates, these appear as brick red stains in the nappy, although normal observation should be made to ensure that the baby is passing urine appropriatley as per the below;

    - **Day 1-2:** 1-2 or more in 24hours
    - **Day 3–5:** should increase by 1 daily, beginning with 3 on the third day and 5 on the fifth day (should also be heavier)
    - **Day 6+:** 6 or more heavy wet nappies in 24hours.

- Baby girls may pass a vaginal mucous discharge, this may be clear / creamy to blood stained, parents should be reassured that this is normal and will settle in a few days.

Bowel:

- Meconium – the first stool should be passed within 24 hours of birth, showing that the large bowel is patent. Feeding should be assessed and referral to a paediatrician should be made if the baby has not passed meconium in the first 24 hours.

    - **Day 1-2:** 1 or more in 24 hours with meconium.
    - **Day 3-4:** At least 2 (preferably more in 24hours with changing stool.
    - **Day 5+:** At least 2 (preferably more) soft, runny, yellow stools each day.
    - **Weeks 4-6+**: All babies under 4-6 weeks old should have a minimum of 2 stools a day. When breastfeeding is more established, some babies may a go a few days without stooling and breastfed babies are never constipated and when they do pass a stool it should be soft, yellow and abundant.

- Bottle fed babies produce more formed, paler stools They should be advised to seek out midwifery support if their baby does not have their bowels open as expected to ensure there are no feeding problems. A baby with an abnormal bowel movement pattern should be reviewed by a paediatric registrar where there is no perceived feeding problem.
- Constipation – if a bottle fed baby is constipated refer to paediatrician / GP if necessary. Breast fed babies should not become constipated, lack of stooling therefore is indicative that the baby is not breast feeding effectively.

Weight:

- Babies should be weighed at birth, day 5 and around day 10 prior to care being transferred to the health visitor.
- More frequent weights may be needed for those babies on the red traffic light feeding pathway, please refer to the ‘Infant Feeding Guideline’
- Weight loss of up to 10% of birth weight in a term healthy breastfeed infant is common in the early days of life.
- Please refer to the “Weightloss in Term Healthy Breastfed Infant Guideline” for babies with a weighloss of ≥ 8% and follow the appropriate plan.

- Babies not back to birthweight, but who have a clear trend towards birthweight can be discharged from midwifery care, with an individualised feedplan and handover to the Health Visitor.
- A minimum of two feeding assessments should be carried out before day 7, the outcome of the feeding assessment should be discussed with the mother so that she understands the relevance of the assessment and how to recognise effective feeding. Where any issues are identified, a plan of care should be agreed with the mother and be documented in their record.
- Bottle feeding babies with a similar weight loss should be observed during a feed, methods of feeding discussed with the parents and referral to the paediatrician should be made if there is no obvious reason for this weight loss or if concerned. Please refer to 'Managing feeding for babies who are formula fed' guideline.

Overall assessment

- The newborn check should be documented on the Epic patient record.
- Parents should be made aware of deviations from the normal. Staff should make sure parents know to contact the MAMAS Line for midwifery support / advice outside of any planned visits if they have any non life threatening concerns.
- A feeding assessment should be performed, with a review of the ongoing care plans in partnership with the mother at each contact/every day whilst in the hospital or at each community contact/visit.

Mother

- Observation of her general mood
- Blood pressure, temperature, pulse and respiration and saturations. Every woman on the postnatal ward/TCU including **low-risk women must have a full set of observations carried out and recorded on the EPIC MEOWS chart as a minimum once every morning and evening whilst an inpatient.**
- This is separate to the women who require more frequent observations for medical needs. **Women who require hourly observations as part of their plan due to midwifery / medical concerns should be transferred to labour ward for enhanced care** (unless these hourly observations are part of the normal elective caesarean section pathway).
- A breastfeeding assessment should be carried out on each shift whilst the woman is an inpatient or at each telephone consultation/face to face visit once home. Ensure breasts and nipples are comfortable, offer support with positioning and attachment as appropriate. All women that wish to breastfeed should be shown how to hand express prior to discharge from the hospital.
- Women who have chosen to formula feed should be offered the opportunity to recommence breastfeeding if desired. They should have a discussion with the midwife about breast-care and suppressing lactation if not breastfeeding.
- Observe and document lochia, uterus height and tone, frequency/comfort of urination, the perineum and wound.
- Signs or symptoms of VTE and the presence of correctly fitting Anti Embolic Stockings (AES) must be observed at each check.
- Women should undergo an assessment of risk factors for VTE: following birth, 24 hours after birth, if they develop other problems during the puerperium or if they are readmitted during the puerperium. This assessment must be carried out/documented using the EPIC postnatal obstetric VTE risk assessment.

- Regardless of mode of delivery, all women should be educated about the importance of hand washing before and after changing their sanitary pads, to help avoid genital tract sepsis; signs and symptoms of general sepsis should also be discussed and who and when to contact a health professional.

In the community as per the guidelines for postnatal visiting in the community: regular postnatal checks will be decided in partnership with the mother according to individual needs. Women should always be made aware of contact numbers if concerns arise.

A minimum number of visits following transfer home for women covered by our community team will be:

- **On the day after discharge**
- **Day 5**
- **Day 7 (for women with a PICO dressing)**
- **After day 10 to discharge to Health Visitor**

For those mothers and babies on enhanced postnatal care plans, discharge to the Health Visitor will occur anytime up to 28 days.

These may be at the mother's home/current place of residence or HUB/Children's Centre.

Women not engaging with postnatal care or DNA/child not brought on two occasions or more should be discussed with the named midwife for safeguarding.

Women who are out of area should be given the contact details for both the discharge hospital and the transfer hospital; women should be advised that if the community team does not contact them within 24 hours of discharge, they should contact MAMAS Line.

Women whose babies are on the Neonatal Unit (NNU) should be booked into the postnatal ward diary (Wexham) and Triage (Frimley) for their postnatal check and those who are low risk will follow the community visit regime.

Women requiring daily checks such as those with high blood pressure or any concerns will be seen daily or as advised by the midwife/doctor.
The reasons for any additional visits should be clearly documented.
The midwife completing the postnatal check should liaise with the named midwife or her team leader for women who have multidisciplinary needs or who require multi-agency support management of postnatal venous thromboprophylaxis.

Please refer to current VTE guideline (below is an overview of basic care).

When assessing a woman at each postnatal contact, she should be reminded of the significance of calf pain and leg tenderness as this could indicate deep vein thrombosis.

Lower leg and ankle swelling are common following delivery. Elevation and leg exercises can help but oedema may take 4-6 weeks to resolve [(1)].
All readmissions unless contraindicated should have thromboprophylaxis prescribed, legs measured, and AES should be applied.

1.5 Management of Infant Feeding

At each postnatal contact:

A conversation should be had with all women about feeding their baby and this must be documented on Epic, using the infant feeding conversation tab.

All women should be encouraged to keep their baby close and informed of the benefits of having skin to skin contact as often as they can.

A breastfeeding/bottle feeding assessment should be carried out daily whilst in the hospital and at each community contact after discharge. This should be documented in the infant feeding tab within Epic.

If the woman has decided to suppress lactation, she should be advised to wear a well-fitting supportive bra, to avoid stimulation and allow milk reabsorption.

2 ADVICE FOR POTENTIAL LIFE-THREATENING CONDITIONS FOR WOMEN ONCE DISCHARGED HOME FOLLOWING DELIVERY

Mother

Signs & Symptoms	Condition	Action
Sudden and profuse blood loss or persistent increased blood loss	Postpartum haemorrhage	**Call 999 for urgent attention.**
Faintness, dizziness, palpitations/tachycardia	Postpartum haemorrhage Infection	Seek medical attention/ contact the MAMAS Line.
Fever, shivering, abdominal pain, offensive lochia	Infection	Seek medical attention/ contact MAMAS Line.
Headaches accompanied by visual disturbances, nausea or vomiting within 72 hours of birth	Pre-eclampsia Eclampsia	Seek medical attention/ contact MAMAS Line.
Fever, breasts painful and red	Mastitis	Seek medical attention contact MAMAS Line/GP.
Unilateral calf pain redness or swelling. Shortness of breath or chest pain.	Thromboembolism	**Call 999 if life threatening symptoms/attend ED.**

Baby

Signs & Symptoms	Action
High pitched or weak cry Much less responsive or floppy Pale all over Grunts with each breath or chest recession Not feeding Passes much less urine Vomits green fluid Blood in stools Sweating Temperature <36C or >38C	For immdiate life threatening symptoms call 999. If baby is stable parents should contact MAMAS Line. If community midwife is present and baby is stable the Paediatric Registrar can be contacted directly via the switchboard to arrange an appropriate location for the baby to be reviewed.

Stops breathing or goes blue / grey Is unresponsive and cannot be woken shows no awareness of surroundings Has glazed eyes, does not focus Has a fit	Call 999 for urgent attention.

3 RECOGNISING NORMAL PHYSIOLOGICAL INVOLUTION AND LOCHIA

3.1 The uterus should be palpated immediately post-delivery, and before and after transfer to the postnatal ward, ensuring that the bladder has recently been emptied. The fundus should be palpated at each postnatal examination. The amount / duration / sequential changes of lochia over the puerperium varies with each individual woman and with breastfeeding. Women should be advised to change sanitary pads regularly and to refer to a midwife if concerned about amount/nature of lochia, women should be advised to notify a midwife if they pass clots bigger than a fifty pence piece[(1)].

3.2 Postpartum Haemorrhage (PPH) Any moderate to heavy vaginal blood loss, rise in fundal height / atony / bulkiness and or pain following delivery the women should be reviewed urgently by an obstetrician. However if these symptoms are accompanied by signs of hypovolemia an obstetric emergency 2222 call should be made and the emergency box and emergency PPH drugs should be taken to where the woman is situated.

Please refer to the current ‘Postpartum haemorrhage guideline’.

3.3 Genital Sepsis.

Postpartum women are more susceptible to genital tract sepsis; however, the symptoms may be less distinctive so a low threshold to treat for sepsis should be taken. Disease progression may be rapid and women with constant severe abdominal pain and tenderness should be reviewed promptly.[(8)(9)] Increased vaginal blood loss or offensive vaginal loss / odour and / or scoring on MEOWS would prompt an urgent clinical review. Refer to the current Maternity Sepsis Screening tab with the Sepsis navigator on Epic and current ‘Sepsis in Pregnancy and Puerperium’ guideline.

3.4 Sepsis

The key actions for diagnosis and management of sepsis are:

- Timely recognition
- Prompt senior doctor review/invovlement
- Fast administration of intravenous antibiotics

If the woman in your care looks sick or the MEOWS has triggered, use the current Maternity Sepsis Screening tab with the Sepsis navigator on Epic and current ‘Sepsis in Pregnancy and Puerperium’ guideline, this will allow recognition, diagnosis and early intervention leading to better maternal outcome[(8)].

Midwives seeing women postnatally that present as unwells should use the Maternity Sepsis Screening tab within the Sepsis navigator on Epic and refer to the current ‘Sepsis in Pregnancy and Puerperium’ guideline. If sepsis is suspected in the mother then a timley referral/senior review should be requested/organised. The baby will also need to be referred to the neonatal team for review/assessment.

3.5 Management of perineum (including dehiscence and haematoma) and dyspareunia.

Perineal care begins with the timely, efficient repair of the trauma. It continues with the recognition that women need adequate analgesia and comfort if the trauma is not to affect every aspect of their life with a new baby. It finishes when they are comfortable and feel able to resume their sex life without discomfort (dyspareunia). Perineal repair is covered by the guideline for 'repair of perineal trauma'.

The importance of hand washing before and after changing pads must be emphasized to reduce possibility of Streptococcal A genital sepsis.
At each postnatal contact, women should be asked if they have any concerns about the healing of any perineal wound. This could include perineal pain, discomfort or stinging, offensive odour or dyspareunia

- The healthcare professional should offer to assess the perineum at each postnatal daily check whilst an inpatient and once discharged at each community visit.
- Adequate pain relief should be provided or prescribed if necessary.

3.6 Perineal wound dehiscence

This occurs when the wound edges separate, possibly due to oedematous/friable tissue or infection.

- Exclude sepsis, pyrexia, and tachycardia
- Obtain perineal swab with consent
- Document all findings on Epic
- Arrange GP/SHO/REG review
- Consider antibiotic therapy
- Consider involvement of the Tissue Viability Team if appropriate
- Advise that re-suturing is unlikely to help

3.7 Perineal wound haematoma

This occurs when vessels bleed into the vaginal wall resulting in a deep purple swelling and intense pain usually worse on standing. It can cause rapid onset of shock and anaemia

- Treat for shock
- Record observations on EPIC.
- Examine wound/perineum including digital vaginal examination
- Offer analgesia (e.g., paracetamol or NSAID if not contraindicated)
- Notify GP/SHO/Registrar
- Possible exploration under anaesthetic to ligate bleeding vessel
- Blood transfusion if required
- Document all findings on Epic

3.8 Dyspareunia

Painful vaginal intercourse associated with perineal pain is common postpartum (12-62% at 3 months, 17-45% at 6 months and 8-32% 12-18months). Pain negatively affects women's relationships, physical and mental health and overall well-being, yet it remains underdiagnosed and untreated.[10][11]

Women who continue to express anxiety about sexual health problems or who experience pain on intercourse should be referred to a doctor.

3.9 Management of micturition, retention and incontinence

Micturition

There is a natural diuresis due to reabsorption of the increased fluid and breakdown of myometrium during involution. In the absence of firm evidence, good practice supports spontaneous micturition within 6 hours of delivery.

The time and quantity of first void should be documented, if the first void is less than 150mls a further 2 documented voids are required. Refer to Intrapartum and Postpartum Bladder Care guideline if voids are low volume.

If no void after 6 hours refer to current Intrapartum and Postpartum Bladder Care guideline.

Incontinence

All women should be advised to do pelvic floor exercises in conjunction with the information on the discharge leaflet/EPIC. Overflow due to retention should be considered for women experiencing incontinence, particularly when experiencing small voids and/or poor flow.
Persistent or worsening involuntary leakage must be evaluated with physiotherapy referral.
Also refer to the 'Intrapartum and Postpartum Bladder Care guideline'.

3.10 Management of mental health and emotional wellbeing.

Mental health problems remain a leading cause of death in pregnancy and the 12 months after birth, so the messages for women and families remain the same – speak out and get treated early by a specialist team. Health professionals should therefore use each postnatal contact as an opportunity to sensitivley ask about mental health[12].

Suicide continued to be the leading cause of direct maternal death (39%) between 2019 - 2021. With 37% of these women known to have a previous or existing mental health condition. 12% experienced servere and multiple disadvantages, including substance misuse, domestic abuse and mental illness.[12]

For women with a known mental health history, referral would have been made to our Perinatal and Mental Health midwives; these women should be contacted in the antenatal period and support networks put in place if needed.

It is important to

- Note any previous mental health history
- Ask about the woman's mood and emotional well being at each contact
- Ask about her family and social support networks
- Ask about her normal day to day coping strategies
- Involve the partner in support, ask regarding their concerns about her wellbeing
- Observe maternal demeanour, interactions with her baby and behaviour
- Enquire about sleeping and fatigue
- Offer opportunity to discuss the experience of childbirth and debriefing
- Evaluate for "baby blues", signs of postnatal depression
- Encourage pro-active care of own mental health and early access to resource, e.g., social support networks.

4 MANAGEMENT OF HEADACHE, FATIGUE, BACKACHE

Headache, backache and fatigue are commonly reported postnatal symptoms but can also be associated with more serious pathologies, e.g., pre/eclampsia, post-dural puncture, anaemia and post natal depression. Therefore at each postnatal contact women should be asked if they are experiencing any of these symptoms:

- Headache

Mild headaches can be managed with simple analgesia and hydration. Tension or migraine headaches may abate/resolve with relaxation and avoidance strategies. Severe headache should always be reviewed by a doctor, especially if there is a sudden onset, it is unbearable, or is associated with neck stiffness or neurological symptoms. Check blood pressure and refer to Hypertensive Disorders in Pregnancy guideline if appropriate.

Severe and/or postural headache, especially following epidural /spinal anaesthesia may indicate dural tap. Suspected post-dural puncture headaches can be temporarily relieved with caffeine in coffee or caffeinated soft drinks[13].

Early referral to anaesthetists is advised: blood patch maybe considered.

- Backache

This may be associated with epidural /spinal anaesthesia.
There is inconclusive evidence to advocate the use of lumbar supports and no evidence to support specialist or on-going physiotherapy.

Consider sepsis as a cause for backache, especially in streptococcal A infection.

- Fatigue

If a woman is experiencing persistent fatigue, advice may be needed to help her plan strategies including rest, diet and spending time with the baby.[1][2] Where persistent fatigue impacts on the woman's ability to care for herself or the baby, underlying physical, psychological and social causes should be evaluated. Haemoglobin levels should be checked and treated if necessary.

5. POSTNATAL IMMUNISATION

BCG vaccination will be offered to all at risk babies. A BCG clinic appointment must be ordered on Epic prior to discharge. Parents will then be invited to an outpatient BCG vaccination clinic appointment. Parents should receive a information leaflet and be informed that this is an opt-out service.

6. ANTI D IMMUNOGLOBULIN

For women carrying a known Rh negative fetus, immediately following delivery cord blood and maternal blood should be taken and sent. If the cord blood confirms that the baby's blood group is Rh negative, no further action is required. If the blood group is found to be Rh positive, place an Epic order for 1500iu Anti D and administer to the woman within 72hrs of delivery; administer further Anti D as per Kleihauer result. Ensure a RL has been completed for the false negative result.

For women carrying a known Rh positive fetus, immediately following delivery take maternal blood only and place an Epic order for 1500iu Anti D and administer within 72hrs of birth; administer further Anti D as per Kleihauer result. Cord blood is not required.

For women that are Rh negative but who have not had the fetal RhD testing, immediately following delivery take cord and maternal blood. If the baby's blood group comes back as Rh positive, administer Anti D within 72hrs of delivery and further Anti D as per Kleihauer result. Rh negative cord blood results need no further action.

Women should not be sent home without having Anti D if required and the labs should be able to issue this with in 1 hour of receiving samples.

7. CONTRACEPTION

Faculty of Sexual & Reproductive Healthcare[14] recommends that effective contraception is commenced as soon as possible after delivery by both breastfeeding and non-breastfeeding mothers.

Community midwives discuss contraception with women during their 28 week antenatal appointment and women who were planned for an elective caesarean section should have been offerred the insertion of an IUS/IUD when the caesarean section was requested.

Midwives should discuss contraception as part of the discharge process[15] and women who have not had an IUS/IUD should be offered a 3-month supply of the progesterone only pill, women that accept this offer should be administered this prior to discharged with a TTA letter and be informed to contact their GP for further prescriptions. Women who do not wish to start contraception at discharge should be advised that they can access contraceptive care via their GP surgery.

8 THE POSTNATAL TRANSFER/DISCHARGE OF THE MOTHER WHEN HER BABY IS TRANSFERRED TO ANOTHER HOSPITAL

This is for mothers of babies who have to be transferred out to other units to receive specialist care. The purpose is to ensure mothers continue to receive safe and effective postnatal care.

8.1 The midwife/obstetrician should review the mother to ascertain if she is fit for discharge from the ward, or requires on-going inpatient care.

Either:

- A mother who is fit should be discharged according to the normal procedure on the unit
- A bed should be requested on the appropriate ward of the receiving hospital for a mother who is not fit for discharge

8.2 A mother who is fit for discharge:

- Contact the neonatal unit to determine the facilities available for mothers to stay with their babies and if midwifery care is available for the mother's postnatal checks
- Ensure postnatal care is arranged either in the community or in the receiving unit
- Give the mother a copy of her Epic discharge summary for her to share with the midwife providing her care
- Ensure all relevant pathology results are documented on the Epic discharge summary.
- Ensure the woman has a follow up appointment for any ongoing medical conditions if appropriate eg haematology, diabetes
- If the mother is consult-led care Inform the consultant obstetrician and document on Epic.
- Inform the GP and community midwife of discharge via normal protocol
- Provide address/telephone details of the hospital where her baby has been transferred to – this is likely to have been done by NNU, but please ensure that the mother has this information.
- If wishing to breastfeed, ensure that the mother has access to a breast pump and has been given advice on the storage of breast milk.

8.3 A mother who requires transfer to another hospital

- Contact the transferring hospital's postnatal ward to check if a postnatal bed is available.
- Give the mother a copy of her Epic discharge summary for her to share with the midwifery/obstetric staff receiving her care.
- Ensure all pathology results/action plans are documented and printed copies sent with the mother
- Ensure the woman has a follow up appointment for any ongoing medical conditions if appropriate, e.g., haematology, diabetes
- Inform the GP and community midwife of the transfer via normal protocol
- Once assessed fit for transfer, the mother may travel in the family car to the admitting hospital. If ongoing care is required the mother should travel in a paramedic ambulance with a midwife escort.
- Inform the consultant obstetrician and document in the Epic record.
- When discharging on Epic please complete the 'transfer of care to other services' tab within the navigators.

9 AUDITABLE STANDARDS

- Postnatal checks for both mother and baby are carried out as per the guideline.
- Women are signposted to the relevant postnatal information via leaflet / My Frimley Health App / Online.

10 MONITORING

This guideline will be subject to three yearly audit. The audit midwife is responsible for coordinating the audit. Results will be presented to the department clinical audit meeting.

Action plans will be monitored at the quarterly department clinical governance meeting.

11 COMMUNICATION

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness), staff will take appropriate measures to ensure the woman (and her partner, if appropriate) understand the actions and rationale behind them.

12 EQUALITY IMPACT ASSESSMENT

This guideline has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any group.

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Full version control record

Version:	2.0
Guidelines Lead(s):	Kirstie Wells Inpatient Matron (FPH), Abigail Jurd Midwife (FPH).
Contributor(s):	Fiona Lewis Infant Feeding Lead (FPH)
Lead Director / Chief of Service:	Anne Deans
Library check completed:	20/03/2024
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Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Postnatal, PN, checks, baby, newborn, transfer

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	January 2019	Kirstie Fisher, Midwife (FPH), Theresa Thomas (FPH) and Sam Thompson (WPH)	final	First cross site version
1.1	June 2020	Kirstie Fisher, Midwife (FPH), Theresa Thomas (FPH) and Sam Thomson (WPH)	Interim	Amendments by J. Cruse, T. Santacaterina: Addition of care of baby and the postnatal transfer/discharge of the mother when her baby is transferred to another hospital
1.2	March 2024	Kirstie Wells, Midwifery Matron (FPH), Abigail Jurd, Midwife (FPH)	Draft	Scheduled review, updated to reflect EPIC
2.0	May 2024	K Wells Inpatient Matron (FPH), A Jurd Midwife (FPH).	Final	Approved at Cross site Obstetric Clinical Governance Meeting 21/5/24

Related Documents

Document Type	Document Name
Trust Guideline	Thromboprophylaxis and the treatment of VTE in pregnancy and puerperium
Trust Guideline	Infant Feeding
Trust Guideline	Post Partum Haemorrhage (PPH)
Trust Guideline	Perineal Trauma
Trust Guideline	Intrapartum and Postpartum Bladder Care
Trust Guideline	Hypertensive Disorders in Pregnancy
Trust Guideline	Contraception in the immediate postnatal period
Trust Guideline	Term Healthy Breastfeeding Infant who is Reluctant to Feed
Trust Guideline	Neonatal Jaundice
Trust Guideline	Weight Loss in Term Healthy Breastfed Infant
Trust Guideline	Perinatal Mental Health