Document Control

Title

Post Natal Care Planning & Post Natal Information Guideline

Author	**Author's job title**
	Midwife NDDH Bassett Ward Manager
Directorate Women's and Children's	**Department** Maternity Services

Version	Date Issued	Status	Comment / Changes / Approval
3.0	May 2011	Final	Approved by Guideline Group 19th May 2011 and Maternity Patient Safety Forum on 19th May 2011.
3.1	Aug 2011	Revision	Minor Amendments by Corporate Governance to document control report, header and footer, new table of contents, and re-formatted for document map navigation.
3.2	Sep 2011	Revision	New appendix B added and minor amendments by Corporate Governance.
3.3	Apr 2013	Revision	Minor Amendments to reflect the use of Perinatal Institute Postnatal note for Mother and for Baby.
4.0	Jun 2013	Final	Approved by Guideline Group 12th June 2013 and Maternity Patient Forum on 12th June 2013.
4.1	Jun 2013	Revision	Minor amendments by Corporate Governance to version control, document control report, formatting for document map navigation and table of contents. Hyperlinks added.
4.2	Aug 2014	Revision	Addition of Post Natal Discharge from Hospital to Community Midwife Form.
4.3	Nov 2017	Revision	Minor amendments to implementation, table of contents, role of Midwife and Multi-disciplinary teams, Vitamin K, SIDS, immunisation, Guideline re-formatted for document map navigation. Hyperlinks added.

Main Contact	
Midwife & Postnatal Manager Normal birth and Inpatient Services North Devon District Hospital Raleigh Park Barnstaple, EX31 4JB	**Tel: Direct Dial** – 01271 322605/322612 **Tel: Internal** – Ext. 2605/2612
Lead Director Director of Nursing/Operations	
Superseded Documents Not Applicable	

Issue Date	**Review Date**	**Review Cycle**
Nov 2017	Nov 2020	Three years

Consulted with the following stakeholders: • Infection Control • Senior Midwives • Obstetricians and Gynaecologists • Surgical Directorate Management • Women and children's pharmacist
Approval and Review Process: • Maternity Guidelines Group • Drugs and therapeutics committee
Local Archive Reference G:\ Antenatal clinic **Local Path** \ Polices and Guidelines **Filename** Post Natal Care Planning & Post Natal Information Guideline v4.3 Sep 2014

Policy categories for Trust's internal website (Bob)	**Tags for Trust's internal website (Bob)**
Obs and Gynae	Post Natal Care

CONTENTS

1. Purpose

1.1 This document sets out Northern Devon Healthcare NHS Trust's best practice guidelines for the essential core (routine) care that every woman and her baby should receive in the first 6–8 weeks after birth, based on the best evidence available.

1.2 The policy applies to Midwifery Staff/all Trust staff

1.3 The following guideline is based on the best available evidence. It is predominantly centred on the full guideline www.nice.org.uk/CG037 'Postnatal care: routine postnatal care of women and their babies' giving details of the methods and the evidence used to develop this guidance.

1.4 The following guideline has also been adapted in some areas of postnatal care to reflect current NDDH Trust guidelines and Local policy.

1.5 Implementation of this policy will ensure that:

- Best practice advice on the core care of women and babies during the postnatal period is given.
- Women and their families should always be treated with Kindness, respect and dignity.
- The views, beliefs and values and the woman, her partner and her family in relation to her care and that of her baby should be respected at all times.
- Women should be fully involved in planning the timing and content of each postnatal care contact so that care is flexible and tailored to meet her and her baby's needs.
- Women should have the opportunity to make informed decisions about their care and any treatment needed.
- Where women do not have the capacity to make decisions, healthcare professionals should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk).
- Good communication between healthcare professionals and the woman and her family is essential. It should be supported by provision of evidence-based information offered in a form that is tailored to the needs of the individual woman.
- Care and information should be appropriate and the woman's cultural practices should be taken into account. All information should be provided in a form that accessible to women, their families, taking into account any additional needs, such as physical, cognitive or sensory disabilities, and people who do not speak or read English.
- Every opportunity should be taken to provide the woman and her partner or other relevant family members with the information and support they need.
- To advise on appropriate objectives, purpose, content and timing of postnatal contact and care for the woman and her baby.
- To advise on best practices and competencies for assessment of postnatal health and management of postnatal problems in the woman and/or her infant.
- To advise on information, education and support required during the postnatal period.
- To consider good practice in communication between healthcare providers and women.

2. Definition of Postnatal Care

The postnatal period or 'puerperium' is traditionally defined as the time immediately following the birth until the reproductive organs have returned as nearly as possible to their pre pregnant condition, a period estimated to be around 6-8 weeks.

3. Responsibilities

3.1 Role of the Midwife

The Midwife is responsible for:

- Ensuring that all women and their babies receive optimal patient centred care during their postnatal period that is adapted to their individual needs and circumstances for safe and effective, up to date care to be given.
- Ensuring Midwives act as advocate for women, their babies and families by fully informing them on the best available evidence enabling them to understand and make fully informed choices to be involved in their own care planning during to postnatal period.
- Effective communication is essential for Midwives including clear and accurate documentation.
- Ensuring that all appropriate multidisciplinary teams are involved that should be involved according to an individual's needs and circumstances.
- Ensuring that all referrals to the multidisciplinary teams are dealt with in a timely manner for optimal care and outcomes.
- Ensuring accuracy of information in the discharge documentation and checking the correct information and documentation is given to the correct woman on discharge.
- Ensuring all training required by the Trust and Maternity Service is completed and current to best practice and policy.

3.2 Role of the Multidisciplinary group

The Multidisciplinary group is responsible for:

- Ensuring that all appropriate services and expertise, based on an individual's needs and circumstances, if are required, are utilised in a timely and effective manner to achieve optimal care. Effective communication is essential between multidisciplinary teams, including clear and concise documented care plans for continuity of care to be given including any follow up arrangements during the postnatal period.
- Ensuring accuracy of information in the discharge documentation and checking the correct information and documentation is given to the correct woman on discharge.

4. Planning the content and delivery of care

4.1 Principles of care

Each postnatal contact should be provided in accordance with the principles of individualised care.

A coordinating healthcare professional usually the midwife should be identified for each woman and the details documented on the front of the Perinatal Institute Postnatal notes for Mother. Whilst the woman and baby are inpatients Healthcare professionals will be allocated on a shift basis providing continuity of care where possible. On discharge the women and baby care is transferred to a named midwife and associated team members by telephone and clearly documented in the hospital records. A discharge summary is to be completed with patient's correct details and placed in the relevant discharge summary.

A documented, individualised postnatal care plan should be developed with the woman, ideally in the antenatal period or as soon as possible after birth. This should include:

- Relevant factors from the antenatal, intrapartum and immediate postnatal period.
- Details of the healthcare professionals involved in her care and that of her baby, including roles and contact details.
- Details of emergency contact numbers for use during Post Natal period if a problem develops for mother or baby.
- Plans for the postnatal period.

This should be reviewed at each postnatal contact and documented in the Perinatal Institute Postnatal notes for Mother.

Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognise and respond to problems, this information is contained in the Perinatal Institute Postnatal notes for Mother and for Baby.

At each postnatal contact the healthcare professional should:

- Ask the woman about her health and well-being and that of her baby. This should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed.
- Offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion.

- Encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions.

- Document in the care plan all discussions with the woman along with any specific problems and follow-up.

On discharge from hospital the patient will be provided with Perinatal Institute Postnatal notes for Mother and for Baby and all leaflets containing information pertaining to postnatal care for the mother and baby as part of the discharge package. Issue of the discharge package and any other information provided to the woman should be recorded in the individual patient maternity records.

4.2 Professional Communication

Healthcare professionals should be provided with and encouraged to use hand-held maternity records, the postnatal care plans and personal child health records, to promote communication with women. It is the Health visitor's responsibility to ensure the woman receives the child health record, it is the midwife's responsibility to ensure the birth details for the baby and details of care given during the first 10 days are entered on the child health record in a contemporaneous manner.

Once the midwife has assessed that mother and baby are fit to discharge from Maternity services the midwife must ensure that she gives a comprehensive handover of care to the Health Visiting team and that this is clearly documented in the Perinatal Institute Postnatal notes for Mother and for Baby.

If the baby is being discharged from the Special Care Baby Unit into midwifery care a comprehensive handover must be given to the midwife caring for the mother and baby and clearly documented into the Perinatal Institute Postnatal notes for Baby.

If the baby is being discharged from Special Care Baby Unit into Health Visiting care a comprehensive handover must be given to the Health Visitor caring for the mother and baby and clearly documented in the child health record book.

If a woman with multi-agency or multi-disciplinary needs is identified, a co-ordinating healthcare professional will be assigned to her care. The coordinating healthcare professional, normally the midwife, will ensure that the appropriate agencies are involved with the woman's and / or babies care needs, ensuring that the agencies receive all relevant documentation related to the care episode.

Escalation, Communication and Record Keeping in Maternity Guideline

A summary of the labour will be sent to the GP and a copy provided to the Health Visitor in the discharge pack including a copy for the Mother.

Documentation of this should be recorded in the Perinatal Institute Postnatal notes for Mother.

5. Maternal Health

5.1 Information giving

At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions (see Table 2 below) and to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur.

Table 2: Signs and symptoms of potentially life-threatening conditions

Signs and symptoms	Condition
Sudden and profuse blood loss or persistent increased blood loss Faintness, dizziness or palpitations/tachycardia	Postpartum haemorrhage
Fever, shivering, abdominal pain and/or offensive vaginal loss, High or low temp >38.0 <36.0	Infection/Sepsis
Headaches accompanied by one or more of the following symptoms within the first 72 hours after birth: • visual disturbances • nausea, vomiting	Pre-eclampsia/eclampsia
Unilateral calf pain, redness or swelling Shortness of breath or chest pain	Thromboembolism
Any deterioration or prolonged episodes of emotional, mental unbalance. See 5.3 on page 12	Mental Health
E.g. Cardiac disease	Pre-existing medical conditions

- Normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (within 3 days).
- Common health concerns as appropriate (weeks 2–8)

5.2 Life-Threatening conditions: Core care and raised concern

5.2.1 Postpartum haemorrhage

Obstetric Haemorrhage Guideline

In the absence of abnormal vaginal loss, assessment of the uterus by abdominal palpation or measurement as a routine observation is unnecessary.

Assessment of vaginal loss and uterine involution and position should be undertaken in women with excessive or offensive vaginal loss, abdominal tenderness or fever. Any abnormalities in the size, tone and position of the uterus should be evaluated. If no uterine abnormality is found, consider other causes of symptoms (urgent action).

Sudden or profuse blood loss, or blood loss accompanied by any of the signs and symptoms of shock, including tachycardia, hypotension, hypo-perfusion and change in consciousness, should be evaluated (emergency action).

5.2.2 Genital tract sepsis

Maternal Sepsis Guideline

The findings of Mbrrace report (2015) place sepsis as the leading cause of direct maternal deaths. Therefore, an understanding of the risk factors for and during the postnatal period including signs and symptoms of sepsis is vital for professionals to recognise. They must act on with urgency to any abnormal findings for optimal care to be given.

Previous reports have found substandard care, mainly a delay in diagnosis to have attributed to patients deterioration or actual demise.

In the absence of any signs and symptoms of sepsis, routine assessment of temperature is unnecessary.

Temperature should be taken and documented if sepsis is suspected. If the temperature is 37.5 or above on 2 separate occasions and 2hrs apart or a single temp 38.0 or above or below a temp 36.0 and/or other observable signs and symptoms of sepsis (Maternal Pulse above 100bpm, raised respiratory rate above 20, Low O2 sats) further prompt action is needed (emergency action).

Labour ward or senior Obstetrician should be contacted so the appropriate sepsis assessment care pathway can be activated and treatment commenced immediately and according to results and findings.

Clear care plans, with a review should be clearly documented. SBAR's should be used including full completion of early warning charts (MEOWS), together with fluid balance charts, Risk assessment charts, VTE prophylaxis and Maternal Sepsis Tool.

A multidisciplinary approach may be needed dependant on the severity of the symptoms and results of the individual.

5.2.3 Pre-eclampsia/eclampsia

Management of Severe Pre-Eclampsia & Eclampsia Guidelines

A minimum of one blood pressure measurement should be carried out and documented within 6 hours of the birth.

Routine assessment of proteinuria is not recommended.

Women with severe or persistent headache should be evaluated and pre-eclampsia considered (emergency action).

If diastolic blood pressure is greater than 90 mm Hg and / or systolic blood pressure greater than 160mm Hg, and there are no other signs and symptoms of pre-eclampsia, measurement of blood pressure should be repeated within 4 hours.

If diastolic blood pressure is greater than 90 mm Hg and / or systolic blood pressure greater than 160mm Hg, accompanied by another sign or symptom of pre-eclampsia, evaluate further (emergency action).

If diastolic blood pressure is greater than 90 mm Hg and / or systolic blood pressure greater than 160mm Hg and does not fall below 90 mm Hg 0r 160 mm Hg within 4 hours, evaluate for pre-eclampsia (emergency action).

5.2.4 Thromboembolism

Reducing the risk of thrombosis and embolism during pregnancy and the puerperium – Guideline

All women who are admitted to Labour ward or Bassett ward should be measured and appropriate fitting TED stockings applied.

Women should be encouraged to mobilise as soon as appropriate following the birth with each patient being individually risk assessed using the VTE assessment tool in the Purple Postnatal notes. If women are high risk the appropriate management for prevention of a venous thromboembolism is to be commenced. Clear documentation is essential if a high risk patient declines any preventative measures.

Women who present with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis (emergency action).

Women experiencing shortness of breath or chest pain should be evaluated for pulmonary thromboembolism (emergency action).

Routine use of Homan's sign as a tool for evaluation of thromboembolism is not recommended.

Obese women are at higher risk of thromboembolism and should receive individualised care.

5.3 Mental health and well-being

Women who present with Mental Health Concerns in the Perinatal Period Guideline

At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.

Formal debriefing of the birth experience is not recommended.

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

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

5.4 Physical health and well-being

5.4.1 Perineal care

At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound;
The healthcare professional should offer to assess the perineum if the woman has pain or discomfort.

Women should be advised that topical cold therapy, for example crushed ice or gel pads, are effective methods of pain relief for perineal pain.

If oral analgesia is required, paracetamol should be used in the first instance unless contraindicated.

If cold therapy or paracetamol is not effective a prescription for oral or rectal non-steroidal anti-inflammatory (NSAID) medication should be considered in the absence of any contraindications (non-urgent action).

Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated (urgent action).

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

5.4.2 Dyspareunia

Women should be asked about resumption of sexual intercourse and possible dyspareunia 2–6 weeks after the birth.

If a woman expresses anxiety about resuming intercourse, reasons for this should be explored.

Women with perineal trauma who experience dyspareunia should be offered an assessment of the perineum. (See perineal care section)

A water-based lubricant gel to help ease discomfort during intercourse may be advised, particularly if a woman is breastfeeding.

Women who continue to express anxiety about sexual health problems should be evaluated (non-urgent action) and referred to the appropriate healthcare professional.

5.4.3 Headache

For severe headache see section on pre-eclampsia/eclampsia.

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

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

Management of mild postnatal headache should be based on differential diagnosis of headache type and local treatment protocols.

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

5.4.4 Fatigue

Women who report persistent fatigue should be asked about their general well-being, and offered advice on diet, exercise and planning activities, including spending time with her baby.

If persistent postnatal fatigue impacts on the woman's care of herself or baby, underlying physical, psychological or social causes should be evaluated.

If a woman has sustained a postpartum haemorrhage, or is experiencing persistent fatigue, her haemoglobin level should be evaluated and if low, treated according to local policy.

5.4.5 Backache

Women experiencing backache in the postnatal period should be managed as in the general population.

5.4.6 Constipation

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

Women who are constipated and uncomfortable should have their diet and fluid intake assessed and offered advice on how to improve their diet.

A gentle laxative may be recommended if dietary measures are not effective.

5.4.7 Haemorrhoids

Women with haemorrhoids should be advised to take dietary measures to avoid constipation and should be offered appropriate management.

Women with a severe, swollen or prolapsed haemorrhoid or any rectal bleeding should be reviewed by the appropriate medical team.

5.4.8 Faecal incontinence

Women with faecal incontinence should be assessed for severity, duration and frequency of symptoms. If symptoms do not resolve, evaluate further (urgent action).

5.4.9 Urinary retention

Bladder Care Guidelines

Urine passed within 6 hours of urination during labour should be documented.

If urine has not been passed within 6 hours after the birth, efforts to assist urination should be advised, such as taking a warm bath or shower.

If urine has not been passed by 6 hours after the birth and measures to encourage micturition are not immediately successful, bladder volume should be assessed and catheterisation considered (urgent action).

5.4.10 Urinary incontinence

Women with involuntary leakage of a small volume of urine should be taught pelvic floor exercises.

Women with involuntary leakage of urine which does not resolve or becomes worse should be evaluated.

5.4.11 Contraception

Methods and timing of resumption of contraception should be discussed within the first week of the birth or as part of the postnatal discharge discussion prior to discharge from hospital.

The coordinating healthcare professional should provide proactive assistance to women who may have difficulty accessing contraceptive care. This includes providing contact details for expert contraceptive advice.

5.4.12 Immunisation

Anti-D immunoglobulin should be offered to every non-sensitised Rh-D-negative woman within 72 hours following the delivery of an RhD-positive baby.

The MMR vaccine is no longer given to sero-negative women prior to discharge. It is for the women's G.P. to follow up in the community if required. MMR if needed should be given 3 months after anti-D (Rh0) immunoglobulin.

5.5 Safety – Domestic Abuse

Domestic Violence and Abuse Policy

Healthcare professionals should be aware of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management, following guidance from the Department of Health and Trust Guidelines.

5.6 6-8 week check

At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social well-being is reviewed. Screening and medical history should also be taken into account.

6. Maintaining infant health

The purpose of this section of the guidance is to provide the framework for the healthcare professional, with the parents, to facilitate the health and well-being of a baby up to 8 weeks old.

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

- Respiratory rate normally 30–60 breaths per minute.
- Heart rate normally between 100 and 160 beats per minute in a newborn.
- Temperature in a normal room environment of around 37°C (if measured).

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

- Assess their baby's general condition.
- Identify signs and symptoms of common health problems seen in babies.
- Contact a healthcare professional or emergency service if required.

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

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

6.1 Newborn feeding

For Baby Friendly feeding guideline, refer to the link below:-

Newborn Infant Feeding Policy

6.2 Parenting and emotional attachment

Assessment for emotional attachment should be carried out at each postnatal contact.

Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment.

Women should be encouraged to develop social networks as this promotes positive mother/baby interaction.

Group based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them.

Healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit.

6.3 Physical examination and screening

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

A complete examination of the baby recommended by the Newborn Infant Physical Examination Programme Standards (NIPE, 2016/17) should take place within 72 hours of birth. This examination should incorporate a review of parental concerns and the baby's medical history should also be reviewed including: family, maternal, antenatal and perinatal history; fetal, neonatal and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine (and urine stream in a boy).

A physical examination should also be carried out. This should include checking the baby's:

- Appearance including colour, breathing, behaviour, activity and posture
- Head (including fontanelles), face, nose, mouth including palate, ears, neck and general symmetry of head and facial features. Measure and plot head circumference
- Eyes; check opacities and red reflex
- Neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry
- Heart; check position, heart rate, rhythm and sounds, murmurs and femoral pulse volume
- Lungs; check effort, rate and lung sounds
- Abdomen; check shape and palpate to identify any organomegaly; also check condition of umbilical cord
- Genitalia and anus; check for completeness and patency and undescended testes in males
- Spine; inspect and palpate bony structures and check integrity of the skin
- Skin; note colour and texture as well as any birthmarks or rashes
- Central nervous system; observe tone, behaviour, movements and posture. Elicit newborn reflexes only if concerned
- Hips; check symmetry of the limbs and skin folds (perform Barlow and Ortolani's manoeuvres)

- Cry; note sound
- Weight; measure and plot.

The newborn blood spot test should be offered to parents when their baby is 5–days old.

At 6–8 weeks, a neonatal examination should be carried out. In addition, an assessment of social smiling and visual fixing and following should be carried out.

A hearing screen should be completed before discharge from hospital or by week 4 in the hospital programme or by week 5 in the community programme.

Parents should be offered routine immunisations for their baby according to the schedule recommended by the Department of Health.

6.4 Physical health and well-being

Information for parents can be found on pages in the Perinatal Institute Postnatal notes for Baby.

6.5 Jaundice

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

Babies who develop jaundice within the first 24 hours after birth should be evaluated (emergency action).

If jaundice develops in babies aged 24 hours and older, its intensity should be monitored and systematically recorded along with the baby's overall well-being with particular regard to hydration and alertness.

The mother of a breastfed baby who has signs of jaundice should be actively encouraged to breastfeed frequently, and the baby awakened to feed if necessary.

Breastfed babies with jaundice should not be routinely supplemented with formula, water or dextrose water.

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

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

6.6 Skin

Parents should be advised that cleansing agents should not be added to a baby's bath water nor should lotions or medicated wipes be used. The only cleansing agent suggested, where it is needed, is a mild non-perfumed soap.

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

6.7 Thrush

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

Thrush should be treated with an appropriate antifungal medication if the symptoms are causing pain to the woman or the baby or feeding concerns to either.

If thrush is non-symptomatic, women should be advised that antifungal treatment is not required.

6.8 Nappy rash

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

- Hygiene and skin care
- Sensitivity to detergents, fabric softeners or external products that have contact with the skin
- Presence of infection.

If painful nappy rash persists it is usually caused by thrush, and treatment with antifungal treatment should be considered.

If after a course of treatment the rash does not resolve, it should be evaluated further (non-urgent action).

6.9 Constipation

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

If a baby is constipated and is formula fed the following should be evaluated: (urgent action).

- Feed preparation technique
- Quantity of fluid taken
- Frequency of feeding
- Composition of feed.

6.10 Diarrhoea

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

6.11 Colic

A baby who is crying excessively and inconsolably, most often during the evening, either drawing its knees up to its abdomen or arching its back, should be assessed for an underlying cause, including infant colic (urgent action).

Assessment of excessive and inconsolable crying should include:

- General health of the baby
- Antenatal and perinatal history
- Onset and length of crying
- Nature of the stools
- Feeding assessment
- Woman's diet if breastfeeding
- Family history of allergy
- Parent's response to the baby's crying
- Any factors which lessen or worsen the crying.

Healthcare professionals should reassure parents of babies with colic that the baby is not rejecting them and that colic is usually a phase that will pass. Parents should be advised that holding the baby through the crying episode, and accessing peer support may be helpful.

Use of hypoallergenic formula in bottle-fed babies should be considered for treating colic, but only under medical guidance.

Dicycloverine (dicyclomine) should not be used in the treatment of colic due to side effects such as breathing difficulties and coma.

6.12 Fever

The temperature of a baby does not need to be taken, unless there are specific risk factors, for example maternal pyrexia during labour.

When a baby is suspected of being unwell, the temperature should be measured using electronic devices that have been properly calibrated and are used appropriately.

A temperature of 38°C or more is abnormal and the cause should be evaluated (emergency action). A full assessment, including physical examination, should be undertaken and appropriate neonatal early warning (NEWS) charts to be completed if an inpatient.

6.13 Vitamin K

Vitamin K Administration Guidelines for Neonates

All parents should be offered vitamin K prophylaxis for their babies to prevent the rare but serious and sometimes fatal disorder of vitamin K deficiency bleeding (VKDB).

It is recommended that all infants receive an Intramuscular (IM Injection of Vitamin K at birth and parents be aware that oral administration is not as effective as IM at preventing VKDB.

Vitamin K should be administered as a single dose of 1 mg intramuscularly for babies of birth weights > 2kg as this is the most clinically and cost-effective method of administration. Babies born with birth weights <2kg need less Vitamin K to be administered, therefore please refer to the Vitamin K guidelines on appropriate dosages according to birth weight.

If parents decline intramuscular vitamin K for their baby, 2mg oral vitamin K should be offered as a second-line option. Parents should be advised that oral vitamin K must be given according to the manufacturer's instructions for clinical efficacy and will require a further dose at 7 days old. Exclusive breastfeeding babies are offered at one month of age, a 3rd, 2mg oral dose is required.

If parents decline both IM and Oral Vitamin K arrangements for a discussion with a Paediatric Doctor should be made to discuss their concerns and for parents to be informed of the risks of VKDB and all discussions to be documented clearly in the infant's notes.

7. Safety

Home visits are an opportunity to assess relevant safety issues in the home and environment.

The healthcare professional should promote the correct use of basic safety equipment, including, for example, infant seats and smoke alarms and facilitate access to local schemes for provision of safety equipment.

7.1 Co-sleeping and sudden infant death syndrome

The cause of sudden infant death syndrome (SIDS) is not known. It is possible that many factors contribute but some factors are known to make SIDS more likely. These include placing baby on their front or side to sleep. NICE (2017?) state they need clear evidence to say that a factor directly causes SIDS.

Evidence was reviewed relating to co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) in the first year of an infant's life. Some of the reviewed evidence showed that there is a statistical relationship between SIDS and co-sleeping. This means that, where co-sleeping occurs, there may be an increase in the number of cases of SIDS. However, the evidence does not allow NICE (2014) to say that co-sleeping causes SIDS. Therefore the term 'association' has been used in their recommendations to describe the relationship between co-sleeping and SIDS.

The recommendations on co-sleeping and SIDS cover the first year of an infant's life.

- Recognise that co-sleeping can be intentional or unintentional. Discuss this with parents and carers and inform them that there is an association between co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) and SIDS.

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

- Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS may be greater with: parental or carer recent alcohol consumption, or parental or carer drug use, or low birth weight or premature infants.

Parents should be given information about sudden infant death syndrome (SIDS) and co-sleeping, which states 'The safest place for your baby to sleep is in a cot in your room for the first six months'. While it's lovely to have your baby with you for a cuddle or a feed, it's safest to put your baby back in their cot before you go to sleep. There is also a risk that you might roll over in your sleep and suffocate your baby, or that your baby could get caught between the wall and the bed, or could roll out of an adult bed and be injured.'

Parents should be advised never to sleep on a sofa or armchair with their babies.

If parents choose to share a bed with their baby, they should be advised that there is an increased risk of SIDS, especially when the baby is less than 11 weeks old, if either parent:

- Is a smoker
- Has recently drunk any alcohol
- Has taken medication or drugs that make them sleep more heavily
- Is very tired.

If a baby has become accustomed to using a pacifier (dummy) while sleeping, it should not be stopped suddenly during the first 26 weeks.

7.2 Child abuse

Safeguarding Children Policy

Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse.

If there is raised concern, the healthcare professional should follow local child protection policies.

8. Education and Training

Responsibility for education and training on Postnatal Care lies with the Practice development midwives. It will be provided through formal study days and informal training on the ward.

9. Consultation, Approval, Review and Archiving Processes

The author consulted with all relevant stakeholders. Please refer to the Document Control Report.

Final approval will be given by the Maternity Services Guideline Group.

The guidelines will be reviewed every 3 years. The author will be responsible for ensuring the guidelines are reviewed and revisions approved by the Maternity Services Guideline Group in accordance with the Document Control Report.

All versions of these guidelines will be archived in electronic format by the author within the Maternity Team policy archive.

Any revisions to the final document will be recorded on the Document Control Report.

To obtain a copy of the archived guidelines, contact should be made with the Maternity team.

10. Monitoring Compliance with and the Effectiveness of the Guideline

10.1 Standards/ Key Performance Indicators

Key performance indicators comprise:

- Confidential Enquiries into Maternal and Child Health (MBRRACE)
- Family and Friends questionnaire prior to discharge from hospital and the community
- Care Quality Commission reporting (CQC)
- Documentation and use of early warning charts
- Compliance with updated Trust Guidelines

10.2 Process for Implementation and Monitoring Compliance and Effectiveness

Monitoring of implementation, effectiveness and compliance with the Post Natal Care Planning & Post Natal Information guidelines is the responsibility of the senior clinical/management team. The maternity services audit programme and methodology of process, reporting and escalation is described in Appendix A using the audit criterion in Appendix B.

Family and Friends questionnaire are also encouraged to be completed by patients prior to discharge from hospital and within the community setting. Information received from a patients perspective help seek ways of improving maternity services on a local and national level.

Implementation of this guideline is not required, as this practice is already in place.

Staff will be informed of update revised guideline available on the Trust intranet BOB. Staff are responsible and are expected to keep up to date on any improvements to practice and deliver care and advice accordingly.

Non-compliance to the guideline is Datix reported and regular monitoring and review processes put in place.

11. References

- Department of Health (2005) *Responding to domestic abuse: a handbook for health professionals.* London: Department of Health. Available from: www.dh.gov.uk
- National Service Framework for Children, Young People and Maternity Services. Available from: www.dh.gov.uk
- NICE guidance 'Postnatal care: routine postnatal care of women and their babies' (2006), (2015) and reviewed(2017) www.nice.org.uk/CG037
- Department of Health (2005) *Reduce the risk of cot death: an easy guide*. London: Department of Health. Available from: www.dh.gov.uk
- Sudden infant death syndrome recommendations https://www.nhs.uk/conditions/sudden-infant-death-syndrome-sids/
- Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk).
- Newborn Infant Physical Examination Programme Standards 2016/17,

  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524424/NIPE_Programme_Standards_2016_to_2017.pdf
- Mbrrace (2015) Leading cause of maternal death (accessed 13/11/17 included website)

12. Associated Documentation

- **Care of the newborn Immediately after birth guidelines**
- **Child protection policy**
- **Examination of the newborn Guidelines**

- **Infant feeding guidelines**
- **Investigation and Management of Acute Venous Thromboembolism in Pregnancy Guideline.**
- **Women who present with Mental Health Concerns in the Perinatal Period Guideline**
- **Domestic Violence and Abuse Policy**
- **Escalation, Communication and Record Keeping in Maternity Guideline**
- **Vitamin K Administration Guidelines for Neonates**
- **Maternal Sepsis Guideline**
- **Bladder Care Guideline**
- **Safeguarding Children Policy**
- Newborn Infant Physical Examination Programme Standards 2016/17, [accessed via website] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524424/NIPE_Programme_Standards_2016_to_2017.pdf

This guidance is based on the best available evidence. The full guideline www.nice.org.uk/CG037 'Postnatal care: routine postnatal care of women and their babies' gives details of the methods and the evidence used to develop this guidance.

13. Appendix A: Audit Methodology for Post Natal Care Planning and Post Natal Information Guideline

NDHT Obstetrics, Gynaecology and Midwifery Guideline:	Post Natal Care Planning and Post Natal Information Guidelines				
CNST Ref:	Standard:	5	Criterion:	9	
Monitoring arrangements	Clinical Audit			N	
	Monitoring			Y	3 yearly audit
Lead for Monitoring Compliance	Name:			Post Holder	
	Job role:			Ward Manager and Community Team Leader	
Method					

• Sample	1% or 10 sets, whichever is the greater, of all health records of women who have delivered
• Audit tool	An audit tool will be developed using the standard statements set out below. *[may just include first column of Criterion statements table in guidance document]* The tool will be piloted prior to use.
• Data collection process	Patient notes will be audited by the Ward Manager and the Community Team Leader of staff. The information will be recorded using the audit tool.
• Process for collating and reporting data	Data will entered and analysed using appropriate software to show compliance levels.
Frequency of monitoring/audit	3 Yearly
Process for reviewing results and ensuring improvements in performance occur	At the end of the audit, the Ward Manager/Community Team Leader will report results to Maternity Services Patient Safety Forum. Where monitoring identifies deficiencies an action plan will be agreed. Actions will be implemented under the authority of Head of Midwifery Implementation of actions will be monitored by MSPSF

14. Appendix B: Audit Criterion for Post Natal Care Planning and Post Natal Information Guideline

Criterion statements for audit tool							
Ref	Criterion statements	Target	Exceptions	Indicator/Location of information		National guidance Reference	Trust guideline reference
				Where is the information against which compliance can be audited recorded? E.g. Postnatal notes E.g. Trakcare system	Page no/ Field	Which national guidance does this demonstrate compliance with e.g. NICE CG13 pg.22	On which page of the Trust guideline is the relevant statement?
1	Was the process followed for giving						

	information to enable parents to assess their newborns general condition and identify any signs and symptoms of common health problems to enable parents to respond to problems?						
2	Was an individualised postnatal plan developed for each patient?						
3	Was a co-ordinating health care professional appointed?						
4	Were the parents provided with contact details of all the health care professionals?						
5	Were all discussions and information provided to parents clearly documented in Healthcare Records						

15. Appendix C: Post Natal Discharge from Hospital to Community Midwife Form

Appendix A

POST NATAL DISCHARGE FROM HOSPITAL TO COMMUNITY MIDWIFE

Including early discharge direct from Delivery Suite and post natal transfers in from other units