CLINICAL GUIDELINE

Postnatal Care Pathway

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Postnatal Care Pathway

NHS Greater Glasgow and Clyde

Guideline Statement

This document has been developed to set a basic standard of postnatal care for women and their babies. In reference to postnatal day numbers, day 1 postnatal is the day of birth.

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1.0 Roles and Responsibilities:

Midwife	Responsible for providing routine postnatal care for mothers and their babies in both the hospital and community settings in line with current local and national guidance. Develops individualised care plans for mothers and their babies and escalates to the appropriate healthcare professional when there are deviations from normality. Midwives that have been appropriately trained can complete the detailed examination of the new born
Maternity Care Assistants (MCA)	Under the direction of the midwife, they provide care, infant feeding support and parenting skills to support new parents and their babies. To provide basic care to new mothers and undertake maternal observations where required, escalating deviations from normal to Midwife caring for woman.
Obstetricians	To review and recommend care pathways for women where there is a deviation from the normal
Anaesthetists	Specialists in care provision for compromised women. Review and recommend care pathways for women that may require critical care admission. To complete assessment of headache and leg neurology following regional anaesthesia. Can support with postnatal analgesia concerns following obstetric review
Paediatricians /ANNP's	To complete the examination of the newborn and review and recommend care pathways for babies where there has been a deviation from normality
Infant Feeding Specialist Midwife	To provide specialist knowledge and advice on infant feeding to staff and women as required. To provide training to midwifery and MCA staff.

2.0 Care planning and delivery

An individualised postnatal care plan should be developed for every woman and baby which should be reviewed at each postnatal contact. These plans should include:

- Risk assessment of relevant factors from the antenatal, intrapartum and postnatal period
- Details of any healthcare professionals involved in her care and that of her baby, including roles and contact details
- Plans for the postnatal period, including contraception and infant feeding

Length of stay following birth and plan for transfer to community should be discussed with the woman, taking into account her and her baby's health and wellbeing, and the level of support available following transfer.

Every woman should have a named midwife recorded under circle of care on Badgernet. This midwife or their named buddy should provide care following transfer to community from the hospital wherever possible and depending on the demands of the service at the time.

2.1 Immediate Care Following Birth

2.1.1 Care of the Mother

A full set of maternal observations should be completed within 1 hour of 3rd stage completion and repeated prior to transfer to the postnatal ward (additional/more frequent observations may be required if clinically indicated as per GGC MEWS guideline).

Maternal observations should include:

- Temperature
- Pulse
- Respirations
- Blood Pressure
- Lochia assessment
- Uterine Involution
- Fluid balance, including documented time of first void (refer to GGC Postnatal bladder care guideline)

2.1.2 Care of the Newborn

Skin to skin contact between mother and baby should be initiated immediately following the birth unless otherwise clinically indicated or declined. This should be uninterrupted for at least one hour or following the first feed. All mothers should be encouraged to offer the first feed in skin to skin contact when their baby shows signs of readiness. Breastfeeding should be promoted and facilitated in accordance Infant feeding standards.

Newborn Observations and care should include:

- Initial examination of the newborn. This should be completed and documented on Badgernet under 'First Examination'. Any deviations from the norm should be appropriately referred. All findings/actions and any plans should be documented in Badgernet under Baby notes. Ensure ID bands are attached to each ankle with baby's CHI, Date of birth, time of birth, gender and maternal surname.
- Parents should be provided with information on Vitamin K in order to make an informed decision about its administration. It should be offered for all infants as a single Intramuscular dose of 1mg if ≥ 36 weeks or 0.5mg < 36 weeks at birth. If parents decline IM Vitamin K, oral Vitamin K should be offered as second line as per GGC Vitamin K prophylaxis for neonate's guideline. Those opting out of Vitamin K should be referred to the on call middle grade or consultant neonatologist for further discussion.
- Neonatal observations should be carried out in a timely manner, ideally at first check and prior to transfer to the postnatal ward. The 'Warm Bundle' should be commenced on Badgernet at birth and completed prior to transfer to postnatal ward. Any complications or concerns should be escalated for neonatal review.

2.1.3 Enhanced Recovery for Obstetric Surgery in Scotland (EROSS)

Women admitted to recovery following any theatre procedure should have their pulse, respirations, blood pressure and saturations checked every:

- 5 minutes for the first 15 minutes, then
- 15 minutes for an hour, then
- hourly for four hours, then
- 4 hourly for the first 24 hours.

Maternal temperature should be checked on admission to recovery, admission to the postnatal ward and at least 4 hourly thereafter.
Lochia should be observed and any concerns escalated to medical staff. If observations are normal for 24 hours then move to daily observations. (GGC MEWS guidance)
Women can be transferred to the postnatal ward following a full hour of observations in recovery, as long as all observations remain within normal limits.

Due to the risk of complications, women admitted to recovery with an ongoing IV syntocinon infusion should eat and drink as per medical instruction/local policy. Syntocinon should be discontinued as per medical staff instruction and only if lochia is satisfactory. Women must stay in recovery for at least 30 minutes following discontinuation of any syntocinon infusion to ensure lochia remains satisfactory prior to transfer.
Some women may require more frequent observations as per MEWS guidance. Any complications or concerns should be escalated to medical staff and the band 7 in charge.

2.1.4 High Dependency Unit/ Intensive Care Unit

Any woman who requires enhanced care, is unwell or clinically unstable may require admission to High Dependency Unit (HDU) or Intensive Care Unit (ICU). All women requiring additional levels of care should have multidisciplinary team input to decide the most appropriate place of admission.

Women may require HDU admission for:

- Step down care from ICU
- Invasive monitoring i.e. arterial line/ central venous pressure line
- Moderate/severe Pre-eclampsia/HELLP
- Major Obstetric Haemorrhage
- Sepsis
- Starvation Ketoacidosis (SKA)/ Diabetic Ketoacidosis (DKA)

HDU care

- Observations should be completed as per MEWS guidance/ medical instruction, including assessment of wound, lochia and fundus.
- Fluid balance should be accurately recorded on Badgernet and any concerns with output should be escalated to medical staff.
- Women with intra-uterine balloons, vaginal packs, epidural catheters or arterial lines in situ should be reviewed by medical staff prior to removal.
- Refer to section *2.3: Care within First 24 hours* and *Section 2.4: Follow up postnatal contacts* of this guideline and ensure any relevant tasks are completed.
- Women admitted to Maternity HDU should be reviewed at least twice daily by the multidisciplinary team, including review by a consultant obstetrician.
- Women should be encouraged to mobilise as soon as appropriate.
- Ensure a de-brief of events with medical staff has taken place prior to transfer from HDU to the postnatal ward and the woman and her family are given the opportunity to ask any relevant questions. Consider if referral to maternal and neonatal psychological team (MNPI) is appropriate. If the women consents, referral should be made via Badgernet.
- If baby is admitted to the Neonatal unit, please refer to section 4.4 of this guideline.

ICU Care

Women may require ICU admission for:

- Respiratory failure requiring ventilation support
- Haematological failure e.g. severe coagulopathy
- Sepsis with organ failure support
- Cardiac failure requiring pharmacological support or cardiac output monitoring

- Women requiring additional support out with maternity services must be transferred to the appropriate area following review, discussion and agreement between the on-call consultant obstetrician, consultant anaesthetist and consultant intensivist from the adult ICU. Hospital co-ordinators should be informed of any transfer.
- The obstetric team should liaise with the ICU team daily to advise and assist with planning of ongoing care.
- Any woman currently admitted to ICU or any outlying areas within the general hospital should be handed over between obstetric teams to ensure staff are able to provide obstetric support if required.
- Transfer back to maternity HDU will be a joint decision between the ICU consultant, obstetric consultant, obstetric anaesthetic consultant and the midwife/nurse co-ordinators of both units.
- Women admitted to HDU following ICU admission should remain in High dependency for at least 24 hours to assess suitability for transfer to postnatal ward.
- Referral to Maternal and neonatal psychological team (MNPI) should be discussed and offered to women post ICU admission. If accepting, referral should be made prior to transfer to the postnatal ward.
- If ongoing care is required in the non-obstetric setting, this decision will be made between the ICU consultant/ non-obstetric speciality involved in their care and obstetric consultant.
- Please refer to section 4.3 of this guideline for guidance on separate care of mother and baby.

2.2 Transfer to the Postnatal Ward

Due to clinical or social needs of the mother or baby, some women will require a period of care on the Postnatal Ward. This length of stay should be appropriate to the needs of the mother or baby.

- Transfer of mother and baby to the postnatal ward should take place as soon as possible following birth unless otherwise indicated and preferably in skin-to-skin contact.
- Risk assessments, including the postnatal Venous Thromboembolism (VTE), should be completed on Badgernet prior to transfer and if required, VTE prophylaxis should be prescribed on HEPMA.
- If the woman is Rh-D negative, cord bloods and maternal bloods should be taken and sent as per Anti-D Immunoglobulin guideline and prior to transfer to the ward.
- Prior to transfer, the midwife on labour ward or birthing unit should phone and request a bed from the relevant ward.
- Any IV cannula that is no longer clinically indicated should be removed prior to transfer and the removal documented under the relevant cannula tab on Badgernet.
- Following transfer, baby bands should be checked with the mother at the bedside and baby's CHI confirmed via the Badgernet record using an iPad/ Laptop at the bedside.
- The transferring midwife should provide a detailed account of the woman's history, details of birth and the recommended individualised care plan using the SBAR format. Mother and baby should have their own individualised SBAR documented on Badgernet and this should be authorised at the bottom of the form by the midwife assuming care.
- The mother and baby's daily postnatal assessment should be completed immediately following transfer and recorded on Badgernet.

- On admission to the postnatal ward the woman should be orientated to the ward and the buzzer system and visiting policy explained. Parents should be given information and advice about co-sleeping and bed sharing whilst in hospital. This conversation must be documented in Badgernet.
- Ongoing fluid balance is required for all women until they have passed a credible first void or for any women reporting voiding concerns. Refer to the bladder care guideline for further information. Women should be provided with a fluid balance chart and educated on how to record input and output. This should be reviewed by a midwife each shift and any issues escalated to medical staff for review.
- The benefits of ongoing skin to skin and how to recognise early feeding cues should be discussed with all parents.
- Women that have chosen to breastfeed should be educated on how to recognise effective attachment and how to perform hand expressing.
- The ward handover sheet should be updated and should include relevant information about mother and baby including outstanding tasks, feeding information and any observation requirements.

2.3 Within the First 24 hours of Birth

- Women should be offered timely and relevant information to enable them to promote their own and their baby's health and wellbeing and to recognise and respond to problems.
- All women should be given information about the physiological process of recovery following birth. Women should be advised to report any health concerns to a healthcare professional, in particular, heavy lochia, feeling unwell (i.e. Shivering, offensive loss, dizziness, shortness of breath), unilateral calf pain, increased abdominal or perineal pain and any difficulties in passing urine.
- Partners can choose to stay overnight to help provide postnatal support. Ensure partners are informed that we do not have bed or shower facilities for them on site. If opting to stay, partners can sleep in a chair at the bedside and should not bed share with the women at any point. Partners should not use the toilet on the ward and should be directed to the nearest visitor toilet during their stay.
- Women without an indwelling catheter should pass urine within 6 hours of birth and this should be documented in Badgernet under bladder care. For further information regarding bladder care management, please refer to the GGC Bladder Care guideline.
- Women should be provided with information on perineal care and hygiene and asked about any concerns regarding perineal trauma. The midwife should carry out an examination of any perineal trauma/repair as part of the daily examination and document this in the woman's records. Women who have had a caesarean birth should be have a wound site examination and be provided with information regarding wound care and healing.
- All women should have a full set of observations completed on admission to the ward. Women should be encouraged to mobilise as soon as appropriate following birth.
- Ensure pressure areas are assessed and documented under Pressure Ulcer Risk Assessment tab on Badgernet within 2-6 hours of admission to postnatal ward. In the event of a pressure ulcer being suspected/identified a referral to tissue viability should be completed via Trakcare. Refer to GGC Tissue viability: pressure ulcer prevention for further guidance.
- Women that require an ongoing IV cannula should have a visual infusion phlebitis (VIP) score completed every 12 hours. Cannulas should be removed as soon as they are no longer clinically indicated or if there are any signs of phlebitis/thrombophlebitis.
- In dwelling urinary catheters should be left in situ for a minimum of 6-12 hours for planned caesareans and 12 hours following any unplanned caesareans, assisted vaginal births, manual removal of placenta or following regional analgesia. Women with OASIS should have an indwelling catheter left in situ for a minimum of 24 hours. Following

removal all women should complete a trial of void. Further information on management can be found on the GGC bladder care guideline.

- Women who have had epidural or spinal anaesthesia should have a leg neurology assessment completed. Women should be asked if they can straight-leg raise 4 hours following their last epidural top up/ spinal insertion. If unable to leg raise or any red flags are present (*appendix 2*), the on-call anaesthetist should be contacted for immediate review.
- For mothers that have given birth at home the Midwife should ensure that the mother and baby are stable and that the parents have contact numbers for advice and emergencies before leaving.
- If a woman is Rh-D negative, the cord and maternal bloods should be chased, and Anti-D immunoglobulin administered as soon as possible and within 72 hours of birth.
- The midwife should carry out a thorough assessment of baby's wellbeing and document this in the newborn assessment tab on Badgernet. This should be completed daily as a minimum whilst on the ward and at each visit in the community
- Babies at risk of sepsis should identified and managed as per GGC Early onset sepsis in the neonate guideline. All observations should be documented on Badgernet and any deviations from norm, discussed with the parents and escalated to the Neonatal team.
- Jaundice should be assessed at each postnatal contact. Parents should be offered information about physiological jaundice including:
    - That it normally occurs around 3-4 days after birth
    - Reasons for monitoring and how to monitor, particularly for babies with darker skin tones
- If Jaundice is suspected, a transcutaneous bilirubinometer (TCB) reading should be completed unless the baby is under 35 weeks, under 24 hours old, Direct Antibody Test (DAT) positive or they have previously had phototherapy. These babies should have an urgent Serum Bilirubin level (SBR) completed instead of a TCB level and they should be referred to neonatal team for review. Further information on jaundice diagnosis and management is available from the GGC Jaundice: neonatal guideline.

2.4 Follow up postnatal contacts

- Following admission observations or on completion of EROSS observations, all women should have daily observations completed during their admission.
- Any women with observations that deviate from the norm should have additional observations completed as per MEWS guidance and escalated to medical staff where required.
- 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
    - perform basic parent craft including bathing, infant feeding and changing nappies
    - Understand new born behaviours, including recognising early feeding cues
    - contact a healthcare professional or emergency service if required *(refer to appendix 3)*

  This includes giving written information, demonstrations where relevant and discussing the important symptoms parents should be aware of.
- The Newborn Physical Examination (NIPE) should be performed, with consent, by an appropriately trained health professional between 6 - 72 hours of birth. Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both parents in the care of their baby and enable them to learn more about their baby's needs.
- All parents should be offered pulse oximetry screening for their baby and this should be completed between 6-8 hours from birth. Results should be documented under baby examination and under the dropdown of oxygen saturations on Badgernet. Results of

screening should be documented as a baby critical alert. Any baby with an amber or red result should be managed as per Pulse oximetry screening guideline.

- The newborn blood spot test should be offered to all parents and performed when their baby is between 96 - 120 hours old. Informed consent should be obtained.
- Healthcare professionals should be alert to risk factors and safeguarding concerns. If any concerns are raised, staff should follow local child protection policies.

2.5 Transfer from Postnatal Ward to Community Care

- Prior to transfer home it is important that all observations for the mother and baby are completed by the discharging midwife and they are within normal parameters. Ensure any women with ongoing hypertension requiring medication have appropriate follow up arranged.
- Ensure Anti- D has been administered if required.
- Ensure post birth Hb result has been obtained for any women at risk of postnatal anaemia e.g. PPH ≥ 1000mls or weight assessed EBL as per MABL (appendix 1), any clinical indication (Dizziness, tachycardia), pre-birth Hb <90g/l
- Women prescribed oral iron during the antenatal period or any woman with a postnatal haemoglobin < 10g/l should be recommended to continue on oral iron for 3 months postnatally.
- Ensure VTE risk assessment has been completed and the woman is transferred home with relevant LMWH, sharps box and instruction on administration. Provide IDL medications and discuss correct administration. Any TTO medications issued to the mother, including any issued for their baby, should be documented on the medications tab on Badgernet.
- Ensure any woman that meets the GGC postnatal medical review guidance has been reviewed by medical staff prior to transfer to community.
- Discuss contraception options with all women prior to transfer home. Ensure conversation and any issued contraception is documented under 'Contraception' tab on Badgernet.
- Ensure the baby has had a completed NIPE examination documented on Badgernet and any outpatient referrals required have been sent.
- Ensure all babies have had their pulse oximetry screening completed as per GGC guideline.
- If the mother is Hep B positive, ensure Hep B immunoglobulin and vaccine have been administered to the baby.
- All breastfeeding women should have at least one breastfed observed to ensure the baby is feeding effectively. Babies not effectively feeding should be encouraged to remain as an inpatient for ongoing support. Ensure women have been educated on how to correctly perform hand expressing.
- Ensure any women going home requiring additional feeding support, including ongoing expressing, has the facility to continue expressing at home and is educated on the planned expressing schedule and storage of breastmilk. Ensure women are transferred home with their expressed breastmilk from the ward breastmilk fridge.
- Ensure parents that have chosen to formula feed have been offered a demonstration on sterilising equipment, making up feeds safely and encourage cue based feeding. Ensure parents are aware 'first milks' should be continued for the first year.
- The baby must have passed urine within the 1st 24 hours and meconium by 48 hours.
- Confirm hearing screening of the newborn has completed or arranged to be completed as an outpatient
- If a baby has had an SBR test (Serum Bilirubin Test) whilst in hospital, ensure the result has been documented on Badgernet and any follow up arranged if necessary.
- All women should have a discharge talk completed prior to going home and the postnatal conversation, postnatal education and contraception discussion should be completed on Badgernet. All breastfeeding women should have a feeding assessment completed and

documented under the breastfeed observation. The midwife should complete a postnatal assessment, risk assessment, and transfer to community care for mother and baby on Badgernet. The Transfer to community care should be completed and the contents of the paperwork should be confirmed with the mother to ensure that the details are correct including an up to date telephone number and address they will be residing at during community care. The Transfer to community care should be confirmed and saved on Badgernet to allow transfer of the document to portal and a printed copy should be given to the mother to take home and a second copy sent to the community midwives office.

- All women should receive information regarding their and their baby's wellbeing, how to contact their Midwife, accessing emergency services, help with breast feeding support and advice. Discuss signs of sepsis in babies with parents and complete 'warning signs of sepsis' section on baby transfer of care. Where mother or baby has specific needs, this should be clearly documented and the relevant care plan in place.
- Ensure the parents have a completed birth registration card and are aware how to register their baby's birth.
- It is the transferring Midwife's responsibility to ensure all details are correct and any follow up appointments are arranged where mother or baby are referred to allied services. This should be communicated to the woman.
- Where the woman is moving to a temporary address this should be clearly highlighted. If the mother and baby are being transferred to separate addresses, this needs to be clearly documented. If the baby is being transferred to foster parents ensure that information regarding the foster parents is not included in the printed information given to the mother as this may be a breach of confidentiality.
- If the woman lives out of area and is being transferred home from one of our Glasgow units, the transfer of care should be sent to the unit community midwives as normal and the community team will contact the responsible local unit to arrange follow up and handover care. If the woman lives out of area and is being transferred home from any of our Clyde units, it is the responsibility of the discharging midwife in the ward or birth unit to phone the correct community area and hand over care.
- If there is ongoing Social Work support, ensure there is no requirement for a post birth conference decision **prior** to transfer home. Ensure the allocated social worker is informed of transfer to community care.
- We advise that parents transport their baby home from hospital in a car seat. It is the responsibility of the parents to safely transport their baby from the ward, to have read the car seat instructions and to ensure their baby is safely secured for transfer home.

2.6 Early Transfer Home

Women may choose to be transferred home rather than be admitted to the postnatal ward following birth. All women that have had an uncomplicated pregnancy, labour and birth with a term baby should be offered early transfer to community care as standard practice.

2.6.1 Contraindications to Early Transfer Home (this list is not exhaustive)

Maternal

- Raised blood pressure in the antenatal, intrapartum or postnatal period.
- Operative delivery
- Complications of the third stage i.e. postpartum haemorrhage (>1,000ml), manual removal of placenta
- Infection risk
- Any women that has had regional analgesia or IV opioid administration.
- Medical complications e.g. diabetes, cardiac anomalies
- Social factors e.g. cause for concern, safeguarding risks
- Women requiring additional bladder care support e.g. indwelling catheters
- Women anticipated to have a post birth Hb ≤ 90g/l (Refer to MABL table in appendix 1 to aid clinical judgement)

Baby

- Babies under observation e.g. NEWs, hypoglycaemia protocol
- Babies requiring additional feeding support
- Babies at risk of pathological jaundice e.g. Direct coombes positive
- Babies < 37 weeks

2.6.2 Process for Early Transfer to Community Care

The current transfer to community process should be followed as per routine postnatal transfer from the postnatal ward. In addition to completing all tasks outlined in section 2.5 please ensure:

- the mother has passed urine within 6 hours following the birth (refer to GGC postnatal bladder care guideline)
- The baby has had at least one feed and this feed was observed by a midwife to ensure baby is feeding effectively. If bottle feeding parents should be offered a demonstration and provided with relevant literature to educate them on how to safely make bottles. All parents should be educated on feeding cues.
- If the woman is Rh-D negative, she **should not** be transferred to community until the cord blood and maternal blood results have been checked and Anti-D immunoglobulin administered if required. If the women opts to be transferred home prior to administration, ensure she has an appointment to return the next day for Anti D administration.
- Parents should be advised to observe their baby's nappy and expect urine to be passed within the first 24 hours and meconium to be passed within the first 48 hours.
- Any woman giving birth at home or opting to be transferred home prior to completion of the NIPE and pulse oximetry, should have arrangements made to have this completed in the community within 24 hours of birth. If your unit is unable to facilitate this in community then the woman must be given a time to return to the unit within 24 hours of birth to have this completed.

2.7 Community Care

- Postnatal care in the community will be provided by the Community Midwives and Maternity Care Assistants. The Community Midwife is the coordinating health professional for all women including those with multi-professional and multidisciplinary needs.
- On the first visit the community midwife should check that the following are done, parents aware of the process and time scale for activities listed:
    - Full physical check of mother and baby including visualising the perineum and any wounds, discussion around common health problems, assessment of mental wellbeing and the importance of relationship building with baby.
    - Full breastfeeding assessment and give help with breastfeeding as required.
    - Discuss sterilization and making up of feeds if appropriate
    - Ensure parents are aware how to register birth with Registry Office and how to register with GP once birth registration completed
    - Check parents understanding of risk factors and ways to reduce incidence of cot death including advice on bed sharing and smoking.
    - Check if an additional dose of Vitamin K is required (only if 1st dose given orally)
    - Ensure NIPE and Pulse oximetry screening has been completed
    - Discuss all issued medication and check if the mother has been prescribed Low Molecular Weight Heparin (LMWH). If so, ensure she is confident to self-administer and has been given a sharps bin.
    - Discuss pelvic floor care, signs of concern and when to seek help
    - Discuss visiting plan and arrange next visit

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- All women should be visited on the day following transfer to community, preferably by their named Community Midwife and an appropriate plan made for first home visit. The timing of this visit should consider the clinical needs of mother and baby, method of feeding, preference of the mother and the availability of named midwife.
- This first home visit should be used to assess individual needs of the mother and baby. Where issues have been identified a management plan should be clearly documented on Badgernet for both mother and baby.
- As a minimum, postnatal MEWS should be completed on day 1, 2 and 3, day 5/6 and day 10/ day of discharge. Additional observations should be completed as clinically indicated.
- The Newborn Blood Spot Screening should be carried out when the baby is between 96 and 120 hours old, with informed consent (see guidelines for Newborn Screening). In exceptional circumstances, samples can be obtained between day 5 to day 8. Please ensure all details are correct, including baby CHI, and spots are correctly filled.
- All routine postnatal care for mother and baby will consist of:
    - First visit - initial risk assessment, information and care planning, MEWS.
    - Third day visit – if exclusive breastfeeding or < 37 weeks at birth, complete weight if over 60 hours old, feeding assessment and MEWS
    - Fifth/ Sixth day visit– Newborn Blood Screening test (if baby is > 96 hours old), weight, feeding support and MEWS
    - Discharge visit – from day 10 onwards. Ensure the mother and baby are both clinically well prior to discharge. All babies should be reweighed by day 14 to ensure there is ongoing weight gain. Any ongoing feeding support should be discussed with Health Visitor prior to discharge. If your unit has a local agreement that Health Visitors complete the day 14 weight, ensure it is clearly handed over that the weight is outstanding at time of discharge. If Health Visitors are unable to attend before day 14, weights should be completed by the discharging midwife between days 10 to 14.
- If a baby is < 60 hours old at the time of the day three visit, an additional visit should be completed on day four to weigh the baby. This in addition to the above care schedule and should not be in place of a day three visit.
- Consider a visit on day 8 if there are indications for an additional weight or if feeding support/ assessment is required or there are any other clinical concerns.
- Visits may be combined if first visit coincides with third or fifth day. Additional visits arranged as required determined by assessment of clinical and social needs.
- Care where appropriate can be carried out by a Maternity Care Assistant, however the planning and evaluation of care plans should be completed by the Midwife or in conjunction with the healthcare professional prescribing the care.
- Women with any feeding issues or concerns should be given advice and have an appropriate feeding plan put in place.

2.8 Discharge to Health Visitors

- Women and their baby's would routinely be discharged to the care of the Health Visitor between day 10 and 14. This discharge visit should be completed by the named midwife and can be moved to after day 10 if the named midwife is not on duty as long as both mother and baby are well (please ensure contact number have been given if the woman requires an earlier visit). If the baby is near but below birth weight by the time of the discharge visit the midwife can, where appropriate, make arrangement with the health visitor to ensure follow up.
- Ensure outpatient appointments have been arranged if required and hearing screening has been completed.
- If the parents opted for oral vitamin K schedule, ensure they have the correct information for administration and a full prescription to complete the treatment.(See Vitamin K prophylaxis for neonates guideline)

- Women with ongoing breastfeeding issues should have a feeding plan in place that should be assessed by a midwife for improvement. If improvement is seen and baby is gaining weight, the mother and baby can be transferred to Health Visitor. If there is no improvement despite a feeding plan being in place, discuss referral to infant feeding team for support. Any feeding concerns and ongoing feeding support requirements should be communicated to the Health Visitor at time of transfer.
- Women can remain under community midwife care past the 10-14 days if there are ongoing feeding support requirements, prolonged neonatal jaundice or wound care requirements. Health Visitors will complete their first postnatal visit between 11-14 days. Where Midwives are still providing care past day 14 they will remain the lead practitioner but should still inform the Health Visitors of the woman and any relevant issues.
- Where there are complex issues within a family this should be communicated to the health visiting team. It is recommended that in the most complex cases the midwife, social worker and health visitor have face to face discussions regarding any care plans in place prior to discharge.

2.9 Readmission

- All mothers and babies requiring readmission to hospital should have a clinical risk assessment by the appropriate clinician to determine which clinical area would be most appropriate to ensure an effective and efficient care pathway.
- If the woman needs admission to the general hospital but there are no available beds, admission to the postnatal ward would be negotiated with the on call consultant and hospital co-ordinator.
- For babies requiring readmission from home, please refer to *appendix 4* for guidance on the most appropriate referral location. If unsure please discuss with paediatric staff prior to transfer.
- Women that are well and have been readmitted for neonatal concerns, i.e. weight, feeding issues or jaundice, can follow the community care schedule for MEWS observations as per section 2.7 of this guideline.
- All readmission to the postnatal ward should be cared for in a side room, where possible.
- A Datix report should be completed for all readmissions for maternal or neonatal concerns. Readmissions for feeding support with no clinical concerns, i.e. normal weight loss, no neonatal jaundice, does not require a datix.
- Once mother and baby have been transferred back to community, the Badgernet records should be completed, and the routine transfer process followed ensuring the transfer paperwork is forwarded to the community midwives as per guidelines.

Where readmissions are for weight loss due to breastfeeding issues the Specialist Infant Feeding Midwife should be informed to facilitate any extra support as required

3.0 Maintaining Maternal and Newborn Health

During the postnatal period women should be offered information and advice regarding their own health and wellbeing. The following guidance outlines the minimum care that should be provided to mothers and should be used in conjunction with the relevant trust guidelines.

3.1 At each postnatal contact

- The midwife should carry out a thorough assessment of maternal wellbeing and document this in the postnatal assessment tab on Badgernet. This should be completed daily as a minimum whilst on the ward or at each Midwife visit in the community.
- Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. This should be discussed at least once prior to transfer from the hospital to community and any concerns raised should be escalated appropriately.

- Assessment for emotional attachment should be carried out at each postnatal contact and healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit.
- Mothers should be encouraged to keep their baby as close to them as possible and continue to support skin to skin contact throughout the postnatal period will help with this. Support parents to understand their baby's needs for frequent touch and sensitive visual and verbal communication to help bonding with their baby
- Home visits in the community should be used as opportunities to promote parent or mother to child emotional attachment. All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment.
- All women should be offered ongoing education and support for their chosen feeding method. Breastfeeding women should be educated on how to ensure their baby is feeding effectively and given contact information if they have infant feeding concerns.
- Mothers should be advised of the importance of taking regular analgesia to ensure adequate pain management. Any concerns regarding a woman's pain management should be escalated to the obstetrician.
- Ensure that parents are aware of how to complete basic baby cares, including bathing, changing nappies and that they are educated on safe sleeping.
- Parents should be given advice at each postnatal contact about reducing the risk of Sudden Unexpected Death in Infants (SUDI) and co-sleeping (as detailed in the Co-sleeping and Bed sharing for Mothers and Babies leaflet). This conversation must be documented on Badgernet and if noted to be co-sleeping this should also be recorded.
- Information should be given to all parents regarding contraception prior to transfer from the hospital to community and before discharge from maternity care.

4.0 Separate care of mother and baby

4.1 Reasons for Separate Care

- Maternal request, e.g. Mother relinquishing baby
- Child protection proceedings, e.g. Child Protection Order
- Maternal condition, necessitating transfer to Intensive Care Unit (ICU)
- Neonate's condition, necessitating transfer to Neonatal Unit (NNU).

4.2 Maternal Request or Care Proceedings

- If separate care is due to an anticipated Safeguarding concern it is the responsibility of the Midwife at the birth to notify the social work team within the local authority the mother resides in. For babies with Child protection plans in place, this information should be located in the Social Summary section in the summary page of the Badgernet record. Any plans and safeguarding concerns should be documented here. The midwife should document the conversation under the communication tab on Badgernet. During normal working hours, the woman's duty social worker should be contacted. If out of hours, the Emergency Out of Hours Social Work team within the woman's local authority should be contacted and information handed over to the postnatal ward.
- Careful consideration needs to be given to ensure the most appropriate place for the baby. The postnatal ward is not always an appropriate place for the baby to be cared for as there are no facilities to care for babies unattended by parents or guardians. Whenever possible a decision must be taken regarding the appropriate place of care, considering the safety and clinical needs of the baby, prior to birth. Neonatal Unit (NNU) can facilitate admission where required and this must be discussed and agreed prior to transfer.
- Consideration should be given to whether a parent or guardian can be accommodated with the baby on the postnatal ward where we are unable to transfer the baby home to the care of community midwives.

4.3 Maternal condition, necessitating transfer to ICU

- Following discussion with neonatal unit, babies may be admitted to Special Care until the mother is transferred back to the maternity High Dependency Unit or if a prolonged admission is anticipated, until they are fit for discharge to the other parent/legal guardian.
- Liaise with the ICU team and the mother's family to deem if contact can be facilitated between mother and baby. Babies should be transferred to ICU in a cot with a midwife escort. Baby bands must be checked with the mothers ID band on admission.
- On transfer back to HDU, babies should be discharged from the NNU and roomed in with their mother unless there are ongoing neonatal concerns that require an extended admission.

4.4 Neonatales condition, necessitating transfer to NNU

- Contact between the parents and their baby should be facilitated at the earliest opportunity. Parents should be made aware there are no restrictions to them being with their baby whilst in the NNU.
- Timing may be dictated by maternal condition, and this should be communicated with the parents.
- 'vCreate' should be offered to parents. Forms can be obtained from the NNU. This creates a secure network for neonatal to send pictures and videos to parents.
- If breastfeeding, hand expressing should be commenced at the earliest opportunity, ideally within the 1-2 hours. If unable to facilitate within the first hour, this should be supported within 6 hours of birth. Double pumping should be completed following each hand expression on 'initiate' function for 15 minutes (GGC Expressed Breastmilk guideline). Any colostrum obtained should be clearly labelled and transferred to the NNU for storage. Expressing should be documented under 'expressing assessment' in Badgernet

5.0 Recordkeeping

- All staff must maintain clear and accurate records that should be completed at the time or as soon as possible after the event.
- All maternal observations and discussions to be recorded in the mothers postnatal records on Badgernet. Management plans to be clearly documented and this should include relevant factors from the antenatal, intrapartum and immediate postnatal period and plans for the postnatal period and where there has been deviation from the norm.
- Prior to transfer to the Postnatal Ward or home, the Midwife should complete the risk assessments in the maternal and baby postnatal records.
- SBARs should be completed at each handover and updated with relevant information.
- Mother and baby/babies to have patient identification labels as per Trust Patient Identification Policy.
- Prior to transfer to the postnatal ward, the labour and birth summary and SMRO2 should be completed on Badgernet. Ensure baby's CHI is accurately completed on Badgernet.
- Prior to transfer to community, ensure a midwife has completed the transfer of care to community for both mum and baby on Badgernet and the maternity IDL is completed on Portal.

6.0 Statement of evidence/references

- UNICEF, The baby friendly initiative 'Having meaningful conversations with mothers; A guide to using the baby friendly signature sheets' Available from: unicef.org.uk/babyfriendly
- GG&C MEWS guidance, Available from: [CG] MEWS guidance | Right Decisions (scot.nhs.uk)
- GG&C Vitamin K Prophylaxis for neonates, Available from: Vitamin K prophylaxis for neonates (scot.nhs.uk)

- GG&C Postnatal Bladder care, Available from: [CG] Postnatal bladder care | Right Decisions (scot.nhs.uk)
- GG&C Tissue Viability: pressure ulcer prevention, Available from: [CG] Tissue viability: pressure ulcer prevention | Right Decisions (scot.nhs.uk)
- GG&C Postpartum Sensory Neurological Deficits, Available from : [CG] Postpartum Sensory Neurological Deficits | Right Decisions (scot.nhs.uk)
- GGC Bathing newborn infants, Available from: Bathing newborn infants (scot.nhs.uk)
- GGC Early onset sepsis in the neonate: prevention and treatment, Available from: Early onset sepsis in the neonate: prevention and treatment (scot.nhs.uk)
- GGC Expressed breastmilk (maternal and donor), Available from: Expressed breast milk (maternal and donor) (scot.nhs.uk)
- GGC Immunisation guideline for neonates, Available from: Immunisation guideline for neonates (scot.nhs.uk)
- GGC Jaundice: neonatal guideline, Available from: Jaundice : neonatal guideline (scot.nhs.uk)
- GGC Newborn Blood Spot Screening, Available from: Newborn Blood Spot Screening (scot.nhs.uk)
- GGC Caesarean Section, Available from: [CG] Caesarean section | Right Decisions (scot.nhs.uk)
- GG&C Admission Criteria: Neonatal unit and Transitional care, Available from: Admission criteria: Neonatal Unit & Transitional Care (scot.nhs.uk)
- NICE 2021 Postnatal Care, Available from: Recommendations | Postnatal care | Guidance | NICE
- Connelly, A (2021), Maximum Allowable Blood Loss (MABL) Table.

Appendix 1

Maximum Allowable Blood Loss (MABL)

The following can be used as a tool, alongside clinical judgement, to assist with the prediction of a postnatal haemoglobin (Hb) <90 g/l. This is to assist in identification of women that may require repeat haemoglobin prior to transfer to community and may require additional management. The following calculation identifies the volume of blood loss that is anticipated to result in a postnatal Hb <90g/l in relation to a woman's third trimester weight and pre- birth haemoglobin. Regardless of weight and starting Hb any loss ≥ 1000ml should offered a postnatal Hb prior to transfer home. Please note these values do not replace clinical assessment and judgement and any woman symptomatic of anaemia should have appropriate investigations and management. Weight and pre-birth Hb should be rounded down to the nearest value.

3rd Trimester weight	Initial Hb: 95g/l	Initial Hb: 100g/l	Initial Hb: 105g/l	Initial Hb: 110g/l
≤ 50 kg	260ml	500ml	710ml	910ml
55kg	290ml	550ml	785 ml	1,000ml
60kg	320ml	600ml	855ml	1,090ml
65kg	340ml	650ml	930ml	1,180ml
70kg	365ml	700mls	1,000ml	1,270ml
75kg	375ml	710ml	1,020ml	1,295ml
80kg	380ml	720ml	1,030ml	1,310ml
85kg	395ml	750ml	1,070ml	1,360ml
90kg	400ml	765ml	1,090ml	1,390ml
95kg	420ml	800ml	1,140ml	1,450ml
≥100kg	420ml	800ml	1,140ml	1,455ml

NHS Greater Glasgow and Clyde

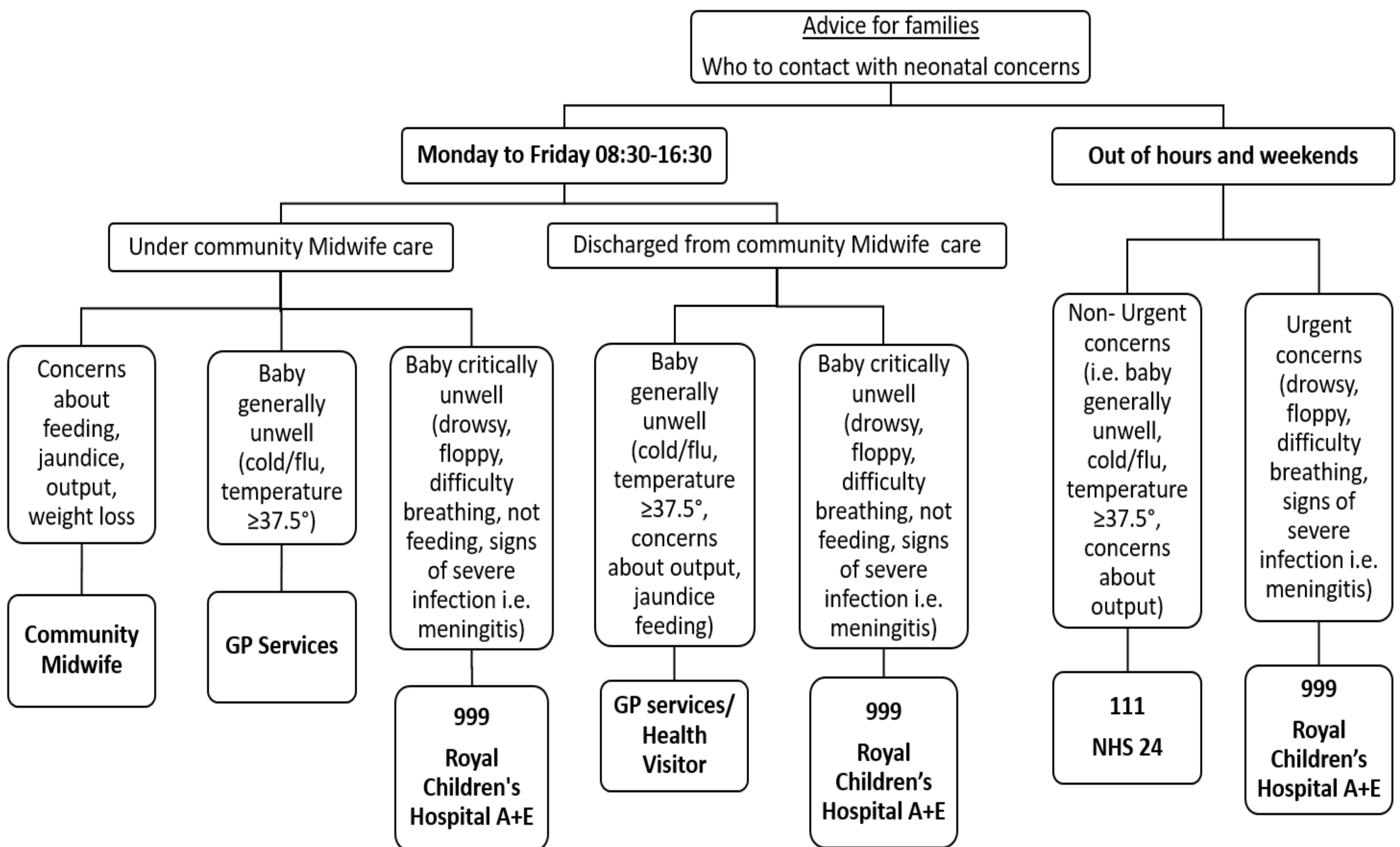
Appendix 2

Leg neurology assessment red flags. For further information of management please refer to GGC postpartum sensory neurological deficits guideline.

Red Flags

- Increasing motor weakness 4 hours after spinal anaesthesia or last epidural top-up of local anaesthetic
- Radicular pain (shooting/lancinating pain distributed along the dermatome of a nerve. It may or may not be associated with other neurological features)
- Urinary retention
- Urinary/faecal incontinence

Appendix 3



Postnatal Care Pathway

Appendix 4
Flow chart for midwives when referring babies for re-admission