Manchester University
NHS Foundation Trust

DOCUMENT CONTROL PAGE

Title:	Postnatal Care Guidelines
Version:	1.2
Supersedes:	1 (ORC and Wythenshawe) and Postnatal Care Guideline V4.5 (North Manchester)
Application:	All Staff

Originated /Modified By:	Lesley Chan and Sarah Owen/Emma Coulton, Emily McClure, Lisa Sharpen
Designation:	Matrons for Inpatient Care
Ratified by:	Site Obstetric Quality and Safety Committee
Date of Ratification:	23rd June 2021

Issue / Circulation Date:	11th August 2021
Circulated by:	Clinical Governance Team Maternity
Dissemination and Implementation:	Clinical Governance Team Maternity
Date placed on the Intranet:	11th August 2021

Planned Review Date:	1st July 2024
Responsibility of:	Clinical Governance Team Maternity

Minor Amendment (If applicable) Notified To:	Notified To: Site Obstetric Quality and Safety Committee Summary of amendments: **Update**: Info on birth talks at Wythenshawe site **Change**: Cut off for PN FBC for PPH and obstetric discharge changed (see 2.3.1.10) **New**: Appendix 5. Women requiring daily PN Consultant review. Some changes for all sites inc. prolonged IP stay now > 72 rather than > 48hrs.
Date notified:	13th July 2022

EqIA Registration Number:	2021-135R

1 Introduction

Postnatal (PN) care should be delivered in partnership with the woman and should be individualised to meet the needs of each family. The aim of postnatal care is to empower the woman to care for her baby and herself so as to promote their longer-term physiological and emotional well-being. For most women and babies, the postnatal period is uncomplicated; core postnatal care is also about recognising any deviation from expected recovery after birth and then about evaluating and intervening appropriately (NICE, 2021). Use this guideline in partnership with other relevant guidelines to provide safe and holistic postnatal care.

2 Detail of the guideline

2.1 Developing an individualised postnatal care plan

The aim of the postnatal check is to assess the woman's physical, mental and psychological well-being and to evaluate the baby's health.

Following the birth, it is the responsibility of the midwife providing postnatal care to develop an individualised postnatal care plan including:

- Relevant factors from the antenatal (AN), intrapartum (IP) and immediate postnatal (PN) period
- Requirements for obstetric review
- Details of the health professionals involved in mum and baby's care
- Plans for the PN period
- Consideration for any current safeguarding care plans

This should be reviewed at each PN contact.

Be aware that the 2020 MBRRACE-UK reports on maternal and perinatal mortality showed that women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring. The reports showed that compared with white women (8 per 100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is: 4 times higher in black women, 3 times higher in mixed ethnicity women (25 per 100,000) and 2 times higher in Asian women (15 per 100,000; does not include Chinese women).

2.2 At each assessment the midwife providing care should:

- Undertake appropriate observations of the woman and her baby. See *2.3*.

- Ask the woman about her health and well-being and that of her baby encouraging the woman and her family to report any concerns in relation to her physical and mental health.
- Ask the woman about her emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.
- Encourage women to discuss changes in mood, emotional state and behaviour outside their usual pattern.
- Review the individualised PN care plan and discuss it with the woman. NB. Women who remain an inpatient for over 72 hours and who are not suitable to be discharged require a consultant plan – see *Appendix 5* for all sites and *Appendix 6* for Wythenshawe and North Manchester.
- The woman and baby should be evaluated based on the below (see *2.3*) and referral to the appropriate healthcare professionals made as required.
- Check maternal rhesus status and ensure appropriate follow up has occurred/is planned for those who are rhesus negative
- If a referral to another non-obstetric specialty is deemed to be necessary then the wards on-call consultant at Oxford Road Campus (ORC), or the consultant on-call at Wythenshawe or North site, should be informed and the plan of care discussed.
- Provide the woman with feedback about her own and her baby's progress. She should also be given the opportunity to ask questions about the birth and the care that she has received.
- If a debrief is requested and the midwife feels unable to accommodate this, at ORC and Wythenshawe the case notes should be given to the relevant consultant's secretary where a formal 6 week debrief can be arranged. At North Manchester, the midwife should email the appropriate midwifery or obstetric contact for this to be organised.
- Where a midwifery debrief would be beneficial, referral requests should be emailed to: birthtalkORC@mft.nhs.uk and birthtalkwythenshawe@mft.nhs.uk for ORC and Wythenshawe sites respectively.
- Ensure a safe and supportive environment for infant feeding. See the *Infant feeding (including collection and storage of expressed breast milk (EBM) guideline* and the Trust-wide guideline *Safer Sleeping Practice for Infants.*
- Women should be offered information and reassurance on:
    - the physiological process of recovery after birth and what to expect
    - The importance of pelvic floor exercises
    - normal patterns of emotional changes in the postnatal period and that these usually resolve within 10-14 days of giving birth
    - What support is available (statutory and voluntary)
      (NICE, 2021)

- Offer relevant and timely information to enable women to promote their own and their babies' health and well-being and to recognise and respond to problems.
- Document observations, discussions and plan of care
- At discharge from inpatient postnatal care and during subsequent community contacts, 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
    - Who to contact if any concerns arrive at different stages including to contact emergency services on 999 if they think their baby is seriously ill.

(NICE, 2021)

2.3. Postnatal observations in hospital

2.3.1. Maternal wellbeing –

2.3.1.1. General wellbeing including sleep and diet

Women should be invited to discuss topics which affect their daily lives. Reassurance and further necessary care or referral can then be organised by the midwife. Women should be advised about the postnatal period, what to expect and when/how to seek further advice.
During the initial postnatal period, a risk assessment should be completed by the midwifery/nursing team to identify infants at increased risk. Families should be made aware of the risk of baby falls and how to reduce the risks (*See* policy: *Management of babies who accidentally fall in hospital*

2.3.1.2. Observations

Routine observations should be performed once per day, as a minimum, for women who are in hospital; this includes women receiving midwife-led care. The frequency of observations should be determined by clinical need and in accordance with the Modified Early Obstetric Warning Score guideline. A minimum of one blood pressure measurement should be carried out and documented within 6 hours of the birth (NICE 2006). Where a deviation from normal parameters is detected increased levels of observations should be undertaken. At ORC and Wythenshawe site observations must be entered onto Patientrack™ whilst if the woman is an inpatient. At Saint Mary's North Manchester, observations must be recorded on the MEOWS chart.

Women who are outpatients should have observations performed if there are clinical indications or as part of their individualised postnatal care plan.

See: Modified Early Obstetric Warning Score (MEOWS) guideline.

The following signs and symptoms require prompt urgent referral:

- pyrexia > 38ºC
- sustained tachycardia > 100 bpm
- breathlessness (RR > 20; a serious symptom)
- abdominal or chest pain
- sudden or profuse blood loss, ongoing heavy vaginal loss or signs and symptoms of shock. *See The Management of Postpartum Haemorrhage and Massive Obstetric Haemorrhage Guideline* diarrhoea and/or vomiting
- uterine or renal angle pain and tenderness
- the woman is generally unwell or seems unduly anxious, distressed or agitated
- evidence of distended bladder or unable to pass urine with sensation of full bladder. See *Postpartum Urinary Retention Guideline.*
- Women with persistent or severe headache

A normal temperature does not exclude sepsis as paracetamol and other analgesics may mask pyrexia. Infection must also be suspected and actively ruled out when a woman who has recently given birth has persistent vaginal bleeding and abdominal pain. If there is any concern, the woman must be referred back to the maternity unit/ referred to the obstetric team. *See also the guideline for Sepsis in pregnancy and puerperium: Early recognition, diagnosis and treatment.*

2.3.1.3. Vaginal loss

- Assessment of vaginal loss
- In the absence of abnormal vaginal loss, it is not necessary to perform assessment of the uterus by abdominal palpation.
- Uterine involution and position should be undertaken in women with excessive or offensive vaginal loss, abdominal tenderness or fever. Any abnormalities should be evaluated and if no uterine cause found then consider other causes of symptoms.
- Women should be encouraged to seek medical advice if they experience sudden or very heavy vaginal bleeding, or persistent or increased vaginal bleeding, which could indicate retained placental tissue or endometritis

2.3.1.4. Breast assessment and infant feeding *See* local *Infant feeding* guidelines

- Nipple Pain – offer assistance with position and attachment. Consider thrush if pain persists following correct position and attachment.
- Engorgement – Advise a well-fitting bra and treat with frequent unlimited breast feeding, breast massage, if necessary hand expression and analgesia.
- Mastitis – Advise women to report signs and symptoms of mastitis urgently including flu like symptoms, red, tender and painful breasts. Women with signs and symptoms of mastitis should be offered referral to the infant feeding team for assistance with positioning and attachment and advised to:
  - continue breastfeeding and/or hand expression to ensure effective milk removal; if necessary, this should be with gentle massaging of the breast to overcome any blockage
  - take analgesia compatible with breastfeeding
  - increase fluid intake.

  If the signs and symptoms of mastitis do not ease, the woman should be evaluated as she may need antibiotic therapy.
- For women requiring additional support a referral to the infant feeding team should be considered.
- In the event of a breast lump identification with or without pain, follow the *NICE Breast Cancer – Recognition and Referral 2 Week referral Pathway.*

2.3.1.5. Passing urine

- See *Postpartum Urinary Retention Guideline*.
- Consider signs and symptoms of infection.
- All women will receive information on how to perform pelvic floor exercises following delivery of their baby
- Women with involuntary leakage of a small volume of urine should be taught pelvic floor exercises. If symptoms are not improving or worsen prior to discharge, refer to physiotherapy.

2.3.1.6. Bowels

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 ineffective.

Haemorrhoids

- Women with haemorrhoids should be given dietary advice to avoid constipation.
- Women with severe, swollen or prolapsed haemorrhoid or any rectal bleeding should be evaluated (urgent action).

Faecal incontinence

- Any new onset faecal incontinence should prompt a medical review.
- Women with faecal incontinence should be assessed for severity, duration and frequency of symptoms. If symptoms do not resolve women should be referred for a medical opinion.

2.3.1.7. Legs

- Review visually for signs and symptoms of deep vein thrombosis and perform VTE assessment.
  See local prevention of VTE and local Acute VTE in pregnancy and the puerperium guidelines.
- Women should be encouraged to mobilise as soon as appropriate following the birth and made aware of symptoms of, and factors that, increase risk of a DVT
- Women with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis

2.3.1.8. Perineum and caesarean section wound

- All women who have had caesarean section should have their wound reviewed on removal of the dressing or earlier where indicated.
- All women who have sustained perineal trauma at birth should have their perineum inspected by a midwife prior to discharge from hospital and discharge from maternity services.
- Women should be asked if they have any concerns regarding the healing process of any wound including pain, discomfort, offensive odour, dyspareunia or wound break down.
- Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated.
- Offer women advice regarding effective pain relief methods including topical cold therapy.
- Offer advice regarding the importance of hand and perineal hygiene.
- Ensure any appropriate referrals to physiotherapy, the Warrell Unit and/or the OASI clinic have been completed.
- Consideration for early referral to tissue viability for complex wounds should be made for high risk women

2.3.1.9. Back Pain

Women experiencing back pain in the postpartum period should be managed as per the general population once complications at any epidural/spinal site are excluded.

2.3.1.10. Postnatal Anaemia

For women who have experienced a postpartum haemorrhage (>1000ml EBL), have a Hb of below 100g/dL at booking or are symptomatic of anaemia, a full blood count (FBC) should be obtained six hours post-delivery.

See also *Anaemia in pregnancy and the puerperium guideline.*

Women should be advised about the signs and symptoms of postnatal anaemia.

Women who have been prescribed iron during pregnancy should be given a 6 week postnatal supply.

2.3.1.11. Fatigue

Women who report persistent (>24hours) fatigue should be asked about their general wellbeing and offered advice on diet and exercise including spending time with her baby/feeding technique. If persistent postnatal fatigue impacts on the woman's self-care or baby's care, underlying physical, psychological or social causes should be explored and a FBC obtained.

2.3.1.12. Mental Health

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

It is important that at days 10-14 the woman is asked about the resolution of baby blues and is assessed appropriately. Consider postnatal visits up to 28 days to offer support with perinatal mental health where appropriate.

Women should be encouraged to help to look after their mental health by looking after themselves, including getting rest, exercise, help caring for baby, talking about their feelings and accessing social support networks.

If a woman has any past or present severe mental illness or there is a family history of severe perinatal mental illness in a first-degree

relative, be alert for possible symptoms of postpartum psychosis in the first 2 weeks after childbirth (NICE, 2014).

If women are already known to the Specialist Midwives for Mental Health, the team should be notified of the woman's delivery and will offer support regarding their perinatal mental health. If created throughout pregnancy, personalised care plans should be followed for these women.

2.3.2. Neonatal well-being - See also site-specific guidelines on Transitional Care (TCU) or Neonatal In-reach Service on the relevant Postnatal Wards. These guidelines will outline the roles and responsibilities of the TCU/in-reach team who support midwives and maternity assistants on the postnatal wards with babies who have a 'special care' requirement but are judged to be clinically stable enough to remain on the postnatal ward with their mothers rather than be admitted to the Newborn Intensive Care Unit (NICU). Babies should all be labelled as per the *Newborn Security and Suspected Missing Baby* guideline.

2.3.2.1. General wellbeing including sleep pattern and feeding See local infant feeding, safe sleeping practice for infants and management of babies who fall guidelines.

2.3.2.2. Alertness, tone, colour – See local Neonatal Early Onset Sepsis and Neonatal Jaundice guidelines.

2.3.2.3. Skin integrity

- Parents should be advised that cleaning agents should not be added to baby's bath water and medicated lotions or wipes should not be used.
- Consider causes of nappy rash, presence of infection and/or presence of thrush.
- Midwife to ensure that the neonatal body map is completed to highlight any noticeable features i.e. birthmarks, bruising or birth injuries.

2.3.2.4. Bowel movements

- 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.
- If baby is constipated and is formula fed the following should be evaluated
    - Feed preparation technique
    - Quantity of fluid taken
    - Frequency of feeding

    - Composition of feed
- A baby who is experiencing increased frequency or looser stools than usual should be evaluated urgently.

2.3.2.5. Passed urine

If a baby has not passed urine within 24 hours, the baby should be evaluated to determine cause and referred appropriately.

2.3.2.6. Assessment of the cord

Parents should be advised regarding keeping the umbilical cord clean and dry and that antiseptic should not be used routinely.

2.3.2.7. Oral assessment

Babies who appear to have tongue tie should be evaluated further reviewing feeding and referring if necessary.

2.3.2.8. Weight

Baby should be weighed on day 5 (up 10% weight loss from birth should be considered acceptable) and day 10 (baby should be back at birth weight or over). Any baby outside this range requires discussion with the neonatologist.

2.3.2.9. Parenting and emotional attachment

- Assess and promote parent to baby emotional attachment.
- Healthcare professionals should be alert to risk factors and to the signs and symptoms of child abuse and follow local safeguarding procedures.
- Healthcare professionals to ensure that all families are provided with ICON advice during their admission.

2.3.3. Length of hospital stay

Length of hospital stay should be discussed between the individual woman and her midwife, taking into account the health and well-being of the woman and her baby and the level of support available following discharge.

2.3.4. Routine discharge of a mother and her baby from the postnatal ward

2.3.4.1. The midwife must ensure that:

- The woman and/or baby are medically fit for discharge (see appendix 4).
- Safeguarding concerns have been reviewed and an appropriate plan is in place. A copy of the internal safeguarding or social services referral should be filed in the neonatal records. See *appendix 2* for note regarding adding confidential safeguarding information to the electronic discharge.
- The appropriate maternal and neonatal checks have been completed.
- The Newborn and Infant Physical Examination (NIPE) is completed or plans are in place for it to be completed in the community and that the parents have a Personal child health record (red book) with the appropriate completed documentation. All babies being discharged without having had an NIPE should have pre-ductal and post-ductal saturations performed and documented prior to discharge. Any abnormalities must be reported to a neonatologist and plans for discharge postponed. If a woman is being discharged out of MFT catchment area the NIPE must be completed while the baby is an inpatient.
- Newborn blood spot screening has been completed where the baby is day 5 or older.
- Neonatal and maternal cannulae are removed.
- Anti D has been given where appropriate
- Information regarding postnatal discharge (either written leaflets or on-line) has been provided.
    - Make sure that the woman is aware of the process for community Midwife (CMW) home visits.
    - Ensure that the woman has contact details for all relevant healthcare professionals including community midwives, maternity triage and GP.

  - Women should be advised of the signs and symptoms of potentially life-threatening conditions for mum and baby prior to leaving hospital or upon leaving a woman following a home birth.
  - Women should be given advice on how to strengthen their pelvic floor following pregnancy and delivery. Women should be aware to discuss any concerns with their community midwife, maternity triage or GP.
  - Discuss contraception and advice regarding possible dyspareunia 2-6 weeks following birth has been given.
  - Encourage women to book their smear test if this is due. This should be completed at around 3 months postnatal.
  - Ensure that parents have been given advice regarding sudden infant death syndrome. See Trust-wide *Safer Sleeping practice for Infants Guideline.*
  - Consider giving parents information about the Baby Check scoring system and how it may help them to decide whether to seek advice from a healthcare professional if they think their baby might be unwell
  - Advise the mother she must register the birth within 42 days (NMC, 2010)

- TTO's (take out medications) have been prescribed, ordered, arrived at the ward, checked, given using positive patient identification and their use explained.
- Plans are in place for necessary follow up appointments and appropriate referrals as per the individualised postnatal care plan.
- The postnatal discharge proforma is completed and discharge address and telephone number and GP are correct.
- Site specific electronic discharge paperwork completed.
- The completed electronic discharge summary must be passed on to the GP.
- The baby has been referred to community NICU midwifery team if appropriate (*see Appendix 1*)
- Where women have multiagency needs the midwife providing postnatal care will ensure that the appropriate health professionals are informed that the woman has given birth and check that all appropriate care is in place before discharge.

2.3.5. Discharge of Mother and her baby when the baby is being placed with an alternate carer (e.g. foster care prior to adoption).

2.3.5.1. Legally, a mother has parental responsibility for her baby. This responsibility may be shared with her spouse. Responsibility may also be shared with a local authority, following a court order. If the baby's non-birth parent is not married to the mother then he does not have parental responsibility until he is named on the birth certificate (DOH 2003).

2.3.5.2. The baby should remain with his/her mother following delivery and on transfer to the ward unless medically indicated or in extreme circumstances when the social worker deems an alternative method of transfer to be in the child's best interests. This is to ensure continuity of care and enable appropriate liaison with all multidisciplinary professionals. Where it is not possible for both mother and baby to be on the same postnatal ward, the named midwives for the mother and baby on each ward must ensure good communication is maintained and all the multidisciplinary team are kept informed of the whereabouts of both mother and baby.

Separation of mother and baby can only be enforced if the woman has signed a "Section 20" for voluntary placement into foster care; or the social worker has an "Emergency Protection Order" in place; or the Police have issued a "Police Powers of Protection" at the direction of the allocated social worker. If none of the above are in place, the baby can still be cared for separately if the woman has agreed and it is clearly documented that she has consented to do so. The woman is also free to withdraw the consent or the Section 20, and in which case the baby should be returned to her care, having first notified the allocated social worker and the Matron for Safeguarding. Consider contacting security for presence on the ward during a removal if deemed necessary.

2.3.5.3. **Maternal Communication** – In addition to all points on **2.3.4.1** the midwife must ensure that -

- Electronic discharge includes the information stating the baby is being placed into alternative care. **Do not** include details of the baby's discharge address on the mother's electronic discharge printout.
- The Community Midwife, G.P., Modern Matron for Safeguarding, Social Worker and other health professionals are notified as appropriate.

2.3.5.4. Neonatal Communication – in addition to relevant points on 2.3.4.1 the midwife must -

- Ascertain who will be responsible for the care of the baby following discharge documenting the following:
    - Name, address, telephone number of carer
    - Ensure baby stickers are amended with carer's details and address (NOT birth mother's details) in order for the 5 day blood spot test results to be appropriately communicated.
    - Name, address, telephone number of GP with whom baby will be registered.
    - To enable appropriate care to be given by the foster parents at all times; identify whether the baby has or may have specific problems which the foster parent(s) will require notification of, e.g. specific feeding needs or outpatient follow-up.
    - Complete and issue child health record to foster parent. Explain to the foster carer that this is the child's personal child health record. It will be used by every health professional that cares for the child to document important health information.
- Ensure that the baby is discharged into the care of a bona fide personnel;
    - Agree a date and time for the discharge of the baby into the care of the foster parent ensuring that the Social Worker is present to identify the carer.
    - Check the identification of the Social Worker documenting this has been checked.
    - Check the identification bracelet to ensure the correct baby is discharged from the ward, and document this has been done in the case notes.
    - Escort the foster carer and Social Worker with baby off the premises.
- Give the foster carer contact telephone number for the Community Midwife and document that this has been done on the discharge planner.
- **Do not** give details of the mother's obstetric history.
- **Do not** give a copy of the maternal electronic discharge to the foster parents. Appropriately completed neonatal postnatal discharge summary is required for information sharing with community midwives and child health – see local admin teams for site specific process. Foster carers' address and GP should be included if

known. An additional copy of the printout should be filed in the baby's medical notes.

- Discuss the safe transportation of the baby.
- Issue and explain details of administration of any take home medication for the baby which must, 'contain the patient's name, details of the drug name and full instructions for use along with the date of dispensing, quantity and any special storage requirements or expiry date etc.
- Notify the following personnel;
    - Community Midwife
    - Radio Telephone Room (ORC site only) – ring to confirm details have been received.
    - Send discharge details to the G.P. where the baby is to be registered if known
    - Inform the Social Worker that the baby is fit for discharge.
    - Safeguarding Team.
    - Health Visitor.

2.4. Postnatal home visits:

2.4.1. Process for postnatal visiting

2.4.1.1. The relevant community midwifery team is notified of the discharge from Saint Mary's Hospital, using the information on the electronic discharge summary.

2.4.1.2. The schedule of visiting to a woman and her baby will be dependent upon need. For women with identified risk factors an individual plan of visits will be developed; this may include continued support from the community midwifery team until 28 days. The minimum level of visiting offered to women is:

Primary visit- This will be the day after discharge from hospital or the day of the birth for women giving birth at home. This visit is to:

- Assess maternal and neonatal wellbeing (see *sections 2.3.1. and 2.3.2.*)
- Reiteration of emergency contact numbers
- Discuss signs and symptoms of life-threatening emergencies for either the mother or her baby
- Support women to promote their own and their babies' health and well-being and to recognise and respond to problems by providing information and advice.

Day 5 – This visit can be undertaken by a midwife or Community Midwife Support Worker

- Assessment of maternal and neonatal wellbeing (see *sections 2.3.1. and 2.3.2.*).
- Newborn screening
- Weighing of baby

Day 10 - This may be in the home setting or an appointment at a community-based postnatal clinic.

- Assessment of maternal and neonatal wellbeing (see *sections 2.3.1. and 2.3.2.*)
- Weighing of baby
- Transfer of care to the Health Visitor if deemed appropriate.

2.4.1.3. Home visits should be used as an opportunity to assess relevant safety issues and promote safety education. Healthcare professionals should promote correct use of basic equipment.

2.4.1.4. **Maternal well-being:** *As per 2.3.1.*with the exception of undertaking MEOWS. If not clinically indicated routine observations (pulse, temperature, blood pressure etc…) are not necessary at home visits. If the woman is at home and appears seriously unwell an emergency ambulance should be requested. At each postnatal contact, give the woman the opportunity to talk about her birth experience, and provide information about relevant support and birth reflection services, if appropriate.

2.4.1.5. **Neonatal well-being** – *See 2.3.2. O*n-call neonatologists can be contacted via switchboard by community healthcare professionals if they have neonatal concerns .

3. Communication

All women with learning disabilities, visual or hearing impairments or those whose first language is not English must be offered assistance with interpretation where applicable, and where appropriate a telephone interpreter must be used. It is paramount that clear channels of communication are maintained at all times between all staff, the women and their families. Once any decisions have been made/agreed, comprehensive and clear details must be given to the woman thereby confirming the wishes of the women and their families.

The contents of any leaflet issued must be explained in full at the time it is issued. All communication difficulties (including learning difficulties) and

language barriers must be addressed as outlined in the previous paragraph at the time the leaflet is issued. Ensure the provision and discussion of information of the risks and benefits with women during the antenatal, intrapartum and postnatal periods.

Staff should aim to foster a culturally sensitive care approach in accordance with the religious and cultural beliefs of the parents and families in our care.

4. Equality diversity and Human Rights Impact Assessment

This document has been equality impact assessed using the Trust's Equality Impact Assessment (EqIA) framework.

The EqIA score fell into low priority; no significant issues in relation to equality, diversity, gender, colour, race or religion are identified as raising a concern.

5. Consultation, Approval and Ratification Process

During development this guideline has been reviewed by senior midwives, obstetricians, anaesthetists, neonatologists and neonatal nurses from both Saint Mary's ORC and Saint Mary's at Wythenshawe and amended for use at Saint Mary's at North Manchester. It has been ratified by the Site Obstetric Quality and Safety Committee.

It will be formally reviewed 3 years following its ratification or sooner if there are significant changes in evidence based practice.

6. References

CMACE *Saving Mothers' Lives reviewing maternal deaths to make motherhood safer*: 2006–2008

National Institute for Health and Care Excellence (2021) Postnatal Care (NG194) NICE, Manchester

National Institute for Health and Care Excellence (NICE) (2014) Antenatal and postnatal mental health: clinical management and service guidance (CG192) NICE, Manchester

7. Appendices

Appendix 1: Referral Criteria to NICU Community Midwife
Appendix 2: Postnatal Discharge of Mother and Babies with Safeguarding Concerns
Appendix 3: Postpartum contraception
Appendix 4: Women appropriate for midwifery discharge

Appendix 1: Referral Criteria to NICU Community Outreach

The criteria are based on the work of the Greater Manchester Neonatal Outreach Clinical Reference Group (NOCRG). In addition the criteria also take in to account infants who have undergone surgery on the NICU at Saint Mary's:

- All babies who weigh 2.2kg or less
- Babies who have been on the NICU for 7 days or longer
- Babies whose gestation is less than 35 weeks
- Complex medical needs e.g. Short term palliative care, oxygen dependent infants, tube feeding, cardiac anomalies etc.
- Any other medical concerns –including post-operative surgical conditions requiring on-going care.
- All infants who meet the criteria and are resident within the MFT outreach catchment area.

Appendix 2

POSTNATAL DISCHARGE OF MOTHER AND BABIES WITH SAFEGUARDING CONCERNS

COMPLETE ELECTRONIC DISCHARGE AS REQUIRED

(AT THE END SECTION "REMARKS" THERE WILL BE AN ADDITIONAL PROMPT "ARE THERE ANY SAFEGUARDING CONCERNS?")

COMPLETE ANY ADDITIONAL REMARKS AND PRINT OFF

(GIVE THIS COPY TO MOTHER TO TAKE HOME FOR THE COMMUNITY MIDWIFE)

RETURN TO ELECTRONIC AND DOCUMENT ANY FURTHER CONCERNS RELATING TO SAFEGUARDING

(SAVE THE UPDATED INFORMATION AND PRINT OFF THE COMPLETED COPY FOR MATERNITY RECORDS)

COMPLETED POSTNATAL DISCHARGE SUMMARY IS REQUIRED FOR SHARING WITH COMMUNITY MIDWIVES AND CHILD HEALTH – see local admin teams for site specific process

Appendix 3: Postpartum contraception

- Postpartum family planning (PPFP) aims to prevent unintended pregnancy and closely spaced pregnancies after childbirth.

- Contraception should preferably be discussed with all women while they are still pregnant to allow time to choose postpartum contraception. Contraception should **not** be discussed with a woman who is in active labour.

- IUDs and implants are the most effective reversible methods of contraception.

- If the patient chooses a method such as sterilisation that cannot be provided there and then, ensure that an interim method is provided in order to prevent unintended pregnancy.

Intrauterine devices (copper IUD/ Levonorgestrel releasing IUD, Mirena)

If not inserted within 48 hrs of delivery, insertion should be delayed until 4 weeks after the birth (referred to as 'interval insertion') to reduce the risk of uterine perforation.

The IUD can be inserted at the time of caesarean section via the uterine incision once the placenta has been delivered. While rates of IUD expulsion after postpartum insertion are slightly higher than after interval or later insertion, the benefits of providing highly effective contraception immediately after delivery outweigh this disadvantage.

Use of a copper IUD postpartum does not interfere with breastfeeding.

Failure rate 1/200.

Implants

Implants can be inserted immediately postpartum. If inserted before 3 weeks after delivery, there is no need to check for pregnancy. Postpartum implant use does not interfere with lactation. Failure rate 1/1000

Sterilisation

Female sterilisation can be performed within the first 7 days postpartum or at any time after the baby is 6 weeks old. Between 7 days and 6 weeks there is an increased risk of complications as the uterus has not fully involuted.

Progestogen only injectable contraceptives

Progestogen only injectable contraceptives (Depo Provera) can be started immediately postpartum in both breastfeeding and non-breastfeeding women. Postpartum POI contraceptives do not interfere with lactation. Failure rate 3/100.

Progestogen only contraceptive

POPs can be started immediately postpartum. Postpartum POP use does not interfere with lactation. Failure rate 9/100

Lactational amenorrhoea method

Women who are breastfeeding their infants can rely on the contraceptive effects of lactation to prevent unintended pregnancy provided that they are: (1) experiencing amenorrhoea; (2) fully or nearly fully breastfeeding; and (3) less than 6 months postpartum. Once menstruation returns, breastfeeding frequency decreases or the baby is 6 months old, another method of contraception should be started and all available methods are suitable for use. Failure rate 2/100.

Combined oral contraceptive

COCs should not be used by breastfeeding women until the baby is 6 months old because they may interfere with breastfeeding.
Women who are not breastfeeding may start COCs at 3 weeks postpartum unless they have additional risk factors for venous thromboembolism (VTE), in which case they should not start COCs until 6 weeks after childbirth. Failure rate 9/100

References

Faculty of Sexual & Reproductive Healthcare (2014), Male and Female Sterilisation. available online at https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/

Royal College of Obstetricians and Gynaecologists (2015), Best practice in postpartum family planning - Best Practice Paper No. 1, available online at https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-1---postpartum-family-planning.pdf

Royal College of Obstetricians and Gynaecologists (2016), Female Sterilisation – Consent Advice no 3, available online at https://www.rcog.org.uk/globalassets/documents/guidelines/consent-advice/consent-advice-3-2016.pdf

Appendix 4: Women appropriate for midwifery discharge

1) Normal vaginal delivery or uncomplicated instrumental delivery completed in the delivery room
2) No treatment in theatre
3) Estimated blood loss ≤ 1500ml and Hb >75g/L (if postnatal Hb tested)
4) Normal observations postnatally following transfer to ward
5) Not under a specialist medical disorders clinic
6) Woman well and not causing medical concern
OR
7) **Have been reviewed by a doctor and documented as fit for midwife led discharge (MLD)**

Appropriate for midwifery discharge if "yes" to 1-6 OR 7.

Appendix 5: Postnatal women and people requiring Consultant review

1) Post HDU care
2) PPH > 1500ml
3) Postnatal readmission
4) Prolonged obstetric stay > 72 hours
5) Unstable hypertension on medication
6) BMI >50
7) IV antibiotics > 24 hours
8) Underlying medical condition or surgical complication
9) Patients involved in a never event e.g. a retained swab
OR
9) **Any concern about condition from midwife or junior doctor**

ORC: Please ensure patients are added to the consultant review list on chameleon in the morning ready for the ward round. All patients must also be reviewed by the junior doctor on the morning round to avoid any delays.

Wythenshawe and North: Please use sheet below.

Manchester University
NHS Foundation Trust

Appendix 6: Postnatal Obstetric Consultant Review sheet

Obstetric consultant reviews

Bed no	Initials	MOD	TTO	Reason for review	Bloods review

Patients requiring consultant review

- Post HDU care
- PPH > 1500ml
- Postnatal readmission
- Prolonged obstetric stay > 72 hours
- Unstable hypertension on medication
- BMI >50
- IV antibiotics > 24 hours
- Underlying medical condition of surgical complication
- Patients involved in a never event e.g. retained swab
- Any concern about condition from a midwife or junior doctor