Postnatal care pathway

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Guideline to be followed by (target staff):

To be read in conjunction with the following documents:
Maternity Infant Feeding Policy
Newborn Infant Physical Examination
Expressing Colostrum Antenatally PIL
Infant Feeding Policy
NBBS

Are there any eCARE implications? Yes

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The purpose of this policy is to ensure that all staff at Milton Keynes University Hospital (MKUH) NHS Foundation Trust understand their roles and responsibilities caring for service users and their newborn babies during the postnatal period. The following guidance outlines the minimum care that should be provided to mothers and should be used in conjunction with the relevant trust guidelines.

Executive Summary

This guideline is intended to support and guide the management of service users and their babies who are in the postnatal period. This guideline is only for use for babies born over 35+0 weeks gestation who do not require medical intervention at birth and are well enough to remain with their mothers for normal care or neonatal transitional care.

In addition to the care of the late preterm, this document also incorporates the care of early term, or late term babies on the postnatal ward born between 1.8 – 2kg will need additional monitoring due to their small size.

Be aware that the 2020 MBRRACE-UK reports on maternal and perinatal mortality showed that women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring. The reports showed that: compared with white women (8 per 100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is:

– 4 times higher in black women (34 per 100,000)

– 3 times higher in mixed ethnicity women (25 per 100,000)

– 2 times higher in Asian women (15 per 100,000; does not include Chinese women) please see references there is now a newer version MBRACE 2023 – you might want to update this data.

The neonatal mortality rate is around 50% higher in black and Asian babies compared with white babies (17 compared with 25 per 10,000) women living in the most deprived areas are more than 2.5 times more likely to die compared with women living in the least deprived areas (6 compared with 15 per 100,000) - the neonatal mortality rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many babies dying in the most deprived areas compared with the least deprived areas (12 compared with 22 per 10,000) (NICE NG194, 2021)

Please note: Care of late preterm infants requiring admission to NNU, and those with complex additional needs is beyond the scope of this guideline.

Definitions

ANNP – Advanced Neonatal Nurse Practitioner
BAPM – British Association of Perinatal Medicine
BCG – Bacille Calmette-Guérin
BFI – Baby Friendly Initiative
BFO – Breast Feeding Observation
BG – Blood Glucose
BM – Blood Glucose Reading
Bung – Purple bung manufactured for use with oral syringes to hold collected breastmilk
CC – Confidential Communique
CHINS – Close, Head, Inline, Nose, Sustainable
CSF – Cerebrospinal Fluid
Cup Feeding – Offering a feed via a sterile single use cup of breastmilk or formula
DoCC – Department of Critical Care
EBL – Estimation of Blood Loss
EBM – Expressed Breast Milk
EDM – Electronic Document Management
EqIA – Equality Impact Assessment
FGM-IS – Female Genital Mutilation Information Sharing
GBS – Group B Streptococcus
GP – General Practitioner
IAPT – Improving Access to Psychological Therapies
IM – Intramuscular
IUGR – Intra Uterine Growth Restriction
IV – Intravenous
IVAB – Intravenous Antibiotic
LMWH – Low-Molecular-Weight Heparin
MRSA – Methicillin-Resistant Staphylococcus Aureus
MRN – Medical Record Number
NBBS – Newborn Blood Spot Screening
NEC – Necrotising Enterocolitis
NEWS – Neonatal Early Warning System
NEWT – Newborn Early Warning Trigger & Track
NIPE – Newborn and Infant Physical Examination
NLS – Neonatal Life Support
NNU – Neonatal Unit
OD – Once Daily
PCHR – Paediatric Child Health Record
POC – Point-of-Care
PROM – Prolonged Rupture of Membranes
Rh-D – Rhesus D (RhD) antigen
SBAR – Situation, Background, Assessment, Recommendation
SGA – Small for Gestational Age
SIDS – Sudden Infant Death Syndrome
Syringe Feeding – Offering a feed via sterile single use oral syringe of breastmilk
TCB – Transcutaneous Bilirubinometer
TTO – To Take Out
VIP – Visual Infusion Phlebitis
VTE – Venous Thromboembolism
WHO – World Health Organisation

1.0 Roles and Responsibilities:

Chief Executive and Trust Board

Provision of environment – facilities, service and systems support Links with all the other relevant risk management committees.

Divisional Manager

To support forward planning of the service in relation to infant feeding and support the Baby Friendly Initiative accreditation process

Divisional Chief Midwife

Facilitate staff training and ensure compliance with policy to support best practice. Ensure the accurate collection of breastfeeding data.

Lead Midwife for Risk Management

To ensure the protocols and policies are adhered to. Discuss risks identified and action required to prevent risks.

Midwife

Responsible for providing routine postnatal care for mothers and their babies in both the hospital and community settings in line with current national guidance. Develops individualised care plans for mothers and their babies and escalates to the appropriate healthcare professional when there are deviations from normality. To complete the examination of the newborn as per examination of the newborn guideline if appropriately trained.

Nursery Nurse

Under the direction of the midwife provide care and infant feeding support and new parents and their babies. To perform neonatal observations and assist in the provision of transitional care, escalating deviations from normal to Midwife caring for the service user/baby.

Maternity Care Assistant and maternity support worker

Under the direction of the midwife 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 service user.

Obstetricians

– To review and recommend care pathways for women requiring medical intervention in the antenatal, intrapartum or postpartum period. Prescribe necessary medication including contraception, add any additional information on the discharge notification where necessary. Organise any postnatal debrief after discussion with a consultant and emailing the Obstetric Team Hub (Obs.Gynae@mkuh.nhs.uk)

Paediatricians/ANNP's

To review and recommend care pathways for babies where there has been a deviation from normality.

2.0 Implementation and dissemination of document

This document will be presented in team meetings, risk management meetings, Maternity and Paediatric guideline groups and Clinical Improvement Groups. It will be accessible on the hospital intranet.

As part of this commitment the service will ensure that:

- All new staff are orientated with this policy on commencement of employment.
- All staff receive training to enable them to implement the policy as appropriate to their role.
- New staff receive BFI training within six months of commencement of employment.
- The International Code of Marketing of Breast-milk Substitutes is implemented and adhered to throughout the service.
- All documentation fully supports the implementation of these standards.

3.0 Processes and procedures

3.1 Care planning and delivery

A coordinating healthcare professional should be identified for each service user. Based on the changing needs of the service user and baby, this may change over time.

An individualised postnatal care plan should be developed with the service user ideally in the antenatal period or as soon as possible after the birth, prior to transfer to the postnatal ward or home. 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 the baby, including roles and contact details
- Plans for the postnatal period
- Review and actioning of Baby Alerts

Individualised care plans for the postnatal period should be reviewed at each postnatal contact.

Length of stay following birth and plan for discharge should be discussed with the service user, taking into account the health and wellbeing of the service user and her baby, and the level of support available following discharge.

4.0 Immediate Care Following Birth

4.1 Immediate Care of the Mother

Following the completion of the third stage of labour, an inspection of the perineum and genital tract should be carried out to identify any trauma present and if required a repair carried out. Please refer to Perineal Trauma and Repair Guideline for further information.

The service user should be offered clean linen and assistance given to wash or shower as soon as possible following birth and if she wishes to do so.

One set of maternal observations should be completed within 1 hour of 3rd stage completion (additional/more frequent observations may be required if clinically indicated).

Maternal observations should include:

- Temperature
- Pulse
- Respirations
- Blood Pressure
- Oxygen saturations
- Lochia assessment
- Uterine Involution
- First void - urine volume (refer to bladder care guideline)

Where there are any complications or concerns, obstetric review should be sought immediately.

Risk assessments, including the postnatal Venous Thromboembolism (VTE), Waterlow score, VIP score and patient handling risk assessment should be completed on eCare prior to transfer to the postnatal ward and VTE prophylaxis prescribed, if required.

If the service user is Rh-D negative cord bloods and maternal bloods should be taken and sent as per Prophylactic Anti-D Immunoglobulin guideline on the labour ward prior to transfer to the ward.

4.2 Immediate care of the newborn

Skin to skin contact between birthing person and baby must be initiated immediately following the birth unless otherwise clinically indicated or declined by the mother and should be allowed to continue uninterrupted for at least one hour or following the first feed. Mothers temperature should be checked to ensure within normal range.

Breastfeeding must be promoted and facilitated in accordance with the Newborn Feeding Policy change to Maternal Infant Feeding Policy N.B there is also a Neonatal Infant Feeding Guideline – should the 2 not be amalgamated. The baby should be allowed to take its first breastfeed without interruption of its innate reflex to find and attach to the breast.

Newborn Observations and care of baby should include:

- Initial examination of the newborn. After a baby is born, the Midwife will carry out an initial preliminary examination on the baby. This includes a top to toe assessment of the baby for any obvious signs of abnormality or deviation from the normal, Head Circumference, temperature and weight. The Midwife must explain the purpose of the examination to the parents. The baby must be observed naked in good light with consideration to

thermoregulation. Deviation from the normal should be appropriately referred and all findings/actions and plan documented in eCare.

- 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 dose of 1mg IM. If parents decline IM Vitamin K, oral Vitamin K should be offered as second line.(suggest giving full title of PIL: Vitamin K for newborn babies)

- Ensure any neonatal observations required are carried out in a timely manner, temperature check should not be taken at birth – baby requires time to adapt to conditions, however observations should not be delayed until after transfer to the postnatal ward.

Where there are any complications or concerns, paediatric review should be sought immediately.

Parents will be provided with the Paediatric Child Health Record (PCHR/Red book prior to transfer to the Postnatal Ward, or home if being discharged from Labour Ward. The Midwife must explain the purpose of the book and advise it must always remain with the parents during their stay (not on the notes trolley on ward or sent home).

5.0 Early Transfer Home from Labour Ward

Women that have had an uncomplicated pregnancy, labour and birth may choose to go home within 6-8 hours of the birth.

5.1 Contraindications to Early Discharge (this list is not exhaustive)

Maternal

- Raised blood pressure in the antenatal, intrapartum or postnatal period.
- Assisted vaginal birth
- Complications of the third stage i.e. postpartum haemorrhage, manual removal of placenta and examination under anaesthetic
- Infection risk
- Babies who have been born by assisted vaginal birth
- Medical complications e.g. diabetes, cardiac anomalies
- Social factors e.g. cause for concern, safeguarding risks

Neonatal

- Babies undergoing observations
- Babies requiring additional feeding support
- Babies born by instrumental or assisted birth

- Babies identified antenatally (via Baby Alert) as requiring additional investigations/intervention.

5.2 Process for Early Discharge

The current discharge process should be followed as per routine postnatal discharge from the postnatal ward:

- All babies should have their Newborn and Infant Physical Examination (NIPE) completed by an appropriately trained practitioner prior to discharge. Where this is not possible, the maternal notes should be retained on Labour Ward and an outpatient NIPE appointment made for the next day or within a maximum of 72 hours. Alternatively, arrangements can be made for this to be carried out at home during the first day visit if an appropriately trained midwife is available. If the baby is sent home without a NIPE, the baby must have pre and post ductal saturations taken and documented prior to discharge.

- Prior to discharge home it is important that all observations for the mother and baby are within normal parameters. The mother should have passed urine within 6 hours following the birth (refer to bladder care guideline) and the baby taken adequate feed. This feed should be observed for signs of effective feeding and must be documented including BFO if breast feeding.

- The midwife should ensure that the mothers and baby's postnatal records are completed in full, and a daily check has been completed and documented on eCare.

- The Maternity Discharge Form should be completed informing the Community Midwife of the discharge (Appendix 1) and left in the Discharge Book on labour ward for collection by the Community Midwifery teams. The service user's sticker should also be placed in the discharge book with the service user's current telephone number and signed/printed by the discharging midwife.

- If the service user is Rh-D negative, she **must not** be discharged until the cord blood and maternal blood results have been checked and Anti-D immunoglobulin administered if required.

- Hearing screening will either be completed by the hearing screening team prior to discharge, or where this is not possible (due to discharge time etc) an outpatient appointment will be arranged and parents should be advised they will receive an appointment letter.

6.0 Transfer to the Postnatal Ward

- Due to clinical and/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 is appropriate following delivery unless otherwise indicated, and preferably in skin-to-skin contact.

- Prior to transfer to the ward the Midwife on labour ward or in theatre should phone and request a bed with the Midwife in charge on ward 9. Following a brief description of the service user's assessment and plan of care, the shift lead should allocate a bed whilst on the phone and inform the calling midwife to avoid any delays when arriving on the postnatal ward.

- Following transfer, handover of care should take place at the beside as per the Multi-professional Handover of Care (Maternity) guideline. The mother should be involved in this, so she is aware of her plan of care during the postnatal period.

- The transferring midwife should provide a detailed account of the service user's history, birth and individualised care plan using SBAR and document the SBAR handover on eCare. Information regarding any Baby alerts should also be handed over.

- The Mother and Baby's daily postnatal assessment should be completed immediately following transfer and recorded in eCare.

- On admission to the postnatal ward the parents should be given information and advice about co-sleeping and bed sharing whilst in hospital (as detailed in the Co-sleeping and bed sharing for Mothers and Babies Guideline). This conversation must be documented in eCare. Name the PIL Bed Sharing Tips. And add Caring for your baby at night and when sleeping.

- The service user should be orientated to the ward facilities, given fresh water and shown how to contact staff. This is then documented in the mother's record. The service user should be informed of visiting times and given the patient information leaflet for partners or family members staying overnight on the ward. (name the leaflet Birthing Partners Staying Overnight). The partner or family member who will be staying must be made aware that they could be asked to leave if they are found to be breeching the behavioral expectations.

- The ward handover sheet should be updated by the Midwife handing over, this should include whether the baby requires a NIPE examination and any baby alerts.

7.0 Maternal Inpatient care

7.1 Maintaining Maternal 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. For postnatal PILs, please see the trust intranet.

The MEOWS scoring chart should be used and observations taken at least 4 times per day for service users who are still under the care of the obstetric team. Escalation should be followed as appropriate for medical review as needed. Observations may be more frequent depending on the service users' obstetric management plan. Service users who are midwifery led care and inpatients for neonatal reasons, for example feeding support or neonatal IVABs should have observations taken once per day.

Any woman who has required extended length of stay over 48 hours (for maternal condition not baby's condition) should be considered for a senior review by a consultant or senior registrar.

All woman can be signposted to Birth Afterthoughts clinic, however those with more serious obstetric events should be considered for postnatal debrief with a consultant, for example eclampsia, emergency Caesarean needing General anaesthetist, major obstetric haemorrhage after vaginal birth requiring surgical intervention (balloon/laparotomy), any HDU or ITU stay (this

list is not exhaustive). The junior obstetrician should make contact with the consultant regarding the need for a formal postnatal debrief, and email to the Womens Hub.

Once the woman has been reviewed by the medical team and deemed fit from medical perspective, the woman can be referred back to the midwifery team to facilitate discharge.

All women who have an operative birth via Caesarean should have a medical review prior to discharge. This should include discussion regarding

- Reasons behind the need for Caesarean birth
- The woman's recovery from surgery (bladder/bowel/lochia)
- post-operative recovery and wound care
- contraception

Ideally all woman who have had an operative vaginal birth should have a review with the medical team to ensure understanding of events in labour and need for intervention. This may occur prior to arrival on the postnatal ward. If midwifery staff feel a woman needs a further review regarding the operative vaginal birth, this can be requested and would follow the same lines as a post Caesarean review.

All women who have required intravenous antibiotics during labour (apart from those for GBS prophylaxis) require a medical review within 24 hours of arrival within the postnatal ward.

A VTE assessment should be carried out for all woman post birth, the medical team should prescribe low molecular weight heparin in accordance to the guidelines (reducing the risk of venous thromboembolism)

Postnatal contraception (desogestrel 75 mcg 3 month supply, depot injection (150mg medroxyprogesterone, implant) can be offered to all woman prior to discharge.
Should they choose one of these methods, this needs to be documented on the discharge notification to the GP.

7.2 Within the First 24 hours of Birth

Women should be offered timely and relevant information to enable them to promote their own and their babies' health and wellbeing and to recognize and respond to problems. Parents should be advised of the signs and symptoms of potentially life-threatening conditions and to contact their healthcare professional immediately or call for emergency help if any symptoms occur. PILs are available in the discharge packs, as well as on the intranet and include (but are not limited to) Jaundice in Newborn Babies, Paediatrics, Patients and Relatives Information, Patient Information Leaflet, Umbilical Cord Care.

Parents, family members and carers should be offered information and reassurance on their baby's social capabilities as this can promote parent–baby attachment.

All women should be given information about the physiological process of recovery following birth, and that some health problems are common, with advice to report any health concerns to a healthcare professional, in particular:

Signs and Symptoms	Possible 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	Infection
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

PIL Care of your perineum after the birth of your baby, and Caring for your wound after having a caesarean section can be given.

Is there a leaflet on eclampsia (the one on ore-eclampsia makes no mention about after birth) and thromboembolism

Women should pass urine within 6 hours of birth and this should be documented in eCare. For further information regarding bladder care management, please refer to the Bladder Care guideline, Caesarean Section Guideline and Enhanced Recovery after Caesarean Section Delivery guideline.

Blood pressure should be measured immediately after birth. This should also be repeated within the first 6 hours after birth. More frequent observations may be required if clinically indicated.

Women should be encouraged to mobilise as soon as appropriate following birth.

For women who have delivered via vaginal delivery or caesarean section, please refer to the appropriate guidelines for detailed guidance on management following delivery.

If a service user 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.

8.0 Inpatient neonatal care

8.1 Maintaining Infant Health

Each neonate should be undressed and reviewed head to toe daily for their postnatal check. This should be documented clearly in e-Care and any anomalies should be escalated to the neonatal team.

Specific care pathways should be followed for newborns with risk factors (this list is not exhaustive):

- Meconium Stained liquor
- PROM

- GBS
- Babies at risk of hypoglycemia
- Babies at risk of neonatal abstinence syndrome
- Babies born with birthweight under the 10th centile.
- Late preterm infant

8.1 Neonatal passing of urine and meconium

If the neonate has not passed urine or opened their bowels within the first 24 hours of life, they must be referred urgently to the neonatal team for review.

8.2 NIPE examination

The Newborn Physical Examination (NIPE) should be performed by an appropriately trained health Professional within 72 hours of birth as per Examination of the Newborn guideline as per Newborn Infant Physical Examination CHP/GL/2.

8.3 Oxygen saturations for all babies

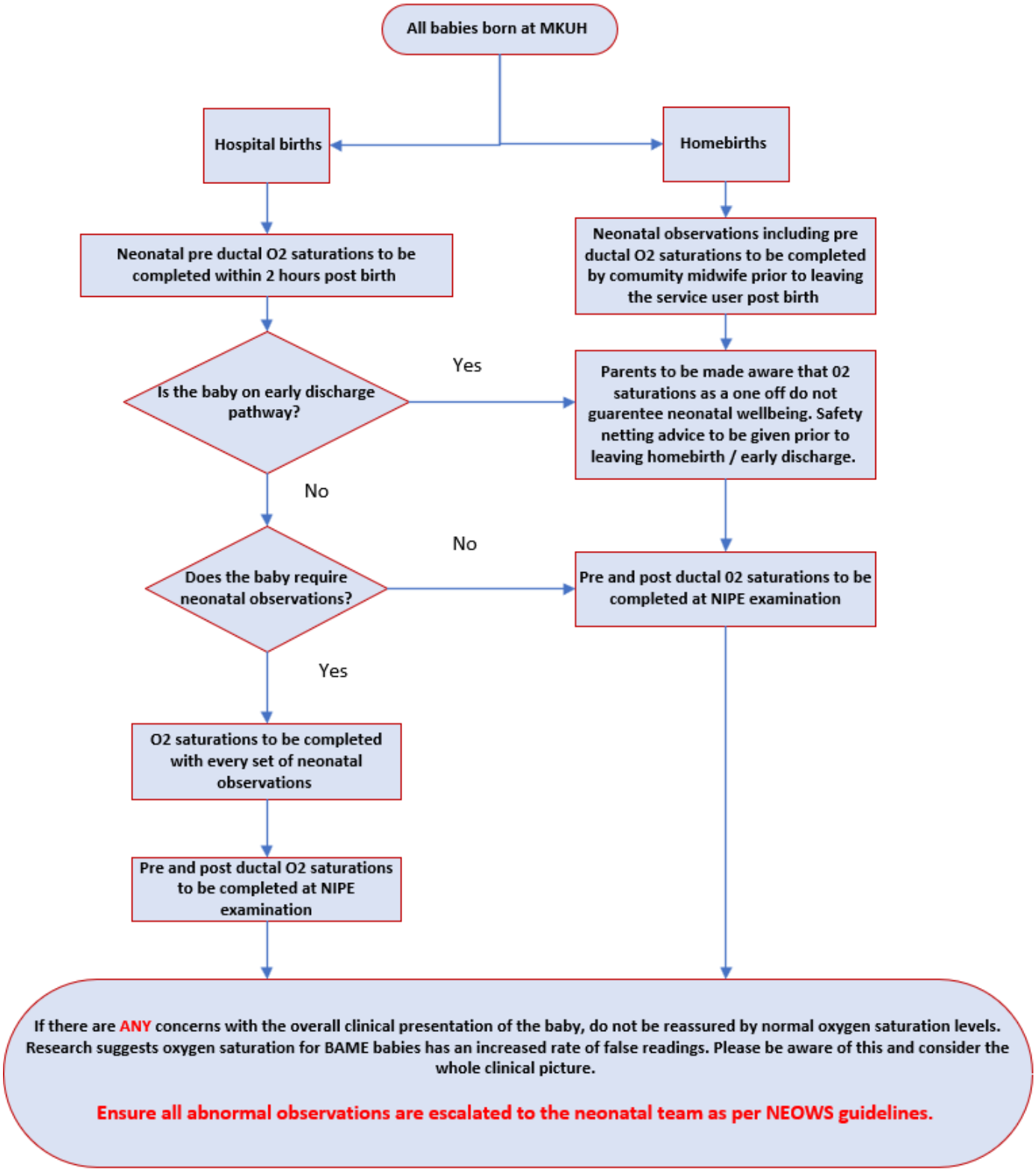
All babies born at the trust require observations and oxygen saturation measurements as a minimum. Please see flowchart 1 bwelow.

8.3 Neonatal Observations

Babies admitted to the postnatal ward may require additional neonatal observations for several reasons, which should include:

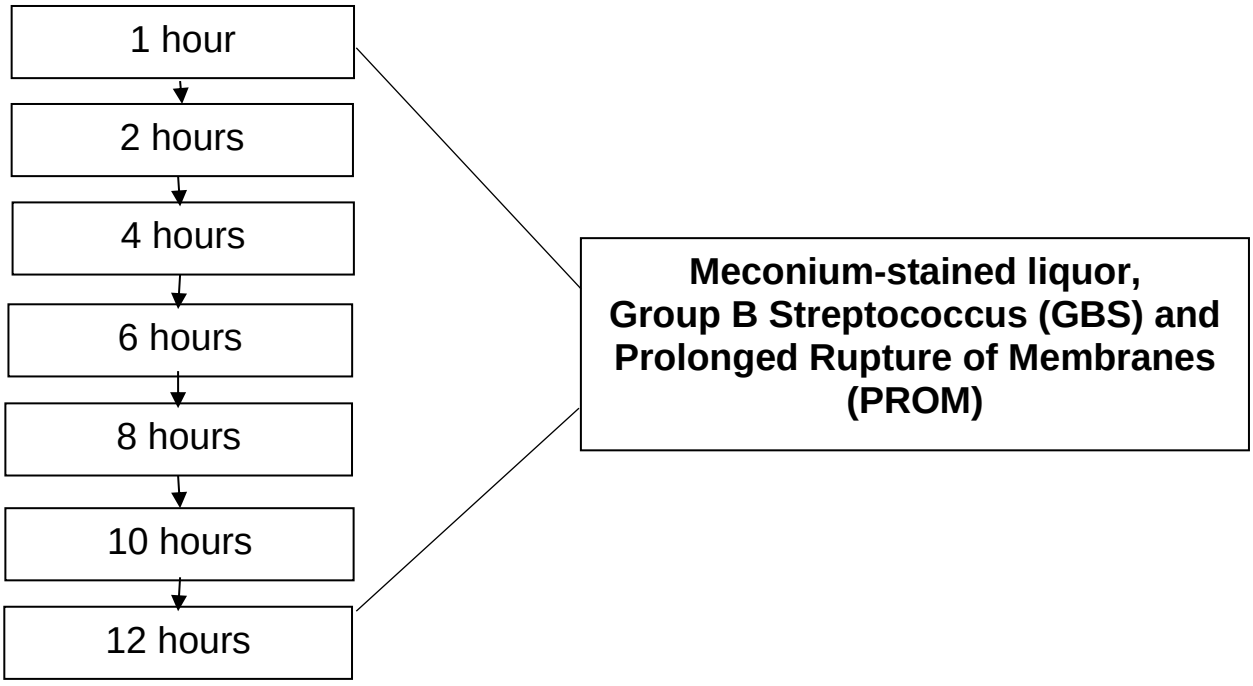
- Heart rate
- respiratory rate
- Temperature
- Muscle tone
- General wellbeing
- Chest movements and nasal flare
- Skin colour including perfusion by testing capillary refill
- Feeding
- Oxygen saturations

Please see flowchart 2 below for details on the timings for neonatal observations.



For all neonatal observations, please see flowchart 2 below

Neonatal Observations



4 hourly observations
(see below for duration)

Hypoglycaemia pathway (for duration of pathway)
Centile (above 2nd and below 10th)
Neonatal IV Antibiotics
Phototherapy
Babies on reluctant feeder pathway
Neonatal Abstinence Syndrome

Any baby with symptoms of possible sepsis or born to women who have evidence of chorioamnionitis are to be referred immediately to the Paediatric Team.

8.4 Meconium stained Liquor

Babies born in meconium stained liquor should be closely monitored for the first 12 hours following birth, at 1 hour, 2 hours and then 2 hourly for 10 hours.

The following babies at risk of EOS should be monitored for the first 12 hours following birth, at 1 hour, 2 hours and then 2 hourly for 10 hours.

- Term babies born to women with Pre-labour rupture of membranes (PROM) more than 24 hours before labour.

- Confirmed rupture of membranes for more than 18 hours in a preterm birth defined as 36+6 weeks

- Invasive Group B Streptococcal Infection in a previous baby

- Maternal Group B Streptococcal colonization, bacteriuria, or infection in the current pregnancy where mother has not received intrapartum antibiotics at least 2 hours before delivery If intrapartum antibiotic prophylaxis is completed greater than 4 hours prior to delivery, this does not count as a risk factor

- Intrapartum fever higher than 38°C if suspected or confirmed bacterial infection

- Clinical diagnosis of chorioamnionitis

If a baby has more than 1 risk factor or develops clinical features of infection, the peadiatrican/ ANNP must be contacted immediately to perform a PSS and commencement of IVABS. For further information please see the Neonatal Sepsis and Antibiotic Guideline change to Neonatal Antibiotic and Sepsis Guideline

8.6 Babies on Neonatal IV antibiotics

Baby should have 4 hourly observations for the duration of the time on Neonatal IV antibiotics.

8.7 Babies under phototherapy

Baby should have 4 hourly observations for the duration of the time under the phototherapy overhead or on the bilisoft bed.

8.8 Neonatal Abstinence Syndrome

Babies should be observed every 4-6 hours using Neonatal drug withdrawal score chart.

8.9 Babies between 10th and 2nd Centile

If a baby is <10th centile but >2nd centile it must have 4 hourly observations for 24 hours using the NEWS chart. If there are any triggers on NEWS, it must commence the Hypoglycaemia Pathway, using the appropriate plans. Suggest See Appendix 4: Plan A: Management of neonate at risk of hypoglycemia

8.10 Babies ≤2nd Centile

In addition to completing the Hypoglycaemia Pathway, these babies must be able to maintain their temperature. They must be weighed on days 3 and 4 to ensure a pattern of weight gain is evident. These can be done in community if discharged home.

8.11 Babies less than 2kg

Due to the increased risk of impaired thermoregualtion, these babies must have a temperature taken every 4 hours. This includes babies whose weight has dropped below 2kg.

9.0 Babies at risk of hypoglycaemia

The following babies are high risk for hypoglycaemia and should be should be identified at birth and placed on the hypoglyceamia pathway. This includes earlu feeding, regular assessment of feeding and clinical condition, and blood glucose (BG) monitoring.

- Late preterm (35-36+6 weeks gestation) cared for on maternity wards. See also Section 11.0
- IUGR (≤2nd centile or below). See also Section 3.4.7
- Maternal diabetes
- Maternal use of beta-blockers, such as Labetalol (any dose antenatally or in labour)
- Hypothermia <36.5°C
- Suspected/confirmed early onset sepsis in the baby.
- Perinatal acidosis (cord arterial pH <7.1 & base deficit ≥12mmol/L)
- Low Apgar score at birth < 5 @ 1 minute < 6 @ 5 minutes
- SGA babies (<10th centile) See also Section 3.4.7.

9.1.1 Antenatal Recommendations

Mothers of babies identified as at risk in the antenatal period should be encouraged to collect colostrum (see Expressing Colostrum Antenatally patient leaflet).leaflet is actually called Antenatal Colostrum Collection. The importance of skin-to-skin contact, responding to feeding cues, the benefits of breastfeeding and the importance of frequent early feeds should be discussed. The leaflet

9.1.2 Thermoregulation

The link between hypothermia and hypoglycaemia is well known. It is crucial that babies at risk of hypoglycaemia are kept warm, with their temperature maintained between 36.5°c and 37.5°c. This begins at birth, where thorough drying of the baby is essential, skin-to-skin contact should be commenced and a red hat should be applied. The room temperature should always be recorded.

Skin-to-skin contact should be the first method of choice used for thermoregulation, providing the mother's temperature is within normal limits. However, some babies may also need to be cared for in a hot cot to facilitate thermoregulation. The temperature of the hot cot is usually initially set at 39°c and reduced gradually according to clinical judgement once the baby's temperature has stabilised. Once the hot cot has been removed, the baby's temperature must be monitored 4 hourly for a further 12 hours to ensure this is stable. Skin to skin contact should always be encouraged.

9.2 Hypoglycaemia pathway

Term Babies on Hypoglycaemia pathway need to have two prefeed blood glucose readings above 2mmol. They also need 4 hourly observations for the duration of the Hypoglycaemia pathway. They should not be discharged until 24 hours of age and feeding is established, including breastfeeding observation using BFI tool. Please see section 11 for management of late preterm babies.

9.3 Clinical signs and symptoms of hypoglycaemia

The clinical signs associated with hypoglycaemia are non-specific, so blood glucose measurement must be undertaken in any infant who presents with one or more of the abnormal signs listed below. If a newborn appears unwell or shows signs of hypoglycaemia refer immediately to a paediatrician/ANNP.

- Jitteriness
- Altered level of consciousness
- Hypothermia <36.5°C
- Lethargy
- High pitched cry
- Hypotonia/floppiness
- Apnoea
- Seizures
- Cyanosis

9.4 Neonatal Blood Sugar Values

In the first 48 hours of life, a term baby on the postnatal ward should have a blood sugar value of 2.0mmol/l and above, a preterm baby should have a value of 2.6mmol/l and above. A neonate over 48 hours of age should have a blood sugar reading of above 3mmol/L

9.5 Prevention of hypoglycemia after birth

- Dry the baby thoroughly including head and put a red hat on.
- Place the baby in skin-to-skin contact with the mother to provide warmth and to facilitate the initiation of feeding.
- Check maternal temperature.
- Ensure that the room temperature is warm.
- Begin care pathway in management plan A (see Appendix 4).
- If the mother intends to breastfeed, but the baby has not latched within one hour of birth, the mother should be assisted to hand express colostrum. This should be given to the baby immediately.
- For women who choose to feed formula milk, offer 10-15ml/kg/feed within the first hour. – this varies from the current BAPM 2024 guidance which states *"For women who choose to formula feed, offer a feed within the first hour after birth at a volume of 40 to 60 ml/kg/day for the first 24 hours. Implement modified responsive paced feeding by ensuring intervals of no more than three hours from the beginning of one feed to the next. Depending on BG measurement, increase the volume of infant formula if necessary. It is possible that the baby's ability to utilize ketone bodies may be limited by the use of infant formula milk. Feeds should be increased with age to 70 to 90 ml/kg/per day at 24 to 48 hours; 100 to 120 ml/kg/per day 48 to 72 hours. Feed responsively when BG measurements have been above 2.0mmol/L on two consecutive occasions. If the baby does not show feeding cues, i.e., is a*

reluctant feeder and has no signs of illness, refer to Practice Points 26 and 27. 40-60ml/kg/day"

- Commence 4 hourly observations using the NEWS chart. These must include temperature, respiratory rate, heart rate and response to stimulus. (BAPM, 2023,p.10) (BAPM 2024, p.41)
- Ensure at least 3 hourly feeds.

9.6 Breastfeeding whilst on hypopathway

To enhance early metabolic adaptation, it is vital that the baby feeds frequently and effectively.

- If the baby is not showing signs of effective feeding within one hour, encourage continuous skin-to-skin contact and teach the mother to hand express.
- Any colostrum which is expressed should be given immediately to the baby.
- Continue to express at least 8-10 times per 24-hour period (including at least once at night) until baby is feeding effectively.
- Support to resume breast milk feeds as soon as possible.
- Do not allow more than three hours to pass between feeds until the Hypoglycaemia Pathway has been completed.
- Once Hypoglycaemia Pathway is complete, return to responsive feeding.
- Continue feeding support for 24 hours after Hypoglycaemia Pathway has been completed.
- Do not discharge until mother and midwife are satisfied that effective feeding is established and at least one BFI Breastfeeding Assessment has been completed.

9.7 Clinical Management of Hypoglycaemia:

Please see Appendix 4 for clinical management plans:
Plan A: Management of neonates at risk of hypoglycaemia
Plan B: Management of pre feed blood sugar 1.0-1.9

All babies with a low blood sugar on hand held blood sugar POC device should have the value checked on a blood gas machine.

9.8 Babies with a blood sugar less than 1.0mmol

These babies should have an urgent neonatal review. The blood sugar should be rechecked on the blood gas machine to ensure accuracy. (BAPM,2024) If the baby has clinical signs of hypoglycaemia and/or a confirmed Blood glucose level of less than 1,0mmol the baby should be moved to the Neonatal Unit for further management.

Any baby developing hypoglycaemia beyond 24 hours of age may have an underlying cause e.g. sepsis, metabolic / endocrine disorder and should be referred to the paediatrician/ANNP for further assessment, investigations and treatment.

10.0 Prevention of weight loss

10.1 Day following discharge from hospital

A Breastfeeding observation, using BFI tool should be undertaken by Midwife.
Any concerns should be addressed, plan made and documented in the notes, including checklist.

10.2 Day 3

All babies require a weight on this day.
Undertake a Breastfeeding Observation using BFI tool
Implement a Management Plan as necessary for any infant feeding issues (see Maternity infant feeding policy)
Consider referral to Infant Feeding Lead Midwife for specialist support, if required.
If formula feeding observe a feed, ensuring baby is feeding effectively.

10.3 Day 4

Weigh baby on this day if appropriate.

10.4 Day 5

Weigh baby on this day if appropriate.
Undertake a Breastfeeding Observation using BFI tool
Implement a Management Plan as necessary for any infant feeding issues (see maternity infant feeding policy). – capitalise letters and add DOC0155
Consider referral to Infant Feeding Lead Midwife for specialist support, if required.
If formula feeding observe a feed, ensuring baby is feeding effectively.

10.5 Day 10-14

Weigh the baby
If the baby has regained its birthweight and both mother and baby are well, then they are able to be discharged.
Continue with Management Plans where appropriate, if not able to be discharged.

11.0 Care of the late preterm infant – Babies born from 35+0 weeks to 36+6

11.1 Postnatal ward care of the late Preterm

Summary:

Late preterm infants are at increased risk of mortality and morbidity in the neonatal period and throughout later life and have different needs compared to infants born at full term. Late preterm infants require enhanced postnatal monitoring for the prevention, identification and management of common morbidities including hypothermia, hypoglycaemia, jaundice and feeding issues.

Early discharge of late preterm infants before demonstration of weight gain (normally at day 4) is not advised to allow effective feeding to be established. Late preterm infants should be reviewed daily by the neonatal medical team. Discharge planning should be collaborative between the medical team and midwifery team. Information should be provided to parents about support that is often needed for late preterm infants during the neonatal period. Consider PIL 'care of your baby born a little early on the postnatal ward'

11.2 Antenatal counselling of the parents of a late preterm baby:

The parents should be counselled by the midwifery team explaining the likely clinical course of the admission. The importance of being born premature should not be minimised. The importance of family centered care should be introduced, and the collaboration between parents and hospital staff. A realistic timeline should be discussed with parents, explaining the criteria for the baby to be discharged home, and that this will take a minimum of 4 days. Parents should understand that whilst the aim is for the baby to stay with mother on the postnatal ward, the baby may require more specialist care on NNU.

11.3 Stabilisation and management of the late preterm infant

- A member of the neonatal medical team must be present for the delivery.
- Assess the baby as per NLS guidelines.
- Ensure an appropriate thermal environment as much as possible.
- Encourage skin to skin contact after drying the baby, ensuring the head is covered. Consider maternal temperature and condition.
- Ensure a breast feed or colostrum is given in the first hour of life.
- For parents choosing to feed infant formula, this should also be given within an hour of birth. Parents should be taught to bottle feed their baby using a responsive approach, but ensures that baby as 8-10 feeds in 24 hours.
- Late preterm babies cannot be placed on a reluctant feeder pathway. Any poor feeding should be escalate to the medical team and further observations.
- BAPM preterm optimization passport to be completed (**see Management of Preterm Pre-Labour Rupture of Membranes and Pre-term Labour guideline MIDW/GL/51)**

11.4 Ongoing care

Monitoring

Regular observations of activity, temperature, heart rate, and resp rate for the first 24 hours. (NEWT). This may be prolonged if the baby is on IVABS, or reinitiated If any concerns. Babies less than 2kg must have 12 hourly temperature monitoring during the admission at a minimum.

11.5 Hypoglyceamia and feeding

All preterm babies must complete the hypopathway, with lowest acceptable blood sugar level of 2.6mmol in the first 48 hours. After this time the Blood sugar should be 3 and above. Any concern about feeding frequency/amount, or clinical condition may require additional blood sugar measurement.

Families must be supported to optimise lactation and the transition to breastfeeding or formula feeding as per the family's choice.

Instigate early feeding, ideally within one hour of birth. Support a modified responsive feeding approach (8-10 feeds in 24 hours) Late preterm babies must not be placed on a reluctant feeder pathway. Any poor feeding should be escalated to the medical team and further observations initiated as appropriate. Parents should be asked to fill out the neonatal feeding record to demonstrate feeding patterns to assist with assessment.

The baby should be weighed on day 3 and 4, and weight gain should be demonstrated before discharge.

11.6 Thermoregulation

Regular temperature monitoring should be undertaken during the first 24 hours, and daily on subsequent days for all late preterm infants which they are on the postnatal ward as a minimum. Any baby born 1.8kg -2kg should have a hot cot following skin to skin as standard.

11.7 Medical review

Each late preterm infant will be reviewed daily by the neonatal medical team and the baby will remain on the postnatal list. Any deviation from the normal should prompt timely review of the baby and if appropriate consideration of moving to NNU.

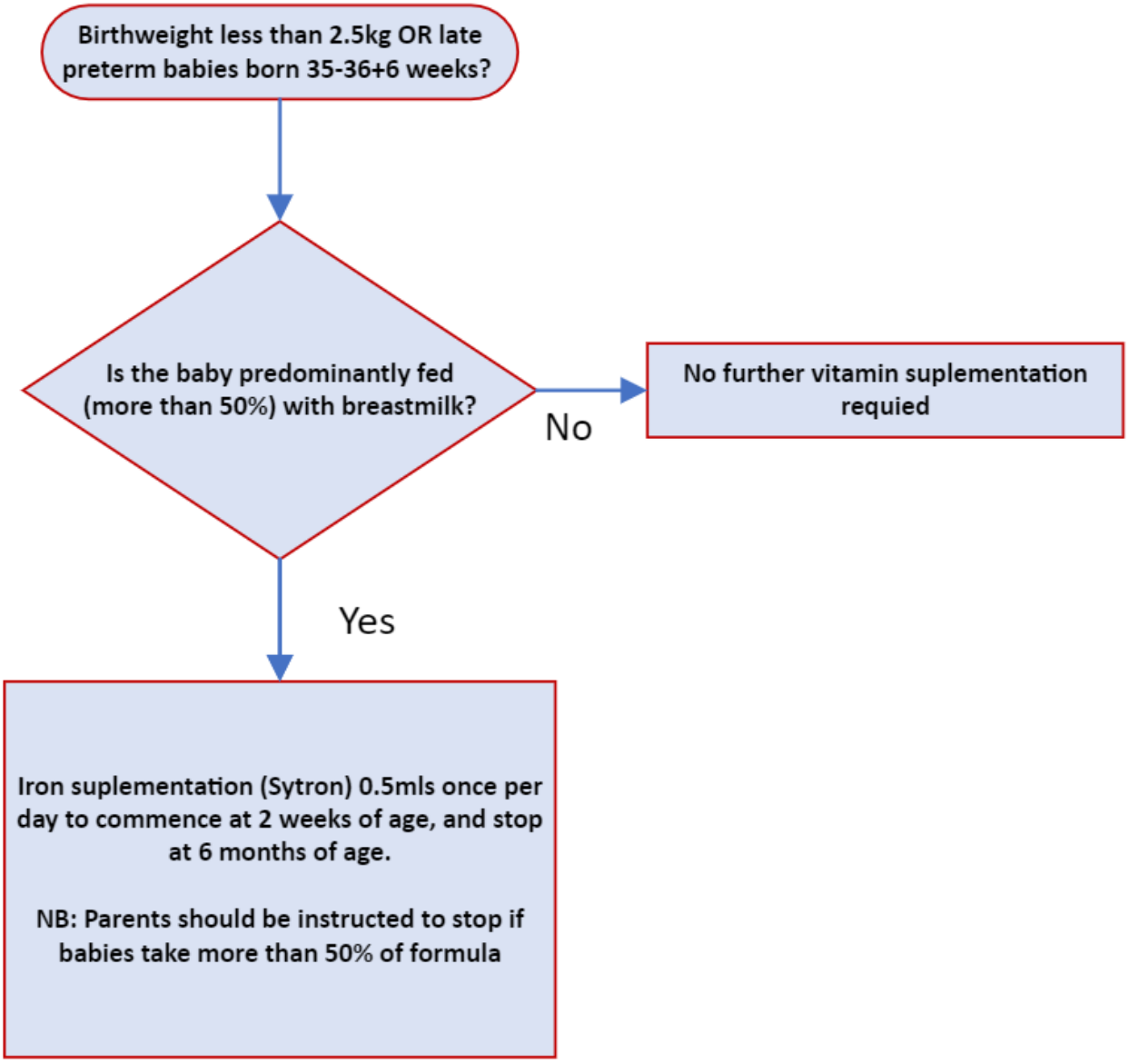
11.8 Vitamin supplementation

All babies born from 34 weeks to 36+6 weeks should have Abidec prescribed 0.6mls once daily.

This should commence immediately and continue for 1 year.

In addition, Babies with a birth weight less than 2.5kg, or who are born between 35+0 and 36+6 gestation may require Iron supplementation (sytron).

Please follow flowchart when assessing eligibility for this.



11.9 Discharge planning

The decision to discharge the baby from the neonatal unit should be a collaboration between the midwifery and medical team and the parents.
A baby is able to be discharged when meeting the following criteria:

- The parents are confident with feeding.

- The baby's condition is stable
- Weight loss is less than 10% of the birth weight and being regained.
- The baby is maintaining its own temperature with light clothing and bedding.
- Any babies born at less than 2kg require Neonatal consultant follow up and referral to the Neonatal Conmunity team.
- TTO completed for abidec/ Sytron (if required) and parents understand how to draw up.

12.0. Use of hot cot or warmer mattress

A hot cot or warmer mattress should be used for babies at risk of hypothermia.

12.1 Instructions for the use of hot cot

- Connect the mattress to the module and plug it in
- Switch it on and observe the initial safety checks
- Ensure the device is set to 39°c degrees to start with and push 'Play' on the Cosytherm2 model to commence warming.
- On the Cosytherm2 model it will show blue (heating in progress), green (mattress temperature reached) or orange (mattress temperature too high).
- To alter press unlock on the Cosytherm2 or press and hold the thumb print on the Inditherm model. Then use the arrows to adjust the temperature.

12.2 Care whilst in hot cot

- Ensure there is only a single sheet layer covering the mattress so maximum heat
- reaches the baby.
- Ensure the baby only has a nappy on and is dressed in a single layer of clothes which should be a vest to support temperature control. Maximum heat should be allowed to transfer to the baby.
- Cover baby using a maximum of one sheet and 2 thin blankets as layers.
- When baby is not on the warmer mattress ideally nurse skin to skin with parents if she is
- warm and well.
- Ensure baby wears a hat and is well covered during this time.
- If not having skin to skin, ensure baby is appropriately dressed and wrapped up and kept
- away from draughts.

12.3 Monitoring and observation

- When baby first commences on the hot cot, their temperature should be recorded at 1 and 2 hours.
- If temperature is below 36.5 degrees then baby must be reviewed by paediatric team, ensuring that baby has got appropriate clothing and layers. If baby has a persistent low temperature, they may need to be transferred to NNU to be nursed in an incubator.
- If the baby has a temperature above 37.5 degrees with appropriate clothing and layers, the temperature of the mattress can be reduced by 0.5 degrees and the temperature rechecked to ensure it is reducing.

- A baby with a temperature higher than 37.5 degrees needs a full set of observations to ensure no signs or symptoms of sepsis.
- If baby's temperature is stable (36.5-37.5) their temperature should be taken every 4 hours and recorded on the NEWT chart. Any triggers require review by Paediatrician as detailed on the NEWT chart.
- After the first 12 hours if the baby's temperature remains stable then the mattress temperature can be reduced by 0.5 degrees every 8 to 12 hours.
- After any change to the warmer mattress temperature the baby temperature should be repeated an hour after then 4 hourly if within normal range.
- Once the mattress has been at 36.5 degree and the baby has had a stable temperature for 8-12 hours the mattress can be discontinued.
- Baby temperature still needs to be monitored 4 hourly for 24 hours after to ensure adequate thermoregulation.

If the baby's temperature drops below 36.5°c at any point the mattress temperature should be increased back to the previous setting again. The baby should also be reviewed by the paediatric team to assess other causes of temperature instability.

13.0 Discharge from Postnatal Ward

- All babies should be seen and have a NIPE completed by a Paediatrician or appropriately trained practitioner prior to discharge. Please change to Newborn Infant Physical Examination This should be documented on NIPE Smart and the printout filed in the Child Health Record (red book).

- All babies requiring observations with any triggers on NEWT should be reviewed by the neonatal team to be assessed as fit for discharge and appropriate care plans should be documented and handed over to the community team.

- **Infants at risk of hypoglycaemia should not be transferred to the community until they are at least 24 hours old.** Ensure effective feeding has been established and at least one Breastfeeding Assessment has been performed (see Maternity Infant Feeding Policy) Day 3 and Day 4 weights must be undertaken**.** Weight gain **must be** evident in babies ≤2nd centile and premature babies.

- The Midwife should complete the postnatal assessment, breastfeeding assessment and discharge sections on eCare. The midwife must ensure the postnatal notes are completed and include any significant risk factors and important information.

- The Midwife should ensure that the eCare depart process is completed, finalised and printed. Once printed go through the contents of the paperwork with the parents to ensure that the details are correct including an up to date telephone number and discharge address.

- Where the service user is being discharged to a temporary address this should be clearly highlighted. If the parents and baby are being discharged to separate addresses, this needs to be clearly documented. If the baby is being discharged to foster parents ensure that information regarding the foster parents is not included in the notes scanned into the maternal EDM as this may be a breach of confidentiality.

- All women will receive discharge information regarding their and their baby's wellbeing, how to contact a Midwife, accessing emergency services, help with breast feeding support and advice. Where parents or baby has specific needs, this should be clearly documented on the

discharge sheet and the relevant care plan in place.The discharge pack with all of the relevant PILS must be given prior to discharge.

- It is the discharging Midwife's responsibility to ensure discharge details are correct and any follow up appointments are arranged where parents or baby are referred to allied services. This should be communicated to the service user.

- The Maternity Discharge Form should be completed informing the Community Midwife of the discharge (Appendix 1) and left in the discharge book on postnatal ward for collection by the Community Midwifery teams. The service user's sticker should also be placed in the Discharge Book and signed by the discharging midwife. The service user's telephone number should also be documented with her sticker. It is vital that any important information regarding the parents and/or baby is documented on the Maternity Discharge form so that the community midwife is alerted to any significant history prior to visiting.

- If the service user lives out of area, the discharging Midwife must contact the appropriate hospital to handover the discharge information or the ward clerk can do this on the midwives' behalf. The midwife should then document that this on the Maternity Discharge form and on eCare.

- If there is a Children's Social Care Maternity Plan check to see if a discharge planning meeting should be arranged prior to the discharge. If the parents is out of area then the Community Midwife, Health Visitor and GP as well as the Safeguarding Midwife of the hospital providing care should be informed of the discharge and ongoing plans.

- Ensure any relevant Safeguarding information is provided on the Discharge paperwork for the GP and Health Visitor e.g. FGM-IS or baby in Care of the local authority.

- Inform service users that vitamin D supplements are recommended for all breastfeeding people (NICE Public health guideline Vitamin D [PH56] https://www.nice.org.uk/guidance/ph56

- 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.

14.0 Separate care of mother and baby

14.1 Reasons for Separate Care

- Maternal request, e.g. Mother relinquishing baby
- Child protection proceedings, e.g. Emergency Protection Order/Interim Care Order
- Maternal condition, necessitating transfer to Department of Critical Care (DoCC).
- Neonate's condition, necessitating transfer to Neonatal Unit (NNU).

14.2 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 Children's Social Care that baby has been born. All Safeguarding plans can be located on a Confidential Communique in Ecare. The Safeguarding lead midwife will also forward copies to EDM under Promoting Welfare tab. It is the responsibility of any healthcare worker to continue the handover of this information and highlighting it on the yellow discharge sheet for accurate ongoing care. For unexpected situations the Emergency Out of Hours Social Worker or Duty Social Worker should be contacted depending on time of day.

- 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. NNU will only be appropriate if the baby has medical / nursing needs.
- 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 discharge the baby home to the care of community midwives.

Please also refer to **Appendix 3**: Practice Charter - Guidance for Social Workers and Midwives when the plan is for a baby to be discharged to the care of the Local Authority.

14.3 Maternal Condition

If the mother is being cared for on the Intensive Care unit, consideration should be given to whether the partner or appropriate guardian can be accommodated with the baby on the postnatal ward.

14.4 Emotional and psychological aspects to consider where babies are separated from parents due to a social or clinical need

Where appropriate, have mother and or partner had the opportunity to hold their baby?
Would mother and partner like to have photographs and footprints of their baby? (This provides the opportunity to commence a Life Story for the baby if is not going home with parents).
Although they may decline all of the above, they may wish to access photographs footprints at a later date, we can facilitate this by placing them in the hospital records. Consider an IAPT referral to support with emotional wellbeing. If the mother is in DoCC and wishes to breastfeed her baby this should be facilitated where possible with the support of the Infant Feeding Specialist midwife in discussion with her next of kin.

15.0 Postnatal care in the community

15.1 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.

- All women should be contacted on the day following discharge, 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. The first home visit should not be longer than 36 hours from postnatal discharge (NICE NG194, 2021)

- This first home visit should be used to assess individual needs of the parents and baby and ensure the first visit checklist is completed (see Appendix 2). Where issues have been identified a management plan should be clearly documented in the handheld postnatal notes for both mother and baby.

- The Newborn Blood Spot Screening (NBBS) should be carried out on day 5 with informed consent (see guidelines for Newborn Screening- being re-written currently). If the neonate has received a blood transfusion then the NBBS can be obtained 72 hours after. If the neonate is too unwell for sample then please liase with the ANNB screening team.

- All routine postnatal care for mother and baby will consist of:

  - First visit - initial risk assessment, information and care planning.
  - Third day visit –weight and feeding assessment
  - Fifth day visits – NBBS, weight if day 3 lost greater than 8%, feeding support.
  - Discharge visit – between day 8-12 finalise care, weight at or near birth weight, ensure contact with Health Visitor in place.
  - In some circumstances where for example safeguarding issues or mental health has been a factor it may be appropriate to continue care up until day 28. This should be clearly documented and it does not mean that regular visits need to take place but that the service user can be in contact with the community team and maternity unit through out this period. It is pertinent that phone calls to check on the service user and baby's welfare happen periodically in this time before arranging discharge. Social and clinical information should be handed over to the health visitors as required.

  - Visits maybe 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.

- The first initial visit should take place in the home and ideally the 3rd day visit also; thereafter if willing, has transport and is clinically well enough a clinic appointment will be offered at an agreed time and location. This could be in a variety of locations but usually either a Childrens' centre or at the hospital.

15.2 At each Postnatal contact

The midwife should carry out a thorough assessment of maternal wellbeing and document this in the postnatal assessment tab on eCare. This should be completed daily as a minimum whilst on the ward or at each Midwife visit in the community in this case it should be documented in the purple postnatal record.

Ask the service user about her health and wellbeing. This should include asking women about their experience of common physical health problems. Any symptoms reported by the service user or identified through clinical observations should be assessed.

Offer consistent information and clear explanations to empower the service user to take care of her own health and that of her baby, and to recognise symptoms that may require discussion.

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

Women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.

The midwife should provide information on normal patterns of emotional changes and ensure she has the leaflet 'Caring for your Mental Health and Wellbeing in the postnatal period'.

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

Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. All women should be provided with the 'Birth Reflections' patient information leaflet prior to discharge.

Ask the service user about her feeding method and carry out at a breastfeeding Assessment as per Newborn Feeding Policy and record in eCare or in the postnatal record. Prior to discharge from the postnatal ward, at least one full breastfeed must be observed and a breastfeeding assessment completed.

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 per Perineal Trauma and Repair guideline as part of the daily examination and documented in the service user's records as per guideline. Women should be provided with the information leaflet 'Care of your perineum after the birth of your baby'.

Women who have had a caesarean section should be have a wound site examination and be provided with information regarding wound care and healing PIL 'Caring for your wound after having a caesarean section'.

Service users 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.

Information should be given to all parents regarding family planning and contraception prior to discharge. Information re contraception can be found at https://www.nhs.uk/conditions/contraception/

All assessments and care plans must be documented in eCare or in the purple postnatal record if at home and followed up if required.

16.0 Follow up postnatal contacts

The midwife should carry out a thorough assessment of infant wellbeing and document this in the newborn assessment tab on eCare or in the postnatal record if at home. This should be completed daily as a minimum whilst on the ward or at each visit in the community.

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.

This includes giving written information and discussing the important symptoms parents should be aware of.
Parents should be given advice at each postnatal contact about reducing the risk of Sudden Infant Death Syndrome (SIDS) and co-sleeping (as detailed in the Co-sleeping and Bedsharing for Mothers and Babies Guideline). This conversation must be documented in eCare or in the postnatal notes.

Jaundice should be visually assessed at each postnatal contact (additional testing such as TCB or Serum Bilirubin is required for any baby presenting with jaundice). 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

After the first 24 hours, if it is identified that a baby is jaundiced, or that the jaundice is worsening, this should be managed as per the Neonatal Jaundice Management guideline.

The newborn blood spot test should be offered to all parents when their infants are 5 days of age (where the day of birth is counted as day 0). Informed consent should be obtained. Samples should be taken as per Newborn Blood Spot Screening guideline and each sample checked with a second member of staff to ensure all information is correct and prevent any avoidable repeats.

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.

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.

Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse and if there is raised concern should follow local child protection policies.

17.0 Readmission

- All mothers and babies requiring readmission to hospital would 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 service user needs admission to the general hospital but there are no available beds, admission to the postnatal ward would be negotiated with the Maternity Lead on Call and the Bed Manager or Clinical Site Manager.

- All readmission to the postnatal ward should be cared for in a side room, where a side room is not available a Radar report should be completed to highlight the risk of infection.

- A Radar report should be completed for all readmissions.
- MRSA screening should be carried out, and results followed up, ensuring treatment is given as required.

- Once mother and baby have been discharged, the electronic records should be completed, and the routine discharge process followed ensuring the discharge 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 to be informed to facilitate any extra support as required. Please refer to the Maternity Infant Feeding Policy . There is no Weight management in the newborn has no separate document.

18.0 Discharge to Health Visitors

- Women and their babies would routinely be discharged to the care of the Health Visitor between the 10th and 12th day.

- 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.

- Where Midwives are still providing care past the 12th day they will remain the lead practitioner but inform the Health Visitors of the service user and any relevant issues.

  - Please ensure that the Postnatal pelvic floor risk assessment screening tool has been completed prior to discharge, and the woman is aware of how to self refer

- Where there are complex issues within a family and a Confidential Communique (CC), 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.

19.0 Record keeping

- All maternal observations and discussions to be recorded in the mothers postnatal records on eCare (or in postnatal notes if in the community), 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.

- For women that have given birth in the hospital all documentation including electronic documentation should be completed prior to transfer to the ward or home.

- For babies born at home the Community Midwife should ensure completion of the electronic records and generate the NHS Number.

- Prior to transfer to the Postnatal Ward or home if early discharge, the Midwife should complete the risk assessments in the maternal and baby postnatal records.

- Mother and baby/babies to have printed patient identification labels as per Trust's Patient Identification Policy.

- 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.

Ensure all paper records are sent to EDM.

20.0 Statement of evidence/references

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Databases searched: (Search history)	NICE, Cochrane Database of Systematic Reviews, BMJ Open Quality, NHS England, MAG Online, ClinicalKey, Medline.

21.0 Governance

21.1 Document review history

Version number	Review date	Reviewed by	Changes made
6.0	**February 2024**	Gill Mallows, Michelle Hancock, Zuzanna Gowlowski, Bridie Lawrence, Elaine Gilbert, Anja-Johansen-Bibby Alex Fry	The following guidelines were merged: Postnatal care pathway, neonatal hypoglycemia. GAP completed against NICE postnatal care pathway 2021, and BAPM recommendations. Total review and update also now to include care of the late preterm baby. For details see below.
6.1	**March 2023**	Natalie Lucas	Addition to checklist for first visit (appendix 2) 'Discuss birth experience and undertaken any actions/ referrals as needed.

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Reviewed and updated by Michelle Hancock, Bridie Lawrence, and Gill Mallows	Maternity and Neonatology	Oct 2023	-	The above amalgamation was completed and this was circulated for comments to the maternity / Paediatric teams. Feeback was that the document did not flow well which caused confusion	No
Michelle Hancock, Gill Mallows, Alex Fry Zuzanna Gowlowski, Lila Ravel	Maternity and Neonatology	November 2023	-	Changes to overall flow of document, addition to include care of late preterm infant. Observations to include oxygen saturations, and section on neonatal vitamin supplementation added. Draft then re-circulated to maternity staff (please see below)	

Circulated to maternity and Paediatric staff	Maternity and Neonatology	22.01.2024	29.01.2024	Feedback from Anja Johansen-Bibby to include more detail around frequency of maternal observations, and postnatal maternal care whilst under care of obstetrics. Section added. General feedback for spelling, grammar etc.	Yes
Sent to Jayne Plant / Matthew Duncan	MKUH library services		14.02.2024	References reviewed. Document reviewed and updated for clarity, flow and editing. Abbreviation table updated.	Yes
Women's Health Guideline Review Group	Women's Health (also attended by Z. Gowlowski and G Mallows.	-	07.02.2024	Final draft version 6.0 approved by group	Yes
Women's Health Guideline Review Group	Maternity	06.03.2024	-	Version 6.1 approved as chairman's actions	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Baby friendly standards are being maintained	BFI audit tool	Infant feeding lead	Quarterly	MatNeo, Women's Health M&M
Preterm birth optimisation passport completion	BAPM TC quarterly report	Governance team	Monthly	Women's Health CSU
Audit of transitional care	TC quarterly report	Governance team	Quarterly report	Women's Health CSU
Unexpected term admission to Neonatal Unit	ATAIN audit	Governance team	ATAIN quarterly report	Women's Health CSU
Postnatal oxygen saturations are completed: • Within 2 hours from birth • With every set of postnatal observations • At NIPE	Audit tool as designed by audit leads	As decided by audit leads	Quarterly from 3 months from implementation of guideline, and then to review at 6 months. (implementation audit)	Audit leads. To present and Women's Health M&M
Babies who require vitamin supplementation receive this as TTO.	Audit tool as designed by audit leads	As decided by audit leads	Quarterly from 3 months from implementation of guideline, and then to review at 6 months. (implementation audit)	Audit leads. To present and Women's Health M&M

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division		**Department**	
Person completingthe EqIA		**Contact No.**	
Others involved:		**Date of assessment:**	
Existing policy/service		**New policy/service**	

Will patients, carers, the public or staff be affected by the policy/service?	
If staff, how many/which groups will be effected?	

Protected characteristic	**Any impact?**	**Comments**
Age	NO	
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?	
How are the changes/amendments to the policies/services communicated?	
Review date of EqIA	

Appendix 1: Maternity Discharge Form Please ensure all information is completebefore discharge to community midwife.

Appendix 1: Maternity Discharge Form

CC ☐
28 day Discharge Plan ☐

Please ensure **ALL** information is complete; add the patient details to the Discharge book and place this yellow form in the Discharge book for **ALL** women upon discharge. **ALL** out of area women **MUST** be called out at the point of discharge and documented as 'completed' in the discharge book

GP Surgery:	***Community Midwife***

Discharging Midwife must ensure all details are complete and correct:

Patient Label with **correct visit address**	
Contact 1:	
Contact 2:	

Is mother D/C to usual home address: Yes ☐ No ☐

If NO please indicate location of 1st visit:

Discharged From:	LW	W9	W10	Other:

If OOA, Pt MUST be called out before adding to D/C book:

Name of hospital:

Name of receiving Midwife:

Date: Time:

Discharged By:	
Date of Discharge:	
Time of Discharge:	
Number of days on discharge:	

Mother discharged with baby?	Yes	No
If No, where is baby? (ie: NNU, another hospital, foster care)		

CC must be updated on discharge and at each encounter.

Baby Details (To be completed by the Intrapartum MW)

Date of birth			
Time of birth			
Type of birth			
Gestation			Admitted to NNU
Sex			
Weight	g	Centile:	SGA
Feeding method	Breast	Bottle	Mixed

Anti D	Given	Required	Not required
Vitamin K at birth	IM	Oral	

PLEASE ADVISE SERVICE USER THAT A CMW WILL SEE THEM AT HOME FOR THE 1ST DAY AND WILL THEN OFFER A POSTNATAL CLINIC APPOINTMENT FOR SUBSEQUENT APPOINTMENTS, BASED ON SUITABILITY.

Maternal Information

Parity		
EBL		
Last Hb: (if applicable for EBL):		Date Taken:
Perineal Trauma		
If C/S:	Suture Material	
	Type of dressing (if still in situ)	

Any Other important details: i.e. Obstetric Emergency / Safeguarding concerns / TTO's etc / plan if out of routine p/n care.

Postnatal Visits

CC ☐

28 day Discharge Plan ☐

Is oral Vitamin K required on D5? YES ☐ No ☐

Date for visit:	P/N Day	Seen by (print name)	Circle reason for visit and document outcome / plan for next visit								Tick if N/A
1st home Visit			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound Review	BF Support	Well-being	Other	
			Weight / % Loss:	NBBS	SBR	BP	Wound Review	BF Support	Well-being	Other	
			Weight / % Loss	NBBS	SBR	BP	Wound review	BF support	Well-being	Other	

Date of Discharge:		Days P/N at Discharge:
Discharged by	Print name:	Signature:
Notes returned on:	Date:	By:

Please use a continuation sheet for additional visits and ensure label attached to 2nd sheet.

Appendix 2: Checklist for 1st Visit by Community Midwives

Checklist for 1st visit by community midwives

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.
- 'Discuss birth experience and undertaken any actions/ referrals as needed
- Give 24 hour contact number to parents
- Full breastfeeding assessment and give help with breastfeeding as required
- Discuss sterilization and making up of feeds if appropriate
- Physical examination of the newborn completed or arranged
- Hearing screening of the newborn completed or arranged with hospital
- Registering birth with Registry Office discussed
- Baby officially registered with GP once birth registration completed
- Child benefit advice, parents to apply online
- 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 Vit K is required (only if 1st dose given orally)
- Check if baby is eligible for BCG and whether this has been consented and a referral made after the NIPE.
- If mother is Hep B or Hep C Positive check baby has received first dose of Hep B vaccination, otherwise please arrange.
- Check if mother has been prescribed LMWH and if so is confident to self-administer and has been given a sharps bin.
- Discuss pelvic floor care, signs of concern and when to seek help
- Give sources of advice for contraception and resuming sexual intercourse
- Check mother's Rhesus status and Anti D given if Rhesus Negative
- Discuss visiting plan and arrange next visit
- Be alert to signs of domestic abuse or child abuse in line with Milton Keynes Safeguarding Policies.

Appendix 3: Best Practice Charter

Guidance for Social Workers and Midwives when the plan is for a baby to be discharged to the care of the Local Authority

Communication

Midwives are to notify Children's Social Care when the service user is admitted in labour and following the birth of the baby at the earliest possible time. This is to ensure the legal department can issue an application to the court on the day of birth and, in any event, no later than 24 hours after birth. All contact numbers will be provided on the Children's Social Care Maternity Plan.

Confidentiality

In order to maintain confidentiality, the 'Midwife in Charge' should arrange for a private space prior to the Social Worker arriving. The Social Worker will keep the Midwife in Charge up to date on the expected time of arrival to facilitate this.

When visiting the hospital, Social Workers should request to speak to the 'Midwife in Charge' when using the intercom and will ensure that they do not announce any private information or the reason for the visit, where members of the public could hear. ID must be produced by the Social Worker on arrival.

Observations on the Ward

The ward staff are not able to provide 1:1 supervision for parents with their babies however Children's Social Care may ask for feedback on the following:

- Worries about the relationship developing between parents and the baby
- Incidents of rough handling
- If any person identified on the maternity plan as being a "person to be excluded" attempts to visit
- Parents leaving for long or frequent periods of time
- *Parents using inappropriate language towards e.g. shouting, name calling etc*
- Are babies being fed/changed and comforted appropriately
- Parents suspected to be under the influence of drugs/alcohol
- Babies showing signs of withdrawal.

Children's Social Care are equally keen to hear positive observations such as responding timely to baby's needs, gentle handling and the development of a positive relationship, as well as worries. It is important that maternity staff endeavour to discuss their observations with the parents as well as informing Children's Social Care.

Going to Court (Care Proceedings)

Social Workers do not have the powers to remove children without the agreement of either the Parents or a Judge.

Removing babies at birth is a last resort and parents would be aware of the plan ahead of the birth. Sometimes events happen which could lead to emergency removal of the baby though an Emergency Care Order, which is distressing but necessary to safeguard the baby.

Once the baby has been born, the Social Worker's statement will be submitted to the court by the Local Authority solicitor. The court will list a hearing, this may take several days. It is the responsibility of the Social Worker to notify the Midwife in Charge on the ward of the court date and the arrangements for the baby in the interim. A conversation with the parents will have taken place about who will care for the baby whilst a court date pending. If parents wish to attend court for the day and the baby is still in hospital, then someone will be identified by the Social Worker to stay with the baby.

If staff have any queries regarding the plans for the family, they can approach the Named Midwife for Safeguarding or the allocated Social Worker. If the Social Worker is unavailable, professionals can ring Family Support Duty on 01908 253818. The Duty Social Worker should be able to either help or forward on your queries to the Social Worker's Team Manager.

When babies remain on the Ward without their mother or if supervision is required

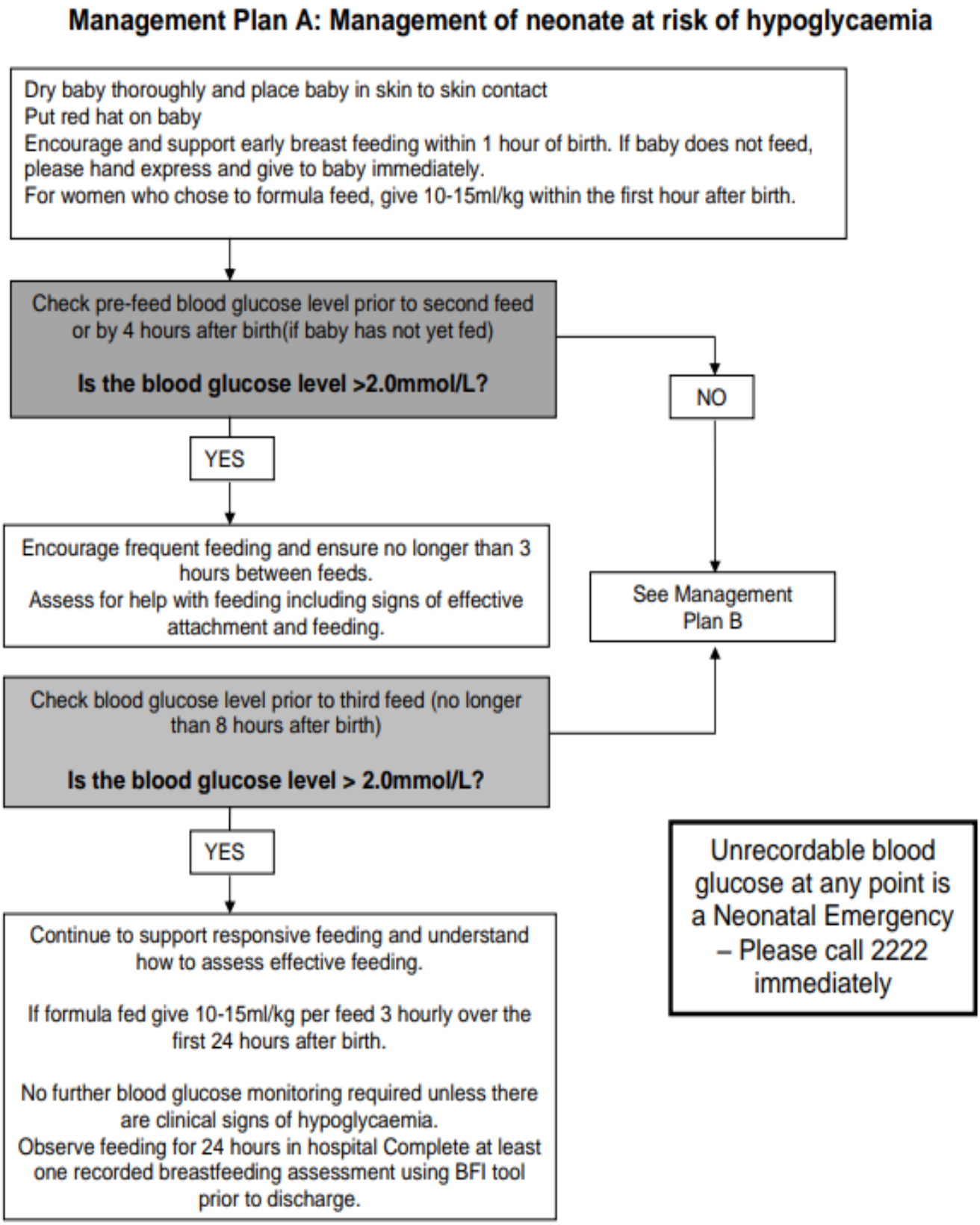
If foster carers, social care support workers or family members are going to be caring for the baby, while they remain in hospital, Children's Social Care will inform the ward of the names of those who are attending the maternity unit and, what the expectations are of them when they are there. There may be situations where they are supervising a parent with a baby, or they may be responsible for meeting the baby's care needs. They will report directly to the Social Worker about their observations. This will be outlined in the Children's Social Care Maternity Plan.

When a baby is ready for discharge

It is the responsibility of the Midwife providing care, to notify the Social Worker when baby is fit for discharge. The Social Worker will provide a time and the names of those who will attend and provide a copy of the Court Order. The Midwife is to ensure that all checks, paper work and medication are completed so as to not delay the discharge and help avoid adding to the stress of the family.

If there are any security concerns, then the Midwife providing care should liaise with hospital security and Social Worker and consideration can be given to using an alternative exit. When leaving, a midwife will escort baby to the door to facilitate a smooth exit from the ward.

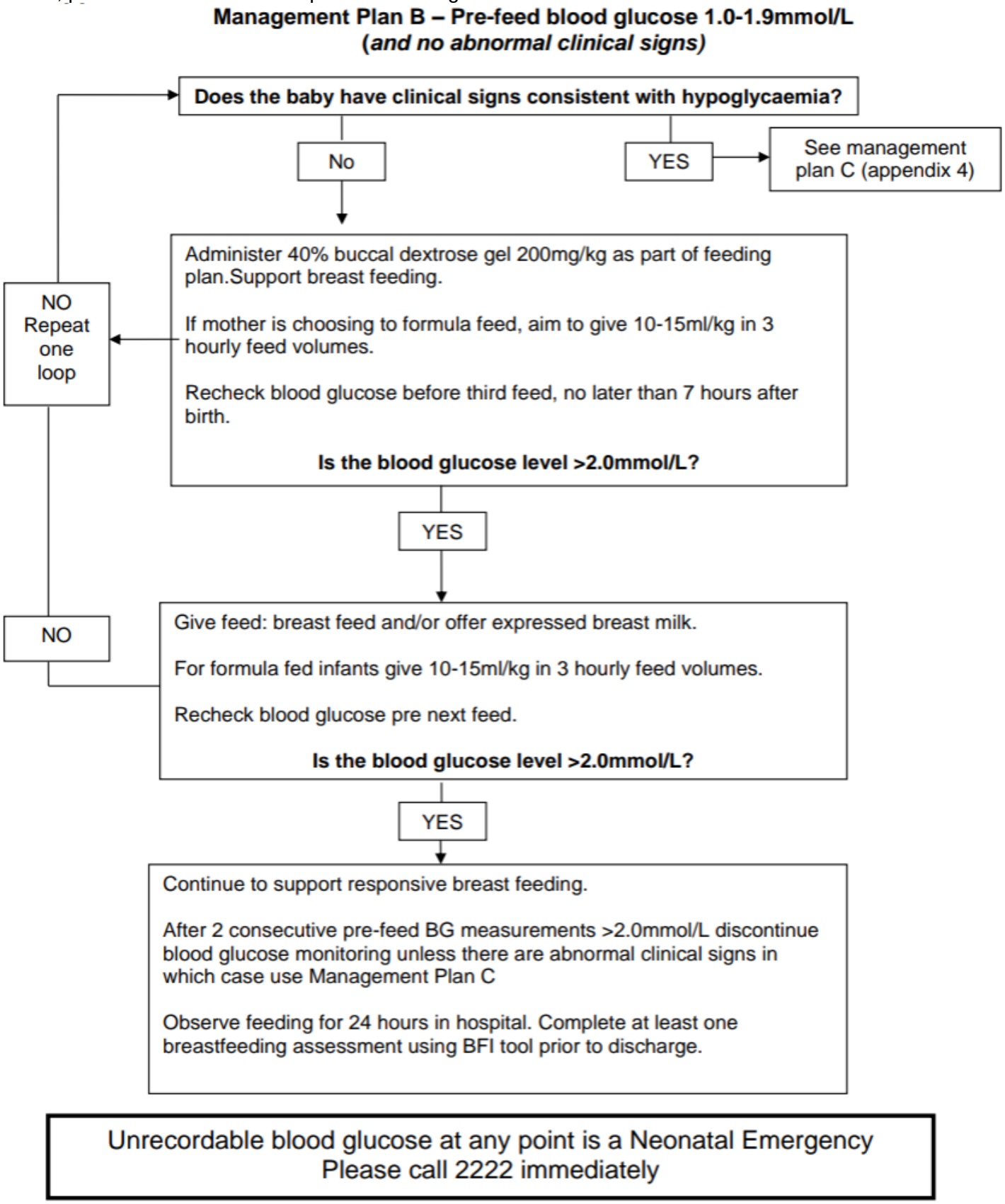
Appendix 4: Plan A: Management of neonate at risk of hypoglycemia



If there are any concerns regarding Hypoglycaemia, a BM can be taken at any time

Plan B – Pre-feed blood glucose 1.0-1.9 (and no abnormal clinical signs)

Any blood sugar below 2mmol on handheld device should be checked on blood gas machine. For preterm infants, plan B should be used for pre feed blood glucose 1.0-2.5



Adapted from: British Association of Perinatal Medicine (2017) *Identification and management of neonatal hypoglycaemia in the full term infant: framework for practice*

Appendix 5: Use of Dextrose gel

Indications:

Blood glucose 1.0-1.9mmol in infant with no abnormal clinical signs
Infants ≥ 35 weeks' gestational age and younger than 48 hours after birth

Notes:

Must be used in conjunction with a feeding plan
For babies with blood glucose <1.0mmol/L, use dextrose gel only as an interim measure while arranging for urgent medical review and treatment with IV glucose

Dose:

Administer 40% buccal dextrose 200mg/kg. Ensure doses are **no less than 30 minutes apart** and a
maximum of 6 doses in 48 hours (0.5ml/kg of 40% dextrose gel).

Weight of baby (kg)	Volume of gel (ml)
1.5-1.99	1
2.0-2.99	1.5
3.0-3.99	2.0
4.0-4.99	2.5
5.0-5.99	3.0
6.0-6.99	3.5

Method of administration:

Draw up correct volume of 40% dextrose gel (Glucogel) using a 2.5 or 5ml oral/enteral syringe.

Dry oral mucosa with gauze, gently administer gel with syringe (no needle) onto the inner cheek and massage into the mucosa using latex-free gloves.

Offer a feed, preferably breast milk, immediately after administering dextrose gel.

Repeat blood glucose measurement as per flow chart.

Appendix 6: Use of hot cot or warmer mattress

Set up

Connect mattress to the module and plug it in

Switch on and perform initial safety checks

Set the device to 39 degrees to start and push 'Play' on the Cosytherm2 model

On Cosytherm2 model it shows blue (heating in progress), green (mattress temperature reached) or orange (mattress temperature too high).

To alter press unlock on the cosytherm2 then use the arrows to adjust the

Monitoring and observation

A baby should have their temperature recorded at 1 and 2 hours when first commencing on a warmer mattress.

If baby's temperature is below 36.5°c with appropriate clothes and layers the baby must be reviewed by a paediatric team with the view to transfer to NNU to be nursed in an incubator.

If the baby's temperature is above 37.5°c with appropriate clothes and layers the mattress temperature should be reduced by 0.5°c, and the temperature rechecked to ensure it is reducing. A full set of observations should be carried out on a baby whose temperature records over 37.5 to ensure there are no signs and symptoms of sepsis.

If the baby's temperature is stable (36.5 – 37.5°c) their temperature should be taken every 4 hours and recorded on a Newborn Early Warning Score (NEWTS) chart. Any triggers must be alerted to the midwife responsible for maternal and neonatal care and a paediatrician as outlined on the chart.

After the first 12 hours, if the baby's temperature remains stable then the mattress temperature can be reduced by 0.5°c every 8 or 12 hours

After any change to the warmer mattress temperature the baby's temperature should be repeated an hour afterwards, then 4 hourly again if within normal range.

Once the mattress has been at 36.5°c and the baby's temperature remains stable for 8–
12 hours, the warmer mattress can be discontinued.

Baby's temperature must be monitored 4 hourly for a minimum of 24 hours after this.
If the baby's temperature drops below 36.5°c at any point the mattress temperature should be increased back to the previous setting again. The baby should also be reviewed by the paediatric team to assess for other causes of temperature instability. Baby should not be discharged until reviewed by a member of the paediatric team who will need to document that baby is fit for discharge