Complete Summary

GUIDELINE TITLE

Postnatal care. Routine postnatal care of women and their babies.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Primary Care. Postnatal care. Routine postnatal care of women and their babies. London (England): Royal College of General Practitioners; 2006 Jul. 392 p. [488 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- June 15, 2005, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): U.S. Food and Drug Administration (FDA) recommended proposed labeling for both the prescription and over the counter (OTC) NSAIDs and a medication guide for the entire class of prescription products.
- April 7, 2005, Non-steroidal anti-inflammatory drugs (NSAIDS) (prescription and OTC, including ibuprofen and naproxen): FDA asked manufacturers of prescription and non-prescription (OTC) non-steroidal anti-inflammatory drugs (NSAIDs) to revise their labeling to include more specific information about potential gastrointestinal (GI) and cardiovascular (CV) risks.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Post natal health and well-being (maternal and infant)

GUIDELINE CATEGORY

Counseling
Evaluation
Management

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To advise on appropriate objectives, purpose, content, and timing of postnatal contacts and care for the woman and her baby
- To advise on best practices and competencies for assessment of postnatal health and management of postnatal problems in the woman and/or her infant
- To advise on information, education, and support required during the postnatal period
- To advise on planning of postnatal care
- To consider good practice in communication between health care providers and women, their partners, and other family members

TARGET POPULATION

Post partum women and their babies up to 8 weeks following birth

INTERVENTIONS AND PRACTICES CONSIDERED

Planning the Content and Delivery of Postnatal Care

1. Principles of care, including identification of coordinating professional and documentation of care plan
2. Provision of information (oral and written)
3. Patient education

Maternal Health Assessment

1. Assessment of life-threatening conditions
    - Postpartum haemorrhage
    - Genital tract sepsis
    - Pre-eclampsia/eclampsia
    - Thromboembolism
2. Assessment of mental health and well-being
3. Assessment of physical health and well-being
4. Follow up 6 to 8-week assessment

Infant Feeding

1. Provision of a supportive environment for breastfeeding, including guidance and support for starting and continuing successful breastfeeding
2. Assessment of successful breastfeeding
3. Provision of information on expression and storage of breast milk
4. Prevention, identification, and treatment of breastfeeding concerns
5. Provision of information on formula feeding

Infant Health

1. Assessment of parenting and emotional attachment
2. Physical examination and screening
3. Assessment of physical health and well-being
4. Assessment of home and environment safety and promotion of safety education
5. Assessment for signs and symptoms of child abuse

MAJOR OUTCOMES CONSIDERED

- Maternal and infant morbidity
- Breastfeeding rates and duration
- Parent-infant attachment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Key Clinical Questions (KCQs)

The KCQs were developed by the Guideline Development Group (GDG) and with assistance from the Technical Team. The KCQs were refined into specific evidence-based questions (EBQs) specifying interventions to search and outcomes to be searched for by the Technical Team and these EBQs formed the basis of the literature searching, appraisal and synthesis.

The total list of KCQs identified is listed in Appendix E in the original guideline document. It was found that for many there was very little literature and what was available overlapped several questions. Where this was the case, the extractions were grouped into topic areas, answering several questions. This is made apparent in the Evidence Tables (see Appendix C & D in the original guideline document).

The Technical Team and the GDG agreed that a full literature search and critical appraisal should not be undertaken for all of these KCQs due to the time and resource limitations within the guideline development process. The Technical Team, in liaison with the GDG, identified those KCQs where a full literature search and critical appraisal were essential. Literature searches were not undertaken where there was already national guidance on the topic to which the guideline could cross refer. This is detailed in Appendix E in the original guideline document.

Literature Search Strategy

The purpose of searching the literature is to identify all the available published evidence to answer the clinical questions identified by the Technical Team and the Guideline Development Group (GDG). The Information Scientist developed search strategies for each question, with guidance from the GDG, using relevant medical subject headings (MeSH) or indexing terms, and free text terms. Searches were conducted between March 2004 and May 2005. Update searches for each question, to identify recent evidence, were carried out in July and August 2005. Full details of the sources and databases searched and the strategies are available from the guideline developer on request.

An initial search for published guidelines or systematic reviews was carried out on the following databases or websites: National Electronic Library for Health (NeLH) Guidelines Finder, National Guideline Clearinghouse, Scottish Intercollegiate Guidelines Network (SIGN), Guidelines International Network (GIN), Canadian Medical Association (CMA) Infobase (Canadian guidelines), National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines (Australian Guidelines), New Zealand Guidelines Group, BMJ Clinical Evidence, MIDIRS (Midwives Information & Resource Service), Cochrane Database of Systematic Reviews (CDSR), Database of Abstracts of Reviews of Effects (DARE) and Health Technology Assessment Database (HTA).

If a recent high quality systematic review or guideline was found that answered the clinical question posed, then in some instances no further searching was carried out.

Depending on the question all or some of the following bibliographic databases were also searched from their inception to the latest date available: MEDLINE,

EMBASE, CINAHL, CENTRAL (Cochrane Controlled Trials Register), PsycINFO, Allied & Complementary Medicine (AMED), DH-Data (Department of Health) & British Nursing Index (BNI).

Databases of the results of the searches for each question or topic area were created using the bibliographic management software Reference Manager.

In most cases it was necessary to search for published literature of any study design because of the nature of the question being posed, and the small amount of published evidence available on the population group relevant to the guideline. However, for questions where the literature was sizeable, systematic review filters were used, and for questions about the effectiveness of an intervention a randomised controlled trial filter was employed to limit studies to these designs. The filters used were devised by the Centre of Reviews and Dissemination, and the Cochrane Collaboration respectively.

Identifying the Evidence

After the search of titles and abstracts was undertaken, full papers were obtained if they appeared to address the GDG's question relevant to the topic. The highest level of evidence was sought. However observational studies, surveys, and expert formal consensus results were used when randomised control trials were not available. Only English language papers were reviewed. The review focused on United Kingdom research where possible. Following a critical review of the full version of the study, articles not relevant to the subject in question were excluded. Studies that did not report on relevant outcomes were also excluded. Submitted evidence from stakeholders was included where the evidence was relevant to the GDG clinical question and when it was either better or equivalent in quality to the research identified in the literature searches.

The reasons for rejecting any paper ordered were recorded.

Competencies for care delivery were searched in accordance with the remit for this Guideline. Little evidence was found and thus the group reviewed and investigated ongoing work within the Department of Health. As defining competencies is the responsibility of the professional registration bodies, the GDG did not regard it as its remit to define all competencies. The GDG did however review the recommendations for care and derived competency recommendations based on these where it was felt that these were particularly important for the implementation of the guideline.

Economic Analysis

A systematic literature review was conducted to assess the economic evidence, applying an economic search filter developed and supplied by the Centre for Reviews and Dissemination to the general search results. The Information Scientist carried out these searches for health economics evidence. The databases searched under this approach were MEDLINE, EMBASE and the NHS Economic Evaluation Database (NHS EED).

Given the limited economic evidence it was decided to perform a broad search for evidence that was designed to identify information about the costs or resources used in providing a service or intervention and/or the benefits that could be attributed to it. No criteria for study design were imposed a priori. In this way the searches were not constrained to randomised controlled trials or formal economic evaluations. Papers included were limited to studies of post-natal care, written in English, and reporting health economic information that could be generalised to U.K.

Identified titles and abstracts from the economics searches were reviewed by a single health economist and full papers obtained as appropriate. The full papers were critically appraisal by the health economist using a standard validated checklist. A general descriptive overview of the studies, their qualities, and conclusions was presented and summarized in the form of a short narrative review. The extractions of economic papers are found in Appendix D of the original guideline document.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++ High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*

2++ High-quality systematic reviews of case-control or cohort studies. High-quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well-conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2- Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal*

3 Non-analytic studies (for example, case reports, case series)

4 Expert opinion, formal consensus

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Critical Appraisal of the Evidence

From the papers retrieved the Health Service Research Fellow (HSFR) synthesised the evidence for each question or questions into a narrative summary. These form the basis of this guideline and are presented in Chapters 4 to 6 of the original guideline document. Each study was critically appraised using the Institute's criteria for quality assessment and the information extracted about included studies is given in Appendix C of the original guideline document. Background papers, for example those used to set the clinical scene in the narrative summaries, were referenced but not extracted.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Developing Key Clinical Questions

The first step in the development of the guideline was to refine the guideline scope into a series of key clinical questions (KCQs) which reflected the routine postnatal care pathway. These KCQs formed the starting point for the subsequent review and as a guide to facilitate the development of recommendations by the Guideline Development Group (GDG).

The KCQs were developed by the GDG and with assistance from the Technical Team. The KCQs were refined into specific evidence-based questions (EBQs) specifying interventions to search and outcomes to be searched for by the Technical Team and these EBQs formed the basis of the literature searching, appraisal and synthesis.

The total list of KCQs identified is listed in Appendix E in the original guideline document.

Forming Recommendations

In preparation for each meeting, the narrative and extractions together with a list of rejected papers for the questions to be addressed were made available to the Guideline Development Group (GDG) one week before the scheduled GDG meeting. These documents were available on a closed intranet site and sent by post to those members who requested it.

GDG members were expected to have read the narratives and extractions before attending each meeting. From the evidence, the Technical Team drafted evidence

statements which synthesised the research evidence. These were presented to the GDG at the meeting and discussed and agreed. Any changes were made to the electronic version of the text on a laptop and projected onto a screen until the GDG were satisfied with the statements. From the evidence statements and the experience of GDG members recommendations were drafted.

All work from the meetings was posted on the closed intranet site following the meeting as a matter of record and for referral by the GDG members.

Areas Without Evidence and Consensus Methodology

The table of clinical questions in Appendix E of the original guideline document indicates which questions were searched. Questions not searched were those which were answered by other national guidance, for example from the National Screening Committee, or questions for which no evidence was available. In some cases, the answers to a question were derived from a related search or recommendation; for example, answers to questions relating to the information needs of women were frequently supplied by the evidence reviewed for the associated condition.

In cases where evidence was sparse, the GDG derived the recommendations via informal consensus methods. Relevant experts in the field were contacted for further information as necessary. Two expert co-optees were nominated by their professional organizations and other experts listed in Section 1.8 of the original guideline document were nominated by the GDG to inform their decisions.

In addition, while the scope of the guideline is routine (or "normal") postnatal care, the vast majority of the research is directed at abnormality or at high risk groups or situations. Therefore, despite extensive literature searches which provided a sound background, many of the recommendations regarding what is core or normal care were derived through informal consensus methods.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations on Interventions*

A At least one meta-analysis, systematic review, or randomised controlled trial (RCT) that is rated as 1++, and is directly applicable to the target population, **or**
A systematic review of RCTs or a body of evidence that consists principally of studies rated as 1+, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Evidence drawn from a National Institute of Health and Clinical Excellence (NICE) technology appraisal

B A body of evidence that includes studies rated as 2++, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Extrapolated evidence from studies rated as 1++ or 1+

C A body of evidence that includes studies rated as 2+, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Extrapolated evidence from studies rated as 2++

D Evidence level 3 or 4, **or**
Extrapolated evidence from studies rated as 2+, **or**
Formal consensus

D(GPP) A good practice point D(GPP) is a recommendation for best practice based on the experience of the Guideline Development Group

IP Recommendation from NICE Interventional Procedures Guidance

*The grading of recommendations was carried out in accordance with the NICE Technical Manual in use at the outset of the guideline development process. However, during the development of the Postnatal Care guidance, NICE protocols were revised and grading of recommendations was abolished. Therefore, the recommendations for postnatal care are not graded in the NICE version of the guideline. They have been retained, as a matter of record, in the full guideline.

COST ANALYSIS

The economic evidence was not summarized in the form of meta-analyses given the limited evidence found. The extractions of economic papers are found in Appendix D of the original full-length guideline document. The Guideline Development Group (GDG) identified three areas which required further economic investigation. These were the costs of provision of Vitamin K to prevent Vitamin K Deficiency Bleeding, the cost implications of the Baby Friendly Hospital Initiative in England and Wales, and the planning and delivery of routine postnatal care. These areas were chosen because it was felt either there was a significant clinical or cost implication, or both. The results of these analyses are presented in the relevant chapters of the original guideline document.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was validated through two consultations.

1. The first draft of the guideline (The full guideline, National Institute for Clinical Excellence (NICE) guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the Full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Evidence categories (Ia-IV) and recommendation grades (A-D, and GPP) are defined at the end of the "Major Recommendations" field.

Planning the Content and Delivery of Care

Principles of Care

D (GPP) - Each postnatal contact should be provided in accordance with the principles of individualised care. In order to deliver the core care recommended in this guideline, postnatal services should be planned locally to achieve the most efficient and effective service for women and their babies.

D (GPP) - A coordinating healthcare professional should be identified for each woman. Based on the changing needs of the woman and baby, this professional is likely to change over time.

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

- Relevant factors from the antenatal, intrapartum, and immediate postnatal period
- Details of the healthcare professionals involved in her care and that of her baby, including roles and contact details
- Plans for the postnatal period

This should be reviewed at each postnatal contact.

D (GPP) - Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour.

D (GPP) - Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognise and respond to problems.

D (GPP) - At each postnatal contact the healthcare professional should:

- Ask the woman about her health and well-being and that of her baby. This should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed.
- Offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion.
- Encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues, and ask questions.
- Document in the care plan any specific problems and follow-up.

D (GPP) - Length of stay in a maternity unit should be discussed between the individual woman and her healthcare professional, taking into account the health

and well-being of the woman and her baby and the level of support available following discharge.

Professional Communication

D (GPP) - There should be local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals. These protocols should be audited.

C - Healthcare professionals should use hand-held maternity records, the postnatal care plans, and personal child health records, to promote communication with women.

Competencies

D (GPP) - All healthcare professionals who care for mothers and babies should work within the relevant competencies developed by Skills for Health (www.skillsforhealth.org.uk). Relevant healthcare professionals should also have demonstrated competency and sufficient ongoing clinical experience in:

- Undertaking maternal and newborn physical examinations and recognising abnormalities
- Supporting breastfeeding women including a sound understanding of the physiology of lactation and neonatal metabolic adaptation and the ability to communicate this to parents
- Recognising the risks, signs, and symptoms of domestic abuse and whom to contact for advice and management, as recommended by Department of Health guidance
- Recognising the risks, signs, and symptoms of child abuse and whom to contact for advice and management, as recommended by Department of Health guidance

Maintaining Maternal Health

General Advice

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

Table. Signs and Symptoms of Potentially Life-Threatening Conditions

Signs and Symptoms	Condition
Sudden and profuse blood loss or persistent increased blood loss Faintness, dizziness, or palpitations/tachycardia	Postpartum haemorrhage
Fever, shivering, abdominal pain, and/or offensive vaginal loss	Infection

Signs and Symptoms	Condition
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

GPP - The Department of Health booklet *Birth to Five*, which is a guide to parenthood and the first 5 years of a child's life, should be given to all women within 3 days of birth (if it has not been received antenatally).

GPP - The personal child health record should be given to all women as soon as possible (if it has not been received antenatally) and its use explained.

GPP - Women should be offered information and reassurance on:

- The physiological process of recovery after birth (within the first 24 hours)
- Normal patterns of emotional changes in the postnatal period and that these usually resolve within 10 to 14 days of giving birth (within 3 days)
- Common health concerns as appropriate (weeks 2 to 8)

Life-Threatening Conditions: Core Care and Raised Concern

Postpartum Haemorrhage

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

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

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

Genital Tract Sepsis

D (GPP) - In the absence of any signs and symptoms of infection, routine assessment of temperature is unnecessary.

D (GPP) - Temperature should be taken and documented if infection is suspected. If the temperature is above 38 degrees C, repeat measurement in 4 to 6 hours.

D (GPP) - If the temperature remains above 38 degrees C on the second reading or there are other observable symptoms and measurable signs of sepsis, evaluate further (emergency action).

Pre-eclampsia/Eclampsia

D (GPP) - A minimum of one blood pressure measurement should be carried out and documented within 6 hours of the birth.

D (GPP) - Routine assessment of proteinuria is not recommended.

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

D (GPP) - If diastolic blood pressure is greater than 90 mm Hg, and there are no other signs and symptoms of pre-eclampsia, measurement of blood pressure should be repeated within 4 hours.

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

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

Thromboembolism

D (GPP) - Women should be encouraged to mobilise as soon as appropriate following the birth.

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

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

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

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

Mental Health and Well-Being

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

A - Formal debriefing of the birth experience is not recommended.

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

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

D (GPP) - Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings, and ensuring they can access social support networks.

Physical Health and Well-Being

Perineal Care

D (GPP) - At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound; this might include experience of perineal pain, discomfort or stinging, offensive, odour or dyspareunia.

D (GPP) - The healthcare professional should offer to assess the perineum if the woman has pain or discomfort.

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

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

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

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

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

Dyspareunia

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

D (GPP) - If a woman expresses anxiety about resuming intercourse, reasons for this should be explored.

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

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

D (GPP) - Women who continue to express anxiety about sexual health problems should be evaluated (non-urgent action).

Headache

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

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

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

D (GPP) - Management of mild postnatal headache should be based on differential diagnosis of headache type and local treatment protocols.

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

Fatigue

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

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

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

Backache

D (GPP) - Women experiencing backache in the postnatal period should be managed as in the general population.

Constipation

D (GPP) - Women should be asked if they have opened their bowels within 3 days of the birth.

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

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

Haemorrhoids

D (GPP) - Women with haemorrhoids should be advised to take dietary measures to avoid constipation and should be offered management based on local treatment protocols.

D (GPP) - Women with a severe, swollen, or prolapsed haemorrhoid or any rectal bleeding should be evaluated (urgent action).

Faecal Incontinence

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

Urinary Retention

D (GPP) - Urine passed within 6 hours of urination during labour should be documented.

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

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

Urinary Incontinence

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

D (GPP) - Women with involuntary leakage of urine which does not resolve or becomes worse should be evaluated.

Contraception

D (GPP) - Methods and timing of resumption of contraception should be discussed within the first week of the birth.

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

Immunisation

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

D (GPP) - Women found to be sero-negative on antenatal screening for rubella should be offered a measles, mumps, rubella (MMR) vaccination following birth and before discharge from the maternity unit if they are in hospital.

D (GPP) - MMR vaccine may be given with anti-D (Rh_0) immunoglobulin injection provided that separate syringes are used and the products are administered into different limbs. If not given simultaneously, MMR should be given 3 months after anti-D (Rh0) immunoglobulin.

D (GPP) - Women should be advised that pregnancy should be avoided for 1 month after receiving MMR, but that breastfeeding may continue.

Safety

Domestic Abuse

D (GPP) - Healthcare professionals should be aware of the risks, signs, and symptoms of domestic abuse and know who to contact for advice and management, following guidance from the Department of Health.

6 to 8-Week Check

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

Table. Maternal Health and Wellbeing Core Information and Advice

All women should be offered information about their own health and well-being

Time Band 1: First 24 hours

Women should be offered information on:

C - The physiological process of recovery after birth, and that some health problems are common.

Women should be advised to immediately report to a healthcare professional:

- **C** - Signs and symptoms of potentially life threatening conditions
- **C** - If they have not passed urine within 6 hours of birth.

Time Band 2: 2 to 7 days (add hours to match pathway)

Women should be offered information and reassurance on:

B - Normal patterns of emotional changes in the postnatal period and that these

usually resolve within 10 to 14 days of giving birth (This information should be offered by the third day)

D (GPP) - Perineal hygiene

D - Contraceptive use which should be commenced by 3 weeks post partum

D - Male and female condoms – which may be used at any time after delivery

D (GPP) - Location and contact details for expert contraceptive advice, which may be from their general practitioner or from a family planning clinic

D (GPP) - Tiredness – which is a normal consequence of new parenthood

D (GPP) - Haemorrhoids – which are common in the postnatal period

C- Involuntary leakage of a small volume of urine – which is commonly experienced after birth

A - Importance of appropriate diet, including high fibre foods, and adequate intake of water.

Women should be advised to report to their healthcare professional:

- **D(GPP)**- Any changes in mood and emotional state outside of their normal pattern (seek information from families/partners if appropriate)
- **D(GPP)** - Itching or bleeding around the anus
- **C** - Faecal urgency or frank faecal incontinence

Time band 3: Weeks 2 to 8 (Day 8 onward)

All women should be offered information that:

- **D(GPP)**- Penetrative sex may be uncomfortable at first

All women should be advised to report to a healthcare professional:

- **D(GPP)**- Any vaginal loss that does not stop by the sixth week after birth
- **D(GPP)** - If pain persists with intercourse
- **D(GPP)** - Severe or persistent backache which is limiting daily activities
- **D(GPP)** - All women should be offered a six to eight week review which focuses on their physical and mental health and well-being.

Infant Feeding

Providing a Supportive Environment for Breastfeeding

A - Breastfeeding support should be made available regardless of the location of care.

D (GPP) - All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents. Each provider should identify a lead healthcare professional responsible for implementing this policy.

A - All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative (www.babyfriendly.org.uk) as a minimum standard.

D (GPP) - Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.

Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding. This includes making arrangements for:

- **A** - 24 hour rooming-in and continuing skin-to-skin contact when possible
- **D (GPP)** - Privacy
- **D (GPP)** - Adequate rest for women without interruption caused by hospital routine
- **D (GPP)** - Access to food and drink on demand

B - Formula milk should not be given to breastfed babies unless medically indicated.

A - Commercial packs, for example those given to women when they are discharged from hospital, containing formula milk or advertisements for formula should not be distributed.

A - Women who leave hospital soon after birth should be reassured that this should not impact on breastfeeding duration.

Information and Community Support

A - Written breastfeeding education materials as a stand-alone intervention are not recommended.

Starting Successful Breastfeeding

GPP - In the first 24 hours after birth, women should be given information on the benefits of breastfeeding, the benefits of colostrum, and the timing of the first breastfeed. Support should be culturally appropriate.

D (GPP) - Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within one hour.

C - Separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example weighing, measuring, and bathing,

should be avoided unless these measurements are requested by the woman or are necessary for the immediate care of the baby.

A - Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth.

D (GPP) - It is not recommended that women are asked about their proposed method of feeding until after the first skin-to-skin contact.

D (GPP) - From the first feed, women should be offered skilled breastfeeding support (from a healthcare professional, mother-to-mother, or peer support) to enable comfortable positioning of the mother and baby and to ensure that the baby attaches correctly to the breast to establish effective feeding and prevent concerns such as sore nipples.

Additional support with positioning and attachment should be offered to women who have had:

- **C** - Narcotic or a general anaesthetic, as the baby may not initially be responsive to feeding
- **D (GPP)** - A caesarean section, particularly to assist with handling and positioning the baby to protect the woman's abdominal wound
- **D (GPP)** - Initial contact with their baby delayed

Continuing Successful Breastfeeding

A - Unrestricted breastfeeding frequency and duration should be encouraged.

D (GPP) - Women should be advised that babies generally stop feeding when they are satisfied, which may follow a feed from only one breast. Babies should be offered the second breast if they do not appear to be satisfied following a feed from one breast.

D (GPP) - Women should be reassured that brief discomfort at the start of feeds in the first few days is not uncommon, but this should not persist.

D (GPP) - Women should be advised that if their baby is not attaching effectively he or she may be encouraged, for example by the woman teasing the baby's lips with the nipple to get him or her to open their mouth.

Women should be advised of the indicators of good attachment, positioning and successful feeding.

Indicators of good attachment and positioning:

- Mouth wide open
- Less areola visible underneath the chin than above the nipple
- Chin touching the breast, lower lip rolled down, and nose free
- No pain

Indicators of successful feeding in babies:

- Audible and visible swallowing
- Sustained rhythmic suck
- Relaxed arms and hands
- Moist mouth
- Regular soaked/heavy nappies

Indicators of successful breastfeeding in women:

- Breast softening
- No compression of the nipple at the end of the feed
- Woman feels relaxed and sleepy

C - Women should be given information about local breastfeeding support groups.

Assessing Successful Breastfeeding

D (GPP) - A woman's experience with breastfeeding should be discussed at each contact to assess if she is on course to breastfeed effectively and identify any need for additional support. Breastfeeding progress should then be assessed and documented in the postnatal care plan at each contact.

C - If an insufficiency of milk is perceived by the woman, attachment and positioning should be reviewed and her baby's health should be evaluated. Reassurance should be offered to support the woman to gain confidence in her ability to produce enough milk for her baby.

B - If the baby is not taking sufficient milk directly from the breast and supplementary feeds are necessary, expressed breast milk should be given by a cup or bottle.

C - Supplementation with fluids other than breast milk is not recommended.

Expression and Storage of Breast Milk

D (GPP) - All breastfeeding women should be shown how to hand express their colostrum or breast milk and advised on how to correctly store and freeze it.

D (GPP) - Breast pumps should be available in hospital, particularly for women who have been separated from their babies, to establish lactation. All women who use a breast pump should be offered instructions on how to use it.

Preventing, Identifying, and Treating Breastfeeding Concerns

Nipple Pain

D (GPP) - Women should be advised that if their nipples are painful or cracked, it is probably due to incorrect attachment.

D (GPP) - If nipple pain persists after repositioning and re-attachment, assessment for thrush should be considered.

Engorgement

D (GPP) - Women should be advised that their breasts may feel tender, firm, and painful when milk "comes in" at or around 3 days after birth.

D (GPP) - A woman should be advised to wear a well-fitting bra that does not restrict her breasts.

A - Breast engorgement should be treated with:

- Frequent unlimited breastfeeding including prolonged feeding from the affected breast
- Breast massage and, if necessary, hand expression
- Analgesia

Mastitis

C - Women should be advised to report any signs and symptoms of mastitis including flu-like symptoms, red, tender, and painful breasts to their healthcare professional urgently.

Women with signs and symptoms of mastitis should be offered assistance with positioning and attachment and advised to:

- **A** - 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
- **D (GPP)** - Take analgesia compatible with breastfeeding, for example paracetamol
- **D (GPP)** - Increase fluid intake

D (GPP) - If signs and symptoms of mastitis continue for more than a few hours of self management, a woman should be advised to contact her healthcare professional again (urgent action).

B - If the signs and symptoms of mastitis have not eased, the woman should be evaluated as she may need antibiotic therapy (urgent action).

Inverted Nipples

D (GPP) - Women with inverted nipples should receive extra support and care to ensure successful breastfeeding.

Ankyloglossia (Tongue Tie)

D (GPP) - Evaluation for ankyloglossia should be made if breastfeeding concerns persist after a review of positioning and attachment by a skilled healthcare professional or peer counsellor.

D (GPP) - Babies who appear to have ankyloglossia should be evaluated further (non-urgent action).

Sleepy Baby

D (GPP) - Women should be advised that skin-to-skin contact or massaging a baby's feet should be used to wake the baby. The baby's general health should be assessed if there is no improvement.

Formula Feeding

D (GPP) - All parents and carers who are giving their babies formula feed should be offered appropriate and tailored advice on formula feeding to ensure this is undertaken as safely as possible, in order to enhance infant development and health, and fulfill nutritional needs.

D (GPP) - A woman who wishes to feed her baby formula milk should be taught how to make feeds using correct, measured quantities of formula, as based on the manufacturer's instructions, and how to clean and sterilise bottles and teats and how to store formula milk

D - Parents and family members should be advised that milk, either expressed milk or formula, should not be warmed in a microwave.

D (GPP) - Breastfeeding women who want information on how to prepare formula feeds should be advised on how to do this.

Table. Infant Feeding Information and Advice

Time band 1: First 24 hours

Women should be offered information and reassurance on:

- **D (GPP)** - Colostrum – which will meet the needs of the baby in the first few days after birth
- **C** - Timing of the initial breastfeed and the protective effect of colostrums. This advice should be culturally sensitive
- **D (GPP)** - The nurturing benefits of putting the baby to the breast in addition to the nutritional benefits of breastfeeding

Time band 2: 2 to 7 days

A woman should be offered information and reassurance on:

Feeding patterns:

- **D (GPP)** - That her baby may have a variable feeding pattern, at least over the first few days, as the baby takes small amounts of colostrum and then takes increasingly larger feeds as the milk supply comes in
- **A** - That when the milk supply is established, a baby will generally feed every 2 to 3 hours, but this will vary between babies and, if her baby is healthy, the baby's individual pattern should be respected

Position and attachment:

D - That being pain free during the feed is an indicator of good position and attachment

Other indicators of good attachment include:

- **D** - Chin touching the breast, with the lower lip rolled down, with the nose free
- **D** - Mouth is wide open
- **D** - Less areola visible below the baby's mouth than above the nipple
- **D** - The baby is swallowing

Signs of successful milk transfer:

The baby has:

- **D** - Audible swallowing
- **D** - Sustained rhythmic suck and swallowing with occasional pauses
- **D** - Relaxed arms and hands
- **D** - Moist mouth
- **D** - Satisfaction after feeding
- **D**- Regular soaked/heavy nappies

The woman:

- **D** - Feels no breast or nipple pain
- **D** - Experiences her breast softening
- **D** - May experience uterine discomfort
- **D** - Observes no compression of the nipple at the end of the feed
- **D** - Feels relaxed and sleepy

D - **Engorgement** - Full breasts are common on day 3 but engorged breasts (hard, hot, inflamed) are a sign of inadequate milk drainage requiring treatment

C - **Safety** - Milk, either formula or expressed breast milk, should not be heated in a microwave as there is a danger of scalding (Advise Family/Partner as appropriate)

B - **Benefits of breastfeeding** - That babies who are exclusively breastfed for 6 months will accrue the greatest health benefits and disease prevention.

A - **Local breastfeeding support groups** - How to access and what services and support they provide.

Women should be advised to report to their healthcare professional:

A - **Urgently**: The signs and symptoms of mastitis including flu like symptoms, red, tender, and painful breasts.

Maintaining Infant Health

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

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

D (GPP) - 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

D (GPP) - Parents, family members, and carers should be offered information and reassurance on:

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

D (GPP) - Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both parents in the care of their baby and enable them to learn more about their baby's needs.

Parenting and Emotional Attachment

D (GPP) - Assessment for emotional attachment should be carried out at each postnatal contact.

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

B - Women should be encouraged to develop social networks as this promotes positive maternal-baby interaction.

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

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

Physical Examination and Screening

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

A complete examination of the baby should take place within 72 hours of birth. This examination should incorporate a review of parental concerns, and the baby's medical history should also be reviewed including family, maternal, antenatal, and perinatal history; fetal, neonatal, and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine (and urine stream in a boy). Appropriate recommendations made by the NHS National Screening Committee should also be carried out (www.nsc.nhs.uk/ch_screen/child_ind.htm).

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

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

D (GPP) - The newborn blood spot test should be offered to parents when their baby is 5 to 8 days old.

D (GPP) - At 6 to 8 weeks, an examination, comprising the items listed above for "physical examination," should be carried out. In addition, an assessment of social smiling and visual fixing and following should be carried out.

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

D (GPP) - Parents should be offered routine immunisations for their baby according to the schedule recommended by the Department of Health.

Physical Health and Well-Being

Jaundice

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

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

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

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

D (GPP) - Breastfed babies with jaundice should not be routinely supplemented with formula, water, or dextrose water.

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

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

Skin

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

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

Thrush

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

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

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

Nappy Rash

D (GPP) - For babies with nappy rash the following possible causes should be considered:

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

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

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

Constipation

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

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

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

Diarrhoea

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

Colic

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

D (GPP) - Assessment of excessive and inconsolable crying should include:

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

- Any factors which lessen or worsen the crying

D (GPP) - Health care professionals should reassure parents of babies with colic that the baby is not rejecting them and that colic is usually a phase that will pass. Parents should be advised that holding the baby through the crying episode and accessing peer support may be helpful.

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

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

Fever

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

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

D (GPP) - A temperature of 38 degrees C or more is abnormal and the cause should be evaluated (emergency action). A full assessment, including physical examination, should be undertaken.

Vitamin K

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

A - Vitamin K should be administered as a single dose of 1 mg intramuscularly as this is the most clinically and cost-effective method of administration.

D (GPP) - If parents decline intramuscular vitamin K for their baby, oral vitamin K should be offered as a second-line option. Parents should be advised that oral vitamin K must be given according to the manufacturer's instructions for clinical efficacy and will require multiple doses.

Safety

A - All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment and promote safety education.

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

B - Parents should be given information in line with the Department of Health guidance about sudden infant death syndrome (SIDS) and co-sleeping, which

states that "The safest place for your baby to sleep is in a cot in your room for the first six months. While it's lovely to have your baby with you for a cuddle or a feed, it's safest to put your baby back in their cot before you go to sleep. There is also a risk that you might roll over in your sleep and suffocate your baby, or that your baby could get caught between the wall and the bed, or could roll out of an adult bed and be injured."

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

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

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

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

Child Abuse

D (GPP) - Health professionals should be alert to risk factors and signs and symptoms of child abuse.

D (GPP) - If there is raised concern, the healthcare professional should follow local child protection policies.

Table. Infant Health Core Information and Advice

Time Band 1: First 24 hours

Parents should be offered information on:

- **GPP** - Vitamin K – in order to make an informed decision about its use
- Physiological jaundice including:
    - **C** - That it normally occurs around 3 to 4 days after birth
    - **D (GPP)** - Reasons for monitoring and how to monitor

Parents should be advised to report to their healthcare professional:

- **D (GPP)** - **urgently**, development of jaundice

Time Band 2: 2 to 7 days

D (GPP) - All women and their families should be given information about availability, access and aims of all postnatal peer, statutory, and voluntary groups and organisations in their local community.

Parents should be offered information and reassurance on:

- **B** - Their infant's social capabilities—as this can promote parent-infant attachment
- **D (GPP)** - Nappy rash—frequent nappy changes and cleansing and exposure of the perianal area reduces babies' contact with faeces and urine
- **A** - Cord care—how to keep the umbilical cord clean and dry
- **A** - Safety—how to reduce accidents, particularly scalds and falls
- **B** - Sudden infant death—how to reduce risk, including co-sleeping

Parents should be advised to report to their healthcare professional:

- **D (GPP)** - Changes in the baby's established bowel pattern (which will take up to 7 days to establish), including hard stools that are difficult to pass or increased frequency of loose stools

Time Band 3: 2 to 8 weeks (Day 8 onward)

All women and their families should be given information about availability, access, and aims of all postnatal peer, statutory, and voluntary groups and organisations in their local community.

Definitions:

Evidence Levels

1++ High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*

2++ High-quality systematic reviews of case-control or cohort studies.
High-quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well-conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2- Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal*

3 Non-analytic studies (for example, case reports, case series)

4 Expert opinion, formal consensus

Recommendation Grades

A At least one meta-analysis, systematic review, or randomised controlled trial (RCT) that is rated as 1++, and is directly applicable to the target population, **or**
A systematic review of RCTs or a body of evidence that consists principally of studies rated as 1+, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Evidence drawn from a National Institute for Clinical Excellence (NICE) technology appraisal

B A body of evidence that includes studies rated as 2++, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Extrapolated evidence from studies rated as 1++ or 1+

C A body of evidence that includes studies rated as 2+, is directly applicable to the target population and demonstrates overall consistency of results, **or**
Extrapolated evidence from studies rated as 2++

D Evidence level 3 or 4, **or**
Extrapolated evidence from studies rated as 2+, **or**
Formal consensus

D(GPP) A good practice point D(GPP) is a recommendation for best practice based on the experience of the Guideline Development Group

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence is identified and graded for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate postnatal care of women and their babies to improve health benefits of mother and infants

POTENTIAL HARMS

None stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in "Standards for better health" issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (listed below). These are available on the NICE web site (www.nice.org.uk/CG037) (see also the "Availability of Companion Documents" field).

- Slides highlighting key messages for local discussion.
- Costing tools
    - Costing report to estimate the national savings and costs associated with implementation.
    - Costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives which support this locally.
- Audit criteria to monitor local practice (see appendix C of the short version of the original guideline document).

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Patient Resources
Quick Reference Guides/Physician Guides
Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Primary Care. Postnatal care. Routine postnatal care of women and their babies. London (England): Royal College of General Practitioners; 2006 Jul. 392 p. [488 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Jul

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Primary Care - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In accordance with guidance from the National Institute of Health and Clinical Excellence (NICE), all Guideline Development Group members' interests were recorded on a standard declaration form that covered consultancies, fee-paid work, share-holdings, fellowships, and support from the healthcare industry.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Routine postnatal care of women and their babies. NICE guideline. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 46 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Routine postnatal care of women and their babies. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 27 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Postnatal care: routine postnatal care of women and their babies. Costing report. Implementing NICE guidance in England. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 36 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

- Costing template. Postnatal care: routine postnatal care of women and their babies. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. various p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Routine postnatal care of women and their babies. Presenter slides. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 22 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Implementation advice. Postnatal care. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 16 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1074. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria can be found in Appendix A of the original guideline document.

PATIENT RESOURCES

The following is available:

- Care of women and their babies in the first 6–8 weeks after birth. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2006 Jul. 15 p. (Clinical guideline; no. 37). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N1075. 11 Strand, London, WC2N 5HR.

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