

Pathways for Maternity Care

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Introduction

The Keeping Childbirth Natural and Dynamic (KCND) programme has been developed to support the multi-professional team to implement the principles outlined in the Framework for Maternity Services in Scotland document. The pathway for normal maternity care is a strand of the KCND programme to facilitate ongoing risk assessment and to ensure evidence-based care by the appropriate professional for all women accessing maternity care across Scotland. The ethos of the pathway is that pregnancy and childbirth are normal physiological processes and unnecessary intervention should be avoided. This pathway is the first in a series of pathways for maternity care.

One of the key principles of the pathway for normal maternity care is the right of pregnant women to be provided with current evidence-based information and to be involved with decisions regarding their care and that of their baby. Good communication between the multi-professional team and women is essential. Women and their families should be treated with respect, dignity and kindness with their views and beliefs being sought and respected at all times.

In order to ensure the pathway for normal maternity care is effective the following principles should be explicitly adopted and practised by maternity care teams:

- There is a shared explicit practice philosophy that supports protects and maintains normality.
- The midwife is the lead professional for healthy women with uncomplicated pregnancies.
- There is consistent high quality communication with women, with relevant information provided at appropriate times.
- Discussion with all women is facilitated to enable them to make decisions regarding care and birth preferences, including place of birth and to encourage women to document these preferences in their handheld record.
- Women are supported to take a central, active role in their own care during pregnancy, labour and the postnatal period.
- There is recognition of the impact of inequality and social exclusion on health and it is ensured that appropriate information, support and referral are provided to all women based on need.

The pathway for normal maternity care requires women to have continuous risk assessment throughout the pregnancy, labour and the postnatal period taking into account that risk status is dynamic and may change over time. It is anticipated that women may move between different care packages, in both directions, as a result of clinical recommendation or maternal choice. The pathway is intended to apply in the majority, but not all cases. As with any guidance document, clinical judgement is always needed when deciding when it is not appropriate to follow care recommendations. This document cannot cover every eventuality so there will be occasions when this guidance may not be followed, but it is important to record in the case notes such deviations and the reasons for them.

The pathway should be used in conjunction with clear local guidance on indications for and the process of transfer from midwife led to maternity team care appropriate to the geographical area.

The pathway for normal maternity care is outlined as follows:

 **Green:** midwife-led care – healthy women with uncomplicated pregnancies should be offered a midwife as their lead professional, being the first point of contact to confirm, book, assess and plan care, although it should be acknowledged that women may still choose to see their GP and/or obstetrician.

 **Amber:** assessment required – Women with any potential medical/obstetric/social risk factors should be further assessed or referred to the appropriate health professional for further assessment or support. Following this assessment women may return to the green midwife led part of the pathway or be referred to the red maternity team part of the pathway for further specialist advice and care. A number of the amber criteria will require clear local guidelines with appropriate education and audit in place.

 **Red:** maternity team care – women with significant medical/obstetric factors should have a consultant obstetrician as the lead professional, sharing care with midwives, GPs and other care providers as appropriate e.g. anaesthetists, diabetologists, cardiologists, neonatologists, psychiatrists and allied health professionals.

In order to support the multi-professional team the pathway also includes evidence-based guidance to help promote normality. These are:

Principles of Care notes – these boxes provide the multi-professional team with guidance on best evidence to support and care for women during all parts of the pregnancy journey.

Normal maternity care pathway notes – the multi-professional team should refer to these notes when following the pathway. These notes will enable them to ensure that women are continually risk assessed and that appropriate care is given that will promote the principles of normality.

There is a link to the evidence base used via the NHS QIS web site:

www.nhshealthquality.org

Antenatal pathway

Principles of antenatal care

- Midwives' own belief in physiological birth should be explicit in their work philosophy and approach to care
- Care should be supported by evidence wherever possible
- Continuity of care/carer should be encouraged
- Promotion of woman's self-belief/confidence around normal birth
- Encourage family and wider community support around normal birth
- Provide a calm, positive environment
- Women should feel able to ask questions as they arise
- Additional visits may be required depending on the individual woman's needs

Extra support that may be required for promotion of a normal birth

- Additional one-to-one time for woman and/or her family
- Referral to community groups/networks
- Planned peer support
- Second opinion from other colleagues, senior midwife or supervisor of midwives
- Allied Health Professional Opinion (e.g. physiotherapist, dietician)
- Counselling services as appropriate

Antenatal notes & pathway

Antenatal notes

Note: **1** First point of contact (Visit 1) initial risk assessment. The following risk factors require immediate referral:

FETAL/NEONATAL:

- Previous congenital abnormality
- Complicated family genetic history

OBSTETRIC/MEDICAL HISTORY

- Long term conditions on medication (except for controlled asthma)
- Require initiation or change of medication
- TSH taken by 12 weeks for women being treated for thyroid disease
- Has previously been advised to seek obstetric care
- No medical history because new to UK
- Acquired or congenital Heart conditions
- Known haemoglobinopathies
- 3 or more consecutive miscarriages and/or identified cause for recurrence
- Significant mental ill health (to include puerperal psychosis)

Note: **2** Maternal history taking (Visit 2) Women with potential obstetric/medical/social risk factors requiring further assessment/support

OBSTETRIC HISTORY

- Assisted conception
- Pelvic floor or cervical surgery
- Women who book after 20 weeks
- Previous pre-term birth
- Pelvic girdle pain

MEDICAL HISTORY

- Neurological disease
- Mental ill health
- Other significant medical history
- Current history of smoking

WOMEN WITH SIGNIFICANT SOCIAL NEEDS

- Complete "Ethnic Origin, Other health-related questions, "Your mental health" and "Home circumstances and support needs" section of SWHMR. Refer to appropriate agency/health professional where appropriate.
- Woman or partner in criminal justice system

CONSIDER OBSTETRIC PLAN FOR DELIVERY IF:

- Previous mid trimester loss
- Previous postpartum haemorrhage greater than or equal to 1000mls
- Previous third/fourth degree perineal tears / female circumcision or cutting
- Previous shoulder dystocia
- Refusing administration of blood/blood products/known Jehovah Witness

ANAESTHETIC HISTORY

- Spinal injury or disease
- Needle phobia
- Anaesthetic complications e.g.
 - History of difficult/failed intubation
 - Previous anaesthetic drug reaction
 - Family history of suxamethonium apnoea
 - Family history of malignant hyperpyrexia
 - Previous technical difficulties with epidural or Spinal block

Note: **3** Maternal history taking (Visit 2) Women with significant medical/obstetric risks factors

OBSTETRIC HISTORY

- Previous caesarean section
- Previous and/or current pre-eclampsia/eclampsia
- Previous stillbirth or neonatal death
- Significant or recurring antepartum haemorrhage
- Placenta praevia found after 24 weeks
- Previous iso-immunisation (eg Rhesus and Kell)

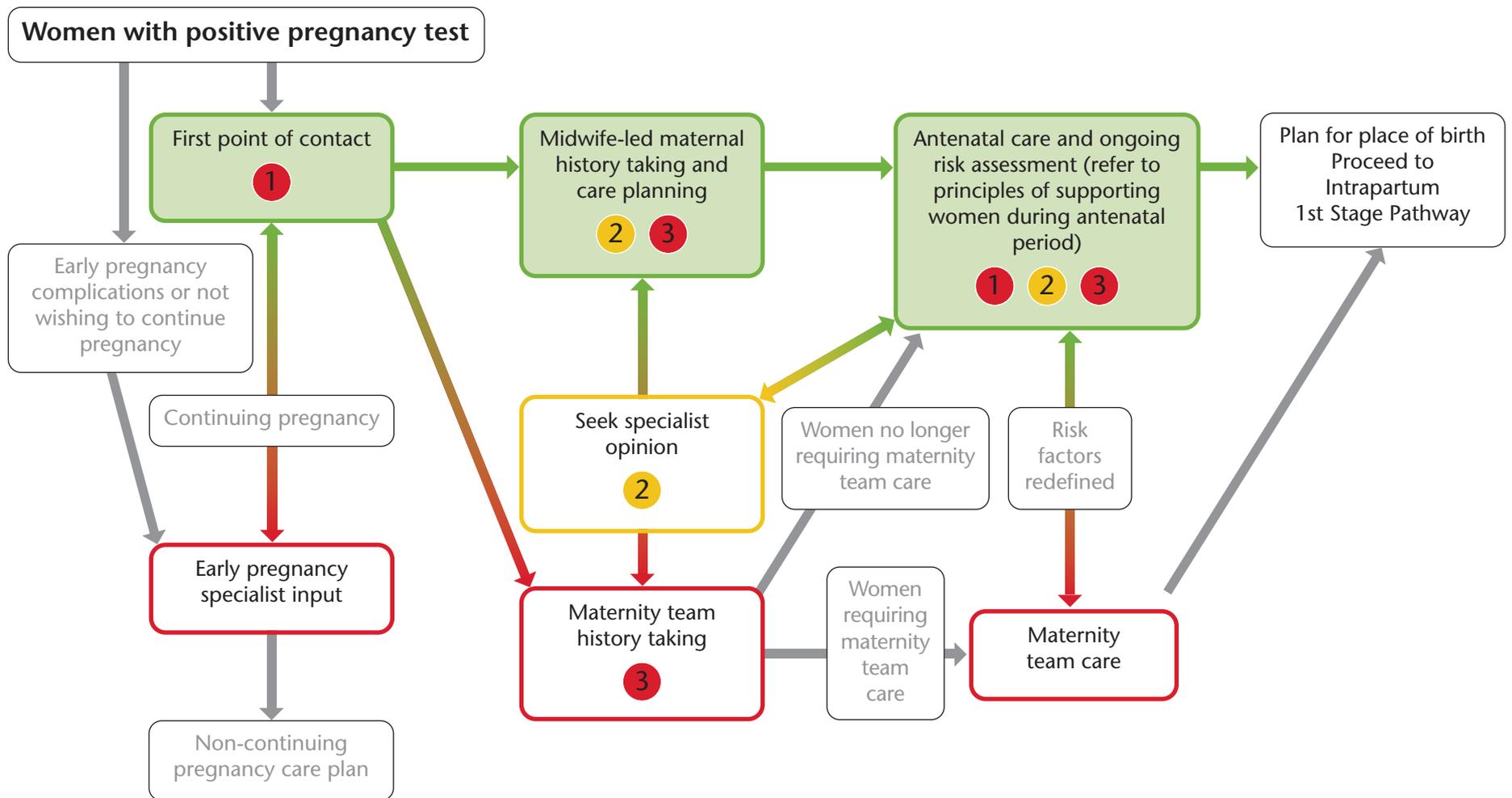
FETAL/NEONATAL:

- Previous or current babies below 10th centile or above the 95th centile
- Previous child with special needs, possibly related to birth

MEDICAL HISTORY

- Significant mental ill health (to include puerperal psychosis)
- Primary family member history of bipolar disorder
- Alcohol and/or drug misuse (within last 12 months)
- Anaphylaxis
- Anti-coagulant therapy
- Active blood borne viruses
- BMI <18 or >35
- Significant gastrointestinal disorders e.g. Crohn's disease, fatty liver of pregnancy
- Diabetes (type I or II) or gestational diabetes
- Essential / secondary hypertension
- Epilepsy
- Heart conditions
- Haematological disease
- Malignancy to include previous molar pregnancy
- Past or current use of non-inhaled steroids or deteriorating asthma / cystic fibrosis
- Renal disease
- Solid organ transplant
- Thyroid disease
- Autoimmune disease

Refer to minimum care schedule



Green: Midwife led care
 Healthy women at low risk, ie: Age : 16 to 40 years inclusive, parity: less than para 5, BMI: 18 to 35 inclusive, singleton pregnancy:

Amber: Assessment required
 Women with potential/medical/obstetric/ social risks identified, requiring further assessment or support (see note 2)

Red: Maternity team care recommended
 Women with significant medical/obstetric/ risks identified (see note 1,3)

Antenatal pathway

Minimum care schedule and ongoing risk assessment (as per SWHMR)

Visit	Week	Care	Particular attention to
1	First point of contact	<ul style="list-style-type: none"> Perform initial risk assessment as per note 1 Information on and scheduling of screening tests offered should be discussed at this visit which should ideally be before 10 weeks gestation 	Maternal emotional and mental health wellbeing (refer to “your mental health” page of SWHMR) ensuring this is assessed on an ongoing basis. Public health issues as indicated in SWHMR should also be addressed
2	8 -<12	<ul style="list-style-type: none"> Maternal history taking as per SWHMR. This visit should occur ideally before 10 weeks and the history taking completed by 12 weeks. It may be of benefit to divide the history taking over two early pregnancy appointments (see SWHMR Guidance for Professionals and Maternal History Taking Best Practice Statement). 	Infant feeding antenatal checklist as per SWHMR Ensure height and weight documented Ensure ‘private time’ is offered
3	15-16	Fundal height, blood pressure and urinalysis + ensure results from all screening tests requested discussed and documented	
4	22-25	as per antenatal appointments page in SWHMR (See Note A below) + ensure results from all screening tests requested discussed and documented	
5	28	as per antenatal appointments page in SWHMR (See Note A below)	Check haemoglobin Antibody check (Rh, Kell) / Atypical red cell alloantibodies Offer Anti D prophylaxis if Rhesus negative
6 (if first pregnancy)	31-32	as per antenatal appointments page in SWHMR (See Note A below).	
7	34-36	as per antenatal appointments page in SWHMR (See Note A and B below) + full discussion of latent phase + offer advice about benefits of antenatal perineal massage to reduce perineal trauma at birth	Discuss preferences for labour and birth as per SWHMR Revisit infant feeding antenatal checklist
8	37-38	as per antenatal appointments page in SWHMR (See Note A and B below) + give information on membrane sweep	Ensure ‘private time’ has been offered during antenatal period
9 (if first pregnancy)	39-40	as per antenatal appointments page in SWHMR (See Note A and B below) + offer membrane sweep if >40weeks + give information on induction of labour (see local guidance for induction planning)	Document membrane sweep in SWHMR
10	41	as per antenatal appointments page in SWHMR + offer membrane sweep and give information on induction of labour (offer induction according to local guidance)	Document membrane sweep in SWHMR



If baby not born by 42 weeks, transfer to maternity team care

Notes

A Height of uterus, blood pressure, urinalysis, oedema, fetal heartbeat and movement and emotional well being

B Fetal growth, presenting part, fetal lie/position, fifths palpable

Antenatal care schedule

Intrapartum pathway

Principles of caring for women in the 1st stage of labour

- Birth environment - relaxed, private, safe with low lighting
- Low technology and one to one support from a midwife and birthing partner(s) present (where desired)
- Facility to eat and drink in labour (availability of isotonic drinks)
- Discuss birth-plan on admission
- Range of non-pharmacological pain-relief
- Avoid routine amniotomy

Maternal Monitoring

- Temperature (36.2°C-37.5°C) BP 4 hourly (diastolic less than or equal to 90mmHg, systolic less than or equal to 150mmHg)
- Refer to local guidance on waterbirth if labouring in water
- Pulse hourly
- Abdominal palpation for descent and position 4 hourly
- Vaginal examination not required unless slow progress is suspected (typical progress $\geq 0.5\text{cm/hr}$ cervical dilation)
- Assess PV discharge
- Encourage regular bladder emptying

Fetal monitoring

- There is no evidence to support admission CTG in healthy women with no complications
- Fetal heart rate 110-160 bpm clear and regular on auscultation
- Intermittent auscultation for 1 minute every 15 minutes after a contraction
- Be aware of a rising or changing baseline as an indicator of potential fetal compromise

Note: 4 Present pregnancy criteria for further assessment (refer to local guidance)

- Less than 16 years and older than 40 years
- Hb <9g/dl
- Previous 3rd or 4th degree tear
- Previous shoulder dystocia
- Platelets <100x10/L
- Elevated Blood Pressure on admission returning to normal
- Abnormal fetal heart rate on admission
- Spontaneous labour following prostaglandins use
- Group B strep
- Pre-labour ruptured membranes between 18 -24 hours
- Meconium (ensure local guidance, education and audit in place)

Note: 5 Present pregnancy criteria for maternity team care

- No antenatal care
- Pre term labour less than 37 weeks
- Post term labour greater than 42 weeks
- Pre term rupture of membranes less than 37 weeks
- Significant or recurring APH
- Abnormal fetal growth/congenital abnormality
- Obstetric cholestasis
- Epidural for analgesia
- Placenta praevia
- Hypertension/pre-eclampsia/eclampsia
- Rhesus iso-immunisation (eg Rhesus and Kell)
- Multiple pregnancy
- Oligohydramnios/polyhydramnios
- Active viral infection eg chickenpox, parvovirus, measles
- Malpresentation

Note: 6 NICE definition of 1st stage of labour

Established first stage of labour – when:

- there are regular painful contractions, and/or
- there is progressive cervical dilatation from 4 cm.

Note: 7 NICE definition of latent phase of labour

A period of time, not necessarily continuous, when:

- there are painful contractions, and
- there is some cervical change, including cervical effacement and dilatation up to 4cm.

Setting

- Labour ward may not be the appropriate environment and latent phase is best experienced in the women's own home.
- Women may need reassurance that the latent phase of labour is normal
- The antenatal ward is an alternative for those women who do not feel comfortable going home
- A repeat request for triage in the latent phase may indicate that assessment in hospital of the mother and fetus is required

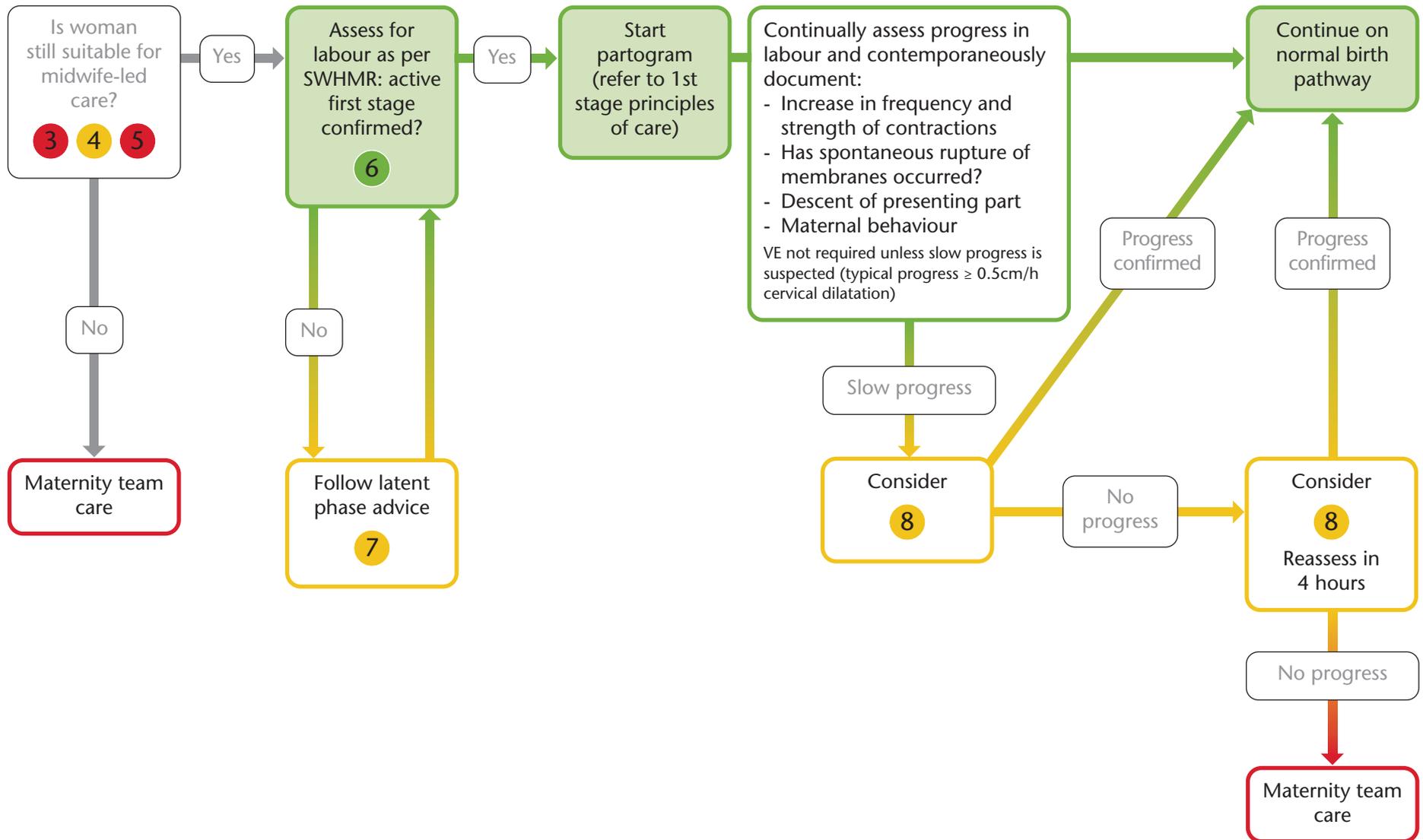
Advice

- Nap and rest if feeling tired, although mobilising may encourage the contractions to establish themselves
- Take light meals and keep hydrated
- Warm showers and baths may provide some pain relief, massage or back rubs can be helpful
- Paracetamol 1gm 6 hourly can be taken. TENs machines should be provided

Note: 8 If slow/no progress in labour, consider:

- Mobilisation
- Optimal fetal positioning
- Nutrition
- Hydration
- Emotional support/environment
- Use of complementary therapy support
- Immersion in water
- Rest
- Maternal and fetal well-being
- Amniotomy should only be performed after careful consideration of all the possible implications

Reassess in a further 4 hours if mother and baby well and with maternal consent.



1st stage pathway

2nd stage pathway

Principles of caring for women in the 2nd stage of labour

- Birth environment - relaxed private, safe with low lighting
- One to one support from a midwife and birthing partner(s) present (where desired)
- Ensure well hydrated (availability of isotonic drinks)
- Mother to adopt upright position where possible
- Non-directed pushing
- Timings need not be applied rigidly. Clinical judgement important

Maternal Monitoring

- Continue temperature 4 hourly (36.2°C-37.5°C)
- Refer to local guidance on waterbirth if labouring in water
- Pulse hourly (60-100 inclusive)
- BP hourly if diastolic less than or equal to 90mmHg, systolic less than or equal to 160mmHg
- Abdominal palpation for descent and position as required to assess progress
- Vaginal examination as required if no obvious signs of progress
- Assess PV discharge
- Encourage regular bladder emptying

Fetal Monitoring

- Intermittent auscultation for 1 minute every 5 minutes after a contraction
- Maternal pulse should be taken if suspected fetal bradycardia or other abnormality to differentiate between the two heart rates

Note: 9 Definition of 2nd stage of labour

Passive second stage of labour:

- the finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions

Onset of the active second stage of labour:

- expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
- active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions
- the head is visible

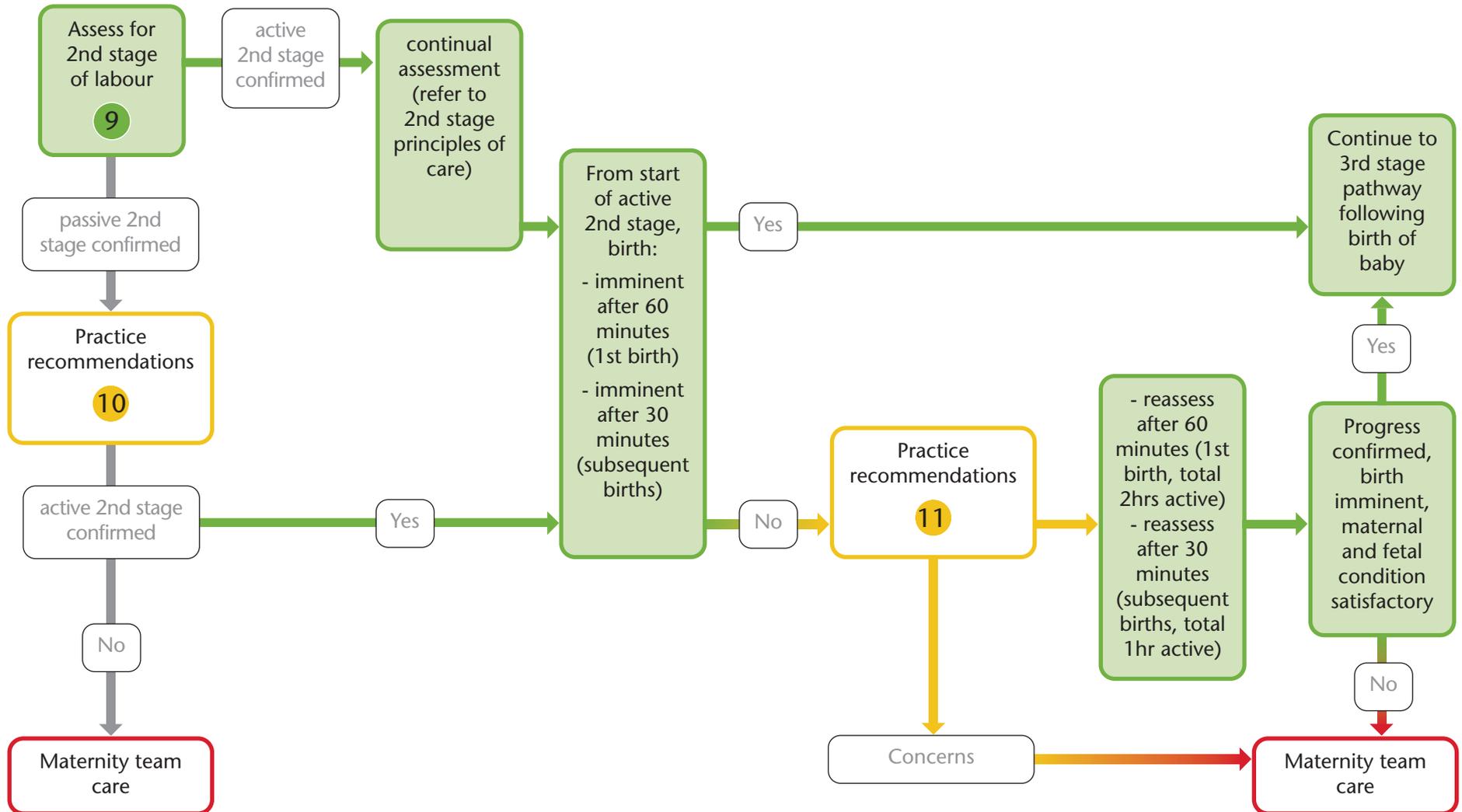
Note: 10 Practice recommendations (passive 2nd stage)

Refer to local guidance re timings

- Assess fetal and maternal well-being
- Assess strength of contractions and abdominal palpation for descent
- Ensure adequate hydration
- Ensure bladder empty
- Consider maternal position /mobilisation
- Assess vaginally for descent and rotation of head
- Consider amniotomy if membranes intact

Note: 11 Practice recommendations (active 2nd stage)

- Consider maternal position – encourage upright posture
- Ensure adequate hydration and nutrition
- Give gentle verbal support and praise
- Consider environment (low light and privacy)
- Consider amniotomy if membranes intact
- Vaginal examination may be indicated if genuine lack of progress



2nd stage pathway

3rd stage notes & pathway

Principles of physiological 3rd stage

- Informed maternal consent
- Uncomplicated labour with effective uterine activity
- Do not clamp and cut cord unless clinically indicated e.g. resuscitation of mother or baby
- Await signs of separation (lengthening of cord, small gush of blood per vagina)
- Strong urge to push may be present or placenta visible at the vulva
- Do not interfere with the fundus or pull on cord
- Physiological 3rd stage should be complete within 60 minutes
- Active management is recommended at 60 minutes

Note: **12** Definition of 3rd stage of labour

The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes.

Physiological management of the third stage is the natural conclusion to a physiological 1st and 2nd stage of labour. It involves a package of care which includes all of these three components:

- no routine use of oxytocic drugs
- no clamping of the cord until at least pulsation has ceased (unless clinically indicated)
- delivery of the placenta by maternal effort.

Active management of the third stage involves a package of care which includes all of these three components:

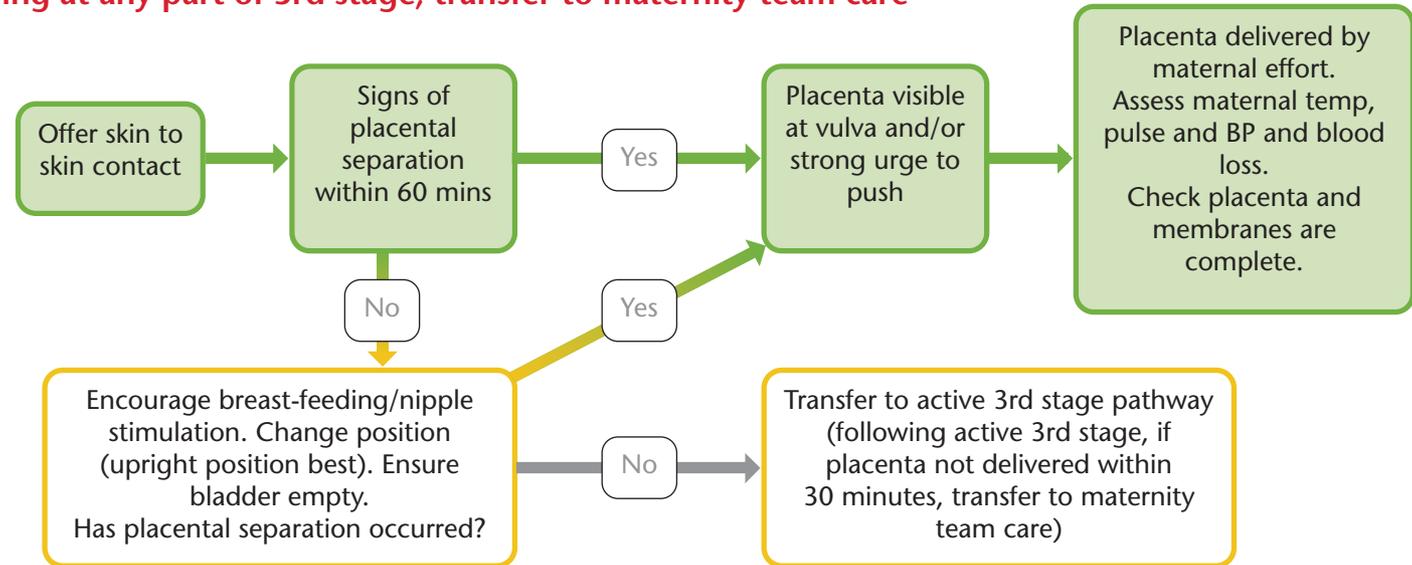
- routine use of oxytocic drugs
- consider delayed clamping and cutting of the cord prior to controlled cord traction (unless clinically indicated)
- controlled cord traction

The third stage of labour is diagnosed as prolonged if not completed within 60 minutes of the birth of the baby with physiological management and 30 minutes with active management.

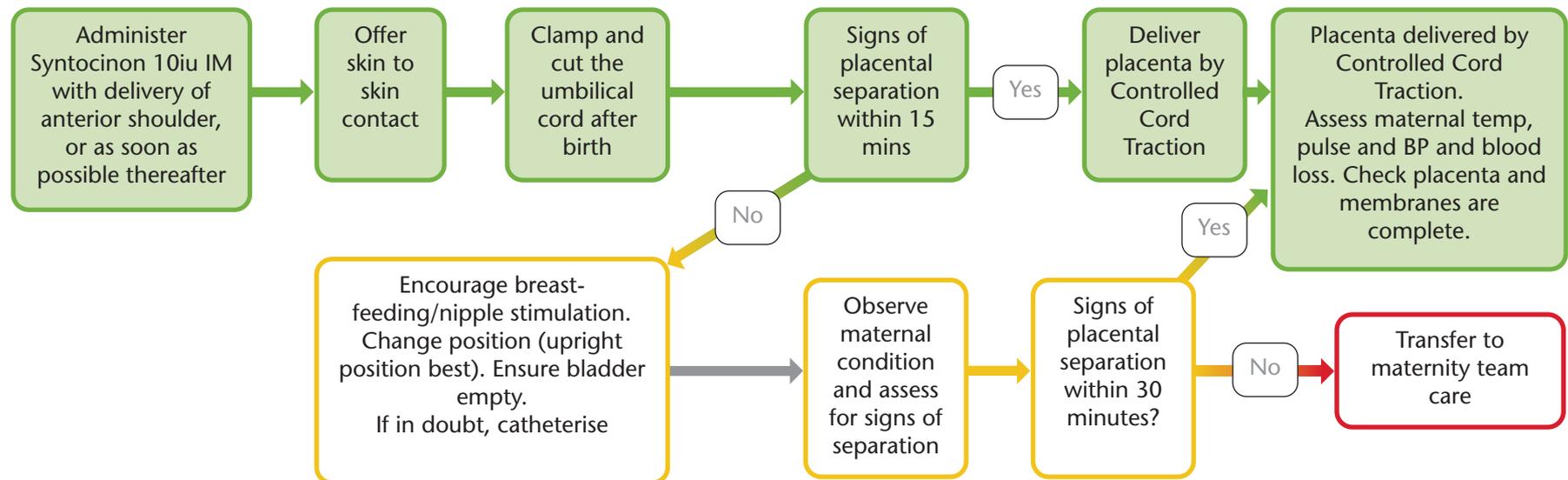
confirm informed maternal choice for either physiological or active 3rd stage – see note 12

If excessive vaginal bleeding at any part of 3rd stage, transfer to maternity team care

**Physiological
3rd stage**



Active 3rd stage

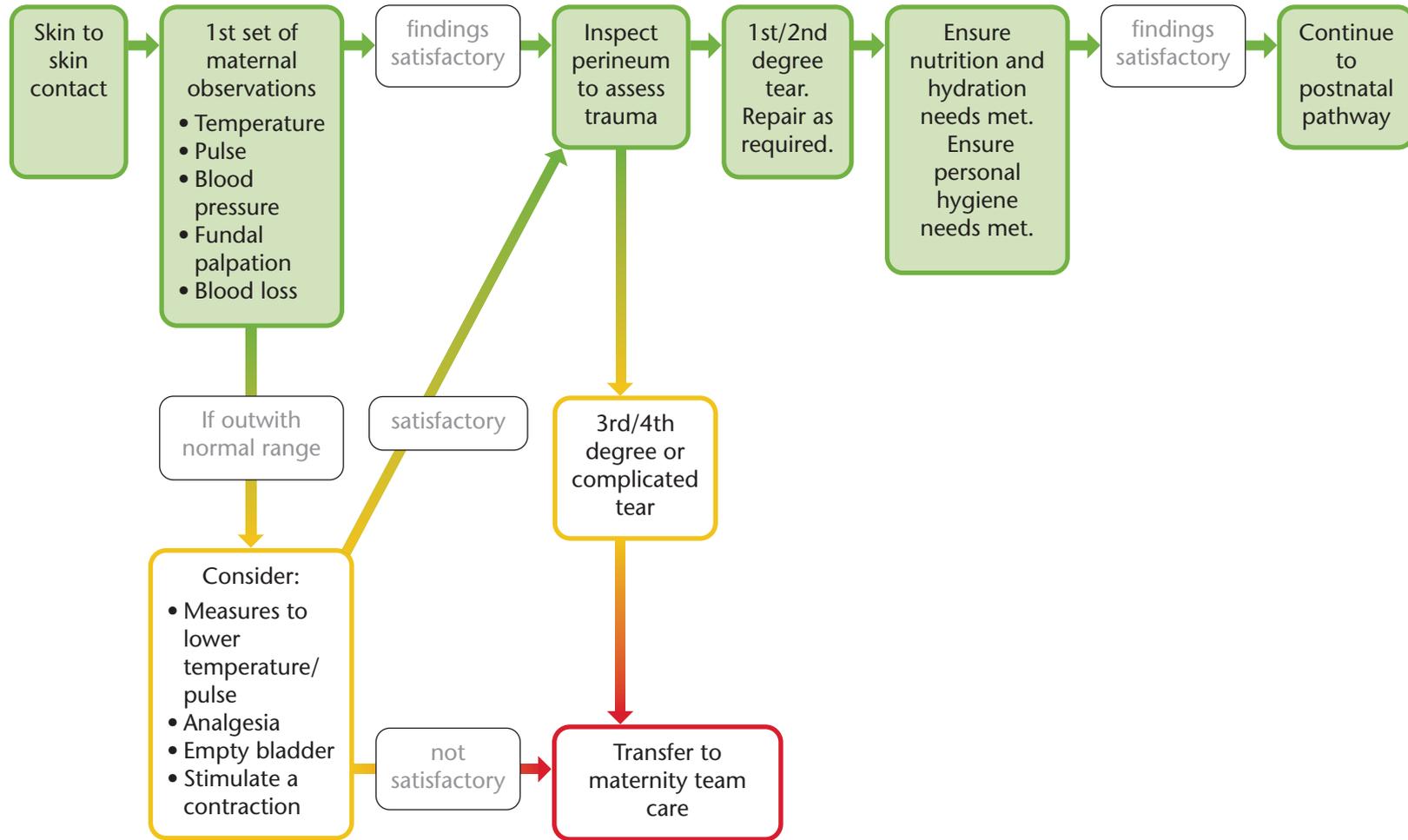


3rd stage pathways

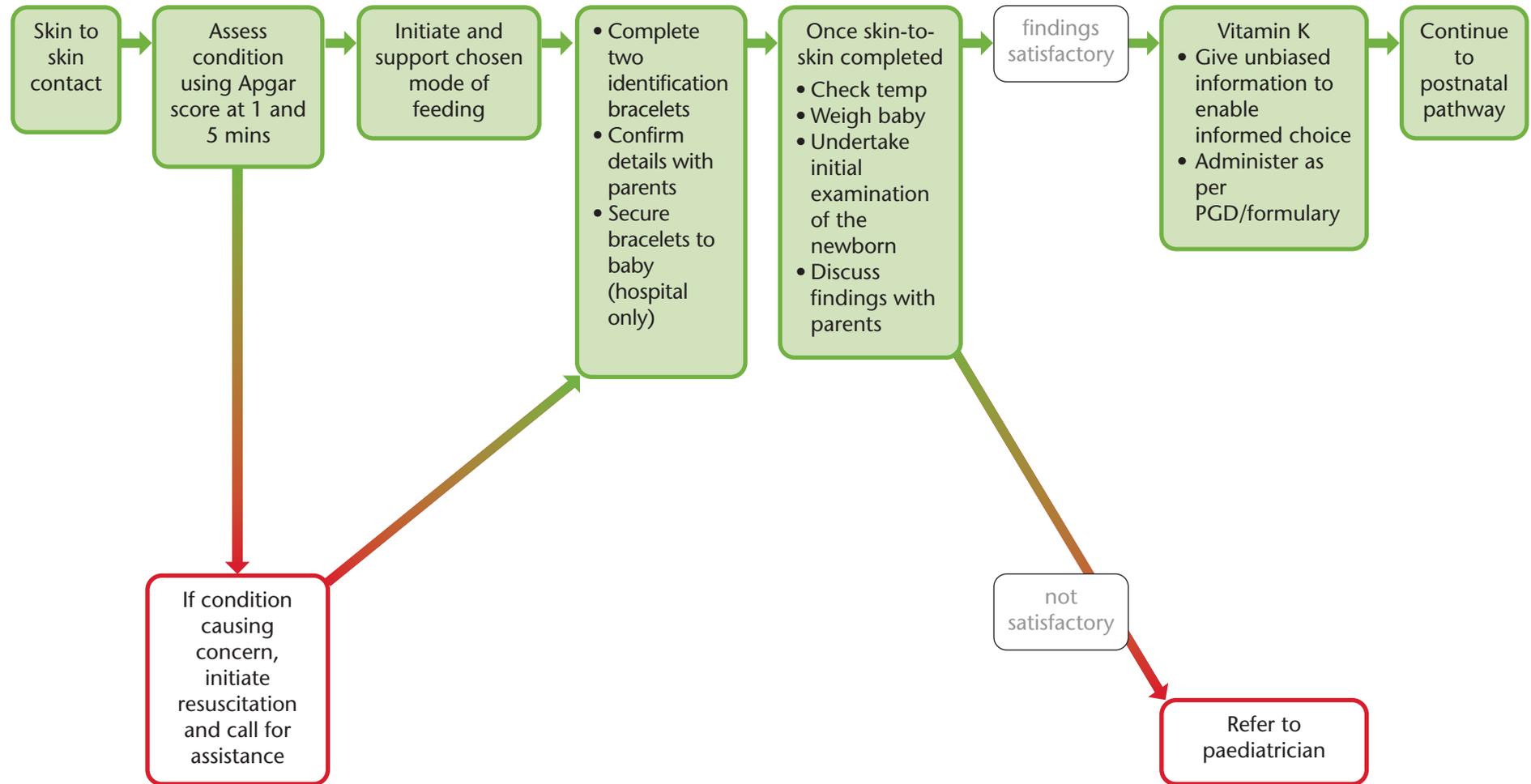
Care in the first hour

Care in the 1st hour pathway - mother

Mother



Baby



Care in the 1st hour pathway - baby

Postnatal pathway

**Principles of
postnatal care and notes**

Principles of postnatal care

Postnatal care should be planned to ensure continuity of care/carer, with a documented, individualised care plan encompassing the mother and baby. The emphasis should be on practical advice and information on pain management, signs and symptoms to look out for, infant feeding, social networks and coping strategies. The pathway advises on what should be carried out during the postnatal period, but the actual number of postnatal visits should be individualised to the mother and baby's needs.

The 2007 Confidential Enquiry into Maternal and Child Health (CEMACH) report recommends that routine observations of pulse, BP, temperature, respiratory rate and lochia are performed for all women for the first three days following birth.

Mother

Note 13

Healthy women with no significant physical, emotional, social or educational needs.

Mother

Note 14

Women with some physical, emotional, social or educational needs.

Physical eg:

- medical: any condition that requires regular observation
- mild/moderate mental ill health (see note 17)
- obstetric: fundus not involuting
- passive smoking

Emotional eg:

- baby requires paediatric care
- gender based violence

Social eg:

- asylum seeker/refugee/travelling community
- current social work involvement
- significant financial/housing issues

Educational eg:

- Learning difficulties that could impact on parenting

Mother

Note **15**

Women with complex physical, emotional, social or educational needs.

Physical eg:

- medical
- active blood borne viruses
- women requiring critical care
- significant mental health issues
- drug or alcohol misuse within last 12 months
- obstetric

Emotional eg:

- mother <18 years age
- of educational age, but not in education
- lacking social support from family/socially isolated
- leaving care services
- presented with concealed pregnancy
- age of father?

Social eg:

- Women or partner in criminal justice system
- child protection issues

Educational eg:

- Learning difficulties that significantly impact on parenting

Mother

Note 16

Mental health:

- Give information on normal patterns of emotional change
- Ensure resolution of baby blues within 10-14 days
- If not resolved after 10-14 days consider postnatal depression and refer to appropriate professional
- Refer to perinatal mental health service if significant mental health issues such as:
 - Previous history of bipolar disorder, schizophrenia or other psychotic illness
 - Previous admission to hospital for treatment of mental illness
 - Close family member with history of bipolar disorder
 - Current mental health problem e.g. depression, anxiety disorder, thoughts of self harm/suicide

Baby

Note 17 Health problems in babies

(adapted from NICE postnatal guideline)

Health problem	Action
Jaundice	Evaluate, consider serum bilirubin & consult local protocol. Advise frequent feeding (waking up the baby if necessary). Supplementary feeds are not routinely recommended for breastfed babies.
Thrush	Offer information and guidance on hygiene. Important to consider treatment of mum and baby.
Nappy rash	Consider hygiene and skin care, sensitivity, infection (for example, thrush)
No meconium in first 24 hours	Emergency action
Constipation	Examine baby and evaluate preparation of formula (urgent action)
Diarrhoea	Examine baby (urgent action) (may be confused with normal consistency of breast milk stools)
Excessive inconsolable crying/colic	Examine baby. Assess general health, take time to document a full history and reassure parents if no abnormality detected (urgent action) Consider support networks
Unwell baby	A full assessment, including physical examination, should be undertaken (emergency action)

Baby

Note 18

A healthy baby:

- has a normal colour for ethnicity
- maintains a stable body temperature
- passes urine and stools at regular intervals (see “What’s in a nappy” NCT leaflet)
- initiates feeds, sucks well on the breast (or bottle) and settles between feeds
- is not excessively irritable, tense, sleepy or floppy
 - has vital signs that fall between the following ranges:
 - Respiratory rate 30 – 60 breaths per minute
 - Heart rate 100 – 160 beats per minute
 - Temperature of around 37°C in normal room environment

Baby

Note 19

Cot Death/bed sharing advice

- Advise parents of latest guidance: ‘The safest place for your baby to sleep is in a cot in your room for the first six months’
- Never sleep on a sofa or armchair with your baby
- Use of a pacifier (dummy) should not be stopped suddenly
- Your baby is at even greater risk if you share a bed when either parent:
 - is a smoker
 - has recently drunk any alcohol
 - has taken medication or drugs that make them sleep more heavily
 - is very tired

Postnatal pathway

Postnatal pathway - day 1

Every contact

Within first 24 hours

From day 2

**Handover to public health
nurse/health visitor**

Always check Maternity Summary Record

Time Line	Mother			Baby		
	Green (see note 13)	Amber (see note 14)	Red (see note 15)	Green (see note 18)	Amber (see note 17)	Red (see note 17)
Every contact	<p>Postnatal exam as per SWHMR</p> <p>Ask about:</p> <ul style="list-style-type: none"> Physical and emotional health and well-being Coping strategies and support Experience of common health problems <p>Discuss vaginal loss, healing of perineum, headache symptoms</p> <p>Give information on:</p> <ul style="list-style-type: none"> Promoting health Recognising common health problems Managing fatigue with diet, exercise and planning activities Encouraging partner involvement <p>Update postnatal care plan</p>	<p>For women with some physical, emotional, social or educational needs, seek further advice or refer to appropriate care</p>	<p>For women with complex physical, emotional, social or educational needs, follow locally agreed referral route</p>	<p>Baby exam as per SWHMR</p> <p>Ask about:</p> <ul style="list-style-type: none"> the baby's health breastfeeding; document any support needed in postnatal care plan <p>Provide advice and support on infant feeding</p> <p>Assess emotional attachment</p> <p>Give information on:</p> <ul style="list-style-type: none"> promoting the baby's health recognising problems the baby's social capabilities local support <p>Update baby care plan</p>	<p>Encourage the woman to contact you if her baby is jaundiced, the jaundice is getting worse or her baby is passing pale stools (see note 17)</p>	<ul style="list-style-type: none"> Be alert to signs of domestic abuse or child abuse. If concerned follow local child protection policy Check Maternity Summary Record for any previous alerts
Within first 24 hours	<p>Physical:</p> <ul style="list-style-type: none"> Be aware of signs & symptoms of life threatening conditions Take & record blood pressure and document first urine void (within first 6 hours) Take & record pulse, temperature, respiratory rate Revise thrombosis risk <p>Emotional:</p> <ul style="list-style-type: none"> Give information on mental health well-being (see note 16) Discuss coping strategies/support (Complete SWHMR 'Feeling confident' sheet and 'Your questions/concerns' sheet) Encourage gentle mobilisation <p>Feeding support:</p> <ul style="list-style-type: none"> Offer ongoing feeding support & advice Observe one full feed if breastfeeding 	<p>If not voided urine within first 6h, refer to local guidance</p>	<p>Life threatening conditions:</p> <ul style="list-style-type: none"> sudden or profuse blood loss offensive/excessive vaginal loss, tender abdomen or fever severe/persistent headache diastolic BP >90mm Hg and systolic >160mmHg and accompanied by another sign/ symptom of pre-eclampsia shortness of breath or chest pain unilateral calf pain, redness or swelling 	<p>Adhere to the 10 steps to successful breastfeeding</p> <p>Confirm and document urine & meconium passed within first 24 hours</p> <p>Give information on:</p> <ul style="list-style-type: none"> bathing (cleansing agents, lotions and medicated wipes are not recommended) keeping umbilical cord clean and dry formula feeding as required <p>Give hearing screening advice and complete a hearing screen within 4-5 weeks</p>		

Postnatal pathway - day 2 onwards

