

Discharge Liaison Midwifery Service Guidance for the postnatal mothers and babies

These guidelines should provide a detailed understanding to the Discharge Liaison Midwives (DLM) of the care and service that has to be given to the mother and baby throughout the home visits. Such guidelines should offer a safety system for the DLM of when to refer and the procedure to facilitate any referrals.

These guidelines are subdivided into:

1.1 Planning the content and delivery of care

1.2 Maternal health

1.3 Infant feeding

1.4 Maintaining infant health

1.1 Planning the content and delivery of care of the DLM

During each postnatal visit, each DLM should provide care based on the principles of individualised care. In order to deliver the core care recommended, the postnatal Discharge Liaison Midwifery (DLM) services should be planned to achieve the most efficient and effective service for women and their babies within the hospital and home environment.

The DLM service should be based on the changing needs of each woman and baby.

A documented and individualised postnatal care plan should be developed with the woman 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 home visits.

This care plan should be reviewed at each postnatal DLM contact.

Women should be offered relevant and timely information to enable them to promote their own and their babies' health and well-being and to recognize and respond to problems in a timely manner.

At each postnatal contact the DLM should:

- Ask the woman about her health and well-being. 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.
- Discuss the infant's health and well-being and assess infant feeding. Provide the necessary advice and support to ensure that adequate infant feeding is maintained. 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 the care and any specific problems and follow-ups.

1.2 Maternal health

Information giving

At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions (table 1) and to contact the DLM and other health care professionals immediately or call for emergency help if any signs and symptoms occur.

Table 1 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
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	Thromboembolism
Shortness of breath or chest pain	

Women should be offered information and reassurance on:

- the physiological process of recovery after birth
- normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (information provided within 3 days)
- common health concerns as appropriate (weeks 2–8).

Life-threatening conditions: core care and raised concern

Postpartum haemorrhage

Assessment of vaginal loss and uterine involution and position should be undertaken with every woman. 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. Please refer to GP/obstetrician if need be.

Sudden or profuse blood loss, or blood loss accompanied by any of the signs and symptoms of shock, including tachycardia, hypotension, hypo perfusion and change in consciousness, should be evaluated immediately by a doctor. .

Genital tract sepsis

In the absence of any signs and symptoms of infection, routine assessment of temperature is unnecessary.

Temperature should be taken and documented if infection is suspected. If the temperature is above 38°C, refer to GP or health centre. Ideally, the DLM should contact the GP or health centre to discuss the situation.

Preeclampsia/Eclampsia

A minimum of one blood pressure measurement taken by the ward midwives/nurses, should be documented on hospital assessment of the DLM

Routine assessment of proteinuria is not recommended.

Women with severe or persistent headache should be having their blood pressure checked and if eclampsia is suspected to refer to Obstetric 2 through A & E.

If diastolic blood pressure is greater than 90 mm Hg, and there are no other signs and symptoms of eclampsia, the mother should be encouraged to visit a doctor for blood monitoring. Women's GP or/and obstetrician can be informed through a phone call.

If diastolic blood pressure is greater than 90 mm Hg and accompanied by another sign or symptom of pre-eclampsia, refer to Obstetric 2 through A & E.

Thromboembolism

Women should be encouraged to mobilise as much as possible.

Women with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis and referred to Obstetric 2 through A & E.

Women experiencing shortness of breath or chest pain should be evaluated for pulmonary thrombo-embolism and refer to Obstetric 2 through A & E.

DLMs should be aware that obese women are at higher risk of thromboembolism.

Mental health and well-being

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 the DLM about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.

Formal debriefing of the birth experience is not recommended.

All DLMs should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.

DLM should advise that symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood) should resolve by 10-14 days. If symptoms have not resolved, the woman should seek advice for referral to the Gynae Out Patient Psychiatric Clinic.

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.

1.2.3 Physical health and well-being

Perineal care

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.

The DLM should assess the perineum and ask if the woman has pain or discomfort.

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

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

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). Please contact General Practitioner (GP) and/or obstetrician according to women's choice to discuss the need for NSAID.

Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated and if detected referred to Obstetric 2 through A&E (urgent action).

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.

Headache

For severe headache see section on eclampsia.

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

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

If the women have severe headaches when standing but not once laying, please contact the anesthetist on call at Delivery Suite for advice.

Fatigue

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.

If persistent postnatal fatigue impacts on the woman's care of herself or baby, underlying physical, psychological or social causes should be evaluated either by her GP/Health Centre/Obstetrician.

Backache

Women experiencing backache in the postnatal period should be managed as in the general population.

Constipation

Women should be asked if they have opened their bowels within 3 days of the birth.

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

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

Haemorrhoids

Women with haemorrhoids should be advised to take dietary measures to avoid constipation.

Women with a severe, swollen or prolapsed haemorrhoid or any rectal bleeding should be evaluated and refer to the women's GP and/or obstetrician. Ideally, the DLM will call the women's choice of doctor to explain situation.

Faecal incontinence

Women with faecal incontinence should be assessed for severity, duration and frequency of symptoms. If symptoms are present refer to the women's GP and/or obstetrician. Ideally, the DLM will call the women's choice of doctor to explain situation.

Urinary incontinence

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

Women with involuntary leakage of urine which does not resolve or becomes worse should be evaluated by the women's choice of doctor (GP and/or obstetrician).

Contraception

Methods and timing of resumption of contraception should be discussed during the DLM home visits.

Mothers should be encouraged to discuss further the choice of contraception that they would like with their obstetrician/GP during the 6 weeks visit.

Immunisation

Women found to be sero-negative on antenatal screening for rubella should be offered an MMR (measles, mumps rubella) vaccination following birth and before discharge from hospital. Women should be advised that pregnancy should be avoided for one month after receiving MMR, but that breastfeeding may continue

1.3 Safety

Domestic abuse

DLMs should be aware of the risks, signs and symptoms of domestic abuse and obtain the woman's consent for referral unless baby is at risk.

DLM should leave the home immediately if she feels threatened or at risk. In these instances, the charge midwife must be immediately notified.

6–8-week check

DLMs should advise each woman on the importance of attending the 6 weeks check up.

1.4 Infant feeding

A supportive environment for breastfeeding

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

All DLMs (hospitals and community) should follow the written breastfeeding policy that is communicated to all staff and parents.

The DLM should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.

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

Continuing successful breastfeeding

Unrestricted breastfeeding frequency and duration should be encouraged.

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.

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.

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. These are given in box 1.

Box 1. Breastfeeding

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.

Women should be given information about the Breast Feeding Walk-in Clinic.

Assessing successful breastfeeding

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 DLM booklet.

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.

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. Midwives at the Breastfeeding Walk-in Clinic should be contacted and appointment given to mother.

Supplementation with fluids other than breast milk is not recommended.

Expression and storage of breast milk

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.

All women who use a breast pump should be offered instructions on how to use it.

Preventing, identifying and treating breastfeeding concerns

Nipple pain

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

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

Engorgement

Women should be advised that their breasts may feel tender, firm and painful when milk 'comes in' at or around 3 days after birth.

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

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

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:

- continue breastfeeding and/or hand expression to ensure effective milk removal; if necessary, this should be with gentle massaging of the breast to overcome any blockage
- take analgesia compatible with breastfeeding, for example paracetamol unless it is contraindicated
- increase fluid intake.

If signs and symptoms of mastitis continue for more than a few hours of self management, the woman should be advised to contact Breast Feeding Walk-in Clinic and/or obstetrician/GP (urgent action).

If the signs and symptoms of mastitis have not eased, the woman should be evaluated by her obstetrician/GP as she may need antibiotic therapy (urgent action).

Inverted nipples

Women with inverted nipples should receive extra support and care to ensure successful breastfeeding.

Ankyloglossia (tongue tie)

Babies who appear to have ankyloglossia should be evaluated by the paediatrician/GP (non-urgent action).

Sleepy baby

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, the DLM should speak to paediatrician and/or refer to Paediatrics Day Care and/or A&E as appropriate.

Formula feeding

All parents and parents 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.

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.

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

Breastfeeding women who want information on how to prepare formula feeds should be advised on how to do this during the DLM visits.

1.4 Maintaining Infant Health

The purpose of this section of the guidance is to provide the framework for the DLM, to facilitate the health and well-being of a baby with the parents. It lays out the care given to a healthy baby and support to be offered to the parents.

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 vital signs of a healthy baby should fall within the following ranges:

- respiratory rate normally 30–60 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°C (if measured).

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 healthcare professional or emergency service if required.

Parents, family members and carers should be offered information and reassurance on:

- their baby's social capabilities as this can promote parent–baby attachment

- the availability, access and aims of all postnatal peer and groups

Parenting and emotional attachment

Assessment for emotional attachment should be carried out at each DLM visit.

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

Women should be encouraged to develop social networks as this promotes positive mother–baby interaction.

DLMs should offer fathers, information and support when deemed required in adjusting to their new role and responsibilities within the family unit.

Physical examination and screening

The aims of any physical examination should be fully explained and the results shared with the parents and recorded in the DLM booklet.

A midwifery physical examination should also be carried out.

Parents should be advised on the immunisations for their baby and the importance of the appointment with paediatricians.

Physical health and well-being

Jaundice

Parents should be advised to contact their paediatrician or GP if their baby is jaundiced, their jaundice is worsening, or their baby is passing pale stools.

If baby is jaundiced, its intensity should be monitored with the bilirubinometer and results recorded and compared with the charts (Appendix 1) to decide referrals or/and adequate care.

If baby is jaundiced, its intensity should be monitored and recorded along with the baby's overall well-being with particular regard to hydration and alertness.

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.

Breastfed babies with jaundice should not be routinely supplemented with formula, water or dextrose water.

If a baby is significantly jaundiced or appears unwell, refer to A&E or paediatrician.

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 by paediatrician (urgent action).

Skin

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.

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

Thrush

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

Mothers with thrush and the symptoms are causing pain to the woman or the baby should be advised to be reviewed by a doctor.

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

Nappy rash

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.

If painful nappy rash persists it is usually caused by thrush, and treatment with antifungal treatment should be discussed with the paediatrician.

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

Constipation

If a baby is constipated and is formula fed the following should be evaluated:

- feed preparation technique
- quantity of fluid taken
- frequency of feeding
- composition of feed.

Diarrhoea

A baby who is experiencing increased frequency and/or looser stools than usual should be evaluated by paediatrician.

Colic

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.

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.

DLMs 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 family/peer support may be helpful.

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

Fever

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

When a baby is suspected of being unwell, the temperature should be measured using electronic devices.

A temperature of 38°C or more is abnormal and the cause should be evaluated immediately by a paediatrician.

Safety

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.

The DLM 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.

Sudden Infant Death Syndrome

Parents should be given information about sudden infant death syndrome (SIDS).

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.

Child abuse

DLMs should be alert to risk factors and signs and symptoms of child abuse.

If there is raised concern, the DLM should follow local child protection policies.