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1.4 Outcome(s)

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2.1List the questions (clinical/non-clinical)

2.2 Describe the literature search strategy

2.3 Describe the method of appraising evidence

2.4 Describe the process the PPPG Development Group used to formulate recommendations

2.5 Provide a summary of the evidence from the literature

2.6 Detail resources necessary to implement the PPPG recommendations

2.7 Outline of PPPG steps/recommendations

**3.0 GOVERNANCE AND APPROVAL**

3.1 Outline formal governance arrangements

3.2 List method for assessing the PPPG in meeting the standards outlined in the

HSE National Framework for developing PPPGs

3.3 Attach any copyright/permission sought

3.4 Insert approved PPPG Checklist

**4.0 COMMUNICATION AND DISSEMINATION**

4.1 Describe communication and dissemination plan

**5.0 IMPLEMENTATION**

5.1 Describe implementation plan listing barriers and /or facilitators

5.2 Describe any education/training required to implement the PPPG

5.3 Identify lead person(s) responsible for the Implementation of the PPPG

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**6.0 MONITORING, AUDIT AND EVALUATION**

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Monitoring

6.1.2 Audit

6.1.3 Evaluation

**7.0 REVISION/UPDATE**

7.1 Describe the procedure for the update of the PPPG

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7.3 Complete version control update on the PPPG template cover sheet

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*Date of HSE and NMBI Publications are correct as of 7 October 2022 however it is the RPHNs/RMs responsibility to ensure that they refer to the most recent editions as they are published.*

**PART A: Outline of PPPG Steps**

**Title of PPPG: Guideline on Maternal Postnatal Care in the Public Health Nursing Service**

**Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth.**

For simplicity of language, this guideline will use the term 'woman' or 'mother' throughout. Cisgender describes a person whose gender identity corresponds to their sex assigned at birth. It is recognised that there is a need for this guideline to be gender inclusive. In order to ensure the inclusion of non cis-women it is acknowledged that when using the words woman or mother in this document it includes people who have given birth who do not identify as a woman/mother. It also refers to women who have given birth but the infant may not be with them due to fostering, adoption, hospitalisation or death of the infant. This will also include the commissioning parent in the case where the infant was born through surrogacy. Similarly, where the term 'parents' is used, this should be taken to include other people who are the infant’s primary caregivers and single parents (NICE 2021).

**A1.0 Notification of birth to Director of Public Health Nursing area**

A1.1. Maternity Hospitals/Units, both within the Republic of Ireland (ROI) and Northern Ireland, notify the Local Health Office (LHO) of all infants born and who reside in the designated LHO. This may be notified to the Child Health Office/DPHN Office/Birth Notification Office and Primary Care Unit Management depending on local arrangements.

A1.1.1 The maternity service sends the birth notification or maternal discharge summary to the local Child Health Office either electronically or in paper format.

A1.1.2 For a number of LHOs, the Child Health Information Systems (CHIS) office receives and inputs the information into the Child Immunisation/Parent Held Record (PHR) software system.

A1.1.3 For other LHOs, the information is received at one or many locations; the DPHN Office, the Birth Notification Office, the Child Health Office and/or Primary Care Unit Management (PCUM) office. By agreement, the DPHN Office and Birth Notification/PCUM, input the information into the Child Immunisation/Child Health/PHR System.

A1. 1.4 The further development and national roll out of the Maternal and Newborn Clinical Management system (MN-CMS) and the standardised transition of care form will standardise the discharge information further.

A1.1.5 Maternity Hospitals/Units can use the Health Atlas address finder facility to help check the correct Local Health Office (LHO) to send the notification. <https://finder.healthatlasireland.ie>. Maternity Hospitals/Units are reminded that it is important for a timely service that both temporary and permanent addresses are flagged on the notification. Where a notification comes from a Maternity Hospital/Unit to an incorrect LHO, the DPHN/LHO must return the notification request to the Maternity Hospital/Unit. The Maternity Hospital/Unit must correct this information and send the notification to the correct LHO. The DPHN/LHO may also send the information to the correct LHO to assist with timely service provision.

A1.2. Self Employed Community Midwife (SECM) notification of birth to PHN service

The SECM will notify the DPHN for the designated LHO of the home birth and pending discharge from SECM service.

A1.3 The private midwife will notify the DPHN for the designated LHO of the home birth and pending discharge from private midwife service.

A1.4 Self-referral to PHN service

This situation may arise where a delivery took place outside of the ROI. The mother/parent (commissioning parent in cases of surrogacy) presents to the Public Health Nursing Service and notification of the infant’s birth has not been communicated from the overseas maternity service as the infant was not born in Ireland. The Public Health Nursing Service will provide a postnatal service to the mother/parent (commissioning parent in cases of surrogacy) for 12 weeks post-delivery or longer if clinically indicated.

A1.5 Where a mother is staying at a temporary address this should be made clear on the discharge summary. It is important that an Eircode is included on the discharge summary to aid the RPHN/RM to locate the house.

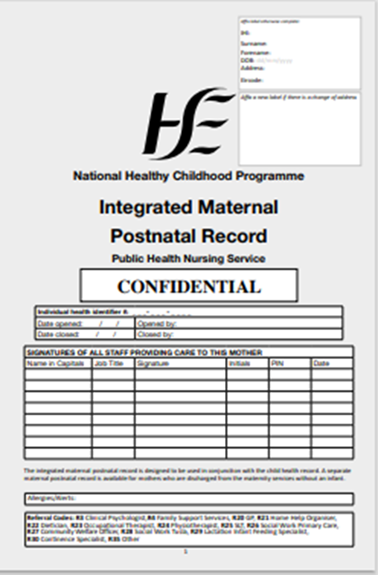
A1.6 All maternity care providers should provide two contact details for the mother including a mobile telephone number if known. Two phone numbers are necessary so that the RPHN/RM can contact the mother to arrange the visit even in the event the phone number has changed or is out of service.

A1.7 A national incident report form (NIRF) NIRF - 01 PERSON should be completed if there is missed care due to a delay or non receipt of a notification from the maternity service or the RPHN/RM is unable to locate the mother see section A2.12.

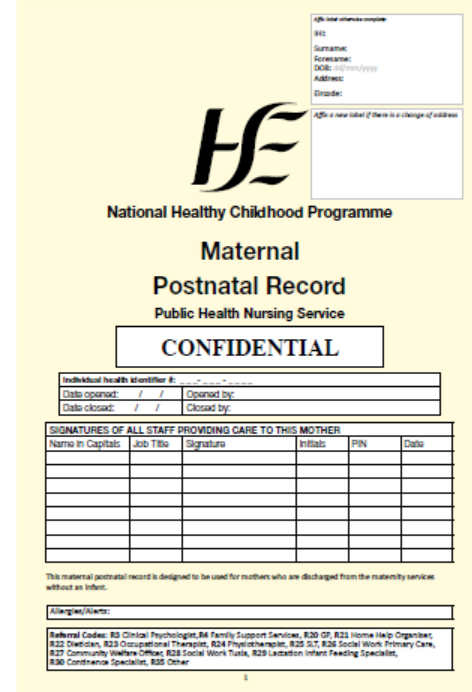
A1.8 The RPHN/RM opens a maternal postnatal record on receipt of the notification. Insert the date opened and opened by information on the front cover of the record.

A1.9 There are two types of maternal postnatal record.

* The integrated maternal postnatal record is integrated into the child health record and avoids duplication of birth details.



* The stand alone maternal postnatal record is available for mothers who are discharged from the maternity service without an infant (e.g. fostering, adoption or death of the infant)



A1.10 The RPHN/RM must confirm receipt of the discharge notification in line with local practices – email or phone. The RPHN/RM should document in the record the date and time of the receipt of the notification.

A1.10.1 In the integrated maternal postnatal record this information is recorded on the primary visit page of the child health record.

A1.10.2 In the stand alone maternal postnatal record this information is recorded on the maternal primary assessment page of the maternal postnatal record.

**A2.0 Maternal Primary Assessment Arrangements**

A2.1 Once discharge notification is received by the RPHN/RM from the DPHN office/child health office, the RPHN/RM will review the discharge notification and make contact with the mother to arrange a convenient time to carry out the maternal primary assessment. The visit should take place at the earliest possible opportunity and bearing in mind the national KPI is a visit within 72 hours of discharge from the maternity service.

A2.2 For some DPHN areas, where there is a weekend/bank holiday period service for discharge notifications, the weekend RPHN/RM should be informed by 12 midday on Friday that the maternal primary assessment is due over the weekend.

A2.3 The RPHN/RM must document in the progress notes of the maternal postnatal record if and when contact was made and the arrangements for the maternal primary assessment.

A2.4 Except in exceptional circumstances e.g. where there is a staff safety issue, the primary postnatal assessment must be carried out in the mother’s home environment. The RPHN/RM will confirm the address and contact numbers with mother and obtain directions/eircode to the home if necessary.

A2.4.1 In exceptional circumstance if the mother must attend a primary care facility for the primary postnatal assessment, it is recommended that they are accompanied at the clinic visit, ideally by their partner, to allow dissemination of advice and information to both parties. The clinical environment should be conducive to carrying out the mother and infant assessments. Parents are also advised of the need to bring the infant in a buggy/car seat to the primary care facility for safety reasons.

A2.5 If the infant is in Special Care infant unit or transferred to a children’s hospital, the RPHN/RM must speak directly with the mother to arrange the most convenient time with her for the primary postnatal assessment and if possible to take place within 72 hours of mother’s discharge from maternity service.

A2.5.1 In the event the infant is transferred to a tertiary centre, a postnatal assessment may be offered at a nearby health centre if the mother is staying with the infant in hospital accommodation.

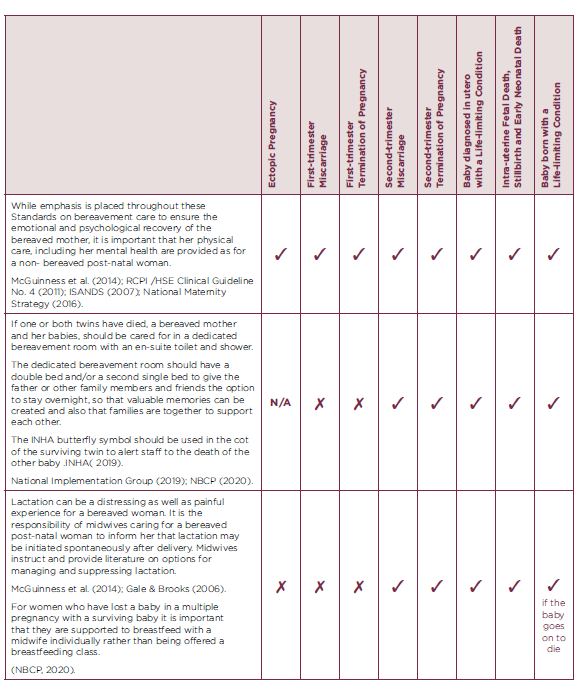
A2.6 If the mother declines a postnatal visit, for example when the infant has remained in hospital, the RPHN/RM should document this in the progress notes (see section 3.0).

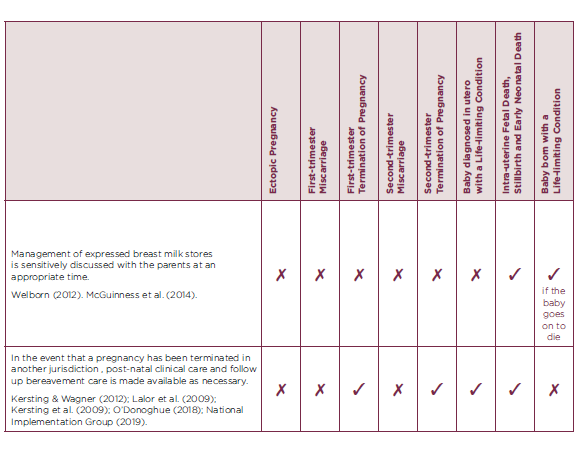
A2.7 Women require postnatal care and advice on self-care when their infant has died i.e. pregnancy loss/perinatal death. In the event of a pregnancy loss or perinatal death, the RPHN/RM can refer to the postnatal care section of the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death

<https://www.hse.ie/eng/services/list/3/maternity/bereavement-care/bereavement-care-following-pregnancy-loss-and-perinatal-death1.pdf> (see table 1).

Support may also be available through the bereavement midwife in the maternity unit. A directory of support services for bereaved parents and healthcare professionals is also available at <https://pregnancyandinfantloss.ie/>

**Table 1 Postnatal care following pregnancy loss and perinatal death**





A2.8 If the mother is temporarily resident at another address the discharge notification should be sent to the area where the mother will be temporarily resident in order for the local RPHN/RM to complete the maternal primary assessment. On the mothers return to her home address that RPHN/RM must transfer the maternal postnatal record to the relevant RPHN/RM.

A2.9 If the mother is permanently at another address the Liaison Office should be notified by the maternity service or RPHN/RM who is aware of the new address, as soon as possible to ensure the discharge notification is sent to the new area.

**A2.10 In the event of a maternal death within the first year of childbirth the RPHN/RM should notify the DPHN. The DPHN should notify the Maternal Death Enquiry Ireland Office** [**https://www.ucc.ie/en/mde/notificationofamaternaldeath/**](https://www.ucc.ie/en/mde/notificationofamaternaldeath/)

Depending on the circumstances a NIRF may be necessary and should be discussed with the DPHN.

A2.11 The RPHN/RM should assess the need for and arrange an interpreter if necessary.

A2.12 Managing Inaccessible Visits

On failing to gain access to the mother’s home,

* The RPHN/RM must phone the maternity hospital/unit to confirm the discharge details, discharge address and next of kin details. Consideration should be given to contacting the hospital social worker or drugs liaison midwife if appropriate.
* The RPHN/RM can telephone the next of kin to request the mother makes contact with the RPHN/RM as soon as possible.
* If the above is not productive, the RPHN/RM/RN should phone the GP. Under article 9 (2) h of GDPR concerning the provision of health and social care services, data concerning health may be requested from the Data Controller (GP). The Data Controller determines if and what information is given.
* All of the above steps should be documented, dated, timed and signed appropriately using the maternal postnatal record.
* The RPHN/RM will inform the ADPHN of the above and discuss actions. An incident form should be completed if discharging address/contact numbers are incomplete or inaccurate
* Following confirmation that it is the correct address the RPHN/RM should leave a PHN visiting card requesting the mother to contact the RPHN/RM at the health centre within 48 hours. This timeline is in line with providing the visit within 72 hours of discharge as per the birth notification visit KPI. Template available at [www.hse.ie/phn](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\phn)
* In the event the address cannot be confirmed (e.g. a rural address without an eircode) then the RPHN/RM is not in a position to leave a PHN visiting card, contact should be made with the Maternity Hospital/Unit /Midwife/GP for further details and documents same in the maternal postnatal record. The RPHN/RM should request advice from the ADPHN if necessary and consider contacting TUSLA duty social worker to discuss case if applicable.

A2.13 Schedule of visits.

A2.13.1 The primary postnatal assessment should take place at the earliest possible opportunity following discharge from the hospital or midwifery service, bearing in mind the national KPI is a visit within 72 hours of discharge.

A.2.13.2 All women who have given birth should be offered a full postnatal assessment. In the event the infant is with parents neither of whom gave birth to the infant e.g. the infant was delivered by a surrogate mother, the RPHN/RM should use clinical judgement to ascertain which sections of the maternal postnatal assessment, care and record are appropriate in the situation. For example, the sections on health promotion and emotional attachment are relevant in this situation. The integrated record in the child health record should be used in this instance.

A.2.13.2.1 In the situation where the woman has been a surrogate and the infant is in the care of the commissioning parents – the standalone maternal record should be used in this instance. The RPHN/RM should use clinical judgement to ascertain which sections of the maternal postnatal assessment, care and record are appropriate in the situation

A2.13.3 In the event that the mother has been discharged by a community midwife, domino scheme midwifery service, HSE homebirth service self-employed community midwife (SECM), private midwife, the RPHN/RM must offer a full postnatal assessment.

A2.13.4 Support and/or follow up visits may be indicated following the assessment and care planning by the RPHN/RM. This will be determined by the RPHNs/RMs clinical judgement and documented in the progress notes.

A2.13.5 At 6 weeks postpartum the mother should attend her GP/Maternity Service for a postnatal check. RPHNs/RMs should encourage mothers to attend this appointment.

A2.13.6 At 12 weeks postpartum, usually coinciding with the 3-month developmental assessment of the infant, the 3 month assessment of the mother should take place.

A2.13.7 All subsequent visits are specified by the RPHN/RM following the assessment and care planning by the RPHN/RM. This will be determined by the RPHNs/RMs clinical judgement.

A2.14 Lone Working

A lone worker risk assessment is completed in accordance with the national HSE Policy on Lone Working (2017a) and with any relevant local PHN department policy for new patient’s unknown to the PHN service based on the information supplied and on individual assessment. Completion of the lone worker risk assessment may be required for patients previously known to the services where risk factors may have changed. Any concern a RPHN/RM has in relation to lone working must be discussed with his/her ADPHN. See the Procedure for the management of Referrals Accepted to the Public Health Nursing Service (2020) for supplementary guidance) [www.hse.ie/phn](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\phn).

**A3.0 Consent Requirements**

A3.1 For the purposes of the national standardised maternal postnatal record, consent is required for the assessment to take place.

* The RPHN/RM should clearly explain to the mother what the postnatal assessment entails and seek verbal consent from the mother for the assessment to take place.
* The obtaining of verbal consent from mother is recorded in the national standardised maternal postnatal record at the start of each assessment.
* Please refer to page 61 of this guideline if the mother is less than 16 years of age (HSE National Consent Policy 2022a).

A3.2 Refusal of consent; In such cases it is important that the RPHN/RM discusses this with the woman in order to understand the rationale and motivation behind her decision to refuse. The RPHN/RM accurately documents the discussion with the mother, including the procedure that has been offered, the evidence base, benefits and risks, possible consequences of declining the service, the mother’s decision to decline and the fact that the implications of this decision have been fully outlined. In addition, if any supporting literature is provided to the woman during the consultation, this should be referenced including the version/edition of the literature.

A3.2.1 In the event that there is refusal of consent the maternity unit should be informed. Seek consent from the woman for their GP to be notified also.

**A4.0 Documentation and the management of the maternal postnatal record**

A4.1 All recording should be:

* legible
* written in black ink
* signed with the RPHN/RM name printed clearly alongside the signature and NMBI number.
* dated and the time written in the 24-hour clock
* documented as soon as possible after providing the nursing/midwifery care
* using HSE approved abbreviations only (HSE 2011, NMBI 2015b)

A4.2 The HSE as a Data Controller must adhere to the principles of data protection which are set out in the General Data Protection Regulation (GDPR) and the Data Protection Acts 1988-2018. Details are provided at [www.hse.ie/gdpr](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\gdpr). Details are provided for all PHN service users in the national PHN service leaflet [www.hse.ie/phn](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\phn).

A4.3 The maternal discharge summary (where available) should be date stamped (by hand or electronically) and attached to the maternal postnatal record. The birth should be recorded in the PHN area birth register.

A4.4 Each side of each page in the maternal postnatal record where mother’s information is documented should have a service user identification label. In the absence of such labels, the mother’s name, unique identifier (if applicable) and date of birth should be written on each page of the record (HSE 2011).

A4.5 The national standardised child health record contains a maternal postnatal record in the maternal record tab of the child health record. The maternal postnatal record must not become a permanent element of the child health record (NHCP 2020a). The maternal postnatal record should be removed and archived separately (as per local procedures) when the child is discharged from the Public Health Nursing Service. Management and transfer arrangements of the maternal postnatal record are detailed in the flow chart A4.9. Refer to the Safe Transfer of Child Health Records procedure for further guidance (HSE 2021b).

A4.6 In the event the mother moves area and the open maternal postnatal record is to be transferred to another RPHN area, it is the responsibility of the origin RPHN to arrange the transfer to the new area in line with local policy and Data Protection legislation. See management and transfer arrangements of the maternal postnatal record flow chart in A4.10.

A4.6 Where a problem/concern is identified during the postnatal assessment, the RPHN/RM identifies a plan of care to ensure care is directed to address the problem/area of concern. Interventions should be documented in the care plan and escalation of care should occur as appropriate. A care plan must be commenced in consultation with the mother. There are a number of maternal standardised care plans developed, these are available at <https://www.hse.ie/nhcp>. The password is available from the DPHN. It is important to note that all careplans should be individualised to the mother as recommended by NMBI (2015b).

A reassessment date should be documented on the care plan. If there has been a significant change in the mother’s needs/condition, an evaluation of the care plan is necessary prior to the reassessment date. Evaluation should include follow up actions/interventions from the care plan. The RPHN/RM must date, time and sign each evaluation. Evaluation/progress sheets must be updated contemporaneously and must provide evidence that the care plan is being implemented. The final evaluation will involve the RPHN/RM using clinical judgement to decide whether the goal/s has been achieved by the mother and closing off the careplan when the goals are achieved.

A4.7 All healthcare professionals must ensure appropriate referrals are made if there are concerns about the mother's health and wellbeing. Consent for any referrals should be sought and documented in the maternal postnatal record. Copies of any referrals made should be securely attached to the maternal postnatal record and filed in the Maternal Record tab of the child health record. See section A3.2 for details regarding refusal of consent. Referral codes are on the front cover of the maternal postnatal record.

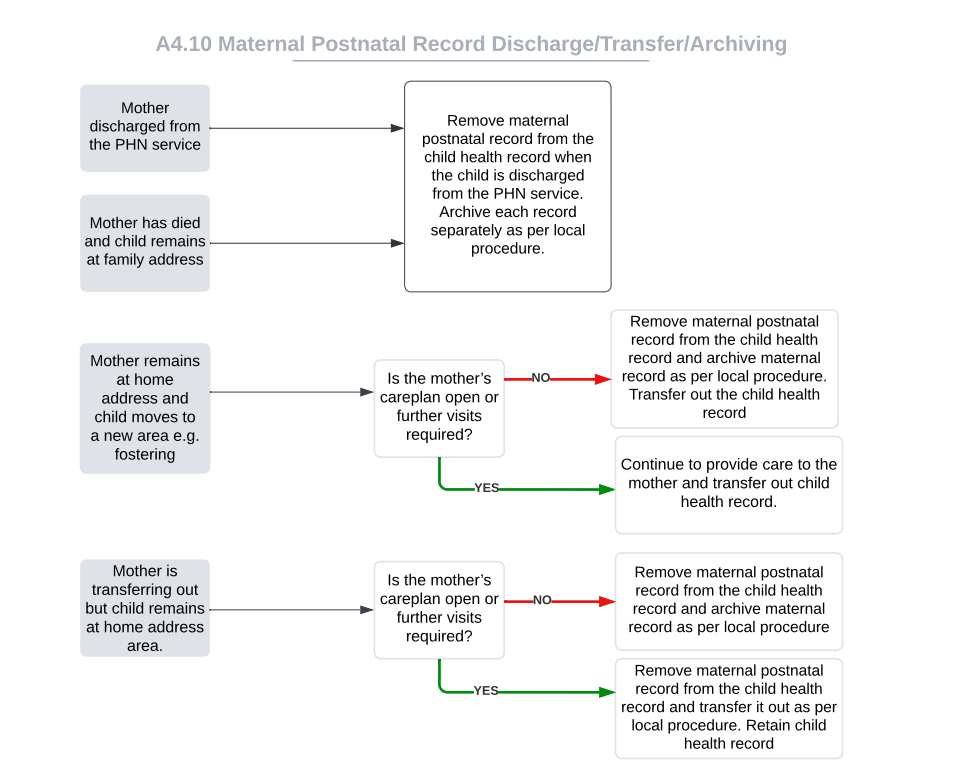
A4.8 A GP/maternity unit referral letter template is available in Appendix V. The ISBAR (3) tool may be a beneficial guide if communicating by phone <https://www.hse.ie/eng/about/our-health-service/healthcare-communication/nhcp-isbar.pdf>

A4.9 Primary Care Metrics

A4.9.1 The mother should be admitted on the RPHNs primary care metrics in accordance with the Primary Care Metrics (PCM) workbook and the Management of Referrals Accepted to the Public Health Nursing Service Procedure (HSE 2020b). The care group the mother is admitted under depends on the age of the mother on the date of admission to the caseload. Ensure that each mother accepted onto the caseload is only counted once.

A4.9.2When discharging from the PCM include women;

* Whose episodes of care are concluded / their care plans are closed with no outstanding review dates
* Who are deceased
* Who have transferred to another area



**A5.0 Maternal Primary Assessment**

**A5.1 General Considerations**

A5.1.1 Upon arrival at the home, the RPHN/RM will introduce himself/herself and explain the role of the PHN service and what the primary postnatal assessment entails to the mother. A full postnatal assessment must be offered to all mothers. Contact details for the PHN service should be given to the mother using the national PHN leaflet available at <https://www.hse.ie/eng/services/list/2/primarycare/national-phn-service/national-phn-leaflet.pdf.>

The leaflet is available in 12 languages.

A5.1.2 Consent must be sought and documented as per section A3.0.

A5.1.3 The mother should, ideally, be examined in a room alone to maintain dignity, respect and privacy and where she feels comfortable to discuss any concerns that she may have. This may provide the opportunity to carry out domestic abuse screening question (A10.1). If a problem or concern is identified, then a personalised care plan is completed and the mother is referred to GP/Maternity unit or other health professional if required.

A5.1.4 The RPHN/RM must follow current HSE guidelines regarding infection prevention and control including hand washing and/or use of alcohol hand gel, Personal Protective Equipment (PPE) and cleaning of equipment. The RPHN/RM should be familiar with the latest guidance regarding the Covid-19 pandemic [www.hpsc.ie](http://www.hpsc.ie).

A5.1.5 The RPHN/RM should follow HSE and NMBI guidelines regarding communication with mothers and their families <https://www.hse.ie/eng/about/who/communications/communicatingclearly/>

A5.1.6 The RPHN/RM should be aware of providing care to all service users including those from diverse ethnic, cultural and religious backgrounds. Further information is available on the Intercultural Awareness E learning programme and the Ethnic Equality Monitoring E learning programme on HSEland. My Health, My Language is a suite of multilingual videos on the Irish health service [https://www.hse.ie/eng/services/mhml/](https://www.hse.ie/eng/services/mhml/%20) The videos aim to make health advice more accessible to Ireland’s migrant community. There are 11 health topics in 17 languages. Topics include:

* What is a GP?

► How do I access Healthcare?

► Medical Card access and how it is used for Primary and GP care

► Dental, eye, hearing

► Contraception

► COVID-19 and pregnancy

► Early Pregnancy

► Late Pregnancy – prepare for birth

► Looking after a new born baby

► Mother’s health after giving birth

► Breastfeeding

A5. 2 Integrated Maternal Postnatal Record

A5.2.1 Front Cover

* Affix a service user identification label. In the absence of such labels, the mother’s name, unique identifier (if applicable), date of birth and address should be written on the cover.
* There is a label space for recording detail of change of address.
* All Staff providing care to the mother must record their name, job title, signature, initials, PIN and the date on the front cover of the record.
* Known allergies should be recorded on the cover.

A5.3 Maternal Primary Assessment

A5.3.1 The RPHN/RM must complete the demographic details, intra and postpartum details, medical/surgical (including underlying serious conditions), obstetric, social, and mental health history in conjunction with the mother ensuring that all details are correct. This section includes questions regarding the mother’s use of alcohol and drugs (Section 9.0) and also regarding domestic, sexual & gender based violence (Section 10.1).

A5.3.2 Social Support has not only been identified as one of the key components in assisting postnatal women in the “Transition to motherhood” but may also prevent postnatal depression, with this in mind the RPHN/RM should discuss and identify the mother’s source of support – this may include partner/maternal grandmother etc.

A5.3.3 Record any medications that the mother is currently taking. . If the RPHN/RM is required to administer medications to the mother, the Medication Request and Administration Record (MRAR) should be completed by the prescriber (GP/ Hospital doctor or Nurse/Midwife Prescriber) prior to the RPHN/RM administering any medication. See the Procedure for the Completion of the Medicines Request and Administration Record for Public Health Nursing Services (HSE 2020c) [www.hse.ie/phn](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\phn) for the most up to date version of the MRAR.

A5.3.4 Discuss the birth history and her experiences with the mother. Discuss the postnatal period and what to expect. Check that the woman understands the information she has been given, and how it relates to her. Provide regular opportunities for her to ask questions, and set aside enough time to listen to and discuss any concerns. If necessary refer the mother to her GP or the perinatal mental health team/birth trauma midwife in the maternity unit as per local procedure.

A5.3.5 If the assessment indicates that a Child and Family Health Needs assessment (CFHNA) is required, this is filed in the CFHNA tab of the child health record. Refer to the CFHNA guideline (HSE 2021b) and CFHNA education on HSEland classroom management system.

A5.3.6 Document if the infection status of the mother was discussed. If yes, specify the infection and the status of diagnosis categorised as provisional, working, confirmed, refuted i.e. hepatitis B provisional.

A5.4 **Physical Assessment**

A5.4.1 General

Mothers should be asked about their general wellbeing. Offer advice on rest, exercise, sleep, nutrition and hydration and planning activities, including spending time with her infant. A reasonable approach is to explain to the mother that she can resume pre-birth activities such as driving, exercise, and sexual intercourse when she is comfortable and ready, and she should limit or avoid activities that cause pain or excessive fatigue. Information for mothers in provided on the HSE website and in the My Pregnancy book.

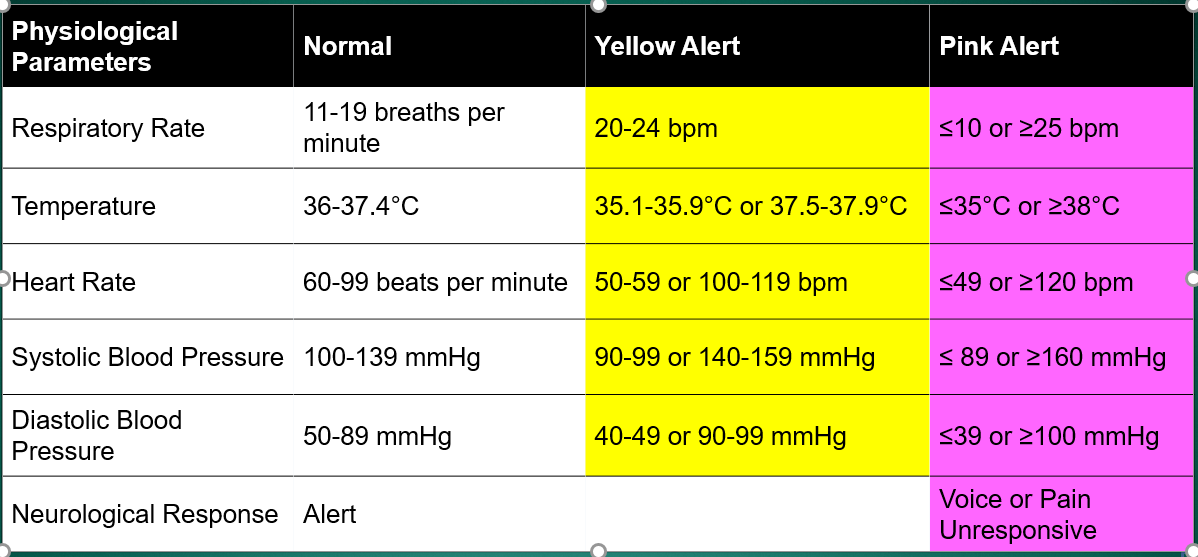
A5.4.2 If persistent fatigue effects the mothers care of herself or her infant, underlying physical, psychological or social causes should be evaluated and a referral to her GP should be made if necessary.

A5. 4.3 Mothers who have been prescribed iron medication should be advised to continue taking it as per prescription/maternity unit instruction.

**A5.5 Vital Signs**

**In order to recognise and respond to postnatal sepsis, all mothers must have a complete set of vital signs taken and recorded at the first visit and, if clinically indicated, at subsequent visits. This includes respiratory rate, temperature, pulse, blood pressure and neurological status.**

Parameters taken from National Clinical Guideline 26: Sepsis Management for Adults (including maternity) DOH 2021



A5.5.1 Neurological

Assessment of neurological response (ACVPU)

Alert is the only acceptable response, in all other responses sepsis should be suspected. The RPHN/RM should call an ambulance and arrange immediate transfer to hospital.

Any fall in the level of consciousness (ACVPU scale) should always be considered significant and acted on immediately. A neurological response is a measure of consciousness and the best response of the following should be measured and documented.

A – Alert and orientated to person, place, time and event.

C – person is awake but acute confusion noted

V – Responds to voice/verbal stimuli.

P – Responds to painful stimuli with a purposeful or non-purposeful movement.

U – Unresponsive - The woman does not respond to any stimuli.

Record in the maternal postnatal record

A5.5.2 Temperature (Adapted from NICE Postnatal Care Clinical Pathway2020 and DOH 2021)

• The accepted normal temperature parameters are 36.0-37.4° C.

• Consider infection if temperature ≥ 37.5◦C and refer to GP

* If temperature ≥ 38◦C Consider sepsis and review in conjunction with other vital signs and clinical presentation. Refer to hospital if sepsis is suspected.
* Hypothermia (≤ 35.9◦C) is a significant finding that may indicate infection/sepsis and should not be ignored.
* RPHN/RM should be aware that the use of paracetamol may mask a pyrexia and consider sepsis if the mother is unwell and apyrexial.
* Thermometers may be tympanic probe type or infra –red non-contact devices. Clinical thermometry is governed by International Standard BS EN ISO 80601‐2‐56:2017, which stipulates the need for regular calibration and maintenance as per manufacturer’s instructions (Royal Marsden 2021).
* Template referral letter to GP/maternity unit available in Appendix V if required.
* Record findings in the maternal postnatal record

A5.5.3 Blood pressure (Adapted from NICE Postnatal Care Clinical Pathway 2020 and DOH 2021).

* Postnatal mothers, who had high blood pressure during pregnancy and/or are on treatment, should follow the advice and continue under the care of the hospital/GP. The RPHN/RM should refer the mother back to the hospital/GP if there are any concerns and commence a care plan. **Routine measurements of BP for the purposes of monitoring pregnancy induced hypertension are not undertaken by PHNs**.
* The acceptable parameters for systolic blood pressure are 100-139mmHg.
* If systolic blood pressure is above 140mmHg consider referral to GP.
* If systolic blood pressure is between 91mmHg and 99mmHg, consider this in conjunction with the other vital signs and baseline through pregnancy if known. See sepsis predisposition and recognition tool in Appendix VII.
* If systolic blood pressure is ≤ 90mmHg consider sepsis, refer to GP/Maternity Hospital. Hypotension is a late sign of deterioration as it signifies decompensation. The physiological changes caused by pregnancy and childbirth can mean that early signs of impending collapse are not easily recognised.
* The acceptable parameters for diastolic blood pressure are 50-89mmHg.
* If diastolic blood pressure is greater than 90 mm Hg, and there are no other signs and symptoms of postpartum pre-eclampsia (See Section A6.5), the RPHN/RM must refer the mother to her GP.
* If diastolic blood pressure is greater than 90 mm Hg and accompanied by another sign or symptom of postpartum pre-eclampsia, (See Section A6.5), refer to hospital immediately.
* Due to concerns regarding the safety of NSAIDs in women with hypertension these should be discussed by the woman with her GP and/or pharmacist.
* Blood pressure should be measured with an upper-arm cuff device with at least one STRIDE BP approved validation study, which was published within the last 10 years and used a recent protocol (AAMI/ESH/ISO 2018; ANSI/AAMI/ISO 2013 or 2009; ESH-IP 2010). If the mid-arm circumference is greater than 33cm, a large cuff should be used. Recommendations regarding approved devices are available for DPHNs.
* Template referral letter to GP/maternity unit available in Appendix V if required.

• Record findings in the maternal postnatal record

A5.5.4 Respiration (DOH 2021)

• Raised respiration rate is a key indicator of infection/sepsis. Count respirations for a full 60 seconds.

• The accepted normal parameters for respiration rate are 11-19 respirations/min.

• Respiration Rate ≥ 20 rpm with any of the following: Heart rate ≥ 100bpm, Temperature ≤ 36◦C or ≥ 38◦C, acutely altered mental status – consider sepsis and refer to Acute Hospital urgently.

* Respiration Rate ≥ 30 rpm – consider infection/sepsis, this is a serious sign and may indicate organ failure and the RPHN/RM should call an ambulance.
* If the mother appears short of breath, consider a pulmonary embolism.

• Record findings in the maternal postnatal record.

A5.5.5 Pulse (IMEWS V2 DOH 2019)

• The accepted normal heart rate parameters are 60-99bpm.

• Count pulse for 60 seconds.

• Pulse Rate ≥ 130 bpm consider sepsis, this is a serious sign and may indicate organ failure and the RPHN/RM should call an ambulance.

* Pulse rate ≥ 100bpm consider postpartum haemorrhage.

• Pulse rate ≥ 100bpm with any of the following: Respiration Rate ≥ 20 rpm, Temperature ≤ 36◦C or ≥ 38◦C, acutely altered mental status – The RPHN/RM should call an ambulance and arrange immediate transfer to hospital.

• Record readings in the maternal postnatal record.

A5.5.6 See sepsis recognition tool in Appendix VII for information regarding Maternal Sepsis Predisposition and Recognition in the Community and vital sign parameters (National Clinical Guideline No. 26 Sepsis Management for Adults (including maternity DOH 2021). This will guide a RPHN/RMs clinical decision making. If the woman has confirmed or suspected sepsis, the infant should be assessed for symptoms or signs of infection, RPHN/RM should inform parent or guardian of this and advise them to seek GP advice (NICE 2021). A table of differential diagnosis is available in Appendix VII. The updated Sepsis eLearning program is available through HSELand.

A5.5.7 Refer to Section A6.0 for signs and symptoms of potential life threatening conditions.

A5.5.8 If the RPHN/RM observes any deviations from the normal, a referral should be made to the GP/ hospital and a care plan must be completed. If necessary, the RPHN/RM should call an ambulance if the mother is clinically unwell and requires urgent attention.

A5.5.9 Mothers are given the “Sepsis – what you need to know” leaflet by the maternity unit. It is also available at <https://www.hse.ie/eng/about/who/cspd/ncps/sepsis/resources/maternity-patient-sepsis-information-booklet.pdf> QR code is available on the PHN service Postnatal Information Sheet

**A5.6.0 Breasts**

A5.6.1 The RPHN/RM should advise and educate the mother on the normal physiological changes to the breast following delivery. All mothers must be asked if they experience any pain and discomfort in their breasts. If necessary, with mother’s consent the RPHN/RM should observe and/or examine both breasts. Encourage mothers to check breasts daily and to seek medical advice if any concerns or feeling unwell.

A5.6.2 RPHNs/RMs should refer to National Infant Feeding Policy for Primary Care Teams and Community Health Organisations (HSE 2019c) for guidance regarding evidenced based best practice in relation to infant feeding. RPHNs/RMs should refer to the HSE policy on the Marketing of Breast Milk Substitutes in the Public Health Services & Working within the Code: a Guide for Staff (HSE 2021c) for guidance as appropriate.

A5.6.3 For mothers who are continuing to breastfeed exclusively or partially;

Determine from the mother how breastfeeding is going for her and what her breastfeeding goals are. Advice and counselling should be tailored to individual needs in line with infant feeding policy recommendations.

A5.6.3.1

* Advise and support the mother with breastfeeding and discuss any issues/concerns.
* Mothers should be counselled and provided support for exclusive breastfeeding at each postnatal contact. Use ‘Breastfeeding a good start in life booklet’ as resource to reinforce information provided <https://www.healthpromotion.ie/hp-files/docs/HNP00376.pdf> or use information provided on the Mychild.ie website.

Breastfeeding progress should be assessed at each postnatal contact. Follow the BOAT guideline recommendations for breastfeeding observation and assessment [https://www.hse.ie/file-library/guideline-on-the-observation-of-a-breastfeed-and-use-of-the-breastfeeding-observation-assessment-tool-boat-resource.pdf](https://www.hse.ie/file-library/guideline-on-the-observation-of-a-breastfeed-and-use-of-the-breastfeeding-observation-assessment-tool-boat-resource.pdf%20) If necessary, consider referral to PHN lactation consultant if available or to the maternity unit breastfeeding support team using the referral template in the BOAT guideline.

* Information regarding breastfeeding twins or triplets is available at <https://www2.hse.ie/wellbeing/child-health/breastfeeding-twins-or-triplets.html>
* Culturally sensitive breastfeeding resources are available for Traveller families at <https://www.paveepoint.ie/pavee-mothers-breastfeeding-overcoming-barriers-in-national-breastfeeding-week>
* Counsel mothers separated from their infant/babies on maximising breast milk production and care of their breast – [Breastfeeding and expressing for your premature or sick infant](https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/child-health-and-wellbeing/breastfeeding-healthy-childhood-programme/breastfeeding-factsheets/breastfeeding-expressing-premature.pdf)
* Inform the mother of resources regarding support groups and the expert helpline available to breastfeeding mothers through [www.Mychild.ie](http://www.Mychild.ie). The QR link to the online breastfeeding support resources is available in the PHN service Postnatal Information sheet (Appendix VI).

A5.6.3.2 Breast engorgement results in breast fullness and firmness, which is accompanied by pain and tenderness. The affected area varies from primarily areolar involvement in some mothers, more peripheral involvement in others, and, in some mothers, both peripheral and areolar involvement.

• Primary engorgement is due to interstitial oedema and onset of copious milk production. It typically occurs between 24 and 72 hours postpartum and peaks around three to five days postpartum.

• Secondary engorgement can occur later due to delayed initiation of breastfeeding, infrequent feeds, poor attachment, ineffective milk transfer or when the mother's milk supply exceeds the amount of milk removed by her infant.

• Breast engorgement is uncomfortable however, any fever should prompt an investigation to rule out an infectious source.

The normal, full breast can be differentiated from problematic engorgement.

The normally full breast will be larger, warmer and uncomfortable but milk flow will be normal.

The engorged breast will look tight and shiny and feel painful. Milk flow may be compromised. If fever is present or if the mother feels systemically unwell, this can be an indication that the engorgement has progressed to a mastitis infection.

* If milk is removed early, often, and effectively by the infant or by milk expression, normal fullness is less likely to become painful engorgement. With unrestricted access to breasts, a new-born may feed often for short periods, such as a few minutes every hour, or for longer stretches. If the infant sleeps for long stretches, encourage parents to keep infant on their body or nearby, and guide infant to the nipple whenever feeding behaviours are shown. This helps to relieve the fullness. The amount of milk a mother produces on day 4 is predictive of her milk supply at 6 weeks. Frequent milk removal and hand expressing colostrum 8-12 times in 24 hours is important. Supportive care for effective milk removal includes: A warm shower/applying warmth as moist heat for a minute or two stimulates milk flow. Breast massage with one or two hands prepares the breast for better milk flow. If the areola is swollen, hand expressing some breastmilk or reverse pressure softening of the areola helps improved attachment and positioning which in turn helps to relieve engorgement and to prevent sore nipples. Continued breast compression while infant is feeding helps to relieve engorgement more effectively. Cool compresses after or between feedings can help lessen inflammation. Mild analgesics may be appropriate and can be discussed by the mother with her pharmacist. Cold may be considered culturally inappropriate in some cultures during the early weeks after birth.  Engorgement typically resolves over a few days but can be more persistent especially if the mother has had IV fluids during labour.
* If engorgement is present, assess mother’s hand expressing skills in relieving engorgement. Offer further support in mastering the hand expressing skills. Link to hand expressing demonstration <https://youtu.be/bnIY2BqshCE>

A5.6.4 Discuss lactation suppression with mother if;

* If mother commenced breastfeeding and decided to cease breastfeeding.
* In the event of the death of an infant. Breast pain and engorgement can be a very distressing symptom for a mother whose infant has died. She may require education around milk suppression if this is her wish. Mothers may also have been administered medication to suppress lactation prior to discharge from the maternity unit e.g. Cabergoline. Some mothers may find comfort in donating their breast milk to a milk bank. Further information can be found at <https://westerntrust.hscni.net>. The Féileacáin postnatal support leaflet is available at the following link <https://pregnancyandinfantloss.ie/feileacain-support-for-you/>

• breastfeeding is contraindicated for the infant or the mother

Topics to discuss include:

• how the body produces milk, what happens when milk production stops, and how long it takes for milk production to stop

• self-help advice, such as:

− avoiding stimulating the breast

− wearing a supportive well fitted bra

− using ice packs (wrapped in a cloth first)

− over-the-counter pain relief

− sparingly expressing milk to ease engorgement

• medicines that can be prescribed to suppress lactation and can be discussed with the GP if necessary.

A5.6.5 If the mother has mastitis she should be supported to continue to breastfeed and to improve milk supply that may have reduced temporarily. The following link has helpful tips during mastitis <https://www2.hse.ie/conditions/child-health/mastitis-while-breastfeeding.html>

A5.6.6 If the mother has a suspected breast abscess, refer to maternity service. Wound care is provided in accordance with the National Wound Management Guideline (HSE 2018a) and the hospital discharge information letter.

A5.6.7 Record the findings in the maternal postnatal record.

A5.6.8 If the RPHN/RM observes any deviations from the normal or suspects an infection or if the mother is feeling systemically unwell, a referral should be made to the GP/hospital and a care plan must be completed

**A5.7 Postpartum Blood Loss**

Normal shedding of blood and decidua is referred to as lochia which can last for two to six weeks. Secondary PPH is defined as abnormal bleeding from the genital tract, from 24 hours after delivery until six weeks postpartum.

A5.7.1 Discuss with women what vaginal bleeding to expect after the birth.

A5.7.2 Check total blood loss volume at delivery or in the immediate postnatal period recorded on the hospital discharge if available. Note the haemoglobin on discharge if available.

A5.7.3 If any of the following are reported by the mother observe colour, amount and consistency of vaginal bleeding and check uterine involution;

• the vaginal bleeding is sudden or very heavy

• the bleeding increases

• passing clots, placental tissue or membranes

• symptoms of possible infection, such as abdominal, pelvic or perineal pain, fever, shivering, or vaginal bleeding or discharge has an unpleasant smell (see section A5.7.3)

• they have concerns about vaginal bleeding after the birth.

A5.7.4 If the RPHN/RM observes any deviations from the normal a referral (Appendix V) must be made to the GP/ Hospital as appropriate and a care plan completed.

A5.7.5 The mother should be advised to seek medical advice if any of the signs or symptoms detailed in A6.2 should occur.

A5.7.6 Record findings in maternal postnatal record.

**A5.8 Uterine Involution**

A5.8.1. Assessment of uterine involution and position must be undertaken if any of the signs or symptoms in A5.7.3 are present or if clinically indicated.

A5.8.2 The mother must be lying on a flat surface on her back with legs straight, ensuring that she has emptied her bladder prior to the examination.

A5.8.3 A normal postpartum fundus is firm, central and well-contracted. Inadequate myometrial contraction will result in atony (ie, a soft, boggy uterus), which is the most common cause of primary postpartum haemorrhage (within 24 hours of delivery). A secondary postpartum haemorrhage is commonly caused by retained tissue or infection. In this case the uterus will be high and may be soft and /or tender.

A5.8.4 If the RPHN/RM observes any deviations from the normal a referral (Appendix V) should be made to the GP/ hospital as indicated and a care plan must be completed.

A5.8.5 Record findings in the maternal postnatal record

**A5.9 Perineum** (Relevant to mothers who have had a vaginal birth or attempted vaginal birth).

A5.9.1 The mother should be advised of the importance of perineal hygiene, including frequent changing of maternity pads, washing hands before and after perineal care and toileting, and daily showering to keep her perineum clean. The RPHN/RM should advise against additives/epsom salts in baths and also to avoid long periods in the bath as this may lead to premature breakdown of the perineum.

A5.9.2 Pelvic floor exercises should be advised as per section A8.3

For mothers who have had a perineal tear or episiotomy:

A5.9.3 As part of assessing perineal wound healing, ask the mother if she has any concerns and ask about:

• pain not resolving or worsening

• increasing need for pain relief

• discharge that has a strong or unpleasant smell

• swelling/harness/bruising

• wound breakdown

* ability to pass urine and stool
* feeling unwell/fever/signs of systemic infection

A5.9.4 The perineum should be inspected for bruising, haematoma, oedema, purulent discharge, inflammation or dehiscence. If the RPHN/RM observes any deviations from the normal or suspects an infection, a referral (Appendix V) should be made to the GP/Hospital and a care plan must be completed.

A5.9.5 Mothers with perineal pain should be advised on perineal hygiene (A5.7.1) and oral analgesics. Consider using a validated pain scale to assess perineal pain (Appendix X). For pain relief the mother should be advised paracetamol- based products or NSAID’s if not contraindicated and as prescribed by GP or to discuss same with her pharmacist. Warm and cold packs are not advised due to the risk of injury. Parallel rolled towels may be comfortable to sit on. Perineal donut cushions are not recommended as they may lead to the formation of dependent perineal oedema and increase the risk of perineal wound breakdown (SA Maternal, Neonatal & Gynaecology Community of Practice, 2018). The RPHN/RM should be aware that perineal pain that persists or gets worse within the first few weeks after the birth may be associated with symptoms of depression, long-term perineal pain, problems with daily functioning and psychosexual difficulties.

A5.9.6 Advise the mother that she should seek medical advice if any of the signs or symptoms detailed in A5.7.3 should occur

A5.9.7 Mothers with third or four degree tears may be linked into a perineal clinic or specialist in the maternity unit depending on local practices. Eating a high-fibre diet and drinking plenty of water, with stool softeners and laxatives as needed, can be useful until perineal healing is nearly complete, especially in women with a disrupted anal sphincter.

A5.9.8 Record the findings in the maternal postnatal record.

**A5.10 Wound (Relevant to mothers who have had a Caesarean Section (CS)**

A5.10.1 Mothers with a CS wound must have their wound inspected at each visit and any issues managed in line with National Wound Management Guidelines (HSE, 2018a).

A5.10.2 Advice should be given about transferring in and out of bed, rolling onto side, no heavy lifting to avoid straining the suture line and straining the abdominal muscles. Advise that they should not drive for 4 - 6 weeks to allow for optimum healing of the wound, however the mother should check with her car insurance company before driving. Further information for mothers on the HSE website.

A5.10.3 Advice should be given on CS wound care including; encourage mother to take prescribed analgesia, to complete antibiotics if prescribed, to wear loose comfortable clothes and cotton underwear, shower daily avoid using perfumed products, to gently clean and dry the wound well.

A5.10.4 If applicable, sutures/clips/negative pressure wound therapy/bead to be removed as per instructions from the Maternity Hospital.

A5.10.5 If applicable, single use negative pressure wound therapy should be removed as per instructions from the Maternity Hospital. If the wound is not fully healed the RPHN/RM should dress the wound with a new wound covering and wound management care plan commenced.

A5.10.6 If appropriate, discuss anti-coagulation therapy and ensure the mother has a sharps bin and patient information leaflet as per local disposal of sharps policy. Encourage mothers to wear compression stockings if prescribed.

A5.10.7 Educate and provide mother with information regarding signs of wound infection such as increasing pain, redness or discharge.

A5.10.8 If the RPHN/RM observes any deviations from the normal or suspects an infection, a referral should be made to the GP/Maternity hospital and a care plan must be completed.

A5.10.9 Record the findings in the maternal postnatal record.

**A5.11 Bladder Function**

Bladder function, micturition and any associated problems must be assessed.

A5.11.1 Discuss the volume, frequency, urgency and any discomfort the mother may have when passing urine, assessing for signs and symptoms of urinary tract infection or urinary retention.

A5.11.2 If the mother presents with symptoms of urinary tract infection refer to GP.

A5.11.3 If the mother presents with urinary retention refer immediately to maternity hospital. Mothers may be asymptomatic or have small voided volumes, urinary frequency or urgency, a slow or intermittent stream, hesitancy, bladder pain or discomfort, urinary incontinence, straining to void, sense of incomplete emptying, or no sensation to void.

A5.11.4 The mother should be asked if she has any problems with the involuntary leaking of urine. If mother reports involuntary leakage/stress incontinence of urine after 6 weeks refer back to the maternity hospital and or continence advisor and or physiotherapist, depending on local practices. Further resources available at <https://www.hse.ie/eng/services/list/2/primarycare/community-funded-schemes/continence/>

A5.11.5 Record findings in the maternal postnatal record.

**A5.12 Bowel Function** (including constipation, faecal incontinence and haemorrhoids)

A5.12.1 Mothers must be asked if they have had their bowels opened within 3 days of the birth. Encourage mothers to give themselves adequate time to pass stool.

A5.12.2 If constipation presents as a problem give advice about appropriate diet to include high fibre and fluids. Review medication (analgesia/iron supplement) and assess if same is a contributing factor, encourage taking medication as prescribed and advise to speak to pharmacist for alternative mild laxative, if necessary.

A5.12.3 The mother should be asked if she has any problems with urgency or the involuntary leaking of faeces. Mothers with faecal incontinence must be referred without delay to their GP/Maternity Hospital for further assessment.

A5.12.4 If the mother has a 3rd degree tear or greater, discuss pelvic floor exercises as per section A8.3, use of laxatives and antibiotic therapy as prescribed. Depending on local policy the mother may require a referral to Women’s Health Physiotherapy if she is not attending the perineal clinic at the maternity unit.

A5.12.5 A mother with haemorrhoids should be advised to take dietary measures to avoid constipation. Where she has a haemorrhoid which is severe, swollen or prolapsed or has rectal bleeding the RPHN/RM should refer the mother to the GP.

A5.12.6 Record findings in the maternal postnatal record

**A5.13 Pain**

A5.13.1 If the mother presents with severe or a persistent headache assess mother’s other physical symptoms, check for dizziness/ visual disturbance/ nausea/vomiting. If these symptoms present with high blood pressure (diastolic blood pressure greater than 90mmhg) refer to hospital immediately for medical assessment. If there are no other signs and symptoms of pre-eclampsia the RPHN/RM must refer the postnatal woman to the GP. See Section A6.5.

A5.13.2 All mothers who had epidural or spinal anaesthesia are advised to report any severe headache (particularly one which occurs while sitting or standing) to their GP as they may need referral to the maternity unit.

A5.13.3 If the mother reports worsening, pain not responding to over the counter analgesia or new severe pain in any location e.g., head, chest, back, abdomen, perineum, this is a cause for concern and infection/sepsis should be suspected. The RPHN/RM must refer the mother to her GP/maternity unit as appropriate.

A5.13.4 Mothers should be advised it is important that they take care of their back after childbirth. The back care leaflet can be downloaded from [www.healthpromotion.ie](file:///C:\Users\slawlor\Desktop\PNR\www.healthpromotion.ie). Referral to the physiotherapist and /or GP should be considered if necessary.

A5.13.5 Back pain may be a symptom of uterine infection or haemorrhage see sections A5.7.3 and A5.8.3.

A5.13.6 Consider using a numerical scale/number rating scale to assess and document severity of pain (for example the Wong Baker FACES pain rating scale Appendix X).

A5.13.7 RPHN/RMs should advise the mother not to engage in activities that require mental alertness (e.g. driving) if she is taking narcotic analgesics.

A5.13.8 Record the findings in the maternal postnatal record

**A5.14 Legs**

A5.14.1 Observe for oedema, varicose veins and advise mother of ways to reduce the oedema; gentle exercise of fingers and toes and light exercise e.g. walking. Elevating her legs above the level of her hips may help to ease leg oedema.

A5.14.2 Observe the legs for redness, swelling, varicose veins and enquire regarding pain/cramps. Advise mother on the signs and symptoms of thromboembolism (VTE). The mother may have anti-embolism socks and /or pharmacological VTE prophylaxis (e.g. Tinzaparin) following the VTE risk assessment in the maternity hospital. See A7.4.

A5.14.3 Record the findings in the maternal postnatal record

**A5.15 Diabetes**

A5.15.1Women with pre-existing diabetes should be advised to attend their routine diabetes care clinic. It is important that women with diabetes are aware of the importance of contraception and preconception care when planning future pregnancies.

A5.15.2 Women with gestational diabetes should be advised to attend their postnatal follow up appointment as directed by their maternity care provider. They should continue to follow lifestyle advice regarding diet and exercise.

**A5.16 Epilepsy**

**This section is taken from the Practice Guide for the Management of Women with Epilepsy (2018)**

[**https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/practice-guide-for-mgt-of-women-with-epilepsy.pdf**](https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/practice-guide-for-mgt-of-women-with-epilepsy.pdf)

In parallel with the routine RPHN/RM assessment the following is a checklist for women with epilepsy (WWE) and infant postnatally:

A5.16.1 Discuss desired method of feeding the infant and if the mother wishes to breastfeed.

WWE should not be discouraged from breastfeeding because of epilepsy. Discuss the risks and benefits of breastfeeding if taking anti-epileptic drugs (AEDs).

Risks of breastfeeding while on AEDs - hypersensitivity in babies exposed to AEDs through mother’s breast milk may develop.

Benefit of breastfeeding babies who were exposed to AEDs in utero - may help babies to

wean off their mothers AEDs.

Possibility of sedation should be considered if mothers taking older AEDs e.g. Phenobarbital

and bottle feeding should be considered.

Monitor infant alertness and infant weight if mother taking AEDs

A5.16.2 To reduce the risk of accidents and minimise anxiety, promote and reinforce infant/toddler

safety in the home.

* If possible, share the care of infant at night (to reduce exhaustion/sleep deprivation) while mother gets alternate full night’s sleep.
* Feeding and /or holding infant – advise sitting on the floor, on a rug or cushion (low to ground) may reduce the potential impact of dropping their child during a seizure.
* Bathing infant – never bath infant alone, use a small amount of water in bath, in event of seizure infant wouldn’t go under water. A “top & tail” wash is a safer alternative than bathing infant while alone.
* Carrying infant – if there are stairs in the house try to have all infant items downstairs so a not carrying infant up and down stairs; use carry cot/car seat up and down stairs to provide protection from a fall in the event of a seizure.
* Where a parent’s seizures affect just one side of their body, they should position their child on the non-affected side, to reduce the risk of falling onto the child.
* Parents who fall over during a seizure (tonic clonic seizure) should be advised against the use of an infant sling.
* Safety gates/ play pens in the home and child reins or wrist straps will prevent child wandering away if the parent has a seizure.
* Advise the use of a pram with a brake that is automatically activated when the handle is released. If using a high chair – ensure it can’t be knocked over (in event of seizure); or consider using a bouncer chair/car seat on floor

A5.16.3 Future pregnancies should be discussed/ planning next pregnancy and seeking preconceptual

counselling with GP/Consultant prior to next pregnancy is recommended.

**A6.0 Signs and Symptoms of Potential Life-Threatening Conditions**

The RPHN/RM must inform mothers and their partners of the signs and symptoms of potentially serious/life threatening conditions, and she should seek medical advice without delay if any of these occur (WHO 2013c, NICE 2021). This information is available in the My Pregnancy book.

A6.1 Signs and symptoms of postpartum haemorrhage: sudden or very heavy vaginal bleeding or passing clots, or persistent/ increased vaginal bleeding, abdominal pain, decreased urinary output, faintness, dizziness, palpitations/tachycardia or feeling generally unwell which could indicate retained placental tissue or endometritis.

A6.2 General signs and symptoms of sepsis:

**S**lurred speech or confusion

**E**xtreme shivering

**P**assing no urine

**S**evere breathlessness

**I**t feels like you are going to die

**S**kin mottled or discoloured

Other symptoms may include temperature >38oC or under 36oC, loss of appetite, fatigue, pain, vomiting, diarrhoea.

Signs and symptoms of pregnancy related infections: painful, red, swollen breast, abdominal or back pain and offensive smelly blood loss, hot, painful swollen wound See section A6.3

A6.3 Signs and symptoms of infection: fever; shivering; abdominal, pelvic or perineal pain, dysuria, breasts red and inflamed, wound red or hard or gaping or vaginal discharge with an unpleasant smell, new or worsening perineal or uterine pain.

A6.4 Signs and symptoms of thromboembolism: unilateral calf pain; tenderness, redness or swelling of calves; shortness of breath or chest pain. The risk is highest in the first few weeks postpartum and then gradually declines to baseline by 12 weeks postpartum. Several factors increase the risk, including but not limited to previous thromboembolism, inherited or acquired thrombophilia, certain medical comorbidities (e.g. sickle cell disease), obesity, smoking, caesarean delivery, and postpartum haemorrhage. Prophylaxis therapy may be recommended by the obstetrician for women at high risk of having a thromboembolic event. See section A5.3.3. for medication administration guidance.

Thrombosis Alert Card [https://thrombosis.ie/alert-card/](https://thrombosis.ie/alert-card/%20) available in 17 languages

A6.5 Signs and symptoms of hypertension, pre-eclampsia, postdural-puncture headache, migraine, intracranial pathology or infection: headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or hypochondrial pain, feeling faint, convulsions (in the first few days after birth).

A6.6 Signs and symptoms of Postpartum Psychosis; symptoms tend to appear shortly after the birth and can include restlessness, agitation and confusion, significant mood disturbance affecting relationships or normal activity, thoughts of harming herself or the infant (NHCP 2018).

A6.7 The signs and symptoms of potential life threatening conditions are detailed in the My Pregnancy book page 209 (NHCP 2018) given to all expectant mothers during pregnancy by their antenatal care provider. Ensure the woman has received the book. A QR link to the online book is available in the PHN service Postnatal Information sheet (Appendix VI) The book is available to download in several languages from the HSE website.

A6.8 Mothers should have received information regarding sepsis from their maternity hospital or service. A QR link to the online sepsis leaflet is available in the PHN service Postnatal Information sheet

A6.8.1 The PHN service Postnatal Information sheet details the signs and symptoms of potential life threatening conditions (postpartum haemorrhage, infection/sepsis, Thrombo/pulmonary embolism, postpartum psychosis, eclampsia). This is available in Appendix VI for RPHNs/RMs to distribute to new mothers and their partners and is available in 12 languages.

**A7.0 Mental Health and Well-being**

**A7.1 Promoting emotional attachment**

Bonding is the positive emotional and psychological connection that the primary carer(s), usually the mother, develops with the infant.

Attachment is a type of innate behaviour in children. It is the earliest relationship that a child develops with their primary carer(s), and an infant behaves in a way that ensures physical proximity and safety. It is affected by the primary carer’s behaviour. This helps them to form positive relationships with others in the future.

A7.1.1 The RPHN/RM should discuss the importance of bonding and emotional attachment with parents and explain the different ways that they can bond with their infant.

A7.1.2 The RPHN/RM could share the following ideas as a way of promoting emotional attachment:

• face-to-face interaction

• skin-to-skin contact

• responding appropriately to the infant’s cues.

More information is available in the “my child” book series and website.

A7.1.3 Discuss with parents the transition to parenthood and potentially challenging aspects of this period that may affect bonding and emotional attachment, including:

* the mother's physical and emotional recovery from birth
* birth trauma or birth complications, including babies who have spent time in SCBU/ ICU
* fatigue and sleep deprivation
* feeding
* mental health issues
* demands of parenthood
* surrogacy or adoption

A7.1.4 The RPHN/RM should recognise that additional support in bonding and emotional attachment may be needed by some parents who, for example:

* have been through the care system
* have experienced adverse childhood events
* have experienced a traumatic birth
* have complex social needs
* current mental health issues.

A7.1.5 Parenting Resources

The support and reassurance provided by the RPHN/RM during the postpartum period helps to instil a sense of confidence in parents and can also help foster a healthy parent-child relationship. See section A8.7.

**A7.2 Emotional Wellbeing**

**The RPHN/RM should be familiar with the following:**

* **Perinatal Mental Health Care: Best Practice Principles for Midwives, Public Health Nurses and Practice Nurses (updated) (2021)** <https://nursing-midwifery.tcd.ie/news/assets/pdf/mind-mothers-project-best-practice-principles-2022.pdf>
* **Mind Mothers E-learning package on HSEland**
* **Specialist Perinatal Mental Health Model of Care**

A7.2.1 Emphasis on the emotional aspects of adjusting to parenthood is important. At each postnatal contact, mothers should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.

A7.2.2 Information regarding the range of perinatal mental health problems should be given to mothers as it assists mothers to prioritise their mental health in the postnatal period. The information will enable the mother to identify when her mental health is compromised beyond what one would expect in early motherhood (Higgins *et al.* 2021). Information regarding infant blues and postnatal depression is available in the “infant blues and postnatal depression” section of the My Child book 0 -2 years (NHCP 2018). A QR link to download this book is available in the PHN service Postnatal Information sheet (Appendix VI)

The Perinatal Mental Health (PMH) suite of leaflets, including depression and anxiety are available to order for all staff through [www.healthpromotion.ie](http://www.healthpromotion.ie) and all the information on the app and the leaflets are available on the SPMHS webpage: <https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/>

A7.2.2.1 The following are suggestions for mothers in pregnancy and in the early postnatal period from the Specialist Perinatal mental health service postnatal depression leaflet. Available on line here <https://www.hse.ie/eng/services/publications/mentalhealth/postnatal-depression.pdf>

• Don’t try to be ‘superwoman’. Try to do less and make sure that you don’t get over-tired.

• Do make friends with other women who are pregnant or have just had a baby. It may be more

difficult to make new friends if you get PND.

• Do find someone you can talk to. If you don’t have a close friend you can turn to, you can find support through one of the organisations named in the leaflet.

• Do go to antenatal classes. If you have a partner, take them with you. If not take a friend or relative with you.

• Don’t stop antidepressant medication during pregnancy without advice. You are more likely to

relapse if you have had severe depression. You need to discuss the risks and benefits of continuing treatment in pregnancy and breastfeeding with your GP or psychiatrist.

• Do keep in touch with your GP and your public health nurse if you have had depression before.

Any signs of depression in pregnancy or PND can be recognised early. They can decide if you need

support from a specialist mental health midwife or specialist perinatal mental health service.

• Do make sure that you have treatment for depression in pregnancy. This may be a talking

therapy and/or medication.

• Do accept offers of help from friends and family.

• Do tell others how you are feeling. You may be surprised how many people feel or have felt the

same way.

• Do make a Wellbeing Plan - this helps you to start thinking about the support you might need in your pregnancy and after the birth. You can download a Wellbeing Plan template from the Tommy’s charity website ([www.tommys.org/pregnancy-information/health-professionals/free-pregnancy-resources/wellbeing-plan](file:///C:\Users\slawlor\Desktop\PNR\www.tommys.org\pregnancy-information\health-professionals\free-pregnancy-resources\wellbeing-plan)).

A7.2.3 All mothers and their families/partners should be encouraged to inform their health care professional about any changes in mood, emotional state and behaviour that are outside of the mother’s normal pattern.

A7.2.4 At 10–14 days after birth, where there is contact with the RPHN/RM, mothers may be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the RPHN/RM should ask the mental health screening questions to identify possible mental health problems (NICE 2014a).

**A7.3 Mental Health Screening at 3 months’ postnatal visit**

**76.3.1 Antenatal and postnatal mental health: clinical management and service guidance NICE 2014a. Perinatal Mental Health Care Higgins *et al.* 2021**

The identification of mothers with mental health problems in the perinatal period can be improved with the use of screening questions.

To help reduce a woman’s fears and anxieties around disclosure, it is important to explain that the reason for the use of screening questions is to help identify if she could benefit from additional support or specialist assessment or intervention. While screening questions are helpful, they should never be used in isolation. **The context of any positive responses to questions should be clarified in discussion with the woman to inform clinical judgement**.

A7.3.1.2 Opening a discussion about mental health

Examples taken from Perinatal Mental Health Care Best practice principles:

“There are a number of things I would like to discuss with you today about your physical health, your relationships and lifestyle and your emotional or mental health if that is ok?”

“I would now like to ask you some questions about your mental health. We ask women these questions as it is common for women to experience mood changes during pregnancy and in the early post-natal period and we would like to support you if you find that you are affected by mood changes or any other mental health issues.”

A7.3.2 All mothers between 12 -14 weeks postnatal (it may coincide with the 3-month core development check) must be routinely asked the screening questions by the RPHN to detect possible PND and/or anxiety.

A7.3.3 However it is important to note, that at any time in the antenatal or postnatal period where clinically indicated, the RPHN/RM may ask the screening questions in order to identify a woman who may be experiencing symptoms of depression and/ or anxiety. The questions are validated for use up to one year following delivery.

A7.3.4

|  |  |  |
| --- | --- | --- |
| Mental Health Screening Questions  Perinatal Mental Health Care (Higgins *et al.* 2021) NICE (2014a) Whooley *et al* (1997) | | |
| Q 1 | During the past month, have you often been bothered by feeling down, depressed or hopeless? | Yes/No |
| Q 2 | During the past month, have you often been bothered by having little interest or pleasure in doing things? | Yes/No |
| Q3 | During the past month, have you been feeling nervous, anxious or on edge? | Yes/No |
| Q4 | During the past month, have you not being able to stop or control worrying? | Yes/No |
|  | **If yes to any of the questions**: Is this something you feel you need or want help with? |  |

A7.3.5 Mothers who answer No to the screening questions are unlikely to be depressed or anxious. However, if the RPHN is concerned about the mother’s mood (clinical judgement), the RPHN may refer to the GP if required.

A7.3.6 If a mother responds positively to any of the screening questions a more extensive conversation about the mother’s mental health is recommended to see if she wants or needs help with the difficulties identified (Higgins *et al.* 2021).

Examples of questions below which could be used in a more extensive conversation regarding the mother’s mental health (mayoclinic.org)

|  |
| --- |
| **SPACE**  **Sleep** disorder – increased, decreased, difficulty getting to sleep  **Pleasure** – lack of enjoyment in activities, hobbies, sports that she would normally enjoy  **Appetite** – increased, decreased or increased cravings for food, weight gain  **Concentration** – difficulties with concentrating, trouble thinking or making decisions  **Energy** – low or decreased, tiredness, small tasks take extra effort (also be aware of anaemia or hypothyroid) |
| **DRAGS**  **D**epressed mood – sadness, tearfulness, emptiness or hopelessness  **R**etardation – slowing down of thoughts, speaking or body movements  **A**gitation – irritability or frustration  **G**uilt - useless, worthless, fixating on past failures or self blame  **S**uicidal Ideation – suicidal thoughts or attempts |

A7.3.7 The RPHN should consider referring the woman to her GP and /or seeking advice from the local Perinatal Health Midwife if the woman answers yes to one or more of the screening questions and the PHN is concerned about the woman’s mental health following further sensitive inquiry.

A7.3.7.1 Why is treatment important?

Most women will get better without any treatment within 3 to 6 months. 1 in 4 mothers with PND are still depressed when their child is one-year-old. However, this can mean a lot of suffering. PND can spoil the experience of new motherhood. It can strain on relationships with baby and partner. Early identification and treatment leads to better outcomes.

A 7.3.7.2 Which treatments are available?

The treatment required depends on how unwell the woman is.

Treatment includes:

* self-help strategies
* talking therapy
* medication

For some women the self-help suggestions below may be enough. If these are not enough, talking therapy may be helpful. For more severe depression, the woman may need medication, with or without talking therapy. Her GP can advise her about these treatments. The GP can refer her to a perinatal mental health service - a specialist service for pregnant women or women with a baby under a year old. Otherwise she may be referred to a Community Mental Health Team. This is usually the case for women with more severe illnesses.

A 7.3.7.3 Self-help strategies

The following are suggestions for mothers from the Specialist Perinatal mental health service postnatal depression leaflet. Available on line here <https://www.hse.ie/eng/services/publications/mentalhealth/postnatal-depression.pdf> and available from www.healthpromotion.ie

• Don’t be frightened by the diagnosis. Many women have postnatal depression and you will get better in time. Your partner, friends or family can be more helpful and understanding if they know what the problem is.

• Do tell someone about how you feel. It can be a huge relief to talk to someone understanding. This

may be your partner, a relative or friend. If you can’t talk to your family or friends, talk to your public health nurse, GP or mental health midwife. They will know that these feelings are common and will be able to help.

• Do take every opportunity to get some sleep or rest during the day or night ask a partner, relative or friend to help with baby care. If you are on your own, try and rest when the baby sleeps. Even if you cannot sleep, take some time to rest and relax.

• Do try to eat regularly, even if you don’t feel like eating. Eat healthy food.

• Do find time to do things you enjoy or help you relax - e.g. go for a walk, read a magazine, listen to music.

• Try to do something enjoyable with your partner, a friend or family member.

• Do go to local groups for new mothers or postnatal support groups. Your public health nurse can tell

you about groups in your area. You may not feel like going to these groups if you are depressed. See if

someone can go with you. You may find the support of other new mothers helpful. You may find some women who feel the same way as you do.

• Do let others help you with housework, shopping and looking after other children.

• Do some exercise. Ask your public health nurse if there is any mother and baby exercise classes

in your area. Walking with your baby in the pram is good exercise. Regular exercise can boost your

mood.

• Do use self-help books and websites.

Mind the bump [https://www.mindthebump.org.au/](https://www.mindthebump.org.au/%20)

Head space [https://www.headspace.com/](https://www.headspace.com/%20)

Mindfulness Relaxation Centre, Beaumont Hospital <http://www.beaumont.ie/marc>.

• Do contact organisations that support women with Postnatal Depression (See A6.3.14).

• Don’t blame yourself, your partner or close friends or relatives. Life is tough at this time, and tiredness and irritability can lead to quarrels. ‘Having a go’ at your partner can weaken your relationship when it needs to be at its strongest. The same can happen with other close family or friends who are trying to support you.

• Don’t use alcohol or drugs. They may make you feel better for a short time, but it doesn’t last. Alcohol and drugs can make depression worse. They are also bad for your physical health.

A 7.3.7.4 Talking therapy

This can be counselling with an individual therapist or group therapy, cognitive behavioural therapy, or psychotherapy. Referrals can be made through primary care or GP as appropriate. Some women opt to attend privately. Information regarding this is available <https://www.hse.ie/eng/services/publications/mentalhealth/postnatal-depression.pdf>

A 7.3.7.5 Medication

GP or mental health service team may prescribe antidepressants. It is important for women to be aware of the following points. There are several types of antidepressants that work equally well, but have different side-effects, usually mild. They are not addictive. They can all be used in PND, but some are safer than others if the woman is breastfeeding. Antidepressants take at least 4 to 6 weeks to have their full effect. They will need to be taken for around 6 months after they take effect. Further information available here <https://www.hse.ie/eng/services/publications/mentalhealth/postnatal-depression.pdf>

A 7.3.8 For mothers receiving mental health care from GP / perinatal mental health services – RPHN should continue to provide postnatal support, include enquiring about the woman’s mental health and wellbeing and provide guidance on the care and management of her infant, and will provide information on local supports in the area.

A7.3.9 If the mother has a current mental disorder or a history of severe mental illness, she should be asked about her mental health at all contacts with the Public Health Nursing Service (NICE, 2014a). The RPHN/RM should liaise with the community mental health services or specialist perinatal mental health service where the mother is attending if appropriate.

A7.3.10 If during the mental health screening process, the RPHN identifies a safety risk to the mother, infant or others an urgent specialist perinatal mental health assessment or community mental health team or emergency department referral may be required. The RPHN immediately refers to the GP by telephone (followed by written referral within 24 hours) in consultation with the mother.

The RPHN or partner/family member must remain with the mother until the GP arrives /or until a family member escorts the mother to see her GP. The mother can be sent to acute hospital by ambulance if necessary. The RPHN should contact their ADPHN if necessary to advise her of the situation in order to reorganise other planned commitments.

A7.3.11The Healthcare Staff Specialist Perinatal Healthcare App is designed to provide the latest information to assist frontline staff in their roles, providing information and services to women seeking information, advice and support for mental health problems in pregnancy and the first year post-partum. Available at: https://PMH.healthcarestaff.app (see Appendix IX).

A7.3.12 Perinatal mental health midwives are available in all hub and spoke sites of the maternity hospitals and may be contacted for advice. Each hub within a hospital group has a specialist perinatal mental health service. Guidance on liaising with and referring to these services should be available locally and is available on the app <https://PMH.healthcarestaff.app>

A7.3.13 Perinatal anxiety and or depression can be an issue for fathers/partners. The RPHN should recommend a GP consultation for the father/partner if the RPHN receives a query from the mother / partner regarding this issue (NICE, 2014a).

A7.3.14 Peer Support

RPHN should facilitate opportunities for the provision of peer support for mothers with depressive and anxiety symptoms in the perinatal period. Suggestions:

* Parent and toddler group
* Infant massage group
* TUSLA Family support service
* Aware support group 1800804848. Aware.ie
* GROW Postnatal Support 1890 474 474. Grow.ie
* Postnatal Depression Ireland 021 492 2083, pnd.ie
* Parentline 1890 92 72 77, parentline.ie
* Cuidiú Irish Childbirth Trust 01 872 4501, cuidiu-ict.ie
* Samaritans 24hr listening service 116123 (no area code necessary) Samaritans.org

**A8.0 Health Promotion and resources**

A8.1 Information regarding resources for family planning and contraception should be offered to mothers. Information is available in the My Pregnancy book provided to all mothers during the antenatal period and also at the website [www.sexualwellbeing.ie](http://www.sexualwellbeing.ie).

A8.2 The abdominal wall is lax postpartum but regains most, if not all, of its normal muscular tone over several weeks; however, separation (diastasis) of the rectus abdominis muscles (DRAM) may persist. Long-term sequelae may include abdominal discomfort, pelvic floor issues, back pain, umbilical or epigastric hernias and cosmetic issues, which may be managed conservatively or surgically (Berens 2021). The mother should be advised of this by the PHN/RM and directed to further information on the HSE website. Not all of the routine postnatal exercises are suitable for women with DRAM and information is available through a QR code in the PHN service postnatal Information sheet (Appendix VI). If DRAM persists after 8weeks following delivery the mother may be referred to the Primary Care physiotherapist or to the maternity hospital physiotherapy department depending on local procedure.

A8.3 Pelvic floor exercises should be discussed with all mothers. Details of pelvic floor exercises are in the My Pregnancy book – this is given to all women at their first antenatal visit. A QR link to the online book is in the PHN service Postnatal information sheet (Appendix VI). Commencement of pelvic floor exercises may depend on perineal healing/comfort.

A8.4 Mothers over the age of 25 years will be invited for cervical screening if they are on the Cervical Check register. Mothers can check their status on www.cervicalcheck.ie. Cervical screening is recommended every 3 years in women aged 25 – 29 years and every 5 years in older women. If the mother is due cervical screening, it is recommended to wait 3 months after delivery. Women who are breastfeeding can attend for screening 3 months’ post delivery. The mother should discuss with her GP or contact www.cervicalcheck.ie.

A8.5 Information regarding regular self-examination of the breast is available in the “make time for your breast health” leaflet on www.breastcheck.ie.

A8.6 Information on healthy eating and nutrition is available in the “just for mothers” section of the My child book 0 -2 years (NHCP 2018).

A8.7 Information regarding local smoking cessation clinics and details of HSE Quitline should be offered if applicable, Freephone 1800 201 203 or text QUIT to 50100.

A8.8 Parenting resources

[https://www.tusla.ie/parenting-24-seven/](https://www.tusla.ie/parenting-24-seven/%20) a Tusla initiative on attachment and bonding, positive parenting, parent child relationships, activities for children, diet etc.

[https://ncca.ie/en/](https://ncca.ie/en/%20%20)  (National Council for Curriculum and Assessment) tips on play for parents for babies and infants and children in six languages

[www.hse.ie/mychild](http://www.hse.ie/mychild) HSE website with parenting, childcare, breastfeeding and self-care advice.

A8.9 Information regarding “infant blues” and postnatal depression is available in the “infant blues and postnatal depression” section of the My child book 0 -2 years (NHCP 2018).

A8.10 A leaflet with links to evidenced-based resources on women’s health after motherhood, breastfeeding support and breastfeeding expert helpline is available in Appendix VI.

A8.11 Information regarding “Your service Your say” should be given to the mother. Email [yoursay@hse.ie](file:///C:\Users\slawlor\Desktop\PNR\yoursay@hse.ie)

**A9.0 Alcohol and drug use**

A9.1 If alcohol or drug use is suspected or confirmed, confirm that mother is attending the local addiction services and/or community mental health services. Arrange referral to GP if mother is not attending services.

A9.2 Complete a CFHNA and discuss outcome with ADPHN (CFHNA training available through the CNMEs). Refer to the Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service (HSE 2021). The proportionate provision of information to the statutory agencies necessary for the protection of a child is not a breach of confidentiality or data protection.

A9.3 If either parent states they are smoking/vaping, offer referral to smoking cessation and give details of HSE Quitline. See Section A8.7. Offer safe sleep/SIDS prevention advice.

**A10.0 Safety**

**A10.1 Domestic, Sexual & Gender Based Violence (DSGBV)**

Antenatal DSGBV screening questions are asked routinely at the booking visit in the maternity unit. Information on a discharge summary may be coded in the following way.

V0 indicates that the woman has been asked and denies violence in the home.

V1 indicates that the woman has been asked and admits violence in the home.

V2 indicates that there is DSGBV and there has been action taken by the hospital staff.

Under the Third National Domestic Sexual and Gender Based Violence (DSGBV) Strategy <https://www.justice.ie/en/JELR/Pages/DSGBV-Strategy>, the HSE will work in partnership with other government departments and agencies to develop a HSE National DSGBV training strategy. This training strategy will support healthcare workers to identify DSGBV and refer victims/survivors to appropriate services. This guideline will be updated accordingly.

**RPHNs and RMs should only ask the DSGBV screening questions when DSGBV training has been completed, see appendix VIII for additional information on screening and resources.**

A10.1.1 **Recognise:** It is important that RPHN/RM enquire about DSGBV **only** **if safe to do so**. RPHN/RM should observe for signs of DSGBV. If it is not feasible to ask the DSGBVscreening questions at the first visit the RPHN/RM should ask them at a follow up visit/appointment.

A10.1.2 **Respond:** If a woman discloses DSGBV the RPHN/RM should respond in a non-judgemental, respectful and culturally safe manner. Take time to listen to the woman, provide information, and offer referrals to specialist help and services.

A10.1.3 **Refer**: Address safety concerns for the woman and her children if trained to do so. Discuss safety planning if trained to do so, or connect the woman with a DSGBV professional who can assist (with her consent).

A10.1.4 Document and complete care plan in the maternal postnatal record.

**A10.2 Child Protection and Welfare**

Where a RPHN/RM identifies any area of concern regarding a child/children where the parent/s are experiencing difficulties in meeting the needs of the child/children as a result of alcohol/drug use, DSGBV**,** mental health problems, learning disability, poverty or where there are risk factors as outlined in Child and Family Health Needs Framework, the RPHN/RM must complete a CFHNA. If support is required by the RPHN/RM the assessments should be discussed with the ADPHN. Referrals should be made to Tusla and other appropriate services. The proportionate provision of information to the statutory agencies necessary for the protection of a child is not a breach of confidentiality or data protection. Refer to the Guideline on the use of the CFHNA for the Public Health Nursing Service for further guidance (HSE 2021).

**A11.0 Maternal 3 month assessment**

A11.1 Bladder Function as per section A5.11

A11.2 Bowel Function as per section A5.12

A11.3 Dyspareunia

Although there is no set time to resume intercourse, it has to be right for both partners. Most women resume sexual relations by six weeks postpartum, which is usually around the time for a GP visit.

A11.3.1 At the 3 month visit, the mother should be advised that if she experiences dyspareunia she should contact her GP.

A11.4 Do you feel safe in your relationship? As per section A10.1

A11.5 Any other concerns? Enquire from the mother if she has any concerns regarding her health and wellbeing and respond appropriately with advice, referrals, care plan etc.

A11.6 Discuss cervical screening section as per section A8.4.

A11.7 Post natal depression screening as per section A7.3.

A11.8 Record all findings regarding the 3 month assessment in the maternal postnatal record.

**QR codes**

The PHN service Postnatal Information sheet in Appendix VI contains QR codes that link to recommended websites. The mother can open these links by using the camera on her phone. Open the camera app on the phone and point the camera to the QR code. If necessary, tap the magnifying lens. The link will show in a notification, tap the link and the chosen website will open.

PART B: PPPG Development Cycle

# 1.0 INITIATION

## Purpose

The purpose of this guideline is to provide guidance to Registered Public Health Nurses (RPHNS) and Registered Midwives (RMs) in the Public Health Nursing service on maternal postnatal care and completion of the national standardised maternal post natal record.

## Scope

The scope of this guideline identifies what will be covered by the guideline

1.2.1 Target users; This guideline applies to all RPHNs and RMs working in the HSE Public Health Nursing Service nationally who are responsible for the provision of maternal postnatal care.

1.2.2 Population to whom it applies; This guideline applies to all mothers who are visited in the postnatal period by the Public Health Nursing service.

## 1.3 Objective(s)

1.3.1 To ensure a national standardised approach by RPHNs and RMs in the Public Health Nursing Service in delivering evidence based maternal postnatal care. This guideline will guide and support the Public Health Nurse/Midwife to conduct a thorough post natal assessment/examination and thereby enable her/him to assess the mother’s physical and psychological /social wellbeing and recognise any deviations from the normal, through a guided assessment process.

1.3.2 To promote the delivery of safe and effective maternal postnatal care in partnership with the mother and her partner.

1.3.3 To provide guidance and clarity to RPHNs/RMs in attaining/maintaining acceptable standards of recording clinical practice in the maternal postnatal record.

1.3.4 To ensure good practice regarding the recording of clinical practice including assessment, care planning and evaluation in the maternal postnatal record in a standardised way.

1.3.5 To ensure that legislative and regulatory requirements are met and that the guideline and resource will act as an educational tool and as a basis for audit and evaluation.

## Outcome(s)

1.4.1 The implementation of a national standardised approach in the assessment and care of postnatal mothers by the Public Health Nursing Service.

1.4.2 The enhancement of the knowledge and skills of the RPHN and RM in the management of the postnatal mother resulting in better health outcomes for the mother.

## 1.5 PPPG Development Group

See Appendix II for Membership of the PPPG Development Group Template.

See Appendix III for PPPG Conflict of Interest Declaration Form Template.

## 1.6 PPPG Governance Group

See Appendix IV for Membership of the Approval Governance Group.

## 1.7 Supporting Evidence

## 1.7.1 Relevant Legislation/PPPGs.

Department of Health and Children (1966) Circular 27/66 District Nursing Service

Department of Health and Children (2000) Circular 41/2000

Department of Health (2018) Slaintecare Implementation Strategy

Department of Health (2018) Towards a Model of Integrated Person-centered Care

General Data Protection Regulation (2016) European Commission

Government of Ireland (1970) Health Care Act

Government of Ireland (2015) Children First Act

Health Information and Quality Authority (2012) National Standards for Safer Better Healthcare

Health Information and Quality Authority (2016) Supporting Peoples Autonomy: a Guidance Document

Health Information and Quality Authority (2017) National Standards for the Prevention and Control of Healthcare Acquired Infections.

Nursing and Midwifery Board of Ireland (2021) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.*

 Nursing and Midwifery Board of Ireland (2015) *Recording Clinical Practice Professional Guidance*

Nursing and Midwifery Board of Ireland (2015) *Scope of Nursing and Midwifery Practice Framework*

National Institute for Health and Clinical Excellence (2021) *Guideline postnatal care of women and babies*. National Institute for Health and Clinical Excellence, London

World Health Organisation (WHO) (2013) *Recommendations on Postnatal care of the Mother and Newborn*

## 

1.7.2 List PPPGs that are being replaced by this PPPG.

This national guideline replaces any previously developed local guidelines regarding the postnatal care of women in the Public Health Nursing service.

1.7.3 List related PPPGs.

Health Services Executive (2011) Standards and Recommended Practices for Healthcare Records Management.

Health Services Executive (2013) Record Retention Periods: Health Service Policy.

Health Service Executive (2016) National Framework for developing policies, procedures, protocols and guidelines (PPPGs).

Health Service Executive (2017) Policy on Lone Working.

Health Service Executive (2018) National Infant Feeding Policy for Primary Care Teams and Community Health Organisations

Health Service Executive (2019) National Infant feeding policy for Maternity & Neonatal Services

Health Service Executive (2019) Data Protection Guidelines.

Health Service Executive (2019) Child Protection and Welfare Policy.

Health Service Executive (2022)Guideline on the Observation of a Breastfeed and use of the Breastfeeding assessment tool (BOAT) resource

Health Service Executive (2022) National Consent Policy.

**1.8 Glossary of Terms**

**1.8.1 Abbreviations**;

|  |
| --- |
| **ADPHN**  Assistant Director of Public Health Nursing |
| **CFHNA** Child and Family Health Needs Assessment |
| **CHO**  Community Healthcare Organisation |
| **DOHC**  Department of Health and Children |
| **DNA** Did not attend |
| **DPHN** Director of Public Health Nursing |
| **EPDS** Edinburgh Postnatal Depression Screening |
| **GDPR** General Data Protection Regulations |
| **GP**  General Practitioner |
| **HIQA**  Health Information and Quality Authority |
| **HSE** Health Services Executive |
| **LHO** Local Health Office |
| **LSCS** Lower (uterine) Segment Caesarean section |
| **PPPG** Policies, Procedures, Protocols and Guidelines |
| **MN-CMS** Maternal and Newborn Clinical Management system |
| **NHCP** National Healthy Childhood Programme |
| **NIRF**  National Incident Report Form |
| **NPRS** National Perinatal Reporting System |
| **PCM** Primary Care Metrics |
| **RPHN** Registered Public Health Nurse |
| **RM** Registered Midwife |
| **SECM** Self Employed Community Midwife |

**1.8.2 Definitions**

|  |
| --- |
| **Appropriate** Matching the circumstances, meeting the needs of the individual, groups or situation (NMBI, Glossary of terms) |
| **Consent:** Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/her to understand the nature, potential risks and benefits of the proposed intervention (HSE National Consent Policy 2022a) |
| **Maternal Postnatal Record:** All information collected, processed and held in a manual formats pertaining to a mother under the care of a RPHN/RM including demographic information, routine assessments, personal care plans, correspondence and communications relating to the person and her care. |
| **Must:** Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed. (NMBI, 2021) |
| **Professional Judgement**: A nurses professional judgement is based on the principles of responsibility, accountability and autonomy as outlined within her professional scope of practice. (NMBI, 2015) |
| **Referral** An act of referring someone for consultation, review, or further action if the required intervention is outside the scope of practice of the healthcare professional. (NMBI Glossary of terms) |
| Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2021) |

# 2.0 DEVELOPMENT OF PPPG

Currently in Ireland there is no national guideline or national standardised maternal postnatal record to support maternal postnatal care in the Public Health Nursing Service. Development of a national maternal postnatal guideline and record will assist good communication and provide a better postnatal experience for women and their babies (HSE 2020d) while leading to a safer, more efficient and person-centred public health nursing service.

## 2.1 List the questions (clinical/non-clinical)

What is the evidence-based guidance on routine postnatal maternal care that should be included in a standardised maternal postnatal record and guideline?

## 2.2 Describe the literature search strategy

Local guidelines and maternal postnatal records currently in use were requested from the national DPHN group. 5 guidelines (representing 20 DPHN areas) and 9 records (representing all 31 DPHN areas) were received. One maternal postnatal record was in use in 18 of the DPHN areas. Current guidelines and postnatal records were also requested from Self Employed Community Midwife (SECM) service, maternity hospitals and domino services. No guidelines and 3 maternal records from 3 services were received. Discussions also took place with members of the Maternal Newborn – Clinical Management System (MN-CMS) team regarding the datasets in use on the MN-CMS system. The MN-CMS is in use in 4 maternity units in the Republic of Ireland however there are plans to roll it out to all 19 maternity units in the country.

A search for relevant strategies, evidence based guidelines, systematic reviews and articles using the search terms clinical guidelines in perinatal/postnatal/postpartum care was performed by a HSE librarian on the following databases: CINAHL, Cochrane database, BMJ Clinical Evidence and MEDLINE. The following websites were accessed Sept-Dec 2020 and again in Oct 2022 to identify publications and guidelines that related to the subject area; Nursing Midwifery Board of Ireland, Health Information & Quality Authority, Health Service Executive, World Health Organisation and the NICE guidelines UK. The NICE (2006) guideline CG 37 on maternal care had a complete review and was published in April 2021 as NICE guideline NG194 publication in April 2021. Meetings took place with a representative of Institute of Health Visiting (iHV) in the United Kingdom to develop and collaborate on work streams relating to best practice in maternal postnatal care across both countries. Collaboration with the Trinity College team responsible for the Mammi research also took place. The Mammi research informed the literature review in terms of current Irish research and resources for mothers. The National Breastfeeding Co-ordinator provided information regarding expert led resources for breastfeeding mothers.

## 2.3 Describe the method of appraising evidence

The evidence found was predominantly from national and international (NICE & WHO) guidelines. An UpToDate clinical care review was also used to inform this guideline. UpToDate is a point of care tool clinical decision support resource associated with improved outcomes developed by Wolters Kluwer. There is a rigorous editorial process. Each topic is assigned an author (a subject matter expert) and at least two separate physician reviewers. The group works together to perform a comprehensive review of the literature, culminating in clear recommendations for treatment and screening which allow clinicians to improve care. The recommendations are always based on evidence.

## 2.4 Describe the process the Guideline Development Group used to formulate recommendations

From the evidence, subgroups of the guideline development group drafted guidance in relation to maternal postnatal care in the PHN service. This guidance was presented to the PPPG development group collectively for discussion. From the evidence statements and the experience of guideline development members’, recommendations were then drafted. The evidence presented answers to the clinical questions posed and provided the best available evidence-based information to guide RPHNs/RMs in their practice. Once the draft guideline received majority approval from the development group it was sent for steering group review.

**2.5** **Provide a summary of the evidence from the literature**

The National Maternity Strategy 2016-2026 (DOH 2016) recognises that for women, the transition to motherhood is an event of a huge social and emotional significance and the strategy aims to create a partnership approach to the delivery of maternity services in Ireland. The strategy recommends that the services are focused on, and responsive to, women and their individual needs. The strategy was developed following the HIQA (2013) report on the investigation into the safety, quality and standards of services provided by the HSE to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar. The HIQA report recommended that a strategy be developed to implement standard, consistent models for the delivery of a national maternity service that reflects best available evidence, to ensure that all pregnant women have appropriate and informed choices, and access to the right level of care and support. Although it is recognised that care in the postnatal period promotes optimal social, physical and emotional health and wellbeing of the mother and infant there is a lack of standardisation provided by PHNs in Ireland (Giltenane *et al*. 2020). The National Women & Infants Health Programme has been established to provide oversight and governance of maternity services, raising quality and standardising care.

Currently, the Health Act (1970) mandates that free healthcare is provided to new mothers by each of the regional health boards. This care is delivered by primary care services, maternity hospitals and community midwifery schemes. As most women return to their community within a few days of delivery, postpartum care is best delivered in a primary care setting (Haran *et al.* 2014). The World Health Organisation (WHO) recommends that the first postnatal visit following discharge from hospital is within 48-72 hours or within 24 hours of birth if home birth (WHO 2013c). The postnatal period begins following the delivery however the end of the postnatal period is not as clearly defined in the literature. As the maternal physiologic changes relating to pregnancy have largely returned to the pre pregnant state by 6 – 8 weeks this is often considered the end of the postnatal period (Berens 2021). However, it is not just physiologic changes and medical issues that need consideration during this time, RPHNs/RMs need to be aware of the psychological needs of the postpartum mother and also to be sensitive to cultural differences that may surround childbirth (Berens 2021). RPHNs/RMs have a key role in supporting child health, families and new babies, screening for postnatal depression, providing breast feeding support and checking the infant’s development, amongst other services (DOH 2016). The impact of the work of RPHNs with families who are vulnerable or at risk due to social disadvantage is particularly important. The focus of the RPHN programme is on identification, prevention and early intervention for families experiencing difficulties allowing appropriately based interventions to prevent situations deteriorating (DOH 2016).

The National Maternity Strategy (DOH 2016) acknowledges that the majority of postnatal care is provided by RPHNs, who visit mother and infant at home soon after their discharge from hospital. Home visits are identified as essential to support a new mother and infant. RPHNs/RMs are directed to prioritise the primary assessment of new mothers and babies within 72 hours of discharge from the hospital or midwifery service (DOH 2016). The mother is also entitled to a 6-week postnatal check up with her General Practitioner under the maternity and infant care scheme. The RPHN then reviews the mother at 3 months post-delivery. If there are no concerns or open issues on the care plan the mother is discharged from the RPHN caseload and primary care metrics at this time. Depending on the RPHNs assessment and subsequent care planning at any of these contacts, more visits may be necessary. In these cases, discharge from the RPHN caseload and primary care metrics would depend on these issues being resolved and the care plan subsequently closed.

At the first post natal contact both WHO (2013c) recommendations and NICE (2021) guidelines clearly identify the need for women to be advised on the signs and symptoms of potential life-threatening conditions, mental health and well-being, physical health and well-being and safety.

Coroners recommendations (2022) following the inquest into the death of a new mother have been incorporated into the recommendations in this guideline. These are available on request.

**Signs and symptoms of potential life-threatening conditions**

According to WHO the postnatal period is a critical phase in the lives of mothers as most maternal deaths occur during this time (WHO 2013c).The Confidential Maternal Death Enquiry (MDE) Ireland 2009-2018 reported a total of **54** maternal deaths occurring during pregnancy or up to 42 days postpartum (O’Hare *et al.* 2017). It has been estimated that for every maternal death there are nine women who develop severe maternal morbidity (SMM) (Plaat & Naik 2011). In a study of SMM for 2015 in 18 of the 19 maternity units in Ireland, the rate of SMM was 6.4 per 1,000 maternities (Manning *et al.* 2018).

Sepsis was the leading cause of direct maternal and mortality in both high- and low-income countries (MBRRACE, 2014). Sepsis was the leading cause of direct maternal mortalities in the Centre for Maternal & Child Enquiries (CMACE, 2011) and the second leading cause of maternal mortalities in the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiry (MBRRACE). The latest MBRRACE (2019) publication shows sepsis as the 4th leading direct cause with an increase in direct causes due to sepsis and an increase in indirect sepsis deaths from the previous report.

Irish data demonstrates an increase in reported diagnoses of both sepsis and infection. In 2018, there were 61,016 live births in Ireland, and 9,471 maternity patients (period from conception up to 42 days post-birth or miscarriage) were either admitted to hospital with an infection or diagnosed with an infection as an in-patient. 442 were diagnosed with sepsis. Identifying pregnant and postnatal women with sepsis can be particularly challenging as clinical and laboratory criteria may overlay with normal pregnant physiology (Parfitt & Hering 2018). The physiological changes of pregnancy, including an increase in heart rate (tachycardia), respiratory rate (tachypnoea) and cardiac output, combined with a rise in white cell count that peaks after delivery, can mask sepsis indicators normally seen in the non-pregnant population. If these observations are persistently abnormal it is important to rule out a pathological reason. Additionally, the altered physiology of pregnancy and the postnatal period can result in women presenting with vague signs and symptoms of sepsis. It may be difficult to distinguish between normal and pathological states. Importantly, pregnant and recently delivered women have a significant capacity to compensate physiologically to major stresses to the body (such as haemorrhage or sepsis), and therefore signs of tachycardia or hypotension (reduced blood pressure) may not appear until late, when sudden clinical deterioration becomes apparent. Sepsis, therefore, requires a high index of suspicion, as it may be difficult to diagnose resulting in delayed initiation of appropriate treatment and significant morbidity or mortality. NICE (2016) guidance on sepsis: recognition, diagnosis and early management stresses that women who are pregnant, have given birth or had a termination of pregnancy or miscarriage in the past 6 weeks are in a high risk group for sepsis.

Three highly publicised maternal deaths have occurred in Ireland since 2007 identifying failings around assessment, monitoring and recognition of sepsis and septic shock. Mortality from maternal sepsis from direct causes is currently 0.5% (HSE 2019e) and 0.44 per 100,000 maternities (Knight M, 2019). The Irish data is based on the number of women who developed sepsis in Ireland during 2018 (HSE 2019e). In order for patients to have the best opportunity to survive they need to present for medical review and have sepsis recognised and managed in an appropriate and timely manner. There is an important role for primary and community care in terms of risk recognition and for public awareness of the signs and symptoms of deterioration that may signal the development of sepsis, in order to ensure the right patient is in the right place at the right time to receive the right treatment (DOH 2021).

Early warning systems (EWS) (or scores) are used by hospital teams to recognise early signs of critical illness and trigger more frequent bedside monitoring and escalation of care. The Irish Maternity Early Warning System (IMEWS) is the first obstetric early warning system to be implemented on a national scale worldwide. It has been implemented in the maternity hospitals and Self-Employed Community Midwife (SECM) services across the country. A sepsis recognition tool has been developed for use in the community if the RPHN/RM suspects sepsis (Appendix VII DOH 2021).

Based on the Sepsis Management for Adults (including maternity) Clinical Guideline (DOH 2021) and UpToDate (2021) guidance, vital sign taking and recording is recommended for RPHNs/RMs at the first visit and the subsequent frequency of observations depends on clinical judgement. Berens (2021) in an UpToDate clinical review recommends a full set of vital signs in routine maternal care. UpToDate is a point of care tool clinical decision support resource associated with improved outcomes developed by Wolters Kluwer. There is a rigorous editorial process in developing the clinical decision tool. Each topic is assigned an author (a subject matter expert) and at least two separate physician reviewers. This group works together to perform a comprehensive review of the literature, culminating in clear recommendations for treatment and screening which allow clinicians to improve care. These recommendations are always based on evidence.

Thermometers may be tympanic probe type or infra –red non-contact devices. Thermometers used for this purpose must have a calibration function. Clinical thermometry is governed by International Standard BS EN ISO 80601‐2‐56:2017, which stipulates the need for regular calibration and maintenance as per manufacturer’s instructions (Royal Marsden 2021).

Blood pressure should be measured with a calibrated aneroid device or an automated machine that has been validated for use in pregnancy. Blood pressure should be measured with an appropriately sized cuff. If the mid-arm circumference is greater than 33cm, a large cuff should be used. Automated methods need to be used with caution, as even devices validated in pregnancy may underestimate blood pressure readings in pre-eclampsia. Therefore, a comparison using a calibrated aneroid device is recommended. All devices, whether aneroid or automated, need to be calibrated for accuracy regularly (HSE 2016b). STRIDE BP is an international scientific non-profit organization founded by hypertension experts with the mission of improving the accuracy of blood pressure measurement and the diagnosis and management of hypertension. STRIDE BP provides international guidance and practice tools on the methodology and technology for accurate blood pressure evaluation according to the latest scientific evidence. A list of recommended devices for use in pregnancy and postpartum is available on the website [www.Stridebp.org](file:///C:\Users\slawlor\Desktop\PNR\www.Stridebp.org)

WHO (2013) and NICE (2021) guidelines advise that women (and their partners) are informed of the signs and symptoms of potentially serious/life threatening conditions, and she should seek medical advice without delay if any of these occur:

• Signs and symptoms of PPH: sudden or very heavy vaginal bleeding or clots , or persistent or increased vaginal bleeding, faintness, dizziness, palpitations/tachycardia, which could indicate retained placental tissue or endometritis.

• Signs and symptoms of infection: fever; shivering; abdominal, pelvic or perineal pain, vaginal discharge with an unpleasant smell, dizziness, breathlessness, agitation or confusion.

• Signs and symptoms of thromboembolism: unilateral calf pain; tenderness, redness or swelling of calves; shortness of breath or chest pain.

• Signs and symptoms of hypertension, pre-eclampsia, postdural-puncture headache, migraine, intracranial pathology or infection: headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or hypochondrial pain, feeling faint, convulsions (in the first few days after birth).

• Signs and symptoms of Postpartum Psychosis; symptoms tend to appear shortly after the birth and can include restlessness, agitation and confusion, thoughts of harming herself or the infant.

These signs and symptoms are detailed in the My Pregnancy book page 209 (NHCP 2018) given to all expectant mothers during pregnancy by their antenatal care provider. This book can be downloaded [www.mychild.ie](http://www.mychild.ie) if the mother has mislaid her copy. A QR code is available in the PHN postnatal information sheet (Appendix VI). This information sheet also gives details of information resources for mothers.

The other critical maternal health outcomes to be considered in this period are maternal morbidities. These include haemorrhage, infections, anaemia and depression (WHO 2013c). The Irish MAMMI (Daly *et al.* 2020) study has found that although many women experience motherhood in excellent physical health and enjoy the emotional fulfilment that it brings, other mothers experience health problems, sometimes caused by pregnancy or an event that happens during or after the infant's birth. Effective care should be underpinned by evidence-based guidelines which aim to enhance patient care and ensure consistency of care across the service. The MAMMI (**M**aternal health **A**nd **M**aternal **M**orbidity in **I**reland) study began in 2013 and has been undertaken by researchers in Trinity College, Dublin. The aim of the MAMMI study is to identify the existence, extent and severity of maternal morbidities in nulliparous women before and during pregnancy and up to one year postpartum. Women were asked about their health and wellbeing at 3 monthly intervals for 1 year following the birth of their first infant. Over 3000 women were recruited to the study and there was a 70% retention rate of the participants at the end of the first year. This is the largest study of the postpartum period for women giving birth in Ireland. The women were asked about the following areas of their health and wellbeing; general health, mental health, readmission to hospital, pelvic girdle pain, urinary incontinence, anal incontinence, sexual health, intimate partner violence, caesarean section, diet and physical activity. The study has now expanded to include a second infant follow-up postnatal survey at 6 and 12 months and also a 5 year follow up study. Table 1 depicts some of the findings from the MAMMI study. Table 2 depicts what women reported in the MAMMI study regarding contacts with healthcare professionals (Daly *et al.* 2020).

**Table 1**

|  |  |
| --- | --- |
| **Morbidity** | **Percentage of women reporting problem at 12 months postpartum** |
| Urinary Incontinence | 48.1% |
| Faecal Incontinence | 4.8% |
| Sexual health issues | 64.0 % |
| Pelvic Girdle Pain (including Back pain) | 79.1% |
| Depression | 12.0% |
| Anxiety | 9.0 % |
| Painful/sore perineum | 3.1% |
| Pain from CS wound | 2.2 % |

**Table 2**

|  |  |
| --- | --- |
| **Contact with healthcare professionals** | **Percentage of women reporting RPHN/RM did NOT ask me about . .** |
| Tiredness or Exhaustion | 29.1% |
| Involuntary loss of urine | 64.6% |
| Involuntary loss of bowel motions | 70.1 % |
| Haemorrhoids | 78.4% |
| Perineal pain | 54.8% |
| Feeling Depressed or low | 35.4 % |
| Sexual health problems | 90.3% |
| Relationship problems | 83.7 % |

The impact of these maternal morbidities should not be underestimated. Research by Haran *et al.* (2014) reports that nearly 70% of women describe at least one physical problem within the first 12 months postpartum. For 25% of these women the problem is deemed to be of moderate severity and 20% have severe problem these problems include tiredness, backache, headaches, perineal and caesarean wound pain. As a consequence to these physical problems other areas of mother’s lives are impacted. There is an increase in women’s functional limitations including their ability to work, look after children or undertake household tasks, and an increase of depressive symptoms (Haren *et al.* 2014). Prevention and reduction of short, medium and long-term consequences can be achieved through effective postpartum care in the community (Haren *et al.* 2014).

It is known from the National Maternity Experience Survey (2020) findings that women want to be informed and they value the opportunity for choice. It has been shown that caring and respectful relationships with healthcare providers can significantly contribute to the overall birth experience. The quality of staff relationships, the strength of communication, non judgemental sensitive questioning and the extent of continuity of care are other key elements that positively impact on women’s overall experiences. Support with feeding, respect for preferences and consistent messages build confidence and trust in healthcare providers (HSE 2020d). For women, being treated with dignity and respect and being fully involved and treated as shared experts in the decision making about their maternity care, being fully informed about physical and mental health changes that occur during pregnancy, having someone to talk to about their worries and fears are key factors for a positive experience.

**Physical health and wellbeing**

WHO (2013) recommends a full postnatal check of the mother during the primary visit. At any subsequent postnatal contact, enquiries should continue to be made about general well-being and assessments made regarding the following: micturition and urinary incontinence, bowel function, healing of any perineal wound, headache, fatigue, back pain, perineal pain and perineal hygiene, breast pain, uterine tenderness and lochia (WHO, 2013). NICE (2021) postnatal care guideline recommends assessing the woman for signs and symptoms of infection, pain, thromboembolism and also assessments of postpartum bleeding, bladder function, bowel function, breast and nipple discomfort.

**Mental health and well-being**

**The following section is adapted from:**

* **Mind Mothers Study Perinatal mental Health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland (Higgins *et al*. 2017b)**
* **Antenatal and postnatal mental health: clinical management and service guidance (NICE Clinical guideline 192 2014).**
* **Postpartum unipolar major depression: Epidemiology, clinical features, assessment, and diagnosis (UpToDate 2021 Viguera, A).**

For most women, pregnancy and motherhood is a positive psychological process, however for some women this life changing event can be associated with psychological distress and mental health problems. Fluctuating emotions from excitement, joy and love to sadness, fear or anxiety are a normal part of adjusting to changed circumstances (Raynor & England 2010). For many women these emotions subside with support empathy, rest and reassurance (Higgins *et al*. 2017b).

The focus of the literature is primarily on depression in the perinatal period, however other mental health problems can and do occur during pregnancy and the postnatal period; anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth (NICE 2014a). NICE (2014a) recommends that mothers with severe symptoms (eg, suicidal ideation with a specific plan and intent, suicidal behaviour, or command auditory hallucinations) should be referred to an emergency department.

Post natal depression is a category of depression that is prevalent within the first few months of the postnatal period (Swain *et al*. 1997 cited in Hill 2010). Most cases develop within the first three months after delivery, with the highest incidence occurring within the 4-6 week period postnatally (Cooper *et al*. 1988, Hewitt & Gilbody 2009, Cox *et al*. 1993 cited in Hill 2010). It is estimated that 15-25% of women will experience a mental health problem either during pregnancy or in the first year postpartum (Higgins 2017b). Between 2006 and 2008 there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK, resulting from mental health problems (NICE 2014).

Despite the prevalence of perinatal mental health problems they frequently go unrecognised. Providing psychological and mental health support to mothers, children and families in the perinatal period is now considered a vital health issue, as early detection and intervention helps improve maternal and infant outcomes, alongside reducing the potential risks of accidental or intentional harm to the mother, infant, other children and the family (Higgins 2017b).

UpToDate (Berens 2021) and NICE (2014a) recommend that primary care clinicians screen all postpartum women, and that screening be implemented with services in place to ensure follow-up for diagnosis and treatment. The rationale for screening is that postnatal depression is serious, prevalent, under-recognized, and treatable, and that standardized, valid screening tools are available. Patients who screen positive, either with a screening instrument or a few clinical questions, require a clinical interview to make the diagnosis. As part of postnatal care mothers can be informed about postnatal mental health problems and how to recognize early symptoms and seek appropriate intervention.

Postpartum depression is often not recognized by women and clinicians because the somatic symptoms of depression overlap with some of the usual discomforts of the acute puerperium, such as fatigue, difficulty sleeping, poor appetite, and low libido. These somatic symptoms should be evaluated in the context of normal expectations for the postpartum period. As an example, lack of energy to the point that patients cannot get out of bed for hours is abnormal and should be distinguished from the normal lack of energy that results from sleep deprivation and caring for an infant. Although postpartum insomnia is common, patients who are unable to sleep even when their babies sleep may have postpartum depression. Women are often reluctant to discuss their depressive symptoms, perhaps because of perceived social expectations that new mothers are happy, which may engender embarrassment, guilt, and stigma. In addition, some mothers fear that their babies will be taken away by child welfare agencies (UpToDate 2021). Mental health problems during and after pregnancy not only have implications for the psychological and physical welfare of the woman but also have implications for the infant and whole family if women are left without support and care (Oates and Cantwell 2011).

NICE (2014a) and Higgins *et al*. (2021) recommend the following screening questions in the postnatal period:

|  |  |  |
| --- | --- | --- |
| Screening Questions | Mind Mothers Project (Higgins *et al.* 2021) |  |
| Q 1 | During the past month, have you often been bothered by feeling down, depressed or hopeless? | Yes/No |
| Q 2 | During the past month, have you often been bothered by having little interest or pleasure in doing things? | Yes/No |
| Q3 | During the past month, have you been feeling nervous, anxious or on edge? | Yes/No |
| Q4 | During the past month, have you not being able to stop or control worrying? | Yes/No |
|  | **If yes to any of the questions**: Is this something you feel you need or want help with? |  |

If a woman responds positively to any of the screening questions or is at risk of developing a mental health problem, or there is clinical concern, consider if trained to do so, using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) as part of a full assessment or referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional (NICE 2014).

**HSE Specialist Perinatal Mental Health Services**

<https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/>

The HSE’s National Specialist Perinatal Mental Health Services Model of Care describes the specialist (secondary and tertiary care) component of an overall perinatal mental health service. This Model of Care supports the seven actions on mental health to be implemented by the HSE’s National Women & Infants Health Programme outlined in Ireland’s first National Maternity Strategy and launched by the Minister for Health in January 2016. Whilst the focus of this specialist service will be women with moderate to severe mental illness, it ensures women with milder mental health problems will be both identified and receive appropriate help from skilled staff within maternity services through the development of the role of the mental health midwife nationally. There are 19 maternity services in Ireland. In each hospital group, the maternity service with the highest number of deliveries is the designated hub. In the smaller maternity services, mental health midwives are being employed to work with liaison mental health teams. Access to the service is through the GP or through the booking clinic and the mental health midwife in both hub and spoke sites. Each hub within a hospital group should have a specialist perinatal mental health service. It’s staffing is multidisciplinary and led by a consultant psychiatrist in perinatal psychiatry. In the remaining maternity units (13) referred to as "spokes", the liaison psychiatry team continues to provide the input to the maternity service with the addition of a mental health midwife. This team will be linked to the hub specialist perinatal mental health teams for advice, regular meetings, training, education and clinical opinions.

The **Healthcare staff Specialist Perinatal Healthcare App** is designed to provide the latest information to assist frontline staff in their roles, providing information and services to women seeking information, advice and support for mental health problems in pregnancy and the first year post-partum. The app is regularly updated with new content, weekly MCQ questions and information on news and event related to perinatal mental health services. Available at: <https://PMH.healthcarestaff.app>

There is growing literature regarding paternal perinatal depression. The estimates of prevalence vary from 1 % to 46 % across studies. Several sociodemographic variables that contribute to depression in fathers in the perinatal period were reported and these include paternal age, lower education levels, parity, an unplanned pregnancy, and maternal depression. Paternal perinatal depression is associated with morbidity within the father’s family, including depression in his partner, maladjustment to parenthood and future psychological problems in his children (Philpott *et al*. 2020).

**The following section is an extract from the National Infant Feeding Policy for Primary Care Teams and Community Health Organisations (HSE 2019c).**

The Global Strategy for Infant and Young Child Feeding (WHO/UNICEF, 2003, p.8) supports exclusive breastfeeding for six months from birth ‘with timely adequate, safe and appropriate complementary feeding, while continuing breastfeeding for two years and beyond’. There is much evidence that breastfeeding is important for the health of both the mother and her infant (Victora *et al.* 2016). The National Maternity Strategy 2016-2026’ (DoH, 2016) identified areas of concern in breastfeeding. These concerns included ‘lack of breastfeeding support in the hospital, community and the home setting’. The overarching aim of the Breastfeeding Action Plan 2016 – 2021 is to increase breastfeeding initiation and duration rates, by supporting and enabling more mothers to breastfeed. A ‘Review and Evaluation of Breastfeeding in Ireland – A 5 year Strategic Action Plan 20052010’ (Mc Avoy *et al*. 2014, p.10) identified as determinants of breastfeeding in Ireland ‘cultural, social and economic circumstances of the mother as well as aspects of maternal age, education and self efficacy’. This review included among other factors poor latch, nipple pain, perceived insufficient milk supply and fatigue as barriers to continued breastfeeding (Mc Avoy *et al*. 2014, p.184). ‘Breastfeeding is a natural process, however mothers may require support, knowledge and education’ (Royal College of Paediatrics and Child Health, 2017, p. 3). A recent umbrella review investigating interventions that promote increased breastfeeding rates conducted by the Health Research Board (Sutton *et al.* 2016) concluded that there is substantial and consistent evidence that education, counselling and support are required during the antenatal period through to the extended postnatal period. This support is more effective if provided ‘face to face and on an ongoing and scheduled basis’ (Sutton *et al.* 2016, p. 58). This face to face support provided by appropriately trained health professionals or peer counsellors is effective in improving breastfeeding duration and exclusivity (McAvoy *et al*. 2014). A Cochrane review (McFadden *et al*. 2017) of support for breastfeeding mothers with healthy term babies highlighted, support when offered to women increases the duration and exclusivity of breastfeeding. According to this review (McFadden *et al*. 2017) this support is effective if offered by trained personnel, professional or lay, during the antenatal and postnatal period, and works best if it involves scheduled visits and is structured to meet the needs of the population.

**Domestic, Sexual and Gender Based Violence (DSGBV)**

In 2016, the National Social Inclusion Office in the Health Service Executive (HSE) commissioned a national training programme to support front-line HSE staff to develop the skills to recognise and respond to victims of DSGBV in vulnerable or at-risk communities. The development of a training programme aligns with the Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021), specifically in relation to Action 1.100: Awareness-raising for professionals who work with persons who are at high risk, marginalised or have specific needs, and Action 1.500: Develop and deliver education/training modules, both initial training and developmental training, for continual delivery to specific target groups in the public sector, i.e. the HSE, with a focus on establishing standards, addressing quality improvement, and measuring outcomes. The training also responds to Ireland’s second National Action Plan on Women, Peace and Security (2015-2018), specifically under Pillar 3: Protection, relief and recovery. The HSE is developing training for frontline staff – this will be delivered to RPHNs/RMs.

**The following section was developed from the work of the working group for the development of a Domestic Abuse PHN led initiative – Limerick CHO 3**

Marie Boyle ADPHN HSE West CHO3

Brenda Mellett Child Health Programme Development Officer, Mid West Community Healthcare

Mary O’Dwyer -Replaced by Maya Dafinova ABC Start Right Programme Manager

Eimear Laffan PHN

Sinead McGuire Principle Social Worker

Ann Hegarty Chief Medical Social Worker ULHG

Monica McElvaneyDirector of Services**,** Adapt House

Denise Dunne Training and Development Co-ordinator, Adapt House

Detective Sergeant Vincent Brick ,An Garda Síochána replaced by Detective Sergeant Gerard Staunton

Sylvia Murphy-Tighe Lecturer University of Limerick

Domestic abuse is a global problem, which can result in dire consequences, even death. The term “Domestic abuse”, used interchangeably with domestic violence, intimate partner violence (IPV) and family violence, is defined “as a pattern of behaviour involving the threat or use of physical, sexual, emotional and/or psychological abuse in close adult relationships (HSE 2019a). However, definitions vary internationally. The UK includes ‘honour’ based violence, female genital mutilation in its definition (Home Office 2012). Coercive behaviour is recognised by the Irish government as a feature of domestic abuse, and is treated as a crime in accordance with the Domestic Violence Act (2018).

The World Health Organisation (WHO 2013) report that between 15 and 70% of women experience domestic abuse worldwide. Irish statistics mirror these figures, with Safe Ireland (2015) reporting that one in four women experience physical and sexual violence from a male partner. Domestic abuse can escalate to femicide (UNODC, 2019). The Violence Policy Centre, USA (2018) reports that 63% of female homicides are committed by an intimate partner. 7 women died violently in Ireland because of domestic abuse in 2018 (Woman’s Aid 2018).

Domestic abuse results in physical harm and injury, psychological trauma, depressive disorders, loss of reproductive control and even death (WHO 2003b; Ellsberg *et al*. 2008; Devries *et al*. 2011, Pallitto *et al*. 2013). The social impacts of domestic violence are immense, resulting in poverty, homelessness, poor productivity and absenteeism from the workplace, with multi-generational cycles of violence often-evident (Safe Ireland 2015). Pregnancy and early motherhood is a time of increased risk, often with domestic abuse beginning or escalating in pregnancy and the postpartum period (Finnbogadóttir and Dykes 2016). The impacts to both mother and infant are well documented (WHO 2013a).

Screening aims to identify women who are experiencing or have experienced domestic abuse in the past with a view to offering an intervention such as information, safety planning and/or onward referral. Universal screening remains controversial. O’Doherty *et al.* (2015) report that although screening increases identification of domestic abuse, there is a lack of evidence of the effect of screening on other outcomes such as referral, re-exposure to violence, health impacts or harm arising from screening. Despite the contentious evidence base on whether universal screening, routine enquiry or a more case-finding approach is preferred, many health sector policies and guidelines recommend domestic abuse screening (HSE 2019a, NICE 2016, Niolon *et al*. 2017; US Preventive Services Task Force 2018). NICE (2016) recommends routine questioning about domestic abuse by “trained” staff in the antenatal and postnatal period, although not without the support of guidelines and referral pathways.

Most women do not object to being asked about domestic abuse (Usta *et al.* 2012). Haggblom and Moller (2007) and Pratt-Eriksson *et al*. (2014) report mixed experiences of women seeking help depending on the individual they met; with regard to nurses, some understood, while others were non-responsive, devoted more attention to physical ailments or even justifying the abuse, leaving the women feeling ashamed. Many nurses and women express the need to build a trusting relationship prior to screening (Bacchus *et al*. 2016, Hooker *et al*. 2016, Jack *et al*. 2017, Burnett *et al*. 2019). Salmon *et al*. (2015) note that, although women may choose not to disclose, asking the question indicates to her that she can disclose during another contact. Barriers to disclosure include feelings of discomfort, fear of perpetrator finding out, and not considering the abuse serious enough (Spangaro *et al*. 2010).

The safety of women and children and health care staff is paramount when dealing with domestic abuse. Evidence shows strong links between domestic abuse and child abuse (Antle *et al*. 2007, Holt *et al.* 2008). In Ireland, PHNs have a role in safeguarding children and have a legal obligation to report child protection concerns (Children First Act 2015).

The community setting presents different challenges to the acute and maternity services, when identifying and responding to domestic abuse and safety issues for women, children and PHN’s must be considered. PHNs have a mandate to visit all mothers after discharge from maternity services, and are ideally placed to give women the opportunity to disclose and signpost women experiencing abuse to additional supportive services, in a safe and confidential manner (Leahy-Warren 2007, Bradbury-Jones & Broadhurst 2015). PHNs have a unique way of establishing a trusting relationship with women, through home visiting and continuity of care (Begley *et al*. 2004). However, PHNs approach to identifying and responding to domestic abuse can greatly affect a mother’s ability to disclose and seek help.

Gaining knowledge and confidence in dealing with domestic abuse and having a clear process to respond to a domestic abuse disclosure is important to community nurses (Hooker *et al*. 2015, Bacchus *et al*. 2016, Hooker *et al*. 2016, Anderzen-Carlsson *et al*. 2018, Burnett *et al*. 2019). Training and skills development prior to implementation of a domestic abuse intervention are vital to success, as are continuous professional development, and refresher training sessions (Hooker *et al*. 2015, Bacchus *et al*. 2016, Hooker *et al*. 2016, Anderzen-Carlsson *et al*. 2018, Burnett *et al*. 2019). Domestic violence training would enhance confidence to open the conversation in a safe and supportive manner. Being adequately and appropriately responded to, having made a disclosure, would enable women to voice their experiences and, perhaps, begin their journey to recovery (Bradbury-Jones & Broadhurst 2015, Pratt-Eriksson *et al*. 2014).

**Child Protection and Welfare**

Every infant and child is dependent on the capacity of the parents to reach his/her normal growth and development potential. Parent/s unmet needs can be a disenabling factor for the child’s well-being and well-becoming. Where an issue/concern is raised either by a parent and/or child it should elicit a response from the RPHN/RM. PHNs/RMs should be particularly concerned regarding children where the parent/s are experiencing difficulties in meeting the needs of the child/children as a result of alcohol/drug misuse, domestic abuse/violence, mental health problems, learning disability, poverty or where there are risk factors as outlined in Child and Family Health Needs Framework. Accordingly, it is in the context of these domains: child development, parenting capacity, and family and environmental factors that the RPHN/RM carries out on a Child and Family Health Needs Assessment (CFHNA) when there are concerns. Refer to the Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service (HSE 2021a). Where a RPHN/RM identifies any area of concern e.g. developmental delay; disability; physical health problem; parenting capacity; family and environmental issues a referral should be made to the appropriate services. Assessments can be discussed with the ADPHN if support is required.

**Health Promotion**

The MAMMI (Daly *et al*. 2020) study reported that mothers struggled to find reliable, trustworthy information and felt they were alone to suffer in silence. As a result of this the MAMMI study engaged with women to co-develop resources for mothers. The women were asked to share what they would have liked available, the response was;

* to know what is and is not normal,
* what you can do to help yourself and
* how to recognise when to seek professional help

The following evidenced based online resources have been developed for mothers and are all available free of charge.

**Journey to birth**

This is a 6-week online resource for mothers on how to prepare their body and mind for birth with research-based advice.

**Women’s Health after motherhood** (WHAM)

A session on taking care of physical and mental health after giving birth

**On – Track (Towards Recovery After Childbirth, through Knowledge)**

These are a series of self-help educational videos on perinatal anxiety, postnatal sexual health and pelvic girdle pain. The videos aim to help women understand the common health issues that may occur in these areas and their impact on everyday life. The videos also instruct the woman on when and how to seek professional help. The videos are currently available in 3 languages.

See Appendix VI for the PHN service Postnatal Information sheet with links to the WHAM and On-Track resources.

By providing appropriate information and supports, maternity services can make ‘every contact count’ to support behaviour change, in particular around reducing lifestyle behaviours with harmful effects such as smoking, as well as increasing protective measures such as immunisation, improved nutrition and physical activity. In addition, it is important that supports and interventions on overall health and wellbeing, including mental health and sexual health, are addressed and supported into the postnatal period (DOH 2016).

**LEGAL CONSIDERATIONS**

**Consent requirements**

The HSE National Consent Policy (HSE 2022a) defines consent as the giving of permission or agreement for a treatment, investigation, receipt or use of a service an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/her to understand the nature, potential risks and benefits of the proposed intervention or service. The HSE National Consent Policy (HSE 2022a) notes that the amount of information provided and the degree of discussion needed to obtain valid consent will vary with the particular situation. For consent to be valid, the service user must:

- Have received sufficient information in a comprehensible manner about the nature, potential risks and benefits of the proposed intervention, of any alternative intervention and of not receiving the intervention;.

- Not be acting under duress.

- Have the capacity to make the particular decision (even if requiring support to do so).

The HSE National Consent Policy (HSE 2022a) notes that the meaning of sufficient information will depend on both the individual circumstances of the service user and on the nature and extent of the intervention/service.

**When the mother is less than 16 years of age**

If the mother is below the age of 16 years, a parent(s)/ legal guardian(s) can consent to the treatment of the child (and for a child below the age of 18 being treated for a mental disorder covered by the Mental Health Act, 2001). The National Consent Policy (HSE 2022a) policy acknowledges that in health and social care practice it is usual to involve parent(s)/legal guardian(s) and seek their consent when providing a service or treatment to a minor under 16. While currently there are no legal provisions in Ireland for minors under 16 years to give consent on their own behalf, it is nonetheless good practice to involve the minor in decisions relating to them and listen to their wishes and concerns in terms of their treatment and care. However, the minor may seek to make a decision on their own without parental involvement or consent. In such circumstances it is best practice to encourage and advise the minor to communicate with and involve their parent(s) or legal guardian(s). It is only in exceptional circumstances that, having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, health and social care interventions would be provided for those under 16 without the knowledge or consent of parent(s) or legal guardian(s).

**When consent is refused**

If an adult with capacity to make an informed decision makes a voluntary and appropriately informed decision to refuse treatment or service, this decision must be respected, even where the service user’s decision may result in his or her death. In such cases it is particularly important to accurately document the discussions with the service user, including the procedure that has been offered, the service user’s decision to decline and the fact that the implications of this decision have been fully outlined (HSE 2022a). Refer to HSE’s National Consent Policy for further details.

**General Data Protection Regulations (GDPR)**

The HSE Data Protection Officer has produced a number of guidance documents in

relation to GDPR.

- HSE Data Protection Policy [(https://www.hse.ie/eng/gdpr/hse-dataprotection-policy/hse-data-protection-policy.pdf)](file:///C:\Users\slawlor\Desktop\PNR\(https:\www.hse.ie\eng\gdpr\hse-dataprotection-policy\hse-data-protection-policy.pdf))

- HSE Privacy Notice - Patients and Service Users

(<https://www.hse.ie/eng/gdpr/hse-data-protection-policy/hse-privacynoticeservice-users.pdf)>

- HSE GDPR Frequently Asked Questions [(https://www.hse.ie/eng/gdpr/gdprfaq/hse-gdpr-faqs-public.pdf)](file:///C:\Users\slawlor\Desktop\PNR\(https:\www.hse.ie\eng\gdpr\gdprfaq\hse-gdpr-faqs-public.pdf))

In order for the HSE to provide its services to service users, it collects and processes

various categories of personal information such as:

- Personal details (date of birth, address, next of kin, contact details)

- Notes and reports about a service users health needs

- Results of investigations such as X-Rays and laboratory tests

- Relevant information from other health and social care professionals,

service users, carers and relatives

The HSE may also process certain special categories of information which may include

racial or ethnic origin, religious or philosophical beliefs and the processing of genetic

data, biometric data for the purposes of uniquely identifying a person, data

concerning health or data concerning a person’s sex life.

The HSE’s legal basis for processing personal data of service users is as follows:

- The processing is necessary in order to protect the vital interests of the person (data subject). This would apply in emergency situations such as in the Emergency Department when unconscious, sharing information with emergency services for rescue or location in storms etc.

- The processing is necessary for a task carried out in the public interest or in the exercise of official authority vested in the data controller (HSE) by the Health Act 2004.

Special categories of data are defined by GDPR and include things like racial or ethnic

origin, religious or philosophical beliefs, genetic data, biometric data, health data, sex

life details and sexual orientation.

The HSE will only process special categories of data where it is necessary.

- For the purposes of preventive or occupational medicine

- For the assessment of the working capacity of an employee

- For medical diagnosis

- For the provision of healthcare, treatment or social care

- For the management of health or social care systems and services, or

- Pursuant to a contract with a health professional

Processing is lawful where it is undertaken by or under the responsibility of:

- A health practitioner, or

- A person who in the circumstances owes a duty of confidentiality with the data subject that is equivalent to which would exist if that person were a health practitioner. For example, the outpatient clinic secretary, Emergency Department receptionist, Primary Care Centre staff etc.

If the purpose of the processing is for a reason other than the reasons above (i.e.

research), the HSE will seek explicit consent to process a service user’s sensitive

personal data.

**Sharing information within the HSE**

Within the HSE, the clinical information collected by a doctor or other healthcare

professional or staff member authorised to process a service users’ data is not passed

on to others within the HSE, unless it is considered necessary for their health or social

care needs or for one of the other reasons set out in the Data Privacy Notice.

**Freedom of Information**

The 2014 Freedom of information Act provides every person with the legal right to access official records held on them by the HSE. The RPHN/RM should ensure that information regarding the mother is documented only in the maternal postnatal record and not in the child health record. Only the mother or her designate should have access to her personal data in the maternal postnatal record.

**Documentation**

Professional record keeping and the documentation and interactions between the patient and healthcare professional are key features in clinical practice. The maintenance of accurate records is also essential given the professional and legal requirements on healthcare practitioners to ensure high standards of practice in this area (NHCP 2020b). The Nursing and Midwifery Board of Ireland (NMBI highlights the importance of appropriate and high-quality documentation in the Code of Professional Conduct (NMBI 2021).

NMBI (2015b) advise that the maintenance of good clinical records is essential for nurses and midwives. The professional guidance states that at a minimum a patient record should include the following:

* An accurate assessment of the person’s physical, psychological and social well-being, and, whenever necessary, the views and observations of family\* members in relation to that assessment.
* Evidence of decision-making and care delivery by nurses and midwives.
* An evaluation of the effectiveness, or otherwise, of the nursing/midwifery care provided.

\*Refer to Recording Clinical Practice Professional Guidance (NMBI 2015b) for more detailed guidance if required.

The maternal postnatal record is used only for the current episode of care following delivery. In the event the mother goes on to have a subsequent delivery a new maternal postnatal record should be opened. The maternal postnatal record is a separate element that is inserted into the maternal record section of the national standardised child health record temporarily. It must not become a permanent element of the child health record (NHCP 2020b). It should be removed and archived (See point A4.9).

**Infection prevention and control considerations (IPC)**

NCEC Draft Guidance on Infection Prevention and Control 2022 (January 2022d). The guideline will be replaced by an approved NCEC Guideline as soon as possible. All staff should refer to [www.hpsc.ie](http://www.hpsc.ie) website for these and updated IPC publications.

The IPC guidance is based on the following core principles:

• An understanding of the modes of transmission of infectious microorganisms and

risk management.

• Effective work practices that minimise the risk of transmission of infectious

microorganisms.

• Governance structures that support the implementation, monitoring and reporting of

IPC work practices.

• Compliance with legislation, regulations and standards relevant to infection control.

The purpose of IPC is to support appropriate and safe healthcare. Effective IPC is central to providing high quality healthcare for patients and a safe working environment for those that work in healthcare settings. Healthcare associated infections (HCAIs) are infections that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAIs includes any infection contracted as a direct result of treatment in a health or social care setting or as a result of healthcare delivery in the community. It is possible to significantly reduce the number of HCAIs through effective IPC. Involving patients and their carers is essential to successful IPC in clinical care. Patients need to be sufficiently informed to be able to participate in reducing the risk of transmission of infectious microorganisms. *Standard Precautions* and *Transmission Based Precautions* are detailed in the IPC guidance. They include advice regarding hand hygiene, use of Personal Protective Equipment, Handling and disposing of sharps, precautions regarding droplet transmission, cleaning of equipment etc. Refer to HSE’s Guidance on Infection Prevention and Control for further details.

**2.6 Detail resources necessary to implement the PPPG recommendations**

* The design and printing of new integrated maternal postnatal record will be incorporated into the existing child health record. A standalone maternal record has been designed for use for mothers discharged without an infant.
* Higher Education Institutes (HEIs) will be required to provide education to student PHNs based on this national guideline. The education should be standardised across the 3 HEIs that offer the Higher Diploma in Public Health Nursing.
* Education of RPHNs/RMs on the use of this guideline and accompanying record will be online modules supported by nurse/midwifery tutors from the Centres for Nursing and Midwifery Education.
* Some DPHN areas will be required to purchase equipment for vital signs monitoring, in other areas this equipment is already in use.

**2.7 Outline of PPPG Steps/Recommendations**

See part A

# 3.0 GOVERNANCE AND APPROVAL

## 3.1 Outline formal governance arrangements

The Directors of Public Health Nursing Forum and The National Women & Infants Health Programme (NWIHP) requested the development of a national standardised maternal post natal record for mothers who are discharged home from hospital, or who have their babies at home and who receive post natal care from Registered Public Health Nurses and Registered Midwives working within the PHN service. A Steering Group for the development of a national postnatal record and associated guidance was formed and this national guideline was commissioned by the Steering Group. Final approval of the guideline was issued from National Community Operations and the Nursing and Midwifery Services Director. Follow up reviews will be initiated by National Lead for PHN service. This national document will be submitted to the National Central Repository Office for referencing. Refer to Appendix IV for Membership of the Approval Governance Group. Steering Group membership is available in Appendix IV.

## 3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final guideline to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the guideline was submitted to Community Operations and to the Office of the Nursing and Midwifery Services Director to confirm that all stages in the revision of the guideline had been completed and met the National Standards for Clinical Practice Guidance (NCEC, 2015). The guideline was approved for national implementation. A signed and dated master copy will be retained within the Office of the Nursing and Midwifery Services Director, Dr Steeven’s Hospital.

## 3.3 Attach any copyright/permission sought

No copyright or permissions are required in relation to this guideline

## 3.4 Insert approved PPPG Checklist

|  |  |
| --- | --- |
| **Standards for developing Clinical PPPG** | **Checklist** |
| **Stage 1 Initiation** |  |
| The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional,  local) and applicable settings are described. | √ |
| Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise. | √ |
| The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG. | √ |
| The target users and the population/patient group to whom the PPPG is meant to apply are specifically described. | √ |
| The views and preferences of the target population have been sought and taken into consideration (as required). | **√** |
| The overall objective(s) of the PPPGs are specifically described. | √ |
| The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care). | √ |
| Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups. | √ |
| Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant. | √ |
| The PPPG is informed by the identified needs and priorities of service users and stakeholders. | √ |
| There is service user/lay representation on PPPG Development Group (as required). | √ |
| Information and support is available for staff on the development of evidence-based clinical practice guidance. | √ |

|  |  |
| --- | --- |
| **Stage 2 Development** | **Checklist** |
| The clinical question(s) covered by the PPPG are specifically described. | √ |
| Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented). | √ |
| Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described). | √ |
| The health benefits, side effects and risks have been considered and documented in formulating the PPPG. | √ |
| There is an explicit link between the PPPG and the supporting evidence. | √ |
| PPPG guidance/recommendations are specific and unambiguous. | √ |
| The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research. | √ |
| There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. | √ |
| Budget impact is documented (resources required). | √ |
| Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate). | √ |
| **Three additional standards are applicable for a small number of more complex PPPGs:**  Cost effectiveness analysis is documented.  A systematic literature review has been undertaken.  Health Technology Assessment (HTA) has been undertaken. | N/A |
|  |  |
| **Stage 3 Governance and Approval** | **Checklist** |
| Formal governance arrangements for PPPGs at local, regional and national level are established and documented. | √ |
| The PPPG has been reviewed by independent experts prior to publication (as required). | √ |
| Copyright and permissions are sought and documented. | N/A |
| **Stage 4 Communication and Dissemination** | **Checklist** |
| A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages. | √ |
| Plan and procedure for dissemination of the PPPG is described. | √ |
| The PPPG is easily accessible by all users e.g. PPPG repository. | √ |
|  |  |
| **Stage 5 Implementation** | **Checklist** |
| Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process. | √ |
| Barriers and facilitators for implementation are identified, and aligned with implementation levers. | √ |
| Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required). | √ |
| There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. | √ |
|  |  |
| **Stage 6**  **Monitoring, Audit, Evaluation** | **Checklist** |
| Process for monitoring and continuous improvement is documented. | √ |
| Audit criteria and audit process/plan are specified. | √ |
| Process for evaluation of implementation and (clinical) effectiveness is specified. | √ |
|  |  |
| **Stage 7 Revision/Update** | **Checklist** |
| Documented process for revisions/updating and review, including timeframe is provided. | √ |
| Documented process for version control is provided. | √ |

I confirm that the above Standards have been met in developing the following:

**Title of PPPG: Guideline on Maternal Postnatal Care in the Public Health Nursing Service**

**Name of Person(s) signing off on the PPPG Checklist:**

|  |  |
| --- | --- |
| **Name: Sinead Lawlor**  **Title: National Practice Development Coordinator for PHN services** | **Signature:SL signature**  **Date:** 11/11/2022 |

**This signed PPPG Checklist must accompany the final PPPG document in order for the PPPG to be approved.**

# 4.0 COMMUNICATION AND DISSEMINATION

**4.1 Describe communication and dissemination plans**.

A Guideline Development Group was established in September 2020 with membership representing key stakeholders. A draft of this guideline was circulated to all DPHNs nationally for review by their respective departments. Feedback was also sought from other key stakeholder groups. These stakeholders included the following; ONMSD, Higher Education Institutes (Nursing), CNMEs, Midwifery representatives, National Women and Infants Health Programme, Assistant Director of Nursing & Midwifery – Sepsis, National Healthy Childhood Programme, Mothers Advocacy group representation – AIMS, National Breastfeeding Coordinator, National Clinical Programme – Mental Health, Pre-hospital Emergency Care Council, National Data Protection Officer, INMO representatives, HSE social Inclusion, Royal College of Obstetricians and Gynaecologists and members of the guideline development group.

All feedback submissions were analysed and reviewed by the developmentgroup and incorporated into the guideline where appropriate. The final draft was submitted to the Steering Group for recommendation to National Community Operations: Primary Care and the Nursing and Midwifery Services Director for final approval. The approved document will be circulated to all DPHNs nationally for dissemination. A copy of the guideline is available on the HSE website to download at; [www.hse.ie/phn](file:///C:\Users\slawlor\Desktop\PNR\www.hse.ie\phn) and the guideline will be available on the HSE National Central Repository.The guideline will be made available to all RPHNs/RMs on the electronic policy portal. Communication in relation to this guideline will clearly identify that it replaces all guidelines in place locally.

# 5.0 IMPLEMENTATION

## 5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

As part of the exploring and preparing stage of implementation, existing guidelines in place in CHOs were reviewed prior to preparing the first draft of this national guideline (available on request). The draft copy of the guideline was circulated to all DPHNs for service review and feedback in February 2021 and October 2021. To implement and operationalize the guideline, updates and discussions took place with the national DPHN group. Existing channels of communication were utilised to inform all relevant staff of the guideline.

To implement and operationalise this guideline, maternal postnatal record documentation will be monitored by the ADPHN as per local procedures. The ADPHN will assess the application of this guideline through team meetings, professional supervision sessions and through caseload audit reviews. The implementation of this guideline supports RPHNs/RMs to provide timely intervention and support to mothers. This will be facilitated by ensuring that all RPHN/RMs are aware of, understand and utilise this guideline. In order to support implementation of the guideline each RPHN/RM will be required to sign a Signature Sheet (Appendix I) confirming that they have read, understood and agree to adhere to the guideline or have confirmed this through the electronic policy portal where it is in use.

## 5.2 Describe education/training plans required to implement the PPPG

## An education programme will be supported by the Centres of Nurse and Midwifery Education (CNME)/OMNSD and through HSEland classroom management system.

* Communication with the Higher Education Institutes responsible for student PHN education to ensure this guideline forms a component of the education programme.
* Local induction programmes for new nurses commencing employment will include briefing on all PPPGs approved for use within the PHN Service.

## 5.3 Identify lead person(s) responsible for the implementation of the PPPG.

## At national level the National Lead for Public Health Nursing and the National Practice Development Co-ordinator for PHN service will lead on the implementation of this guideline and address issues arising nationally with implementation with the support of an implementation group.

**5.4 Outline specific roles and responsibilities**

**National lead for PHN service and the Steering Group for the Development of a National Postnatal Record and associated guidance** isresponsible for developing and recommending this national guideline for use to Primary Care Operations and Nursing and Midwifery Services Director for approval. On approval the Group will ensure the final approved copies are circulated to all DPHNs nationally. The national lead for PHN service is responsible for triggering the review of this guideline.

**National Practice Development Co-ordinator for PHN service** will assist the National lead for Public Health Nursing with the implementation and operationalization of this guideline and address any issues that arise**.**

**Director Public Health Nursing:** The DPHN is responsible for implementing and managing and auditing this guideline within her/his area of responsibility. The DPHN will identify and support ongoing related educational opportunities to further enhance knowledge and skills in relation to maternal postnatal care. The DPHN should ensure that the necessary equipment and resources are available to staff to operationalize this guideline. Within the Community Health areas the DPHN will be responsible in ensuring all nurses under their remit are aware of, have read and have signed the verification document (Appendix I) in relation to this guideline or accessed it through the electronic policy portal. Audit of the use of the guideline will be carried out as outlined in Section 6.1.2 of this guideline.

**Assistant Director Public Health Nursing**: The ADPHN is responsible for the implementation of the guideline through ensuring that the current document is available to all RPHN/RMs in health centres. The ADPHN is responsible for ensuring that all public health nursing staff has knowledge of the guideline. The ADPHN is responsible for ensuring that new staff are informed of the guideline on induction. The ADPHN will ensure that all RPHNs/RMs are aware of any revisions to the guideline and ensure older versions of the guideline are removed from circulation. A database record of all RPHNs/RMs who have signed the signature sheet (Appendix I) will be maintained by the ADPHN and the DPHN will be notified of any noncompliance with sign-off of the guideline. Electronic policy portal where in use will support the DPHN with this governance.

**Role of the RPHN and RMs:** It is every nurse and midwives’ responsibility to ensure they are working within their “Scope of Practice” at all times and that they identify their training needs to their manager to maintain standards of care (NMBI, 2015).

Each RPHN/RM is responsible for adhering to this guideline and to use it to guide their practice in the delivery of the service they provide. Each RPHN/RM is responsible for ensuring that they read and understand the document and sign the attached signature sheet or have confirmed this through the PHN policy portal where it is in use. When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified, it is the responsibility of each RPHN/RM to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the guideline.

**Role of Practice Development Co-ordinator for Public Health Nursing:** The PDC (where in post) supports the implementation and operationalization of this guideline. She/he has a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence-based practice.

# 6.0 MONITORING, AUDIT AND EVALUATION

## 6.1 Monitoring of this guideline will occur by the ADPHN through professional supervision, team meetings and documentation audit.

## 6.2 Audit of the operation of the guideline will be initiated by the DPHN in consultation with the local CHO audit lead or new regional integrated care area once developed. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012a). Audit will be carried out retrospectively by the designated person appointed by the DPHN. This designated person may be the area RPHN, a nursing peer, the ADPHN or other. This guideline will be the standard for audit using the attached audit tool (Appendix XI). The objectives of the audit will be

## to provide evidence of compliance to the national guideline

* to ensure standardisation of application of the guideline

## to identify areas for improvement, make recommendations and prioritize actions.

## Frequency of audit, sampling processes and timescales for completion will be determined at local level following the first initial audit in consultation with the local CHO audit lead.

## 

6.3 Evaluation of the guideline will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings, direct patient feedback and through reviews of National Incident Report Forms (NIRFs) to monitor any Near- Misses/Adverse Incidents. Feedback from Your Service Your Say and through local formal complaints processes will be considered in any revision of the guideline.

## 

# 7.0 REVISION/UPDATE

**7.1 Describe procedure for the update of the guideline** (including date for revision).

This guideline will be revised every three years on the date specified on the front page of the document. This review will be triggered by the National Lead for PHN service.

## 7.2 Identify method for amending guideline if new evidence emerges.

When areas of concern are identified, where legislation is known to have changed or where a health and safety risk is identified, it is the responsibility of each RPHN/RM to ensure that their ADPHN is informed in order to trigger an appropriate review and amendments if necessary are made to the guideline nationally. Practitioners will assist in the revision of the guideline and also request an earlier review of this guideline where required if new evidence-based practice is recommended.

## 7.3 Complete version control update on PPPG Template cover sheet.

This is the first version of a national guideline on the maternal postnatal care in the Public Health Nursing service. See version control document on cover sheet for updated sections.

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# 9.0 APPENDICES

## Appendix I Signature Sheet

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**Appendix I:**

**Signature Sheet**

*I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:*

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| --- | --- | --- | --- |
| **Print Name** | **Signature** | **Area of Work** | **Date** |
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**Appendix II:**

**Membership of the PPPG Development Group**

Please list all members of the development group (and title) involved in the development of the document.

|  |  |
| --- | --- |
| **Chairperson:**  Sinead Lawlor  National Practice Development Coordinator for Public Health Nursing Services  Marie Corbett  Director of Midwifery  Regional Hospital Mullingar | Signature: SL signature  Date: 18/10/2022  Signature:  Date: 18/10/2022 |
| Krysia Lynch  Service User Representative  Association for Improvement in maternity Services – Ireland AIMS  Deirdre Fahy  Public Health Nurse  Barrack St Primary Care Centre, Dundalk, CHO 8 | Signature:  Date: 18/10/2022    Signature:  Date: 18/10/2022 |
| Sheila Geoghegan  Director of Public Health Nursing  Kildare/West Wicklow CHO 7 | Signature:  Date: 18/10/2022 |
| Martina Irwin PHN  North Cork CHO 4  Joined group – April 2021  Colette Treacy ADPHN  Dublin West CHO 7  Joined group – April 2021  Sharon Brady  Public Health Nurse CHO7  INMO representative  Joined group – April 2021  Kathryn Downey  PHN  Dublin South East  Ina Crowley  National Project Officer,  Nursing Midwifery Panning and Development Unit  Elizabeth Balfe  Public Health Nurse Corduff PCT CHO 9  INMO representative  Moved to Steering Group march 2021  Kathy Walsh  Assistant Director of Public Health Nursing  Wicklow, CHO 6  Withdrew from Group Jan 2021  Rita Pender  Public Health Nurse  Steeple House Primary Care Centre CHO 7  Withdrew from Group Nov 2020  Michelle Waldron  Designated Midwifery officer  Withdrew from Group Nov 2020  Katie Holohan -- withdrew from group August 2021  Public Health Nurse  Baggot Street and Sandymount PCT  CHO 6 | Signature:  Date: 18/10/2022  Signature:  Date: 15/9/2021  Signature:  Date: 18/10/2022  Signature:  Date:18/10/2022  Signature:\_\_  Date: 22/9/2021 |
|  |  |

**Appendix III: Conflict of Interest Declaration Form** 

**CONFLICT OF INTEREST DECLARATION**

This must be completed by each member of the PPPG Development Group as applicable

**Title of PPPG being considered:**

Guideline on Maternal Postnatal Care in the Public Health Nursing Service

**Please circle the statement that relates to you**

**1. I declare that I DO NOT have any conflicts of interest.**

**2. I declare that I DO have a conflict of interest.**

**Details of conflict (Please refer to specific PPPG)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Append additional pages to this statement if required)**

**Signature**

**Printed name**

**Registration number (if applicable)**

**Date**

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

**Appendix IV:**

**Membership of the Approval Governance Group (Template)**

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

|  |  |
| --- | --- |
| TJ Dunford  Head of Operations  Primary Care | Signature: TJ Dunford  Date: 24/10/2022 |
| Dr. Geraldine Shaw  Nursing & Midwifery Services Director  ONMSD | Signature: Dr. G. Shaw  Date: 16/11/2022 |
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| --- | --- |
| **Members of Steering Group** | |
| Virginia Pye (Chair) National Lead for Public Health Nursing  Sinead Lawlor National Practice Development Coordinator for PHN service  Margaret Quigley National Lead for Midwifery  Mary O Connor Director,Centre of Midwifery Education Cork  Liz Balfe IMO PHN representative  Sheila Geoghegan Director of Public Health Nursing, Kildare/West Wicklow  Angela Dunne Lead Midwife, National Women’s and Infants Health Programme  Dr. Krysia Lynch Mothers Representative, AIMS  Anne Pardy Programme Manager National Healthy Childhood Programme  Martina Irwin PHN representative CHO 4  Marie Corbett Director of Midwifery, Mullingar Hospital.  Kathryn Downey PHN representative CHO 6  Nicola Gill Meeley Lecturer in Nursing/Programme Director Master in Health Sciences (Public Health Nursing) Galway | |
|  |  |

**Appendix V: GP/Maternity Unit Letter Template** 

**PHN Referral Letter to GP/Maternity Unit**

**Dear Doctor,**

I would appreciate if you could review (Patient’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in view of the problem/s identified below.

*Affix addressograph, otherwise complete following details*:

|  |  |  |
| --- | --- | --- |
| **Name** | **DOB** | **Phone Number (s)** |
| **Address:** | | |
| **Date of Delivery Postnatal Day:** | | |
| **Presenting postnatal problem:** | | |
| **Other information:** | | |
| **Vital Signs (if applicable to mothers presenting problem):**  **Blood Pressure:**  **Pulse:**  **Temperature:**  **Respirations:** | | |

**Patient aware and consents to a referral to GP/Maternity Unit: Yes 🞎 No 🞎**

If you require any further information or have any queries, please do not hesitate to contact me.I would be grateful if you could update me following the consultation.

**PHN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Centre/Health Centre:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referral Delivery method:

Given to Mum to bring to GP/Maternity Unit 🞎 Posted to GP/Maternity Unit 🞎

Emailed to GP/Maternity Unit GP/Maternity Unit 🞎

*\*Insert a copy of the letter into the patient’s chart*

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| --- | --- | --- |
| **Appendix VI PUBLIC HEALTH NURSING SERVICE POSTNATAL INFORMATION (Page 1)**  **Information Resources for Mothers**  *You can scan the QR code using a smartphone camera to go directly to the website* | | |
| **My Pregnancy and My Child books on the HSE Mychild.ie website**  My Pregnancy is a free book from the HSE with advice for during pregnancy and the first few weeks after birth.  My Child 0 to 2 years is a free book from the HSE with advice to help you and your baby from birth to age 2. | |  |
| **BREASTFEEDING**  Advice and support when starting to breastfeed, breastfeeding tips and common questions answered.  Ask our Expert (FREE on-line HSE breastfeeding support service)  Information on breastfeeding support in your area. | |  |
| **Women’s Health After Motherhood (WHAM)**  Learn how to take care of your physical and mental health after giving birth and feel supported during the postpartum period.  *Co-created by the MAMMI study team and women following childbirth –* ***click on join with limited access (Free)*** | |  |
| **MENTAL HEALTH**  Many mothers experience changes in emotions and mood at some point in their pregnancy and in the first few weeks after birth. This is a normal part of adjusting to the changes of becoming a mother. Information on baby blues, anxiety and postnatal depression. Find information here that will guide you through this time. | |  |
| **PELVIC FLOOR EXERCISES**  Learn about the muscles that make up your pelvic floor, the importance of pelvic floor exercises and how to do pelvic floor exercises. | |  |
| **CONTINENCE INFORMATION**  Caring for your bladder and bowel in pregnancy and after childbirth.  Incontinence is a common problem during pregnancy and following childbirth. It can have a significant impact on your quality of life and your daily activities. | |  |
| **WEAKNESS IN TUMMY MUSCLES AFTER CHILDBIRTH – (DRAM).**  Pregnancy causes a weakness in the midline of your tummy muscles. This is because they stretch to let your baby grow. Watch this video to learn more. | |  |
| **SAFE IRELAND**  Creating safety for women and children. | |  |
| **ON-TRACK** (**T**owards **R**ecovery **A**fter **C**hildbirth, through **K**nowledge)  The videos address anxiety, sexual health and pelvic girdle pain, and aim to help women understand the common health issues that may occur in these areas, and the impact on everyday life.  *Co-created by the MAMMI study team and women following childbirth* | |  |
| **WEBSITES/SERVICES OF INTEREST** | | |
| [www.mychild.ie](http://www.mychild.ie)  [www.tusla.ie/parenting-24-seven](http://www.tusla.ie/parenting-24-seven) [www.ncca.ie](file:///C:\Users\slawlor\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\KFBFU6R6\www.ncca.ie)  www.sexualwellbeing.ie [www.breastcheck.ie](file:///C:\Users\slawlor\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\KFBFU6R6\www.breastcheck.ie)  [www.cervicalcheck.ie](file:///C:\Users\slawlor\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\KFBFU6R6\www.cervicalcheck.ie) | [www.pregnancyandinfantloss.ie/feileacain-support-for-you-when-your-baby-dies/](file:///C:\Users\slawlor\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\KFBFU6R6\www.pregnancyandinfantloss.ie\feileacain-support-for-you-when-your-baby-dies\)  Stop Smoking Service – Text **QUIT** to 50100  Your Service Your Say – feedback on the HSE - [yoursay@hse.ie](file:///C:\Users\brendamccormack\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\OSMDOE7J\yoursay@hse.ie) | |

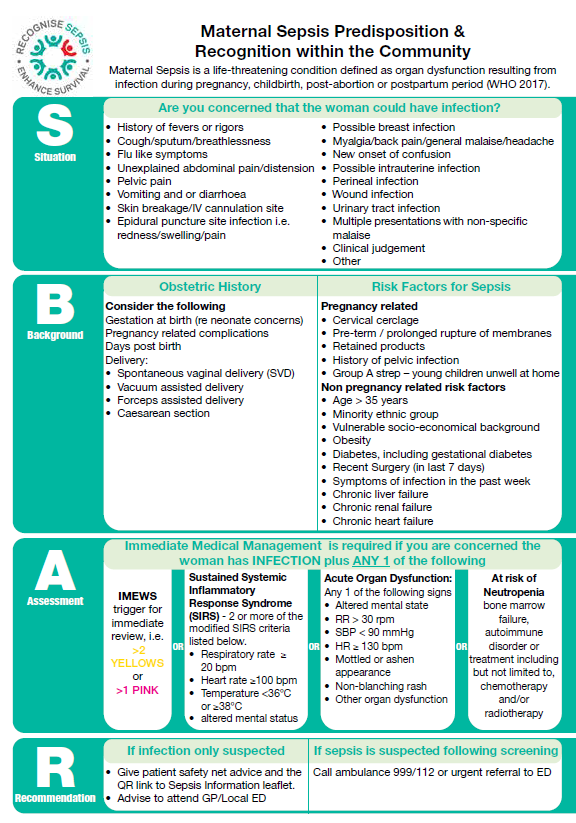
**Appendix VI PUBLIC HEALTH NURSING SERVICE POSTNATAL INFORMATION (Page 2)**

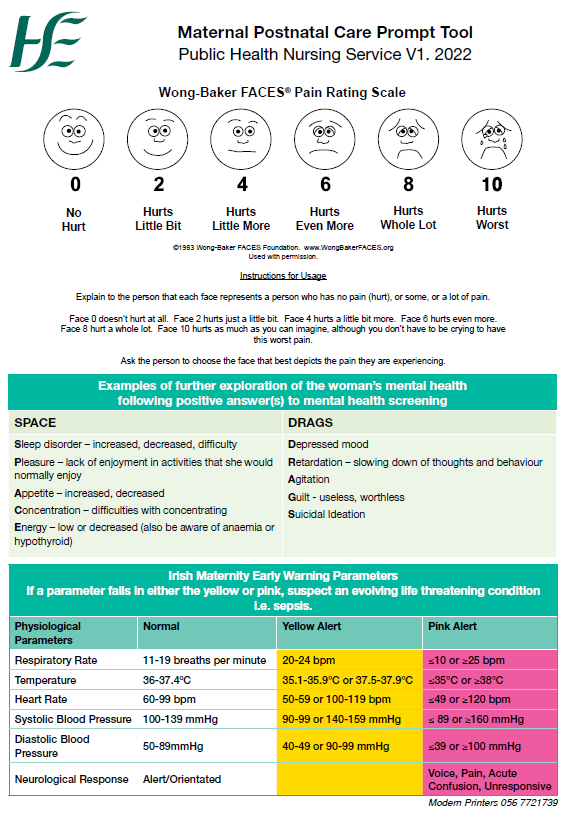
|  |  |  |
| --- | --- | --- |
| **Information on Potential Medical Emergencies for Mothers** | | |
| This is information for you, your partner and/or your family members on some potentially serious conditions that can develop following childbirth. Please watch out for the signs and symptoms and seek medical advice without delay if any of these occur. You should see your GP/ attend hospital emergency department/ call 999 or 112 for an ambulance if necessary. | | |
| **Potential Condition** | **Signs and Symptoms** | **QR Code**  ***Scan for further information*** |
| **Postpartum haemorrhage (Bleeding)** | Heavy vaginal bleeding or large clots  Feeling dizzy or faint  Palpitations / fast heart rate |  |
| **Infection/Sepsis** | Temperature: above 38oC or below 36oC  Pain: may be abdominal, pelvic, back, breast or perineal pain  Vaginal discharge with an unpleasant smell  Urine: not passing or pain when passing  Dizziness, breathlessness; shivering, agitation or confusion | MyChild-_Sepsis_during_after_pregnancy |
| **Blood clots** | Blood clot in the leg;   * Pain or tenderness * swelling or redness in the calf muscle of one leg   Blood clot in the lung;   * Difficulty breathing, shortness of breath * chest pain |  |
| **Postpartum psychosis** | Restlessness, agitation and confusion  Significant mood disturbance affecting relationships or normal activity, thoughts of harming yourself or the baby. | Z:\Child Health\National Child Health Work\QR Codes\Postnatal Handout\Postpartum_Psychosis_PDF_ (1).jpg |
| **Pre-eclampsia/Eclampsia** | Persistent or severe headache accompanied by any of these symptoms; visual disturbances, nausea, vomiting, high abdominal pain, feeling faint |  |

*Information from World health Organisation (2013), NICE guideline NG192 and My Pregnancy book (2018) from the National Healthy Childhood Programme* [*www.mychild.ie/books*](http://www.mychild.ie/books)

**Appendix VII: Adapted from National Clinical Guideline No 26 DOH 2021)**

**Maternal Sepsis Recognition Tool For PHN Service**

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**Acknowledgements: Karn Cliffe Doctor of Midwifery, Interim Chief Director of Nursing & Midwifery, Dublin Midlands Hospital Group, Olivia O’Connor Practice Development Coordinator PHN Service CHO 2.**

**Consider deferential complications**

**TABLE: DIFFERENTIAL DIAGNOSIS: COMMON MATERNAL CLINICAL FEATURES**

|  |  |
| --- | --- |
| (Bowyer et al., 2017) Acute pulmonary embolism | Hypotension, tachypnoea, tachycardia, low-grade fever |
| Amniotic fluid embolism | Hypotension, tachycardia, haemorrhage |
| Acute pancreatitis | Fever, nausea, vomiting, abdominal pain |
| Acute fatty liver of pregnancy | Fatigue, nausea, vomiting, abdominal pain, jaundice, impaired level of consciousness |
| Adverse drug reactions, drug fever | Hypotension, relative bradycardia, fever, rash, angio-oedema |
| Acute liver failure-drug related/viral | Jaundice, nausea, vomiting, abdominal pain impaired level of consciousness |
| Acute adrenal insufficiency | Weakness, fatigue, nausea, anorexia, weight loss, hypotension, fever |
| Acute pituitary insufficiency | Failure to lactate, hypotension, relative bradycardia, polyuria, polydipsia |
| Autoimmune conditions | Low-grade fever, rash (e.g. malar rash), arthritis, dry eyes or mouth, mouth ulcers, diagnostic serology |
| Concealed haemorrhage including ectopic pregnancy | Hypotension, tachycardia, low-grade fever |
| Disseminated malignancy | Low-grade fever, weight loss |
| Pelvic thrombosis | Pelvic pain, fever |
| Transfusion reactions | High fever, rigors, dysrhythmia, tachypnoea, hypotension, rash, bleeding, haematuria |

Used with kind permission from SOMANZ (2017) (National Sepsis Guideline 2020)

**Appendix VIII: Domestic Sexual and Gender Based Violence**

**Signs of Domestic Violence** Signs that a woman may be experiencing domestic abuse include but are not limited to the following:

* She seems afraid of her partner or is always very anxious to please him.
* She stops seeing friends or family.
* She says that her partner continually phones or texts her when she is out of the house and wants to know where she is and whom she is with at all times.
* She may have unexplained bruises or cuts.
* She may have little money or access to cash, even when she is working or the family appears to have sufficient funds.
* She may have changed her behaviour, becoming more withdrawn, anxious or depressed

**When is it safe to discuss domestic abuse?**

To maintain safety of Public Health nurses, women and children

* Undertake a risk assessment to ensure your safety, whether in the woman’s home or in the health centre.
* Adhere to lone working guideline
* Check regularly that the environment is safe and private for women and PHNs.
* Ensure two nurses are in attendance for any home visits if there is a known history of Domestic Sexual and Gender Based Violence
* If a woman discloses domestic abuse, ensure she is alone when domestic abuse is discussed. Relatives or friends should not be present during the discussion or any child who can report on the conversation, unless a woman clearly indicates she wants a relative or friend for support.

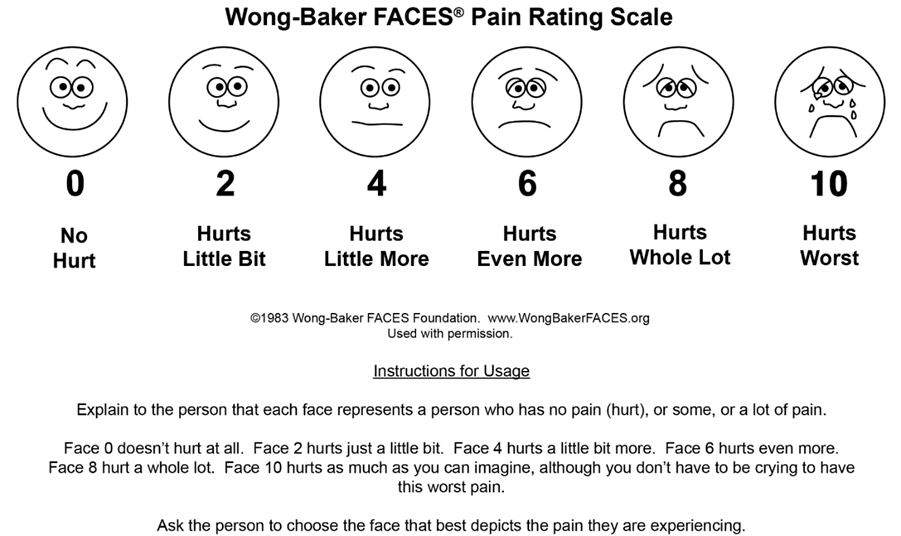
**Domestic** **Sexual and Gender Based Violence – specialist help and services**

|  |
| --- |
| **Women’s Aid - National helpline 1800 341 900** |
| **Safe Ireland**  [**https://www.safeireland.ie/**](https://www.safeireland.ie/)  <https://www.safeireland.ie/get-help/where-to-find-help/> |
| **HSE National Domestic, Sexual and Gender-Based Violence Training Resource Manual**  [**https://www.hse.ie/eng/about/who/primarycare/socialinclusion/other-areas/domestic-violence/dsgbv-training-resource-manual.pdf**](https://www.hse.ie/eng/about/who/primarycare/socialinclusion/other-areas/domestic-violence/dsgbv-training-resource-manual.pdf) |
| **HSE Practice Guide on Domestic, Sexual and Gender Based Violence**  [**https://www.tusla.ie/uploads/content/Domestic\_Practice\_Guide\_on\_DSG\_bassed\_violence.pdf**](https://www.tusla.ie/uploads/content/Domestic_Practice_Guide_on_DSG_bassed_violence.pdf) |
| **HSE Policy on Domestic, Sexual and Gender Based Violence**  [**https://emed.ie/Administration/Docs/HSE\_Policy\_Domestic\_Sexual\_Gender\_Based\_Violence\_Feb\_2011.pdf**](https://emed.ie/Administration/Docs/HSE_Policy_Domestic_Sexual_Gender_Based_Violence_Feb_2011.pdf) |

**Appendix IX** Perinatal Mental Health information App

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**Appendix X Wong Baker FACES pain rating scale**

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