South Australian Perinatal Practice Guideline

Postnatal Care

Routine care of the well woman and neonate

Note:
This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

Explanation of the Aboriginal artwork:
The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant woman. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of Perinatal Practice Guideline (PPG)

The guideline describes routine care for well women following birth (including caesarean section) and neonates born from 37 weeks gestation. It includes recommendations for standard observations, assessments and education. It does not describe management if the clinical situation deviates from normal. Clinicians will need to refer to specific PPGs and local policies/procedures for escalation pathways and more specific details.

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Summary of Practice Recommendations

Postnatal care should be woman-centred and support parenting abilities.

Clinical assessment should include the woman's fundus, lochia, vital signs, bladder, perineum/wound and psychological state.

For women that birth in hospital, discharge planning should commence on admission.

Women should be given information on indications to contact their maternity care provider when they are at home.

Women should be referred to the CaFHS and be given information about local community support services.

Abbreviations

CaFHS	Child and Family Health Service
DASSA	Drug and Alcohol Services SA Health
EPDS	Edinburgh Postnatal Depression
GBS	Group B Streptococcus
h	Hour
HIV	Human immunodeficiency virus
LAM	Lactational amenorrhoea method
mmol/L	Millimole per litre
PGL	Plasma Glucose Level
RDR	Rapid Detection Response
SAPR	South Australian Pregnancy Record

Postpartum Care

Puerperium

The puerperium starts immediately after the birth of the placenta and membranes and ends at approximately six weeks.[1] Following birth, the woman begins the process of physical and psychological recovery.[1] All of the woman's body systems are returning to their pre-pregnant state.[1]

The postnatal period is an important time for the woman to develop parenting skills to confidently care for her baby. Care of the woman should be individualised according to her needs and documented on the appropriate care plan.

Discharge planning is ongoing from time of admission to discharge and should be discussed in the antenatal period. Early discharge (within 6 hours) is an option for women and their babies with no complications after vaginal birth. Early discharge (within 24 hours) may also be an option for women following elective caesarean section without complications.

Women who have a planned birth at home require assessment of both mother and baby to ensure that they meet the criteria for remaining at home. Midwives need to remain in the home for a minimum of 4 hours following birth. See *Planned Birth at Home* Clinical Directive available at www.sahealth.sa.gov.au/perinatal.

Woman and Family-Centred Care

The Australian Department of Health *Woman-centred care: Strategic directions for Australian maternity services* document states that, "Women are the decision-makers in their care and maternity care should reflect their individual needs."[2(p7)] It includes a number of principles that clinicians should use to underpin maternity care, for example:

- Women are treated with dignity and respect throughout maternity care.
- Maternity care is holistic, encompassing a woman's physical, emotional, psychosocial, spiritual and cultural needs.
- Women receive individualised information and appropriate care that is based on current, high quality evidence.
- Women have access to individualised culturally safe and responsive care in their preferred language.
- Women's choices and preferences are sought and respected throughout maternity care.
- Women have access to mental health information, assessment, support and treatment from conception until 12 months after birth.
- Women are provided with and can readily access information about all locally available maternity services.

Initial management

In the first few hours after the birth of the baby skin to skin contact should be encouraged for all women and their babies for a minimum of 1 hour.[1] The woman will remain in the birth area for several hours depending on clinical status until she is stable and transfer to the postnatal ward or home is appropriate.

Initial management includes regular clinical assessment of the woman's fundus, lochia, vital signs, bladder and the woman's psychological state and supporting her to feed her baby. The following postnatal checks apply to all women after birth and are adapted depending on the woman's clinical situation and according to local policies/procedures.

Admission to postnatal ward

The postnatal midwife should receive a comprehensive bedside handover including the woman's antenatal journey, labour and birth details, care plan, discharge planning and woman's wishes including her social and cultural needs.

The midwife should introduce herself or himself, orientate the woman to her room/ward, and discuss plans for her postnatal care pathway. A complete assessment of the woman's condition should then be undertaken.

Maternal Postnatal Wellbeing

Cultural needs

All women should be asked about their cultural needs and where possible these needs should be facilitated, or an alternative plan made with the woman.

Vital signs

Vital signs include respiratory rate, blood pressure, pulse, temperature, sedation score, pain score and level of consciousness.

Vaginal Birth

Vital signs should be checked:

- Every 15 minutes for the first hour following vaginal birth
- On admission to the postnatal ward or prior to leaving the woman's house following home birth
- As clinically indicated or as per local protocols but not less than twice daily for inpatients.

Caesarean Section Birth

Recommended frequency of checking vital signs following caesarean section is:

- Every 15 minutes for first hour
- Hourly up to 4 hours
- 4 hourly until 24 hours post-birth
- Twice daily thereafter whilst an inpatient.

Oxygen saturation evaluation is required in some sites (refer to local procedures).

Braden score to assess pressure injury risk as per local procedures.

Bromage score to measure motor block following neuraxial analgesia as per local procedures.

Following administration of intrathecal or epidural morphine

Hourly respiratory rate and sedation score for 12 hours and then 2 hourly until 24 hours.

Rapid Detection and Response (RDR) Maternal Observation Chart (Form MR59G)

Use of the *Rapid Detection and Response Maternal Observation* Chart is recommended to assist clinicians in recognising and responding to clinical deterioration. Any observations in the shaded area require additional observations and actions and potential medical review depending on the woman's complete clinical picture.

Additional observations may be recommended with specific clinical conditions – see relevant PPG available at www.sahealth.sa.gov.au/perinatal.

Staff should be alert for the signs and symptoms of sepsis that include fever, shivering, hypothermia, tachycardia, tachypnoea, altered mental state, hypotension, oliguria, ileus, pain, offensive vaginal loss, oedema, hyperglycaemia in the absence of diabetes and altered blood picture.3[2] Further information can be found via the *Antibiotics in the Peripartum Period* PPG available at www.sahealth.sa.gov.au/perinatal. Also see SA Health *Sepsis for health professionals* information.

Uterus

The uterus should be palpated for size, tone and position in the postnatal period following vaginal birth at the same time as vital sign assessment.[3] Any deviations from normal require closer observation and a medical review depending on the woman's complete clinical picture.

If the woman's uterus is palpated to one side this may be related to urinary function. If there is uterine atony, palpate and massage the fundus until firm. Encourage the woman to void and if unsuccessful catheterisation should be considered. [3] Assess the woman's lochia and if excessive activate local escalation/emergency procedures as clinically indicated.

Where subinvolution of the uterus is confirmed, causes may be related to infection, presence of retained products of the placenta and/or membranes and a medical review is indicated. [3]

Where a woman has undergone a caesarean section, palpation of the uterus can be very painful for the first three or four days post birth and uterine palpation should not be performed routinely. [3]

Lochia

The amount, colour and consistency of the lochia should be observed at the same time as vital sign assessment or as part of general assessment when the woman is at home.[1] Women should also be asked about the presence of clots and if/when they occurred.[1] Any increase in vaginal loss (which might be brighter or heavier than previously), passing clots or the presence of an offensive vaginal loss requires closer monitoring and consideration for a medical review. [3] Women should be informed to contact their care provider if this occurs.

Perineum

With consent, the woman's perineum should be observed, and the presence of trauma, swelling or bruising monitored along with her degree of discomfort, approximation of wound/suture line and any signs of infection. There is some evidence to suggest that the following can assist with perineal pain and discomfort:[1]

- oral analgesia e.g. paracetamol
- diclofenac suppositories (especially in first 24-48h)
- localised cooling treatment e.g. ice packs in first 24 hours

Women should be given information about regular pad changes, keeping the perineum dry after showering or bathing and pelvic floor exercises.

Caesarean wound

Provide advice on care of the wound dressing (including good hand hygiene, keeping clean and dry and when to remove), reporting redness or odour, fever, pain or swelling. [3] Seek medical input for suspected infection or haematoma.[3] Ensure women are provided with specific information about caesarean recovery.

Bladder function

Encourage women to void within 2-3 hours of birth. Women should be assessed for normal postpartum void parameters (two consecutive voids > 200mL and no symptoms of abnormal voiding function). Women should continue to monitor their bladder function, specifically if she is passing normal amounts of urine, decreased or absent sensation to void, presence of frequency or urgency, dysuria, abnormal uterine position, and any pain or discomfort felt with voiding.[1,3] Refer to the *Bladder Management for Intrapartum and Postnatal Women* PPG available at www.sahealth.sa.gov.au/perinatal.

Bowel function

Most women will revert back to their pre-pregnant bowel function status in the puerperium.[1] Women who have experienced perineal trauma may have concerns about damaging their stitches and may require reassurance that they should not avoid opening their bowels or fear dislodging the sutures.[1] Ask the woman about the pattern and frequency of bowel movements and compare with pre-pregnancy pattern.[3]

Constipation and haemorrhoids are common conditions reported in the puerperium.[3] Recommend a diet that contains fibre and increased fluids to assist with constipation.[3] Some women with constipation may require an aperient if dietary changes do not relieve her symptoms.[3] Women with haemorrhoids should be advised to adopt a diet high in fibre and fluids, aperients to soften the stools, and topical applications that can reduce oedema and pain.[3]

Breast Care

Breastfeeding should be initiated during the initial skin to skin time following birth. Further information on breastfeeding, including the management of initial feeding, feeding cues, positioning and attachment and frequency of feeds is available in the *Breastfeeding* PPG available at www.sahealth.sa.gov.au/perinatal.

With consent, the woman's breasts should be examined for physical problems (engorgement, cracked or bleeding nipples, signs of thrush or mastitis).[1] Information on the management of mastitis can be found in the *Antibiotics in the Peripartum Period* PPG available at www.sahealth.sa.gov.au/perinatal.

Mobilisation

Early mobilisation should be encouraged where possible. If women have limited mobility, the Braden risk assessment tool can be used to determine risk of pressure injury. Women with a history of venous thromboembolism or other risk factors may require postpartum thromboprophylaxis. Refer to the *Thromboprophylaxis and Thromboembolic Disease in Pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal.

Postpartum anaemia

Women who had a primary postpartum haemorrhage or had iron deficiency or anaemia in pregnancy are at increased risk of postpartum anaemia.[4] Use the Australian Red Cross Lifeblood Haemoglobin Assessment and Optimisation in Maternity Postpartum flowchart to guide practice. See also the *Anaemia in Pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal.

Psychological wellbeing

Clinicians should be alert to the woman's psychological wellbeing and how the woman is coping with her birth experience and transition to motherhood. Assessment of the woman's emotional wellbeing, including need for birth debriefing +/- additional input should be ongoing throughout the postnatal period.

Awareness of pre-existing mental health issues and potential impact on postnatal wellbeing and infant bonding is essential. Women should be screened for possible depressive disorders using the Edinburgh Postnatal Depression Scale (EPDS) 6-12 weeks after birth or earlier if there are concerns. See *Anxiety and Depression in the Perinatal Period*, *Psychological Distress after Birth (Managing women in distress after a traumatic birth experience)*, *Women with Significant Psychosocial Needs*, and *Psychotic Disorders in the Perinatal Period* PPGs available at www.sahealth.sa.gov.au/perinatal.

Psychosocial needs

Determine the presence of any significant psychosocial needs e.g. women with issues related to mental health, substance misuse, domestic violence, physical/intellectual disability, serious / chronic medical problems and history of sexual abuse, previous abuse of an infant or attachment issues.

If any of the above factors are identified, the midwife should provide care to support the woman's emotional wellbeing and facilitate notification of the woman's admission to the appropriate allied health supports e.g. Social Worker, Mental Health Worker, GP, Continence Nurse Advisor or midwife from DASSA Obstetric Unit.

Any suspicion that an infant is or may be at risk of harm should be referred to the Department for Child Protection via the Child Abuse Report Line (CARL). See Child Protection: Mandatory Reporting Policy for more detail.

Contraception

All women should be offered information about contraception during pregnancy and prior to discharge. There are a number of options available for women postnatally, some of which can be used immediately, and these methods should be discussed (see Appendix). The woman is able to choose the method most suitable to her needs.[5]

Education

Appropriate advice and information leaflets / online resources (as per individual hospital criteria) should be given to the woman following admission e.g. leaflets on Safe Sleeping. These should be in a language she can read with appropriate education and the use of an interpreter if indicated.

Consider the following educational needs:

- Breastfeeding (including signs of effective breastfeeding and expected frequency of feeds)
- Information in relation to artificial feeding principles and practice to be provided **only** if the woman is artificially feeding
- Parenting skills and general baby care
- Personal hygiene
- Importance of rest and sleep
- Healthy diet
- Care of the pelvic floor
- Mental health and wellbeing
- Infant behaviour
- Immunisation
- Kidsafe sleeping and child restraints
- Infant resuscitation
- Indications to contact their health care provider (e.g. signs of infection, poor feeding)

Baby Wellbeing

Identification

Ensure and check the baby's identification labels (name, date of birth and hospital record number) are correct according to individual hospital procedures.

Vital signs

All newborns should have a risk assessment at birth, hourly observations for the first four hours of life and prior to discharge. The Rapid Detection and Response Neonatal Observation Chart (RDR MR59J) is recommended to facilitate early recognition and response to neonatal deterioration.

Minimum observations taken with the neonate at rest include:

- Respiratory Rate
- Heart Rate
- Temperature
- Oximetry Screening on all neonates between 4 and 12 hours of age

Additional observations should be taken based on the clinical condition, risk assessment, deterioration or concern by parents or staff. Regional hospitals should have a low threshold for consulting tertiary services. Contact the Perinatal Advice Line on phone: 137 827.

Newborn Examination

A complete newborn examination should be undertaken by a suitably qualified/accredited medical officer or midwife/nurse within 4 hours of birth to assess the neonate's transition to extrauterine life and to detect obvious congenital anomalies. It includes:

- Review of maternal medical, obstetric and psychosocial history
- Review of antenatal and intrapartum progress (including the results of any screening or additional tests) and mode of birth

- Neonate's condition at birth (including any resuscitation required and cord blood gases if taken)
- Gestational age at birth and percentiles for head circumference, length and weight. Values should be plotted on percentile chart
- Physical examination (including position and tone of extremities, cry, skin, perfusion, head shape, fontanelles, sutures, hair, face, eyes, ears, mouth, palate, tongue, neck, chest, torso, breath sounds, heart sounds, abdomen, umbilicus, bowel sounds, genitalia, upper and lower limb pulses, anus, spine, limbs, feet, hands, digits and hips.
- Neurological examination (including level of consciousness, spontaneous activity, tone, muscle strength and primitive reflexes)

Refer to local procedures for further detail. The examination should be documented in the neonate's medical record and My Health and Development Record (blue book).

Baby wellness checks

Regular physical assessments of the neonate include assessment of posture/general symmetry/tone, activity/spontaneous movement, responsiveness, skin (colour, turgor, integrity), head (eyes, nose, mouth, fontanelles), neck, upper extremities, abdomen (including umbilicus), genitalia, elimination (voiding frequency and stool frequency, colour and consistency), lower extremities, and general neurological assessment).

Measurement of weight, length, head circumstance should be undertaken soon after birth (following skin to skin time) and repeated as per local guidelines or if there are concerns.

Any abnormalities require additional input from medical staff.

Infant feeding

Most women in South Australia will initiate breastfeeding, but frequently need support to commence and sustain breastfeeding. Refer to the *Breastfeeding* PPG available at www.sahealth.sa.gov.au/perinatal for specific information.

The RDR Neonatal Observation Chart states that a minimum of 1 feed per shift should be observed whilst in hospital with attachment, suck and swallow scores assigned. If the woman and baby have an early discharge or birth at home, one breastfeed should be observed prior to discharge or before the midwife leaves the woman's home. Additional feeding observation and support should be undertaken based on the clinical picture and maternal questioning in relation to infant behaviour and elimination.

If the woman / intended parent / foster parent elects to artificially feed the baby, details on appropriate anticipated volumes, formula preparation and sterilisation of bottles and teats should be given.

Neonatal Hip Screening and Developmental Dysplasia of the Hip

All babies should be screened as part of the newborn examination for developmental dysplasia of the hip. Serial hip examinations are also required at the 1-4 week, 6-8 week and 6-9 month baby health checks.

All parents should be educated on the importance of avoiding swaddling legs in an extended and adducted posture and of allowing free movement of the legs. Further information about neonatal hip screening can be found in the *Neonatal Hip Screening and Developmental Dysplasia of the Hip* PPG available at www.sahealth.sa.gov.au/perinatal.

Neonatal Hypoglycaemia

Babies who may need plasma glucose level (PGL) monitoring include well babies who are at risk, unwell babies, babies who are disinterested in feeding, hypothermic or jittery and babies born to diabetic mothers. Follow the guidelines for management of hypoglycaemia for all newborns who meet the criteria for testing in the *Neonatal Hypoglycaemia* PPG available at www.sahealth.sa.gov.au/perinatal. A PGL of less than 1.5 mmol/L requires urgent treatment.

Neonatal Jaundice

All babies should be assessed clinically for jaundice at least daily while in hospital and at home visits either by blanching the skin with a fingertip in bright natural or white fluorescent light, or by using a transcutaneous point-of-care light reflectance meter. The exceptions are those babies who are having close monitoring of blood (plasma or serum) total bilirubin levels. See the *Neonatal Jaundice* PPG for further information about identification and management, available at www.sahealth.sa.gov.au/perinatal.

Neonatal sepsis

Careful observation and examination are vital to early detection of neonatal sepsis. The extent of observation required will depend on the risk assessment for individual babies. Chorioamnionitis, preterm labour, preterm prelabour rupture of the membranes, ruptured membranes > 18 hours, maternal positive GBS status are risk factors for sepsis. The need for positive pressure ventilation during resuscitation at birth, apnoea, poor skin perfusion, and abnormal feeding behaviour (not interested in feeding for 8 hours after birth or the last feed) are other signs of sepsis. Further information about the identification and management of neonatal sepsis is available in the *Early Onset Neonatal Sepsis* PPG available at www.sahealth.sa.gov.au/perinatal.

Medication / Immunisation

Vitamin K (konakion)

Parents should receive written information during the antenatal period about the importance of vitamin K prophylaxis. Vitamin K should be given soon after birth with parental consent. Refer to the *Vitamin K* Neonatal Medication Guideline available at www.sahealth.sa.gov.au/neonatal.

Hepatitis B Vaccine

Parents should receive written information during the antenatal period about the importance of Hepatitis B vaccination. The first dose of Hepatitis B vaccination should be given to all infants within 12 hours of birth with parental consent. See the *Hepatitis B in Pregnancy* PPG available at www.sahealth.sa.gov.au/perinatal or the *Hepatitis B Vaccine* Neonatal Medication Guideline available at www.sahealth.sa.gov.au/neonatal for more details.

Screening Tests

Neonatal Screening Test (NST)

The NST is used to screen newborns for inborn errors of metabolism and other genetic disorders like cystic fibrosis and congenital hypothyroidism. Early diagnosis and intervention can significantly reduce or prevent death and morbidity including intellectual impairment. A link to parent information can be found here.

The NST should be performed as close to 48 hours of age as possible (range 36-56 hours) on all newborns. Record the NST card number in the medical record and My Health and Development Record (blue book).

Hearing Test

All parents should be offered a newborn hearing screen as part of the Universal Neonatal Hearing Screening Program to detect congenital hearing loss. This can be undertaken from 4 hours post vaginal birth and from 24 hours post caesarean section birth. The hearing test should be performed within 30 days of birth, preferably prior to discharge from the hospital.

Infant bathing

Bathing of the newborn is no longer routine post-birth. If the mother has a blood-borne virus, the following is recommended:

- Prior to any injections, the skin at the injection site should be cleaned with soap and water or an alcohol swab prior to administration
- Hepatitis B & C – Consider a bath or washing any visible blood from the infant prior to others holding the baby
- HIV – Wash all maternal blood from hair and skin from the baby

Discharge planning and management

Discharge planning starts during the antenatal period and continues from admission to the hospital through to discharge.

- Encourage early discharge to home as soon as stable after birth if no complications.
- Early postnatal transfer to other hospitals can be arranged following review of both the woman and her baby by appropriate medical officers (as per individual hospital criteria). The midwife should phone the receiving hospital before transfer to verify bed availability.
- The individual hospital's discharge planner / postnatal care pathway should be completed before discharge.
- Request medical review if any concerns about maternal or neonatal wellbeing.
- Complete discharge summary and transfer letters.
- Ensure contraception has been prescribed (if applicable).
- Before discharge, the midwife should ensure that the woman understands the process for completing and lodging the following forms and that they are all in her possession:
    - Birth Registration
    - Centrelink Parent Pack
        - Newborn Child Declaration Form (for Medicare enrolment and Family Tax Benefit and other Centrelink claims)
        - My Health Record registration form
- Complete the My Health and Development Record ('Blue Book') and give to the woman with explanation.
- Provide information for Community Support Services, particularly breastfeeding support.
- Offer Midwifery Home Visiting Service visit(s) as per individual hospital criteria.
- For Aboriginal women transferred from rural and remote areas, appropriate referral back to community health services should occur to ensure timely follow-up once they are back on Country.
- Encourage postnatal follow up with GP at 2 weeks and 6 weeks post-birth.
- If hearing screen has not been performed prior to discharge from hospital, ensure Hearing Screen is offered by CaFHS.

Postnatal Care in the Woman's Home

Postnatal care in the woman's home can generally be provided by the Midwifery Group Practice or Home Visiting Midwife (depending on local policy).

- Total number of visits should be guided by the woman's individual circumstances. Individual sites may have specific criteria to determine visits.
- The midwife's personal safety should be paramount as per local policy/procedures.

Assessment

Routine maternal checks include assessment of uterine involution, lochia, perineum or caesarean section wound (if applicable), breasts and bladder and bowel function.

Assessment of psychosocial wellbeing and adapting to parenthood/infant attachment can be undertaken in a conversational manner.

Routine baby checks include a Baby Wellness Check (as described above) along with weight, length and head circumference measurement as per local protocol.

Specific questioning (+/- observation) to determine effectiveness of feeding should be undertaken at each visit.

Additional assessment for neonatal jaundice including skin colour and infant behaviour should occur.

Any physical concerns should warrant assessment of vital signs +/- referral to the hospital for medical review or an ongoing plan for assessment and management in the woman's home or with community services.

Education

A key objective of midwifery care at this time is to ensure that the woman and her partner are confident in the care of their baby. Education and reassurance to support this should be provided.

Parents should also be made aware of their local community services.

Information for online resources and supports should also be provided. Some useful resources include:

- Beyond Blue
- PANDA
- The Black Dog Institute
- MumSpace
- Australian Breastfeeding Association
- Red Nose Safe Sleeping brochures (available in different languages)

Specific resources for Aboriginal families include:

- Raising Children Network: Aboriginal and Torres Strait Islander Parents
  - Breastfeeding, bottle feeding and solids
  - Health and daily care (including safe sleeping)
  - Safety
- WellMob Parenting
- Kidsafe SA *Sleeping Your Baby Safely* brochure (for Aboriginal families)

Child and Family Health Services (CaFHS)

Inform the woman that, as part of the Child and Family Health Services (CaFHS) Universal Home Visiting Program, she will be contacted to make an appointment for a home visit with a CaFHS nurse within the first two weeks.

- In high risk infant situations, a referral should be made to CaFHS for inclusion in the two year sustained home visiting program

CaFHS offer a range of services for children aged 0-5 years including:

- Support with feeding, settling, sleeping, emotional wellbeing, being a parent, child safety etc.
- Health and developmental checks
- Parenting groups

Locations and appointment times can be found at www.cyh.com or phone 1300 733 606.

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Appendix: Postnatal Contraception Options

Contraceptive	When it can be used/fitted	Indicated with Breastfeeding	Other information
Barrier methods e.g. condoms	When required	Yes	Can be used immediately.
Diaphragms and cups	6 weeks	Yes	Needs to be refitted postnatally when the uterus has returned to non-pregnant size.
Intrauterine devices	Within 48 hours of birth or delay until after 4 weeks (28 days)	Yes	May cause the menstrual period to be longer or heavier in some women. Additional contraception is required from day 21 until the device is fitted. IUCDs are over 99% effective.
The IUS system e.g. *MIRENA®*	Within 48 hours of birth or delay until after 4 weeks (28 days)	Yes	Some women experience irregular or lighter bleeding which usually settles. Additional contraception is required from day 21 until the device is fitted. The IUS is over 99% effective.
Implant e.g. *Nexplanon*	Immediately following birth	Yes	Can cause irregular bleeding in most women in the first 12 months. *Nexaplon* is over 99% effective.
Contraceptive injection e.g. *Depo-Provera®*	Immediately following birth	Yes	Injections given sooner than 6 weeks can lead to irregular heavy bleeding. Effective for up to 13 weeks. *Depo-Provera* is over 99% effective.
Progesterone only pill	Immediately following birth	Yes	If commenced at day 21 efficacy is immediate. Must take at the same time each day.
Combined hormonal contraception e.g. combined oral contraceptive, contraceptive vaginal ring	From 6 weeks post-birth	Yes, after 6 weeks	Can be used from 3 weeks if not breastfeeding and no risk factors for venous thromboembolism (VTE). Contraindicated in women with hypertension or history of venous thromboembolism.
Natural family planning	As soon as required	Yes	Can be difficult to determine fertility during breastfeeding.
Lactational amenorrhoea method (LAM)	Post-birth	Yes	Can be over 98% effective proved the baby is fully breastfed and under 6 months old and the woman is amenorrhoeic.
Female or Male sterilisation	Not advisable shortly after birth	Yes	Both methods are almost 100 % effective, Vasectomy is considered irreversible. Female sterilisation involves a general anaesthetic and would require mother baby separation – recommend reversible methods in the initial months.

Adapted from Steen, Jackson & Brown, 2020[1] and Faculty of Sexual and Reproductive Healthcare, 2017[5]

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Policy history: Is this a new policy (V1)? **Y**
Does this policy amend or update and existing policy? **N**
If so, which version?
Does this policy replace another policy with a different title? **Y**
If so, which policy (title)? Normal Pregnancy, Labour and Puerperium Management PPG separated into 3 PPGs

Approval Date	Version	Who approved New/Revised Version	Reason for Change
15/09/2021	V1	Clinical Governance, Safety & Quality Policy Domain Custodian	Original SA Clinical Governance, Safety & Quality Policy Domain Custodian approved version