National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Postnatal Midwifery Care for Mother and Infant

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women and their infants in the postnatal period, in a hospital setting or a community setting in the woman's home.

Following a comprehensive literature review a number of evidence-based recommendations for the provision of postnatal care for women and infants were agreed upon.

Key Recommendations

No.	Section 1: Maternal Care	Grade
	Physiological Assessment of the Woman	
1.	A comprehensive physiological assessment is recommended as part of quality postnatal care. It includes assessment of uterine involution, vaginal bleeding, maternal vital signs, micturition and bowel function, perineal/abdominal wound healing, headaches and pain. Escalate care if abnormalities are identified.	Best Practice
2.	Every woman should have a VTE risk assessment completed in the postpartum period. This includes women in the homebirth setting.	Best Practice
3.	We recommend that all women be closely monitored and encouraged to void within four to six hours after birth or after the removal of a urinary catheter, as early identification is key to managing urinary retention. The timing and volume of the first void after birth or after the removal of a urinary catheter should be documented in the healthcare record.	1B
4.	If the woman or the healthcare professional has concerns at any time regarding wound breakdown or infection, the Midwife should assess the woman's perineum, providing an appropriate explanation and gaining consent. If the perineal wound breaks down or there are ongoing healing concerns, the woman should be referred urgently to the maternity services for review.	Best Practice
5.	We recommended that women in the postnatal period be informed of the signs and symptoms of potentially life-threatening conditions and how to contact their healthcare professional.	1C
	Management of Common Ailments	
6.	Women should be informed of the pharmacological and non-pharmacological methods of pain relief for perineal and uterine involution pain. Perineal pain relieving methods should be individualised, based on the woman's preferences, considering the presence of perineal trauma, the intensity of the pain, multiple sources of postpartum pain (i.e. perineal, uterine, breast) and the use of other forms of pain relief.	1B
7.	Following a caesarean section, women should be offered paracetamol and a non-steroidal anti-inflammatory drug in combination (unless contraindicated) to reduce the need for opioids. If the woman's pain is not controlled with the prescribed analgesia, a medical review should be sought.	1B
8.	We recommend that women be advised to eat a high-fibre diet, drink 1.5-2 litres of fluid per day, and adopt a correct toilet position for bowel emptying to ensure normal bowel function is maintained.	2C

9.	Women should be advised on the techniques used to manage breast engorgement, regardless of their infant feeding choices. To reduce the incidence of painful cracked nipples, mothers who are breastfeeding should be supported by observing and reviewing infant positioning and attachment to the breast.	Best Practice
	Supporting Infant Feeding	
10.	We recommend that all women and infants be supported to practice skin-to-skin contact throughout the postnatal period.	2B
11.	We recommend that women who breastfeed their baby be supported in establishing and maintaining lactation in the postnatal period.	Best Practice
12.	Women who bottle-feed their baby should receive information on how to prepare a bottle and responsive bottle-feeding safely.	Best Practice
13.	We recommend that all women be supported in understanding their infant's behaviours and needs, including recognising feeding cues, how to wake a sleepy infant, knowing when their infant has fed sufficiently, and safer sleeping practices. They should be supported in holding their infant close and bonding when feeding, according to early feeding cues.	Best Practice
14.	Women should be supported to remain with their infant during the day and night if it is safe to do so (rooming-in).	Best Practice
	Management of Anaemia	
15.	A full blood count (FBC) should be measured within 48 hours of delivery in all women with the following: PPH of >500mls, uncorrected antenatal anaemia, a known iron deficiency anaemia or any woman with signs or symptoms of anaemia.	1B
16.	Women with Hb<10g/dL, who are haemodynamically stable, asymptomatic, or mildly asymptomatic, should be offered elemental iron 100-200 mg daily for at least 3 months and repeat FBC and ferritin at the end of therapy to ensure Hb and iron stores are replete.	1A
17.	Women who are symptomatic of anaemia should be referred to the obstetric team for review.	Best Practice
	Administration of Anti-D immunoglobulin	
18.	Offer Anti-D Ig to every non-sensitised RhD-negative woman who delivered/birthed an RhD-positive infant. Anti-D Ig should be administered as soon as possible and within 72 hours of birth. If a woman declines Anti-D Ig, she should have the opportunity to discuss with an obstetrician the possible implications for her next pregnancy.	1C
	Emotional Well-Being and Maternal Mental Health	
19.	We recommend that all healthcare professionals should be aware of the signs and symptoms of maternal mental health conditions that may be experienced in the weeks/months following birth. Women should be asked about and have the opportunity to discuss mood/mental health issues at each postnatal contact. Further screening tools should be utilised as required.	Best Practice
20.	We recommend that, if postnatal depression, puerperal psychosis, severe anxiety disorders or stress reactions are suspected, women should be assessed and urgently referred to the General Practitioner (GP), medical team/perinatal mental health team (PMHT)/mental health team as appropriate.	Best Practice

	Contraception Advice	
21.	We recommend that a discussion regarding contraception methods should take place prior to discharge, including barrier, hormonal and Long-Acting Reversible Contraception (LARC) methods. The discussion should also include how to access contraception.	Best Practice
No.	**Section 2: Infant Care**	**Grade**
	Postnatal Care Needs of the Newborn	
22.	We recommend initiating skin-to-skin contact and starting infant feeding within the first hour of life.	2B
23.	We recommend that the midwife or neonatologist/paediatrician perform the initial examination of the newborn to determine the infant's general well-being, confirm the gender, and identify serious anomalies that require immediate attention.	1B
24.	Any findings requiring escalation or further review should be discussed with the parents. A referral to the neonatologist/paediatrician should be made and documented in the healthcare record.	Best Practice
25.	Following the initial newborn examination, the clinical examination and screening of the newborn (including examination of the eyes, heart, hips, and testes) should be carried out within 72 hours of birth by an appropriately trained healthcare professional.	1B
	Vitamin K and the Prevention of Vitamin K Deficiency Bleeding	
26.	We recommend that all infants receive phytomenadione by intramuscular injection to prevent vitamin K deficiency bleeding in the newborn. Parents should be advised that phytomenadione administered orally is less effective than when administered intramuscularly, and subsequent doses are required.	1B
	Umbilical Cord Care	
27.	We recommend clean, dry cord care to reduce the risk of infection in the newborn.	1B
	Infant Skin Care	
28.	We recommend that bathing of an infant is delayed until 24 hours after birth (or at a minimum of 6 hours if cultural reasons do not permit) unless the mother is HIV/Hepatitis B positive, in which case the first bath should occur at the earliest opportunity following birth.	1C
29.	We recommend plain water should be the first choice for skin when bathing and cleansing during nappy changes. Routine application of topical emollients in term, healthy newborns for the prevention of skin conditions is not recommended.	1C
	Management of Infant Weight Loss	
30.	Infant weight loss over 10% of the birth weight requires clinical assessment, a detailed history to assess feeding, and referral to a neonatologist/paediatrician. Measures to improve infant weight gain should be documented in the healthcare record and communicated to the GP/PHN. A referral to an infant feeding specialist should also be considered.	1C
	Reducing the Risk of Neonatal Hypoglycaemia	
31.	Routine screening and monitoring of blood glucose levels are not necessary in healthy asymptomatic term newborn infants following a normal pregnancy and birth.	2C

32.	Initiation of infant feeding should ideally occur within the first hour of life, reducing the risk of hypoglycemia. Newborn infants should be kept warm, with their body temperature maintained between 36.5°C and 37.5 °C.	2B
33.	If signs of hypoglycemia are observed, a blood glucose measurement should be taken and an urgent review by a neonatologist/paediatrician should be sought.	2B
	Assessment of Neonatal Jaundice	
34.	Parents/carers should be informed about neonatal jaundice, including how to recognise the signs of jaundice and when to seek a medical review.	Best Practice
35.	Routine assessment of jaundice should form part of the infant's assessment of well-being. When undertaking a visual inspection for jaundice, examine the naked infant in bright, preferably natural light. Examine the sclerae and gums, and gently press the skin to check for signs of jaundice, which may appear as blanched skin. If jaundice is suspected or if the infant is non-caucasian, a TcB meter should be used.	Best Practice
36.	We recommend that all midwives caring for infants in the community setting should have access to TcB meters.	Best Practice
37.	Infants who develop any jaundice in the first 24 hours after birth should be reviewed by a neonatologist/paediatrician. Infants in the community setting should be referred to the on-call neonatologist/paediatrician as the infant requires urgent investigation. Refer to the HSE Newborn Clinical Examination Handbook for further guidance on the management of jaundice.	Best Practice
38.	We recommend that all infants have a TcB performed on discharge from the hospital or at 72 hours if not discharged.	Best Practice
	Newborn Screening	
39.	We recommend that pulse oximetry screening for congenital heart disease be performed on all newborn infants in line with the National Neonatal Practice Guideline, Neonatal Pulse Oximetry Screening for Congenital Heart Disease in Asymptomatic Infants in Postnatal Maternity Care.	1C
40.	We recommend that all newborn infants have a Newborn Bloodspot Screening (NBS) test in line with the Practical Guide to Newborn Bloodspot Screening in Ireland.	1C
41.	We recommend that all babies be offered a newborn hearing screening test in line with the National Newborn Hearing Screening Programme.	1C
	Vitamin D Supplementation	
42.	We recommend giving infants 5 micrograms of vitamin D3 as a daily supplement from birth to 12 months if they are either breastfed or taking less than 300ml of infant formula per day. Midwives should be aware of the Standard Operating Procedure – Testing infants for Congenital Cytomegalovirus (cCMV) following "No Clear Response" on Universal Newborn Hearing Screening.	1C
	Nirsevimab Immunisation	
43.	Nirsevimab immunisation should be recommended for all newborn infants in line with the current advice from the National Immunisation Advisory Committee.	1B

	'Red Flags' for Serious Illness in Infants	
44.	At each postnatal contact, mothers should be asked if they have concerns about their infant's general well-being, feeding or development.	Best Practice
45.	Prior to transferring home from the hospital or midwifery-led unit, or in the immediate postnatal period in the case of a homebirth setting, parents/carers should be given information (both verbally and in writing) on when and where to seek prompt, urgent attention.	Best Practice
	Emotional Attachment and Optimising Infant Mental Health	
46.	We recommend providing women and their families with information and resources which promote and support bonding and emotional attachment, including the benefits of these interventions for positive infant mental health in the immediate and longer term.	Best Practice
	Safer Sleep Practices	
47.	Mothers should be advised on safe sleeping practices to reduce the risk of sudden infant death syndrome. The use of the HSE Mychild.ie 0-2 book can aid the discussion.	Best Practice
No.	**Section 3: Discharge Planning and Interprofessional Communication**	**Grade**
	Transferring Care to the Community Setting	
48.	The transfer of care from the maternity unit/hospital to community care should be made in partnership with the woman, considering her needs, preferences, and available support.	Best Practice
49.	Before transfer to community care, the woman should be given information on when to seek medical advice and relevant contact numbers. This information should also be available in a written format and be available in other languages.	Best Practice
50.	Transfer of care should include sharing relevant information between healthcare professionals.	Best Practice

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this Guideline include:

1. There is documented evidence of a comprehensive maternal assessment. This should include assessment of uterine involution (as part of the initial assessment), vaginal bleeding, maternal vital signs, micturition and bowel function, perineal/wound healing, headaches and pain.
2. Women are provided with information on who to contact if any concerns arise.
3. There is documented evidence of the initial newborn assessment as outlined in the Newborn Clinical Examination Handbook.
4. There is documented evidence that all infants have a TCB performed prior to discharge or at 72 hours of age
5. Every woman (hospital and homebirth setting) should have a VTE risk assessment completed in the postnatal period.

Recommended reading:

1. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines How_to_Develop_HSE_National_Policies_Procedures_Protocols_and_Guidelines_gQBQ4os.pdf
2. National Institute for Health and Care Excellence. Postnatal Care NG 194 [Internet]. 2021. Available from: https://www.nice.org.uk/guidance/ng194
3. World Health Organization. Recommendations on maternal and newborn care for a positive postnatal experience. [Internet]. 2022. Available from: https://www.who.int/publications/i/item/9789240044074
4. National Institute for Health and Care Excellence. Caesarean Birth NICE Guidance (NG 192) [Internet]. 2025. Available from: https://www.nice.org.uk/guidance/ng192/chapter/Recommendations#care-of-the-woman-after-caesarean-birth
5. The Faculty of Sexual and Reproductive Healthcare. FSRH Guideline Contraception After Pregnancy [Internet]. 2017. Available from: https://www.fsrh.org/standards-and-guidance/documents/contraception-after-pregnancy-guideline-january-2017/
6. Vallejo N, Mc Cormack E, Rowland M, Dado M, Healy M, Brosnan M, et al. National Clinical Practice Guideline: Intrapartum Care for Women on the Supported Care Pathway [Internet]. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists.; 2025. Available from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/
7. Health Service Executive/ The National Healthy Childhood Programme. The Newborn Clinical Examination Handbook [Internet]. 2018. Available from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/child-health-and-wellbeing/newborn%20exam.pdf
8. National Institute for Health and Care Excellence. Faltering growth: recognition and management of faltering growth in children. NICE guideline [Internet]. 2017. Available from: https://www.nice.org.uk/guidance/ng75
9. British Association of Perinatal Medicine. Identification and Management of Neonatal Hypoglycaemia in the Full-Term Infant (Birth-72 hours). A BAPM Framework for Practice. 2024. https://www.bapm.org/resources/identification-and-management-of-neonatal-hypoglycaemia-in-the-full-term-infant-birth-72-hours
10. Newborn Bloodspot Screening Laboratory (NBSL). A Practical Guide to Newborn Bloodspot Screening in Ireland [Internet]. 2022. Available from: https://www.hse.ie/eng/health/child/newbornscreening/newbornbloodspotscreening/information-for-professionals/a-practical-guide-to-newborn-bloodspot-screening-in-ireland.pdf
11. Moon R, Carlin R, Hand I. Evidence Base for 2022 Updated Recommendations for a Safe Infant Sleeping Environment to Reduce the Risk of Sleep-Related Infant Deaths. Paediatrics. 2022;150(1):e2022027991. DOI: 10.1542/peds.2022-057991

Authors

Duggan J, Helen H, Dixon A, Cronolly C, Stanciu C, Murphy H, Gilligan E, Joyce L, Sarma S, Keegan C & Rowland M. National Clinical Practice Guideline on Postnatal Midwifery Care for the Mother and Infant: National Women and Infants Health Programme and the Institute of Obstetricians and Gynaecologists, March 2026.

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/