National Women & Infants Health Programme

National Clinical Practice Guideline

Postnatal Midwifery Care for Mother and Infant

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Guideline Development Group

Jennifer Duggan, Registered Advanced Midwife Practitioner, Galway University Hospital

Heather Helen, Lecturer in Midwifery, University of Galway

Aisling Dixon, Registered Advanced Midwife Practitioner, Portiuncula University Hospital

Carmel Cronolly, Candidate Advanced Midwife Practitioner, Galway University Hospital

Dr Claudia Stanciu, Paediatric Registrar, Mayo University Hospital

Helen Murphy, Director of Midwifery, Galway University Hospital

Eithne Gilligan, CMM2 Community Midwifery, Galway University Hospital

Lorna Joyce, Public Health Nurse, Galway

Dr Susmita Sarma, Consultant Obstetrician, Galway University Hospital

Caroline Keegan, Assistant Professor of Midwifery University of Galway

Mary Rowland, Assistant Director of Midwifery, National Women and Infants Health Programme

Guideline Programme Team

Professor Keelin O'Donoghue, Clinical Lead for Guideline Development

Nicolai Murphy, Programme Manager

The National Midwifery Clinical Guideline Programme

Angela Dunne, National Lead Midwife, National Women and Infant Health Programme

Clare Kennedy, Assistant Director of Midwifery, National Women and Infant Health Programme

Approved by

The National Women and Infants Health Programme (NWIHP) and the Institute of Obstetricians and Gynaecologists (IOG) Clinical Advisory Group (CAG), March 2026

Version Number: Version 1.0

Publication Date: May 2026

Date for Revision: May 2029

Electronic Location:

https://www2.healthservice.hse.ie/organisation/national-pppgs/

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

Version control

Version	Date Approved	Section numbers changed	Author

Cite this document as:

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, May 2026.

National Policy ☐ National Procedure ☐ National Protocol ☐ National Guideline ☐
National Clinical Guideline ☒

National Clinical Guideline
Postnatal Midwifery Care for Mother and Infant

DOCUMENT GOVERNANCE [1]	
Document Owner (post title):	National Clinical Lead for Guideline Development in Maternity and Gynaecology Services, National Women and Infants Health Programme (NWIHP)
Document Owner name:	Prof Keelin O'Donoghue
Document Owner email:	NWIHP.Corporate@hse.ie
Document Commissioner(s):	Prof Keelin O'Donoghue, National Clinical Lead for Guideline Development in Maternity and Gynaecology Services
Date Document Approved:	March 2026
Document Approved by:	Dr Cliona Murphy Clinical Director, NWIHP Chair, NWIHP/IOG Clinical Advisory Group
Document Approver Sign-off:	Cliona Murphy.
Document Approver Registration number:	17256
Development Group Name:	Jennifer Duggan, Heather Helen, Aisling Dixon, Carmel Cronolly, Dr Claudia Stanciu, Helen Murphy, Eithne Gilligan, Lorna Joyce, Dr Susmita Sarma, Caroline Keegan, Mary Rowland.
Development Group Chairperson:	Mary Rowland

DOCUMENT MANAGEMENT [2]			
Date effective from:		01/05/2026	
Date set for next review:		01/05/2029	
Your Reference No: *(if applicable)*		Click or tap here to enter text.	
Current version no:	1.0	**Archived version no:**	N/A
Note: HSE National PPPGs and Clinical Guidelines should be formally reviewed every 3 years, unless new legislative/regulatory or emerging issues/research/technology/audit etc. dictates sooner.			

[1] Records the governance and approval of the document.
[2] Records the control information about the document.

DOC TITLE: Postnatal Midwifery Care for Mother and Infant
VERSION NO: 1.0 EFFECTIVE FROM DATE: 01/05/2026 REVISION DUE DATE: 01/05/2029

VERSION CONTROL UPDATE [3]		
Version No. (most recent version first)	**Date reviewed** (most recent date first)	**Comments** (1 sentence max, if required)
1.0	01/05/2026	Original publication
Additional notes: If there are no amendments to the National document following a formal review, the date and detail of the review must still be recorded in the version control update box.		

PUBLICATION INFORMATION [4]
Topic:
Postnatal Midwifery Care for Mother and Infant
National Group:
Guideline Development Programme, National Women and Infants Health Programme
Short summary:
Evidence-based recommendations for caring for women post-birth and infants following birth. This Guideline aims to provide a nationally standardised approach for all maternity units, community midwifery teams, self-employed community midwives (SECMs), General Practitioners (GPs), practice nurses and Public Health Nurses (PHNs) to promote consistency of practice standards.
Description:
This national guideline provides evidence-based recommendations for postnatal midwifery care of mother and infant. It addresses maternal physiological assessment, management of common ailments, infant feeding support, anaemia, mental health, and contraception. Infant care recommendations cover newborn examination, vitamin K, jaundice, neonatal screening, and discharge planning, promoting standardised care nationally.

[3] Records details of the document review or update, even if no changes are made.
[4] Records the document information required for publication on the HSE National Central Repository.

Contents

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

Chapter 1: **Initiation**

The National Clinical Effectiveness Committee (NCEC) and the Health Information and Quality Authority (HIQA) define clinical guidelines as systematically developed statements based on a thorough evaluation of the evidence to assist practitioners and patients in making decisions about appropriate healthcare for specific clinical circumstances across the entire clinical spectrum.[1]

1.1 Purpose

The purpose of this Guideline is to develop and provide comprehensive, evidence-based guidance for the provision of postnatal care for women and infants. This document provides guidance to healthcare professionals (HCPs) on delivering safe, evidence-based care to pregnant women. A comprehensive literature review was undertaken, which included a review of international guidelines. Where there is a lack of strong evidence, consensus, and expert opinion informs the clinical practice recommendations. This Guideline is designed to guide clinical judgment but not to replace it.

1.2 Scope

Target Users

The Guideline is a resource for all clinicians working in maternity services in the field of postnatal care. Postnatal care is provided in various settings for example, labour ward, theatre recovery area, postnatal ward, midwifery-led units and in the homebirth setting. This Guideline applies to postnatal care, whether delivered in a hospital setting or a community setting in the woman's home.

This Guideline promotes a multi-disciplinary approach and applies to midwives, advanced midwifery practitioners,[2] doctors, public health nurses, practice nurses, health and social care professionals involved in the care of postnatal services in hospitals and community settings.

Target Population

This Guideline describes routine care for healthy women following birth (including caesarean section) and infants born from 37 weeks' gestation. It includes recommendations for standard observations of well-being, physical and psychological assessments and education. It does not describe management that may be offered if a woman's or infant's clinical assessment deviates from normal parameters. Clinicians will need to refer to specific policies, protocols, procedures, and guidelines (PPPGs), as well as local policies and procedures, for escalation pathways. It is the midwife's responsibility to escalate care to the multidisciplinary team when deviations from normal or expected ranges are identified, which is in line with national guidelines.[3]

1 National Clinical Effectiveness Committee (NCEC) and Health Information and Quality Authority (HIQA) (2015) National quality assurance criteria for clinical guidelines. Version 2. Dublin: NCEC and HIQA. https://www.hiqa.ie/sites/default/files/2017-01/National-Quality-Assurance-Criteria.pdf

2 Nursing and Midwifery Board of Ireland (NMBI) Advanced Practice (Midwifery) Standards and Requirements. (2018) Dublin.

3 Nursing and Midwifery Board of Ireland (NMBI) Practice Standards for Midwives. (2022) Dublin.

This Guideline is also a resource for women and their partners during the postnatal period, outlining the standards expected to ensure safe, high-quality care.

The minimum duration of a postnatal ward stay is outside the scope of this Guideline. The decision to discharge a woman and infant should be made on an individual basis, taking into account the supports available to the woman, any birth or postnatal complications, as well as the health and well-being of the infant. Refer to the local discharge policy for further guidance.

Where mentioned, community care refers to care provided to women and infants by community midwifery teams, public health nurses, and general practitioners (GPs), as well as by the attending Midwife prior to her departure following a home birth.

The timing of resuming exercise in the postnatal period is not addressed in this guideline. Midwives should refer to the HSE Every Move Counts: National Physical Activity and Sedentary Behaviours Guidelines for Ireland: For Pregnant and Postpartum Women.[4]

1.3 Objective

To provide evidence-based recommendations for caring for women post-birth and infants following birth. This Guideline aims to provide a nationally standardised approach for all maternity units, community midwifery teams, self-employed community midwives (SECMs), General Practitioners (GPs), practice nurses and Public Health Nurses (PHNs) to promote consistency of practice standards.

1.4 Guideline Development Process

The Guideline Developers agreed to undertake this work under the direction of the Guideline Programme Team (GPT). The GPT commissioned an Expert Advisory Group (EAG) to critically review the Guideline prior to submission to the National Women and Infants Health Programme (NWIHP) for final approval. See Appendix 1 for EAG membership and Appendix 2 for the Guideline development process.

The EAG reviewed the Guideline on two occasions, firstly in November 2023 and again in June 2025. The National Directors of Midwifery Forum were also invited to review and provide feedback in 2025 prior to the EAG meeting.

The Guideline Development Group comprised healthcare professionals with a special interest in or expertise in maternity services. This group has representatives from hospitals, the community, and academia. Membership includes professionals from the areas of Midwifery, Paediatrics, Public Health, and Obstetrics.

The Guideline Developer Group members are acknowledged below:

- Jennifer Duggan, Registered Advanced Midwife Practitioner
- Heather Helen, Lecturer in Midwifery
- Aisling Dixon, Registered Advanced Midwife Practitioner
- Carmel Cronolly, Candidate Advanced Midwife Practitioner
- Dr Claudia Stanciu, Registrar in Paediatrics
- Helen Murphy, Director of Midwifery
- Eithne Gilligan (until Dec. 2023), Clinical Midwife Manager 2
- Lorna Joyce, Public Health Nurse
- Dr Susmita Sarma, Consultant Obstetrician

4 HSE Every Move Counts: National Physical Activity and Sedentary Behaviours Guidelines for Ireland: For Pregnant and Postpartum Women

- Caroline Keegan, Assistant Professor of Midwifery
- Mary Rowland, Assistant Director of Midwifery

1.5 Stakeholder involvement

Stakeholders are people who have a common interest in improving health services. This includes persons responsible for delivering and those receiving services related to the clinical guideline.

Stakeholder review group members and the Association for Improvements in the Maternity Services Ireland (AIMS) service user representatives were invited to review the guideline during the development process (Appendix 3). The Guideline Development Group would like to acknowledge the reviewers' contribution to its development.

1.6 Disclosure of interests

Guideline developers and reviewers bring a range of experiences and perspectives to the work of the National Guideline Programme. Both Guideline developers and stakeholders/reviewers will likely have a variety of interests, arising from different contexts and activities done in a professional or personal capacity. These can include employment and other sources of income, speaking engagements, publications, research, and membership of professional or voluntary organisations. The involvement of individuals with relevant content expertise is essential for enhancing the value of Guideline recommendations; however, these individuals may also have interests that can lead to conflicts of interest, as may peer reviewers, patient representatives, and researchers.

All interests should be declared if, in the view of a reasonable person, they are relevant, or could be perceived to be relevant, to the work of the Clinical Practice Guideline in question.[5] Declaring an interest does not mean there is a conflict of interest.

It is important that interests are openly declared so they can be appropriately managed. Conflicts of interest can bias recommendations and ultimately harm women and the healthcare system. Disclosures of interests and appropriate management of conflicts of interest, when identified, are therefore essential to producing high-quality, credible health guidelines.[6]

The Guidelines International Network (GIN), a global network of Guideline developers that aims to promote best practices in the development of high-quality guidelines, developed a set of nine principles to provide guidance on how financial and non-financial conflicts of interest should be both disclosed and managed. It is recommended that Guideline developers follow the GIN principles.[7]

For this National Clinical Practice Guideline, all Guideline developers are asked to complete a conflict of interest declaration form. The guideline programme team will manage the response to declared interests in accordance with GIN principles. Conflicts of interest may be reported in the published Guideline, and declarations of interest can be made available.

No disclosures of interests were made from the Guideline Developer Group.

---

5 NICE (2019) Policy on declaring and managing interests for NICE advisory committees https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/declaration-of-interests-policy.pdf

6 Traversy G, Barnieh L, Akl EA, Allan GM, Brouwers M, Ganache I, Grundy Q, Guyatt GH, Kelsall D, Leng G, Moore A, Persaud N, Schünemann HJ, Straus S, Thombs BD, Rodin R, Tonelli M. CMAJ. 2021, 193(2):E49-E54. DOI: 10.1503/cmaj.200651 https://www.cmaj.ca/content/193/2/E49

7 Holger J. Schünemann, Lubna A. Al-Ansary, Frode Forland, et al.; for the Board of Trustees of the Guidelines International Network. Guidelines International Network: Principles for disclosure of interests and management of conflicts in guidelines. Ann Intern Med. 2015;163:548-553. doi: 10.7326/M14-1885. https://www.acpjournals.org/doi/10.7326/m14-1885

1.7 Disclaimer

These guidelines has been prepared using a multidisciplinary approach to promote and facilitate the standardisation and consistency of good clinical practice. The information in this guideline is current at the time of publication.

The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the Clinician in light of clinical data presented by women and the diagnostic and treatment options available. The clinical material offered in this Guideline does not replace or remove clinical judgment or the professional care and duty necessary for each individual woman. The clinical care provided in accordance with this Guideline should be delivered within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible for the following:

- Discussing care with women in an appropriate environment that enables respectful, confidential discussion. This includes the use of interpreter services where necessary.
- Listening to women and being responsive to their needs and preferences.
- Offering women information about their choices and ensure informed consent is obtained.
- Providing care within the professional scope of practice, meeting all legislative requirements and maintaining standards of professional conduct.
- Applying standard precautions and additional precautions, as necessary, when delivering care.
- Documenting all care in accordance with local and mandatory requirements.

1.8 Use of language

Within this guidance we use the terms ‘woman’ and ‘women’s health’. However, it is important to acknowledge that people who do not identify as cis-gender women are excluded from this descriptor, including people who identify as transgender, gender diverse and gender non-binary.[8] While there has been a trend to remove the word ‘woman/women’ and use ‘gender neutral’ language in policy and practice in relation to women’s reproductive health and wellbeing, there is no evidence base to inform this change.[9] We also appreciate that there are risks to desexing language when describing female reproduction.[10, 11]

Services and delivery of care must be appropriate, inclusive and sensitive to the needs of people whose gender identity does not align with the sex they were assigned at birth. This includes training and education regarding diverse pathways to pregnancy and the use of practices which affirm the sexual and gender identities of all people using Obstetrics and Gynaecology services. Finally, all those using maternal and reproductive health care and services should receive individualised, respectful care including use of the gender nouns and pronouns they prefer.[7]

---

8 Moseson H, Zazanis N, Goldberg E, et al. The Imperative for Transgender and Gender Nonbinary Inclusion. Obstet Gynecol. 2020;135(5):1059-1068. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7170432/

9 Council of Deans of Health. Midwifery Network position paper: use of sexed language. May 2023. https://www.councilofdeans.org.uk/2024/02/midwifery-network-position-paper-use-of-sexed-language/

10 Brotto LA, Galea LAM. Gender inclusivity in women’s health research. BJOG: An International Journal of Obstetrics & Gynaecology. https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.17231

11 Gribble KD, Bewley S, Bartick MC, et al. Effective Communication About Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language. *Frontiers in Global Women’s Health*. 2022;3. Accessed June 9, 2022. https://www.frontiersin.org/article/10.3389/fgwh.2022.818856

Language use is key to effectively communicate options, recommendations, and respectfully accept a woman's fully informed decision.[12] With this in mind, the use of birth is preferable to the term delivery in all circumstances and is used consistently where possible throughout the guidelines. It is acknowledged that in some circumstances (e.g., in the case of a medically indicated intervention or surgery) and in some contexts, substituting with the term delivery is considered appropriate and this term may be used instead.

1.9 Adopting a trauma-informed approach to maternity care

Many women accessing maternity services may have experienced historical or current trauma prior to, or during pregnancy – including emotional, physical, sexual abuse, rape and torture. The perinatal period (pregnancy, birth and the postpartum) can be a time when previous trauma is triggered.[13] Maternity care procedures which may seem routine and 'non-invasive' to healthcare professionals (HCPs), e.g., abdominal palpation or providing breastfeeding support can be triggering for some women with a history of trauma, as can intimate procedures such as vaginal examinations.[14]

Trauma-informed care (TIC) is a developing approach to healthcare which recognises the importance of psychological safety, and the need to prevent or resist re-traumatisation of individuals.[15] It is based on 4 key principles (known as the 4Rs): (1) realisation of trauma; (2) recognition of trauma; (3) responding to trauma and (4) resisting re-traumatisation.[16] A trauma-informed approach to maternity care means that all staff in an organisation have an understanding of the impact of trauma on individuals, families and organisations.[17] While a universal approach is yet to be agreed, within clinical practice and research, many organisations recognise the need to move towards becoming trauma-informed in the provision of maternity care.[15, 18] Such an approach requires commitment, investment and transformation within maternity services.

12 https://blogs.bmj.com/bmj/2018/02/08/humanising-birth-does-the-language-we-use-matter/

13 Horsche A., Garthus-Niegel S., Ayers S, Chandra P., Hartmann K., Caisbuch E., Lalor J (2024). Childbirth-related posttraumatic stress disorder: definition, risk factors, pathophysiology, diagnosis, prevention, and treatment. Am J Obstet Gynecol. 2024 Mar;230(3S): S1116-S1127. doi: 10.1016/j.ajog.2023.09.089

14 Montgomery E. Feeling safe: a metasynthesis of the maternity care needs of women who were sexually abused in childhood. Birth 40:88-95. Birth. 2013 Jun;40(2):88-95. doi: 10.1111/birt.12043

15 Vogel TM, Coffin E. (2021). Trauma-informed care on labor and delivery. Anesthesiol Clin. 2021 Dec;39(4):779-791. doi: 10.1016/j.anclin.2021.08.007

16 Substance Abuse and Mental health Services Administration. SAMHSA'a Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

17 Law C, Wolfenden L, Sperlich M, Taylor J. A (2021). Good practice guide to support implementation of trauma-informed care in the perinatal period. The centre for early child development (Blackpool, UK) commissioned by NHS England and NHS Improvement in 2021. https://www.england.nhs.uk/publication/a-good-practice-guide-to-support-implementation-of-trauma-informed-care-in-the-perinatal-period/

18 Ayers, S., Horsch, A., Garthus-Niegel, S., Nieuwenhuijze, M., Bogaerts, A., Hartmann, K., Karlsdottir, S. I., Oosterman, M., Tecirli, G., Turner, J. D., Lalor, J., & COST Action CA18211 (2024). Traumatic birth and childbirth-related post-traumatic stress disorder: International expert consensus recommendations for practice, policy, and research. *Women and birth : journal of the Australian College of Midwives, 37*(2), 362-367. https://doi.org/10.1016/j.wombi.2023.11.006

In simple terms, HCPs should recognise the impact of women's previous or current history of trauma (whether disclosed or not) and adopt a universally sensitive approach to care provision that recognises the impact of trauma on service users and HCPs. Examples of this include ensuring clear communication and consent is sought before any procedures/interventions, ensuring women are provided with dignity and respect at all times.

Women want to talk about their birth experience with healthcare professionals following birth. Findings by Baxter[19] provide evidence of an association between a negative birth experience and emotional distress. Women who have increased levels of distress are more likely to need additional support from professionals. Opportunities for de-briefing following birth should be offered as advocated by HSE National Maternity Experience Survey (2020). The National Clinical Practice guideline on the screening and management of domestic violence[20] recommends that:

- Postnatal screening of domestic violence for all women takes place prior to discharge from hospital, or community and domiciliary services using the Recognise, Respond and Refer algorithm.
- Disclosures of domestic violence are notified with consent to General Practitioners (GPs) and Public Health Nurses (PHNs) in discharge letters to ensure further and ongoing support for women.

19 Baxter J. Postnatal debriefing: women's need to talk after birth. British Journal of Midwifery. 2019 Sep 2;27(9):563-71. https://doi.org/10.12968/bjom.2019.27.9.563

20 Webster J, Lawlor S, Kavanagh D, Breen A, Sheil O, McCarthy AM, O'Brien Green S, Kirby F, Leahy M. National Clinical Practice Guideline: Management of Domestic Violence and Abuse in Pregnancy. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. May 2024 National Clinical Practice Guideline Screening and Management of Domestic Violence in Pregnancy and the Early Postnatal Period (rcpi.ie)

Chapter 2:
Clinical Practice Guideline

Background

Irish maternity services compare well internationally in terms of safety and clinical outcomes; however, historical service deficits have undermined public confidence in maternity services in recent years.[1] In light of this, a National Maternity Strategy was developed to fundamentally overhaul maternity services and recognise the value of the best available evidence. The Strategy aims to inform women about choices in maternity care, stratify pregnancy risk, and support them throughout their pregnancy journey.[1]

A strategic priority of the National Maternity Strategy is to standardise practice with consistent and equitable women-centred care across all settings nationally. The Strategy acknowledges pregnancy and birth as a normal physiological process where care is woman-centred and takes account of women's experiences and preferences.[1] Similarly, support from partners, friends, and family should be encouraged during the postnatal period according to the woman's wishes.[2] Each woman will have a named lead healthcare professional/midwifery team who will have overall clinical responsibility for her care. Whilst the Strategy supports an evidence-based and team-based approach to care across all settings, it also advocates for integrated care as close to home as possible. This places midwives as part of the multidisciplinary team (MDT) between the community and hospital, supporting the woman through all stages of her pregnancy.[1]

The International Confederation of Midwives[3] and the Nursing & Midwifery Board of Ireland (NMBI)[4] state that midwives offer care based on a philosophy recognising 'pregnancy and childbearing as usually a normal physiological process' and is a profound experience with significant meaning to a woman, her family, and the community. The NMBI Practice Standards for Midwives recognise the provision of safe, competent, kind, and compassionate care, informed by the best available evidence, the midwife's expertise, and the woman's experiences, preferences, and values as fundamental standards of care.[5] The scope of midwifery practice[4] is inclusive of women during pregnancy, labour, and into the postpartum period, recognising midwives: *'care for and help the mother during labour and monitor the condition of the baby in the womb using appropriate clinical and technical means, conduct spontaneous deliveries, examine and care for the newborn infant and take all initiatives that are required, including resuscitation if necessary and care for and monitor the progress of the mother in the postnatal period, advising her on infant care so that the baby makes the best possible progress' (page 11 & 12)*.

The guideline development group identifies that integrated team-based care, stakeholder involvement, strengthening of midwifery roles, robust governance structures, and evidence-based practice guidelines are essential for care to be considered woman—and family-centred, safe, and accessible.

The post-birth experience or puerperium starts immediately following the birth of the infant, placenta and membranes. This is generally referred to as the postnatal period.[6] The mother begins the process of physical and psychological recovery, where the woman's body systems return to their pre-pregnant state.[6]

There is much debate as to when post-birth or postnatal care should end, but it is generally recognised as ending at approximately six weeks.[7] However, the most recent guidance by the National Institute for Health and Care Excellence on routine postnatal care does not define the length of the postnatal period as it depends on individual care needs.[2] The Nursing and Midwifery Board of Ireland defines the postnatal period as extending from immediately after birth to 6 weeks (42 days) typically.[5] This will be the timeframe adopted by this Guideline.

Recommendations relevant to this Guideline may also be found in the following documents:

- National Clinical Practice Guideline: Intrapartum Care of Women on the Supported Care Pathway.[21]
- National Clinical Practice Guideline: Management of Domestic Violence and Abuse in Pregnancy.[22]
- National Clinical Practice Guideline: Assessment and Management of Stress Urinary Incontinence in Women.[23]
- National Clinical Practice Guideline: Prevention and Management of Primary Postpartum Haemorrhage.[24]
- HSE Every Move Counts: National Physical Activity and Sedentary Behaviours Guidelines for Ireland: For Pregnant and Postpartum Women.[4]

21 Vallejo, N., Mc Cormack, E., Rowland, M., Dado, M.P., Healy, M., Brosnan, M., Imcha, M., Plans, C., National Clinical Practice Guideline: Intrapartum Care of Women on the Supported Care Pathway. National Women and Infants Health Programme, June 2025.

22 Webster J, Lawlor S, Kavanagh D, Breen A, Sheil O, McCarthy AM, O'Brien Green S, Kirby F, Leahy M. National Clinical Practice Guideline: Management of Domestic Violence and Abuse in Pregnancy. National Women and Infants Health Programme and the Institute of Obstetricians and Gynaecologists. May 2024

23 Craven, S., Salameh, F., O' Sullivan, S. National Clinical Practice Guideline: Assessment and Management of Stress Urinary Incontinence in women. National Women and Infants Health Programme and the Institute of Obstetricians and Gynaecologists. December 2022

24 Byrne B, Spring A, Barrett N, Power J, McKernan J, Brophy, D, Houston C, Faryal R, McMahon E, Manning C, Murphy P, Ni Ainle F. National Clinical Practice Guideline: Prevention and Management of Primary Postpartum Haemorrhage. National Women and Infants Health Programme and the Institute of Obstetricians and Gynaecologists, December 2022.

Section 1: Maternal Care

Introduction

This section will address the recommended maternal care, information, and support the woman should receive in the postnatal period. It will include providing information so the woman is aware of the normal variances of physiology post-birth and when abnormalities arise that require escalation to other healthcare professionals. This section refers to the ongoing postnatal care of the woman. The immediate postnatal care for women (defined as the first postnatal hour) is addressed in the *National Clinical Practice Guideline: Intrapartum Care for Women on the Supported Care Pathway (2025).* The assessment and repair of perineal trauma are also covered within this guideline.

Clinical Question 2.1: What is the recommended care when undertaking a physiological assessment of the woman in the postnatal period?

Evidence Statement

Early detection of conditions that may adversely affect women's health and well-being is an important component of quality postnatal care.[8] Regardless of place of birth, all postpartum women should have a comprehensive postnatal assessment, starting from the first hour following birth. The assessment should include evaluation of vaginal bleeding, uterine contraction, fundal height, temperature, pulse, and blood pressure.[8] Subsequent postnatal contact after the initial 24 hours after birth, assessment should include enquiries concerning general well-being, micturition, bowel function, healing of any perineal/abdominal wound, headaches, fatigue, perineal pain and hygiene, breast pain, uterine tenderness and lochia.[8]

Vaginal bleeding

Normal shedding of blood and decidua is referred to as lochia rubra (red/red-brown) and lasts for the first few days following birth. Vaginal discharge then becomes increasingly watery, called lochia serosa (pinkish brown), which lasts for two to three weeks. Ultimately, the discharge turns yellowish white, the lochia alba. Microscopically, lochia consists of serous exudate, erythrocytes, leukocytes, decidua, epithelial cells, and bacteria. Up to 15% of women continue to pass lochia when seen for a routine postpartum visit six to eight weeks after birth. The duration of lochia does not appear to be related to lactation or to the use of either oestrogen-containing or progesterone-only contraceptives, but women with bleeding conditions may be prone to a longer duration of passing lochia.[9]

The National Institute for Health and Care Excellence (NICE) guideline on Postnatal Care[2] recommends that women should be advised on what vaginal bleeding to expect after birth, and advise women to seek medical advice if:

- vaginal bleeding is sudden or very heavy
- bleeding increases
- they pass clots, placental tissue or membranes
- have symptoms of possible infection, such as abdominal, pelvic or perineal pain, fever, shivering, or vaginal bleeding or discharge that has an unpleasant smell
- she has concerns about vaginal bleeding after the birth

Uterine contraction/involution and fundal height

Uterine involution is the process that occurs immediately after the birth of the placenta, where the uterus begins to return to its non-pregnant size and condition. Contraction of the interlacing myometrial muscle bundles constricts the intramyometrial vessels and impedes blood flow, which is the major mechanism preventing haemorrhage at the placental site.[10] Myometrial retraction is a unique characteristic of the uterine muscle that enables it to maintain its shortened length following successive contractions, and this process results in the involution of the uterus. Inadequate myometrial contraction will result in atony (i.e. a soft, boggy uterus), which is the most common cause of primary postpartum haemorrhage. In addition to myometrial contraction, thrombosis of large vessels at the placental site is a secondary haemostatic mechanism for preventing blood loss.[9] Immediately after birth, the fundus is normally firm, non-tender, globular, and located midway between the symphysis pubis and umbilicus. In the next 12 hours, it rises to just above or below the umbilicus, then recedes by approximately 1 cm/day to lie midway between the symphysis pubis and umbilicus by the end of the first postpartum week. It is not palpable abdominally by two weeks postpartum and attains its normal non-pregnant size by six to eight weeks postpartum. This process is modestly affected by pre-birth uterine over distention, multiparity, and caesarean birth (the uterus is slightly larger in these cases) as well as breastfeeding (the uterus is slightly smaller at three months postpartum in breastfeeding individuals).[11] Routine assessment of the uterus by abdominal palpation or measurement in the absence of abnormal vaginal loss is not necessary[12] as there is no evidence that uterine size is predictive of complications.[11, 13]

Maternal observations

Recording of vital signs includes respiratory rate, temperature, maternal heart rate, blood pressure and AVPU neurological response and should be completed at each set of observations.[13] The baseline recordings and the woman's individual clinical circumstances should determine the subsequent frequency of observations. If these observations are not within normal parameters, they should be repeated and escalated accordingly using the ISBAR tool. Refer to Irish Maternity Early Warning System (IMEWS) V2 National Clinical Guideline No. 4 2019.[13]

Micturition

Hormonal changes in pregnancy affect the bladder's function during pregnancy and the puerperium.[14,15] The bladder adapts during pregnancy, with increased capacity, tone, and urethral length.[15,16] These physiological changes protect against urinary incontinence in pregnancy, however childbirth may lead to postpartum urinary retention (PUR).[16]

There are variances when describing PUR, leading to a broad incidence range of PUR, ranging from 0.18% to 47%.[17] Yip et al. describe PUR as manifesting in two forms: overt and covert.[18] Overt PUR is characterised by an inability to urinate 6 hours following vaginal birth or requires re-catheterisation 6 hours subsequent to catheter removal following a caesarean section. Covert PUR, is denoted by a post-void residual volume (PVRV) exceeding 150 mL following the initial spontaneous urination, as gauged by ultrasound or catheter, indicative of incomplete urination.[18] Unidentified PUR has been associated with damage to the upper urinary tract, recurrent urinary tract infections, long-term bladder dysfunction, and urinary retention.[19]

A recent systematic review and meta-analysis identified risk factors for PUR.[20] The meta-analysis included[21] studies with a total of 36951 participants. Instrumental delivery, extended labour duration, episiotomy, nulliparity, epidural analgesia, labour induction/augmentation, and perineal injury are significant risk factors for PUR.[20]

Bowel function

Normal bowel activity is considered to be between three movements a day and three movements a week.[21] It is normal not to have a bowel movement for a few days post-birth, which may increase the risk of constipation. Women should be advised that any disruption to their normal bowel pattern should resolve within days of the birth, taking into account the recovery required by the presence of perineal trauma. They should also be reassured about the effect of a bowel movement on the area that has been sutured.[22]

Perineal wound healing

As part of assessing perineal wound healing, the woman should be asked if she has any concerns and specific questions about:[2]

- Pain not resolving or worsening
- Increasing need for pain relief
- Discharge that has a strong or unpleasant smell
- Swelling
- Wound breakdown
- Fever and/or flu-like symptoms

Good perineal hygiene should be advised, including daily showering of the perineum, frequent changing of sanitary pads, and hand washing.[2] If the woman or the healthcare professional has concerns about perineal healing or if the woman asks for reassurance, offer an examination of the perineum.[2] If there is evidence of perineal breakdown or there are ongoing healing concerns, the woman should be referred to specialist maternity services.

Abdominal wound healing

A wound disrupts the normal structure and function of the skin. To ensure proper healing through the expected stages, the wound base should have a good blood supply, be clear of infection and be moist.[23] The overall goal in managing acute wounds is to provide an optimal wound-healing environment with little disturbance to the wound, thereby reducing the risk of bacterial contamination.[24]

Wound dressings play a pivotal role in wound healing and achieving an optimal moisture balance within the wound. The primary objective of wound management is to eliminate or control all factors that prevent healing and to develop and maintain conditions that promote and enhance healing.[24]

Due to the limited randomised controlled trials, there is a variance in the management of wounds and removal of dressings. The removal of dressings from clean or clean/contaminated surgical wounds within 48 hours of surgery (i.e. the period of epithelization) appears to have no detrimental effect on outcomes, compared with removal after 48 hours.[25] A subsequent randomised controlled trial involving 320 women who underwent scheduled caesarean birth reported no detrimental effects from dressing removal at 6 versus 24 hours post-surgery.[26] The NICE guidance on caesarean birth[27] recommends that caesarean section wound care should include the removal of standard dressings 6 to 24 hours after the caesarean birth. Conversely, the HSE National Wound Management Guidelines (2018) advises that decisions about how to dress a wound following surgery should be based on the woman and wound assessment, the care plan, the woman's preference and comfort and cost of the dressing.[24]

Women with increased risk factors for delayed wound healing may benefit from the use of Negative Pressure Wound Therapy (NPWT). The evidence from a Cochrane systematic review examining the effect of NPWT on preventing surgical site infections (SSIs) and wound complications found moderate-certainty evidence that NPWT results in fewer SSIs than treatment with standard dressings.[28]

Headaches

The postpartum period is characterised by hormonal and other physiological changes, sleep deprivation, dehydration, psychological stress, and fatigue. Although headaches are common in the postpartum period, the prevalence across studies varies widely, depending on the definitions used, method of ascertainment (e.g., discharge diagnosis, postal survey, patient evaluation), timing (from two to four days postpartum to one year after birth), and patient population (e.g., breastfeeding status).[29, 30, 31]

A prospective study (985 postpartum women) found that of the 381 women who reported mild or moderate headaches, the most common aetiologies were tension-type (38.3%), migraine (26.8%), musculoskeletal (11.3%), postdural puncture (4.7%) and cervicogenic (3.4%).[29] A further retrospective study of 95 postpartum women with severe unrelenting headache greater than 24 hours and less than 42 days from the time of birth, the types and frequencies of headache were tension-type (39%), pre-eclampsia/eclampsia (24%), post-dural puncture (16%), migraine (11%), pituitary haemorrhage/mass (3%), cerebral venous thrombosis (3%), and other (4%).[30] A retrospective review found that of 63 postpartum women who presented with acute postpartum headache, 27% (17/63) had a primary headache disorder (most commonly migraine), and 73% (46/63) had a secondary headache disorder (post-dural puncture headache, pre-eclampsia, pituitary apoplexy, cerebral venous thrombosis, moyamoya, reversible cerebral vasoconstriction syndrome (RCVS), posterior reversible encephalopathy syndrome (PRES), vertebral artery dissection, medication-related headache, anaemia related headache).[31]

Persistent or severe headaches, which could indicate hypertension, pre-eclampsia, post-dural-puncture headache, migraine, intracranial pathology or infection, warrant a medical review.[2]

Perineal pain

Women who have experienced episiotomy, labial or perineal tears, assisted vaginal birth, wound infection or breakdown, or traumatic birth have an increased risk of depression, long-term perineal pain, problems with daily functioning and psychosexual difficulties.[2] Pain management will be discussed in more detail in clinical question 2.2.

Venous thromboembolism (VTE)

Thrombosis and thromboembolism remain the leading cause of direct maternal deaths during or up to six weeks after the end of pregnancy.[32, 33] As women are at an increased risk of VTE in the postnatal period, reassessment of VTE should be undertaken.

Refer to the National Clinical Practice guideline for further guidance: Venous Thromboprophylaxis in Pregnancy 2013.[34] This guideline is being revised and is due to be published in 2026.

Clinical Practice

The following observations are considered core components of quality postnatal care, regardless of the location (i.e. maternity ward, home, and midwifery-led unit).

Uterine contraction/involution and vaginal bleeding/lochia

- All postpartum women should have an assessment of vaginal bleeding, uterine contraction, fundal height, and vital signs recorded in the healthcare record. Escalate care if abnormalities are identified.
- Observe for signs and symptoms of post-partum haemorrhage, including sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations, and tachycardia.

Refer to National Clinical Practice Guideline – Prevention and Management of Primary Postpartum Haemorrhage[35] for further guidance.

Maternal observations

The frequency of observations should be determined by the risk assessment of the woman.

- Women who have a low-risk pregnancy, labour and birth should have a complete set of vital signs taken and recorded on the IMEWS chart within 12 hours of arriving at the postnatal ward and then every 24 hours as a minimum subsequently.
- A minimum frequency of 4-hourly observations applies to all women under review for infection or hypertension. All standard vital signs should be recorded for these observations, including respirations, maternal pulse, temperature, blood pressure, pain score, and neurological response.
- Women who had a caesarean birth or required surgical intervention should be monitored more closely, and a complete set of vital signs (urinalysis only if applicable) should be recorded.
    - Every 5 minutes for 15 minutes
    - Thereafter, every 15 minutes for 1 hour
    - Thereafter, every 30 minutes for 1 hour
    - Thereafter, every hour for 2 hours
    - Thereafter, every 4 hours for 48 hours
    - Thereafter, daily until discharge

In the homebirth setting: following birth, a complete set of vital signs should be taken and recorded on the IMEWS chart prior to the Midwife leaving the home.

Early transfer home: a complete set of vital signs should be taken at each postnatal visit and recorded on the IMEWS chart.

Refer to the Irish Maternity Early Warning System (IMEWS) V2 National Clinical Guideline No. 4 2019[14] for further guidance.

Observe for signs and symptoms of infection, such as history of fever or rigours, flu-like symptoms, unexplained abdominal pain, pelvic pain, wound/breast/perineal infection or new onset of confusion. If sepsis is suspected, refer to the Department of Health 2021 Sepsis Management for Adults (including maternity). National Clinical Guideline No. 26.pdf for further guidance.

Micturition

All women should be monitored and encouraged to void within four to six hours post-birth or removal of a urinary catheter as early identification is the key to management of urinary retention. The timing and volume of the first void should be recorded, and if this void is over 200mls, no further action is required. If the void is less than 200 mL, refer to the obstetric team for review.

If a woman has not voided urine by 6 hours postpartum and measures to encourage micturition, such as taking a warm bath or shower, have not been immediately successful, seek a review from the obstetric team.

In the home birth setting, ensure the woman has passed urine prior to the Midwife departing the home following the birth.

Bowel function

Women should be asked about their bowel function at each postnatal check. Clinical question 2.2 will discuss dietary advice and preventative measures for constipation.

Perineal wounds and healing

Women should be advised of the importance of perineal hygiene, including frequent changes of sanitary pads, washing hands before and after, and daily bathing or showering to keep their perineum clean.

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 appropriate explanation and gaining consent.

If the perineal wound breaks down or there are ongoing healing concerns, refer the woman urgently to the maternity services for review.

Abdominal wound (caesarean section)

The wound site/dressing should be observed regularly for bleeding in the immediate postoperative period. The type and amount of exudate should be documented in the healthcare record. Refer to the maternal healthcare record for obstetric post-operative instructions.

After the initial 24 hours, continue to observe the wound site for signs of haemorrhage, haematoma, infection or dehiscence. This may be evident by the woman complaining of increasing pain or warmth of the wound, or as discharge, oozing or redness visible through the dressing. If there are concerns, refer to the obstetric team for review.

In line with the HSE National Wound Care Guideline (2018), decisions about how to dress a wound following surgery should be based on the woman and wound assessment, the care plan, the woman's preference and comfort and cost of the dressing. Further guidance on wound management can be found in the HSE National Wound Management Guideline (2018).[36]

Headaches

Persistent or severe headaches, which could indicate hypertension, pre-eclampsia, post-dural-puncture headache, migraine, intracranial pathology or infection, warrant a medical review.

Pain

During each postnatal check, all women should be asked about pain (perineal and/or abdominal wound) and other perineal conditions, such as perineal trauma healing and haemorrhoids. They should also be advised on pain-relieving options available (to be discussed further in clinical question 2.2).

Venous thromboembolism (VTE)

Women should be encouraged to resume their usual mobility capabilities as soon as possible postpartum to reduce the risk of complications and VTE. Women who have received epidural/spinal analgesia should mobilise when sensation returns and be able to perform a straight leg raise without weakness (within 4 hours of the last epidural dose) or as instructed by the anaesthetist. All women should have a VTE risk assessment completed in the postpartum period. This includes women in the homebirth setting. Refer to the national clinical practice guideline: Venous Thromboprophylaxis in Pregnancy 2013 venous-thromboprophylaxis-in-pregnancy.pdf (hse.ie) for further guidance.[34] Please note that this guideline is currently under review and an update is due to be published in 2026.

Special consideration

All women should be informed of the signs and symptoms of potentially serious complications, and medical advice should be sought without delay – refer to table 1. This is particularly important in the event of a woman availing of the 'early transfer home (ETH)' service or a homebirth, as medical assistance may not be immediately available.

Table 1. Signs and symptoms of potentially serious complications

- sudden or very heavy vaginal bleeding (more than usual period blood loss), or persistent or increased vaginal bleeding, which could indicate retained placental tissue or endometritis
- abdominal, pelvic or perineal pain, fever, shivering, or vaginal discharge with an unpleasant smell, which could indicate infection
- leg swelling and tenderness or shortness of breath, which could indicate venous thromboembolism
- chest pain, which could indicate venous thromboembolism or cardiac problems
- persistent or severe headache, which could indicate hypertension, pre-eclampsia, post-dural-puncture headache, migraine, intracranial pathology or infection
- worsening reddening and swelling of breasts persisting for more than 24 hours despite self-management, which could indicate mastitis
- symptoms or signs of potentially serious conditions that do not respond to treatment

At each postnatal contact, women should be offered information and advice to enable them to identify signs and symptoms of potential serious conditions (as described above) and how to contact their healthcare professional or emergency service if required. Women should also be provided with the opportunity to talk about their birth experience and provide information about relevant support and birth reflection services, if appropriate.

Recommendations

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.
2. Every woman should have a VTE risk assessment completed in the postpartum period. This includes women in the homebirth setting.
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.
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.
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.

Clinical Question 2.2: What is the recommended management of common ailments in the postnatal period?

Evidence Statement

Women undergo significant physiological changes in the postpartum period, which are brought about by both hormonal and mechanical effects. These changes lead to a range of commons symptoms, including pain and discomfort, which can negatively affect a woman's postnatal experience.[8]

Perineal pain and uterine cramping/involution pain

Perineal pain and uterine cramping/involution pain is a common symptom following a vaginal birth and may result from perineal trauma or present in women with an intact perineum. This pain can negatively impact the woman's social and emotional well-being as a result of reduced mobility, discomfort and difficulty passing urine or faeces, interfering with their ability to care for their newborn and establish breastfeeding.[8]

A Cochrane systematic review assessed the effectiveness and safety of pharmacological and non-pharmacological analgesia for pain relief of after-birth pains following vaginal birth.[37] The review compared non-steroidal anti-inflammatory drugs (NSAIDs), opioids, paracetamol and placebos and found that NSAIDs and paracetamol may be as effective as each other at relieving pain from uterine cramping/involution following vaginal birth.[37] Furthermore, NSAIDs may be more effective than opioids at relieving pain from uterine cramping/involution.[37]

A further Cochrane review evaluated the effectiveness of localised cooling treatments (ice packs and gel pads) compared with no treatment or other cooling treatments for pain relief following perineal trauma.[38] Although there is very low-certainty evidence that supports the use of cooling treatments, women's self-rated perineal pain following the use of cold pads may be less than that of women who had no treatment (one study, 100 women). When comparing ice packs with cold gel pads, the review found no difference in self-rated perineal pain (3 studies, 338 women). The authors concluded that the use of concurrent treatments may be required to address perineal pain, including prescription and non-prescription analgesia.[38] Pharmacological analgesics to relieve postpartum pain include oral and rectal analgesics. Oral paracetamol should be the first-line choice when oral analgesia is required for the relief of postpartum perineal pain.[8]

Wound pain

NICE guidance on caesarean birth recommends the use of paracetamol and a non-steroidal anti-inflammatory drug in combination (unless contraindicated) to reduce the need for opioids and to allow them to be stepped down as early as possible.[27]

Constipation

Constipation in the postpartum period may potentially result from a range of antepartum, intrapartum and postnatal events, such as haematinics taken in pregnancy (i.e. iron, vitamin B 12), disrupted eating and drinking in labour and in the postpartum period, analgesia used in labour or post birth, and perineal pain related to trauma, haemorrhoids and psychological and situational factors.[8] A Cochrane systematic review evaluated the effectiveness and safety of interventions for preventing postpartum constipation.[39] They compared the use of laxatives versus no intervention (placebo) and laxative plus bulking agent versus laxative only in women who underwent surgical repair of third-degree perineal tears (5 trials). The evidence was found to be of low to very low certainty. Therefore, the authors were unable to

draw general conclusions about the effectiveness and safety of laxatives in preventing postpartum constipation.[39] The WHO recommends that dietary advice on preventing constipation should include promoting a healthy, balanced diet with adequate water and dietary fibre intake. The routine use of laxatives to prevent constipation is not recommended and should be used only if dietary modifications or fibre supplementation fail to relieve constipation.[8]

Painful or cracked nipples

Sore or painful nipples are one of the most common complaints by mothers in the immediate postpartum period. A common cause of breast pain in the lactating mother is due to incorrect breastfeeding technique. A poor latch may result in injury to the nipple and may interfere with the infant's ability to empty the breast, which may result in engorgement, plugged ducts, mastitis, and breast abscess. Pain due to nipple injury needs to be distinguished from nipple sensitivity, which usually increases during pregnancy and peaks approximately on the fourth postpartum day. Normal nipple sensitivity can be differentiated from pain due to nipple trauma by differences in their timing and course.[37, 40]

Breast engorgement

Breast engorgement is the pathological overfilling of the breasts with milk, characterised by hard, painful breasts and difficult breastfeeding.[41,42] It affects between 15-50% of women and may lead to mastitis. The management of breast engorgement should aim to provide rapid relief of breast pain, enable successful infant attachment to the breast, facilitate efficient drainage of milk from the breasts and prevent further complications such as mastitis and breast abscesses.[42]

Clinical Practice

Perineal/involution/wound pain

All women should be asked about perineal pain and other perineal conditions (e.g. perineal trauma healing and haemorrhoids) at each postnatal check. Perineal pain relieving methods should be individualised, based on the woman's preferences, considering the presence of perineal trauma, intensity of the pain, multiple sources of postpartum pain (i.e. perineal, uterine, breast) and the use of other forms of pain relief.

Local cooling aids (such as crushed ice placed between layers of a pad, or a gel pack between layers of a pad) can be offered to women in the immediate postpartum period for the relief of acute perineal trauma pain, sustained during birth. These can be used for up to 20 minutes at a time and used regularly in the first 48 hours after birth. Women should be advised to inform their healthcare professional if perineal pain worsens, as it may be a manifestation of postpartum complications such as haematomas, haemorrhoids or infection.

Provided there are no contraindications, paracetamol is recommended as the first-line choice when oral analgesia is required for the relief of postpartum perineal pain. In cases when local perineal cooling and/or paracetamol if not effective in relieving perineal pain, women should be advised of other pharmacological pain relief options.

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.

Constipation

All women should be asked about their bowel movements during the postnatal check and receive dietary advice and information on factors associated with constipation. To prevent/minimise constipation, women should be advised to:

- drink 1.5-2 litres of fluid daily (avoiding irritants such as caffeine, fizzy drinks and alcohol)
- have a high-fibre diet – fresh fruit, dried fruit, vegetables, whole grain breads, porridge, beans and lentils
- stay active
- adopt the correct toilet position by using a small step or footstool under the feet, leaning forward, and placing elbows on the knees

Further information is available: https://www2.hse.ie/conditions/constipation-pregnancy/

Painful cracked nipples/engorgement

In line with the HSE Infant Feeding Policy, midwives should observe mother and infant breastfeeding and review positioning and attachment to the breast. Offer advice if required to ensure correct positioning and attachment. Women should be advised on the techniques used to manage breast engorgement, regardless of their infant feeding choices. The management of sore nipples, engorgement and mastitis will be addressed in the national clinical practice guideline for infant feeding (currently under review).

Recommendations

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.**
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.**
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.**
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.**

Clinical Question 2.3: How should women be supported in feeding their infant?

Evidence Statement

Breastfeeding provides numerous health benefits for the woman and her infant. Breast milk contains bioactive components, such as growth factors, immunoglobulins, and antimicrobial compounds that influence an infant's microbiome and immune maturation.[43, 44] Breastfed babies have a lower risk of sudden infant death syndrome, allergy, and acute infections, including gastroenteritis, otitis media and respiratory infections.[45] In later childhood, benefits include lower levels of obesity 46 and higher cognitive performance.[47] Women who breastfeed have reduced risks of breast cancer, ovarian cancer, and type 2 diabetes.[45] The WHO recommend that infants be exclusively breastfed for the first 6 months of life and that breastfeeding should continue as part of their diet with appropriate complementary weaning foods up to 2 years old and beyond.[48]

The National Standards for Infant Feeding in Maternity Services (2022) outline the optimum care for infant feeding as part of the Health Service Executive Baby Friendly Initiative (BFI). The BFI is a recognised global quality improvement programme designed to improve care for pregnant women and mothers within maternity services. Its components are reflected within various HSE infant feeding policies and guidelines. For further guidance, refer to the National Standards for Infant Feeding in Maternity Services[49] and the National Infant Feeding Policy for Maternity and Neonatal Services.[50]

Clinical Practice

All mothers and infants, regardless of feeding method, should be supported to:

- Practice skin-to-skin contact throughout the postnatal period. Refer to the Intrapartum Care Guideline for Women on the Supported Care Pathway for further details on skin-to-skin contact and the required observations. Partners should be given the support and opportunity to do so where appropriate (refer to clinical question 2.8 for further guidance).
- Understand their infant's normal behaviours and needs (including feeding cues, how to wake a sleepy infant, knowing when their infant has fed sufficiently, and safer sleeping practices).
- Remain together during the day and night.
- Hold their infant close and bond when feeding and feed according to early feeding cues.

Breastfeeding

Mothers and babies should be supported and enabled to breastfeed and receive assistance at every feeding point if needed. This should include observing breastfeeding to ensure the infant can attach and feed at the breast with effective breast milk transfer.

Where a mother is separated from their infant or if the infant is unable to feed directly from the breast, they should be supported to express breast milk (within the first hour and at least 8 times daily) and then transition to breastfeeding when she/the infant is ready.

Mothers who need to give supplementary feeds alongside breastfeeding should be supported to optimise the amount of breast milk their infant receives. Commercial milk formula and fortifiers should be provided only when medically indicated or as part of a fully informed maternal choice. Mothers who give supplementary feeds alongside breastfeeding should receive support on the safe preparation, handling and feeding of expressed breast milk/commercial milk formula. If a mother decides not to breastfeed, she should be supported in her decision, and education should be provided.

Bottle-feeding

Women who bottle-feed should receive information on how to prepare a bottle and responsive bottle-feed safely. Mothers should be encouraged to bond and practice responsive parenting by responding to their baby's cues, giving the majority of feeds themselves, holding their baby close to their skin during feeds, and pacing the bottle feeds.

Refer to the HSE 2019 National Infant Feeding Policy for Maternity & Neonatal Services.pdf[50] for further guidance.

Recommendations

10. We recommend that all women and infants be supported to practice skin-to-skin contact throughout the postnatal period.
11. We recommend that women who breastfeed their baby be supported in establishing and maintaining lactation in the postnatal period.
12. Women who bottle-feed their baby should receive information on how to prepare a bottle and responsive bottle-feeding safely.
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.
14. Women should be supported to remain with their infant during the day and night if it is safe to do so (rooming-in).

Clinical Question 2.4: What care and advice should be given to women experiencing anaemia in the post-natal period?

Evidence Statement

Iron deficiency is the most common deficiency state globally, and remains a significant problem in the developed world. The WHO and the British Committee for Standards in Haematology defines postpartum anaemia as Hb <10 g/dL.[51, 52] It is associated with lethargy, physical weakness, decreased mental alertness and reduced milk production.[53]

The British Committee for Standards in Haematology[52] recommends that a full blood count (FBC) should be measured within 48 hours of delivery in all women with the following:

- an estimated blood loss of >500 ml and uncorrected anaemia detected in the antenatal period or
- symptoms suggestive of anaemia postnatally should have their Hb checked within 48 hours

Treatment options for postpartum anaemia include oral iron supplementation, intravenous iron therapy and blood transfusion. Oral iron is an effective way to replace iron. The recommended dose of elemental iron for treating iron deficiency is 100-200 mg daily.[52] Women should be counselled as to how to take oral iron supplements correctly. This should be taken on an empty stomach, 1 hour before meals, with a source of vitamin C, such as orange juice, to maximise absorption. Other medications or antacids should not be taken at the same time.[52]

Clinical Practice

Prompt recognition of iron deficiency in the antenatal period, followed by iron therapy, may reduce the risk of postpartum anaemia.

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
- Known iron deficiency anaemia
- Any woman with signs or symptoms of anaemia

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. The management of women who are symptomatic of anaemia is beyond the scope of this guideline and should be referred to the obstetric team for review.

Women should be advised on how to take oral iron supplementation. To maximise absorption, oral iron should be taken on an empty stomach one hour before meals—ideally in the morning—with a source of vitamin C. Other medications, antacids, tea or coffee should not be taken at the same time.

Recommendations

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.**
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.**
17. **Women who are symptomatic of anaemia should be referred to the obstetric team for review.**

Clinical Question 2.5: What advice and care is offered to women who are Rhesus D negative in the postnatal period?

Evidence Statement

Rhophylac (anti-D immunoglobulin) 300µg (1500 I.U) must be recommended to every non-sensitised Rhesus D (RhD) negative woman as soon as possible following birth (within 72 hrs) following the birth of an RhD Positive infant.[54] In instances where a feto-maternal haemorrhage (FMH) is more than 15mls, the standard dose of Anti-D immunoglobulin (Ig) will not prevent allo-immunisation. Therefore, it is recommended that a Kleihauer test be performed to estimate the size of the FMH.

Risk factors associated with large FMHs are:[55]

- Abdominal trauma
- Unexplained hydrops fetalis
- Placental abruption
- External cephalic version
- Multiple pregnancies (at birth)
- Stillbirth and intrauterine deaths
- Instrumental deliveries and caesarean section
- Manual removal of the placenta

For women who have had cell-free fetal DNA (cffDNA) testing during pregnancy, it is recommended that umbilical cord blood be saved, even if the fetal blood group is known, for quality purposes to identify the infant's blood group. In the unlikely event that this result does not correlate with the cffDNA result, the woman can be offered anti-D within 72 hours following birth.[56]

Some women who have received anti-D Ig during pregnancy may have detectable anti-D in their blood following birth. As it may be difficult or impossible to distinguish between such passive anti-D Ig and weak anti-D resulting from early immunisation, anti-D Ig should be offered to any eligible woman with a weak anti-D antibody at birth unless it has been confirmed that she is already sensitised.

Clinical Practice

In line with the National Clinical Practice Guideline – The use of anti-D immunoglobin for the prevention of RHD haemolytic disease of the newborn, it is considered best practice to offer Anti-D Ig to every non-sensitised RhD-negative woman who delivered 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.

Refer to the HSE 2012 Clinical Practice Guideline – the use of anti-D immunoglobin for the prevention of RhD haemolytic disease of the newborn. Please note that this guideline is currently under review.

Recommendations

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.**

Clinical Question 2.6: What is the optimum care for a woman's emotional well-being and mental health in the postnatal period?

Evidence Statement

While many women/couples experience pregnancy and childbirth as a joyous and exciting occasion, the transition to parenthood is an emotionally charged time. It is important for midwives to be able to identify emotional changes and adjustment reactions as a woman transitions to motherhood, and distinguish them from the early warning signs of emotional distress or mental illness.[57]

Postpartum mood disorders are common following birth. It is important that postpartum care includes routine assessment for postpartum depression and anxiety. If the woman reports symptoms persisting after two weeks postpartum, the Midwife may consider assessment using a validated tool, such as the self-report 10-item Edinburgh Postnatal Depression Scale or the Whooley questions. It is important to ascertain the woman's feelings about her birth rather than routinely referring all women who have had a traumatic birth, according to HCPs. It is also important to acknowledge that the mental health service provision varies according to geographical location in Ireland.

Postpartum blues

The term 'postpartum blues' refers to a transient condition characterised by several mild depressive symptoms such as sadness, crying, irritability, anxiety, insomnia, exhaustion, and decreased concentration, as well as mood lability that may include elation.[58, 59] Symptoms typically develop within two to three days of birth, peak over the next few days, and resolve within two weeks of onset.[57] Studies described an overall prevalence of postpartum blues of 39%, ranging from 13.7% to 76%, according to the cultural and geographical contexts.[60] Postpartum blues are common and self-limiting and do not require referral to a GP or perinatal mental health team.

Postnatal depression (PND)

PND describes the more severe or prolonged symptoms of depression that last more than two weeks. This condition interferes with a mother's ability to function normally in her daily routines, including caring for her infant.[61] An estimated 10-15% of new mothers are affected by mild postnatal depression.[62]

Puerperal psychosis

Puerperal psychosis is the least common but most severe psychological condition. It is usually sudden and occurs within the first week or two of birth.[57] Vanderkruik et al reported an incidence of puerperal psychosis of 1-2 per 1000 women.[64] Signs and symptoms include a change in mood, restlessness, agitation, confusion, insomnia, neglect of self and/or the infant's needs, irrational behaviour, fear and severe depression.

Post-traumatic stress disorder (PTSD)

This term is most commonly associated with individuals who have suffered the onslaught of war and has emerged in the literature around maternity care.[57] Regier et al. state that PTSD is categorised as a trauma and stress-related disorder when a person has been exposed directly or indirectly to threatened death, actual or threatened serious injury or sexual violence.[63] Possible risk factors for PTSD include pre-pregnancy stress (sexual/physical trauma, history of PTSD or other mental health disorders), a negative pregnancy experience (fear of childbirth, low support, perceived lack of control, maternal morbidity, pregnancy complications) or birth issues/complications (lack of social support, emergency caesarean birth, instrumental vaginal birth, postpartum haemorrhage, stillbirth or poor neonatal outcome) but available data are not robust or consistent.[64-67]

The multiple determinants of Childbirth-related Post Traumatic Stress Disorder (CB-PTSD) mean that not all complex births are experienced by women as traumatic, and not all traumatic births result in CB-PTSD. Signs and symptoms of PTSD include intrusive thoughts or images resulting in nightmares, panic attacks or 'flashbacks' about the birth, detachment from loved ones and difficulty with a mother-infant relationship, avoidance, especially of issues relating to pregnancy/birth, hypervigilance/increased arousal – having a sense of imminent disaster, sleep disturbances, irritability or angry outbursts, anxiety/depression.[65] These features apply where symptoms are present for more than one month.

Clinical Practice

Women should be asked about their emotional well-being, family and social support, and usual coping strategies for dealing with day-to-day matters. Women and their partners, families, and friends should be encouraged to tell a healthcare professional about any changes in mood, emotional state, and behaviour that are outside of the normal pattern for the postnatal woman.

All healthcare professionals should be aware of the signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after birth. Additional early postpartum follow-up visits for mood and adjustment assessment should be considered in women at high risk for postpartum mood disorders, such as women with a prior history of depression, anxiety, bipolar disorder, previous postpartum depression, or other psychiatric conditions requiring treatment. Clinics should have local resources available to provide additional support when indicated. Women should be asked about the resolution of baby blues (tearfulness, feelings of anxiety and low mood). If postnatal depression, puerperal psychosis, severe anxiety disorders or stress reactions are suspected, the woman should be assessed and urgently referred to their GP/medical/perinatal mental health/mental health team as available.

Postnatal depression

If the symptoms related to low mood have not resolved by 10-14 days after birth, the woman should be assessed for postnatal depression. A validated assessment tool, such as the self-report 10-item Edinburgh Postnatal Depression Scale or the Whooley questions, is recommended.

Puerperal psychosis

Women with suspected puerperal psychosis should be referred urgently for medical, psychiatric or obstetric review as appropriate. Observe the mother's behaviour, especially in relation to her infant. Assess the welfare of the infant and ensure adequate supervision is provided for the mother to ensure she is caring for and feeding her infant. This may include giving emotional and practical help. Advise the woman and her support person regarding the benefits of support groups and ensure that the relevant contact details are provided upon discharge. Follow-up care should be arranged, including a mental health clinic appointment and/or support from the community mental health nurse, midwife, public health nurse, and social worker as necessary.

Post-traumatic stress disorder

Midwives and other healthcare professionals should support women to talk about their pregnancy and birth experience if they wish to. It is important to consider a trauma-informed approach that does not make women re-tell their experience and possibly re-traumatises women. Women are advised to avail of the help and support of families and friends. Interventions suggested to help include debriefing, structured psychological interventions, expressive writing interventions, and encouraging skin-to-skin contact with healthy infants immediately postpartum.

Recommendations

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.
20. We recommend that, if postnatal depression, puerperal psychosis, severe anxiety disorders or stress reactions are suspected, that women should be assessed and urgently referred to the General Practitioner (GP), medical team/perinatal mental health team (PMHT)/mental health team as appropriate.

Clinical Question 2.7: What contraception advice should be provided to women prior to discharge?

Evidence Statement

The timely advice regarding contraception in the postnatal period is important. This discussion should take place early in the postnatal period, as some women may have resumed sexual activity before their 6-week GP check. In addition, the requirements of caring for an infant can add to the existing barriers to accessing effective methods of contraception.[68] The Faculty of Sexual Health and Reproductive Healthcare recommends that all postpartum women have access to the full range of contraceptives, including the most effective long-acting reversible contraception (LARC) methods, to start immediately after childbirth. This should not be limited to those women with conditions that may pose a significant health risk during pregnancy and vulnerable groups (including young people) at risk of a short inter-pregnancy interval or an unintended pregnancy.[68]

There are many methods of contraception available to help prevent pregnancy, including barrier and hormonal methods. Methods can vary widely in their effectiveness and may fail for several reasons, including incorrect use or failure of the medication device or method. Choosing the correct method of contraception can be challenging, as issues such as beliefs, attitudes, method of infant feeding, side effects, future pregnancy plans, cost and accessibility should be considered.[68] The best method of contraception to choose is one that is agreed with the woman/couple, is used consistently and is convenient.

Clinical Practice

The woman should be advised that it is possible to become pregnant again even if her period has not returned. A discussion regarding contraception methods should take place prior to discharge, including barrier, hormonal and LARC methods. The discussion should also include how to access contraception.

Women should be reassured that it is very normal to experience a reduction in libido and arousal. There are many factors which can affect libido such as hormonal changes, discomfort as her body is recovering from the birth along, with fatigue as a result of caring for a newborn. She should be advised to wait until any bleeding has stopped, perineum is fully healed, and she feels ready both physically and emotionally to resume intercourse.

For more information on the choices available, refer to the following:

https://www2.hse.ie/pregnancy-birth/trying-for-a-baby/coming-off-contraception/types-contraception/

Factsheets – Irish Family Planning Association (ifpa.ie)

IE_WH_LARC_SMART Alternatives to the Pill_2.pdf (mycontraception.ie)

https://www.fsrh.org/Common/Uploaded%20files/documents/contraception-after-pregnancy-guideline-oct2020.pdf

Recommendations

21. **We recommend that a discussion regarding contraception methods should take place prior to discharge, including barrier, hormonal and LARC methods. The discussion should also include how to access contraception.**

Section 2: Infant Care

Introduction

This section will address the postnatal midwifery care of the term infant. It will outline the recommended care, examinations and screening of the infant. These assessments allow for the early detection of anomalies, with the opportunity for prompt referral and treatment. It also provides a baseline examination from which to monitor the infant's progress. This guideline should be used alongside related guidelines for all other aspects of the management of newborn care, including immediate neonatal care, resuscitation, thermal protection and supporting successful feeding. Refer to the National Clinical Guideline – Intrapartum Care for Women on the Supported Care Pathway for the immediate care of the newborn.[69]

Clinical Question 2.8: What are the postnatal care needs of the newborn?

Evidence Statement

Skin-to-skin contact

Skin-to-skin contact refers to as the practice where a baby is dried and laid directly on the mother's bare chest after birth, both of them covered in a warm, dry blanket and allowed undisturbed skin-to-skin for at least an hour or until the first feed.[70] It has physiological benefits for both the woman and the baby and is recommended.[71-74] Antenatal discussion on the benefits of skin-to-skin contact is recommended.[74] With the mother's consent, the baby should be placed on her chest after birth to enable skin-to-skin contact to take place. This process triggers both the baby's and mother's instinctive behaviours, which help establish attachment and support the baby in seeking out food.[75] A Cochrane systematic review has shown the clear benefits of skin-to-skin contact, particularly in the first hour after birth:[75]

- calms and relaxes both mother and baby
- regulates the baby's heart rate and breathing, helping them to better adapt to life outside the womb

- stimulates digestion and an interest in feeding
- regulates the baby's temperature
- enables colonisation of the baby's skin with the mother's friendly bacteria, thus protecting against infection
- stimulates the release of hormones to support breastfeeding and mothering

Infant feeding

Infant feeding is an integral part of the postnatal period. The WHO recommends that breastfeeding be initiated early to facilitate the establishment of breastfeeding. However, parents' infant feeding choices should be respected, and the information provided should be individualised to the parents' needs.[2] The benefits of breastfeeding have been discussed previously in clinical question 2.3. Refer to the national infant feeding policy for further details.[49]

Initial newborn examination

The early detection of conditions that may adversely affect the health and development of the newborn is an important component of quality routine postnatal care. (8) The initial examination aims to determine infant's general well-being, confirm their gender, and identify serious anomalies that require immediate attention. The evidence to support this recommendation is largely derived from The Newborn Clinical Examination Handbook (hse.ie)[76]

Clinical Practice

Skin-to-skin contact

Skin-to-skin contact is addressed in the Intrapartum Care Guideline for Women on the Supported Care Pathway; however, as it can be practised routinely in the postnatal period, it is also included in this guideline. In order to keep the infant warm and dry, cover the infant with a warm, dry blanket or towel while maintaining skin-to-skin contact with the woman. Mothers and their infants should have immediate, unhurried and uninterrupted safe skin-to-skin contact, which is continued for at least 60 minutes or until after the first feed, considering the need for the infant to be given time to go through the instinctive post-birth stages.

Infants should not be in skin-to-skin contact with their mother when she is receiving Entonox or other analgesics that affect her consciousness and awareness of the baby's position. If the mother cannot initiate skin-to-skin contact immediately after birth, she should be supported in doing so as soon as possible. Birth companions should be given the support and opportunity to do so where appropriate. Avoid separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example, weighing, measuring and bathing, unless the woman requests these measures or are necessary for the baby's immediate care.

Mothers and their birth companions should be provided with guidance as soon as is practically possible after the birth about the importance of recognising changes in the baby's colour or tone and the need to alert staff immediately if they are concerned. All babies should be routinely monitored when in skin-to-skin contact with their mother or birth companion.

Observations should include:

- Checking that the baby's position is such that a clear airway is maintained, observing respiratory rate and chest movement. Listen for unusual breathing sounds or the absence of noise from the baby
- Colour – the baby should be assessed by looking at the whole of the baby's body, as the limbs can often be discoloured first. Subtle changes to colour indicate changes in the baby's condition

- Tone – the baby should have a good tone and not be limp or unresponsive
- Temperature – ensure the baby is kept warm during skin contact

Infant feeding

Regardless of the woman's chosen method of infant feeding, the care provided should respect her decision, and the information provided should meet the individual needs of the woman and infant.

Initial newborn examination

This examination should ideally occur after the baby has had skin-to-skin contact and had its first feed (unless contraindicated). The Midwife or Neonatologist/Paediatrician should conduct a detailed, documented head-to-toe examination of the newborn baby to detect any major physical abnormalities and identify any problems requiring referral. Any examinations or treatment of the baby should be undertaken with parental consent and either in their presence or, if this is not possible, with their knowledge.

Examine the infant thoroughly and systematically, examining each physiological system. The initial assessment commences with inspection or observation using the Apgar score. Follow a logical sequence from head to toe throughout the examination. Observe and note the following:

- A review of family, maternal and antenatal history
- Birth weight, head circumference, length and body temperature are recorded
- Observation of the baby's general condition, including colour, breathing, behaviour, activity and posture
- Examination of the exposed parts of the baby first: scalp, head (including fontanelles), face, nose, mouth, including tongue, palate, ears, neck and general symmetry of head and facial features
- Examination of the baby's eyes (size, position, absence of discharge)
- Examine the baby's neck, clavicles, limbs, hands, feet and digits, assessing proportions and symmetry. Unwrap the baby to complete the exam
- Assessment of the baby's cardiovascular system – colour, heart rate, rhythm, oxygen saturation
- Respiratory effort and rate
- Observation of the baby's abdomen – colour, shape and examination of the condition of the umbilical cord
- Observation of the baby's genitalia and anus to check completeness and patency
- Inspection of the bony structures and skin of the baby's spine, with the baby prone
- Note the colour and texture of the skin as well as any birthmarks or rashes
- Observation of the tone, behaviour, movements and posture to complete the assessment of the central nervous system (CNS)
- If concerned, undertake a more detailed neurological examination, e.g. eliciting newborn reflexes
- To provisionally assess the newborn's hips and check the symmetry of the limbs and skin folds. The hips require further examination during the examination of the newborn
- Note the sound of the baby's cry

Document findings in the infant's healthcare record. If an abnormality is suspected or diagnosed, escalate these findings to the neonatologist/paediatrician.

Following the initial newborn examination, a clinical examination and screening of the newborn (including examination of the eyes, heart, hips, and testes) should be carried out by an appropriately trained healthcare professional within 72 hours of birth.

In addition to the initial newborn examination (hospital setting only)

Ensure and check that the baby's identification labels (surname of mother, sex, date of birth, and hospital number) are correct and checked with the mother prior to being placed on the infant's wrist and ankle. Advise parents to inform the Midwife if the identification bands fall off or appear to irritate/cause trauma to the infant's skin.

Recommendations

22. **We recommend initiating skin-to-skin contact and starting infant feeding within the first hour of life.**
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.**
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.**
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.**

Clinical Question 2.9: Why is Vitamin K recommended for all newborn infants?

Evidence Statement

Vitamin K deficiency bleeding (VKDB) was first identified over a century ago[77] and presents as unexpected bleeding, often with gastrointestinal haemorrhage, ecchymosis and, in many cases, intracranial haemorrhage. In infants, VKDB is typically caused by vitamin K deficiency due to insufficient prenatal storage of vitamin K and insufficient vitamin K in breast milk. Three types of vitamin K deficiency bleeding (VKDB) have been classified: early onset (occurring in the first 24 hours post-birth), classic (occurring at days 2 to 7) and late onset (at 2 to 12 weeks and up to 6 months of age).

Early VKDB is commonly associated with maternal medications that inhibit vitamin K activity, such as antiepileptics (phenytoin, carbamazepine and barbiturates), vitamin K antagonists (warfarin, coumarin), antituberculosis drugs (isoniazid, rifampicin) and some antibiotics (cephalosporins).[77]

Classic VKDB is associated with low vitamin K intake. Clinical presentation is often mild, with bruises, gastrointestinal blood loss, or bleeding from the umbilicus and puncture sites. Blood loss, however, can be significant, and intracranial haemorrhage, although rare, has been described. The incidence of classical VKDB has been more recently estimated at 0.4-1.7 per 100 in the absence of vitamin K prophylaxis.[78]

Late VKDB occurs primarily in exclusively breastfed infants who have received no or inadequate neonatal vitamin K prophylaxis. Approximately half of these infants will have underlying malabsorption or liver problems. Intracranial bleeding (up to 60%) is the predominant manifestation of late-onset VKDB.[77]

Vitamin K prophylaxis protects almost all infants if administered intramuscularly or by multi-dose oral regimes.[79] Current national and international guidelines recommend that all newborn infants receive a single dose of 1mg of Vitamin K intramuscularly (IM) at birth, as this is the most clinically and cost-effective method of administration. A systematic review confirmed that routine administration of IM vitamin K at birth effectively prevents VKDB.[79]

Administration of Vitamin K requires informed consent. The woman should be offered an explanation and education regarding the signs and symptoms of Vitamin K deficiency bleeding.[80]

Clinical Practice

Intramuscular Phytomenadione/Konakin MM Paediatric is preferred at any gestation due to its prolonged effect and the absence of the requirement to give extra oral doses under normal circumstances. It is recommended that phytomenadione (1mg/0.1ml) be administered intramuscularly (IM) as it is the most clinically and cost- effective. Although phytomenadione can be administered orally for the prophylaxis of vitamin K deficiency bleeding (VKDB) in healthy infants of 36 weeks' gestation or older, parents should be advised that it is less effective than the IM route and subsequent doses are required.

Following a discussion with the woman, consent should be obtained prior to the administration of Phytomenadione (Oral Phytomenadione/Vitamin K MM Paediatric).

If the parents request oral Phytomenadione/Vitamin K MM Paediatric for their infant, 2mg should be administered preferably within 2 hours of birth, followed by a second dose of 2mg at 4-7 days. Exclusively breast-fed infants require a further 2mg oral dose at 4 weeks of age. Arrangements should be put in place to ensure that the doses are administered by a healthcare professional.

In the event of parents declining Phytomenadione (IM or oral)

Refer to a neonatologist/paediatrician for further informed discussion and document this in the healthcare record. An opt-out form should be completed.

Recommendations

26. **We recommend that all infants receive phytomenadione by intramuscular injection to prevent haemorrhagic disease of the newborn (HDN). Parents should be advised that phytomenadione administered orally is less effective than when administered intramuscularly, and subsequent doses are required.**

Clinical Question 2.10: What is the recommended care and advice for infant umbilical cord care?

Evidence Statement

Infection of the umbilical cord stump (omphalitis) may lead to septicaemia in the neonate.[81] A Cochrane systematic review sought to determine the effect of antiseptics on newborn's umbilical cord versus routine care for prevention of morbidity and mortality in both hospital and community settings. The review included 34 trials involving 69,338 babies and included studies conducted in both developed and developing countries. They found insufficient evidence to support the use of an antiseptic in cord care to reduce the incidence of omphalitis compared with dry cord care in hospital settings.[81]

Clinical Practice

When caring for the cord, observe clean cord care practices i.e. strict hand hygiene, clamping and cutting the cord using sterile instruments and keeping the cord dry and exposed to air. In order to aid cord separation, advise the mother to fold the nappy below cord and prevent contamination from stool/urine. During nappy changes, the cord and umbilicus should be observed for signs of localised infection such as redness, discharge, odour and tracking. The following are signs and symptoms of systemic infection and warrant a medical review:

- General malaise (irritability, lethargy, poor feeding)
- Unstable temperature, respiratory and cardiovascular disturbances
- Cutaneous abnormalities including jaundice or petechiae
- Rigid/distended abdomen

Recommendations

27. **We recommend clean, dry cord care to reduce the risk of infection in the newborn.**

Clinical Question 2.11: What advice and care is recommended for infant skin care?

Evidence Statement

The neonatal skin undergoes significant developmental changes during the transition from an aquatic in-utero to an aerobic extra-uterine environment. Slightly before term at 38-39 weeks' gestation, vernix will be present in the infant's armpits and is of no consequence as it is a variation of normal skin condition. Over 40-41 weeks' gestation, the infant's skin has a dry consistency and cracked at flexures. The adaptation to the extra-uterine environment is facilitated by several vital functions, including thermoregulation, water and electrolyte homeostasis, and protection against trauma, environmental toxins, and infections.[82] Skin care practices can influence skin integrity, acid mantle, skin microbiome diversity, immunomodulation, and prevention of infection.[83]

There continues to be debate about when and how to give the newborn infant their first bath.[84-87] Delayed bathing for at least 24 hours is recommended; however, if cultural reasons do not permit such a delay, wait for a minimum of six hours. A systematic review supports delaying the first newborn bath by 24 hours and, if not possible, by at least six hours to improve thermoregulation and breastfeeding rates in term healthy newborn infants.[87] The Rainbow Clinic advises that for infants born to a woman who is HIV/hepatitis B positive, the first bath should occur at the earliest opportunity following birth to prevent the transmission of maternal infection to the newborn.[88]

The impact of the infant's first bath, whether given with water alone or with skin cleansing products, on skin barrier function is unknown.[83] Plain water for the first four weeks is advocated, as soap, cleansers, and even pure water can temporarily raise the skin's pH, which can result in skin rashes and atopic dermatitis.[71]

Clinical Practice

Parents should be informed of the benefits of delaying the infant's first bath in terms of thermoregulation and breastfeeding. Ideally, the infant's first bath should be delayed for at least 24 hours; however, it may be performed earlier when the parents request it. The use of emollients or soap products is not recommended. In the event of infants born to a woman who is HIV positive/hepatitis B positive, it is recommended that the infant be bathed at the earliest opportunity.

Recommendations

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.**
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.**

Clinical Question 2.12: What is the recommended practice for the management of infant weight loss?

Evidence Statement

Some weight loss in the first few days of life is typical for a healthy well infant and is usually related to fluid adjustments. Weight loss outside normal parameters requires recognition, further assessment, escalation and action. Midwives need to be aware of normal infant weight loss patterns to recognise deviations from these parameters. Excessive weight loss in infants is associated with neonatal complications such as jaundice and dehydration, which may cause renal failure, thrombosis, hypovolemic shock, and seizures.[89]

It is common for babies to lose some weight in the first few days after birth; for most infants, weight loss typically ranges from 5-7%,[73] with weight gain usually resuming by three to four days of age. Most infants have returned to their birth weight by two weeks, and nearly all infants reach their birth weight by three weeks of age.[89] Infants who lose more than 10% of their birth weight require clinical assessment for evidence of dehydration or illness that may account for the weight loss, and a detailed history to assess feeding.[89] If supplementation with an infant formula is given to a breastfed infant, breastfeeding support should be provided to the woman. Expressing breast milk to promote milk supply and feeding the infant with any available breast milk before introducing any infant formula is advised.[90]

It is recommended that breastfed infants be weighed on day 3 and again on day 5. Formula-fed infants should be weighed on day 5 and once again prior to discharge from midwifery care at 14 days. It is rare for formula-fed infants to lose over 10% of birth weight. In this situation, the infant should be immediately referred to the neonatal/paediatric team for assessment.[76, 90]

Clinical Practice

Women should be advised to monitor the infant's output and should expect one stool (meconium) and void in the first 24 hours. Observe for changes in the frequency and amount of urine and stools. In the event of an infant's weight loss exceeding 10%, a clinical assessment is required to evaluate for evidence of dehydration or illness that may account for the weight loss, along with a detailed history to assess feeding practices. A referral to an infant feeding specialist should be considered if the infant is breastfed. Observe a full breastfeed to ensure correct positioning for good attachment to transfer milk effectively. The Breastfeeding Observation Assessment Tool (BOAT)[91] is a useful resource for assessing breastfeeding in community settings.

Escalate to a neonatologist/paediatrician if any of the following weight-related issues:

- Weight loss of more than 10%
- No weight gain
- Weight has not returned to birth weight at three weeks of age

Supplementation with formula milk may improve weight gain; however, it is associated with an earlier cessation of breastfeeding. Additional breastfeeding support should be provided when a breastfed infant is supplemented with formula milk. Expressing breast milk to promote milk supply and feeding the infant with any available breast milk before giving any infant formula is advised. Measures to improve infant weight gain should be documented in the healthcare record and communicated to the GP/PHN.

Recommendations

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.**

Clinical Question 2.13: What is the recommended practice to reduce the risk of neonatal hypoglycaemia?

Evidence Statement

Neonatal hypoglycaemia is a common metabolic disorder presenting in the first days of life. Transient hypoglycaemia occurs as a normal physiological event following birth, but persistent hypoglycaemia can result in brain injury and long-term developmental impairment.

Blood glucose levels (BGL) in healthy term infants fall in the first two hours of life during the transition to extra-uterine life. An asymptomatic, transient and mildly low BGL after birth is normal.[92,93] It occurs due to the transition from a continuous transplacental glucose supply from the mother in utero to an intermittent supply from milk feeds. Routine screening and monitoring of blood glucose levels are not necessary in healthy asymptomatic term newborn infants following a normal pregnancy and birth.[94]

However, a universal approach to diagnosis and management is still lacking. Most episodes of hypoglycaemia are asymptomatic, and symptoms, when they occur, are non-specific. The concentration and duration of BGLs which cause neurological damage are unclear.[95] It is generally accepted that the BGL is low in the first six hours of life. There is a lack of international consensus about the normal range for pre-feed plasma glucose in a normal, healthy infant during this time period. The lowest is usually in the first two to four hours of life, then, by four to six hours of age, stabilizes at 2.5-4.4 mmol/L (may be up to 6.2 mmol/L).[95] Recognising which newborn infants are at risk of hypoglycaemia and establishing protocols for treatment are essential to avoid possible deleterious effects on neurodevelopment.

The British Association of Perinatal Medicine (BAPM) recommend that infants at high risk of hypoglycaemia and require routine blood glucose monitoring include:[95]

- Fetal growth restriction (<2nd centile)
- Infants of mothers with diabetes
- Infants of mothers taking beta-blockers in the third trimester and/or at the time of birth

Several studies have identified a correlation between antenatal corticosteroid administration and an increased risk of neonatal hypoglycaemia.[96-99]

Clinical Practice

As recommended by the British Association of Perinatal Medicine, infants at risk of hypoglycaemia should be identified at birth and placed on a care pathway that includes early provision of energy, regular assessment of feeding and clinical condition, and blood glucose monitoring. Refer to local protocols for further guidance until the National Neonatal Guideline: Neonatal Hypoglycaemia >35 weeks and < 48 hrs old is published.

Routine screening and monitoring of blood glucose levels is not necessary in healthy asymptomatic term newborn infants following a normal pregnancy and birth. Initiation of infant feeding should ideally occur within the first hour of life, reducing the risk of hypoglycaemia. Newborn infants should be kept warm, with their temperature maintained between 36.5 °C and 37.5 °C. This begins at birth, where thorough drying of the infant is essential, and skin-to-skin contact should be commenced. Safe skin-to-skin contact should be facilitated for all mothers and infants regardless of the feeding method (previously addressed in clinical question 2.3).

The Midwife should observe for clinical signs of hypoglycaemia, such as:

- Abnormal feeding behaviours (not waking for feeds, not sucking effectively, appearing unsettled and demanding very frequent feeds), especially after a period of feeding well
- Jitteriness
- Altered level of consciousness
- Hypothermia less than 36.5 °C
- Lethargy
- High-pitched cry
- Hypotonia/floppiness
- Apnoea
- Seizures
- Cyanosis
- Mother's concerns

As the clinical signs associated with neonatal hypoglycaemia are non-specific, blood glucose measurement should be undertaken in any infant who presents with any one of the abnormal signs outlined above. An urgent review by a neonatologist/paediatrician is warranted.

Recommendations

31. **Routine screening and monitoring of blood glucose levels are not necessary in healthy asymptomatic term newborn infants following a normal pregnancy and birth.**
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 temperature maintained between 36.5 °C and 37.5 °C.**
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.**

Clinical Question 2.14: How does the Midwife assess neonatal jaundice?

Evidence Statement

Hyperbilirubinaemia is a term used to describe excess of bilirubin in the blood and presents as jaundice, a yellowing of the skin and sclera.[100] It is common in both term and preterm infants and is caused by the predisposition of the production of bilirubin and limited ability to excrete it.[100] For most infants, jaundice is not an indication of an underlying disease and will resolve spontaneously. Symptoms usually begin day 2 to 3 of life and last between 10 and 14 days. In rare cases, infants with early onset jaundice (detectable clinically before 24 hours of age) may develop severe hyperbilirubinemia that can lead to bilirubin encephalopathy and kernicterus.

Risk factors for **severe hyperbilirubinaemia** include:[76]

- Infants born less than 38 weeks' gestation
- More than 10% weight loss
- Exclusive breastfeeding
- Early discharge
- Bruising/cephalohaematoma
- Non-caucasian
- Family history
- Haemolysis

Unfortunately cases of kernicterus and critical hyperbilirubinaemia continue to occur in many developed countries, including Ireland.[100-105]

Although Total Serum Bilirubin (SBR) testing is the gold standard, transcutaneous bilirubin (TcB) can be applied to a predictive risk nomogram, which may indicate a need for SBR testing. Treatment for jaundice is always based on SBR measurements. A 2023 Cochrane Systematic review conducted by Okwundu et al (23 studies, 5058 participants) set out to determine the diagnostic accuracy of transcutaneous bilirubin measurement for detecting hyperbilirubinaemia in newborns. The review found due to the high sensitivity of TcB to detect hyperbilirubinaemia, TcB devices are thought to be reliable screening tests, however positive tests should be confirmed through serum bilirubin measurement. 97 Transcutaneous bilirubin metre (TcB) devices are an inexpensive, non-invasive test for the evaluation of hyperbilirubinemia and should be performed if the infant is clinically jaundiced. TcB correlates well with serum bilirubin if TcB is less than 200umol/l.[100]

A 2022 systematic review (five studies, 377814 participants)[106-110] conducted by Khurshid et al. evaluated the effectiveness of universal TcB screening at discharge compared to clinical screening (visual inspection and/or risk factors) in term healthy neonates.[111] One RCT reported that universal TcB at discharge reduced readmission for jaundice (1858 neonates; OR=0.24, 95% CI=0.13 to 0.46; low certainty evidence).[106] A meta-analysis of non-randomised studies reported that the effect was uncertain (four studies, 33467 neonates; OR=1.01, 95% CI=0.38 to 2.70; very low certainty evidence).[107-110] Notably, the Okwundu et al. study found universal TcB at discharge decreased the number of neonates with severe hyperbilirubinemia (one trial, 1858 neonates; RR=0.27, 95% CI=0.08 to 0.97; low certainty evidence), which is in line with previous work.[106]

Clinical Practice

Parents/carers should be informed about neonatal jaundice and including:

- Risk factors for developing significant hyperbilirubinaemia
- How to check the infant for jaundice
- What to do if they suspect jaundice
- The importance of recognising jaundice in the first 24 hours and seeking urgent medical advice
- Importance of checking the infant's nappies for dark urine or pale chalky stools
- The fact that neonatal jaundice is common and reassurance that it is usually transient and harmless

Routine jaundice assessment should form part of the infant's well-being assessment. Infants with risk factors associated with an increased likelihood of developing significant hyperbilirubinaemia should receive an additional visual inspection during the first 48 hours of life. As jaundice levels typically peak between days 3-5, a risk assessment is required if the infant is being discharged earlier. We recommend that all infants have a TcB performed on discharge from the hospital or at 72 hours if not discharged.

When looking for jaundice (visual inspection), examine the naked infant in bright, preferably natural light. Examine the sclerae and gums, and press lightly on the skin to check for signs of jaundice in blanched skin. If jaundice is suspected or if the infant is non-Caucasian, a TcB meter should be used as part of the assessment. If a TCB meter is unavailable (for example, in the community setting), arrangements should be made to assess the infant. These arrangements should be made at local level. Medical devices (including point-of-care meters) used in community or clinical settings must comply with the HSE Medical Device Equipment Management Policy.

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 neonatologist/paediatrician on call as the infant requires urgent investigation.

Refer to the HSE Newborn Clinical Examination Handbook for the management of jaundice.[76]

Recommendations

34. Parents/carers should be informed about neonatal jaundice, including how to recognise the signs of jaundice and when to seek a medical review.
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.
36. We recommend that all midwives caring for infants in the community setting should have access to TcB meters.
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 neonatologist/paediatrician on call as the infant requires urgent investigation.** Refer to the HSE Newborn Clinical Examination Handbook for further guidance on the management of jaundice.
38. We recommend that all infants have a TcB performed on discharge from the hospital or at 72 hours if not discharged.

Clinical Question 2.15: What are the recommended newborn screening tests?

Screening is a process of identifying healthy people who may have an increased risk of having a disease or condition. Once identified, those at increased risk are offered information, further testing, clinical management and treatment if required. It is important to note that screening is a pathway and not a diagnostic tool. The HSE Children's Screening Services provides the National Newborn Bloodspot Screening Programme and the National Newborn Hearing Screening Programme as part of the National Healthy Childhood Programme.[112] In addition to these programmes, the maternity services have implemented pulse oximetry screening nationally.

Evidence Statement

Pulse oximetry screening is a validated screening method for critical congenital heart disease (CHD). A pulse oximeter measures the amount of oxygen carried around the body by red blood cells using a sensor placed on the newborn infant's hand or foot. The pulse oximetry test is a non-invasive, easily performed test that assists in diagnosing CHD in the early, pre-symptomatic stage. CHD occurs in nearly 1% of live births; approximately one-quarter of these will be critical congenital heart disease (CCHD).[113] CCHD is defined as any cardiac lesion from which infants die or require surgery or cardiac catheterisation within the first 28 days of life to prevent death or severe end-organ damage.[113,114] Early detection of CCHD before acute cardiovascular collapse leads to improved cardiopulmonary and neurological outcomes.[115] However, most infants are asymptomatic at birth. Newborn screening for CCHD can help identify some cases to allow prompt diagnosis and treatment, and may prevent disability or fatal outcomes. A Cochrane systematic review of 21 studies (n = 457,202 participants) reported an overall sensitivity of 76.3%, a specificity of 99%, and a false-positive rate of 0.14%. There were no significant differences in sensitivity or specificity for foot-only versus both foot and right-hand measurements.[113]

Newborn Bloodspot Screening (NBS), known as the 'heel prick test', forms part of a public health programme for screening infants shortly after birth. The aim of NBS programmes is primarily to identify disorders which, if left undiagnosed and untreated, pose risks of developmental delay, severe disability, or premature death. The testing involved in NBS is primarily performed by measuring metabolites, enzyme activity, or other biomarkers in samples of blood collected on filter paper following pricking of the infant's heel. All conditions that form part of the National Newborn Bloodspot Screening Programme (NNBSP) have been selected because they have a relatively high incidence within the Irish population and fulfil, in part or in full, the internationally set criteria for newborn screening.[112,114]

Universal Newborn Hearing Screening (UNHS) for hearing loss is recommended in all infants as soon as possible after birth.[115] There are two main tests used in UNHS: oto-acoustic emissions (OAE) and automated auditory brainstem responses (AABR) (sometimes called brainstem auditory evoked responses (BAER). OAE and AABR are simple, non-invasive 30-minute bedside tests.[115] UNHS programs detect permanent bilateral hearing loss (PBHL) (permanent conductive or sensorineural hearing loss of 40 dB or greater in the better ear) and unilateral loss. The prevalence of severe or profound permanent bilateral hearing loss (PBHL) (>60 dB loss) in infants is 1 to 1.5 per 1000 live births.[115,116] An additional 1 to 2 per 1000 infants have bilateral mild to moderate hearing loss or unilateral hearing loss of any degree. Both severe and profound PBHL result in significant impairments to language. The newborn hearing screening programme aims to identify all infants born with permanent hearing loss before they reach the age of 3 months. Early identification of hearing loss improves the long-term outcomes for infants, including speech development, language and communication skills. It also provides parents with the support and advice they need as early as possible for literacy development, functioning in adulthood, and quality of life.

Clinical Practice

Pulse oximetry screening should be performed on all newborn infants. For further guidance, refer to the National Neonatal Practice Guideline—Neonatal Pulse Oximetry Screening for Congenital Heart Disease in Asymptomatic Infants in Postnatal Maternity Care (add link once published).

Newborn Bloodspot Screening should be recommended for all newborn infants as part of the HSE Children's Screening Services. The screening should be performed in accordance with national guidance—refer to A Practical Guide to Newborn Bloodspot Screening in Ireland, for further guidance.

Universal Newborn Hearing Screening (UNHS) should be recommended for all newborn infants as part of the HSE Children's Screening Services. If the parent opts not to have the screening test, provide them with information leaflets with checklists to help them check on their infant's hearing as they grow older. Advise them to speak to their public health nurse or GP if they have concerns about their infant's hearing.

Midwives should be aware of the Standard Operating Procurement, developed by the National Programme for Paedritrics and Neonataology on testing infants for Congential Cytomegalovisus (cCMV) following "No clear Response" on Unvoersal Newborn Hearing Screening. This SOP can be accessed at local level.

Standard Operating Procedure Testing Infants for Congential Cytomegalovirus (cCMV) follwoing "No clear response" on Universal Newborn Hearing Screeing. National Clinical Programme for Paediatrics and Neonatology and the National Women and Infants Health Programme.

Recommendations

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.**
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.**
41. **We recommend all babies be offered a newborn hearing screening test in line with the National Newborn Hearing Screening Programme. Midwives should be aware of the Standard Operating Procedure – Testing infants for Congenital Cytomegalovirus (cCMV) following "No Clear Response" on Universal Newborn Hearing Screening.**

Clinical Question 2.16: Why is Vitamin D recommended for all newborn infants?

Evidence Statement

Vitamin D has an essential role in bone mineralisation, muscle contraction, nerve conduction, general cellular functioning and the immune system.[117] Vitamin D is essential in the metabolism of calcium and phosphate, skeletal growth and bone health, but is also involved in other functions such as the modulation of the function of activated B and T lymphocytes, insulin production, the secretion of thyroid-stimulating hormone and myocardial contractility. Adequate bone mineralisation in the first year of life lays the foundation for strong bones in later life.[118] The primary natural source of vitamin D is from skin synthesis following sunlight exposure. Dietary sources of vitamin D are limited, and oily fish is the only significant source. Small amounts are found in egg yolk, red meat and fortified foods, such as formula milk, some cereals and fat spreads.

Infants are generally considered to be at risk of vitamin D deficiency as they have limited stores at birth, infrequent exposure to sunlight, and relatively large vitamin D requirements due to rapid growth, leading to nutritional rickets.[118] Vitamin D levels are low in breast milk, predisposing infants who are exclusively breastfed or have less than 500 ml of infant formula daily to vitamin D deficiency.[119, 120]

A Cochrane systematic review examined the effect of vitamin D supplementation on infant's vitamin deficiency, bone density and growth in healthy-term breastfed infants.[80] The review found that 400 IU/day may increase vitamin D levels (6 studies; 334 participants; low-certainty evidence) and may reduce the incidence of vitamin D insufficiency (4 studies; 274 participants; low-certainty evidence).[80]

In Ireland, the Food Safety Authority of Ireland (FSAI) recommends that infants up to 1 year of age who are exclusively breastfed or take less than 300 ml of infant formula per day be given a daily vitamin D supplement. Infants up to 1 year of age who are formula fed should not be given a daily vitamin D supplement if they are having more than 300 ml of infant formula a day as it is fortified with vitamin D.[121]

Clinical Practice

Women who are exclusively breastfeeding should be advised that their infants receive a daily 5µg vitamin D-only supplement from birth to 1 year of age. The preferred form of vitamin D supplement is vitamin D3. However, for those who wish to avoid foods of animal origin, vitamin D2 is also suitable.

Infants taking less than 300 ml of formula per day (i.e. infants who are fed a combination of breastmilk and formula) should be given a daily 5µg vitamin D-only supplement. In the event of changing from breastfeeding to exclusively formula feeding, women should be advised to stop vitamin D supplementation. Infants that are exclusively formula feeding should not receive a daily vitamin D supplement or any supplement containing vitamin D, as there are adequate amounts of vitamin D added to commercial formula milk.

Recommendations

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.**

Clinical Question 2.17: Why is nirsevimab recommended for all newborn infants?

Evidence Statement

Respiratory syncytial virus (RSV) causes annual epidemics during autumn and winter in temperate climates and continues to significantly affect public health and healthcare systems. It is a leading cause of respiratory tract infections and places vulnerable populations, including infants, older adults, and immunocompromised individuals, at increased risk. Almost all infants will have had an RSV infection by two years of age. However, those aged less than six months are at the highest risk for severe disease. Infection-induced immunity is not fully protective and repeated lifelong infections are common. RSV causes a considerable socioeconomic burden due to the impact of infant infections and hospitalisations on healthcare systems and caregivers.[122]

In infants, RSV typically causes a self-limiting upper respiratory tract infection (URTI) with rhinorrhoea, pharyngitis, nasal congestion, coughing, sneezing, tachypnoea, and decreased appetite. Lower respiratory tract disease occurs as bronchiolitis or pneumonia, with fever in <50% of infections, increased work of breathing, hyperinflation, croup (laryngotracheobronchitis), and wheezing. Typically, between 1% and 3% of infants with RSV infection require hospitalisation. Treatment is supportive (supplemental oxygen and/or respiratory support, and feeding support).[122]

RSV is highly contagious. Transmission occurs through contact with aerosolised viral particles generated through sneezing, coughing, or from contaminated surfaces or fomites. Large-particle droplets can survive on contaminated surfaces for up to six hours, making handwashing the most effective infection control procedure. The frequent occurrence of mild or asymptomatic infection in otherwise healthy individuals makes infection control challenging.[122]

Nirsevimab, a monoclonal antibody for the prevention of RSV lower respiratory tract infection, is now available for administration to newborn infants. Clinical trials and real-world data demonstrate that nirsevimab is very effective in preventing hospitalisation from RSV infection. Across all endpoints, a single dose of nirsevimab has been shown to have a sustained and consistent reduction in severe RSV infections in infants. The picture that emerges is that nirsevimab leads to an 80% reduction in RSV hospitalisations in infants.[122] Refer to the HSE National Procedure on Nirsevimab to reduce RSV and associated hospitalisations in Infants[122] for further guidance.

Clinical Practice

Nirsevimab immunisation should be recommended for all newborn infants in line with the current National Immunisation Advisory Committee. The administration should be performed per national guidance.

Recommendations

43. **Nirsevimab immunisation should be recommended for all newborn infants in line with current advice from the National Immunisation Advisory Committee.**

Clinical Question 2.18: What are the 'Red Flags' for serious illness in infants in the postnatal period?

Evidence Statement

It is important to provide education to parents on signs and symptoms of common health problems in infants in order to reduce the delay in seeking care. The NICE guideline on neonatal infection advises that prior to transfer home from hospital or midwifery-led units or in the immediate postnatal period in the case of infants born at home, parents of carers should be advised to seek urgent medical help if they are concerned that their infant:[123]

- Is showing abnormal behaviour (for example inconsolable crying or listlessness)
- Is unusually floppy
- Has an abnormal temperature unexplained by environmental factors (lower than 36 °C or higher than 38 °C)
- Has abnormal breathing (rapid breathing, difficulty in breathing or grunting)
- Has a change in skin colour (for example, where the baby becomes very pale, blue/grey or dark yellow)
- Has developed new difficulties with feeding

This advice should be given in person, and as written information.[121]

Clinical Practice

At each postnatal contact, mothers should be asked if they have concerns about their infant's general well-being, feeding or development. Changes in the infant's behaviour or signs, such as refusing feeds or a change in the level of responsiveness, may indicate a change in the infant's well-being. Infants who have not passed meconium within the first 24 hours may indicate a serious disorder and require a medical review and assessment.

Prior to transferring home from the hospital or midwifery-led unit, or in the immediate postnatal period in the case of the homebirth setting, parents should be advised to seek urgent medical assistance if they are concerned that their infant:

- Is showing abnormal behaviour (for example, inconsolable crying or listlessness)
- Is unusually floppy
- Has an abnormal temperature unexplained by environmental factors (lower than 36 °C or higher than 38 °C
- Has abnormal breathing (rapid breathing, difficulty in breathing or grunting)
- Has a change in skin colour (for example, where the baby becomes very pale, blue/grey or dark yellow)
- Has developed new difficulties with feeding

This advice should be given verbally and supported by written information such as 'when your child is sick' (mychild.ie).

In line with the NICE guidance on postnatal care, the following should be considered as 'red flags' for serious illness in infants:

- appearing ill to a healthcare professional
- appearing pale, ashen, mottled or blue (cyanosis)
- unresponsive or unarousable
- having a weak, abnormally high-pitched or continuous cry
- abnormal breathing pattern, such as grunting respirations, increased respiratory rate (over 60 breaths/minute), chest recession
- temperature of 38 °C or over or under 36 °C
- non-blanching rash
- bulging fontanelle
- neck stiffness
- seizures
- focal neurological signs
- any jaundice in the first 24 hours after birth
- diarrhoea associated with dehydration
- frequent forceful (projectile) vomiting
- bilious vomiting (green or yellow-green vomit)

If an infant is thought to be seriously unwell based on a 'red flag' or an overall assessment of their condition, an immediate medical assessment is warranted. In the event of the home setting, an immediate medical assessment with an appropriate emergency service should be arranged. This may mean attending emergency or paediatric services or calling an ambulance.

Recommendations

44. **At each postnatal contact, mothers should be asked if they have concerns about their infant's general wellbeing, feeding or development.**
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.**

Clinical Question 2.19: How can the Midwife support and promote emotional attachment, optimising infant mental health?

Evidence Statement

Pregnancy, birth and the transition to parenthood are major adjustment periods for women, babies, and families, and the meanings attached to this period can be experienced positively or negatively. The mother-infant relationship, in addition to meeting an infant's physical needs, involves sensitive, responsive care, positive early experiences, and interactions that promote the infant's emotional and developmental well-being.

Knowing the significance of the early days and weeks in an infant's life to their lifelong health and well-being, midwives are uniquely placed, working in partnership with women, to foster and support parents' knowledge, skills, confidence and responsiveness as they learn to care for their infant.

Secure, early attachments with a responsive caregiver are associated with the following:[124-127]

- Improved language skills
- Better social competence
- Greater academic achievement with higher verbal and maths ability and reading comprehension
- Improved concentration and focus
- Being better able to manage emotions, control impulses, communicate feelings and empathise with others
- Early childhood obesity prevention when feeding cues are responded to appropriately
- Ongoing negative experiences and adversity influence a baby's developing organs and stress response system. Exposure to prolonged early stress influences the developing stress-response system and can increase later stress-related disorders such as mental health problems, drug abuse, diabetes and cardiovascular diseases
- Influencing how they parent their own children

The NICE guidance on postnatal care outlines the potentially challenging aspects of the postnatal period that may affect bonding and emotional attachment, including:[2]

- The woman's physical and emotional recovery from birth
- Experience of a traumatic birth or birth complications
- Fatigue and sleep deprivation
- Feeding concerns
- Demands of parenthood

Clinical Practice

Healthcare professionals should recognise the impact of birth, both physical and psychological, on mothers' ability to bond with their infants. Women and their families should be provided 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. Women should have the opportunity to discuss their birth experiences with their healthcare professionals. The woman's lived experience of birth should be acknowledged in a non-judgemental manner. Practices to support the maternal-infant dyad, such as skin-to-skin and rooming-in, should be encouraged. Parents should be encouraged to develop their relationship with their infants by:

- Making eye contact
- Responding to the infant's cues (i.e. smiling, cooing, crying)
- Holding their infant close
- Talk, sing, read stories

Further information is available: https://www2.hse.ie/babies-children/parenting-advice/baby-and-child-mental-wellbeing/your-babys-mental-health/

Discuss and signpost parents to information on developmental milestones so they can recognise when to be concerned while acknowledging that all babies develop individually. Further information is available: https://www2.hse.ie/babies-children/checks-milestones/developmental-milestones/0-6-months/

Recommendations

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.**

Clinical Question 2.20: What is the role of the Midwife in educating women, and families, to promote and support safer sleeping practices and reduce the risk of Sudden Infant Death syndrome (SIDS)?

Evidence Statement

The term SIDS (Sudden Infant Death Syndrome) is used when a sleeping infant, who has apparently been quite well, is found unexpectedly dead. It is sometimes referred to as cot death. In 1991, the National Institute of Child Health and Human Development (NICHD) Group in the United States published the following definition which SIDS is referred to as "the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history".[128]

In Ireland, the SIDS rate has declined from 2.0 (1980-93 inclusive) to 0.8 per 1000 live births (1994-2000 inclusive) and now accounts for four in every ten deaths in infancy, from one month to one year.[129] Safe sleep practices are associated with a reduction in the incidence of SIDS.[130-133]

As the cause of SIDS is not fully known, it cannot be prevented entirely. However, research has shown practices that can reduce the risk. The American Academy of Pediatrics (AAP)[131] recommends the following measures to create a safe sleeping environment.

- Place the infant on their back on a firm surface such as a crib, bassinet with a tight-fitting sheet.
- Avoid using soft bedding, including crib bumpers, blankets, pillows and soft toys.
- Share a room with parents, but not the same sleeping surface, preferably until the infant turns one but at least for the first six months. Room-sharing decreases the risk of SIDS by as much as 50%.
- Avoid infant's exposure to smoke, alcohol and illicit drugs.

Bed sharing is a common parenting strategy in many Western countries with 20-25% of respondents reporting bed-sharing in the first four weeks following birth; many reported unintentional bed-sharing[132-136] Unintentional bed-sharing occurs when parents fall asleep while feeding their infants, or at a time when they are particularly tired or their infants are unsettled.[131] Based on the evidence, the AAP is unable to recommend bed sharing under any circumstances. It is advised that parents be informed of the increased risk associated with bed sharing.[131]

More than 10 times the baseline risk of parent-infant bed sharing when:

- Parent has impaired alertness or ability to wake due to fatigue, or use of medications with sedating effects (certain antidepressants, analgesia) or substances (e.g. alcohol, illicit drugs).
- Bed sharing on a soft surface such as a sofa, couch or armchair.

5-10 times the baseline risk of parent-infant bed sharing when:

- Term, normal weight infant <4 months, even if neither parent smokes and even if the infant is breastfed. This is a particularly vulnerable time, so parents who choose to feed their infants aged <4 months in bed need to be especially vigilant to avoid falling asleep.
- Bed sharing with anyone who is not the infant's parent, including non-parental caregivers and other children.

2-5 times the baseline risk of parent-infant bed sharing:

- Preterm or low birth weight infant, even if neither parent smokes.
- Bed sharing with soft bedding accessories, such as pillows or blankets.

Parents who unintentionally fall asleep while feeding their infant should be advised to return the infant to a separate sleep surface as soon as they awaken.[129]

Clinical Practice

Mothers should be advised on safe sleeping practices to reduce the risk of SIDS. For the first 6 months, infants should sleep on their backs in a cot, crib, or Moses basket in the same room as the parent. Bed sharing or co-sleeping in the same bed can be dangerous, as it increases the infant's risk of suffocation and overheating.

Parent(s) should not bed share/co-sleep with their infant if either parent:

- Are over-tired
- Are smokers
- Have consumed alcohol

- Have consumed recreational and/or opioid drugs or medication that may make them drowsy

Parent(s) should not bed share/co-sleep with their infant if the infant:

- Is less than 3 months old
- Was premature (born before 37 weeks)
- Had a low birth weight (less than 2.5 kg)
- Or there are other children or pets in the parental bed

Parents who unintentionally fall asleep while feeding the infant should be advised to return the infant to a separate sleep surface as soon as the parent awakens.

Car seats, swings, infant seats, sling carriers and similar devices are not recommended for routine sleep in the home. If the infant falls asleep in a sitting device, they should be placed on their back to sleep as soon as possible.

The guidance in the mychild.ie book can be used to aid the discussion https://www2.hse.ie/documents/316/HSE_My_Child_0_to_2_years_book_version_7_0_May_2024.pdf

Recommendations

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 years book may aid the discussion.**

Section 3: Discharge Planning and Interprofessional Communication

Clinical Question 2.21: What is the process of transferring care to the community setting?

Introduction

Discharge planning starts during the antenatal period and continues from admission/onset of birth (at home) through discharge. Regardless of the place of birth, midwives provide postnatal care and discharge information to support the mother and family's transition to parenthood/home. Thus, continuity of care with the identified lead health professional will continue into the postnatal period. Midwives work in partnership with women, taking into account their wishes and preferences for the postnatal period. As implementation of the National Maternity Strategy is ongoing, there are various options for discharge planning nationally, such as early transfer home, routine discharge from maternity services to public health nursing, or community midwifery teams. Therefore, this section will address the essential components of discharge planning from the maternity unit/hospital to community care (community midwifery teams or public health nursing/GP) or before the Midwife leaves after a home birth.

Evidence Statement

Discharge planning supports the continuum of care and facilitates timely discharge from the hospital. A multidisciplinary integrated approach should be provided for discharge in line with the needs of the woman and infant. Comprehensive discharge assessment and education will enhance the individual needs of mothers/families before discharge and identify those who may require additional support. Effective communication between healthcare professionals is essential for the safe transfer of care.[2]

Clinical Practice

Before transferring from the maternity unit to community care or before the Midwife leaves after a home birth, the Midwife should:

- Assess the woman's health
- Assess the woman's bladder function by measuring the volume of the first void after giving birth
- Assess the infant's health (including physical inspection and observation) and ensure the infant has passed urine
- If the infant has not passed meconium, advise the parents that if this does not occur within 24 hours of birth, they should seek advice from a healthcare professional
- Ensure that a plan for feeding the baby is in place, including observing at least one effective feed (regardless of the feeding method).

Before transferring a woman from the maternity unit or hospital to community care, discuss the timing of the transfer with her and ask about her needs, preferences, and available support.

Women should be provided with the following information:

- What to expect in the postnatal period
- The importance of pelvic floor exercises – for further guidance refer to the HSE Every Move Counts: National Physical Activity and Sedentary Behaviours Guidelines for Ireland: For Pregnant and Postpartum Women
- When to seek medical advice, including contact numbers. This information should be supported by written information such as 'when your child is sick' (mychild.ie)
- Supports available in the community (such as community postnatal hubs, breastfeeding groups)
- Provide advice and contact details on who to contact in the event of an emergency. This should also be available in written format.

Before discharge from maternity services to public health services/GP, women should be advised on the following:

- The postnatal follow-up appointments with her GP
- The process for registering the infant's birth

Communication between healthcare professionals at the transfer of care is paramount. This includes transferring from maternity units/hospitals to community midwifery teams or from maternity services to Public Health Nursing/GP.

Based on the NICE guidance on postnatal care, the following information should be shared with the relevant healthcare professional:

- The pregnancy, birth, postnatal period and any complications
- Plan of ongoing care, including any condition that requires long-term management
- Problems related to previous pregnancies that may be relevant to current care
- Previous or current mental health concerns
- Female genital mutilation (mother or previous child)
- Who has parental responsibility for the baby, if known
- The woman's next of kin
- Any safeguarding issues
- Concerns regarding the infant's health and care
- Infant feeding

Recommendations

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.**
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 written format and be available in other languages.**
50. **Transfer of care should include sharing relevant information between healthcare professionals.**

Chapter 3: **Development of Clinical Practice Guideline**

3.1 Literature search strategy

A comprehensive literature review was undertaken, including national and international publications. The author assessed the quality of this evidence for each outcome according to criteria such as study design, risk of bias, and effect size during development by the guideline programme team during the review.

The literature search analysed international guidelines from Europe, the UK, the USA, Canada, New Zealand, and Australia. In addition, a review of the Cochrane Central Register of Trials was undertaken. A wide range of sources, including literature from peer-reviewed journals, systematic reviews, randomized clinical trials, and prospective studies, are provided as evidence to support the recommendations for each clinical question.

The use of the PICO tool (T) format – Population, Intervention, Comparison, Outcome, (Time) enabled a clear focus on the clinical question (NCEC, 2013). Electronic databases MEDLINE, EMBASE, and CINAHL were utilised. The search was limited to English language, peer-reviewed articles ranging between March 2022 and June 2025. Search phrases varied according to clinical questions, but key terms included postnatal, postpartum, puerperium, post-birth also, midwife, community setting and community midwife. Keywords were combined with Boolean operators to focus the search further.

The results yielded from these searches were reviewed. Subsequently, a detailed literature review was carried out, including international clinical practice guidelines on relevant subject areas.

3.2 Appraisal of evidence

Following a comprehensive literature review, the quality, validity and relevance of the evidence gathered were critically appraised by the Guideline developers under the following headings:

- Study design
- Relevance of primary and secondary outcomes
- Consistency of results across studies
- Magnitude of benefit versus magnitude of harm
- Applicability to practice context

A number of evidence-based recommendations for the management of postnatal care pathways were agreed upon. They have been adapted to reflect care in the Irish healthcare setting.

3.3 AGREE II process

While being developed, the Guideline was assessed using the AGREE II checklist (Appendix 4) as recommended by the Department of Health in the 'How to Develop a National Clinical Guideline: A Manual for Guideline Developers', 2019.[25]

The purpose of AGREE II is to provide a framework to:

1. Assess the quality of guidelines.
2. Provide a methodological strategy for the development of guidelines; and
3. Inform what information and how the information ought to be reported in the guidelines.

3.4 Literature review

Details of supportive evidence-based literature for this Guideline are reported in chapter two.

- The literature review was conducted by Caroline Keegan, Jennifer Duggan, Heather Helen, Aisling Dixon, Carmel Cronolly, Helen Murphy, Eithne Gilligan and Claudia Stanciu between March and November 2022. Mary Rowland conducted a further literature review between December 2024 and June 2025.
- The final documents selected were reviewed by the guideline development group.
- There is substantial international evidence available to answer the clinical questions proposed within hospital and community settings. However, there is a dearth of evidence for community postnatal care and community midwifery services from an Irish perspective.
- The quality of evidence available is, for the most part, strong evidence.
- The evidence reviewed comes from both national and international studies and has been adapted to fit the Irish context.
- Literature was used when the evidence was relevant, strong and applicable to the Irish setting and omitted when this was not the case.

3.5 Grades of recommendations

GRADE offers a transparent and structured process for developing and presenting evidence summaries and for carrying out the steps involved in developing recommendations.[26] While we acknowledge that an extensive GRADE approach is not possible for this particular work, we have used the suggested language set out in the GRADE table when making recommendations (Appendix 5).[27]

25 Department of Health (2019). How to develop a National Clinical Guideline: a manual for guideline developers. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

26 Guyatt, Gordon, et al. "GRADE Guidelines: 1. Introduction—GRADE Evidence Profiles and Summary of Findings Tables." *Journal of Clinical Epidemiology*, vol. 64, no. 4, 2011, pp. 383-94, https://doi.org/10.1016/j.jclinepi.2010.04.026

27 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. doi: 10.1016/j.ajog.2013.07.012

3.6 Future research

An important outcome of the Guideline development process is highlighting gaps in the evidence base.

The questions of relevance to this Guideline include;

1. Community postnatal services in Ireland are relatively uncommon, highlighting a dearth of evidence in this area. The collection of Irish data relative to the provision of postnatal services, particularly in community settings, would be beneficial for future developments in service provision.
2. What are the benefits of midwives versus public health nurses providing postnatal care to women in the community in Ireland?
3. Breastfeeding research – hospital and community initiatives to support exclusive BF.
4. Evaluate the effectiveness of midwife-led, early discharge home postnatal care (in terms of content, frequency and timing of contacts) in improving maternal and newborn outcomes.
5. Evaluate the effectiveness and cost-effectiveness of providing postnatal care at home versus in the hospital.
6. What is the role of eHealth in the future for midwives providing postnatal care?
7. The effect of increasing caesarean birth rate on postnatal care.

Chapter 4: Governance and Approval

4.1 Formal governance arrangements

The Guideline developers wrote this Guideline under the direction of the Guideline Programme Team (GPT). An Expert Advisory Group was formed to review the Guideline prior to submission for final approval with the National Women and Infants Health Programme. The roles and responsibilities of the group members and the process were clearly outlined and agreed upon.

4.2 Guideline development standards

This Guideline was developed by the Guideline Developer Group (GDG) within the overall template of the HSE National Framework[28] for developing Policies, Procedures, Protocols and Guidelines (2023) and under the supervision of the Guideline Programme Team.

A review was conducted by a group of experts, specialists and advocates (the EAG) prior to approval by the Clinical Advisory Group (CAG) of the National Women and Infants Health Programme (NWIHP) with final sign-off for publication by CAG Co-Chairs the Clinical Director of NWIHP and the Chair of the IOG. See Appendix 6 for a list of CAG members.

28 Health Service Executive (2023). How to develop HSE National Policies, Procedures, Protocols and Guidelines (PPPGs).

Chapter 5:
Communication And Dissemination

A communication and dissemination plan for this Guideline has been developed by the GPT and endorsed by NWIHP.

Effective, ongoing, and clear communication is essential for explaining why the Guideline is necessary and securing continued buy-in. It provides an opportunity to instil motivation within staff, helps overcome resistance to change and gives an opportunity for feedback.[29]

The Clinical Guideline will be circulated and disseminated through the Guideline Programme Team and the professional networks that developed and reviewed it.

Senior management within the maternity units is responsible for appropriately disseminating new and updated guidelines. Local hospital groups, including Guideline committees, are also instrumental in circulating new and updated guidelines and promoting their use in the relevant clinical settings.

The HSE will make this Guideline and supporting documents available to all employees through standard networks. Electronic versions available on the https://www2.healthservice.hse.ie/organisation/national-pppgs/ and RCPI websites https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/ and other communication means can be used to maximise distribution.

29 Department of Health (2018). NCEC Implementation Guide and Toolkit. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/?

Chapter 6: **Implementation**

6.1 Implementation plan

Implementation was considered at the beginning and throughout the Guideline development process. The local multidisciplinary clinical team, senior executive and clinical management in each maternity and gynaecology unit are ultimately responsible for the appropriate structured adoption and implementation of the Guideline within their area of responsibility. They must ensure that all relevant personnel under their supervision have read and understood the Guideline and monitor both its effectiveness and adoption.

Within each site, local multidisciplinary teams are responsible for the clinical implementation of Guideline recommendations and ensuring that their local clinical practices and processes reflect and are aligned with the Guideline recommendations.

The following have been put in place to facilitate the implementation of this Guideline.

- Quick Summary Document (QSD) for clinical staff (includes key recommendations, auditable standards, algorithms and recommended reading)
- Clinical Guideline mobile application
- Plain language summary

6.2 Education plans required to implement the Guideline

It is acknowledged that this Guideline should be complemented by ongoing education, training and assessment where required. Regular and repeated education sessions will be provided to midwives and the multidisciplinary team. Collaboration with colleagues in General Practice and Public Health will inform them of the guideline.

6.3 Barriers and facilitators

To ensure the successful implementation of guidelines, it is first necessary to look at potential barriers and facilitators. Taking these into account when developing the implementation plan should improve levels of support from relevant users (DOH 2018, 2019).

Barriers may be categorised as internal (specific to the Guideline itself) or external (specific to the clinical environment).

The Guideline Development Group has aimed to address any internal barriers during the development of this Guideline.

Potential external barriers include:

- Structural factors (e.g. budget or service redesign)
- Organisational factors (e.g. lack of facilities or equipment)
- Individual factors (e.g. knowledge, skills, training)
- Woman's perceptions

In the case of this Guideline it will be necessary to examine possible barriers and consider implementation strategies to address them. By example, this may include discussion with relevant management groups with regards budgetary impact or providing training to the relevant staff.

Facilitators for this guideline are

- Midwives currently providing community postnatal care including postnatal hubs
- Directors of Midwifery, Advanced Midwife Practitioners and colleagues striving to expand postnatal midwifery services in the community through DOMINO and Early Transfer Home (ETH) schemes.
- Women and families who have previously used these services and request to use them again.

6.4 Resources necessary to implement recommendations

The implementation of this Guideline should be undertaken as part of the quality improvement of each hospital. Hospitals should review existing service provision against this Guideline, identifying necessary resources required to implement the recommendations in this Guideline.

Chapter 7: Audit and Evaluation

7.1 Introduction to audit

It is important to audit both the implementation of the Guideline and its influence on outcomes to ensure that this Guideline positively impacts the care of the woman. Institutions and health professionals are encouraged to develop and undertake regular audits of Guideline implementation. Personnel responsible for conducting the audit should be identified upon receipt of the most recent version of the Guideline.

7.2 Auditable standards

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

Auditable standards for this Guideline include, but are not limited to:

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.[77]
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.

7.3 Evaluation

Evaluation is a formal process for determining the extent to which an intervention's planned or desired outcomes are achieved.[30]

Implementation of this Guideline will be audited periodically at a national level, with standards set by the NWIHP. To support implementation, senior hospital clinical management should also evaluate the auditable standards locally.

30 Health Information Quality Authority (2012). National Standards for Safer Better Healthcare [Internet]. Available from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

Chapter 8: **Revision Plan**

8.1 Procedure for the update of the Guideline

It may be a requirement to amend, update or revise this Guideline as new evidence emerges. This Guideline will be reviewed at national level every three years, or earlier if circumstances require it, and updated accordingly.[31]

The Guideline Development Group will be asked to review the literature and recent evidence to determine if changes are to be made to the existing Guideline. If the Guideline Development Group are unavailable, the GPT, along with the NWIHP senior management team, will select a suitable expert to replace them.

If no amendments are required to the Guideline following the revision date, the details on the revision tracking box must still be updated, which will be a new version number and date. The recommendations outlined in this Guideline remain valid until a review is completed.

8.2 Method for amending the Guideline

As new evidence becomes available, it is inevitable that Guideline recommendations will fall behind current evidence-based clinical practice. It is essential that clinical guidelines are reviewed and updated with new evidence as it becomes available.

To request a review of this Guideline, one of the following criteria must be met:

a. Three years since the Guideline was published

b. Three years since last review was conducted

c. Update required as a result of new evidence

Correspondence requesting a review of the Guideline should be submitted to the National Women and Infants Health. Any such requests should be dealt with in a timely manner.

31 Health Service Executive (2023). How to develop HSE National Policies, Procedures, Protocols and Guidelines (PPPGs).

Chapter 9: **References**

1. Department of Health. Creating a Better Future Together, National Maternity Strategy 2016-2026 [Internet]. 2016. Available from: https://www.gov.ie/pdf/?file=https://assets.gov.ie/18835/ac61fd2b66164349a1547110d4b0003f.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. International Confederation Midwives (ICM). Core Document Philosophy and Model of Midwifery Care [Internet]. 2014. Available from: www.internationalmidwives.org/assets/files/general-files/2020/07/cd0005_v201406_en_philosophy-and-model-of-midwifery-care.pdf
4. Nursing and Midwifery Board of Ireland. Scope of Nursing and Midwifery Practice Framework. 2015.
5. Nursing and Midwifery Board of Ireland. Practice Standards for Midwives [Internet]. 2022. Available from: https://www.nmbi.ie/NMBI/media/NMBI/NMBI-Practice-Standards-for-Midwives.pdf
6. World Health Organization. WHO Technical Consultation on Postpartum and Postnatal Care [Internet]. 2010. Available from: https://www.who.int/publications/i/item/WHO-MPS-10.03
7. Steen M, Jackson K, Brown A. Physiology and Care during the Puerperium. In: Myles Textbook for Midwives. UK: Elseiver; 2020. p. 715-37.
8. 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
9. Chi C, Bapir M, Lee C, Kadir R. Puerperal loss (lochia) in women with or without inherited bleeding disorders. American Journal of Obstetrics and Gynaecology. 2010;203(1):56.e1-5.
10. Negishi H, Kishida T, Yamada H. Changes in uterine size after vaginal delivery and cesarean section determined by vaginal sonography in the puerperium. Archives of Gynecology & Obstetrics. 1999;263:13-6.
11. National Institute for Health and Care Excellence. Routine Postnatal Care of Women and their Babies. NICE; 2017.
12. Bergström S, Limombo A. Puerperal measurement of the symphysis-fundus distance. Gynecologic and Obstetric Investigation. 1992;34(2):76-8.
13. Crowther S & Waller N Chapter 44. Women and family-centred postnatal care. In: Mayes' Midwifery. Macdonald S & Johnson G (Eds.) Sixteenth Edition. UK: Elsevier; 2024
14. Department of Health. Irish Maternity Early Warning System (IMEWS) NCEC National Clinical Guideline No. 4 Version 2 [Internet]. 2019. Available from: https://www.gov.ie/en/collection/517f60-irish-maternity-early-warning-system-imews-version-2/
15. Mulder F, Hakvoort R, Schoffelmeer M, Limpens J. Postpartum urinary retention: a systematic review of adverse effects and management. International Urogynecology Journal. 2014;25(12):1605-12.

16. Cunningham F, Leveno K, Bloom S. William's obstetrics. 23rd edition. New York: McGraw-Hill; 2010.
17. Mohr S, Raio L, Gobrecht-Keller U, Kuhn A. Postpartum urinary retention: what are the sequelae? A long-term study and review of the literature. Int Urogynecol J. 2022;33(6):1601-8.
18. Yip S, Brieger G, Hin L, Chung T. Urinary retention in the post-partum period. The relationship between obstetric factors and the post-partum post-void residual bladder volume. Acta Obstet Gynecol Scand [Internet]. 1997;76(7):667-72. Available from: https://doi.org//10.3109/00016349709024608
19. Stanley A, Connor B. Implementing a clinical practice guideline to manage postpartum urinary retention. J Nurs Care Qual. 2015;30(2):175-80.
20. Li L, Chen Q, Li H, Yi S. Risk factors for postpartum urinary retention: An updated systematic review and meta-analysis. Int J Gynecol Obstet. 2025;168(10):10-24.
21. Royal College of Nursing (RCN). Bowel Care Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of Faeces. 2019.
22. Wray J, Steen M. Chapter 24 Physical health problems and complications in the puerperium. In: Myles' Textbook for Midwives E-Book. 16th edition. Elsevier Health Sciences; 2014.
23. Bowler P, Duerden B. Wound microbiology and associated approaches to wound management. Clin Microbiol Rev. 2001;14(2):244-69.
24. Health Service Executive. National Wound Management Guidelines [Internet]. 2018. Available from: https://healthservice.hse.ie/about-us/onmsd/quality-nursing-and-midwifery-care/hse-national-wound-guidelines-2018.html
25. Toon C, Ramamoorthy R, Gurusamy K. Early versus delayed dressing removal after primary closure of clean and clean-contaminated surgical wounds. Cochrane Database of Systematic Reviews. 2015;
26. Peleg D, Eberstark K, Warsof S, Cohen N. Early wound dressing removal after scheduled cesarean delivery: A randomized controlled trial. Am J Obstet Gynecol. 2016;215(3):388.e1-5.
27. 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
28. Norman G, Shi C, Gog E. Negative pressure wound therapy for surgical wounds healing by primary closure. Cochrane Database of Systematic Reviews. 2022;(4).
29. Goldszmidt E, Kern R, Chaput A. The incidence and etiology of postpartum headaches: a prospective cohort study. Can J of Anaesth. 2005;52(9):971-7.
30. Stella C, Jodicke C, How H. Postpartum headache: is your work-up complete? American Journal of Obstetrics & Gynecology. 2007;196(4):318-e1-7.
31. Vgontzas A, Robbins M. A Hospital Based Retrospective Study of Acute Postpartum Headache. Headache. 2018;58(6):845-51.
32. Knight M, Bunch K, Tuffnell D. Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. Oxford: National Perinatal Epidemiology Unit, University of Oxford.; 2021.
33. Knight M, Bunch K, Felker A. Saving Lives, Improving Mothers' Care Core Report – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2023.

34. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and HSE Clinical Care Programme in Obstetrics and Gynaecology and Irish Haematology Society. Clinical Practice Guideline: Venous Thromboprophylaxis in Pregnancy. 2013.

35. Byrne B, Spring A, Barrett J, Power J. National Clinical Practice Guideline: Prevention and Management of Primary Postpartum Haemorrhage. [Internet]. National Women and Infants Health Programme and the Institute of Obstetricians and Gynaecologists. 2022. Available from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

36. HSE National Wound Management Guidelines [Internet]. The Office of Nursing and Midwifery Service Director; 2018. Available from: http://www.hse.ie/eng/about/who/onmsd

37. Deussen A, Ashwood P, Martis R. Relief of pain due to uterine cramping/involution after birth. Cochrane Database of Systematic Reviews. 2020;(10).

38. East C, Dorward E, Whale R. Local cooling for relieving pain from perineal trauma sustained during childbirth. Cochrane Database of Systematic Reviews. 2020;10.

39. Turawa E, Musekiwa A, Rohwer A. Interventions for preventing postpartum constipation. Cochrane Database of Systematic Reviews. (8).

40. Lawrence R, Lawrence R. Breastfeeding: A Guide for the Medical Professions. 8th edition. Maryland Heights: Elseiver Mosby; 2015. 253 p.

41. McClellan H, Kent J, Hepworth A. Persistent Nipple Pain in Breastfeeding Mothers Associated with Abnormal Infant Tongue Movement. International Journal of Environmental Research and Public Health. 2015;12(9):10833-45.

42. Zakarija-Grkovic I, Stewart F. Treatments for breast engorgement during lactation. Cochrane Database of Systematic Reviews. 2020;9.

43. Ballard O, Morrow A. Human milk composition: nutrients and bioactive factors. Pediatr Clin North Am. 2013;60(1):49-74.

44. Gila-Diaz A, Arribas S, Algara A. A Review of Bioactive Factors in Human Breastmilk: A Focus on Prematurity. Nutrients. 2019;11(6):1307.

45. Victora C, Bahl R, Barros A. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. The Lancet. 2016;387(10017):475-90.

46. Horta B, Loret de Mola C, Victora C. Long-term consequences of breastfeeding on cholesterol, obesity, systolic blood pressure and type 2 diabetes: a systematic review and meta-analysis. Acta Paediatr. 2015;104(467):30-7.

47. Kramer M, Aboud F, Mironova E. Breastfeeding and child cognitive development: new evidence from a large randomized trial. Arch Gen Psychiatry. 2008;65(5):578-84.

48. World Health Organization. Global strategy for infant and young child feeding [Internet]. World Health Organization & United Nations Children's Fund (UNICEF); 2003. Available from: https://www.who.int/publications/i/item/9241562218

49. Health Service Executive. National Standards for Infant Feeding in Maternity Services [Internet]. 2022. Available from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-reports-on-womens-health/national-standards-for-infant-feeding-in-maternity-services.pdf

50. Health Service Executive. National Infant Feeding Policy for Maternity & Neonatal Services [Internet]. 2019. Available from: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/PPPG_Document_Development_and_Inventory

51. World Health Organization. Guideline on haemoglobin cut-offs to define anaemia in individuals and populations [Internet]. 2024. Available from: https://iris.who.int/bitstream/handle/10665/376196/9789240088542-eng.pdf
52. British Committee for Standards in Haematology. UK Guidelines on the Management of Iron Deficiency in Pregnancy. BCSH. 2011;
53. Breymann C, Honegger C, Hösli I. Diagnosis and treatment of iron-deficiency anaemia in pregnancy and postpartum. Archives of Gynecology and Obstetrics. 2017;(296):1229-34.
54. The Irish Haematology Society, Institute of Obstetrics and Gynaecologists, Royal College of Physicians of Ireland and Obstetrics and Gynaecology Programme HSE Directorate for Quality and Clinical Strategy. Clinical Practice Guidance: The Use of Anti-D Immunoglobulin for the Prevention of RhD Haemolytic Disease of the Newborn. [Internet]. Health Service Executive & Institute of Obstetricians and Gynaecologists; 2014. Available from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/anti-d-immunoglobin-prevention-of-rhd-haemolytic-disease-of-the-newborn.pdf
55. Qureshi H, Massey E, Kirwan D. BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. Transfusion Medicine. 2014;24:8-20.
56. Soothill P, Finning K, Lathan T. Use of cff DNA to avoid administration of anti-D to pregnant women when the fetus is RhD-negative: implementation in the NHS. BJOG. 2015;122(12):1682-6.
57. Raynor M, Griffiths-Haynes H. Chapter 6: Parent-infant relationship. In: Midwifery Essentials: Perinatal Mental Health E-book. India: Elseiver; 2022.
58. Buttner M, O'Hara M, Watson D. The structure of women's mood in the early postpartum assessment. Assessment. 2011;19(2):135-259.
59. O'Hara M, Wisner K. Perinatal mental illness: definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2014;28(1):3-12.
60. Valentine S, Alshabani N, Godfrey L, Paul E. Considerations for the provision of PTSD treatment among pregnant women with substance use histories: A clinical conceptual model based on case consultation field notes. Gen Hosp Psychiatry. 2023;84:3-11.
61. Stoodley C, McKellar L, Ziaian T, Steen M. The role of midwives in supporting the development of the mother-infant relationship: a scoping review. BMC Psychology. 2023;11(71).
62. Woody C, Ferrari A, Siskind D. A systematic review and meta-regression of the prevalence and incidence of perinatal depression. Journal of Affective Disorders. 2017;219:86-92.
63. Vanderkruik R, Barreix M, Chou D, Allen T. The global prevalence of postpartum psychosis: a systematic review. BMC Psychiatry. 2017;17(1):272.
64. Regier D, Kuhl E, Kupfer D. The DSM-5: Classification and criteria changes. World Psychiatry. 2013;12(2):92-8.
65. Yildiz P, Ayers S, Phillips L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. Journal of Affective Disorders. 2017;208:634-45.
66. Frusta M, Sandall J, Bick D. A systematic review of the relationship between severe maternal morbidity and post-traumatic stress disorder. M+BMC Pregnancy Childbirth. 2012;10(12):125.
67. Andersen L, Melvaer L, Videbech P, Lamont R. Risk factors for developing post-traumatic stress disorder following childbirth: a systematic review. Acta Obstetricia et Gynecologica Scandinavica. 2018;91(11):1261-72.

68. 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/

69. 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/

70. Hugill K. Neonatal skin cleansing revisited: Whether or not to use skin cleansing products. British Journal of Midwifery. 2014;2(22):694-8.

71. World Health Organization. Intrapartum care for a positive childbirth experience. [Internet]. 2018.

72. National Institute for Health and Care Excellence. Intrapartum Care [Internet]. 2023. Available from: www.nice.org.uk/guidance/ng235

73. United Nations International Children's Emergency Fund (UNICEF). Guide to the UNICEF UK Baby Friendly Initiative Standards [Internet]. 2017. Available from: https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2014/02/Guide-to-the-Unicef-UK-Baby-Friendly-Initiative-Standards.pdf

74. Health Service Executive. Skin to Skin Contact with Newborns. [Internet]. 2023. Available from: https://www2.hse.ie/babies-children/breastfeeding/a-good-start/skin-contact/

75. Moore E, Bergman N, Anderson G. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews. (11).

76. 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

77. Phillippi J, Holley S, Morad A. Prevention of vitamin K deficiency bleeding. Journal of Midwifery & Women's Health. 2016;61(5):632-6.

78. Busfield A, Samuel R, McNinch A. Vitamin K deficiency bleeding after NICE guidance and withdrawal of Konakion Neonatal: British Paediatric Surveillance Unit study, 2006-2008. Archives of Disease in Childhood. 2013;98(1):41-7.

79. Sankar M, Chandrasekaran A, Kumar P. Vitamin K prophylaxis for prevention of vitamin K deficiency bleeding: a systematic review. Journal of Perinatology. 2016;36(1):S29-35.

80. Tan M, Abrams S, Osborn D. Vitamin D supplementation for term breastfed infants to prevent vitamin D deficiency and improve bone health. Cochrane Database of Systematic Reviews. 2020;(12).

81. Imdad A, Bautista R, Senen K. Umbilical cord antiseptics for preventing sepsis and death among newborns. Cochrane Database of Systematic Reviews. 2013;5.

82. Visscher M, Adam R, Brink S. Newborn infant skin: physiology, development, and care. Clinics in Dermatology. 2015;33(3):271-80.

83. Bouslimani A, da Silva R, Kosciolek T. The impact of skin care products on skin chemistry and microbiome dynamics. BMC Biology. 2019;17(47).

84. World Health Organization. WHO recommendations on Newborn Health [Internet]. 2017. Available from: https://apps.who.int/iris/handle/10665/259269

85. Brandon D, Hill C, Heimall L. Neonatal skin care: evidence-based clinical practice guideline. Association of Women's Health, Obstetric and Neonatal Nurses. 2018;147.

86. Lund C, Kuller J, Durand D. Baby's first bath: Changes in skin barrier function after bathing full-term newborns with water vs liquid baby cleanser. Pediatric Dermatology. 2020;37(1):115-9.

87. Priyadarshi M, Balachander B, Gupta S. Timing of first bath in term healthy newborns: A systematic review. Journal of Global Health. 2022;12(12004).

88. The Rainbow Clinic. Preventing Perinatal Transmission: A practical guide to the antenatal and perinatal management of HIV, Hepatitis B, Hepatitis C, Herpes Simplex & Syphilis [Internet]. 2015. Available from: http://www.ssstdi.ie/guidelines

89. Miyoshi Y, Suenaga H, Aoki M. Determinants of excessive weight loss in breastfed full-term newborns at a baby-friendly hospital: a retrospective cohort study. International Breastfeeding Journal. 2020;15(19).

90. 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

91. HSE National Public Health Service. Guideline on the Observation of a Breastfeed and Use of the Breastfeeding Observation Assessment Tool (BOAT) Resource [Internet]. 2022. Available from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/child-health-and-wellbeing/breastfeeding-healthy-childhood-programme/policies-and-guidelines-breastfeeding/

92. Güemes M, Rahman S, Hussain K. What is a normal blood glucose? Archives of disease in childhood. 2016;101(6):569-74.

93. British Association of Perinatal Medicine. Identification and Management of Neonatal Hypoglycaemia in the Full-Term Infant (Birth-72 hours). A BAPM Framework for Practice. 2017;

94. Adamkin D. Committee on Fetus and Newborn. Postnatal glucose homeostasis in late-preterm and term infants. Pediatrics. 2011;127(3):e20103851.

95. 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;

96. di Pasquo E, Saccone G, Angeli L, Dall'Asta A. Determinants of neonatal hypoglycemia after antenatal administration of corticosteroids (ACS) for lung maturation: Data from two referral centers and review of the literature. Early Human Development. 2020;143(104984).

97. Burns C, Rutherford M, Boardman J, Cowan F. Patterns of cerebral injury and neurodevelopmental outcomes after symptomatic neonatal hypoglycemia. Pediatrics. 2008;122(1):65-74.

98. Gupta K, Rajagopal R, King F, Simmons D. Complications of Antenatal Corticosteroids in Infants Born by Early Term Scheduled Cesarean Section. Diabetes Care. 2020;43(4):104984.

99. Gyamfi-Bannerman C, Thom E, Blackwell S. Antenatal Betamethasone for Women at Risk for Late Preterm Delivery. N Engl J Med. 2016;7(374):1311-20.

100. Okwundu C, Olowoyeye A, Smith J. Transcutaneous bilirubinometry versus total serum bilirubin measurement for newborns. Cochrane Database of Systematic Reviews. 2023;(5).

101. Lauer B, Spector N. Hyperbilirubinemia in the newborn. Pediatrics in Review. 2011;32(8):341-9.

102. Manning D, Todd P, Maxwell M. Prospective surveillance study of severe hyperbilirubinaemia in the newborn in the UK and Ireland. Archives of Disease in Childhood-Fetal and Neonatal Edition. 2007;92(5):342-6.

103. Allen N, Mohammad F, Foran A. Severe hyperbilirubinaemia and kernicterus: more caution is needed in newborn jaundice surveillance. Irish Medical Journal. 2009;102(7):228-9.

104. Kemper A, Newman T, Slaughter J. Clinical practice guideline revision: management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. Pediatrics. 2022;150(3):e2022058859.

105. Bhutani V, Johnson L, Sivieri E. Predictive ability of a pre-discharge hour-specific serum bilirubin for subsequent significant hyperbilirubinemia in healthy term and near-term newborns. Pediatrics. 1999;103(1):6-14.

106. Okwundu C, Bhutani V, Smith J. Predischarge transcutaneous bilirubin screening reduces readmission rate for hyperbilirubinaemia in diverse South African newborns: A randomised controlled trial. S Afr Med J. 2020;(110):249-54.

107. Alkalay A, Bresee C, Simmons C. Decreased neonatal jaundice readmission rate after implementing hyperbilirubinemia guidelines and universal screening for bilirubin. Clin Pediatr. 2010;49:830-3.

108. Flynn M. A quality improvement project to decrease serum bilirubins and increase appropriate phototherapy use by following the AAP guidelines in a well nursery. Pediatr Nurs. 2017;(43):143-8.

109. Kuzniwicz M, Escobar G, Newman T. Impact of universal bilirubin screening on severe hyperbilirubinemia and phototherapy use. Pediatrics. 2009;(124):1031-9.

110. Wickremasinghe A, Karon B, Saenger A. Effect of universal neonatal transcutaneous bilirubin screening on blood draws for bilirubin analysis and phototherapy usage. J Perinatol. 2012;32:851-5.

111. Khurshid F, Roa S, Sauve C. Universal screening for hyperbilirubinemia in term healthy newborns at discharge: A systematic review and meta-analysis. J Glob Health. 2022;12(12007).

112. Health Service Executive. Report of the HSE's National Children's Screening Programmes 2020-2022. 2023.

113. Engel M, Kochilas L. Pulse oximetry screening: a review of diagnosing critical congenital heart disease in newborns. Medical Devices: Evidence and Research. 2016;11:119-203.

114. American Academy of Pediatrics. Newborn screening: critical congenital heart defects. [Internet]. 2019. Available from: https://doi.org//10.1542/peds.2024-069667

115. World Health Organization. World Report on Hearing. [Internet]. 2021 p. 252. Available from: https://www.who.int/publications/i/item/9789240020481

116. Lieu J, Kenna M, Anne S. Hearing Loss in children: a review. JAMA. 2020; 324(21): 2105-205

117. Clarke B. Nomral bone anatomy and physiology. Clinical Journal of the American Society of Nephrology 2008; 3 (Suppl 3): S131-9

118. Creo A, Thacker T, Pettifor J, Strand M, Fischer P. Nutirtional rickets around the world: an update. Paediatrics and International Child Health. 2017; 37 (2): 84-98

119. National Institute for Health and Care Excellence. Vitamin D: Supplement use in specific population groups. 2017 www.nice.org.uk/guidance/ph56

120. Winzenberg T, Jones G. Vitamin D and bone health in childhood and adolescence. Calcif Tissue Int. 2013;92(2):140-50.

121. Food Safety Authority of Ireland. Guidance for Food Businesses: the Safety of Vitamins and Minerals in Food Supplements [Internet]. 2020. Available from: https://www.fsai.ie/getmedia/208e3265-be5d-41d1-87d5-76f51b3149fa/guidance-for-food-businesses-the-safety-of-vitamins-and-minerals-in-food-supplements(1).pdf

122. National Clinical Programme for Paediatrics and Neonatology and the National Women and Infatns Health Programme. Nirsevimab to Reduce Respiratory Syncytial Virus (RSV) and Associated Hospitalisations in Infants.

123. National Institute of Clinical Excellence. Neonatal infection: antibiotics for prevention and treatment [Internet]. 2024. Available from: https://www.nice.org.uk/guidance/ng195

124. Scherer E, Hagaman A, Chung E. The relationship between responsive caregiving and child outcomes: evidence from direct observations of mother-child dyads in Pakistan. BMC Public Health. 2019;19(252):1-10.

125. Miller P, Commons M. The benefits of attachment parenting for infants and children: A behavioral developmental view. Behavioral Development Bulletin. 2010;16(1):1-14.

126. Landry S, Smith K, Swank P. Responsive parenting: establishing early foundations for social, communication, and independent problem-solving skills. Developmental Psychology. 2006;42(4):627-42.

127. Salter Ainsworth M. Attachment as Related to Mother-Infant Interaction. Advances in the Study of Behaviour. 1979;9:1-51.

128. Willinger M, James L, Catz C. Defining the Sudden Infant Death Syndrome (Sids): Deliberations of an Expert Panel Convened by the National Institute of Child Health and Human Development. Pediatric Pathology. 1991;11(5):677-84.

129. Mehanni M, Cullen A, Kilberd B. The current epidemiology of SIDS in Ireland. Irish Medical Journal [Internet]. 2000;93(9):264-8. Available from: http://hdl.handle.net/10147/128343

130. Doering J, Lim P, Ward T. Prevalence of unintentional infant bedsharing. Applied Nursing Research. 2019;46:28-30.

131. 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. Pediatrics. 2022;150(1):e2022027991.

132. Cunningham H, Vally H, Bugeja L. Bed-sharing in the first 8 weeks of life: An Australian study. Maternal and Child Health Journal. 2018;22:556-64.

133. Dennis C, Brown H, Brennenstuhl S. Prevalence and predictors of postpartum maternal and infant bed-sharing among Chinese-Canadian women. Behavioral Sleep Medicine. 2020;18:120-30.

134. Ball H. Bed-sharing practices of initially breastfed infants in the first 6 months of life. Infant and Child Development. 2007;4:387-401.

135. Blair P, Ball H. The prevalence and characteristics associated with parent-infant bed-sharing in England. Archives of Disease in Childhood. 2004;89(12):1106-10.

136. McCoy R, Hunt C, Lesko S. Frequency of bed sharing and its relationship to breastfeeding. Journal of Developmental & Behavioral Pediatrics. 2004;25(3):141-9.

Bibliography

Health Information Quality Authority (2012). National Standards for Safer Better Healthcare [Internet]. Available from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

Department of Health (2015). NCEC Standards for Clinical Practice Guidance. Available at: https://www.nmbi.ie/NMBI/media/NMBI/Forms/standards-for-clinical-practice-guidance-ncec.pdf

National Clinical Effectiveness Committee (NCEC) and Health Information and Quality Authority (HIQA) (2015) National quality assurance criteria for clinical guidelines. Version 2. Dublin: NCEC and HIQA. https://assets.gov.ie/11533/2d070cb758a44fcb8b56f28784b10896.pdf

Department of Health (2018). NCEC Implementation Guide and Toolkit. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

Department of Health (2019). How to develop a National Clinical Guideline. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

Health Service Executive (2019). National Review of Clinical Audit. Available from: https://www2.healthservice.hse.ie/organisation/ncca/

Scottish Intercollegiate Guidelines Network (SIGN). A guideline developer's handbook. Edinburgh: SIGN; 2019. (SIGN publication no. 50). [November 2019]. Available from URL: http://www.sign.ac.uk

Society of Maternal-Fetal Medicine. SMFM Clinical Practice Guidelines Development Process [Internet]. Available from: https://www.smfm.org/publications

Health Service Executive (2025), National Centre for Clinical Audit Nomenclature – Glossary of Terms, National Quality and Patient Safety Directorate.

Health Service Executive (2023). How to Develop HSE National Policies, Procedures, Protocols and Guidelines (PPPGs). How_to_Develop_HSE_National_Policies_Procedures_Protocols_and_Guidelines_gQBQ4os.pdf

Supporting Evidence

GRADE: http://www.gradeworkinggroup.org/

AGREE: http://www.agreetrust.org/agree-ii/

Glossary

ACOG	American College of Obstetricians and Gynaecologists
AGREE	Appraisal of Guidelines for Research and Evaluation
BFI	Baby Friendly Initiative
BGL	Blood Glucose Level
CAG	Clinical Advisory Group
CCHD	Critical Congenital Heart Disease
CF	Cystic Fibrosis
CHD	Congenital Heart Disease
CHT	Congenital Hypothyroidism
dB	Decibel
DCT	Direct Coombs Test
DOMINO	DOMiciliary In and Out
DVT	Deep Vein Thrombosis
EAG	Expert Advisory Group
ETH	Early Transfer Home
FMH	Feto-Maternal Haemorrhage
g/dL	Grams per deciliter
GIN	Guidelines International Network
GP	General Practitioner
GPT	Guideline Programme Team
GRADE	Grading of Recommendations, Assessments, Developments and Evaluations
Hb	Haemoglobin
HCP	Healthcare Professional
HDN	Haemorrhagic Disease of the Newborn
HSE	Health Service Executive
Ig	Immunoglobulin
IOG	Institute of Obstetricians and Gynaecologists
IU	International Units
LARC	Long-Acting Reversible Contraceptives
MDT	Multi-Disciplinary Team
mmol/L	Millimoles per litre
MLU	Midwifery Led Unit (Alongside/Freestanding)

NBS	Newborn Bloodspot Screening
NCEC	National Clinical Effectiveness Committee
NICE	National Institute for Health and Care Excellence
NNBSP	National Newborn Bloodspot Screening Programme
NMBI	Nursing and Midwifery Board of Ireland
NPWT	Negative Pressure Wound Therapy
NSAIDs	Non-steroidal anti-inflammatory drugs
NWIHP	National Women and Infants Health Programme
PBHL	Permanent Bilateral Hearing Loss
PHN	Public Health Nurse
PKU	Phenylketonuria
PPPG	Policy, Procedures, Protocols and Guidelines
PTSD	Post Traumatic Stress Disorder
PUR	Postnatal Urinary Retention
RCOG	Royal College of Obstetricians and Gynaecologists
RCPI	Royal College of Physicians of Ireland
RhD	Rhesus D
RSV	Respiratory Syncytial Virus
SBR	Serum Bilirubin
SECM	Self Employed Community Midwife
SIDS	Sudden Infant Death Syndrome
SpO2	Oxygen saturation
TcB	Transcutaneous Bilirubin
TIC	Trauma-Informed Care
TORCH	Toxoplasmosis, Rubella, Cytomegalovirus, Herpes Simplex and Syphilis
TSH	Thyroid Stimulating Hormone
UNHS	Universal Newborn Hearing Screening
UNICEF	United Nations International Children's Emergency Fund
VTE	Venous Thromboembolism
WHO	World Health Organization

Appendix 1: **Expert Advisory Group Members 2021-present**

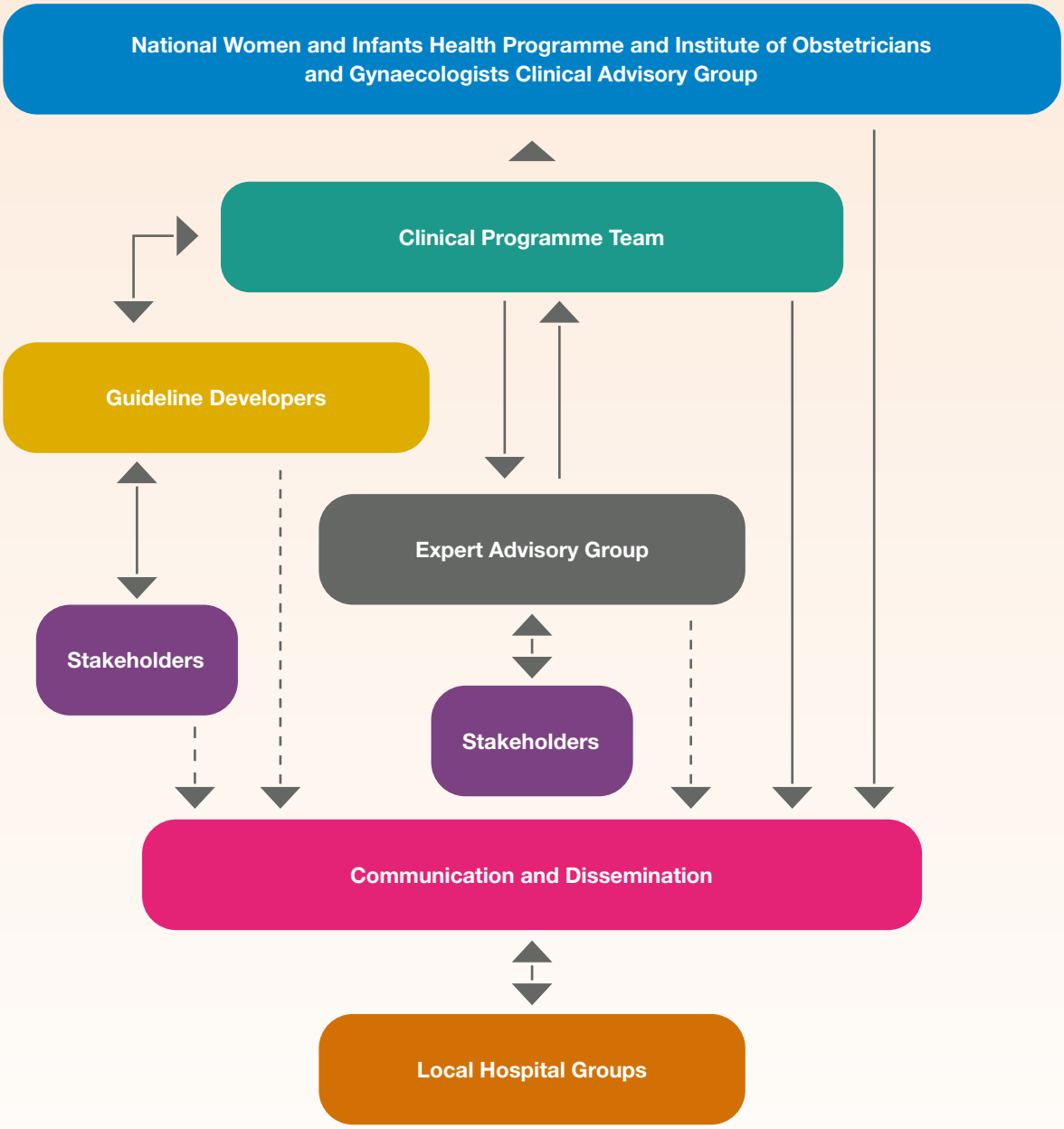
Member	Profession	Location
Dr Mairead Butler	Consultant Obstetrician and Gynaecologist	University Hospital Waterford
Dr Nicholas Barrett	Consultant Anaesthesiologist, Lead for Obstetric Anaesthesiology services	Limerick University Hospital
Dr Venita Broderick	Consultant Obstetrician and Gynaecologist	National Maternity Hospital Dublin
Ms Siobhan Canny	Group Director of Midwifery	Saolta University Health Care Group
Ms Triona Cowman	Director of the Centre for Midwifery Education	Centre for Midwifery Education, Coombe Women & Infants University Hospital
Ms Marie Culliton	Lab Manager/Chief Medical Scientist	National Maternity Hospital Dublin
Ms Niamh Connolly-Coyne *and* Ms Mandy Daly	Board of Directors Members *(Shared nomination)*	Irish Neonatal Health Alliance
Ms Sinéad Curran	Dietician Manager	National Maternity Hospital
Dr Niamh Conlon	Consultant Histopathologist	Cork University Hospital
Ms Georgina Cruise	National Manager	Patient Advocacy Service
Ms Jennifer Dempsey	Clinical Tutor in Midwifery	University College Dublin
Dr Orla Donohoe	Specialist Registrar, Obstetrics and Gynaecology and SWEC Fellow	St George Hospital, Sydney, Australia
Ms Alana Dineen	Senior Clinical Pharmacist	Cork University Maternity Hospital
Prof Maeve Eogan	Consultant Obstetrician and Gynaecologist National Clinical Lead SATU (HSE)	Rotunda Hospital Dublin
Dr Brendan Fitzgerald	Consultant Perinatal Pathologist	Cork University Hospital
Dr Daniel Galvin	Specialist Registrar, Obstetrics and Gynaecology	Cork University Maternity Hospital

Member	Profession	Location
Ms Stacey Grealis	Patient Research Partner	Independent Living Movement Ireland
Ms Fiona Hanrahan	Director of Midwifery and Nursing	Rotunda Hospital Dublin
Ms Laura Harrington	Principal Medical Social Worker	National Maternity Hospital Dublin
Dr Caroline Joyce	Principal Clinical Biochemist, Cork University Hospital Adjunct Clinical Lecturer, University College Cork.	Cork University Hospital University College Cork
Dr Chaitra Jairaj	Consultant Perinatal Psychiatrist	Coombe Women & Infants University Hospital, Dublin Midland Regional Hospital Portlaoise
Dr Cathy Monteith	Consultant Obstetrician and Gynaecologist	Our Lady of Lourdes Hospital Drogheda
Oana Marian	PhD, Post-Doctoral Researcher	Pregnancy Loss Research Group, INFANT Centre, University College Cork
Prof John Murphy	Consultant Neonatologist Clinical Lead for the National Clinical Programme for Paediatrics and Neonatology	National Women and Infants Health Programme
Ms Janet Murphy	Advanced Midwifery Practitioner	University Hospital Waterford
Dr Jill Mitchell	Specialist Registrar, Obstetrics and Gynaecology	Cork University Maternity Hospital
Dr Aisling McDonnell	Specialist Registrar, Obstetrics and Gynaecology	Mater Misericordiae University Hospital Dublin
Dr Ciara McCarthy	General Practitioner ICGP and NWIHP Women's Health Lead	Irish College of General Practitioners
Ms Orla McCarthy	Clinical Specialist Physiotherapist in Pelvic Health	Cork University Maternity Hospital
Dr Sarah Nicholson	Locum Consultant Obstetrician and Gynaecologist	Sligo University Hospital
Dr Donough J. O'Donovan	Director Neonatal Intensive Care Unit Consultant Neonatologist/Paediatrician	University College Hospital Galway

Member	Profession	Location
Mr Fergal O' Shaughnessy *and* Dr Brian Cleary *(Shared nomination)*	Senior Pharmacist, Honorary Lecturer *and* Chief Pharmacist, Honorary Clinical Associate Professor and Medications Lead, Maternal & Newborn Clinical Management System	Rotunda Hospital Dublin Royal College of Surgeons in Ireland
Dr Gillian Ryan	Consultant Obstetrician and Gynaecologist	University Hospital Galway
Ms Nora Vallejo	Advanced Midwife Practitioner	Coombe Women & Infants University Hospital, Dublin

Member 2021-2025	Profession	Location
Dr Katherine Astbury	Consultant Obstetrician and Gynaecologist	University Hospital Galway
Dr Richard Duffy	Consultant Perinatal Psychiatrist	Rotunda Hospital Dublin
Ms Clare Farrell	Physiotherapy Manager	Coombe Women & Infants University Hospital, Dublin
Ms Marie Finn	Medical Social Work Counsellor	Saolta University Health Care Group
Prof Declan Keane	Consultant Obstetrician, Gynaecologist, Professor of Obstetrics and Gynaecology	National Maternity Hospital Dublin, Royal College of Surgeons in Ireland
Ms Áine Kelly	Physiotherapy Manager	Coombe Women & Infants University Hospital, Dublin
Dr Fergus McCarthy	Consultant Obstetrician, Gynaecologist	Cork University Maternity Hospital, University College Cork
Dr Sarah Petch	Specialist Registrar, Obstetrics and Gynaecology	National Maternity Hospital Dublin
Ms Margaret Quigley	National Lead for Midwifery	Office of Nursing and Midwifery Services Director
Prof Valerie Smith	Chair of Midwifery	University College Dublin
Ms Marita Hennessy	Post-Doctoral Researcher	Pregnancy Loss Research Group, INFANT Centre, University College Cork

Appendix 2:
Guideline Programme Process



Appendix 3: **Stakeholder Review Group**

Name	Profession	Location
Angela Dunne	National Lead Midwife	National Women and Infants Health Programme
Clare Kennedy	Assistant Director of Midwifery	National Women and Infants Health Programme
Prof John Murphy	Consultant Neonatologist/National Clinical Lead Neonatology	National Women and Infants Health Programme
Margo Dunworth	Neonatal Nurse Lead	National Women and Infants Health Programme
Nicolai Murphy	Programme Manager – National Maternity Guidelines	National Women and Infants Health Programme
Dr Linda Biesty	Associate Professor/Senior Lecturer in Midwifery	National University of Galway
Margaret Quigley	National Lead for Midwifery	Office of the Nursing and Midwifery Services Directorate
Bernadette Toolan	Clinical Midwife Manager 3	University Maternity Hospital Limerick
Emmeline Farrell	Designated Midwifery Officer	St Luke's General Hospital, Kilkenny
Laura Mc Hugh	National Breastfeeding Co-ordinator	HSE Health & Wellbeing, Strategy and Research
Kara Spratt	Service User Advocate	
Dr Krysia Lynch	Chair AIMS Ireland	AIMS Ireland
Claire Kerin	Research Officer	AIMS Ireland
Ursula Nagle	Registered Advanced Nurse Practitioner – Perinatal Mental Health	Rotunda Hospital, Dublin
Gráinne Milne	Director of Midwifery	Our Lady of Lourdes Hospital, Drogheda
Katie Bourke	Director of Midwifery	Cork University Maternity Hospital
Sandra O'Connor	Director of Midwifery	Kerry University Hospital

Appendix 4: **AGREE II Checklist**[32]

AGREE Reporting Checklist 2016

This checklist is intended to guide the reporting of Clinical Practice Guidelines.

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
DOMAIN 1: SCOPE AND PURPOSE		
1. OBJECTIVES *Report the overall objective(s) of the guideline. The expected health benefits from the guideline are to be specific to the clinical problem or health topic.*	☐ Health intent(s) (i.e., prevention, screening, diagnosis, treatment, etc.) ☐ Expected benefit(s) or outcome(s) ☐ Target(s) (e.g., patient population, society)	
2. QUESTIONS *Report the health question(s) covered by the guideline, particularly for the key recommendations.*	☐ Target population ☐ Intervention(s) or exposure(s) ☐ Comparisons (if appropriate) ☐ Outcome(s) ☐ Health care setting or context	
3. POPULATION *Describe the population (i.e., patients, public, etc.) to whom the guideline is meant to apply.*	☐ Target population, sex and age ☐ Clinical condition (if relevant) ☐ Severity/stage of disease (if relevant) ☐ Comorbidities (if relevant) ☐ Excluded populations (if relevant)	
DOMAIN 2: STAKEHOLDER INVOLVEMENT		
4. GROUP MEMBERSHIP *Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/ rating the evidence and individuals involved in formulating the final recommendations.*	☐ Name of participant ☐ Discipline/content expertise (e.g., neurosurgeon, methodologist) ☐ Institution (e.g., St. Peter's hospital) ☐ Geographical location (e.g., Seattle, WA) ☐ A description of the member's role in the guideline development group	

32 AGREE Reporting Checklist is available on the AGREE Enterprise website, a free and open access resource to support the practice guideline field (www.agreetrust.org)

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
5. TARGET POPULATION PREFERENCES AND VIEWS *Report how the views and preferences of the target population were sought/considered and what the resulting outcomes were.*	☐ Statement of type of strategy used to capture patients'/publics' views and preferences (e.g., participation in the guideline development group, literature review of values and preferences) ☐ Methods by which preferences and views were sought (e.g., evidence from literature, surveys, focus groups) ☐ Outcomes/information gathered on patient/public information ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations	
6. TARGET USERS *Report the target (or intended) users of the guideline.*	☐ The intended guideline audience (e.g. specialists, family physicians, patients, clinical or institutional leaders/administrators) ☐ How the guideline may be used by its target audience (e.g., to inform clinical decisions, to inform policy, to inform standards of care)	
DOMAIN 3: RIGOUR OF DEVELOPMENT		
7. SEARCH METHODS *Report details of the strategy used to search for evidence.*	☐ Named electronic database(s) or evidence source(s) where the search was performed (e.g., MEDLINE, EMBASE, PsychINFO, CINAHL) ☐ Time periods searched (e.g., January 1, 2004 to March 31, 2008) ☐ Search terms used (e.g., text words, indexing terms, subheadings) ☐ Full search strategy included (e.g., possibly located in appendix)	
8. EVIDENCE SELECTION CRITERIA *Report the criteria used to select (i.e., include and exclude) the evidence. Provide rationale, where appropriate.*	☐ Target population (patient, public, etc.) characteristics ☐ Study design ☐ Comparisons (if relevant) ☐ Outcomes ☐ Language (if relevant) ☐ Context (if relevant)	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
9. STRENGTHS & LIMITATIONS OF THE EVIDENCE *Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies. Tools exist that can facilitate the reporting of this concept.*	☐ Study design(s) included in body of evidence ☐ Study methodology limitations (sampling, blinding, allocation concealment, analytical methods) ☐ Appropriateness/relevance of primary and secondary outcomes considered ☐ Consistency of results across studies ☐ Direction of results across studies ☐ Magnitude of benefit versus magnitude of harm ☐ Applicability to practice context	
10. FORMULATION OF RECOMMENDATIONS *Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and the methods used to resolve them.*	☐ Recommendation development process (e.g., steps used in modified Delphi technique, voting procedures that were considered) ☐ Outcomes of the recommendation development process (e.g., extent to which consensus was reached using modified Delphi technique, outcome of voting procedures) ☐ How the process influenced the recommendations (e.g., results of Delphi technique influence final recommendation, alignment with recommendations and the final vote)	
11. CONSIDERATION OF BENEFITS AND HARMS *Report the health benefits, side effects, and risks that were considered when formulating the recommendations.*	☐ Supporting data and report of benefits ☐ Supporting data and report of harms/side effects/risks ☐ Reporting of the balance/trade-off between benefits and harms/side effects/risks ☐ Recommendations reflect considerations of both benefits and harms/side effects/ risks	
12. LINK BETWEEN RECOMMENDATIONS AND EVIDENCE *Describe the explicit link between the recommendations and the evidence on which they are based.*	☐ How the guideline development group linked and used the evidence to inform recommendations ☐ Link between each recommendation and key evidence (text description and/or reference list) ☐ Link between recommendations and evidence summaries and/or evidence tables in the results section of the guideline	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
13. EXTERNAL REVIEW *Report the methodology used to conduct the external review.*	☐ Purpose and intent of the external review (e.g., to improve quality, gather feedback on draft recommendations, assess applicability and feasibility, disseminate evidence) ☐ Methods taken to undertake the external review (e.g., rating scale, open-ended questions) ☐ Description of the external reviewers (e.g., number, type of reviewers, affiliations) ☐ Outcomes/information gathered from the external review (e.g., summary of key findings) ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations (e.g., guideline panel considered results of review in forming final recommendations)	
14. UPDATING PROCEDURE *Describe the procedure for updating the guideline.*	☐ A statement that the guideline will be updated ☐ Explicit time interval or explicit criteria to guide decisions about when an update will occur ☐ Methodology for the updating procedure	
DOMAIN 4: CLARITY OF PRESENTATION		
15. SPECIFIC AND UNAMBIGUOUS RECOMMENDATIONS *Describe which options are appropriate in which situations and in which population groups, as informed by the body of evidence.*	☐ A statement of the recommended action ☐ Intent or purpose of the recommended action (e.g., to improve quality of life, to decrease side effects) ☐ Relevant population (e.g., patients, public) ☐ Caveats or qualifying statements, if relevant (e.g., patients or conditions for whom the recommendations would not apply) ☐ If there is uncertainty about the best care option(s), the uncertainty should be stated in the guideline	
16. MANAGEMENT OPTIONS *Describe the different options for managing the condition or health issue.*	☐ Description of management options ☐ Population or clinical situation most appropriate to each option	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
17. IDENTIFIABLE KEY RECOMMENDATIONS *Present the key recommendations so that they are easy to identify.*	☐ Recommendations in a summarized box, typed in bold, underlined, or presented as flow charts or algorithms ☐ Specific recommendations grouped together in one section	
DOMAIN 5: APPLICABILITY		
18. FACILITATORS AND BARRIERS TO APPLICATION *Describe the facilitators and barriers to the guideline's application.*	☐ Types of facilitators and barriers that were considered ☐ Methods by which information regarding the facilitators and barriers to implementing recommendations were sought (e.g., feedback from key stakeholders, pilot testing of guidelines before widespread implementation) ☐ Information/description of the types of facilitators and barriers that emerged from the inquiry (e.g., practitioners have the skills to deliver the recommended care, sufficient equipment is not available to ensure all eligible members of the population receive mammography) ☐ How the information influenced the guideline development process and/or formation of the recommendations	
19. IMPLEMENTATION ADVICE/TOOLS *Provide advice and/or tools on how the recommendations can be applied in practice.*	☐ Additional materials to support the implementation of the guideline in practice. For example: ☐ Guideline summary documents ☐ Links to check lists, algorithms ☐ Links to how-to manuals ☐ Solutions linked to barrier analysis (see Item 18) ☐ Tools to capitalize on guideline facilitators (see Item 18) ☐ Outcome of pilot test and lessons learned	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
20. RESOURCE IMPLICATIONS *Describe any potential resource implications of applying the recommendations.*	☐ Types of cost information that were considered (e.g., economic evaluations, drug acquisition costs) ☐ Methods by which the cost information was sought (e.g., a health economist was part of the guideline development panel, use of health technology assessments for specific drugs, etc.) ☐ Information/description of the cost information that emerged from the inquiry (e.g., specific drug acquisition costs per treatment course) ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations	
21. MONITORING/AUDITING CRITERIA *Provide monitoring and/or auditing criteria to measure the application of guideline recommendations.*	☐ Criteria to assess guideline implementation or adherence to recommendations ☐ Criteria for assessing impact of implementing the recommendations ☐ Advice on the frequency and interval of measurement ☐ Operational definitions of how the criteria should be measured	
DOMAIN 6: EDITORIAL INDEPENDENCE		
22. FUNDING BODY *Report the funding body's influence on the content of the guideline.*	☐ The name of the funding body or source of funding (or explicit statement of no funding) ☐ A statement that the funding body did not influence the content of the guideline	
23. COMPETING INTERESTS *Provide an explicit statement that all group members have declared whether they have any competing interests.*	☐ Types of competing interests considered ☐ Methods by which potential competing interests were sought ☐ A description of the competing interests ☐ How the competing interests influenced the guideline process and development of recommendations	

From: Brouwers MC, Kerkvliet K, Spithoff K, on behalf of the AGREE Next Steps Consortium. The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. BMJ 2016;352:i1152. doi: 10.1136/bmj.i1152.

For more information about the AGREE Reporting Checklist, please visit the AGREE Enterprise website at http://www.agreetrust.org

Appendix 5: **Grades of Recommendation**[33]

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested language
1A. Strong recommendation, high-quality evidence	Benefits clearly outweigh risk and burdens, or vice versa	Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk	Strong recommendations can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present	We strongly recommend… We recommend that …should be performed/ administered… We recommend that …. is indicated/ beneficial/ effective…
1B. Strong recommendation, moderate-quality evidence	Benefits clearly outweigh risk and burdens, or vice versa	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate	Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present	We recommend… We recommend that … should be performed/ administered… We recommend that … is (usually) indicated/ beneficial/ effective…

33 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. https://pubmed.ncbi.nlm.nih.gov/23978245/

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested language
1C. Strong recommendation, low-quality evidence	Benefits appear to outweigh risk and burdens, or vice versa	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain	Strong recommendation that applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality	We recommend… We recommend that … should be performed/ administered… We recommend that … Is (maybe) indicated/ beneficial/ effective…
2A. Weak recommendation, high-quality evidence	Benefits closely balanced with risks and burdens	Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk	Weak recommendation: best action may differ depending on circumstances or patients or societal values	We suggest… We suggest that… may/might be reasonable...
2B. Weak recommendation, moderate-quality evidence	Benefits closely balanced with risks and burdens, some uncertainty in the estimates of benefits, risks and burdens	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate	Weak recommendation; alternative approaches likely to be better for some patients under some circumstances	We suggest… We suggest that … may/might be reasonable...

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested language
2C. Weak recommendation, low-quality evidence	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain	Very weak recommendation: other alternatives may be equally reasonable	We suggest … is an option We suggest that … may/might be reasonable.
Best practice	A recommendation that is sufficiently obvious that the desirable effects outweigh undesirable effects, despite the absence of direct evidence, such that the grading of evidence is unnecessary			We recommend… We recommend that … should be performed/ administered… We recommend that… Is usually) indicated/ beneficial/effective

Appendix 6: **NWIHP/IOG CAG Membership (2025-)**

Dr Cliona Murphy (Chair, 2023-). Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Director, National Women and Infants Health Programme.

Dr Suzanne O'Sullivan (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Director of Education and Training, Obstetrics and Gynaecology, Institute of Obstetricians and Gynaecologists. Chair, Institute of Obstetricians and Gynaecologists.

Dr Venita Broderick (2024-). Clinical Lead Gynaecology, National Women and Infants Health Programme.

Dr Brian Cleary (2023-). Chief Pharmacist, Rotunda Hospital. Medications Lead, Maternal and Newborn Clinical Management System Project.

Angela Dunne (2023-). Director of Midwifery, National Women and Infants Health Programme.

Prof Seán Daly (2023-). Master, Consultant Obstetrician and Gynaecologist, Rotunda Hospital.

Prof Maeve Eogan (2023-). Consultant Obstetrician and Gynaecologist, Rotunda Hospital. Clinical Lead, Sexual Assault Treatment Units, National Women and Infants Health Programme.

Prof Richard Greene (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, National Perinatal Epidemiology Centre, University College Cork.

Prof John Higgins (2023-). Cork University Maternity Hospital, Consultant Obstetrician and Gynaecologist, Clinical Director, Ireland South Women and Infants Directorate.

Prof Shane Higgins (2023-). Master, Consultant Obstetrician and Gynaecologist, National Maternity Hospital.

Dr Mendinaro Imcha (2023-). Clinical Director, Consultant Obstetrician and Gynaecologist, University Maternity Hospital Limerick.

Prof John Murphy (2023-). Clinical Lead Neonatology, National Women and Infants Health Programme.

Dr Aoife Mullaly (2023-). Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Lead, Termination of Pregnancy Services, National Women and Infants Health Programme.

Prof John Morrison (2023-). Consultant Obstetrician and Gynaecologist, University Hospital Galway. Clinical Director, Saolta Maternity Directorate.

Kilian McGrane (2023-). Director, National Women and Infants Health Programme.

Prof Keelin O'Donoghue (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Lead, National Guidelines, National Women and Infants Health Programme.

Prof Mike O'Connell (2023-). Master, Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital.

Ms Davinia O'Donnell (2024-). General Manager | National Women and Infants Health Programme

Dr Vicky O'Dwyer (2023-). Consultant Obstetrician and Director of Gynaecology, Rotunda Hospital.

Dr Mairead O'Riordan (2024-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital.

Dr Fergal O'Shaughnessy (2025-) Senior Pharmacist, Rotunda Hospital.

Prof Nóirín Russell (2023-). Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, Cervical Check.

Dr Carmen Regan (April 2024). Clinical Lead Obstetrics, National Women and Infants Health Programme.

Dr Orla Shiel (2024-). Consultant Obstetrician and Gynaecologist, National Maternity Hospital.

Ms Clare Thompson (2023-). Consultant Gynaecological Oncologist, The Mater, Dublin.