Royal United Hospital Bath NHS
NHS Trust

RUH

Patient information: Postnatal care

This leaflet contains some useful information about caring for you and your baby

Healthcare you can Trust

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What Care To Expect After the Birth of Your Baby

Most women feel, and are, well during their pregnancy and so most antenatal and postnatal care is provided by midwives, maternity care assistants and GPs in the community.

In hospital

Length of stay

Maternity units are very busy places and most women are keen to take their babies home and be with their families as soon as possible.

If you are well following the birth of your baby you may go home after 3-6 hours. We are only able to offer a longer stay if the midwives or obstetrician feel you have a clinical need.

Visiting

There is open visiting for baby's father and siblings from 8.00 am until 9.00 pm. Other visitors (a maximum of two at a time) are welcome from 2:00pm until 4:00pm and 6:30pm until 7:30pm.

Visiting is restricted because newly delivered mothers tire easily. No children under 16 years old are permitted except for the mother's own.

We request that all visitors leave the maternity unit premises by 9pm.

We reserve the right to amend visiting access according to clinical need.

Calling for assistance

Due to the geographical layout of the wards, a member of staff may not always be visible. For this reason, it is important when you do require assistance to use the call bell which is supplied with every bed.

Telephone enquiries

Confidentiality prevents staff from giving other people information over the phone. Mobile phones may be used, however we ask you to respect people's privacy and turn your mobiles to silent between the hours of 10.00pm and 8.00am.

Security

We are anxious to secure the safety of both you and your baby; therefore visiting is restricted to help us maintain a safe environment. All midwifery staff and other health care professionals wear identification badges. If there is someone without an identity badge caring for you and your baby please inform the midwifery staff straight away.

Please do not let anyone follow you into the unit. Ask them to ring the bell to gain access.

Breastfeeding

We are committed to following the principles which promote breastfeeding. Expert assistance with all aspects of breastfeeding is available. Please ask for help. We also have some breastfeeding peer support volunteers who help on Mary Ward and there are many support groups available in the community. Please refer to the 'Essential Guide to feeding and caring for your baby' that you should have received during your pregnancy or ask your community midwife.

Artificial feeding

Support and advice will be given on a one-to-one basis to ensure safe preparation and storage of milk. A DVD, 'Formula Explained' is available to watch which explains and demonstrates the safe preparation of formula feeds. Please ask if you would like to view this.

Rooming in

Your baby will remain with you at all times. This enables you to establish bonding, recognise early feeding cues and helps you to get to know your baby. It also means you know where your baby is. Hospitals no longer have nurseries. There are facilities for you to change your baby in the cot and bath your baby at bedside.

Please do not leave your baby unattended or on your bed at any time.

Due to the narrowness and height of hospital beds, the increased chances of a mother being on sedative medication, and the hard floor, we do not support baby bed-sharing or co-sleeping in hospital.

At home you should not share a bed with a baby if you (or any other person in the bed):

- are a smoker (no matter where or when you smoke)
- have drunk alcohol
- have taken any drug or medication which could make you extra sleepy
- are otherwise unusually tired to a point where you would find it difficult to respond to your baby as this will increase the risk of cot death.

Single rooms

Single rooms are available on Mary Ward at the RUH. Please ask your midwife for further information. A charge is often made for this facility.

Mothers with babies in neonatal intensive care

For women whose babies require admission to the neonatal intensive care unit (NICU), midwifery care is available from your own midwifery team once you have been discharged from hospital. It may be possible to see a midwife in the day assessment unit (DAU) when you come in to visit your baby in NICU Monday to Friday but not on weekends. Please discuss the arrangements with your midwife prior to leaving hospital.

Registration of births

All babies must be registered within 42 days of birth. If you are married, either you or your husband can register the birth. If you are not married and wish to have your partner's name on the birth certificate, you must both register the birth. Please ring your local registry office for further details.

Care once you are at home

We aim to offer home visits to every mother following discharge from hospital. Following individual discussion with mothers the venue and number of visits during the postnatal period are agreed upon and these may vary depending on clinical need. A midwife or maternity care assistant will undertake these visits. At around 10 days postnatally if all is well care is transferred to the health visitor team.

If you do not receive a visit by a midwife the day after you leave hospital, please telephone the on-call midwife.

In certain specific circumstances the midwife may continue to care for you beyond ten days. You will be provided with emergency contact numbers once you are home.

Personal hygiene

Hygiene and comfort are important after having your baby. It is a good idea to:

- Use a mirror to have a look at your wound or perineum to check that it is healing well and inform your midwife if there are any signs of inflammation (redness, pain, swelling) or bruising, or if you have any concerns
- Change your pads frequently to help prevent infection
- Wear cotton underwear rather than synthetic
- Wash your hands before and after using the toilet
- Do not use highly scented soaps and bubble-baths in the first week or while wounds are healing. If you want to use oils, consult a qualified aromatherapist first
- We advise that you only use sanitary pads and avoid using tampons

Discharge from midwifery care

On or around your tenth postnatal day, if all is well, your care will be transferred to the health visitor and a copy of your care summary and discharge details will be sent to your GP and health visitor.

Postnatal checks

A postnatal check is performed six weeks after the birth for you and your baby. Your GP is likely to carry out this check. You will need to arrange this appointment. Should you require a postnatal follow up with a consultant, this appointment will be sent to you. If you are unsure please ask your midwife.

Birth Reflections

The Birth Reflections service is a midwife led listening service, which gives women and their partners a single discussion session with a midwife from the Birth Reflections team.

If you would like to use this service please contact the ward clerk on Mary Ward at the Royal United Hospital, Bath on 01225 824662; they will refer your details to the Birth Reflections Midwife. The midwife will contact you to arrange an appointment that is convenient for you. A questionnaire is given out at the end of the meeting, for women to give feedback on the Birth Reflections service.

Getting to know your baby

General appearance

Your baby's colour should be pink. As the circulation develops the extremities such as the hand and feet may have a blue tinge. this is quite normal. If in doubt look at your baby's central abdomen; this should be pink at all times.

If your baby is blue or pale in colour, contact medical help immediately for advice. For babies with darker skin tones, their tongue should always be pink.

You will notice that babies tend to keep their fists clenched, elbows bent, hips and knees flexed. They will hold their arms and legs closely to their body.

Babies are born with primitive reflexes. These will be examined by a midwife or a doctor at birth and then again when your baby is 6 weeks old.

These include:

- Sucking reflex – they will suck on the breast, a teat, or a finger.
- Grasp reflex – they will close their fingers when pressure is applied to their palm.
- Moro or Startle reflex – their arms will be thrown out to the sides and to the back if startled.
- Due to immaturity of their nervous system, arms, legs and chin may tremble or shake when they are crying or agitated – this is normal.

Abnormal movements may include:

- Stiffening of the body
- Staring spells
- Periods of unresponsiveness

If you notice any of these you must seek medical advice immediately.

Normal body temperature will range from 36.5^{O}C to 37^{O}C. If you check your baby's temperature and it is 0.5^{O}C above this and your baby appears unwell, seek medical advice. For further advice about your baby's temperature, please see the Cot Death leaflet in the discharge pack or refer to the safe sleeping information in the Essential Guide to Feeding & Caring for your Baby leaflet.

Baby examination

Your baby will receive a physical examination within the first 72 hours following birth. This is a screening test undertaken by paediatricians or midwives who have successfully completed the Examination of the Newborn course. The examination will be explained to you and your partner and the results documented in your maternity notes. If any concerns are highlighted the midwife will refer your baby to the appropriate specialist.

Skin care

Once you begin to look at your baby's skin you will notice a variety of little marks and rashes. A baby's skin is very sensitive, so avoid soap if you can.

When some babies are born they have tiny white spots called milia over their nose. These are caused by blocked sebaceous glands and will usually disappear within a few days.

Another common problem is a blotchy red rash with pinhead papules which is another common disorder; this is known as Erythema Toxicum or Urtiara Neontorium. No treatment is required for this.

Heat rashes commonly occur and are recognised as a reddened area often in the folds of the skin with hard pinpoint centres. The rash quickly disappears when the baby cools down.

Umbilical cord

The umbilical cord dries and then separates following birth. As it separates it is common for:

- The cord to smell offensive
- To be moderately moist.
- To bleed a small amount from the base.

Any redness on the baby's abdomen near the umbilicus should be reported to the midwife or health visitor.

Separation differs in each baby; it may take a few days or a few weeks. It will be monitored by the midwife.

Newborn blood spot screening for your baby

In the first week after birth you will be offered a blood spot screening test for your baby.

Why should I have my baby screened?

Newborn blood spot screening identifies babies who may have rare but serious conditions. Most babies screened will not have any of the conditions but, for the small numbers who do, the benefits of screening are enormous. Early treatment can improve their health and prevent severe disability or even death.

What are newborn babies screened for?

All babies in England are screened for phenylketonuria, congenital hypothyroidism, sickle cell disorders, cystic fibrosis and MCADD. If you want to know which conditions are screened for in your area please ask your midwife.

Phenylketonuria

About 1 in 10,000 babies born in the UK has phenylketonuria (PKU). Babies with this inherited condition are unable to process a substance in their food called phenylalanine. If untreated, they will develop serious, irreversible mental disability. Screening means that babies with the condition can be treated early through a special diet, which will prevent severe disability and allow them to lead a normal life. If babies are not screened, but are later

found to have PKU, it may be too late for the special diet to make a real difference.

Congenital hypothyroidism

About 1 in 4,000 babies born in the UK has congenital hypothyroidism (CHT). Babies with CHT do not have enough of the hormone thyroxine. Without this hormone, they do not grow properly and can develop serious, permanent, physical and mental disability. Screening means that babies with CHT can be treated early with thyroxine tablets, which will prevent serious disability and allow them to develop normally. If babies are not screened and are later found to have CHT, it may be too late to prevent them becoming seriously disabled.

Sickle cell disorders

About 1 in 2,500 babies born in the UK has a sickle cell disorder (SCD). These are inherited disorders that affect the red blood cells. If a baby has a sickle cell disorder, their red blood cells can change to a sickle shape and become stuck in the small blood vessels. This can cause pain and damage to the baby's body, serious infection, or even death. Screening means that babies with SCD can receive early treatment, including immunisations and antibiotics, which, along with parent education, will help prevent serious illness and allow the child to live a healthier life.

Cystic fibrosis

About 1 in 2,500 babies born in the UK has cystic fibrosis (CF). This inherited condition can affect the digestion and lungs. Babies with CF may not gain weight well, and may have frequent chest infections. Screening means that babies with CF can be treated early with a high energy diet, medicines and physiotherapy. Although a child with CF may still become very ill, early treatment is thought to help them live longer, healthier lives.

If babies are not screened for CF and they do have the condition, they can be tested later but parents may have an anxious time before CF is recognised.

MCADD (Medium Chain Acyl-CoA Dehydrogenase Deficiency)

About 1 in 10,000 babies born in the UK has MCADD. Babies with this inherited condition have problems breaking down fats to make energy for the body. This can lead to serious illness, or even death. Screening means that most babies who have MCADD can be recognised early, allowing special attention to be given to their diet, including making sure they eat regularly. This care can prevent serious illness and allow babies with MCADD to develop normally. Screening babies for MCADD is important, so those with the condition can be identified before they become suddenly and seriously ill.

Will screening for these conditions show up anything else?

Screening for cystic fibrosis (CF) includes testing some babies for the most common gene alterations that cause CF. This means screening may identify some babies who are likely to be genetic carriers of cystic fibrosis. These babies may need further testing to find out if they are a healthy carrier, or have CF.

Screening identifies babies who are genetic carriers of sickle cell or other unusual red blood cell disorders. Carriers of sickle cell disorders are healthy and will not be affected by the condition. Rarely, other conditions such as beta thalassaemia major can be identified. In this condition, the baby does not make enough red blood cells and needs treatment for severe anaemia.

How will the midwife take the blood spots?

At five days after birth the midwife will use a special device to

collect some drops of blood from your baby's heel onto a card. This may be uncomfortable and your baby may cry. You can help by making sure that your baby is warm and comfortable and by being ready to feed and cuddle your baby.

Are repeat blood samples ever needed?

Occasionally, the midwife or health visitor will contact you and ask to take a second blood sample from your baby's heel. This may be because there was not enough blood collected, or the result was unclear. Usually the repeat results are normal.

Screening is recommended

Screening your baby for all these conditions is strongly recommended but it is not compulsory. If you do not want your baby screened for any or all of these conditions, discuss it with your midwife. All your decisions will be recorded in your notes. If you think your baby might not have been screened, speak to your midwife or GP.

How will I hear about the results?

Most babies will have normal results, indicating that they are not thought to have any of these conditions. A health professional will usually let parents know the screening result and record it in the baby's personal child health record by the time the child is 6-8 weeks old.

- Some babies are found to be carriers. Their parents will usually be told by the time the child is 6-8 weeks old
- If a baby is thought to have phenylketonuria (PKU), parents will be contacted before the baby is 3 weeks old and given an appointment to see a specialist
- If a baby is thought to have congenital hypothyroidism (CHT), parents will be contacted before the baby is 3 weeks

old and given an appointment to see a specialist

- If a baby is thought to have cystic fibrosis (CF), parents will be contacted before the baby is 4 weeks old
- If a baby is thought to have a sickle cell disorder (SCD), the parents will be contacted before the baby is 6 weeks old
- If a baby is thought to have MCADD, parents will be contacted before the baby is 3 weeks old and given an appointment to see a specialist.

If a baby is thought to have one of the conditions, he or she will need further tests to confirm the result. The purpose of screening is to identify babies more likely to have these conditions. Screening is not 100% accurate.

What happens to your baby's blood spots after screening?

After screening, newborn blood spots are stored for at least five years and may be used in a number of ways:

- To check the result or for other tests recommended by your doctor
- To improve the screening programme
- For public health monitoring and research to help improve the health of babies and their families in the UK. This will not identify your baby and you will not be contacted.

The use of these blood spots is governed by a Code of Practice, available from your midwife, or by visiting www.screening.nhs.uk/bloodspot. In the future there is a small chance researchers may want to invite you or your child to take part in research linked to the blood spot programme. If you do not wish to receive invitations to take part in research, please let your midwife know.

Neonatal jaundice

Jaundice is one of the most common conditions in newborn babies and is usually temporary and harmless. However, if the jaundice persists, some babies may need medical attention.

Jaundice refers to the yellow colouration of the skin and the sclerae (whites of the eyes) caused by the accumulation of bilirubin in the skin and mucous membranes. Jaundice is caused by a raised level of bilirubin in the body, a condition known as hyperbilirunaemia.

Approximately 60% of term and 80% of preterm babies develop jaundice in the first week of life, and about 10% of breastfed babies are still jaundiced at 1 month.

For most babies, jaundice is not an indication of an underlying disease, and this early jaundice (termed 'Physiological Jaundice') is generally harmless.

A few babies will develop very high levels of bilirubin which can be harmful if not treated. In rare cases it may cause brain damage.

Breastfed babies are more likely than bottle-fed babies to develop physiological jaundice within the first week of life. Prolonged jaundice – that is, jaundice persisting beyond the first 14 days – is also seen more commonly in these babies. Prolonged jaundice is generally harmless, but can be an indication of serious liver disease.

What causes jaundice?

- Babies need a high level of red blood cells before they are born to help to carry oxygen around the body. After birth

they don't need such a high number

- Old red blood cells are broken down. Waste substances are produced. One of the waste substances is a dark yellow pigment called bilirubin
- In the liver there are chemicals called enzymes which break down the waste substances. The waste substances are then passed out of the body in the urine
- In newborn babies the enzymes are sometimes slow to work. The waste products can then build up causing the baby to be jaundiced. This is often the case when a baby is born early
- If the mother has a different blood group from the baby then more red cells may be broken down. More pigment will be made making the baby look jaundiced
- If a baby is bruised during birth they may develop jaundice
- Other causes include infections and early feeding difficulties.

Which babies are more likely to develop jaundice that needs treatment?

The following types of babies are more likely to develop jaundice that needs treatment:

- Babies who were born early (at less than 38 weeks gestation)
- Babies who have a brother or sister who had jaundice that needed treatment as a baby
- Babies whose mother intends to breastfeed exclusively
- Babies who have signs of jaundice in the first 24 hours after birth.

Whether your baby looks jaundiced or not, the doctor or midwife should check whether your baby is at risk of developing high

levels of jaundice soon after birth, and if so, the doctor or midwife should give your baby an additional check for jaundice during the first 48 hours.

Testing for jaundice

Your newborn baby should be checked for signs of jaundice at every opportunity, especially in the first 72 hours. This will include looking at your naked baby in bright light (natural light if possible) to see if they appear yellow. You can detect jaundice more easily by pressing lightly on the skin.

A yellowing of the whites of the eyes and the gums are helpful indicators of jaundice in babies with darker skin tones. You or the doctor or midwife can carry out the check.

If it looks like your baby has jaundice, then it is important that the level of bilirubin is measured. The doctor or midwife should not rely on visual inspection alone to estimate the bilirubin level. Measuring the level of bilirubin can be done very simply; they may use tables or charts for this.

Your baby may have jaundice that lasts longer than your doctor or midwife expects. If so, you and your doctor or midwife should look for pale, chalky stools and/or dark urine and urgent further tests will be needed. A table or chart may also be used for this.

How to check your baby for jaundice:

- Jaundice means a yellow colour to the skin
- It is often noticed first in the whites of the eyes
- A baby who is jaundiced may become rather sleepy and slow to feed
- Check your baby in a bright, preferably natural light
- Baby may have dark urine or pale chalky stools

- Your midwife will also carry out these checks at postnatal contacts.

What to do if you suspect jaundice in your baby

Feed effectively at least 8 times in 24 hours. If you are concerned, contact your healthcare professional.

How is jaundice treated?

Most babies don't need any treatment. The jaundice slowly fades. Giving water does nothing to lower the bilirubin levels and may even cause them to rise. If the jaundice is getting worse a small sample of blood is taken from the baby's heel. This is tested in the laboratory. The result is compared with the pigment level we would expect in a baby of that age. If the result is high the baby may need a treatment called phototherapy.

Babies in the first 24 hours

If your baby looks jaundiced in the first 24 hours after birth, your baby will need a blood test urgently. Once the doctor or midwife knows the results of the blood test, more tests may be needed to see if there is an underlying illness causing the jaundice.

Treating jaundice

If your baby needs treatment for jaundice, this will be done in hospital. Your baby will be monitored to see if the treatment is working, and tests for other conditions will be carried out as necessary.

Phototherapy

There are different types of phototherapy. Most types of phototherapy involve placing the baby under a special light

(not sunlight). Light of a certain wavelength makes it easier for bilirubin to be removed from the body. Phototherapy is a non-invasive procedure. This means that it doesn't penetrate the body – for example with a cut in the skin or an injection.

During phototherapy your baby will be placed on his or her back unless they have other conditions that prevent this. Your baby's temperature should be monitored and your baby should be checked to make sure that he or she is not becoming dehydrated by feeding regularly and assessing their wet and dirty nappies. Your baby's eyes may need to be protected and they may be placed in a bed especially for babies or an incubator.

The different types of phototherapy are:

- **Single light source** – If the doctor or midwife recommends that your baby needs treatment for jaundice, your baby should be treated using a single light source. The treatment may be stopped from time to time for up to 30 minutes so you can feed and cuddle your baby, and change their nappy. You should be given help with feeding. If the bilirubin level is very high or rising quickly, your baby may need to be treated with continuous multiple phototherapy straight away (See below)
- **Fibreoptic phototherapy** is another type of phototherapy. Your baby lies on a blanket or pad through which light shines. Your baby does not need to be placed in a separate cot for this
- **Continuous multiple phototherapy** – If your baby's jaundice does not improve after light or fibre optic phototherapy, continuous multiple phototherapy may be offered. This involves more than one light and often a fibre optic blanket at the same time. During continuous multiple phototherapy, you may carry on breastfeeding. Your baby might need extra milk (expressed breast milk or formula) during this treatment.

How long will treatment take?

In most cases, babies are treated for a couple of days. Regular blood tests will be taken. The treatment will be stopped once the amount of pigment has fallen to a certain level.

The jaundice should have gone completely in three weeks. If it hasn't, please contact your GP.

Postnatal depression

The 'baby blues'

Around half of all new mothers get the 'baby blues' which tends to occur a few days after the birth and lasts a day or so. You may feel elated one moment then suddenly feel emotional and upset, and cry for no particular reason.

The 'blues' may be caused partly by sudden changes in hormone levels after the birth and partly from the emotional shock of giving birth, tiredness and all the changes taking place in your life. Symptoms usually disappear within a few days.

Postnatal depression

This is a more serious and long-lasting condition than the 'blues'. It can affect the relationship between you, your baby and your family and the effect can last after the depression itself has lifted. It is therefore important to identify postnatal depression and get help early.

How is postnatal depression different from the 'baby blues'?

Postnatal depression can occur soon after birth but it can develop more gradually any time up to a year later. You and

those around you may not realise the extent of your distress for weeks or months.

It is not your fault you feel the way you do. Postnatal depression does not mean you don't want or love your baby. Postnatal depression is a real condition – it can and should be treated.

How does postnatal depression feel?

It can show itself in different ways. Many symptoms might be experienced by anyone who has just had a baby, but with postnatal depression they are more extreme. Some people describe a kind of emotional loneliness.

Moods and feelings

- Feeling sad and miserable most of the time.
- Feeling scared, anxious or panicky for no good reason.
- Unable to enjoy (including a loss of interest in) sex.
- Unable to look forward to things and to laugh.
- Avoiding friends and social contact.
- Unable to make even small decisions.
- Finding it difficult to concentrate and remember things.
- Feeling useless or worthless, blaming yourself when things go wrong.
- Having thoughts about harming yourself.

Physical symptoms

- Unable to sleep or eat. Alternatively, wanting to sleep or eat all the time.
- Suffering from aches and pains and being more vulnerable to infections.

What causes postnatal depression?

No one really knows for sure; however a combination of stresses and worries may make postnatal depression more likely, such as:

- Difficult birth
- Hormonal changes (although this is not clear)
- Rekindled grief from previous loss
- Demanding baby; all babies are different and some do cry more and settle less easily than others
- Family relationship difficulties
- External stresses like unemployment, housing and financial problems.

How might postnatal depression affect my baby?

Babies can be sensitive to their mother's moods and prolonged untreated postnatal depression can affect your relationship with your baby.

Getting help

Postnatal depression is nothing to be ashamed of. It is important to recognise it as early as possible. Health visitors in particular are trained to identify it. They will help every mother to complete a questionnaire called the Edinburgh Postnatal Depression Scale some weeks after the birth. If you are identified as having postnatal depression it may be a relief to know you are simply suffering from something treatable. Fathers can get depressed too and may need a similar kind of help.

Medication

Your GP may discuss the option of antidepressant medication. Often this can lift your mood and shift the worst symptoms,

making you feel more yourself again. Appropriate medication can be chosen for breastfeeding women. Medication is usually offered along with support and counselling.

Support and counselling

This helps most people to some extent. The type of support available will depend on your local services available and the severity of the condition. It may be from:

- A health visitor
- A counsellor employed by your GP practice
- A mental health worker, e.g. community psychiatric nurse or psychiatrist
- Family therapy (for the whole family) or mother and baby counselling from a child psychotherapist may be offered locally.

You will need enough space and opportunity to talk about your own situation and your feelings about it. This may involve reflecting on your own experiences – of pregnancy and birth, your own childhood and parenting and possibly other relevant life experiences.

Practical tips

You may know before the birth you are vulnerable to postnatal depression because you have had depression before, you have had a recent bereavement, you have lost a baby before or you are having relationship problems. These tips may help:

- During the pregnancy tell friends and family you are worried about postnatal depression and discuss the support they might offer. Discuss these worries with your GP and midwife as well.
- If possible try to avoid too many changes like moving house while pregnant. Sometimes these things are unavoidable

but they increase stress levels and sometimes loneliness.

- Try to make contact with other pregnant women, e.g. through antenatal classes and breastfeeding peer support groups
- Try to get plenty of rest as tiredness can make depression worse
- Try to arrange some baby-free time even if it's just for a long soak in the bath. Accept as much help as possible. You are not letting the baby down; you will both benefit
- Get professional help early if you are feeling depressed.
- Listen to others if they say you seem low
- Let them read this leaflet to help them understand how you are feeling. Remember, postnatal depression is treatable and in time you will feel better.

Not all women suffer from postnatal depression but all might find it beneficial to reflect on their birth experience. Please see page 8 for the service we offer.

Further help

Your GP or health visitor will advise you on the support organizations in your immediate area. Some helpful national organisations are:

Meet-a-Mum Association (MAMA)

Support for people suffering from postnatal illness and their families.
Phone: 020 8768 0123
Web: www.mama.org

Association for Postnatal Illness

Phone: 020 7386 3868 (Helpline)
Web: www.apni.org

Sure Start

Services and information for parents and children under 4.
Phone 020 7273 4830 for details of your nearest Sure Start programme.

Parentline

Help and advice for anyone looking after a child
Freephone: 0808 800 222
Web: www.parentlineplus.org.uk

Childcare Link

Information about childcare in your local area
Freephone: 0800 096 0296
Web: www.childcare.gov.uk

Contact a Family

Help for families caring for a child with a disability/special need
Free phone: 0808 808 3555
Web: www.cafamily.org.uk

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6. Robertson KJ (1993) Neonatal jaundice – mechanism and diagnosis. *(Modern midwife 3, 28-33)*

For further information, please access:

http://www.dh.gov.uk for The Pregnancy Book

www.babyfriendly.org.uk

Contact telephone numbers:

• Antenatal Clinic	01225 824659
• Antenatal Reception	01225 824645
• First Trimester Screening Clinic	01225 825414
• Labour Ward, Princess Anne Wing, RUH	01225 824447 01225 824847
• Day Assessment Unit (DAU)	01225 826454
• Mary Ward, Princess Anne Wing, RUH	01225 824662
• Bath Community Midwives	01225 824669
• Chippenham Birthing Centre	01249 456469
• Frome Birthing Centre	01373 454763
• Paulton Birthing Centre	01761 412107
• Shepton Mallet Birthing Centre	01749 342378
• Trowbridge Birthing Centre	01225 711319

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