James Paget University Hospitals NHS
NHS Foundation Trust

Trust Guideline for the Management of Postnatal Care: Planning, Information and Discharge Guideline

A Clinical Guideline recommended for use

In:	Women's health - Obstetrics
By*:*	Obstetricians, Midwives, Paediatricians
For:	Pregnant Women
Key words:	Postnatal
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Reported as approved to	Guidelines Monitoring Group (Maternity)
Document issued:	April 2016
To be reviewed before:	April 2019
To be reviewed by:	Kirsty Cater – Risk and Governance Manager
Document Reg. No:	GUI/FADS/OBS/JU3004/07

Version Information

Version No	Updated By	Updated On	Description of Changes
7	Kirsty Cater	April 2016	Reviewed and updated
6	Jayne Utting and Ann walker	March 2013	Reviewed - Add amendment to postnatal observation regimes
5	Jayne Utting	July 2010	Reviewed - Following CNST level 1 in preparation for CNST level 2
4	Jayne Utting	February 2010	Reviewed and reformatted - In preparation for CNST level 1 assessment
3	Laurie Howarth	August 2013	Reviewed
2	Julie Horan	September 2005	Reviewed
1	Laurie Howarth	April 2003	New Guideline

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1. Quick reference

All Midwives, Midwifery Support Workers and Nursery Nurses who provide postnatal care to women and babies on Delivery Suite, Dolphin Suite, Postnatal Ward and in the Community Setting

All mothers and babies will have an individualised postnatal care plan that will provide a framework for high standard care in the postnatal period whilst remaining flexible to meet the needs of the women and baby. Within this plan, midwives will consider any issues related to the health or well-being of mother and/or baby from during the antenatal and intrapartum period and ensure these issues are reflected and included within the postnatal care plan. Postnatal care will also:

1. Be planned and delivered in partnership with the woman to meet her individual needs
2. Ensure safe transfer of care between clinical settings
3. Ensure safe transfer of and responsibility for care between Midwives and Health Visitors

Communication is of paramount importance between all members of the multidisciplinary team.

2. Objective/s

The objectives of this guideline are to ensure:

- Process for developing an individualised postnatal care plan
- Process for ensuring that there is a coordinating healthcare professional for each woman
- Process for offering every women an opportunity to talk about her birth experiences
- Process for ensuring all women have the opportunity to ask questions about the care she receives
- Process for giving information (written and verbal) to enable parents to assess their newborn's general condition and identify signs and symptoms of common health problems and how they can respond to this
- Process for ensuring the parents have contact information for relevant healthcare professionals regardless of the place of birth
- Requirement to document all discussions with the woman
- System for postnatal visiting once the woman has been transferred into community care
- Process for monitoring compliance with the guideline and practice

3. Rationale

To ensure all women receive care during the postnatal period that is planned, effective and safe as well as fulfilling their unique needs for information and empowerment to care for themselves and their baby.

4. Broad recommendations

A holistic approach to planning and provision of postnatal care for the woman, the baby and the family has been shown to promote the parental experience and support adaptation to the new family structure and dynamic. Some elements of the postnatal care plan can be assessed and planned in the antenatal period. These can be discussed with the woman prior to delivery.

4.1 Immediate (0-24 hours following delivery/birth) requirements of postnatal care:

All women require close monitoring and attention following delivery to ensure:

- Immediate assessment of health and wellbeing following delivery
- Physiological adaptation to the postnatal/non-pregnant state
- Assessment to detect if any deviations from the normal are becoming evident (e.g. postnatal raised blood pressure, signs of infection or increasing lochia/p.v. blood loss indicating primary or secondary postpartum haemorrhage)
- Emotional and psychological support to facilitate the transition from pregnant to new mother status
- Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

All babies require close monitoring and attention following delivery to ensure:

- Successful adaptation to extra uterine life (breathing, heart rate, temperature control)
- Detect any immediate or apparent health issues/congenital abnormalities
- Commencing and establishing adequate and suitable feeding regimes according to needs of the baby
- Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life threatening conditions in the baby that require emergency treatment.
- Women, their partner or the main carer are given information on the association between co sleeping and sudden infant death syndrome (SIDS) at each postnatal contact.

4.2 Developing an individualised postnatal care plan (see Postnatal Care documents at the end of this guideline):

The postnatal care plan should be developed by midwives as soon as possible following birth taking into consideration:

- The immediate health/social needs of mother and baby
- Any pre-existing (to the pregnancy) health or social issues including any multiagency or multidisciplinary involvement
- Any health or social issues that have arisen during the pregnancy/delivery/immediate postpartum period
- Any deviations from the normal physiological state of either mother or baby requiring referral to a relevant medical colleague for opinion/management

The plan of care should be discussed with the woman and all discussions with the woman documented in the postnatal notes/care plan.

Any deviations from the normal must be documented including the referral process to the appropriate medical colleague (Obstetrician/Paediatrician/General Practitioner). The medical professional should document any decisions made or additions to the postnatal care plan as a result of their assessment.

4.3 Ongoing (24 hours to day 30) requirements of postnatal care:

All on-going postnatal care must be assessed and provided according to the individual needs of the woman and her baby. Transfer to community midwifery care and onto on-going Health Visitor care must be made according to the health and wellbeing of the woman and the baby. All assessments made regarding on-going postnatal care must be discussed with the woman and documented in the notes.

4.4 Coordinating Health Professional responsible for the Postnatal Care Plan:

The midwife responsible for the delivery/present at the delivery of the baby is responsible for commencing the postnatal care planning process. This role may be passed on to another midwife depending on the location and venue of care.

4.5 Hospital birth and postnatal stay –

Once the initial postnatal care plan has been generated, the midwife responsible for delivery/present at delivery should hand over the responsibility for the ongoing care planning process to the receiving midwife on the postnatal ward using the SBAR (situation, background, assessment, recommendation) tool in the postnatal kardex. Postnatal care planning on the ward is the responsibility of the midwife allocated to care for the women each shift. At the point of transfer from postnatal ward to community midwifery care, the discharging ward midwife hands over responsibility to the community based midwife who receives notification from the ward clerks that transfer to community has been made.

4.6 Hospital birth and same day transfer to community –

Once the initial postnatal care plan has been generated, the midwife responsible for delivery/present at delivery should hand over the responsibility for the care planning

process to the receiving community midwife. The receiving community midwife is defined as being the named midwife where possible but if not on duty, then it is her delegated team colleague who receives the information from the ward clerks that transfer to community has been made.

4.7 Home birth –

The midwife responsible for the delivery generates the initial postnatal care plan then, if not the woman's named midwife, hands over the responsibility for the continuation of postnatal care planning to the named midwife if on duty or to her delegated team colleague.

4.8 Continuing postnatal care planning –

As the postnatal care continues at home, the midwife conducting the visit must assess the plan in place and amend/update according to the individual needs of the woman and her baby. All amendments or additions to the care plan must be discussed with the woman and the amendment, addition and discussion must be documented in the care plan.

Midwives must liaise closely with the Health Visitor and General Practitioner to enable a smooth and seamless transition of care especially where there are additional physical or support needs.

4.9 Transfer to care of Health Visitor –

Community Midwives and Health Visitors must meet regularly (once a month) to discuss the midwives case load and anticipate the need for any pre-birth joint visits required. The Health Visitor may make a visit to the woman during the antenatal period. The Community Midwife must notify the Health Visitor of the birth and the date when she is due to discharge the woman from midwifery care so the Health Visitor can arrange to visit the women before discharge from midwifery care. In the cases of any ongoing health/social issues, the midwife must contact the Health Visitor to inform her of these and document all discussions between midwife and Health Visitor in the postnatal notes. The midwife must ensure the woman has the contact details for her Health Visitor prior to discharge from Midwifery care.

4.10 Multiagency Involvement/Needs -

Women with specific multiagency needs or ongoing involvement should be under the care of the Eden Team. The midwives within this team will be responsible for coordinating the care for these women and babies throughout the postnatal period ensuring regular contact and involvement with the Health Visitor and any other agencies involved.

Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.

Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems.

4.11 Transfer from hospital to community setting:

The well woman may be transferred from hospital to community setting if:

- She is fit for transfer (assessed via discharge examination/check)
- The baby is fit to go home (assessed via discharge examination/check)
- She is happy to go home (balanced with the demands of the service to maximise bed occupancy)
- The notes have been checked by a midwife to ensure all postnatal recommendations made in the antenatal/intrapartum period have been incorporated into the postnatal care plan
- The midwife has checked if the women requires anti-D, Rubella vaccine, or suture removal (if LSCS suture removal, the woman must be advised accordingly and arrangements for this made with the community midwife and documented)
- Any ongoing medications, for example for analgesia, are obtained and supplied
- Any follow-up appointments made (gestational diabetics are reviewed by Diabetic Specialist Midwife to ascertain if the woman requires 6week postnatal GTT. If so, this will be booked and results sent back to GP/hospital diabetic clinical as required and this plan of care documented in the notes)
- Correct discharge address and contact details confirmed and put in 'discharge book' for ward clerks to notify community midwifery team
- 'What you need to know after having a baby' booklet given, Family Planning Association leaflet given, Baby Zone leaflet given and provision of these leaflets documented in the notes
- All women given opportunity to talk about their birth experiences and ask questions about care received and leaflet to be given
- The mother has been advised of when she will receive a visit at home (usually the day after transfer to community) and how to contact the hospital prior to this time if required
- Discharge details entered onto coding summary sheets for the ward clerks
- The mother may be transferred home with the hand held postnatal notes
- Photocopies of the relevant documentation has been completed.

4.12 A midwife led discharge can occur in the following circumstances:

Spontaneous and instrumental vaginal delivery where-

- The woman is physically well
- There has been a 3rd stage blood loss within normal limits
- There has been normal postnatal lochia
- There has been no excessive perineal trauma (i.e. no 3rd or 4th degree tears)
- There are no medical or obstetric complications either pre-existing, within the pregnancy, delivery or immediate postnatal period which require a medical review or examination (e.g. pre-eclampsia)
- There are no treatments ongoing which require hospital care (e.g. IV antibiotics)
- If instrumental delivery – if the procedure was a low cavity forceps delivery and did not involve mechanical rotation of the baby's head (e.g. Keilland's rotational forceps delivery)

- The baby is well and considered fit for discharge as specified in this guideline

If any of these conditions are not met, the woman must be reviewed by the Obstetrician and transfer into community agreed by them taking into consideration any ongoing care needs.

4.13 Lower Segment Caesarean Section Deliveries:

As above and if the woman has been reviewed by an Obstetric Doctor and found to

- Be physically well (observations within normal limits)
- Be eating and drinking normally
- Have blood loss at delivery within acceptable limits
- Have no medical or obstetric complications either pre-existing, within the pregnancy, delivery or immediate postnatal period which require a medical review or examination (e.g. pre-eclampsia)
- Have no treatments ongoing which require hospital care (e.g. IV antibiotics)
- Have had urinary catheter removed and she is passing urine spontaneously
- Have had all drains removed
- Have a clean and dry wound that is healing
- Have been offered a debrief from the delivery

If deemed fit for discharge, in addition to all other required postnatal information, she should also be given a recovery from LSCS leaflet and have the provision of this leaflet documented in her notes.

4.14 Transfer of baby:

The discharge of ALL babies from the postnatal ward must include a review of the records to ensure that all antenatal, intrapartum and postnatal instructions have been followed and the following must be carried out:

- The baby must receive a newborn examination by a paediatrician, Paediatric/Neonatal Nurse or Midwife Neonatal Examiner. A copy of the NIPE Smart summary should be attached to the neonatal notes.
- All babies will have their birth details clearly documented on the postnatal notes including gestation at birth, date and time of birth, birth weight, head circumference and vitamin K status to ensure this information is transcribed into the Child Health Record Book when it is issued and its' use explained by the Health Visitor when she first visits the baby at home (in some areas, the woman may have already been issued with the Child Health Book and if so, the midwife must ensure all the baby's information is transcribed into the book).
- Newborn hearing screen should be conducted prior to discharge where possible. Community midwives are to perform this if it has not been done in the hospital.
- The parents/carer must be given a copy of the 'What you need to know after having a baby' booklet and be shown the section on caring for the baby and signs of common health problems and what to do about it if the parent/carer becomes concerned.

- The midwife must check if the baby requires any follow-up e.g. hip ultrasound or BCG and any appointments made and parents/carer informed and details documented.

4.15 Postnatal Visiting arrangements:

Prior to the woman leaving hospital, she must be informed of when the Midwife will visit her at home (this would usually be the day after hospital discharge).

The on-going visiting arrangements should be based on assessment of the woman's needs and wishes and the needs of her baby. All decisions related to postnatal visiting arrangements must be documented in the postnatal notes/care plan. The midwife must ensure the woman is aware of when the next visit will be and what to do if she requires a midwife before that time.

Midwives may allocate a Community Midwifery Support Worker to visit when appropriate if their skills at supporting feeding or teaching related to care of the baby are required.

Midwives will offer midwifery support for a minimum of 10 days or longer if required up to 28 days depending on the individual need.

4.16 Postnatal Debrief:

Women must be offered the opportunity to discuss their birth experience and ask questions about the care they have received at each postnatal contact and provision of this offer documented in the postnatal notes. There is a dedicated Women's experience lead and women should be advised regarding this service.

Instrumental/Operative Delivery- Women who have had either an instrumental or operative delivery must be seen during the hospital postnatal period by the delivering Doctor or a delegated representative if they are off-duty. This contact must be documented and details of any discussions detailed in the obstetric or postnatal notes.

4.17 Formal debriefing service:

Some women need the opportunity to discuss their delivery and/or care received at some point during the weeks, months or years following having a baby. A debrief appointment can be booked via ANC, with the women's experience lead.

4.18 Postnatal Information Provision (Process):

Women should be given timely and relevant information to enable them to promote their health, their baby's health and recognise and respond to problems that may arise. This information is in the back of the postnatal notes and the woman will keep this on transfer home and discharge from midwifery care.

This information includes-

- 24 hour contact number for ward 11, Delivery Suite and Dolphin Suite for concerns throughout the postnatal period
- Information of visiting arrangements for midwife, G.P and Health Visitor (including how to contact a midwife if a visit is not scheduled)

- How the woman will receive her Child Health Record and have its' use explained by the Health Visitor (if she does not already have it)
- Registering the birth of the baby
- Postnatal health information for the woman and how to detect a problem and who to contact if a problem occurs
- Postnatal exercises
- Caring for your baby – advice on what care a baby requires and how to do it including feeding, changing, bathing
- Information to help prevent Sudden Infant Death Syndrome
- Information of examinations the baby will receive and when
- Information on signs of illness or a problem in the baby to help parents assess the general condition of their baby and detect any common health problems and also what to do if they are concerned
- Contacting your midwife or other sources of support

In addition, women must also be given-

- The 'Baby Zone' leaflet – further information about prevention of SIDS and keeping your baby healthy
- Family Planning Association leaflet 'Your Guide to Contraceptive Choices – after you've had your baby'
- UK National Screening Committee leaflet 'Screening tests for your baby'

4.19 Verbal Postnatal information/care demonstration:

During the course of postnatal care provision, women will be given verbal information by Midwives or Midwifery Support Workers or Nursery Nurses relevant to their care or issues related to their baby. They may also receive a demonstration on a principle of care e.g. baby bathing or nappy changing. This information given must be documented in the notes.

4.20 Documentation:

Documentation can be seen as the cornerstone to effective postnatal care provision. Adequate antenatal and intrapartum documentation can help planning and provision of postnatal care by identifying issues that require attention/support during the postnatal care period.

Midwives must document:

- The postnatal care plan in the postnatal notes
- Any assessments, additions or amendments made to the care plan detailing the reasons for this
- All discussions with the women about her baby, her care, the care plan and any assessments, additions or amendments made to it
- The provision of postnatal information leaflets (as listed) by signing the relevant boxes in the newborn notes related to discharge
- The provision of verbal postnatal information
- To offer of the opportunity to discuss birth/care experiences and ask questions at every postnatal contact

Midwifery Support Workers/Nursery Nurses must document:

- Any assessments, additions or amendments made to a care plan following discussion of this with a midwife and her approval for the addition or amendments to the plan
- Any verbal information given
- Any demonstrations of care provided

5. Staff Training /Qualifications

See Training Needs Analysis which can be accessed via the Intranet or via Practice Development Midwife.

6. Clinical audit standards

- Provision of information to enable parents to assess their baby's general condition and identify any signs and symptoms of common health problems to enable parents to respond to problems
- Provision of contact details for the relevant healthcare professionals regardless of the place of birth to the new parents
- Identification of the coordinating healthcare professional for women with multiagency or multidisciplinary needs

To ensure that this document is compliant with the above standards, the following monitoring processes will be undertaken:

Monitoring Compliance / Effectiveness Table (Appendix 1).

7. Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this document on behalf of the Maternity Service who has agreed the final content. During its development it has been circulated for comment to:
Obstetric Consultant Group
Obstetric Registrar Group
Head of Midwifery
Clinical Midwifery Managers
Maternity Risk and Governance Manager
Supervisor of Midwives
Clinical Midwives
Midwifery Led Birthing Coordinator

This version has been endorsed by the Maternity Guideline Committee James Paget University Hospital.

8. Distribution list/ dissemination method

Distributed through intranet and via email mailing system to appropriate bodies

9. References

Principle Legislation or Guidance Referenced

- Teaching Women the Method of Sterilising Equipment and Safe Preparation of Infant Formula – Clinical Guideline
- Support for women who choose to bottle feed their baby – Clinical Guideline
- Readmission of Babies due to Feeding Problems – Clinical Guideline
- Weighing Babies born at 37 weeks gestation and over – Clinical Guideline
- Management of Meconium at Delivery – Clinical Guideline
- Management of the Newborn (Group B haemolytic Streptococcus) – Clinical Guideline
- Examination of the Newborn (including immediate examination, full examination and criteria for midwives trained in examination of the newborn) – Clinical Guideline
- Supported Postnatal Care : NICE Standard CG66.

10. Appendices:

Monitoring Compliance / Effectiveness Table — Appendix 1

Element to be monitored	Audit Lead	Quantity	Frequency	Reporting Arrangements	Action Lead	Changes in practice and lessons to be shared
Provision of information to enable parents to assess their baby's general condition and identify any signs and symptoms of common health problems to enable parents to respond to problems	Risk Management Midwife	1% of all women who have delivered	Annually	Risk and Governance Forum	Risk and Governance Forum	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders
Provision of contact details for the relevant healthcare professionals regardless of the place of birth to the new parents	Risk Management Midwife	1% of all women who have delivered	Annually	Risk and Governance Forum	Risk and Governance Forum	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with all the relevant stakeholders
Identification of the coordinating healthcare professional for women with multiagency or multidisciplinary needs	Risk Management Midwife	10 sets of those with multiagency/multidisciplinary needs	Annually	Risk and Governance Forum	Risk and Governance Forum	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate and lessons will be shared with all the

						relevant stakeholders