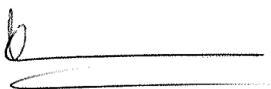


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Community Midwifery Team	All Midwives All Obstetricians	All Maternity Support Workers Paediatric Staff
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Amended to reflect changes in procedure and use of postnatal mother and baby notes		
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	All Midwives All Obstetricians All Paediatric Doctors Critical Care Team	Division of Women & Children's Guideline Intranet Server
Approved by: Clinical Director for Women and Children's Services	 Clinical Director Date: 22nd August 2016	

Version	Type of Change	Date	Author
4	Routine review and update	June 2015	Jane Leverton Community Midwifery Manager
5	Amendments to section 5.2, Postnatal visiting and inclusion of Appendix 2	July 2016	Andrew Simpson Midwife, Workplace Educator

Burton Hospitals NHS Foundation Trust
Division of Surgery
Women and Children's Services

Postnatal Care

1.0 Introduction

Postnatal care should be structured to meet the requirements of each individual mother and baby in order to promote long term physical and emotional wellbeing for both. Communication is a cornerstone of good clinical practice in achieving this and is expected that there are effective systems of communication between all team members and each discipline, as well as with the parent(s) and their families.

The Maternity Service aims to have an approved system for ensuring that every woman has a documented, individualised postnatal care plan which is implemented and monitored.

2.0 The Scope of this Guideline

This guideline refers to postnatal care planning in the following settings:

- Queen's Hospital, Burton (QHB)
- Samuel Johnson Midwifery Led Unit (SJHMLU)
- Community Midwifery

3.0 Process for Developing an Individualised Care Plan

The Midwife must keep clear and accurate records of discussions & assessments made and create and document an individualised postnatal care plan with the woman as soon as possible after birth (NICE 2006), this should include:

- Relevant factors from the antenatal, intrapartum and immediate postnatal period.
- Details of the healthcare professionals involved in her care and that of her baby including roles and contact details
- Plans for the postnatal period

This care plan should be reviewed at each postnatal contact and revised accordingly in response to changing needs and circumstances. All discussions and actions arising therein should be documented in the postnatal notes

3.1 Low Risk Women

The lead professional(s) for women identified as being low risk care will be the midwifery team. The individual midwife providing care to the woman should be identified and documented on the front cover of the postnatal notes as the lead professional. An individualised care plan will be formulated using the Perinatal Institute Postnatal notes for Mother and for Baby and the plan of care will be assessed and developed by the midwife in agreement with the woman. The postnatal woman and baby check will be documented in the postnatal notes for Mother and for Baby

On transfer to the community midwife copies of the relevant discharge letters will be inserted

into the postnatal mother and baby notes which will be given to the woman at discharge to pass to the Community Midwife at the initial visit. At the initial postnatal visit the community midwife will decide on the schedule of further visits based on identified needs of the client. The content of this and subsequent visits will be documented in the postnatal notes.

The discharge from midwifery care will be documented in the postnatal mother and baby notes on final contact from the community midwife and transfer to the health visiting team will be made. It is the community midwives' responsibility to ensure that completed patient records are returned to the antenatal clinic at Queen's Hospital Burton within 28 days of delivery.

3.2 High Risk Women

For women identified as being high risk the appropriate lead healthcare professional is the Obstetrician. The obstetrician should be identified and documented on the front cover of the postnatal notes as the lead professional. The individual midwife providing care to the woman post discharge should also be identified and documented on the front cover of the postnatal notes.

High risk women will require an electronic care plan and may also have documented patient care notes within the HISS system. A discharge plan of care agreed with the Obstetrician will be written in the patient health records. For women with multiagency/multidisciplinary needs the postnatal care plan should be made in conjunction with appropriate identified leads (e.g. Social Services, mental health team).

The postnatal discharge examination (woman) will be performed by an Obstetric SHO (FY1/2) who will document their findings in the patient health records and then consult with the Obstetric Registrar to confirm that the woman is fit for discharge.

For women who have had instrumental deliveries (ventouse or forceps) midwives can perform the discharge providing an Obstetrician has documented in the patient notes that they are suitable for midwife discharge.

Once this has been agreed the midwife will document any findings and actions on the relevant discharge letters and in the postnatal notes for Mother and for Baby. The discharge letters will be inserted into the postnatal mother and baby notes which will be given to the woman at discharge to pass to the Community Midwife at the initial visit.

It should be noted that when the woman remains high risk at the point of transfer to the community, e.g. history of pre-eclampsia, MOH, social issues, then there is a need for a verbal midwife to midwife transfer.

The community midwife will plan a schedule of visits based on identified needs of the client and the requirements of the obstetrician.

4.0 Assessment of Babies

An assessment of babies well being will be carried out by the midwife daily whilst in hospital and at every routine postnatal visit in the home. This assessment will be documented in the postnatal baby notes by the midwife.

4.1 Identifying Signs and Symptoms of Health Problems

It is imperative that families are supported to understand how to identify important signs and

symptoms of health problems in the newborn. Signs and symptoms of illness are identified in the postnatal perinatal baby notes on page 20.

The midwife should discuss these signs and symptoms with the woman and emphasise the importance of informing the midwife, General Practitioner or of seeking urgent medical attention via dialling 999 if any of the identified symptoms present. The midwife should document, sign and date in the postnatal baby notes that this discussion has taken place.

5.0 Transfer to Community Care

On discharge the Midwife must:

- Ensure the baby has been examined and discharged by a suitable qualified health care professional, or that it has an appointment for the baby check clinic in Lichfield as appropriate
- Discuss the contents of the baby notes highlighting the relevant sections of information
- Discuss the contents of the mothers notes
- Give any information leaflets felt to be helpful to the mother and document this in the notes
- Insert a copy of the mothers postnatal/baby discharge letters into the relevant postnatal notes and give to the woman
- Instruct the woman to give these notes to the Community Midwife at the initial home visit
- Give the woman the Child Health record book and explain its purpose
- Provide postnatal telephone contact numbers via fixing an information sticker to the front of the postnatal notes for mother
- Give additional contact details for other support agencies (see appendix 1)
- Document contact details for identified leads (e.g. Social Services, mental health team) for women with multiagency/multidisciplinary needs on the front sheet of the postnatal notes for mother in the section "Primary care contacts".

Mother and Baby discharge details need to be confirmed with woman as follows:

- Demographics
- Discharge address
- Woman's contact telephone number
- GP
- Community midwife

Every care should be taken to ensure that a current discharge address and contact details are obtained in case the woman is not going to the home address. If women are planning to be discharged to an address outside the local area then photocopies of the mother and baby postnatal notes up to the point of discharge should be made. The photocopied notes should go with the mother and baby and the originals kept locally.

5.1 Informing Community Midwife of woman/baby discharge

- Community office staff (QHB) will collect discharge letters from the postnatal wards up until 3.00 pm Monday – Friday
- Discharges after 3.00 pm will be either emailed to the team (Burton team) or rang out by the office staff to the named midwife/senior CMW at approximately 4.00 pm or 9.00 am the next day
- Staff from SJH and the Neonatal Unit will inform the Community office (QHB) of

discharges from their departments

- Discharge details must be recorded in the maternity discharge book
- The community office staff (QHB) telephone out of QHB area to the relevant Maternity Unit each day.
- At weekends and bank holidays the discharges will be coordinated and rung out by the Community Midwife, out of area ones by ward 16.
- Late discharges are coordinated and rung out by Community office or ward 16

5.2 Postnatal Visiting

- It is expected that a minimum of 3 contacts will be made with women following transfer to community care. However, if the woman has had an extended hospital stay for >5 days post birth then she may be seen only twice, at the primary visit and then the discharge contact, depending on clinical need.
- The first contact will normally be a home visit
- Further contacts can be either via a home visit or via a postnatal clinic
- Routine postnatal visits undertaken by the midwife require a full assessment of both mother and baby
- In low-risk women with no previously identified problems, the Day 5 visit will be undertaken by the MSW for the purpose of performing the NNST and weighing babies only. A simple question and answer assessment will be conducted as per the new MSW Day 5 sticker, (see appendix 2). If any concerns are raised or identified during the visit, the midwife will be contacted.
- Where a non-routine postnatal home visit is conducted for maternal assessment only e.g. BP Check or wound check, then a baby assessment is not required
- Similarly, where a non-routine visit is conducted for neonatal assessment only e.g. feeding issues or jaundice, then a maternal assessment is not required

5.3 Transfer of care to Health Visitor

When care of the women is transferred to the health Visitor the community midwife will complete the maternal discharge summary on page 16 of the postnatal notes for mother, and also the baby discharge summary on page 19 of the postnatal notes for baby (or page 5 of the Personal Child Health Record and then fixing the copy to page 19 of the postnatal notes for baby).

All maternity records will be returned to the hospital to be amalgamated with the patient health records. The child health record will remain with the parents to pass on to the Health Visitor for onward completion.

5.4 Women who suffer pregnancy loss

Women suffering a pregnancy loss are identified as being high risk and the appropriate lead healthcare professional is the Obstetrician. A discharge review will be performed by an obstetrician to confirm the woman is fit to be discharged. In such cases the postnatal discharge examination will usually be performed by the midwife caring for the woman.

Every care should be taken to ensure that a current discharge address and contact details are obtained prior to discharge in case women are not going to their home address.

Direct one to one communication with the community midwife caring for the woman should be made to inform them of events.

The woman should only be given documentation relevant to her postnatal care, which will not include any postnatal baby documentation.

5.5 Baby discharged to carers other than the mother

Where the baby is with carers other than the mother e.g. foster care, the postnatal notes relevant to the baby should be photocopied. The photocopied notes should go with the baby and the originals kept locally.

5.6 Woman discharged without the baby

If the woman is discharged without her baby e.g. the baby is an inpatient on NNU. The woman should only be given documentation relevant to her postnatal care.

6.0 Offering a Debrief

6.1 Postnatal Inpatient

Once delivered every woman should be given the opportunity to discuss her birth experience. This should be discussed with each woman during the early postnatal period. The woman should be encouraged to talk to staff involved in her care, to express any concerns or ask questions regarding any aspects of the care provided.

Prior to discharge a debrief can be offered by the following:

- Midwife at the delivery
- Midwife caring for the woman on the postnatal ward.
- Ward Manger
- Maternity Matron/Delivery Suite
- Supervisor of Midwives
- Obstetric Registrar/Associate Specialist/Consultant

6.2 Postnatal Patient Transferred to the Community

If a woman requests a debrief of her birth experience the community midwife can debrief the patient or alternately refer the woman to the following:

- Ward Manger
- Supervisor of Midwives
- Community Midwifery Manager
- Obstetric Registrar/Associate Specialist/Consultant
- Patient Advice and Liaison Services (PALS)

6.3 Patient Advice and Liaison Services (PALS)

It is recognised that some women may feel dissatisfied with elements of their care; if they feel that a debrief is not a satisfactory response to their enquiries or that local management of an informal complaint is sufficient to address their concerns then they may wish to make representation to the Patient Advice and Liaison Services (PALS).

PALS information leaflets should be available in all clinical areas and all women should be informed about the PALS service and given their contact details as appropriate

6.4 Procedure for making a formal complaint

If a client wishes to make a formal complaint she should be advised to write to the Chief Executive at: Burton Hospital NHS Foundation Trust, Belvedere Road, Burton on Trent, Staffordshire, DE13 0RB

7.0 References

Department of Health. (2004) Maternity Standard, National Service Framework for Children, Young People and Maternity Services. London: COI. Available www.dh.gov.uk

Department of Health.(2007). Maternity Matters: Choice, access and continuity of care in a safe service. London: COI. Available at: www.dh.gov.uk

Essence of Care – Patient Focused Benchmarking Health Care Practitioners (April 2003)
Department of Health

National Institute for health and Clinical Excellence. (2006).updated 2014 Routine Postnatal care of women and their babies. LONDON: NICE. Available at: www.nice.org.uk

Nursing & Midwifery Council (2002) Guidelines for records and record keeping CNST

Perinatal Institute. Postnatal Notes for Mother – Version 6.2m (2008) Available at: www.preg.info/postnatal

Perinatal Institute. Postnatal Notes for Baby – Version 6.1B (2008)

Available at: www.preg.info/postnatal

Roper N, Logan W.W and Tierney A J (2000) The Roper-Logan-Tierney Model of Nursing: Based on Activities of Living

Contact Telephone Numbers

To Contact your Community Midwife:

Community Midwife Office **9-5** 01283 566333 extn 4351
 Community Midwife (on call) **5pm-9am** 01283 566333 ext 4355 or Samuel Johnson 01543 412905

Sir Robert Peel Hospital Midwifery Office **01827 263870 (not always manned)**

To Contact your Health Visitor Please contact your GP Surgery to obtain contact details

Breastfeeding Support

National Childbirth Trust

www.nct.org.uk

Ashby, Burton and Coalville 0844 243 6043 - option 1 Lichfield and Tamworth 0844 243 6189 - option 1
 Uttoxeter 0844 243 6306 - option 1 Derby and District 0844 243 6104 - option 1
 Birmingham North 0844 243 6054 - option 1 Stafford, Chase and District 0844 243 6278 - option 1

La Leche League 24 hour Service www.laleche.org.uk Helpline: 0845 120 2918

Children's Centres

Amington Children's Centre, Tamworth 01827 475161
 East Staffordshire Children's Centre, Burton on Trent 01283 233400
 Cannock Children's Centre, Cannock Chase 01543 469894
 Newhall Children's Centre, Newhall 01283 211157
 Stafford Children's Centre, Stafford 01785 854700
 Woodville Children's Centre, Woodville 01283 224795

National & Local Helplines

Domestic Violence Helpline 0808 2000 247
 Karma Nirvana (forced marriage & honour based violence) 0800 5999 247
 NSPCC 0800 800 500
 Women's Aid 08457 023 468
 East Staffs Housing Advice 01283 528613 Out of Hours 01283 528528
 Kiaura (refuge provision, support & IDVA) 01283 569598 / 07973 731889 / 07970 745275
 Pathway (refuge provision, support, children's support 24hrs) 01543 676800
 Relate 01283 561697
 SARAC (Support & counselling for domestic abuse & sexual abuse) 01283 517185

Mental Health

Burton and District Mind www.burtonmind.co.uk 01283 566696
 Uttoxeter Mind www.uttoxetermind.co.uk 01889 568440
 Mid Staffs Mind www.mind.org.uk 01543 462907

Housing and Local Council Contacts

Staffordshire Borough Council 01785 619000 East Staffs Borough Council 01283 508000
 South Derbyshire Dist Council 01283 595758 North West Leics Dist Council 01530 454545

Social Services

Staffordshire Child and Family Services Child and Family Social Work Team

Telephone: **First Response** on 0800 131 3126, Mon-Fri 0800-20.00 or contact firstr@staffordshire.gov.uk
 Outside office hours 0845 6042886

Leicestershire County Council

Children and Young People childrenservices@leics.gov.uk 0116 305 6631
 Out of Hours social-services@leics.gov.uk 0116 2551606

Maternity Support Worker Day 5 Checklist.

YES NO

Does the mother feel generally well in herself?

Do the parents have any concerns regarding themselves or baby?

Do the mother and baby appear well?

Have you or the parents any concerns regarding baby passing urine?

(Note number per day).

Have you or the parents any concerns regarding baby's stools?

(Note number per day and colour).

Has the mother and baby previously had a breastfeeding assessment?

Are there any concerns voiced or observed regarding feeding?

If A/F, are there any concerns regarding feeding and sterilising?

If A/F, have they had an artificial feeding demonstration?

What is the baby's weight today?

What, if any, is the baby's weight loss, (expressed as %)?.....

Are there any signs of jaundice?

Have the parents previously consented to the NNST?

Are the parents still happy for the baby to have the NNST?

Comments/Action

Appendix 2

Name (Print)	Signature	Date	Time	Next appointment/visit
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Has the NNST been completed?

Has all necessary documentation been completed?

Do the parents wish to be contacted by the midwife?

Do you have any concerns?

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