# Postnatal Care Pathway

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| **Classification** : | Guideline |
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**Guideline to be followed by (target staff):** Midwives, clinicians and support workers in the hospital and community settings.

**To be read in conjunction with the following documents:**

- Postnatal Support Following Your Discharge from Hospital Patient Information Leaflet
- Depression- Antenatal and Postnatal Patient Information Leaflet
- Birth Afterthoughts Patient Information Leaflet
- Vitamin K Patient Information Leaflet
- Caesarean Birth Patient Information Leaflet
- Tongue Tie Ankloglossia Patient Information Leaflet
- Enhanced Recovery after Caesarean Section Guideline
- Caesarean Section Guideline
- Perineal Trauma and Repair Guideline
- Operative Vaginal Delivery Guideline
- Bladder care guideline
- Newborn Feeding Policy
- Co-sleeping and Bedsharing for Mothers and Babies Guideline
- Jaundice Management of the Neonate
- Multiprofessional Hanover of Care (Maternity) Guideline
- Prophylactic Anti-D Immunoglobulin Guideline
- Vitamin K Prophylaxis Guideline
- Weight Management in the Newborn Guideline

**Are there any eCARE implications?** No

**CQC Fundamental standards:**

Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

## Disclaimer -

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

# Index

## Guideline Statement

In response to NICE recommendations set out in the NICE Postnatal Guideline (2015) this document has been developed to set a basic standard of postnatal care for women and their babies.

## Executive Summary

To provide consistent, high quality, personalised postnatal care for women in Milton Keynes in line with current National Guidance.

**To provide a standardised approach to care for all health professionals involved in the delivery of postnatal care including Midwives, Nurses, Nursery Nurses, Maternity Support Workers, Obstetricians and Paediatricians/ ANNP's**

## 1.0 Roles and Responsibilities:

**Midwife** - Responsible for providing routine postnatal care for mothers and their babies in both the hospital and community settings in line with current national guidance. Develops individualised care plans for mothers and their babies and escalates to the appropriate healthcare professional when there are deviations from normality. To complete the examination of the newborn as per examination of the newborn guideline if appropriately trained.

**Nursery Nurse** – Under the direction of the midwife provide care and infant feeding support and new parents and their babies. To perform neonatal observations and assist in the provision of transitional care, escalating deviations from normal to Midwife caring for the woman/baby.

**Maternity Care Assistants** – Under the direction of the midwife provide care, infant feeding support and parenting skills to support new parents and their babies. To provide basic care to new mothers and undertake maternal observations where required, escalating deviations from normal to Midwife caring for woman.

**Obstetricians** – To review and recommend care pathways for women where there is a deviation from the normal

**Paediatricians/ANNP's** – To complete the examination of the newborn as per Examination of the Newborn Guideline and review and recommend care pathways for babies where there has been a deviation from normality.

**Infant Feeding Specialist Midwife** – To provide specialist knowledge and advice on infant feeding to staff and women as required. To provide training to maternity, neonatal and paediatric staff as per the Mandatory Training Guideline for Maternity (With Training Needs Analysis). To provide ongoing support and training to Breastfeeding Peer Support volunteers.

## 2.0 Implementation and dissemination of document

This document will be accessible electronically on the hospital intranet.

# 3.0 Processes and procedures

## 3.1 Care planning and delivery

A coordinating healthcare professional should be identified for each woman. Based on the changing needs of the woman and baby, this may change over time.

An individualised postnatal care plan should be developed with the woman ideally in the antenatal period or as soon as possible after the birth, prior to transfer to the postnatal ward or home. 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 the baby, including roles and contact details
- Plans for the postnatal period

Individualised care plans for the postnatal period should be reviewed at each postnatal contact.

Length of stay following birth and plan for discharge should be discussed with the woman, taking into account the health and wellbeing of the woman and her baby, and the level of support available following discharge.

Women who are under the care of a continuity of care team should have a named midwife who will provide and plan care for the postnatal period wherever possible and depending on the demands of the service at the time.

## 3.2 Immediate Care Following Birth

### Care of the Mother

Following the completion of the third stage of labour, an inspection of the perineum and genital tract should be carried out to identify any trauma present and if required a repair carried out. Please refer to Perineal Trauma and Repair Guideline for further information.

The woman should be offered clean linen and assistance given to wash or shower as soon as possible following birth and if she wishes to do so.

One set of maternal observations should be completed within 1 hour of 3rd stage completion (additional/more frequent observations may be required if clinically indicated).

Maternal observations should include:

- Temperature
- Pulse
- Respirations
- Blood Pressure
- Lochia assessment
- Uterine Involution
- First void - urine volume (refer to bladder care guideline)

Where there are any complications or concerns, obstetric review should be sought immediately.

Risk assessments, including the postnatal Venous Thromboembolism (VTE), Waterlow score and patient handling risk assessment should be completed on eCare prior to transfer to the postnatal ward and VTE prophylaxis prescribed if required.

If the woman is Rh-D negative cord bloods and maternal bloods should be taken and sent as per Prophylactic Anti-D Immunoglobulin guideline on the labour ward prior to transfer to the ward.

**Care of the newborn**

Skin to skin contact between mother and baby must be initiated immediately following the birth unless otherwise clinically indicated or declined by the mother and should be allowed to continue uninterrupted for at least one hour or following the first feed.
Breastfeeding must be promoted and facilitated in accordance with the Newborn Feeding Policy. The baby should be allowed to take its first breastfeed without interruption of its innate reflex to find and attach to the breast.

Newborn Observations and care of baby should include:

- Initial examination of the newborn (Refer to the Newborn Baby Pathway). Deviation from the norm should be appropriately referred and all findings/actions and plan documented in eCare.

- Parents should be provided with information on Vitamin K in order to make an informed decision about its administration. It should be offered for all infants as a single dose of 1mg IM. If parents decline IM Vitamin K, oral Vitamin K should be offered as second line.

- Ensure any neonatal observations required are carried out in a timely manner, temperature check should not be taken at birth – baby requires time to adapt to conditions, however observations should not be delayed until after transfer to the postnatal ward.

Where there are any complications or concerns, paediatric review should be sought immediately.

Parents will be provided with the Paediatric Child Health Record (PCHR/Red book prior to transfer to the Postnatal Ward, or home if being discharged from Labour Ward. The Midwife must explain the purpose of the book and advise it must always remain with the parents during their stay (not on the notes trolley on ward or sent home).

### 3.3 Early Transfer Home from Labour Ward

Women that have had an uncomplicated pregnancy, labour and birth may choose to go home within 6 hours of the birth.

#### 3.3.1 Contraindications to Early Discharge (this list is not exhaustive)

**<u>Maternal</u>**

- Raised blood pressure in the antenatal, intrapartum or postnatal period.

- Operative delivery

- Complications of the third stage i.e. postpartum haemorrhage, manual removal of placenta and examination under anaesthetic
- Infection risk
- Medical complications e.g. diabetes, cardiac anomalies
- Social factors e.g.. cause for concern, safeguarding risks

**Baby**

- Babies undergoing observations
- Babies requiring additional feeding support

### 3.1.2 Process for Early Discharge

The current discharge process should be followed as per routine postnatal discharge from the postnatal ward:

- All babies should have their Newborn and Infant Physical Examination (NIPE) completed by an appropriately trained practitioner prior to discharge. Where this is not possible, the maternal notes should be retained on Labour Ward and an outpatient NIPE appointment made for the next day or within a maximum of 72 hours. Alternatively, arrangements can be made for this to be carried out at home during the first day visit if an appropriately trained midwife is available.
- Prior to discharge home it is important that all observations for the mother and baby are within normal parameters and that the mother has passed urine within 6 hours following the birth (refer to bladder care guideline) and the baby has taken an adequate feed. This feed should be observed for signs of effective feeding.
- The midwife should ensure that the mothers and baby's postnatal records are completed in full, and a daily check has been completed and documented on eCare.
- The Maternity Discharge Form should be completed informing the Community Midwife of the discharge (Appendix 1) and left in the Discharge Book on labour ward for collection by the Community Midwifery teams. The woman's sticker should also be placed in the discharge book with the woman's current telephone number and signed/printed by the discharging midwife.
- If the woman is Rh-D negative, she **must not** be discharged until the cord blood and maternal blood results have been checked and Anti-D immunoglobulin administered if required.

## 3.4 Transfer to the Postnatal Ward

- Due to clinical or social needs of the mother or baby some women will require a period of care on the Postnatal Ward. This length of stay should be appropriate to the needs of the mother or baby.

- Transfer of mother and baby to the postnatal ward should take place as soon as possible following delivery unless otherwise indicated and preferably in skin-to-skin contact.

- Prior to transfer to the ward the Midwife on labour ward or in theatre should phone and request a bed with the Midwife in charge. Following a brief description of the woman's assessment and plan of care, the shift lead should allocate a bed whilst on the phone and inform the calling midwife to avoid any delays when arriving on the postnatal ward.

- Following transfer, handover of care should take place at the beside as per the Multi-professional Handover of Care (Maternity) guideline. The mother should be involved in this, so she is aware of her plan of care during the postnatal period.

- The transferring midwife should provide a detailed account of the woman's history, birth and individualised care plan using SBAR and document the SBAR handover on eCare.

- The Mother and Baby's daily postnatal assessment should be completed immediately following transfer and recorded in eCare.

- On admission to the postnatal ward the parents should be given information and advice about co-sleeping and bed sharing whilst in hospital (as detailed in the Co-sleeping and bed sharing for Mothers and Babies Guideline). This conversation must be documented in eCare.

- The woman should be orientated to the ward facilities, given fresh water and shown how to contact staff. This is then documented in the mother's record. The woman should be informed of visiting times and given the patient information leaflet for partners or family members staying overnight on the ward. The partner or family member who will be staying must read and sign the agreement form and made aware that they could be asked to leave if they are found to be breeching the agreement.

- The ward handover sheet should be updated by the Midwife handing over, this should include whether the baby requires a NIPE examination and/or BCG vaccination..

## 3.5 Maintaining Maternal Health

During the postnatal period women should be offered information and advice regarding their own health and wellbeing. The following guidance outlines the minimum care that should be provided to mothers and should be used in conjunction with the relevant trust guidelines.

### 3.5.1 Within the First 24 hours of Birth.

Women should be offered timely and relevant information to enable them to promote their own and their babies' health and wellbeing and to recognise and respond to problems.

All women should be given information about the physiological process of recovery following birth, and that some health problems are common, with advice to report any health concerns to a healthcare professional, in particular:

| Signs and Symptoms | Possible condition |
|---|---|
| Sudden and profuse blood loss or persistent increased blood loss<br>Faintness, dizziness or palpitations/tachycardia | Postpartum Haemorrhage |

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| Fever, shivering, abdominal pain and/or offensive vaginal loss | Infection |
| Headaches accompanied by one or more of the following symptoms within the first 72 hours after birth: Visual disturbances, nausea, vomiting. | Pre-eclampsia/eclampsia |
| Unilateral calf, pain, redness or swelling<br>Shortness of breath or chest pain | Thromboembolism |

Women should pass urine within 6 hours of birth and this should be documented in eCare. For further information regarding bladder care management, please refer to the Bladder Care guideline, Caesarean Section Guideline and Enhanced Recovery after Caesarean Section Delivery guideline.

A minimum of one blood pressure should be measured and documented within 6 hours of the measurement taken immediately following birth. More frequent observations may be required if clinically indicated.

Women should be encouraged to mobilise as soon as appropriate following birth.

For women who have delivered via operative vaginal delivery or caesarean section, please refer to the appropriate guidelines for detailed guidance on management following delivery.

If a woman is Rh-D negative, the cord and maternal bloods should be chased, and Anti-D immunoglobulin administered as soon as possible and within 72 hours of birth.

### 3.5.2 At each Postnatal contact

The midwife should carry out a thorough assessment of maternal wellbeing and document this in the postnatal assessment tab on eCare. This should be completed daily as a minimum whilst on the ward or at each Midwife visit in the community.

Ask the woman about her health and wellbeing. This should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed.

Offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion

Encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions.

Women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.

The midwife should provide information on normal patterns of emotional changes and ensure she has the leaflet 'Postnatal depression'.

Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviors that are outside of the woman's normal pattern.

Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. All women should be provided with the 'Birth Afterthoughts' patient information leaflet prior to discharge.

Ask the woman about her feeding method and carry out at a breastfeeding Assessment as per Newborn Feeding Policy and record in eCare. Prior to discharge from the postnatal ward, at least one full breastfeed must be observed and a breastfeeding assessment completed.

Women should be provided with information on perineal care and hygiene and asked about any concerns regarding perineal trauma. The midwife should carry out an examination of any perineal trauma/repair as per Perineal Trauma and Repair guideline as part of the daily examination and documented in the woman's records as per guideline. Women should be provided with an information leaflet prior to discharge.

Women who have had a caesarean section should be have a wound site examination and be provided with information regarding wound care and healing.

Mothers should be advised of the importance of taking regular analgesia to ensure adequate pain management. Any concerns regarding a woman's pain management should be escalated to the obstetrician.

Information should be given to all parents regarding family planning and contraception prior to discharge from the hospital and maternity care.

All assessments and care plans must be documented in eCare and followed up if required.

## 3.6 Maintaining Infant Health

During the postnatal period parents should be offered information and advice regarding the health and wellbeing of their baby. The following guidance outlines the minimum care that should be provided to mothers and should be used in conjunction with the relevant trust guidelines.

### 3.6.1 Within the first 24 hours

Parents should be offered timely and relevant information to enable them to promote the health and wellbeing of their baby and recognise and respond to problems.

Parents should be advised of the signs and symptoms of potentially life-threatening conditions and to contact their healthcare professional immediately or call for emergency help if any symptoms occur.

Parents, family members and carers should be offered information and reassurance on their baby's social capabilities as this can promote parent–baby attachment.

Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both parents in the care of their baby and enable them to learn more about their baby's needs.

The aims of any physical examination should be fully explained by the healthcare professional and the findings and results shared with the parents and recorded in the postnatal plan and the parent held child record.

The Newborn Physical Examination (NIPE) should be performed by an appropriately trained health Professional within 72 hours of birth as per Examination of the Newborn guideline.

### 3.6.2 Follow up postnatal contacts

The midwife should carry out a thorough assessment of infant wellbeing and document this in the newborn assessment tab on eCare. This should be completed daily as a minimum whilst on the ward or at each visit in the community.

At each postnatal contact, parents should be offered information and advice to enable them to:

- assess their baby's general condition
- identify signs and symptoms of common health problems seen in babies
- contact a healthcare professional or emergency service if required.

This includes giving written information and discussing the important symptoms parents should be aware of.

Parents should be given advice at each postnatal contact about reducing the risk of Sudden Infant Death Syndrome (SIDS) and co-sleeping (as detailed in the Co-sleeping and Bedsharing for Mothers and Babies Guideline). This conversation must be documented in eCare or in the postnatal notes.

Jaundice should be visually assessed at each postnatal contact (additional testing such as TCB or Serum Bilirubin is required for any baby presenting with jaundice). Parents should be offered information about physiological jaundice including:

- That it normally occurs around 3-4 days after birth
- Reasons for monitoring and how to monitor

After the first 24 hours, if it is identified that a baby is jaundiced, or that the jaundice is worsening, this should be managed as per Jaundice Management of the Neonate guideline.

The newborn blood spot test should be offered to all parents when their infants are 5 days of age (where the day of birth is counted as day 0). Informed consent should be obtained. Samples should be taken as per Newborn Blood Spot Screening guideline and each sample checked with a second member of staff to ensure all information is correct and prevent any avoidable repeats.

Home visits in the community should be used as opportunities to promote parent or mother to child emotional attachment. All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment.

Assessment for emotional attachment should be carried out at each postnatal contact and healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit.

Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse and if there is raised concern should follow local child protection policies.

## 3.7 Separate care of mother and baby

### 3.7.1 Reasons for Separate Care

- Maternal request, e.g. Mother relinquishing baby
- Child protection proceedings, e.g. Emergency Protection Order/Interim Care Order
- Maternal condition, necessitating transfer to Department of Critical Care (DoCC).
- Neonate's condition, necessitating transfer to Neonatal Unit (NNU).

### 3.7.2 Maternal Request or Care Proceedings

- If separate care is due to an anticipated Safeguarding concern it is the responsibility of the Midwife at the birth to notify Children's Social Care that baby has been born. For babies with a Children's Social Care Maternity Plan this can be located in the Purple Safeguarding Folders in each clinical area. The midwife should sign the form to confirm this communication has taken place. This plan should be scanned to EDM on discharge from the Maternity Unit. For unexpected situation the Emergency Out of Hours Social Worker or Duty Social Worker should be contacted depending on time of day.
- Careful consideration needs to be given to ensure the most appropriate place for the baby. The Postnatal Ward is not always an appropriate place for the baby to be cared for as there are no facilities to care for babies unattended by parents or guardians. Whenever possible a decision must be taken regarding the appropriate place of care, considering the safety and clinical needs of the baby, prior to birth. NNU will only be appropriate if the baby has medical / nursing needs.
- Consideration should be given to whether a parent or guardian can be accommodated with the baby on the postnatal ward where we are unable to discharge the baby home to the care of community midwives.

Please also refer to Appendix 4: Best Practice Charter - Guidance for Social Workers and Midwives when the plan is for a baby to be discharged to the care of the Local Authority.

### 3.7.3 Maternal Condition

If the mother is being cared for on the Intensive Care unit, consideration should be given to whether the partner or appropriate guardian can be accommodated with the baby on the postnatal ward.

### 3.7.4 Emotional and psychological aspects to consider where babies are separated from parents due to a social or clinical need

- Where appropriate, have mother and or partner had the opportunity to hold their baby?
- Would mother and partner like to have photographs and footprints of their baby? (This provides the opportunity to commence a Life Story for the baby if is not going home with parents).
- Although they may decline all of the above, they may wish to access photographs footprints at a later date, we can facilitate this by placing them in the hospital records.
- Consider a Talk for Change referral to support with emotional wellbeing.
- If the mother is in DoCC and wishes to breastfeed her baby this should be facilitated where possible with the support of the Infant Feeding Specialist midwife in discussion with her next of kin.

### 3.8 Discharge from Postnatal Ward

- All babies should be seen and have a NIPE completed by a Paediatrician or appropriately trained practitioner prior to discharge. (Please refer to Examination of the Newborn guideline). This should be documented on NIPE Smart and the printout filed in the Child Health Record (red book).
- The Midwife should complete the postnatal assessment, breastfeeding assessment and discharge sections on eCare. The midwife must ensure the postnatal notes are completed and include any significant risk factors and important information.
- The Midwife should ensure that the eCare depart process is completed, finalised and printed. Once printed go through the contents of the paperwork with the mother to ensure that the details are correct including an up to date telephone number and discharge address. A printed copy should be given to the mother to take home and be given to the health visitor on her first visit.
- Where the woman is being discharged to a temporary address this should be clearly highlighted. If the mother and baby are being discharged to separate addresses, this needs to be clearly documented. If the baby is being discharged to foster parents ensure that information regarding the foster parents is not included in the notes scanned into the mothers EDM as this may be a breach of confidentiality. A copy should be given to the mother to take home and given to the Health Visitor on her first visit.
- All women will receive discharge information regarding their and their baby's wellbeing, how to contact their Midwife, accessing emergency services, help with breast feeding support and advice. Where mother or baby has specific needs, this should be clearly documented on the discharge sheet and the relevant care plan in place.

- It is the discharging Midwife's responsibility to ensure discharge details are correct and any follow up appointments are arranged where mother or baby are referred to allied services. This should be communicated to the woman.

- The Maternity Discharge Form should be completed informing the Community Midwife of the discharge (Appendix 1) and left in the discharge book on postnatal ward for collection by the Community Midwifery teams. The woman's sticker should also be placed in the Discharge Book and signed by the discharging midwife. The woman's telephone number should also be documented with her sticker. It is vital that any important information regarding the mother and/or baby is documented on the Maternity Discharge form so that the community midwife is alerted to any significant history prior to visiting.

- If a baby has had an SBR test (Serum Bilirubin Test) whilst in hospital, attach a copy of the SBR chart to the yellow discharge form then place in the discharge book to be collected by the community midwives in the morning. The copy of the SBR chart can then be kept by the community Midwives without leaving the hospital premises further SBR test done can then be plotted.

- If the woman lives out of area, the discharging Midwife must contact the appropriate hospital to handover the discharge information. The midwife should then document that this on the Maternity Discharge form and on eCare.

- If there is a Children's Social Care Maternity Plan check to see if a discharge planning meeting should be arranged prior to the discharge. If the mother is out of area then the Community Midwife, Health Visitor and GP as well as the Safeguarding Midwife of the hospital providing care should be informed of the discharge and ongoing plans.

- Ensure any relevant Safeguarding information in provided on the Discharge paperwork for the GP and Health Visitor e.g. FGM-IS or baby in Care of the local authority.

- We advise that parents transport their baby home from hospital in a car seat. It is the responsibility of the parents to safely transport their baby from the ward, to have read the car seat instructions and to ensure their baby is safely secured for transfer home.

### 3.9 Community Care

- Postnatal care in the community will be provided by the Community Midwives and Maternity Care Assistants. The Community Midwife is the coordinating health professional for all women including those with multi-professional and multidisciplinary needs. The Community midwife's name and contact details are included on the front of the health records and if applicable the case loading team name and team numbers sticker.

- All women should be contacted on the day following discharge, preferably by their **named** Community Midwife and an appropriate plan made for first home visit. The timing of this visit should consider the clinical needs of mother and baby, method of feeding, preference of the mother and the availability of named midwife. The first home visit take place should not be longer than 48 hours from postnatal discharge.

- This first home visit should be used to assess individual needs of the mother and baby and ensure the first visit checklist is completed (see Appendix 2). Where issues have

been identified a management plan should be clearly documented in the handheld postnatal notes and on e-Care for both mother and baby.

- The Newborn Blood Spot Screening (NBBS) should be carried out on day 5 with informed consent (see guidelines for Newborn Screening). In exceptional circumstances the NBBS can be taken up to day 8 but should not be delayed without agreement from the Screening Team.

- All routine postnatal care for mother and baby will consist of:

  - First visit - initial risk assessment, information and care planning.
  - Third day visit –weight and feeding assessment
  - Fifth day visits – NBBS, weight if day 3 lost greater than 8%, feeding support.
  - Discharge visit – between day 8-12 finalise care, weight at or near birth weight, ensure contact with Health Visitor in place.

- Visits maybe combined if first visit coincides with third or fifth day. Additional visits arranged as required determined by assessment of clinical and social needs.

- Care where appropriate can be carried out by a Maternity Care Assistant, however the planning and evaluation of care plans should be completed by the Midwife or in conjunction with the healthcare professional prescribing the care.

### 3.10 Discharge to Health Visitors

- Women and their babies would routinely be discharged to the care of the Health Visitor between the 10th and 12th day. This discharge visit should be completed by the **named** midwife when the timing of that visits does not compromise clinical care.

- If the baby is near but below birth weight by the time of the discharge visit the midwife can, where appropriate, make arrangement with the health visitor to ensure follow up.

- Where Midwives are still providing care past the 12th day they will remain the lead practitioner but inform the Health Visitors of the woman and any relevant issues.

- Where there are complex issues within a family and a Confidential Communique (CC), this should be communicated to the health visiting team. It is recommended that in the most complex cases the midwife, social worker and health visitor have face to face discussions regarding any care plans in place prior to discharge.

### 3.11 Recordkeeping

- All maternal observations and discussions to be recorded in the mothers postnatal records on eCare (or in postnatal notes if in the community), management plans to be clearly documented and this should include relevant factors from the antenatal, intrapartum and immediate postnatal period and plans for the postnatal period and where there has been deviation from the norm.

- For women that have given birth in the hospital all documentation including electronic documentation should be completed prior to transfer to the ward or home.

- For babies born at home the Community Midwife should ensure completion of the electronic records and generate the NHS Number.

- The Birth Notification should be forwarded to Child Health and the Birth Register retained by the Maternity Department.

- Prior to transfer to the Postnatal Ward or home if early discharge, the Midwife should complete the risk assessments in the maternal and baby postnatal records.

- Mother and baby/babies to have printed patient identification labels as per Trust Patient Identification Policy.

- For mothers that have given birth at home the Midwife should ensure that the mother and baby are stable and that the parents have contact numbers for advice and emergencies before leaving.

- Ensure all paper records are sent to EDM.

### 3.12 Readmission

- All mothers and babies requiring readmission to hospital would have a clinical risk assessment by the appropriate clinician to determine which clinical area would be most appropriate to ensure an effective and efficient care pathway.

- If the woman need admission to the general hospital but there are no available beds, admission to the postnatal ward would be negotiated with the Maternity Lead on Call and the Bed Manager or Clinical Site Manager.

- All readmission to the postnatal ward should be cared for in a side room, where a side room is not available a Datix report should be completed to highlight the risk of infection.

- A Datix report should be completed for all readmissions.

- MRSA screening should be carried out, and results followed up, ensuring treatment is given as required.

- Once mother and baby have been discharged, the electronic records should be completed, and the routine discharge process followed ensuring the discharge paperwork is forwarded to the community midwives as per guidelines.

- Where readmissions are for weight loss due to breastfeeding issues the Specialist Infant Feeding Midwife to be informed to facilitate any extra support as required. Please refer to the Newborn Feeding Policy and Weight Management in the Newborn Guideline.

## 4.0 Statement of evidence/references

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**External weblink references:** Please note that although Milton Keynes University Hospital NHS Foundation Trust may include links to external websites, the Trust is not responsible for the accuracy or content therein.'

# 5.0 Governance

## 5.1 Document review history

| Version number | Review date | Reviewed by | Changes made |
|---|---|---|---|
| 4.0 | 05/2020 | Laura Jewell | Full review of document in line with most recent NICE guidance |

## 5.2 Consultation History

| Stakeholders Name/Board | Area of Expertise | Date Sent | Date Received | Comments | Endorsed Yes/No |
|---|---|---|---|---|---|
| Julie Cooper | Head of Midwifery | 01/06/2020 | 15/06/2020 | Incorporated | Yes |
| Natalie Lucas | Audit and guidelines Midwife | 01/06/2020 | 15/06/2020 | Incorporated | Yes |
| Georgena Leroux | Practice development Midwife | 01/06/2020 | 24/062020 | Incorporated | Yes |

## 5.3 Audit and monitoring

| Audit/Monitoring Criteria | Tool | Audit Lead | Frequency of Audit | Responsible Committee/Board |
|---|---|---|---|---|
| a) The woman and baby's individualised postnatal care plan is reviewed and documented at each postnatal contact.<br><br>b) 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.<br><br>c) 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. | Audit | Midwives and doctors as designated by audit leads | Annually | Audit group meeting |

| | | | | |
|---|---|---|---|---|
| d) Safer infant sleeping is discussed with women, their partner or the main carer at each postnatal contact.<br><br>e) Women receive infant feeding support and advice from a service that uses an evaluated, structured programme.<br><br>f) Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.<br><br>g) Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.<br><br>h) Parents are provided with contact details for relevant healthcare professionals regardless of place of birth | | | | |

### 5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

| **Equality Impact Assessment** | | | |
|---|---|---|---|
| Division | Women's and Children's Health | Department | Maternity |
| Person completing the EqIA | Laura Jewell | Contact No. | |
| Others involved: | | Date of assessment: | 05/2020 |
| Existing policy/service | Yes | New policy/service | No |
| | | | |
| Will patients, carers, the public or staff | Yes | | |

| | |
|---|---|
| be affected by the policy/service? | |
| If staff, how many/which groups will be affected? | *All staff working within the maternity department providing postnatal care to women and babies* |

| Protected characteristic | Any impact? | Comments |
|---|---|---|
| Age | NO | Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff |
| Disability | NO | |
| Gender reassignment | NO | |
| Marriage and civil partnership | NO | |
| Pregnancy and maternity | NO | |
| Race | NO | |
| Religion or belief | NO | |
| Sex | NO | |
| Sexual orientation | NO | |

| |
|---|
| What consultation method(s) have you carried out? |
| *Circulation via email for comments, discussed at the guidelines meeting* |
| How are the changes/amendments to the policies/services communicated? |
| *Circulation via email, discussed at the guidelines meeting and WH CIG* |
| What future actions need to be taken to overcome any barriers or discrimination? |

| What? | Who will lead this? | Date of completion | Resources needed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| Review date of EqIA | | | |

# Appendix 1: Maternity Discharge Form

**Please ensure all information is complete before discharge to community midwife.**

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## Appendix 1: Maternity Discharge Form (Version 3a)

**Please ensure ALL information is complete; add the patient details to the Discharge book and place this yellow form in the Discharge book for ALL women upon Discharge** CC ☐

| Community Midwife: | GP Surgery: |
|---|---|

| Patient I.D Label with correct visit address | Discharged From | LW | W9 | W10 | Other: |
|---|---|---|---|---|---|
| | Date of Discharge: | | | | |
| | Time of Discharge: | | | | |
| | Number of days on discharge: | | | | |
| | Mother discharged with baby | Yes | No | | |
| | If No, where is baby? | | | | |
| | Discharged by | Print name | Signature | | |

| Phone 1: |
|---|
| Phone 2:: |

| Alternative 1st visit address if not usual place of residence: |
|---|

| Confidential Communique updated | Yes | No | N/A |
|---|---|---|---|
| | | | |

### Baby Details (please circle as appropriate)

| | | | |
|---|---|---|---|
| Date of birth | | | |
| Time of birth | | | |
| Type of birth | | | |
| Gestation | | | NNU |
| Sex | | | |
| Weight | g | Centile: | |
| Feeding method | Breast | Bottle | Mixed |
| Feeding assessment completed prior to discharge | | Yes | No |
| Feeding Support Visit required | | Yes | No |
| BCG (please circle one) | Given | Required and referral made | Not required |
| Anti D (please circle one) | Given | Required | Not required |
| Vitamin K at birth | IM | Oral (further dose(s) required) | |

**Can mother attend Maternity Clinic? Yes** ☐ **No** ☐

### Maternal Information

| | | | |
|---|---|---|---|
| Parity | | | |
| EBL | | | |
| Last Hb: (if applicable for EBL): | | Date Taken: | |
| Perineal Trauma | | | |
| If C/S: | Suture Material | | |
| | Type of dressing (if still in situ) | | |
| Smoking status (at discharge from hospital) | Smoker | CO: | Non-smoker |
| Any Other important details: i.e. Obstetric Emergency / Safe-guarding concerns / TTO's, 2nd Oral Vitamin K dose etc | | | |

| Date of visit | No days | Seen by (print) | Comments / Reason for visit | V if No Access |
|---|---|---|---|---|
| | | | | |

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MRN:

CC ☐

## DAY 5 Checklist

| For Oral Vitamin K only | Oral dose given at birth and documented in red book ☐ | 2nd dose given on day 5 and documented in red book ☐ | Final dose arranged with GP ☐ |
|---|---|---|---|

## *Community Postnatal visits*

| Date for visit: | No days | Seen by (print) | Comments/Reason for visit | √ if No access |
|---|---|---|---|---|
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## To be completed by Community Midwife upon discharge from Postnatal care

| | | | |
|---|---|---|---|
| **NBBS** offered and accepted ☐ | NBBS declined ☐ | NBBS not offered ☐ | NBBS ineligible ☐ |
| Offer date: | Test date: | Screening status: | |

| | | | |
|---|---|---|---|
| **Hearing screening** offered and accepted ☐ | Hearing screening declined ☐ | Hearing screening not offered ☐ | Hearing screening ineligible ☐ |
| Offer date: | Test date: | Screening status: | |

| | | | |
|---|---|---|---|
| **NIPE** offered and accepted ☐ | NIPE declined ☐ | NIPE not offered ☐ | NIPE ineligible ☐ |
| Offer date: | Test Date: | Screening status: | |

| | | |
|---|---|---|
| Date of Discharge: | | |
| Number of days on discharge: | | |
| Discharged by | Print name | Signature |
| Notes returned to Office and added to book | Print name | Date |

| | | | |
|---|---|---|---|
| Smoking status | Smoking | CO level: | Non-smoker |
| Feeding method | Breast | Bottle | Mixed |
| CC updat-ed | Yes | No | N/A |

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## Additional Postnatal Visits

| Date for visit: | No days | Seen by (print) | Comments/Reason for visit | √ if No access |
|---|---|---|---|---|
| | | | | |
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# Appendix 2: Checklist for 1st Visit by Community Midwives

## Checklist for 1st visit by community midwives

On the first visit the community midwife should check that the following are done, parents aware of the process and time scale for activities listed:

- Full physical check of mother and baby including visualising the perineun and any wounds, discussion around common health problems, assessment of mental wellbeing and the importance of relationship building with baby.
- Give 24 hour contact number to parents
- Full breastfeeding assessment and give help with breastfeeding as required
- Discuss sterilization and making up of feeds if appropriate
- Physical examination of the newborn completed or arranged
- Hearing screening of the newborn completed or arranged with hospital
- Registering birth with Registry Office discussed
- Baby officially registered with GP once birth registration completed
- Child benefit advice, parents to apply online
- Check parents understanding of risk factors and ways to reduce incidence of cot death including advice on bed sharing and smoking.
- Check if an additional dose of Vit K is required (only if 1st dose given orally)
- Check if baby is eligible for BCG and whether this has been consented and given
- If mother is Hep B or Hep C Positive check baby has received first dose of Hep B vaccination, otherwise please arrange.
- Check if mother has been prescribed LMWH and if so is confident to self-administer and has been given a sharps bin.
- Discuss pelvic floor care, signs of concern and when to seek help
- Give sources of advice for contraception and resuming sexual intercourse
- Check mother's Rhesus status and Anti D given if Rhesus Negative
- Discuss visiting plan and arrange next visit
- Be alert to signs of domestic abuse or child abuse in line with Milton Keynes Safeguarding Policies.

# Appendix 3: Having Meaningful Conversations Signature Sheet

## Conversations in the postnatal period: Key points

Remember: explore what parents already know → accept → offer relevant information*

**After birth**

All mothers are offered support with
- Unhurried skin contact
- Recognising early feeding cues
- Offering the first feed in skin contact

| Signature: | Date: | Comments: |
|---|---|---|
| | | |

**Postnatal**

**All mothers** are offered support to
- Appreciate the importance of closeness and responsiveness for mother/baby wellbeing
- Hold their baby for feeding
- Understand responsive feeding

**Breastfeeding mothers** are offered support to
- Hand express
- Value exclusive breastfeeding
- Understand how to know their baby is getting enough milk
- Access help with feeding when at home

**Mothers who formula feed** are offered support to
- Sterilise equipment and make up feeds
- Feed their baby first milks
- Limit the number of people who feed their baby

| | Signature: | Date: | Comments: |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**Breastfeeding Assessments**

Breastfeeding assessments carried out using the breastfeeding assessment form (minimum of two in the first ten days) and an appriopriate plan of care made. This may include referral for additional/specialist support.

| | Signature: | Date: | Comments: |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

*refer to the health professionals' guide for more information

# Appendix 4: Best Practice Charter

## Guidance for Social Workers and Midwives when the plan is for a baby to be discharged to the care of the Local Authority

### Communication

Midwives are to notify Children's Social Care when the woman is admitted in labour and following the birth of the baby at the earliest possible time. This is to ensure the legal department can issue an application to the court on the day of birth and, in any event, no later than 24 hours after birth. All contact numbers will be provided on the Children's Social Care Maternity Plan.

### Confidentiality

In order to maintain confidentiality, the 'Midwife in Charge' should arrange for a private space prior to the Social Worker arriving. The Social Worker will keep the Midwife in Charge up to date on the expected time of arrival to facilitate this.

When visiting the hospital, Social Workers should request to speak to the 'Midwife in Charge' when using the intercom and will ensure that they do not announce any private information or the reason for the visit, where members of the public could hear. ID must be produced by the Social Worker on arrival.

### Observations on the Ward

The ward staff are not able to provide 1:1 supervision for parents with their babies however Children's Social Care may ask for feedback on the following:

- Worries about the relationship developing between parents and the baby
- Incidents of rough handling
- If any person identified on the maternity plan as being a "person to be excluded" attempts to visit
- Parents leaving for long or frequent periods of time
- *Parents using inappropriate language towards e.g. shouting, name calling etc*
- Are babies being fed/changed and comforted appropriately
- Parents suspected to be under the influence of drugs/alcohol
- Babies showing signs of withdrawal.

Children's Social Care are equally keen to hear positive observations such as responding timely to baby's needs, gentle handling and the development of a positive relationship, as well as worries. It is important that maternity staff endeavour to discuss their observations with the parents as well as informing Children's Social Care.

## Going to Court (Care Proceedings)

Social Workers do not have the powers to remove children without the agreement of either the Parents or a Judge.

Removing babies at birth is a last resort and parents would be aware of the plan ahead of the birth. Sometimes events happen which could lead to emergency removal of the baby though an Emergency Care Order, which is distressing but necessary to safeguard the baby.

Once the baby has been born, the Social Worker's statement will be submitted to the court by the Local Authority solicitor. The court will list a hearing, this may take several days. It is the responsibility of the Social Worker to notify the Midwife in Charge on the ward of the court date and the arrangements for the baby in the interim. A conversation with the parents will have taken place about who will care for the baby whilst a court date pending. If parents wish to attend court for the day and the baby is still in hospital, then someone will be identified by the Social Worker to stay with the baby.

If staff have any queries regarding the plans for the family, they can approach the Named Midwife for Safeguarding or the allocated Social Worker. If the Social Worker is unavailable, professionals can ring Family Support Duty on 01908 253818. The Duty Social Worker should be able to either help or forward on your queries to the Social Worker's Team Manager.

## When babies remain on the Ward without their mother or if supervision is required

If foster carers, social care support workers or family members are going to be caring for the baby, while they remain in hospital, Children's Social Care will inform the ward of the names of those who are attending the maternity unit and, what the expectations are of them when they are there. There may be situations where they are supervising a parent with a baby, or they may be responsible for meeting the baby's care needs. They will report directly to the Social Worker about their observations. This will be outlined in the Children's Social Care Maternity Plan.

## When a baby is ready for discharge

It is the responsibility of the Midwife providing care, to notify the Social Worker when baby is fit for discharge. The Social Worker will provide a time and the names of those who will attend and provide a copy of the Court Order. The Midwife is to ensure that all checks, paper work and medication are completed so as to not delay the discharge and help avoid adding to the stress of the family.

If there are any security concerns, then the Midwife providing care should liaise with hospital security and Social Worker and consideration can be given to using an alternative exit. When leaving, a midwife will escort baby to the door to facilitate a smooth exit from the ward.