Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

POSTNATAL CARE

Amendments			
Date	Page(s)	Comments	Approved by
Dec 2012		Full document review	Women's Health Guidelines Group
Jan 2013		'Information sheet' changed to 'postnatal welcome pack'	Women's Health Guidelines Group
May 2018		Complete Guideline refresh	Women's Health Guidelines Group
Nov 2021		Complete Guideline refresh	Women's Health Guidelines Group
March 2023		Whole guideline reviewed and postnatal analgesia guideline combined into this guideline.	Women's Health Guidelines Group

Compiled By: Katie Spiers – Community and Abbey Birth Centre Matron
Jan Thurgood - Inpatient Matron
Luisa Jbira – Community Team Leader
Liz Jennis – Infant Feeding Lead
Enrica Boscarato – Joan Booker Ward Manager

Ratified by: Women's Health Guidelines Group

Date Ratified:
Next Review Date:
Target Audience: Staff working in Maternity services

Impact Assessment Carried Women's Health Guidelines Group

Out By:

Comments on this document to: Women's Health Guidelines Group

See also:

- Maternal Transfer
- Birth reflections information leaflets
- Home Birth guideline
- Infant Feeding guideline
- Handover of care (on site)
- Immediate Care of the Newborn
- Training Needs Analysis (TNA)
- Obesity guideline
- ASPH Trust Interpreting Services guideline
- VTE guideline
- Mental Health guideline
- Screening Information leaflet
- Postnatal Care leaflet
- Postnatal Review by Doctors on Postnatal Ward (SOP)
- Neonatal Jaundice guideline
- Weighing Baby pathway
- Newborn Bloodspot Screening guideline
- Perinatal Mental Health guideline

Contents

Purpose of this guidance:

The National Institute for Health and Clinical Excellence (NICE) April 2021 has developed Guideline 194 Postnatal care. NICE guideline [NG194], which provide midwives and other health care providers with guidance to identify the essential core (routine care) that every woman/birthing person and her baby should receive in the first 6-8 weeks after birth. For most women and babies, the postnatal period is uncomplicated, but every woman/birthing person should be risk assessed to form the basis of an individualised plan of care. This guideline gives advice when additional care may be needed and indicates the degree of urgency when dealing with risks.

NICE public health guidance (Nov 2014 Guideline 11 Maternal and child nutrition supplements this guidance with recommendations for improving the nutrition of all pregnant (or planning to become pregnant) and breast feeding mothers and children. They are particularly relevant for mothers and babies from low-income families.

This local guidance is based on the above guidelines and details how they may be implemented by the midwifery services for Ashford and St Peter's Hospital (ASPH) Trust. This guideline also provides the minimum schedule for post natal visiting. All midwives and maternity support workers (MSWs) have access to the above guidelines via the intranet (remote access for the ASPH community teams).

Philosophy of postnatal care:

Care provided by Midwives, MSWs and Nursery Nurses (NNs) should be delivered in partnership with the women and should be individualised to meet the needs of the woman/birthing person and baby.

Women and their families should always be treated with kindness, respect and dignity. Good communication is essential and women should have the opportunity to make informed decisions about their care and any treatment needed.

The woman/birthing person's cultural practices should be taken into account and all information should be provided in a form that is accessible to them and their families, taking into consideration any additional needs such as disabilities or English not being their first language. Should a woman/birthing person require interpretation services, all hospital and community maternity staff have access Language Line interpreting services and patient information leaflets can be provided in various languages upon on request.

The midwife has overall responsibility for the care of all mothers and babies she has taken handover for during their shift. During a shift MSWs can be asked to perform maternal observations and provide feeding support, and where appropriately trained and achieved their competency can also undertake venepuncture. The midwife can delegate neonatal observations, SBR's, Newborn Blood Spot Screening and daily examinations of term well babies to Nursery Nurses.

Where MSWs or Nursery Nurses undertake tasks on behalf of the midwife, any concerns must be escalated to the named midwife immediately so that prompt action can be taken.

Ward Structure

Joan Booker ward is comprised of 38 beds shared between ante-natal and post-natal women. The ante-natal bay has 9 beds, leaving the remaining 29 beds for post-natal women and their babies. At times there will be more than 6 ante-natal women and they should be accommodated _In the location most appropriate at the time depending on the acuity and total number of ante-natal women and birthing people.
Ante-natal and post-natal women should not share the same bay where possible. If the unit is under pressure for beds and the bays need to be mixed then this should be discussed with the ward manager or in their absence the labour ward shift leader. If the number of ante-natal women reaches 12 or exceeds this can a second ante-natal bay should be created.

Ward Staffing

Joan Booker Ward, Ward Manager Monday – Friday 07:30-15:30

Day Shift. 07.30-20.00hrs

- 4 Midwives 3 Midwives +1 Registered Nurse (R/N)
- 2 Maternity support workers
- 1 Nursery nurse
- Discharge Coordinator

Staff on a long day are entitled to a 1 hour meal break, which will be allocated at the beginning of the shift by the midwife in charge. The expectation is that all staff will have completed their breaks by 15.30 hours. If by 14.00hrs meal breaks have not been started this must be escalated to the ward manager or to the bleep holder.

The Consultant of the week is available Monday-Friday. The Consultant of the week visits the ward daily to see all Ante-natal patients and will also see any Post-natal women requiring a Senior review after the Antenatal ward round.

Night Shift 19:30-08:00

- 4 Midwives/ 3 Midwives + 1 Registered Nurse
- 2 Maternity support workers
- 1 Nursery nurse

Staff on a night shift are entitled to a 1 hour meal break which will be allocated at the beginning of the shift by the midwife in charge. The expectation is that all staff will have completed their breaks by 04.00hrs. If by 02.00hrs staff breaks have not been started this must be escalated to the labour ward shift leader.

Ward Routine

- Breakfast is self-service from the front of the ward at 06.30 until 08.30; staffare to ensure that anyone unable to walk to the breakfast bar has breakfast taken to them.
- The maternity assistants will offer a bed change to each woman/birthing person daily at the beginning of the shift. To also include any linen required for the cots.
- Maternal observations should be carried out as per individual need
- **Safety Huddle to be held each day at 11.30**.
- This should be attended by all staff on the ward unless they are undertaking clinical care and unable to leave the woman/birthing person. No confidential information is to be shared as the safety huddle is held in a public space. The purpose of the safety huddle is for all staff to update the team on their workload and any barriers to them completing their work. This time can also be used to disseminate information to the staff surrounding patient safety initiatives.
- Lunchtime medicine round starts at 12.00pm.
- Lunch is served from 12.15pm onwards and is taken to the bedside. In the morninthe MSWs will take meal requests from all women on the ward.
- Early evening medicine round starts at 6pm.
- Supper is served at 5.15pm.
- Evening medicine round starts at 10pm.
- If a woman/birthing person misses a meal there are 'ready meals' available on the ward for staff to prepare. Staff should not re heat food. Please refer to the catering manual on the ward for further guidance.

Visiting Times

Partners and mothers own children only may visit from 10.00hrs until 22.00hrs.

All staff to be aware of families with particular needs, i.e. transfers from other hospitals, women whose baby is unwell in NICU, safeguarding, women and family members with special needs. They require a more flexible approach to visiting. Midwife in charge to ensure ward clerks are aware of any woman/birthing person with particular needs. This also includes updating all staff including the ward clerk if an individual is not allowed to visit. A photograph of that individual must be available for staff to refer to.

If a partner wishes to stay overnight and there are exceptional circumstances they may do so once this has been discussed and agreed with either the ward manager or MOC/SMOCprovided the woman/birthing person is in a side room.woman/birthing person. It should be explained to the partner that where they remain on the ward between 23.00hrs-07.00 as the door entry bell on the ward is very disruptive. They are to remain fully clothed at all time so that other women are not offended. Staff must keep a record of any visitor staying overnight for fire/security purposesAny mother who is under the age of 18 years unless there are safeguarding or clinical concerns should be offered a side room and a responsible adult allowed to stay if the mother wishes.

Transfer to Joan Booker Ward.

Mother and baby must have a bed and cot allocated on Cerner prior to transfer to the ward. Once transferred to the postnatal ward, the mother and baby will be allocated a named midwife/RN to be responsible for the coordination of her postnatal care/recovery. At each change of shift the woman/birthing person should be informed of who her allocated midwife/RN is for that shift.

woman/birthing person

Admission to Joan Booker Ward

- Bedside handover using SBAR format between the two midwives should be verified on BadgerNet to confirm.

- Midwife/ RN/Nursery Nurse to check baby labels with the midwife handing over care. When a baby is identified as only having only one labe, details should be checked and confirmed with the parents by a member of staff on JBW, a second label should then be completed, checked with the parents and applied to the ankle. Where a baby is found to have no labels on admission it is essential to identify the baby,. If the baby has just come to the ward and has never left the parents then it may be labelled by 2 midwives immediately, documented in the notes and a datix completed. All babies on the ward should then have their name labels checked and the MOC informed.

- Ensure the risk status (bobble hat) has been correctly identified. this also needs to be correctly identified on the board in the handover room. Document risk status (bobble hat) under management plan on Badgernet notes. Ensure the mother has a copy of the Infant feeding patient information leaflet, this will depend on the gestation of the baby and the mothers chosen method of feeding.

- Ensure mother has been orientated to the ward, i.e. Bathrooms, meal times and refreshments and that she has access to her call bell and fresh drinking water.

- Ensure woman/birthing person is aware of the Cot alarm an how to use the alarm. There is information available in each bay/bedspace.

- The Midwife receiving handover must note the time of the baby's last feed. Support with feeding should be offered to all mothers regardless of their chosen method of feeding. Feeding assessments must be completed as required on Badgernet.

Maternal well-being in the postnatal period:

- Following birth, a full set of observations must be recorded (temp, pulse, B/P and respirations) and documented on Badgernet
- The frequency of observations must be accurately entered onto Badgernet by the midwife and observations repeated as indicated by the MEOWS score. MSW's are not to alter the frequency of observations.
- woman/birthing personwoman/birthing personMeasure and document the first two urine voids, which should be of 200mls or greater. Midwives must check that this occurs within the first 6 hours following birth or following the removal of urinary catheter. This must be clearly recorded on Badgernet – see Bladder Care Guideline.
- All women to have a VTE assessment after delivery on Labour Ward and then 24 hours later on JBW, or if clinical conditions change.
- At each postnatal contact by a Midwife assess the woman/birthing person's health, including the following;
- Emotional changes – assessment for emotional attachment should be made at each postnatal contact
- Symptoms and signs of infection
- Pain
- Vaginal discharge and bleeding
- Bladder function
- Bowel function
- Nipple and breast discomfort and symptoms of inflammation including suppression of lactation where appropriate
- Symptoms and signs of Thromboembolism
- Symptoms and signs of anaemia
- Symptoms and signs pre-eclampsia

For women/birthing person who have had a vaginal birth

- Perineal healing

For women/birthing person who have had a caesarean birth

- Wound healing
- Any woman/birthing person who does not have access to the internet must be given a copy of their discharge summary.

- Women/birthing people should be advised of the signs and symptoms of potentially life-threatening conditions (see table 1 below) and how to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur. This is essential for women having an early discharge and should preferably take place with a relative present, giving information of what action to take and contact numbers to use. The woman/birthing person should also be made aware of the phone number for 'Call the Midwife' advice line to contact for urgent advice.

Staff must be alert to life threatening conditions and take prompt action see table 1

Should a women's condition cause clinical concern, escalation to a doctor via an SBAR handover.should be made without delay.

The SHO should review the women below and they should not be discharged by the midwife woman/birthing personuntil this has been completed and any TTO's prescribed.

- 3rd / 4th degree Tears
- Any Caesarean Section who has yet to be discharged to Midwife Led Care
- Postpartum haemorrhage >1000ml
- Women with chorioamnionitis who require de-escalation of antibiotics
- Any women the midwives have clinical concerns with (this should be escalated as per the usual pathways for unwell women/birthing people)
- Women/birthing people with pre-existing and Gestational Diabetes (requiring insulin)

Regular skills drills are carried out in all clinical areas – see Training Needs Analysis.

Table 1 - Postnatal risk assessment- signs and symptoms of potentially life-threatening conditions (NICE 2006)

Signs and symptoms	Condition
Sudden and profuse blood loss or persistent increased blood loss Faintness, dizziness or palpitations/tachycardia	Postpartum haemorrhage
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 Shortness of breath or chest pain	Thromboembolism
Excessive emotional changes / detachment from the baby	Depression/Psychotic disorder (any identified antenatal risks)

If a woman/birthing person requires any investigations or care that requires her to leave the baby on the ward then the partner or visitor should assume responsibility. If that is not possible then a member of staff should be designated to care for the baby. The mother's care should not be compromised. If there are difficulties in faciliatating this then this must be escalated to the SMOC/MOC immediately.

Post_Natal Analgesia

Women post birth have compelling reasons to achieve optimal pain relief, because they are expected to recover expeditiously and to care for their newborns. Consequently, it is necessary that pain relief is safe, effective and does not interfere with the mother's ability to care for her infant and that it results in no adverse neonatal effects in breast feeding women. The mainstay of post natal pain relief is Paracetamol +/- Non-Steroidal Anti-Inflammatory Drugs (NSAID's). All post natal pain relief should be prescribed before transfer to the post natal ward. Paracetamol should be considered the analgesic of choice. Where Paracetamol alone is ineffective use of NSAID's should be considered. Ibuprofen and Diclofenac produce low levels in breast milk and are the preferred NSAID'

Women who cannot have NSAID's must have alternative analgesia prescribed. It should be noted that the MHRA have advised that codeine is not appropriate in women who are breast feeding

Women who are unable to have NSAID's in the early post natal period eg haemorrhage; PET etc should have their analgesia reviewed once their clinical condition is stable (preferably before transfer to the post natal ward) and NSAID's prescribed then if they have no other contraindications

ANALGESIA AFTER VAGINAL BIRTH

Single 100mg Diclofenac suppository to be given after suturing

WOMEN WHO CAN HAVE NSAID'S (BREAST OR BOTTLE FEEDING)	WOMEN WHO ARE BREAST FEEDING WHO CANNOT HAVE NSAID'S	WOMEN WHO ARE NOT BREAST FEEDING AND CANNOT HAVE NSAID'S
• Paracetamol 1g 6 hrly PRN (TTO own supply) • Ibuprofen 400mg 6 hrly PRN Start from 6 hours if diclofenac suppository has been administered (TTO own supply)	• Paracetamol 1g 6 hrly PRN (TTO own supply) • Tramadol 50mg 6 hrly PRN (TTO for 3 days only via pharmacy)	• Paracetamol 1g 6 hrly PRN (TTO own supply) • Codeine Phosphate 60mg 6 hrly PRN (TTO for 5 days, prescription must indicate that the women is not breast feeding via pharmacy)

ANALGESIA FOLLOWING CAESARIAN SECTION

Single 100mg Diclofenac suppository to be given after caesarean section

WOMEN WHO CAN HAVE NSAID'S (BREAST OR BOTTLE FEEDING)	WOMEN WHO ARE BREAST FEEDING WHO CANNOT HAVE NSAID'S	WOMEN WHO ARE NOT BREAST FEEDING AND CANNOT HAVE NSAID'S
• Paracetamol 1g 6 hrly PRN (TTO own supply) • Ibuprofen 400mg 6 hrly PRN Start from 6 hours if diclofenac suppository has been administered (TTO own supply) • Oramorph 20 – 30mg 2 hrly PRN (not for TTO's)	• Paracetamol 1g 6 hrly PRN (TTO own supply) • Tramadol 50mg 6 hrly PRN (TTO for 3 days only via pharmacy) • Oramorph 20 – 30mg 2 hrly PRN (not for TTO's)	• Paracetamol 1g 6 hrly PRN (TTO own supply) • Codeine Phosphate 60mg 6 hrly PRN (TTO for 5 days, prescription must indicate that the women is not breast feeding via pharmacy) • Oramorph 20 – 30mg 2 hrly PRN (not for TTO's)

The anaesthetic team will review the analgesia of all post caesarean section women the day after delivery and will increase the dose of Tramadol if needed. Ned to check this is correct.

If higher doses of Tramadol are needed the dose should be reduced 24 – 36 hours after the increase to assess whether the woman is fit for discharge on low dose of Tramadol. Tramadol TTO's will only be for 50mg QDS for 3 days.

Writing a TTO for Tramadol.

Tramadol is now a SCHEDULE 3 controlled drug The strength, form, dose and total quantity in words and figures must be stated. Eg: Tramadol 50mg capsules. 50mg po QDS PRN. Please supply **twelve (12) capsules.**

If a woman is discharged on Tramadol and is breast feeding please document this in the mothers notes, baby's care plan and inform community midwives by documenting this in the comments box on the Post Natal Discharge Form. Tramadol for a brief period is not associated with significant side effects in babies or mothers, however midwives need to advise mothers to observe baby for signs of drowsiness and how to raise concerns.

Community Midwives should be aware that if the mother has used all her TTO's and still requires prescription analgesia she will need to be reviewed by the GP. (Women who are breast feeding should also have the baby reviewed by the GP).

Safeguarding

If there has been an identified risk of domestic abuse or mental health issues, including substance abuse, staff must be aware that this can continue into the postnatal period. Staff need to be aware and escalate concerns to the Named Midwife for Safeguarding Children

Vulnerable Women/birthing people. They must ensure that the child protection plans are followed, and issues must be clearly documented on BadgerNet, which includes any agreed management plans. (See Maternity Safeguarding Children Guideline). The Midwife responsible for the mother/birthing person must ensure the management plan is followed.

If mother or birthing person who requires targeted post-natal care this must be annotated on the 'Transfer to community care' information and discussed with the mother/birthing person

Safeguarding is the responsibility of all staff. The Safeguarding file on the ward contains the minutes of the monthly safeguarding meeting and any alerts. Liaise with the safeguarding team during normal working hours. It is the responsibility of **all staff** to familiarise themselves with the safeguarding process and to attend mandatory training.

Physiotherapy referral

Any woman/birthing person/birthing person who has sustained a 3rd or 4th degree tear should be referred to the women's health physiotherapist via Badgernet. This must be done as soon after delivery as possible to ensure the woman/birthing person is seen in a timely fashion. If the woman/birthing person wants to go home prior to being seen by the physiotherapist the discharging midwife must ensure that the referral has been made as the woman/birthing person will be seen as an outpatient.

Urogynae referral

Please follow the Bladder care guideline.

Baby wellbeing

AT NO TIME SHOULD ANY BABY BE LEFT UNATTENDED ANYWHERE AWAY FROM THE MOTHER'S/BIRTHING PERSON'S BEDSPACE.

If a mother need to leave the ward for any reason then her partner/visitor should assume responsibility.

- At each postnatal contact the baby will be assessed and if any problems are identified this must be escalated to the relevant Healthcare professional. This should include a discussion on neonatal jaundice.

Healthy babies should have

- Normal colour for their ethnicity
- Be able to maintain a stable body temperature
- Pass urine and stools at regular intervals
- Feed responsively, either via breast or bottle and be settled post feed and not be excessively irritable, tense or floppy

Where observations are being recorded on a newborn infant, these must be completed and recorded on a NEWTT chart with any deviations from the expected norms escalated as appropriate.

Normal neonatal vital signs fall within the following ranges:

- Respiratory rate normally 30-60 breaths per minute.
- Heart rate normally between 110-160 beats per minute in the newborn.
- Temperature in a normal room environment of around 37degrees centigrade.

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- Respiratory rate normally 30-60 breaths per minute.
- Heart rate normally between 110-160 beats per minute in the newborn.
- Temperature in a normal room environment of around 37degrees centigrade.

- On a daily basis the labels must be checked by either the midwife or the nursery nurse completing the neonatal check. The labels should be securely attached to each ankle. If the baby has one label only then a second label must be completed, checked with the parents and attached to the other ankle.
- In the event of the baby having no labels then ALL babies on the ward must have their labels checked to confirm they are with the correct mother before the baby with the missing identity labels is re-labelled. The midwife or nursery nurse who identifies the risk is responsible for completing a Datix in line with Trust protocol.
- Following birth the baby should have a full physical examination (NIPE) by either a neonatal/paediatric doctor or a midwife qualified to do Examination of the Newborn, within 6 hours to 72 hours of birth. Parents should be present and a copy of the completed NIPE check to be placed in the child health record (Red Book).
- All babies that require BCG must be identified on a daily basis, and referred for a BCG appointment by the midwife or doctor completing the NIPE examination.

- All parents must be given a feeding leaflet with details of safe feeding, signs of effective feeding and how to seek help in the community prior to discharge home.
- Staff must observe and document at least one effective feed before discharge and all birth parents should be shown how to hand express.
- A daily feeding assessment must be completed while the birth parent and baby remain on the postnatal ward and appropriate feeding support offered if the feeding assessment highlights any red flags for poor feeding.
- Ensure parents have access to the information on newborn screening.
- Promote emotional support to encourage attachment for both mother and father. Encourage social networks and introduce the resources within the local children centres.
- Provide information, both verbal and written, on recommendations regarding the reduction of sudden infant death syndrome and safer sleep. The Lullaby Trust is signposted in the feeding leaflets
- All families are given the opportunity to attend a discharge talk. Daily teaching on feeding, nurturing and safer sleep will be provided by the Discharge Co-ordinator or the Infant Feeding Team. Any parent who chooses to formula feed must be given information/demonstration on preparing feeds and sterilizing feeding equipment. In any safeguarding case a demonstration feed must be offered.

Well Baby Clinic

This clinic is supported by the Midwives and Nursery nurses. This is not a self- referral clinic and appointments need to be booked by the CMW or MSW. The clinic is held every afternoon. The Infant Feeding Team run drop in community feeding clinics 4 days a week. Up to date details can be found on the ASPH maternity webpage and in the feeding leaflets. Booking is not necessary and parents are recommended to attend for ongoing feeding and peer support.

Antenatal and postnatal feeding education classes are held weekly. A rotation of 3 birth preparation classes also include postnatal skills including bathing and nappy changing. Details are all found on the ASPH maternity webpage.

If a tongue tie is suspected, staff must provide adequate feeding support to maximise and protect breastfeeding. Referrals are made electronically via the Badgernet system and the Infant Feeding Team will contact the parents to arrange an appointment time and feeding follow up.

Transitional Care

- Babies who born between 34+0 weeks- 35+6 weeks plus those requiring extra support, i.e. NGT feeding will be cared for in transitional care. The nurse in transitional care will be responsible for the care of the baby, but the care of the mother remains with the midwife.

- It is the responsibility of the discharging midwife to ensure that the mother understands the process and has adequate medication whilst she remains on the ward. Once discharged Cerner must updated to reflect this. It should be documented that the mother/birthing person is 'lodging' on the ward with the baby.

Discharge from Post Natal Ward

- Midwife to confirm the correct discharge address telephone number is recorded on Cerner and BadgerNet.

- Inform the woman/birthing person that she will be visited at home the following day anytime up until 6pm.

- The midwife will ensure the woman/birthing person is given discharge advice and ensure she knows how to access her notes electronically. Any woman/birthing person who does not have access to the internet must be given a copy of their discharge summary and a discharge pack.

- Discharging midwife to check that the NIPE examination, hearing screening and BCG (if eligible) have been offered and appropriately recorded on BadgerNet. If it is identified that any part of this has not been completed, the midwife must see that there are alternative follow up arrangements made for these to be done. This needs to be handed over to the community midwives assuming care for the mother and baby.

- **If a baby is discharged home (including those out of area babies) before a NIPE examination has been completed, a set of pre and post ductal sats must be completed and documented on BadgerNet.** The parents should be asked to return the following morning after 10:00 and details left for the MEON midwife in their communication diary.

- Ensure all women/birthing people have the contact number for the 'Call the Midwife Line'

- Ensure VTE risk assessment is completed on Badgernet

- Complete transfer of care to POSTNATAL COMMUNITY for mother and baby.
- Save clinical reports and tick box for asp-tr.postnataldischarges@nhs.net
- Women being discharged out of area add the email address to "Additional Recipient" field, click on authorise and authorise with user login details.
- Save and close; if sent correctly you will get a message saying "email with report has been sent"
- Women should ideally not go home without TTO's if they are required. Where unavoidable, it is the responsibility of the discharging midwife to ensure that the TTO's have been ordered from pharmacy and that the women/birthing person, or partner, are aware to call the ward prior to collecting outstanding medication. This must be clearly documented on BadgerNet.

- Discharge mother and baby from BadgerNet and Cerner in realtime.

Feedback

Encourage women and their families to complete “Viewpoint real time feedback form. The data is collected every month and published on the Trust website

Complaints

In the event of a woman/birthing person or her family expressing concerns regarding her care, the midwife should discuss the concerns with the family and document the conversation. If the midwife is unable to do this, it should be escalated to the Ward Manager, maternity bleep holder, or another midwifery manager/team leader. If this does not resolve the problem or the woman/birthing person and or family wish to pursue the complaint then direct them to PALS. This information can be found on the trust website. Printed information should also be available on the ward.

Community

Arrangements for postnatal visiting should be discussed during the antenatal period and should be consistent with the recommendations of the Department of Health ***Maternity Matters*** (April 2007). These specify choice of place for postnatal care within the home or any other community setting including Children’s Centres.

- The first community postnatal visit will usually be the day following discharge from the postnatal ward but this may vary, depending upon the needs of the woman/birthing person and her baby and will be decided upon by the midwife discharging from hospital.

- Discharges from other hospitals must be downloaded on a daily basis from the trust email.
  asp-tr.postnataldischarges@nhs.net

- On receipt of the discharge summary from outside areas, the relevant geographical midwifery team will be notified and the discharge summary will be placed on the outlook calendar of the community team assuming care

- Postnatal care plans will be documented on BadgerNet. All postnatal visits will be documented on the outlook calendar including when the mother and baby are next to be visited.

Minimum schedule for community post natal visits

Primiparous	Multiparous
CMW to visit the woman/birthing person and baby at home on the first day following discharge	Telephone call in the morning following discharge to agree with woman/birthing person location and timing of first community visit

Day 3 phone call or visit/PNC including weight, depending on baby bobble hat guideline	Day 3 phone call or visit/PNC including weight, depending on baby bobble hat guideline
Day 5 for blood spot and to weigh baby/assess maternal and baby wellbeing either at home or in a postnatal clinic	Day 5 for blood spot and to weigh baby/assess maternal and baby wellbeing either at home or in a postnatal clinic
Day 10-12 in post-natal clinic to weigh baby/ assess maternal well-being and discharge to HV	Day 10-12 or in postnatal clinic to weigh baby/assess maternal and baby wellbeing and discharge to health visitor (HV)

Special Considerations

The above schedule is the minimum number of postnatal contacts by the community maternity services. It may be necessary for further visits (e.g. post caesarean section or hypertension - see guidelines) and the reasons for those visits will be documented in the postnatal care plans. Vulnerable women/ safeguarding concerns or plans will require further visits and these will be stipulated in the Postnatal Management Plan on badgernet.

Criteria for enhanced postnatal care

An individualised postnatal care plan should be developed and documented with the woman/birthing person ideally in the antenatal period, and then reviewed after the birth. Where relevant, enhanced visits should have been discussed with the woman/birthing person antenatally, and a plan clearly documented on Badgernet. It is not appropriate for this to be left to the hospital midwife discharging the woman/birthing person to assess the need for enhanced visits, unless concerns arise during her stay. Enhanced visits are for women who have complex social situations or emotional needs:

Safeguarding Children/Social services involvement
Teenage pregnancy - under 19
Mental health – depression, anxiety, previous PND, any serious mental health condition
Substance Misuse
Domestic Abuse (visit in pairs)
Disability
English not first language – requires interpreter
Vulnerable
Obstetric – traumatic birth

This should be reviewed at each postnatal contact.
Enhanced visits are for up to 28 days postnatal.

Minimum Care required at post-natal visits

At the first postnatal visit following discharge the CMW will do a thorough assessment and plan for post-natal care.

The midwife will ensure that the mother has;

- Child health record (red book).

- Portal access, to be able to access her maternity records and any relevant information leaflets on Badgernotes.
- Information on newborn blood spot screening. The newborn blood spot test will offered when the baby is 5 days old. See Newborn Bloodspot Screening guideline.
- Safe sleeping advice.
- Information on how to register the baby's birth
- Access to all relevant telephone numbers and contact details for healthcare professionals and emergency services including breastfeeding support services and postnatal support groups.
- Information about perineal/wound hygiene and signs of infection, haemorrhage and bladder care.
- Information on promoting health, recognising common health problems and managing fatigue, diet and exercise should be given to the woman/birthing person and her family.
- Information to be able to assess their baby's general condition, identify signs and symptoms of common health problems, and how to contact a healthcare professional or emergency service if required.
- Information on coping with a crying baby, such as comfort methods, that it is ok to walk away if the baby is safe, and never to shake or hurt a baby.
- Documentation in Red Book of baby's hearing screening and NIPE check.

Physical Examination of Mother and Baby

Undertaking maternal and newborn physical examinations enables the midwife to recognise any abnormalities and act appropriately.

The CMW should ask the woman/birthing person about whether she is experiencing any physical health problems associated with the postnatal period. Where a possible problem is identified a clinical assessment should be carried out and a plan of care agreed and documented. It may be necessary to take maternal blood pressure, pulse, temperature, and respirations.

The health professional should discuss the baby's health and document their assessment within the care plan. Babies should be stripped naked at each visit to observe for any rashes, marks, or bruising.

It is important to assess baby's feeding at every contact to pick up on any concerns and provide support.Whenrequired,afeedingplanshould be agreed with the woman/birthing person and clearly documented so that other visiting Community Midwives can follow the plan and early referrals made, as appropriate, to the Infant Feeding Team. The infant feeding assessment should be completed on two occasions before day 7, usually the first visit and day 5. Any mother who chooses to use formula feed will have a discussion on preparing feeds and sterilizing feeding equipment at home.

All babies should be checked for signs of jaundice at each contact – See Neonatal Jaundice guideline. All women should also be given information regarding jaundice and should be encouraged to contact the midwife if the baby becomes jaundiced or if the condition worsens.

Emotional Well-being

Women should be asked about their emotional well-being at each visit, taking into account what family and social support they have, and their usual coping strategies for dealing with day to day matters.
Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman/birthing person's normal pattern. Women should also be offered information and reassurance on the physiological process of recovery after birth with regards to emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth.
If there are concerns about a woman/birthing person's mental health in the postnatal period, the community midwife can refer to the Perinatal Mental Health Midwife and/or the woman/birthing person's GP – see Perinatal Mental Health guideline.

Weighing babies within the midwifery postnatal period

- See Weighing Babies Pathway
- Healthy babies normally lose weight in the first week of life due to normal physiological adaptation to extra-uterine life. This weight loss is usually transient and of no significance but may be exaggerated if there is difficulty in establishing feeding or if the baby is ill.
- Only approved digital scales that have been well maintained and have been calibrated annually should be used. All scales should be placed on a hard surface and the baby should be weighed naked.
- Any baby with a weight loss over 12.5% must be referred into hospital via the JBW team immediately. Regardless of weight loss any baby considered to be unwell should go directly to A&E.
- A baby should not be transferred to the care of the HV until acceptable weight gain and feeding has become established (although the baby does not have to be above its birth weight).
- Refer babies with static or faltering growth beyond 10 days to the Infant Feeding Team asp-tr.infant-feeding@nhs.net

Transfer/discharge of care to the Health Visitor

- Most women will receive postnatal care within the community for 10 -12 days following the birth of their baby. At this stage, care would normally be transferred to the HV.
- The baby's cord does not need to be off on discharge, as it may take longer than 10 days to separate. Advise the woman/birthing person to contact the advice line if there are any concerns after discharge.
- Women having on-going care to 28 days should also be handed over to the named HV at 10-12 days for information, and a further updated plan of care before discharge.
- Upon discharge from the midwife, a mother and baby Transfer of Care to Health Visitor should be completed on Badgernet, and the reports saved – these reports are then automatically sent to the GP and HV.
- In cases where there are safeguarding concerns, the midwife should liaise regularly and at discharge with the named Health Visitor directly, either by phone, face to face, or email.

Birth Reflections

This information is included in the postnatal information leaflet on BadgerNet

Parent(s) should be informed that baby's illnesses can become serious very quickly. Therefore they should ask for help sooner rather than later. The following symptom checklist can help parent(s) decide whether they need to seek medical attention for their baby by contacting the midwife or doctor.

If the baby has any of the following, call Pregnancy Advice Line

High pitched or weak cry	Takes less than a third of feeds	Passes much less urine
Much less responsive or floppy	Vomits green fluid	Has blood in stools
Pale all over	High fever or sweating	Jaundice within 24hrs of life
Grunts with each breath	Diarrhoea (urgent)	

If the baby has any of the following urgent symptoms, call 999:

Stops breathing or goes blue	Cannot be woken
Is unresponsive and shows no awareness of what it going on	Has a fit
Has glazed eyes and does not focus on anything	

A referral to Birth Reflections can be made on badgernet via the ‘wellbeing referral’, or if the woman/birthing person wishes to contact them herself, she can call 01932 722879.

REFERENCES

- Bladder care Guideline
- Baby feeding Guideline
- **NMC** 2015 *The Code* NMC London
- **NMC** 2009 Record Keeping: Guidance for nurses and midwives Nursing and Midwifery Council London
- **NICE** 2021 Postnatal care (**NG194**)

Monitoring

Compliance with this guideline will be monitored as detailed in the table below. Where monitoring has identified deficiencies, recommendations and an action plan will be developed.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
a. process for developing an <u>individualised postnatal care plan</u> b. process for giving information to enable parent(s) to assess their new-born's general condition and identify any signs and symptoms of common health problems to enable parent(s) to respond to problems c. process for ensuring that parent(s) have contact details for the relevant healthcare professionals regardless of the place of birth d. process for ensuring that there is a coordinating	Joan Booker matron	1% Health Records audit of Women who have delivered	Annually	Women's Health Governance Group	Joan Booker Ward manager Community Team leaders.	Communication bulletin, staff meetings, quality and safety half days, quality and Safety Whiteboard, the newsletter- Sharing Lessons Learnt from PMRT.

healthcare professional for women with multiagency or multidisciplinary needs e. system for postnatal visiting once the woman/birthing person has been discharged from the hospital/midwifery led unit f. documentation in the health records of all of the above						

ASPH - Equality Impact Assessment Tool

Name: Postnatal Care

Policy/Service: Maternity services

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
To ensure that women receive appropriate individualised care that is developed in partnership with the mother. The policy provides guidance for staff caring for mothers in the postnatal setting to ensure that care is provided in an equitable way
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
This guideline was developed to ensure that women are treated with dignity, respect and kindness. Sources include NICE guidance, cross reference to other local policies and guidelines and current practice and documentation.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Appears fair to all
Conclusion • Provide a summary of the overall conclusions
No impact identified
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
None-Reconsider at next review

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.