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	6	'Information sheet' changed to 'postnatal welcome pack'	Women's Health Guidelines Group
May 2018		Complete Guideline refresh	Women's Health Guidelines Group

Compiled By: **Jan Thurgood, Jo Wilding, Alison Howker**

Ratified by: **Women's Health Guidelines Group**

Date Ratified: December 2012
Next Review Date: May 2021
Target Audience: Staff working in Maternity services

Impact Assessment Carried Out By: Women's Health Guidelines Group

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

Purpose of this guidance:

The National Institute for Health and Clinical Excellence (NICE) July 2006, has developed **Guideline 37 Routine postnatal care of women and their babies** which provide midwives and other health care providers with guidance to identify the essential core (routine care) that every woman 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 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 care assistants (MCAs) have access to the above guidelines via the intranet (remote access for the ASPH community teams).

Philosophy of postnatal care:

Care provided by Midwives and MCAs (Maternity care Assistants) and Nursery Nurses should be delivered in partnership with the women and should be individualised to meet the needs of the woman 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'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 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 MCAs 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 MCAs 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 6 beds, leaving the remaining 32 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 side rooms.

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.

Staffing

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

Day Shift. 07.30-20.00hrs

- 4 Midwives
- 2 Maternity assistants
- 1 Nursery Nurse
- Infant feeding team; 1Midwife and 1 Maternity assistant, hours will vary.

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.

Night Shift 19:30-08:00

- 4 Midwives
- 2 Maternity assistants.

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, the staff are 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 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 as per VitalPAC.
- **Safety Huddle to be held each day at 12.00**, this should be attended by all staff on the ward unless they are undertaking clinical care and unable to leave the woman. 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 12.30pm.
- Lunch is served from 12.15pm onwards and is taken to the bedside. In the morning the maternity assistants/ ward clerk 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 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 mother's own children may visit from 08.00hrs until 22.00hrs.
All other visitors may visit from 13.00hrs until 22.00hrs.
3 visitors at the bedside.
No children under the age of 16 unless they are the mother's own children.

All staff to be aware of families with particular needs, ie 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 with particular needs.

If a partner wishes to stay overnight they may do so provided the woman is in a side room. Where possible the woman should be moved to a side room to facilitate this. It should be explained to the partner that where possible they remain on the ward and 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 purposes.
Any 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 she wishes.

On transfer to the postnatal ward, the mother will be allocated a named midwife to be responsible for the coordination of her postnatal care/recovery. At each change of shift the woman should be informed of who her allocated midwife is for that shift.

This information is also written on the white board outside the midwives' office on Joan Booker ward. The named midwife allocated on booking remains the same on discharge back to the community unless women are out of area for postnatal care.

Good record keeping is an integral part of high quality care (NMC 2008) and it is important that there are effective systems of communication between women and their care giver. All discussions that take place throughout the woman's maternity care pathway must be documented in the relevant sections of Badgernet maternity records.

Admission to Joan Booker Ward.

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

- Midwife/ Nursery Nurse to check baby labels with the midwife handing over care. When a baby is identified as only having only one label details should be checked and confirmed with the parents, 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.

- A member of the infant feeding team to be present at all handovers where possible to ensure the risk status (bobble hat) has been correctly identified. Hat or sticker denoting risk to be placed in the cot and correctly identified on the board in the handover room.

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

- Ensure the mothers medication chart and the baby's feed chart are on a clip board at the end of the bed.

- Receiving midwife to note the time of baby's last feed and to ensure mother understands the importance of completing the baby's feed chart.

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 **AND** VitalPAC

- The frequency of observations must be accurately entered onto VitalPAC by the midwife and observations repeated as indicated by the MEOWS score. MCA's are not to alter the frequency of observations.

- Women 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 should also be made aware of the phone number for Surrey Heartlands Pregnancy Advice Line (ShPA) to contact for urgent advice.

- Any woman who does not have access to the internet must be given a copy of their discharge summary and a discharge pack.

- Measure 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 should receive individualised care because of the increased risk of thromboembolism. All women to have a VTE assessment after delivery on Labour Ward and then 24 hours later on JBW, or if clinical conditions change.
- The midwife will explain the normal physiological process following birth and signs of possible complications including:

  Advise on perineal hygiene.

  Vaginal loss

  Involution of the uterus

  Genital tract sepsis

  Thromboembolism

  Rest and tiredness

  Diet and fluid intake

  Bladder and bowel function (ask about constipation within 2 days of giving birth).

  Breast care, including suppression of lactation

  Emotional changes – assessment for emotional attachment should be made at each postnatal contact.

  Safe sleep assessment

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 or anaesthetist should be made without delay. There is a consultant of the week available from Mon-Friday until 5pm who should be contacted for urgent review should another doctor not be immediately available.

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)

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. 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 postnatal discharge for any women with safeguarding concerns must be documented on an 'Orange' Targeted postnatal discharge form. Unless otherwise stated, babies who are on a safeguarding plan should be cared for in Bay 3 bed 6. These mothers and babies will require demonstrations regarding baby care, to include bathing and feeding, which should be on a one-to-one basis and clearly recorded on BadgerNet.

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 who has sustained a 3rd or 4th degree tear should be referred to the women's health physiotherapist via fax. This must be done as soon after delivery as possible to ensure the woman is seen in a timely fashion. If the woman 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 will be seen as an outpatient.

Urogynae / Postnatal Bladder Care

Women who have failed to void >200mls urine on two separate occasions, either after TWOC or birth must follow the Bladder Care pathway, which is displayed clearly in each of the bays on Joan Booker Ward.

Only women with a residual of >1000mls require referral to the Urogynae team.

Birth Reflections

Women should be routinely offered the opportunity to discuss any aspects of their pregnancy, birth or postnatal experience prior to discharge. This discussion must be clearly documented on BadgerNet. Where appropriate, she may be referred to the Birth Reflections Service.

Baby wellbeing:

- 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 paediatrician 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 the administration of the BCG vaccine will be carried out by the midwife completing the NIPE examination.

- Provide support and information on infant feeding as per unit guidance.
- 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. A member of the feeding team will provide this information during their daily teaching each morning.
- All families are given the opportunity to attend group discharge talks/parent education sessions on the post-natal ward. A member of the Infant feeding team will provide daily teaching each morning on all aspects of feeding. Any mother 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.
- Baby care and bathing/cord care/ nappy changing to be demonstrated in the nursery or feeding hub when requested.
- 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.

Well baby Clinic

This clinic is run by the infant feeding team and is supported by the Midwives and Nursery nurses. This is not a self- referral clinic and appointments need to be booked via the infant feeding team by the CMW or MSW. The clinic is held every afternoon Monday to Friday from 12.00-15.00 in the feeding Hub on Joan Booker ward. The infant feeding Midwives also hold a Frenulotomy clinic every Monday and Friday afternoon and referral for an evaluation of tongue tie should be made via the infant feeding team via email using the Community and Specialist Clinic Referral form. The team will contact the mother with an appointment.

asp-tr.infantfeeding@nhs.net

Transitional Care.

- Babies who require extra support, ie 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.

- If the mother is fit for discharge home but needs to remain in hospital with her baby she can be discharged to the care of the community midwives in the normal way.

- If the mother is out of area, or under the care of the Ashford Hub, then the midwives on the ward will provide her post-natal care.

- 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 and patient centre updated to reflect this the midwife must ensure that on VitalPAC her status is changed to 'no monitoring'.

Discharge from Post Natal Ward

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

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

- The midwife will ensure the woman is given discharge advice and ensure she knows how to access her notes electronically. Any woman 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 have the contact number for ShPA.

- Daily visit sheets to be completed and left in the discharge tray for the community midwives.

- Women being discharged out of area

    - Midwife or ward clerk to email discharge summary to hospital responsible for postnatal care

    - Midwife to ensure that the woman has a copy of her discharge summary and telephone number of the hospital responsible for postnatal care prior to going home.

- 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, or her partner, are aware to call the ward prior to collecting outstanding medication. This must be clearly document on BadgerNet.

  Discharge mother and baby from BadgerNet and patient centre.

Feedback

Encourage women and their families to complete a 'Friends and Family' feedback form, this can either be done via the mother's BadgerNet portal or by completing a paper copy on the ward. The data is collected every month and published on the Trust website.

Complaints

In the event of a woman 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 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 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 filed in the daily work folder.

- A member of the team will be allocated to follow up both mother/ baby's postnatal visits and this will be recorded on the postnatal visit sheet.
- Postnatal care plans will be documented on BadgerNet. All postnatal visits will be documented on the visit sheet.

Minimum schedule for community post natal visits

Primiparous	Multiparous
CMW to visit the woman and baby at home on the first day following discharge	Telephone call in the morning following discharge to agree with woman location and timing of first community visit
Day 5 or 6 for blood spot and to weigh baby/assess maternal and baby wellbeing either at home or in a postnatal clinic	Day 5 or 6 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)
postnatal clinic to assess infant wellbeing infant feeding as required	

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 'Orange' Targeted Postnatal Discharge Plan.

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)
- Information on newborn blood spot screening
- Access to all relevant telephone numbers and contact details for healthcare professionals and emergency services including breastfeeding support services and postnatal support groups.
- Highlight information about perineal hygiene and signs of infection, haemorrhage and bladder care
- At each postnatal visit, the midwife should discuss with the woman her physical and emotional well-being, what family and social support she has and her usual coping strategies for dealing with day to day matters. The woman and her family should be encouraged to inform the CMW or MSW about any mood changes and behaviours that fall outside of the woman's normal pattern.
- The CMW should ask the woman about whether or not 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. Information on promoting health, recognising common health problems and managing fatigue, diet and exercise should be given to the woman and her family.
- The health professional should discuss the baby's health, any jaundice, feeding pattern and document any support needed within the care plan. A breastfeeding assessment will be completed for all breastfeeding women on or around day 5
- Any mother who chooses to use formula feed will have a discussion on preparing feeds and sterilizing feeding equipment at home.
- 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. The newborn blood spot test will offered when the baby is 5-8 days old.

Weighing babies within the midwifery postnatal period

- 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. Therefore, all babies are weighed (naked) at birth and, as a minimum, should be weighed (naked) at 5 days and 10 days old.

- 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.
- Any baby who has lost 10% of its birth weight should be fully assessed and a plan of care made and documented within the care plan *(Maternal and child nutrition NICE public health guidance 2008).* Referral to an infant feeding advisor or paediatrician should be considered.
- Any baby with a weight loss over 12.5% must be referred into hospital via the infant feeding 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).

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.
- Women having on-going care to 28 days should also be handed over to the named HV at this time for information, and a further updated plan of care before discharge.

Process for giving information to enable parent(s) to respond to problems in the community:
This information is included in the postnatal information 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 G.P. or midwife:

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	

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REFERENCES

- **NMC** 2015 *The Code* NMC London
- **NMC** 2009 Record Keeping: Guidance for nurses and midwives Nursing and Midwifery Council London
- **NICE** 2015 Post-natal care up to 8 weeks after birth

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 individualised postnatal care plan b. process for giving information to enable parent(s) to assess their newborn'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 healthcare professional for women with multiagency or multidisciplinary needs	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. The newsletter.

e. system for postnatal visiting once the woman 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.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Postnatal care
Name of Person completing form:	Theresa Spink
Date:	December 2012

Author(s) *(Principle contact)*	Theresa Spink
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Theresa Spink
Date of final draft	December 2012
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*
Women's Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants
Who is the policy/guideline primarily for? All staff delivering postnatal care
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters, educational half day, training sessions
Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*
See *monitoring section of policy*
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment?*(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*
All obstetric Consultants, Women's Health Guidelines Group, Labour Ward Forum, Paediatricians
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes