The Dudley Group NHS Foundation Trust

Date: 23/05/2018

FREEDOM OF INFORMATION REQUEST FOI/014163 – Policy for postpartum women

I was wondering if you would be able to email me your current hospital policy on the routine management of postpartum women at your hospitals please?

Please see below

POSTNATAL CARE ON THE MATERNITY UNIT GUIDELINE			
	DOCUMENT TITLE:	**POSTNATAL CARE ON THE MATERNITY UNIT GUIDELINE**	
	Name of Originator/Author /Designation & Speciality:	Liz Punter – Matron	
	Local / Trust wide	Local	
	Statement of Intent:	*To ensure that all staff are aware of their roles and responsibilities for the maternal and infant care in the postnatal period whilst in hospital*	
	Target Audience:	Midwifery, Obstetrics and Neonatal	
	Version:	6.0	
	Name of Review and Approval Group and Date when Recommended for Ratification	*Policy group*	*Date* *March 17*
	Name of Division/Group and Date of Final Ratification:	GAME	*Date* *14/06/2017*
	Review Date:	December 2019	
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	The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
4	Sept 2012	*Adapted against CNST Standards*
5	April 2013	Adapted 8.4 and 8.5 in line with assessors recommendation. Risk and Assurance Committee
6	June 2017	Reviewed and Adapted Accordingly

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

POSTNATAL CARE ON THE MATERNITY UNIT GUIDELINE

1. INTRODUCTION

The purpose of postnatal care is to provide professional support to the woman and her family during the postnatal period. Postnatal period means the period after the end of labour during which the attendance of a midwife upon a woman and baby is required, being not less than 10 days and for such longer period as the midwife considers necessary (NMC 2013).

Ideally a documented and individualised postnatal care plan should be commenced in the antenatal period or as soon as possible after birth (NICE 2006).

2. PURPOSE OF THE GUIDELINE

To ensure that all staff are aware of their roles and responsibilities for the maternal and infant care in the postnatal period whilst in hospital.

- To give guidance on the process for developing an individualised postnatal care plan for both woman and baby.
- Process for ensuring that there is a coordinating healthcare professional for women with multiagency or multidisciplinary needs.
- To define the procedure for providing postnatal care.
- To define the process for offering every woman an opportunity to talk about her birth experiences.
- To outline the requirement to document all discussions with the woman.
- To define the care of women who have had instrumental or operative deliveries.
- To guide on the transfer from the maternity unit in the postnatal period.

To enable smooth transition of care in the postnatal period between healthcare professionals to promote partnership working and to clarify responsibilities of staff.

3. ROLES AND RESPONSIBILITIES

The co-ordinating healthcare professional must be documented on the front of the woman's postnatal notes.

3.1 Midwife

Are responsible for the planning and management of care for women where no risk factors have been identified in the postnatal period, and for appropriate referral of those women/babies where deviations from the norm occur.

3.2 Obstetrician

Are responsible for planning the care for those women where risk factors have been identified.

3.3 Paediatrician

Are responsible for planning the care for those babies where risk factors have been identified, and for the discharge planning of these babies as appropriate.

3.3 Transitional Care Nurse

Are responsible for babies within Transitional Care. This area is located within the maternity unit.

4. DEFINITIONS/ABBREVIATIONS

OASIS – Trust data collection system.

Modified Obstetric Early Warning System (MEOWS) - a chart used to identify abnormal observations, to detect ill women.

5. PROCESS FOR DEVELOPING AN INDIVIDUALISED POSTNATAL CAREPLAN

5.1 Woman

The woman is risk assessed postnatally using the "mother alerts" and "key to risk" within the postnatal notes for mother. If risks are identified a management plan is developed and documented and this will outline a plan of care agreed between the midwife and the woman.

The woman's "key to risk" is then assessed at every postnatal check and the management plan is reviewed or revised as appropriate.

Normality care indicators are assessed on all women and clearly documented within the management plan pages of the postnatal notes.

5.2 Baby

The baby is risk assessed postnatally using the "baby alerts" and "key to risk" within the postnatal notes for baby. If risks are identified a management plan is developed and documented and this will outline a plan of care agreed between the midwife and the woman.

The baby's "key to risk" is assessed at every postnatal check and management plan reviewed or revised as appropriate.

6. PROCESS FOR ENSURING THAT THERE IS A COORDINATING HEALTHCARE PROFESSIONAL FOR WOMEN WITH MULTIAGENCY OR MULTIDISCIPLINARY NEEDS

When there is a safeguarding plan or other multidisciplinary agencies are involved, the midwife is responsible for informing the named contact of the delivery date and proposed discharge date allowing time for a pre-discharge meeting to then take place if required.

7. PROCEDURE FOR POSTNATAL CARE ON THE MATERNITY UNIT

- Postnatal care commences as soon as the third stage of labour is complete and there are no signs of haemorrhage.
- The maternal and infant postnatal notes should be commenced within one hour of delivery.
- The postnatal discharge letter is commenced as soon as possible following delivery.
- A postnatal pack should be given which contains postnatal information leaflets, to ensure all women receive the information they require following the birth of their baby, leading to an efficient discharge process.

The following leaflets are included in the postnatal pack:

- Exercises and advice following childbirth (DGH)
- Off to a good start, or bottle feeding your baby (UNICEF)
- Your Guide to Contraception choices - after you have had your baby (Family Planning Association)
- Smoking in the postnatal period
- 'Screening Tests for Your Baby' leaflet (NHS National Screening Committee)
- 'Registering a Birth' leaflet (Dudley Metropolitan Borough Council)
- Patient Advice and Liaison Service (DGH).

7.1 Process for offering every woman an opportunity to talk about her birth experiences

The midwife should give the woman the opportunity to discuss her birth experience, offering other support as required, including discussion with an Obstetrician. Any woman who has had an unexpected instrumental or operative delivery should be offered a debriefing discussion with the surgeon or her consultant before discharge or at an arranged outpatient appointment.

Women should be offered relevant and timely information to enable them to promote their own and their babies health and wellbeing, and to recognise and respond to problems (NICE 2006)

7.2 Requirement to document all discussions with the woman

Any discussions that take place with the woman must be documented in the woman's postnatal notes.

7.3 Care of the Woman

- Routine observations of temperature, pulse, respirations and blood pressure, and a top to toe examination of the mother should be made and recorded, using the post-natal stickers in the postnatal notes as soon as possible after delivery. These observations are then repeated and recorded twice a day for the first three days if not discharged prior to this, and once a day thereafter until transfer home. These observations can be performed and recorded more frequently at the discretion of the midwife

  and dependant on clinical need. MEOWS should be used for all observations. Any deviation from normal should be referred to a medical practitioner.
- The woman should be encouraged to pass urine within 6 hours of delivery. If she fails to do so appropriate action must be taken as documented in the bladder care guideline.
- The first urinary void must be documented in the woman's postnatal notes stating an approximate amount.
- The ACE assessment is an assessment of risk of incontinence following birth and should be undertaken and recorded on the postnatal care plan. Women with a high score are referred appropriately.

7.4 Care of the Baby

- The baby should also be examined from top to toe within one hour of delivery and this is documented in the postnatal notes, skin to skin must not be interrupted for this to occur.
- The normal full term healthy baby is able to mobilise energy stores through a process known as counter-regulation, they are not likely to suffer any ill effects. Unless they are symptomatic they do not require blood glucose measurements. The mother should be encouraged to have skin to skin contact with her baby and be taught hand expression to initiate lactation if her baby has not started breastfeeding. (**Appendix 1)** is a feeding flow chart of care involved with the normal term and healthy baby who is breast feeding.
- A baby top to toe examination is then undertaken twice daily for the first three days, then daily until transfer home.
- Any deviations from normal must be referred to the paediatrician.
- The cord clamp remains insitu on the baby, parents should be advised how to keep the umbilical cord clean and dry. If a Midwife makes the decision to remove a cord clamp due to a clinical reason, the cord clamp removers must be used as single use items, and disposed of following use.

- The baby has a temporary printed wrist band placed on its wrist/ankle as soon as possible after birth. This is then exchanged for two computer generated labels with baby's unit number on once the birth is on the OASIS computer. Refer to Label identification of babies after delivery guideline.

- A security tag is placed on the baby and the midwife checks this is present on the computer screen on each shift.
- The midwife must ensure that the baby is feeding adequately through discussion with the mother and by observing a feed. All mothers should be given and shown how to complete a feed chart so that there is a record of feeds taken by the baby and also if bowels have been opened and urine passed.
- Any problems in feeding should be documented and if required referral to Maternity Infant Feeding Assistant (MIFA) or Specialist Midwife Infant Feeding (SPMWIF). Contact Bleep 5050 (09.00-17.00 Monday to friday)
- To comply with NHS England screening requirements all babies require a Newborn Infant Physical Examination (NIPE) within 72 hours of birth. This will be performed by a midwife qualified to perform NIPE, or Advanced Neonatal Nurse Practitioner (ANNP). If this examination is not undertaken,

  in hospital, it will be performed by a community midwife qualified to perform NIPE. Please refer to 'Examination of Newborn Guideline'.

- To comply with NHS screening requirements all babies require a Automated Otoacoustic Emission Test (AOAE) commonly referred to as the newborn hearing screening, which is performed by specially trained Maternity support workers. Ideally this will be performed prior to transfer to community care. Please refer to Newborn hearing guideline.

7.5 Care of women who have had Instrumental or Operative Deliveries

In addition to the above care, women who have had an instrumental or operative delivery will require 30 minute recordings of temperature, pulse and blood pressure for the first 2 hours and then 4 hourly. These observations are to be recorded on a MEOWS chart. If an instrumental delivery occurs in theatre of within a delivery room setting the observations should be charted on the MEOWS at the same frequency and period of time. Close observation of their lochia and inspection of abdominal wound plaster must be undertaken for the first 4 to 8 hours following delivery.

- Pressure areas are assessed following a spinal anaesthetic (***Appendix 2***).
- Intravenous Infusion (IV) is maintained until diet and fluid are tolerated.
- Regular pain relief should be offered and Enoxaparin given once a day until discharge. Please refer to guideline on 'Thromboprophylaxis' post caesarean section.
- If a urinary catheter is insitu this is removed at 6 hours post-delivery if the woman's bromage score is 0, she can walk un aided to the toilet or unless instructed otherwise by the surgeon.

- All women who have had an emergency caesarean section are seen on day one by a surgeon. This allows the woman to debrief and discuss the implications for future pregnancies.
- The wound plaster is removed at least 48hrs post-operative the wound inspected for signs of haematoma or infection. This will be performed by the community midwife if the woman has already been discharged home.
- A Full Blood Count (FBC) is taken in the evening of day 1 and if below 10.0gd/l is reported to the junior doctor so that iron therapy can be commenced (guideline for issue of pre-packed ferrous sulphate tablets to take out (TTO's).
- The woman is seen on day two by the junior doctor to confirm fitness for transfer home.
- Analgesia is prescribed for the woman to take home, please refer to guideline 'Issue of co-codamol TTO's'.

8. DOCUMENTATION

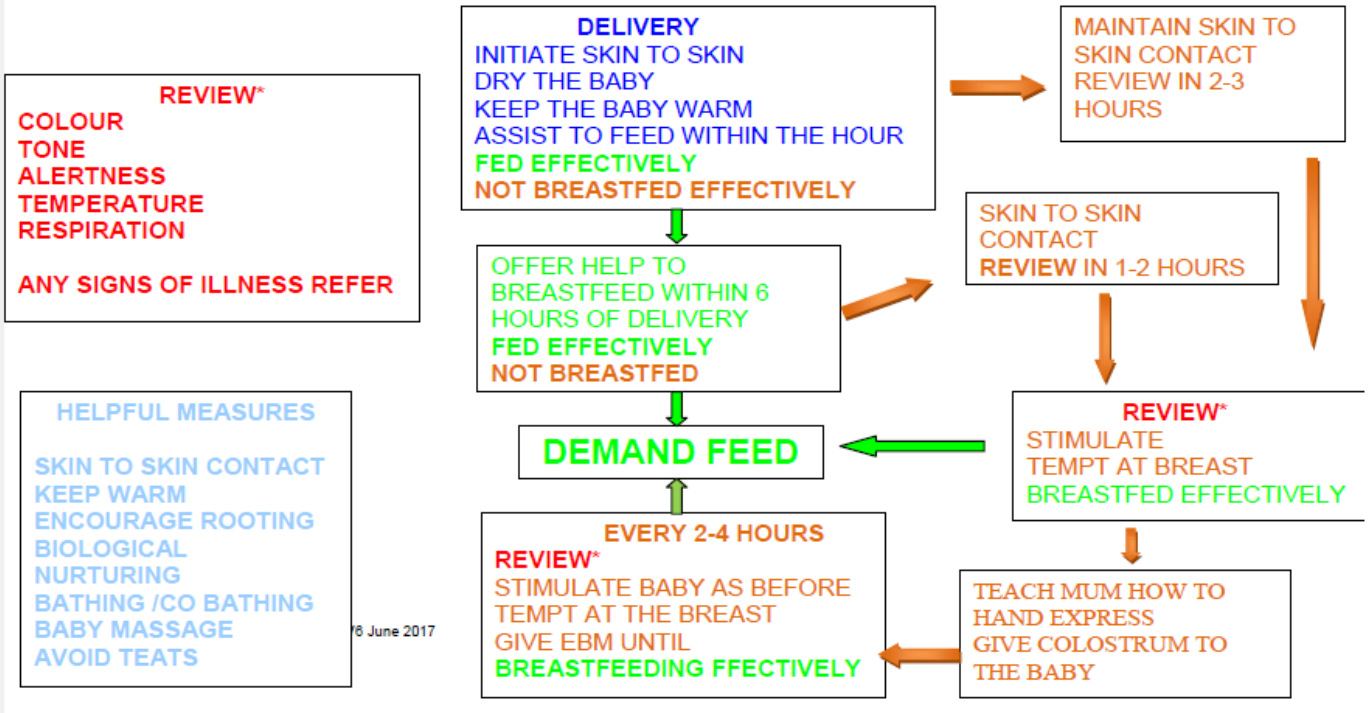
All care provided should be documented within the mother or babies postnatal notes.

9. REFERENCES

NMC (2014). Midwives rules and standards. London: Nursing and Midwifery Council

Appendix 1 BREAST FEEDING HEALTHY TERM NEWBORN BABY

GUIDELINES FOR THE CARE OF BREASTFED HEALTHY TERM NEWBORN BABY. FLOW CHART



6 June 2017

APPENDIX 2 WATERLOW PRESSURE SORE RISK ASSESSMENT

Review and document pressure sore risk factors at every AN admission, during labour and following delivery, or at **ANY POINT WHERE A RISK FACTOR CHANGES.** Document Waterlow score and if score ≥10 document and implement **Action Plan** (see below).

ADAPTED WATERLOW PRESSURE SCORE RISK ASSESSMENT FOR MATERNITY			
BMI		**CONTINENCE**	
20-24.9	0	Complete / catheterised	0
25.29.9	1	Urinary incontinence / ruptured membranes	1
>30	2	Faecal incontinence	2
<20	3	**MOBILITY**	
SEX/AGE		Fully	0
Female	2	Restless / fidgety	1
14-49	1	Apathetic	2
50-64	2	Restricted	3
SKIN TYPE		Chairbound, eg wheelchair	5
Healthy	0	**TISSUE MALNUTRITION**	
Tissue paper	1	Anaemia	2
Dry	1	Smoking	1
Oedema	1	Diabetes	2
Discoloured (Grade1)	2	Surgery	1
Broken (Grade 2-4)	3	**NEUROLOGICAL DEFICIT / TRAUMA**	
APPETITE		Motor / sensory, eg paraplegia, epidural, spinal	4
Average	0	**MAJOR TRAUMA**	
Poor	1	Orthopaedic / spinal injury	5
Nasogastric tube / fluids only	2	On table 2 hours	5
NBM / anorexic	3	On table 6 hours	8

Score: ≥10 at risk ≥15 high risk ≥20 very high risk

ASSESSMENT	ACTION PLAN (where score ≥10) (must indicate sites to be observed, eg sacrum, buttocks, bony prominences, frequency of change of position and any pressure relieving aids used)
AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	
AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	

AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	
AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	
AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	
AN / Labour / PN Date and Time: Waterlow Score: Signature: Print Name:	

ASSESSMENT OF PRESSURE AREAS

(to be undertaken 2 hourly where score ≥10)

DATE/TIME	EVALUATION/ACTION TAKEN Skin Condition: A = Normal B = Red, blanching C = Grade of pressure ulcer if present D = Covered by dressing	INITIALS