Maidstone and Tunbridge Wells
NHS Trust

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NHS Trust

Ref: FOI/GS/ID 4754

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

7 June 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Postpartum women.

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

Trust response:
Please see the following policy.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Postnatal Information and Care Planning Guideline

Target audience:	All maternity staff but particularly relevant to Delivery Suite, Community, Postnatal and Birth Centre Midwives
Main author:	Postnatal Ward Manager (KM)
Other contributors:	None
Document lead:	Maternity Inpatient Matron
	Contact Details: helen.pratt@nhs.net
Directorate:	Women's and Sexual Health
Specialty:	Midwifery
Supersedes:	Postnatal Information and Care Planning Guideline (2011); Version 3.0
Approved by:	Guideline Group **Date**: 23 November 2017
Ratified by:	Clinical Risk Management Group **Date:** 4 December 2017
Review date:	December 2020

Disclaimer: Printed copies of this document may not be the most recent version.
The master copy is held on Q-Pulse Document Management System
This copy – REV4.0

Maidstone and Tunbridge Wells NHS Trust

Document History

Requirement for document:	To comply with national recommendations for good practice when caring for women during the postnatal period: • NICE
Cross References (external):	1. Confidential Enquiry into Stillbirths and Deaths in Infancy. (1998). *5th Annual Report*. London: Maternal and Child Health Research Consortium. Available at: www.cemach.org.uk 2. Department of Health. (2004). *Maternity Standard, National Service Framework for Children, Young People and Maternity Services.* London: COI. Available at: www.dh.gov.uk 3. Department of Health. (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: COI. Available at: www.dh.gov.uk 4. Midwifery 2020 Programme. (2010). Midwifery 2020. Delivering Expectations. Cambridge: Midwifery 2020 Programme. Available at: www.midwifery2020org 5. National Institute for Health and Clinical Excellence. (2006). *Routine postnatal care of women and their babies*. London: NICE. Available at: www.nice.org.uk 6. Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk
Associated Documents (internal):	• Maternity -Record Keeping and the Management of Maternity Record [RWF-WC-OPG-MAT-CG15] • Maternity – Handover of Care (Onsite) [RWF-WC-OPG-MAT-CG8] • Early Days Leaflet (*currently under review*) [RWF-OPLF-PWC26] • Maternity – Newborn feeding including excessive weight loss and reluctant feeder [RWF-WC-OPG-MAT-CG93] • Maternity Transitional Care guideline [RWF-WC-OPG-MAT-CG151] • Maternity – Newborn Infant Physical Examination (NIPE) Screening Guideline [RWF-WC-OPG-MAT-CG92] • Maternity –Hypertensive disorders in pregnancy including severe pre-eclampsia and eclampsia guideline [RWF-WC-OPG-MAT-CG36]

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Postnatal Transfer of Women from the Hospital into the Community and from the Community into Hospital	October 2006
2.0	Postnatal Care Planning supersedes guideline Version 1.0.	November 2009
3.0	Postnatal Care Planning Guideline and Postnatal Information Guidelines combined, revised and updated to reflect service reconfiguration changes	October 2011
4.0	Review and comprehensive update	January 2017 – December 2017

Maidstone and Tunbridge Wells NHS Trust

Postnatal Information and Care Planning Guideline

Contents

Index	Sections
1.0	Introduction and scope of procedural document
2.0	Definitions / glossary
3.0	Duties
4.0	Training / competency requirements
5.0	Procedure for Postnatal Care Planning
5.1	Process for developing an individualised postnatal care plan
5.2	Process for ensuring that there is a co-ordinating healthcare professional for each woman including those with multiagency or multidisciplinary needs
5.3	Process for offering every woman an opportunity to talk about her birth experiences and to ask questions about the care she received
5.4	Process for giving information to enable parents to assess their baby's condition and respond to any problems
5.5	Process for ensuring that the parents have contact details for the relevant healthcare professionals regardless of the place of birth.
5.6	Process for ensuring that parents receive the Child Health Record book (Red Book) and that its use has been explained
5.7	Maternity Service's expectations of staff to document clearly in the health records the discussions and provision of information to parents. Including Special Circumstances.
5.8	Process for discharging women and their babies into the community
5.8.1	High Risk Women & Babies For Elective LSCS For Emergency LSCS Hypertensive History or any other Obstetric issues requiring review Where there is a Concern & Vulnerability Form or any other concerns, including complications during labour or delivery Transitional care babies or where there has been any issue
5.8.2	For both High and Low Risk Women & Babies (being discharged from either TWH or the Birth Centre)
5.9	System for postnatal visiting once the mother has been discharged from hospital/midwife led unit
5.9.1	Readmission to the unit
5.9.2	Final Discharge from Midwifery Care
6.0	Monitoring Compliance and Auditable Standards
Appendices	
1	Process requirements
2	Consultation arrangements
3	Equality Impact Assessment
4	Midwives' Postnatal Discharge Checklist
5	IMPORTANT Postnatal information for women discharged home with hypertension in pregnancy

1.0 Introduction and Scope of Procedural Document

Postnatal care is about empowering the mother to care for herself and her newborn in order to promote their longer term physical and emotional wellbeing.

Appropriate care planning will help to enhance quality and continuity of postnatal care for new mothers. These minimum requirements will help to support the ethos that postnatal care provision is undertaken in partnership with women and that care is offered, not imposed on her. In addition, care is planned through a process of education and discussion to meet individual needs.

Effective communication between parents and all disciplines involved in their care is the cornerstone of good clinical practice and will ensure that families have all the information they need to recognise and act appropriately when there are signs of illness in the newborn or mother.

Scope

This guideline applies to all those Maternity staff who provide postnatal care for women and babies at the Tunbridge Wells Hospital at Pembury on the Delivery Suite and Postnatal Unit and in the midwifery-led Birth Centres at Maidstone and Crowborough and in the community setting.

The aim of this guideline is to:

- Ensure that all mothers and babies have a documented individualised care plan, which will enable a high standard of care and support to be given throughout the postnatal period
- Ensure a holistic approach to care, which is applicable in all care settings
- Ensure postnatal care provision is undertaken in partnership with women to meet individual needs
- Ensure a safe transfer of care from hospital/the Birth Centre to community setting; followed by an appropriate discharge to the health visiting service
- Highlight the importance of communication between all team members and each discipline, as well as with parents and families

2.0 Definitions / glossary

Postnatal Care is received by the woman and her baby for 6-8 weeks following the birth.

Midwives offer midwifery support for a minimum of 10 days, or for a longer period (up to 28 days) depending on the individual need.

SBAR –is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Staff need to use the SBAR multidisciplinary communication framework to ensure a consistent approach to postnatal care planning

'Early Days' leaflet - a Maidstone and Tunbridge Wells NHS Trust leaflet, containing

Contact details for Midwives, Midwifery Liaison Office and Delivery Suites

- Information regarding signs of illness in the mothers and their babies
- Contact numbers for useful Help Groups

Midwives Discharge Checklist (See Appendix Four) – is a tick list which remains in the hospital notes following discharge.

It acts as an aide memoir to midwives when discharging mothers and babies home

E3 – is the maternity electronic Euroking system

EDN – Electronic Discharge Notification

NIPE – is an acronym for Newborn Infant Physical Examination. Routine physical examination of the newborn is an integral part of the universal Child Health Promotion Programme.

NNU – Neonatal Unit (Level 2)

TTO's - is a medical abbreviation related to medication 'to be taken out' i.e. Following discharge as an inpatient

3.0 Duties

It is the registered professional's responsibility to:

- Ensure that there is an effective transfer/handover of care between the multidisciplinary team and between wards, units (including the Birth Centres), hospitals and the community
- Document an individualised postnatal care plan so that vital information is transmitted, enabling continuity of care

4.0 Training / Competency Requirements

Postnatal Care Planning is the responsibility of the multidisciplinary team in all care settings, but is predominantly provided by midwives.

Student Midwives may provide postnatal care, under supervision.

There are no specific training requirements for implementation of this guideline.

5.0 Procedure for Postnatal Care Planning

5.1 Process for developing an individualised postnatal care plan

- Midwives should develop a postnatal care plan for each woman as soon as possible following birth
- Documentation of the postnatal care plan must be made in the Postnatal Care record. This must be up to date and include assessment of the woman using SBAR, the date and time of admission to the postnatal area
- The plan should be reviewed at each postnatal contact and clearly documented in the postnatal notes
- All subsequent care, any changes to the plan and any discussions with the mother must be clearly documented in the Postnatal Care record, including the woman's agreement to all proposed plans.
- Any deviation from the normal must be documented, including the process of referral to the appropriate medical professional.

- The frequency of postnatal contacts should be related to the woman's needs; based on her physical, emotional and social state. Previous experiences as a mother and her baby's health will also influence the plan of care
- Confidentiality should be respected at all times when handling/discussing personal information

5.2 Process for ensuring that there is a coordinating healthcare professional for each woman, including those with multiagency or multidisciplinary needs

- The front page of the Postnatal Care Record must be completed to show who is the Lead Professional for the postnatal care, which Community Midwifery Team will be caring for the mother and include any involved multiagency/multidisciplinary professionals.
- At handovers within TWH or the Birth Centres (between shifts) the midwives on duty must allocate mothers for named midwifery care
- Wherever possible a midwife known to the mother must be allocated to provide care whether in Hospital, Birth Centre or Community Team setting
- Student midwives may take a caseload of postnatal women under supervision of her mentor
- The Health Care Professional must sign, print their name and staff grade at each handover of care
- The midwives should provide care based on the original care plan, or subsequent revisions, developed on admission to the postnatal area within TWH, the Birth Centre or following a home birth. Any changes must be agreed with the woman and documented.
- When transferred to the community setting, the coordinating professional will be the woman's named community midwife
- Care of women with multiagency or multidisciplinary needs must be co-ordinated by an experienced midwife or overseen by the midwifery team lead.

5.3 Process for offering every woman an opportunity to talk about her birth experiences and to ask questions about the care she received

- On admission to the postnatal setting, or at another appropriate opportunity, a Health Professional will offer the time to talk to mother about her birth and document this in the Postnatal Care record
- The postnatal staff can offer the mother an opportunity to discuss her experiences with the relevant Delivery Suite staff, if this is appropriate
- If the mother has unresolved issues then further discussions with the relevant medical staff should be arranged
- On transfer to the community and at discharge from midwifery care, the woman's named midwife will give further opportunities to discuss the birth and to ask questions
- The mother needs to be made aware that if she needs further opportunity to talk, this will be arranged whatever the care setting

5.4 Process for giving information to enable parents to assess their baby's condition and respond to any problems

Following delivery and prior to discharge, women need to be given the following Postnatal Information Leaflets or website links, which will assist them in assessing their baby's general condition and identifying any signs and symptoms of common health problems.

Parents also need to have contact information to enable them to respond to problems.

Anyone without internet access may request a printed copy from staff if they wish:

1. MTW "Early Days" leaflet.
2. KCC "Registering a birth in Kent or Bexley"
3. Postnatal exercise leaflet.

    www.lullabytrust.org.uk/safer-sleep

5. Newborn Screening: www.screening.nhs.uk/annbpublications
6. NHS 'Off to Best Start' booklet: https://www.nhs.uk/start4life/breastfeeding
8. NHS 'Bottle Feeding' booklet –

    www.nhs.uk/start4life/Documents/PDFs/Start4Life_Guide_to_bottle_feeding.pdf

9. Information on MTW's website: www.mtw.nhs.uk/maternity/

When the above information is given to parents the midwife must explain them and answer any questions they may have

The midwife must document in the Postnatal Care record and on the electronic Euroking system E3 that the above have been given and discussed with the parents.

5.5 Process for ensuring that the parents have contact details for the relevant healthcare professionals regardless of the place of birth

- Both the Front Cover of the Postnatal Care Record and the Early Days leaflet contain the contact details for relevant health care professionals within Maidstone and Tunbridge Wells Trust
- The midwife must document in the Postnatal Care Record and on E3 that the Early Days booklet has been given
- If women are going home outside of the Trust boundaries, the midwife must ensure that the correct information is given to the parents.
    - This may entail contacting the relevant hospital and checking directly with them all contact details.
    - This information must then be clearly documented in the woman's Postnatal Care Record and on the E3 form completed and filed in the women's hospital notes.
    - A copy of the delivery E3, neonatal E3 and maternal transfer/Discharge E3 must be given to the woman to take home with her.
    - Making sure details of any relevant care is documented.

- If the mother has had her baby outside the Trust the community midwife will provide a copy of the Early Days leaflet and ensure that the mother has the correct local contact details

5.6 Process for ensuring that parents receive the Child Health Record book (Red Book) and that its use has been explained

- The Child Health Record must be given to the parents prior to discharge. The midwife who completes the labour ward records following the birth will fill in the front page and pages 3 & 4 and send it to the receiving postnatal area with the neonatal notes
- If the NIPE has been performed prior to discharge home the midwife must ensure that a copy of the NIPE is in the Red Book
- The use of the Red Book and the importance of taking it to all contacts with Health Professionals must be explained to the parents
- The midwife must record on the discharge checklist that the Red Book has been given. The discharge checklist remains in the hospital notes for monitoring of compliance to this guideline
- The Child Health Record is also available from the Health Visiting Service. The community midwife must highlight this to parents if this is required.

5.7 Maternity service's expectations of staff to document clearly in the health records the discussions and provision of the information to parents

- Refer to 5.1 for documentation standards required in relation to the development of an individualised postnatal care plan for all women
- The Maternity Service expects that all parents will receive all the necessary written information and be given the opportunity to discuss any issues with a midwife prior to discharge
- The midwife will document in the notes that this has happened by documenting in the maternity notes and on E3. The midwife will record on the discharge checklist that the discussion and leaflets have been given. This record will stay in the hospital notes for monitoring of compliance to this guideline.
- The community midwife will document any discussion and any information which is provided to the mother in the maternity records
- If there are concerns about the health of the baby when the midwife is visiting these will be discussed and advice given about actions to take and/or the relevant professional to contact should there be further concerns. This advice will be documented in the records

Special Circumstances

There will be times when the routine postnatal leaflets and website information are not appropriate for certain women. For example; women who are transferred home following a fetal loss or with a baby on the neonatal unit or with other special needs:

- These women will still require information about potential problems and how to respond to them and will be in need of relevant contact details

- Appropriate information will be given sensitively by the maternity unit staff and or community midwife and advice and information given will be documented in the appropriate medical records

5.8 Process for discharging women and their babies into the community

The well mother and baby may be transferred from hospital into the community when she and the baby are fit for transfer.

5.8.1 High Risk Women and Babies (from TWH)

a. For Elective LSCS

- Discharge can be after 24 hrs, if postnatally well and on the Enhanced Recovery programme
- Electronic Discharge Notification (EDN) must be completed at the surgeon's earliest convenience following the procedure but prior to transfer to the postnatal ward.
    - TTO's to be prescribed by medical staff via EDN at the earliest convenience following delivery to ensure the Enhanced Recovery programmes effectivity.E3 must be completed by the surgeon prior to transfer to the postnatal ward.
    - If the patient is still suitable for Enhanced Recovery Programme then this must be identified on E3 and documented suitable for midwifery discharge.

b. For Emergency LSCS

- Discharge can be after 48 hours
- Prior to discharge, check FBC after 24 hrs
- E3 must be completed prior to transfer to the postnatal ward

- Ensure both medical discharge and EDN completed prior to discharge; obtain the TTO's, preferably on the day prior to anticipated discharge.

c. Hypertensive history or any other Obstetric issues requiring review

- Ensure medical review/discharge preferably the day prior to anticipated discharge
- Ensure EDN completed and obtain TTO's if prescribed. Letter detailing any hypertensive management to be completed by the medical team and a copy sent with the woman for her community midwife (Appendix 5). Also see Maternity – management of hypertensive disorders in pregnancy including severe pre-eclampsia and eclampsia guideline available at::

  http://twhqpulse01:85/QPulseDocumentService/Documents.svc/documents/Active/attachment?number=RWF-WC-OPG-MAT-CG36

- Arrange Outpatient Appointments as appropriate e.g. with third degree tear, by writing a request in the ward diary for the ward clerk to make the appointment,

which will be posted to the mother's address. Appointment request must be documented in the maternity notes and on the E3.

If any serious medical condition exists or requires ongoing management by the GP, e.g. anticoagulant therapy, the discharging doctor must inform the GP via EDN and the community midwife via E3

d. Where there is a Concern & Vulnerability form or any other concerns, including complications during labour or delivery:

- The midwife discharging the woman must ensure that the named community midwife or team lead, if the named midwife is not available, as well as being informed of the woman's discharge, must be verbally informed of any issues that have arisen during her stay at TWH or either Birth Centre
- Social Services, Medical staff, Midwifery Management, Child Protection Lead, Midwifery Liaison, MIMHS, CMHT and Health Visitors must also be informed where appropriate

e. Transitional care babies or where there has been any issue

- Paediatric review and discharge, as appropriate
- Obtain TTO's, if prescribed, and ensure mother is proficient in dispensing medication
- Outpatient Appointments to be arranged by the Paediatric Team as required; if appointment to be posted, then ensure clear documentation in mother's handheld notes and inform mother and community midwifery team of plan

  Ensure community midwifery team are aware of any problems that have occurred such as jaundice/SBRs or feeding difficulties and document in the notes and on babies E3 transfer of care

5.8.2 For both High and Low Risk women and babies (being discharged from either TWH or either Birth Centre):

- Ensure postnatally well and no feeding issues
  - Inform woman of anticipated discharge date/time and the discharge process.
  - Keep informed of any delays that may occur.
  - Ensure bottle demo is carried out for women wishing to artificially feed and hand expressing and milk storage information for breast feeding women.
  - Ensure that all investigations have been followed up, the results documented and acted upon as appropriate
- Ensure all **Fetal Care Plans** identified in the antenatal period have been followed through and any outcomes or ongoing plans are documented in the maternity notes and on E3 for the community midwife

- Complete EDN for mothers and babies to inform GP of the birth, any concerns and any follow up required. Out of area discharge EDN's to be printed and sent via post.
- Give discharge information, leaflets, websites and Baby Child Health Record and document. Please make sure women know when they should be seeking medical advice by explaining the contents of the Early Days leaflet
- The discharge checklist must be completed to ensure that the process is complete (see Appendix Four)
- Ensure the E3 (Transfer of Care) is completed for both mother and baby.
  - The midwife completing the discharge is responsible for ensuring that this information is communicated to the appropriate Community Midwifery team, either via the E3, by email or by telephoning the relevant out of area community base.
  - A contact name must be obtained and documented on the E3 for any out of area discharges
- The address and telephone number must be checked prior to discharge. If different from the known address or a temporary address this must be clearly documented on E3 and all other necessary electronic patient records where necessary
- **The Midwifery Liaison officers** are responsible for ensuring the relevant community midwifery teams receive notice of the discharge.
  - However, on weekends the Community Midwives with a TWH base collect the information from the E3 system to establish visits/workload for the day.
  - TWH-based midwives will contact their colleagues in the outer lying areas (for example Sevenoaks, Edenbridge and Hawkhurst) by telephone to advise of any visits required.
- If there are any concerns regarding the mother and/or baby prior to discharge then the discharging midwife should contact the mother's Community Team and /or any other professionals as appropriate e.g. Social Worker, Health Visitor and GP
- If the mother is going 'out of area' then the 'Mother and Baby Discharge' will be entered onto 'Euroking E3' (Maternity IT system) and the relevant photocopied hand held notes sent home with mother.
  - The Midwifery Liaison Office or Delivery Suite (as appropriate) in the area that the mother is being discharged must be informed of her discharge and a telephone/email handover given.
  - A contact name must be obtained and documented on the E3.
- The All Scripts (electronic patient information system) must be completed on discharge including the correct date and time of discharge

5.9 System for postnatal visiting once the woman has been discharged from Hospital/Midwife led unit

- All women are visited by a Community Midwife on the first day at home and thereafter the Community Midwives visit according to care needs, following discussion with the mother
- Telephone contact may be made instead of a visit if appropriate
- Mothers are advised how to contact their midwifery team, TWH or Birth Centre midwives (as appropriate) for further support when required, or to arrange a visit if not previously planned
- Midwives offer midwifery support for a minimum of 10 days, or for a longer period (up to 28 days) depending on the individual need
- As a minimum, the mother will be visited on the day following transfer home, between 5-8 days to perform the Newborn Blood Spot Test and weigh the baby and between 10-14 days to reweigh baby and discharge from midwifery care if appropriate. Newborn Blood Spot Testing and discharge from Midwifery care may take place at either birth centre where appropriate
- Continuing care is indicated for mothers requiring additional support and to ensure good transition to the Health Visitor

5.9.1 Readmission to the Maternity Unit at TWH

NOTE: ALL women readmitted to hospital during the postnatal period MUST be initially admitted to Delivery Suite or Triage at TWH and be seen by a Senior Obstetrician before transfer to the ward.

Where it is necessary for a postnatal woman to be admitted to hospital, the community midwife or GP should:

- First discuss the admission with the Middle Grade on call
- Ensure the woman and her family are well informed as to the reasons for admission and the plan of care
- Inform the Maternity Unit Co-ordinating midwife of the admission
- Arrange transport as appropriate with either the woman's family or ambulance
- Accompany the woman into hospital, if appropriate
- Ensure verbal and documented handover to staff taking over care
- Community Liaison Office must be informed of all admissions in order to avoid any unnecessary visits
- Rooming in with baby should be encouraged
- Medical review should be as soon as possible following admission
- All readmissions should be reported to the Clinical Risk Manager via the e-reporting system (Datix).

5.9.2 Final Discharge from Midwifery Care

- Discharge from Maternity Care may be at any time between Day 10 and Day 28 when the Community Midwife is happy that mother and baby no longer require postnatal midwifery care
- The midwife will ensure that contact with the mother has been made by the Health Visitor
- There must be additional communication directly with the Health Visitor where there are concerns
- The E3 discharge must be completed by the midwife responsible for discharge and a printed copy sent to the GP
- The Postnatal Care record must be completed and returned to the Trust within one week

6.0 Monitoring Compliance

Monitoring and Audit of this guideline will be identified with issues raised via Clinical Risk / Clinical Governance.

Auditable Standards

- Individual postnatal care plan
- Identified midwife for discharge from maternity unit
- Discussion of birth experiences
- All discussions documented
- Information given to parents and documented, including assessment of the baby's condition, appropriate response to identified problems, contact details of relevant appropriate healthcare professionals. Leaflets issued and discussed to be recorded.
- Arrangements for Community Midwife visits
- Documented issue of Child Health Record (the Red Book).

Maidstone and Tunbridge Wells NHS Trust

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved this policy/procedural document will be published on the Trust intranet by the Maternity Compliance & Safety Co-ordinator.
1.2 On publication of any Maternity document, the Maternity Compliance & Safety Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
1.3 On receipt of the publication notification, all managers should ensure that their staff members are aware of the new publications.

2.0 Review

2.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
2.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

3.0 Archiving

3.1 The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:
Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Postnatal Information and Care Planning Guideline

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Postnatal Ward Manager - email: k.mara@nhs.net

By date: 23 November 2017 *(all documents must undergo a minimum of two weeks consultation)*

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	10/11/17			
Consultant Paediatricians	10/11/17			
Consultant Midwife	10/11/17			
Head and Deputy Heads of Midwifery	10/11/17	10/11/17	Y	Y
Maternity Matrons – Inpatient & Community	10/11/17			
Team Leads including Maternity Day Unit & Antenatal Clinic Leads	10/11/17			
Maternity Clinical Risk Manager	10/11/17			
Midwifery Staff via email	10//11/17	22/11/17	Y	Y
Midwifery Liaison Officers	10/11/17			
Safeguarding Children Lead Nurses	10/11/17			
Perinatal Mental Health Nurse	10/11/17	13/11/17	Y	Y
Screening Co-ordinator	10/11/17	13/11/17	Y	Y
The following staff have given consent for their name to appear in this guideline and its appendices: Helen Pratt Kellie Mara				

The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.

APPENDIX THREE

Equality impact assessment

This policy/guideline includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy/guideline development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	Postnatal Information and Care Planning Guideline
What are the aims of the policy or practice?	To ensure safe care for all pregnant women who receive postnatal care from MTW Trust
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	See References on page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	No
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	An interpreter service is available. At present information leaflets are printed in English
People who have a physical or mental disability or care for people with disabilities	No

Women who are pregnant or on maternity leave	No
Sexual orientation (LGBT)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	None identified
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this guideline/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

APPENDIX FOUR

MIDWIVES' POSTNATAL CHECKLIST
Commence on admission to Postnatal Ward.
Complete on transfer to Community.

Name: ……………………………………….. **Hospital No:** ……………………………….

ON ADMISSION:	**Signed**	**No**	**N/A**
Welcome and orientation to ward, transfer on AllScripts			
VTE audit completed. Dalteparin prescribed if required			
TC? Explain pathway. Offer wrap and demonstrate.			
NIPE booked?			
ELCS –? Enhanced recovery – TTOs prescribed on EDN			
DURING POSTNATAL STAY:			
Check discharge address & contact numbers			
Anti D given. If going home before Anti D, add name to diary. Inform mother of procedure to check if needed and to return.			
EDN completed and E3 commenced for both Mother and Baby **(Start ASAP)**.			
TTOs prescribed by doctor			
Parent craft: Artificial feeding - Bottle demo. Breastfeeding			

advice – positions/storage/expectations			
Infant Feeding Tool completed			
NIPE completed or arranged in community setting.			
AT DISCHARGE:			
Red book. PKU Labels.			
Mother or Baby OPA? e.g. 3rd degree tear, USS, baby BCG. Documented in notes and on EDN.			
Path results checked, acted on and documented in Postnatal Notes			
VIP and Catheter care charts photocopied, originals in outside notes, copies in folder for audit			
Charts, CTGs, baby notes etc. removed from Postnatal notes and ***FILED*** in outside notes			
OUT OF AREA? – E3 Discharge done, copy of E3 for woman, phoned/emailed to relevant hospital.			
TTO's given, signed out on EDN, documented in Postnatal Notes. Instructions given to mother.			
? Hospital PN checks required, appointment in MDU made			
E3 completed.			

Discharge Date: .... /.... /.... Time: ………
Midwife transferring care (PRINT):
..

APPENDIX FIVE

IMPORTANT postnatal discharge information for women with hypertension in pregnancy

______/______/ 20__

Dear Community Midwife / General Practitioner

Re:…………………………………………..................... Hospital No……………………………..

DOB………../………./……….. NHS no………………………………………

This patient is currently ……….days postnatal and has been discharged from the postnatal ward on ………/…………/………..

Diagnosis: **gestational hypertension / gestational proteinuria / pre-eclampsia / chronic hypertension (**Delete appropriate)

In view of her hypertension in pregnancy she requires close postnatal monitoring.

Discharged on Medication YES / NO

DO NOT USE METHYLDOPA POSTNATALLY

DRUG Dose Frequency

______________________ _______ __________

______________________ _______ __________

______________________ _______ __________

Please monitor Blood Pressure daily for 5 days from the date of discharge. If the BP is not within normal limits continue to monitor on alternate days for 2 weeks.

Aim for a Blood Pressure of less than < 140 / 90 and follow management plan below:

IF BP <120/ 70 STOP REGIME.	IF BP <130/ 80 REDUCE REGIME	IF BP > 150/100 REFER TO GP FOR REGIME MANAGEMENT	IF BP >160/110 OR SYPMTOMATIC REFER TO HOSPITAL FOR SAME DAY REVIEW.

<u>Please arrange GP review if still on medication in 2 weeks post discharge.</u>

Consultant clinic Follow up YES / NO ________/______/________ (6-8 weeks postnatal)
(All women with early onset pre-eclampsia <34wks or severe pre-eclampsia or Eclampsia require 6-8 week follow up appointment).

For women **not** requiring Consultant Clinic review:

- Please check the woman's urine at the 6 week postnatal check to ensure that any proteinuria has resolved.
- If proteinuria is still present please check urine PCR
- If urine PCR is raised then GP to please refer to a renal physician.

Women with hypertensive disease in pregnancy are at increased risk of recurrence in future pregnancies and hypertension in later life and therefore justify long term surveillance. Women should be advised regarding weight loss where appropriate.

Name…………………………..Signature……………………………Date…..../………/…….

Please contact Triage 01892 633500 for further information/queries