POSTNATAL CARE PLANNING AND INFORMATION - CLINICAL GUIDELINE

1. Aim/Purpose of this Guideline
1.1 Postnatal care covers care of the woman and her baby after transfer from intrapartum care until the end of the postnatal period. Currently within midwifery care this is usually until 28 days after the birth.

1.2 NICE suggests the following principles of care:
   - Kindness, respect and dignity
   - Views, beliefs and values
   - Women’s full involvement
   - All actions and interventions fully explained
   - Supporting informed decisions

1.3 Postnatal Care is a continuum of pregnancy and birth. The care aims to empower the women to care for herself and new baby, promoting optimum physical and emotional wellbeing. Postnatal care is undertaken in partnership with women and is individualised to meet the specific needs of women and their baby.

2. The Guidance

2.1 Care Planning, Information and Documentation:
Following the birth of the baby, whether in hospital, home or Birth Centre, it is the responsibility of the midwife completing the intrapartum notes to commence the postnatal records. This includes the:
   - immediate care after birth’ page
   - initial post natal assessment’ page including the post natal care plan
   - Initial neonatal assessment’ page.
   - News observations to be completed in first hour for all babies and this NEWS chart to be included in the maternity handheld notes at discharge (New 2016)
   - All neonatal documentation to be written in the neonatal notes main medical folder, a summary to be completed in handheld maternity notes (New 2016)

2.2 Individualised Postnatal Care Plan
The midwife completing the woman’s intrapartum care should ensure that any special considerations or risk factors for the post natal care of both the woman and her baby have been documented in the post natal care plan. This plan should be discussed with the woman
   - This should include relevant factors from antenatal, intrapartum and immediate postnatal period for both the woman and the baby.
   - For all women who have delivered by caesarean section a caesarean section care pathway should be commenced.
   - For all women with an indwelling catheter insitu a catheter care pathway must be commenced.
• For all patients with a cannula insitu please ensure that a care plan is completed and VIP score recorded prior to any transfer and thereafter twice daily until cannula removed (New 2016)
• Evaluations and outcomes of care planning must be documented in the postnatal section of the hand held notes.

2.3 Named Midwife
Each woman will have a named midwife responsible for co-ordinating her post natal care. Whilst in hospital a midwife will be allocated each shift, to co-ordinate the care of the woman and that of the baby. The named midwife will be allocated following the shift handover. The name of the midwife will be documented on the SWIFT + board alongside the woman’s name. The SWIFT + board must be screen shot printed at the end of each shift and stored in the safety brief folder (New 2016)

When transferred to the community the woman’s named midwife for her pregnancy, will continue her post natal care. If the woman’s named midwife is not available a midwife from the same team will provide the post natal care.

The length of stay within the hospital/birth centre should have been discussed with the woman during the antenatal period; this should be discussed again between the woman and her health professional, taking into account the needs of the woman and her baby. This should be discussed again prior to transfer to postnatal ward. (NEW 2016)

Prior to discharge from hospital or birth centre or leaving the home following a homebirth, the system for home visiting will be explained to the woman. In addition the hospital/birth centre professional is responsible for ensuring the woman’s discharge address and contact details are correct. This is documented on post natal information check list. Ensure the woman has contact details and knows to contact the community midwife and to contact if not heard from community midwife the day following discharge (NEW 2016).

On discharge from the hospital/birth centre or prior to leaving the woman’s home following a home birth, the midwife will ensure that the woman has her hand held notes returned to her which will contain the area team’s local contact number including the 24-hour telephone contact number for the on call midwife for the woman’s area. This should be documented as having been done on the post natal information checklist.

When a woman is being prepared for discharge the midwife will complete an early discharge form (EDF) which will contain the relevant details that need to be communicated to the community midwifery teams. This should be documented in the discharge diary and after 1800 hours, the ward diary (New 2016). Discharge details will then be telephoned to the relevant community midwifery team base, if there is specific information that requires discussion the community midwife will be requested to contact the Delivery Suite or Wheal Fortune.

Handheld notes should display sticker stating the team responsible for the woman’s care and EDF phoned out to this number (NEW 2016).

2.4 Women with multiagency, multidisciplinary or safeguarding needs
Any woman that has required support from other agencies or healthcare professionals throughout the ante natal period will have an individualised plan which will be in the delivery suite/community ‘risk’ folder. Once the woman has delivered the plan should be transferred
to the post natal ward risk folder and if the baby is admitted to the neonatal unit a copy of the plan should go into the risk folder on the neonatal unit. This plan will give information or special instructions about post natal and ongoing care, and the name(s) of any health care or other professionals that need to be informed of the birth of the baby and the named health professional responsible for her ongoing care.

2.5 Postnatal Contact
Post natal care in the community will be individualised to the needs of the woman and her baby.
She should be offered consistent information and clear explanations to empower her to take care of her own health and that of her baby. She should be encouraged to report any concerns, discuss issues and ask questions. Specific problem and follow-up care plans should be documented in the management plan section of the postnatal notes for the mother and baby.

2.6 Provision of information
Information giving should start at the point of delivery and continue until the woman and baby are discharged from the maternity service.
The maternity hand held notes contain a section on post birth care, which gives women and their partners’ information about common health problems in the post natal period for both the woman and the baby, and how to recognise and respond to concerns about their baby’s health.
Midwives should sign and date on the neonatal assessment page when they have completed the post natal discussion about the baby’s health.
Patient’s observations charts to be kept at the end of the bed for ease of use (NEW 2016)
Women should be offered the opportunity to talk about their birth experience at the time it is right for them. This may be immediately following birth or it may be well into the post natal period. The midwife that undertakes this discussion should document that this has taken place on the post natal information check list.
Any discussions or information giving that takes place should be documented either on the post natal information check list or within the body of the post natal records.
When Neonatal blood spot screening is carried out on the ward a second practitioner should counter check the quality of the samples and the accuracy of patient details and ward log to be completed. (NEW 2016).
Practitioners undertaking NIPE screening should document details in the handheld record and child health record PCHR (NEW 2016).
Discharge midwife to document the woman’s pressure ulcer risk assessment at discharge (NEW 2016).
Three copies of postnatal discharge should be printed and sent to the 1) woman’s GP 2) patient handheld notes 3) main hospital notes (NEW 2016).
As part of discharge conversation discuss with the woman signs and symptoms of potential life threatening conditions in the postnatal period (NEW 2016).

2.7 Support for parents if the baby has a suspected or poor outcome
If the baby has been diagnosed with an abnormality/condition or has a suspected or poor outcome all discussions with the parents from any member of the obstetric, midwifery or neonatal teams should be documented in either the woman’s or baby’s notes.
If either of the parents have any special needs or English is not their first language, the use of support or interpreting services should be used to ensure that the parents fully understand the information they are being given.
The parents should be given information to assist with accessing support groups or support information. It should be documented in the woman’s/baby’s notes as to what information has been given.

2.8 Discharge from the maternity service
On discharge from the maternity service the midwife must ensure that the post natal information check list is complete and that care has been transferred to the health visiting service and notes to be returned to RCHT (NEW 2016).

2.9 Reference:
National Institute for Clinical Excellence (NICE) 2006: Routine post natal care of women and their families.

## 2 Monitoring compliance and effectiveness

| Element to be monitored | • The audit will take into account record keeping by obstetricians and midwives  
| • The results will be inputted onto an excel spreadsheet  
| • The audit will be registered with the Trust’s audit department |
| **Lead** | • Maternity Risk Management Midwife |
| **Tool** | • Was it documented that a post natal discussion had taken place about the baby’s health and how to recognise and respond to concerns about their baby’s health.  
| • Was it documented that the on call midwife contact number had been given prior to discharge form the hospital/birth centre setting  
| • For women with an individualised plan of care in the delivery suite ‘risk’ folder, was it documented who the named health professional responsible for her care was  
| • For a baby diagnosed with suspected or poor outcome were any discussions with the parents documented in either the woman’s or baby’s notes |
| **Frequency** | • 1% or 10 sets, whichever is the greater, of all health records of women who have delivered, will be audited over a 12 month period. |
| **Reporting arrangements** | • A formal report of the results will be received annually at the maternity risk management and clinical audit forum, as per the audit plan  
| • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed. |
| **Acting on recommendations and Lead(s)** | • Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed  
| • Action leads will be identified and a time frame for the action to be completed by  
| • The action plan will be monitored by the maternity risk |
### Change in practice and lessons to be shared

- Required changes to practice will be identified and actioned within a time frame agreed on the action plan.
- A lead member of the forum will be identified to take each change forward where appropriate.
- The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan.

### 3 Equality and Diversity

3.2 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

3.3 **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Post natal care planning and information, clinical guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>20th May 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>20th May 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>20th May 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252879</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Postnatal Care is a continuum of pregnancy and birth. The care aims to empower the women to care for herself and new baby, promoting optimum physical and emotional wellbeing. Postnatal care is undertaken in partnership with women and is individualised to meet the specific needs of women and their baby.</td>
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<td>Suggested Keywords:</td>
<td>Post natal, Information giving in the post natal period</td>
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<td>Target Audience</td>
<td>RCHT</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td></td>
</tr>
<tr>
<td>Date revised:</td>
<td>20th May 2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical guideline for post natal care planning and information</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity guidelines group</td>
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<td></td>
<td>Obs and Gynae directorate meeting</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
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</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and</td>
<td>Internet &amp; Intranet</td>
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</table>
Document Library Folder/Sub Folder: Midwifery and obstetrics

Links to key external standards: CNST 5.9


Training Need Identified?

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>January 2010</td>
<td>1.0</td>
<td>Initial document</td>
<td>Jan Clarkson Maternity risk manager</td>
</tr>
<tr>
<td>October 2012</td>
<td>1.1</td>
<td>Changes to compliance monitoring</td>
<td>Jan Clarkson Maternity risk manager</td>
</tr>
<tr>
<td>May 2016</td>
<td>1.2</td>
<td>Benchmarked with NICE guidance</td>
<td>Karen Needham Deputy Team Leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mairead Archer Post Natal Ward Sister</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
# Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as <strong>policy</strong>) (Provide brief description):</th>
<th>Post natal care planning and information, Clinical Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Elizabeth Anderson</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 252879</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - Who is the strategy / policy / proposal / service function aimed at?
   - To provide guidance for midwives on care planning and information giving in the post natal period.

2. **Policy Objectives***
   - Midwives to provide individualised care and provision of information.

3. **Policy – intended Outcomes***
   - Women/parents to receive relevant information and advise during the post natal period.

4. **How will you measure the outcome?***
   - Compliance monitoring tool.

5. **Who is intended to benefit from the policy?***
   - Women/parents and their newborn

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

b) If yes, have these *groups been consulted?*

C). Please list any groups who have been consulted about this procedure.

7. **The Impact**
   Please complete the following table.

| Are there concerns that the policy **could** have differential impact on: |
| Equality Strands: | Yes | No | Rationale for Assessment / Existing Evidence |

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Post natal care planning and information, Clinical guideline

Page 8 of 9
<table>
<thead>
<tr>
<th>Age</th>
<th>X</th>
<th>All post natal women/parents and their newborn</th>
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</thead>
<tbody>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td>All post natal women/parents and their newborn</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No

9. If you are not recommending a Full Impact assessment please explain why.

Signature of policy developer / lead manager / director  
Date of completion and submission

Names and signatures of members carrying out the Screening Assessment  
1. Mairead Archer  
2. Karen Needham

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,  
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,  
Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed Sarah-Jane Pedler

Date 20th May 2016