

Postnatal care, including: Early Neonatal discharge & Postpartum Bladder care (V1)

(Supersedes Guidelines for: Postnatal care planning, Early discharge & Bladder care)

Guideline Readership

This guideline applies to all women and babies, attending clinicians; obstetricians, midwives and specialist midwives upon planned discharge from the Heart of England Foundation Trust.

All care is tailored to individual patient needs, with an in-depth discussion of the intended risks and benefits of either undergoing a procedure or declining intervention.

Guideline Objectives

The guideline provides information to all obstetric and midwifery staff to enable the effective provision of safe and individualised postnatal care to mothers and babies within The Heart of England Foundation Trust (HEFT).

It also aims to empower parent(s) to assess the newborns general condition in order to recognise signs of illness in their babies.

Other Guidance

- National Institute for Health and Care Excellence (NICE) (2014) Intrapartum care: care of healthy women and their babies during childbirth. Cg190 Issued December 2014 Available from: www.nice.org.uk (compliant)
- National Institute for Health and Care Excellence (NICE) (2014) Postnatal care. Cg37 Issued December 2014 Available from: www.nice.org.uk (compliant)
- Nursing Midwifery Council (2012) Midwives rules and Standards Available from: www.nmc.org.uk
- Nursing Midwifery Council (2015) Code for Nurses and Midwives Available from: www.nmc.org.uk

For further references refer to end of guideline

Ratified Date: 2nd June 2016

Effective from: 20th July 2016

Review Date: 20th July 2019

Procedure Author(s) / Reviewer(s): S. Wilson – Midwife, PN Ward manager
& Supervisor of Midwives; H. Butler – Midwife & Supervisor of Midwives

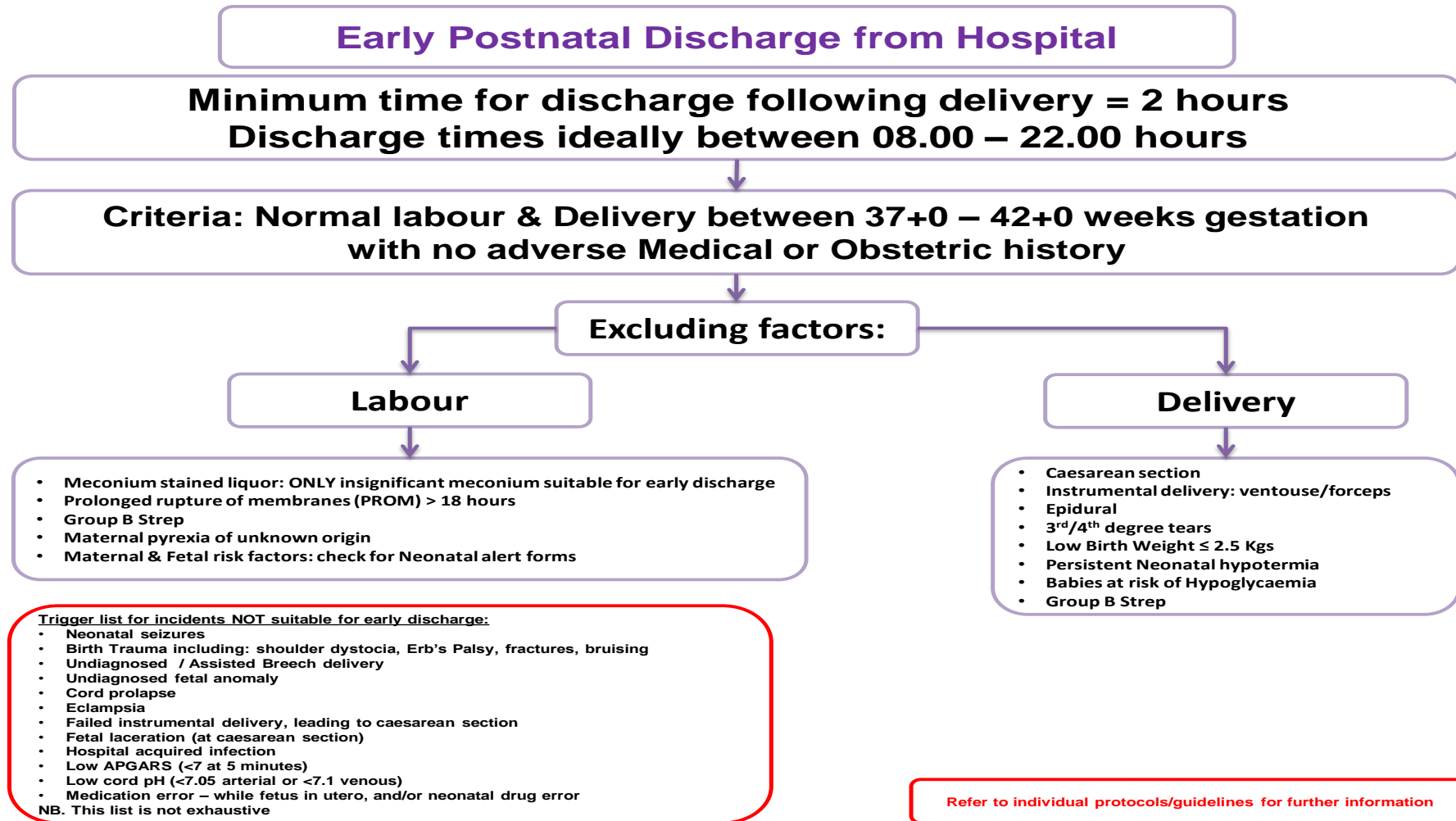
Procedure for the management of Postnatal care, including: Early Neonatal Discharge & Postpartum Bladder care

Contents & page numbers:

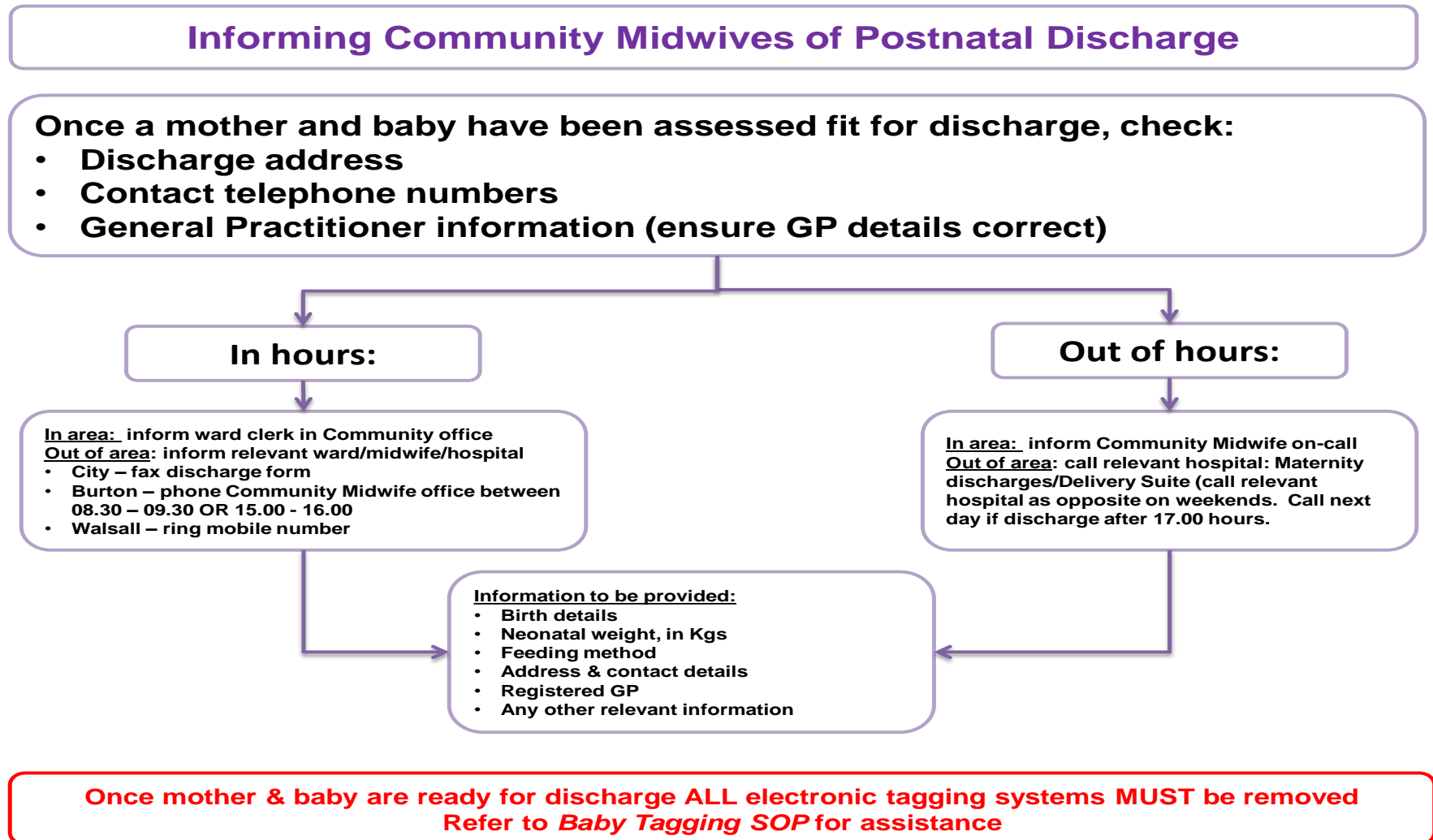
| | | |
|---|---|----|
| 1 | Flowcharts: | |
| | Flowchart 1 - Early postnatal discharge from hospital | 3 |
| | Flowchart 2 – Informing Community Midwife of discharge | 4 |
| | Flowchart 3 – Bladder Care, postpartum Management | 5 |
| 2 | Executive Summary / Overview | 6 |
| 3 | Body of the Procedure | |
| | Examination of the Newborn | 6 |
| | Postnatal Checks | 6 |
| | Other factors prior to discharge | 7 |
| | Documentation | 7 |
| | Contact details | 7 |
| | Discharge checklist | 7 |
| | Incomplete neonatal discharge examination | 8 |
| | Parental responsibility | 8 |
| | Pregnancy loss | 9 |
| | Babies in care | 9 |
| | Neonatal screening | 9 |
| | Infant feeding | 9 |
| | Readmission | 9 |
| | Postpartum Bladder Care | 10 |
| 4 | Reason for development of the procedure | 10 |
| 5 | Methodology | 10 |
| 6 | Implementation in HEFT & Community | 11 |
| 7 | Monitoring & suggested Quality Standards | 11 |
| 8 | References | 11 |
| | Appendices | |
| | Appendix 1 – further reasons for developing the procedure | 12 |
| | Meta Data & Revision History | 13 |

1. Flowcharts

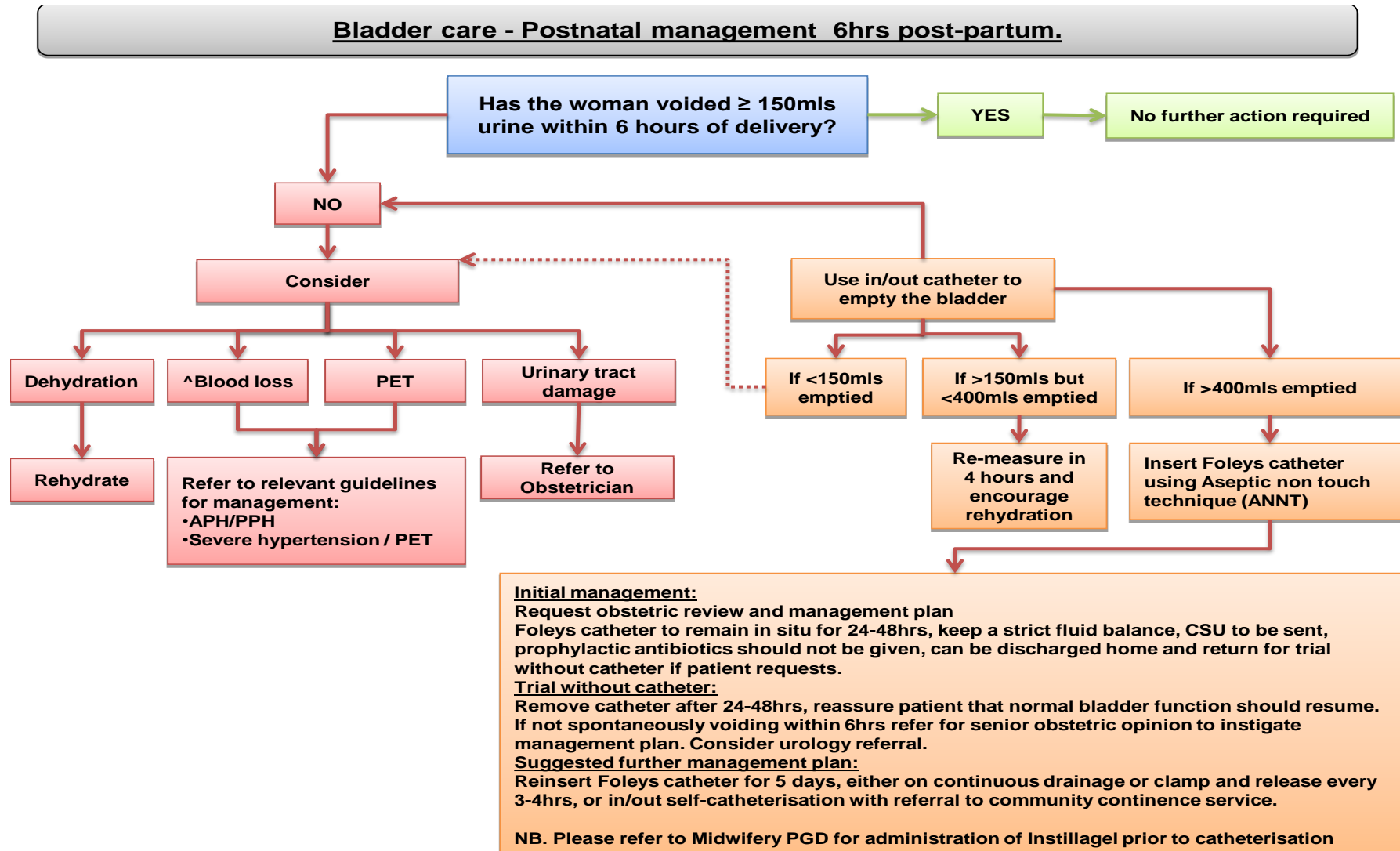
Flowchart 1 – Early Postnatal Discharge from Hospital



Flowchart 2 - Informing Community Midwives of postnatal discharge



Flowchart 3 – Bladder care – Postnatal management 6 hours postpartum



Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

2 Executive summary / Overview

Empowering women to care for themselves and their newborn in the postnatal period is essential to promote their long term physical and emotional well-being. Appropriate care planning will help to enhance quality and continuity of postnatal care for new mothers. Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth (NICE 2006, 2013 & 2014).

Women need to be provided with a postnatal care service that identifies and responds in a structured systematic way, to their individual physical, emotional and social/mental health needs, and which is based on the best available evidence.

Good communication between all healthcare professionals and the woman and her family is essential. Women should have the opportunity to make informed decisions about their care and any treatment needed. Care and information should be appropriate and the woman's cultural practices should be taken into account. Where possible, information should be provided in a form that is accessible to women and their families, taking into account any additional needs, such as physical, cognitive or sensory disabilities and non-English speakers (NICE 2006, 2013 & 2014).

Refer to Appendix 1 for further reading on development of the guideline.

3. Body of the Procedure

Examination of the newborn:

The examination of the newborn can be carried out by a midwife who had completed a recognised Examination of the Newborn course, Advanced Neonatal-Nurse Practitioner (ANNP) or a Neonatologist. If no abnormalities or anomalies are detected then the baby can be considered fit for discharge (refer to Examination of the newborn guideline).

Postnatal Checks: both mother and baby require a satisfactory postnatal examination prior to discharge as per the maternity information system inpatient assessment.

Women with the following conditions/complications should be referred for further opinion prior to discharge:

- Hypertension (Persistently > 140/90)
- Past history of, or suspected DVT
- Maternal pyrexia, treated with antibiotics
- Wound/perineal infection
- Complex medical conditions
- Low Hb. Anaemia that may require transfusion
- Women requiring TTO's not covered by Patient Group Directions(PGDs)/Exemptions
- Bulky uterus / heavy lochia
- Shortness of breath / chest pain
- Difficulty with micturition
- Raised MEoWS score
 - Midwife wishes medical opinion (for any reason)

NB. THIS LIST IS NOT EXHAUSTIVE

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Other factors to be taken into consideration and assessed prior discharge are:

- Ensuring that parents are confident with Feeding (breast or bottle)
- Identification of caregivers and assessment of their ability, availability, and commitment
- Psychosocial / Mental health assessment for parenting risks
- Basic infant care including bathing; skin, cord, and genital care; dressing; and comfort
- Infant safety precautions including proper infant positioning during sleep and use of car seats
- Addressing of any social / Mental health issues re: child protection

- Venous Thromboembolism (VTE) assessment immediately in postnatal period and prior to discharge (RCOG, 2015 recommendation)

Ensure that all relevant documentation has been completed:

During the postnatal period the midwife should ensure that information is given on the following topics:

- Reducing the risk of sudden infant death syndrome (SIDS)
 - Travel safety
 - Registering the birth
 - Newborn screening
 - The role of the community midwife (CMW) and health visitor (HV)
 - Any relevant support groups including contact numbers
 - How to contact health professionals if concerned about the well-being the woman or her baby, including contact numbers
 - Any specific follow-up required for mother or baby
- (This information is reflected in the postnatal notes/maternity information system).

Ensure all relevant contact details have been given:

- Relevant Community midwives numbers and community office number
- Delivery suite number for out of hours and emergency contact
- Contact number for General Practitioner (GP)

Discharge Checklist:

- Antenatal record in medical notes
- Mom's discharge and family planning discussed
- Relevant contact numbers given, i.e. Community Midwife(s), GP, Delivery Suite at delivered hospital and local hospital to area of discharge
- Maternal Hb, TTO's, Anti-D required/given
- Baby discharge examination – including, method of feeding
- Baby TTO's, including Vitamin K required/given
- Information regarding registering birth given
- Appropriate leaflets given, i.e. postnatal (PN) leaflets
- Computer printout completed with all relevant delivery information including copy for GP
- Arrangement of any required postnatal appointments
- Community notification
- Baby labels for neonatal screening tests

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Parent(s) wishing to discharge their baby without a neonatal examination being performed in hospital:

The purpose of the neonatal examination is to screen for non-congenital abnormalities and provide reassurance to the parent(s). It is a systematic examination of the newborn baby, which is an integral part of child health surveillance. In all cases the parent(s) should receive an explanation as to why a newborn examination is necessary.

In order to try and prevent delays in assessment, parent(s) should be advised that there may not always be trained personnel available on the day of their baby's delivery to perform a routine baby check prior to discharge particularly during busy ward times, or in circumstances where staff are called away to assist with emergency procedures. On the anticipated day of discharge any likely delays should be explained to the parent(s) in advance if at all possible.

The neonatal examination should take place within the first 72 hours, ideally within 24 hours following delivery. A full neonatal examination should be undertaken by a Neonatologist, an Advanced Neonatal-Nurse Practitioner (ANNP) or a midwife who has completed a recognised examination of the newborn course (see Examination of the Newborn Guideline for criteria). If this examination is not possible within the hospital and the woman wishes to go home, babies can be transferred to community care with plans for the GP or community midwife to undertake the examination within the stated time frame, provided babies Pulse Oximetry screening test has been undertaken prior to discharge and the results are normal - refer to Examination of the Newborn guideline.

Parental Responsibility

One or more persons with Parental Responsibility can agree to or refuse care or treatment on behalf of a baby, where that decision is consistent with a baby's best interests.

A baby's mother will automatically have Parental Responsibility unless (exceptionally) this has been removed by Court Order. The following are also deemed to have Parental Responsibility:-

1. The father of the baby if he was married to the baby's mother at the time of conception and/or birth;
2. If the father is not married to the baby's mother but has jointly registered the birth of the baby with the mother;
3. The father - if he has entered into a Parental Responsibility agreement with the mother;
4. Any other person or body in whose favour the Court has made a Parental Responsibility Order in respect of the baby.

Staff should be aware that special rules apply in respect of surrogacy arrangements - please refer to surrogacy guideline.

In the event of any query about whether or not an individual has Parental Responsibility, staff are encouraged to obtain advice from the Safeguarding team and/or the Police, particularly in cases where it is considered that the baby is likely to suffer significant or imminent harm if removed from hospital.

In the event that it is not possible to reach agreement with the parent(s) (and no other person with Parental Responsibility agrees to the baby's remaining in hospital) a court can make an Order as to the baby's best interests.

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Pregnancy Loss Termination of pregnancy (TOP) / Intrauterine Death (IUD)

When a woman has suffered a pregnancy loss, she should only be given documentation relevant to her postnatal care. (Refer to Trust guidance - Support Process for women with suspected or actual poor outcome or fetal loss and Mifepristone and Misoprostol for TOP and IUD).

Women whose baby(s) has had a poor outcome still require postnatal visits once leaving hospital, unless they specifically 'opt out' of this service. If the woman opts out this must be clearly documented and the named Consultant informed. Any information should be shared with the woman's GP.

Babies in care

When the baby has been placed with carers, for example: foster care or on neonatal unit (NNU), the postnatal notes applicable to the baby should follow the baby. Both mother and baby will require postnatal visits from the community midwife unless baby remains in the NNU where neonatal nurses/neonatologists are responsible for the baby's well-being.

Neonatal screening

The Heel Prick test is performed on all babies on day 5 (Refer to trust neonatal Heel Prick procedure). Details of the test will be entered into the Personal Child Health Record Book for the Health Visitors information.

All babies also required a hearing test. If the test has not been taken during hospital stay, for example due to early transfer of care, then the parents will be sent an outpatients appointment. The hearing screeners are informed on a daily basis of all deliveries and automatically generate an outpatient appointment for those who have not been screened.

Infant feeding (refer to relevant infant feeding policies)

A baby who is not showing signs of attachment or feeding should not be put forward for early discharge. Assessment of infant feeding should be carried out by the community midwife at each postnatal visit. If concerns arise then appropriate actions must be taken, see attached tool in Appendix 2 for assistance. Unless indicated sooner babies should be weighed at day 5 unless an inpatient when they should be weighed on day 3 and at least once more prior to transfer to a Health Visitor (HV).

Readmission

If there are any concerns during the postnatal period, regarding the well-being of a woman, in the first 28 days either the GP or the CMW (or the woman herself) can refer to Delivery Suite for advice. If the woman (with or without the baby) is readmitted then they are to be placed into a single occupancy room, to reduce the risk of cross infection. All postnatal readmissions require a Datix incident form to be completed.

- The CMWs have responsibility for the women in their remit for up to a maximum of 28 days postnatally. Care is informally handed over to the HV who usually makes contact with the woman in the early postnatal days. A transfer summary should be completed by the CMW and forwarded to the GP and HV.

If the community midwife has any concerns about the well-being of a baby then she should contact either the GP or the Child Assessment Unit (CAU) at the nearest hospital, or refer the baby directly to the Emergency Department (ED).

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Postpartum bladder care:

Factors known to increase the risk of postnatal urine retention:

- Prolonged/difficult labour
- Delay in Second Stage
- Assisted delivery
- Epidural analgesia
- Nulliparity
- Episiotomy
- Perineal / vulval trauma (3rd & 4th degree perineal tear)
- Periurethral trauma
- Birth by CS
- Over distension of the bladder during/immediately following the birth
- Larger infant than normal term baby
- Non English speaking mother

(Buchanan et al, 2013; Carley et al, 2002; Mulder et al, 2012; Weil et al, 1983; Yip et al, 1997)

- Encourage the mother to void urine within 6 hours of giving birth.
- Time and volume of first void should be recorded including daily bladder function in the postnatal record.

Assess the status of the woman's bladder on admission to the postnatal ward. The initial bladder assessment should include:

- A review of the labour and birth history to highlight any risk factors
- Documentation of voiding amount and time

Encourage 4 hourly micturition and observe voiding pattern in the first 24 hours. The frequency and volume of voids will depend on fluid intake, hydration, pain and sensation of bladder filling. Use supportive measures, such as analgesia, ambulation, privacy, warm bath/shower/running water, to enhance micturition.

If at 6 hours post-delivery a woman has not voided ≥ 150 mls of urine, an assessment of bladder fullness should be made (Glavind & Bjork, 2003). In and out catheterisation should be done and a fluid balance chart should be commenced; the use of Instillagel prior to insertion of catheter is recommended. Residual volumes suggested in these guidelines are based on pragmatism and limited evidence (Yip et al, 2005). Refer to flowchart 3 for postnatal management.

If Urinary incontinence is suspected an ultrasound scan (USS) should be performed in order to rule out overflow, if this is the case a Foley's catheter should be inserted for 48 hours and a fluid balance chart commenced. If no overflow is detected – refer to Obstetric Registrar/Consultant and refer further, where appropriate, to urologist/Physiotherapy department.

4. Reason for Development of the Procedure

The procedure provides information to all clinicians on appropriate management of women in preparation for discharge following delivery, including management of postpartum bladder care.

5. Methodology

Development of all guidelines/procedures adheres to a process of examining the best available evidence relevant to the topic, incorporating guidance and recommendations from national and international reports.

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Finalised guidelines/procedures will ultimately be approved and ratified by the Obstetrics and Gynaecology Guideline Group and minuted as ratified.

6. Implementation in HEFT & Community

All members of the Women's Health Guideline group and the O&G Guideline group will be informed at meetings and via trust email of new/updated guidelines/procedures. This information will then be disseminated to all members of the multidisciplinary team, relevant to O&G, via trust email, audit meetings, team (ward) meetings, in-house training and any relevant workshops.

Electronic copies of the guideline/procedures will be available via the trust intranet and paper copies stored within designated clinical areas.

7. Monitoring & Suggested Quality Standards

Adherence and efficiency of clinical guideline/procedures will be monitored through regular clinical audit.

Following clinical audit of a guideline an addendum to change in clinical practice may be necessary. Any change to a clinical guideline requires that it must be ratified by the Obstetrics and Gynaecology Guideline Group locally and minuted at Directorate.

Review dates will be set at a period of three years; however this set period can be overridden in light of new clinical evidence.

All unused/previous guidelines/procedures will be logged and archived electronically, and in paper format within the trust.

8. References:

- Centre for Maternal and Child Enquiries (CMACE) (2011) Saving Mothers' Lives. Reviewing maternal deaths to make motherhood safer: 2006-2008. The eight report of the Confidential enquiries into maternal deaths in the United Kingdom. Vol. 118; Sup.1; March 2011
- Department of Health (2004) Maternity Standard, National Service Framework for Children, Young People and Maternity Services. London: COI
- Department of Health (2007) Maternity Matters: Choice, access and continuity of care in a safe service. London: COI
- MBRRACE-UK (2015) Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Maternal, Newborn and Infant Clinical outcome review programme. Saving lives, improving mother's care. Surveillance of maternal deaths in the UK 2011-2013 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009 -2013 December 2015 Available from: <https://www.npeu.ox.ac.uk/mbrpace-uk>
- MacArthur C, Winter HR, Bick DE, Knowles H, Lilford R, Henderson C. Effects of redesigned community postnatal care on women's health 4 months after birth: a cluster randomised controlled trial. Lancet 2002;359:378
- National Institute for Health and Care Excellence (NICE) (2014) Intrapartum care: care of healthy women and their babies during childbirth. Cg190 Issued December 2014 Available from: www.nice.org.uk

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

- National Institute for Health and Care Excellence (NICE) (2014) Postnatal care. Cg37 Issued December 2014 Available from: www.nice.org.uk
- Nursing Midwifery Council (2012) Midwives rules and Standards. Available from: www.nmc.org.uk
- Nursing Midwifery Council (2015) Code for Nurses and Midwives Available from: www.nmc.org.uk
- 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.
- Royal College of Obstetricians and Gynaecologists (RCOG) (2015) Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. GG37a April 2015 Available from: www.rcog.org.uk

Appendices

Appendix 1 – Further reasons for developing the procedure

The guideline has also been revised with the aim of ensuring mothers and babies are suitable for discharge, including:

- Appropriate assessment
- are satisfied and confident with an discharge
- that a support network is in place (primary care)
- to improve quality of care, generating maternal choice

Mental Capacity: Key issues relating to decisions as to early discharge of neonates

There is a presumption in law that an adult must be assumed to have mental capacity in relation to decisions about their own care and treatment unless it is established that they lack capacity. Similarly, a person is not to be treated as unable to make a decision simply because it is an unwise one. Staff are referred to the Trust's Consent Policy, (available on the trust intranet) the test for capacity under the Mental Capacity Act 2005, and the Act's Code of Practice.

Where a mother has capacity to decide to leave hospital early post-discharge, staff should respect her wishes. If a mother lacks capacity to make the decision to discharge, staff should act in her best interests in consultation with the mother and her family/ carers. Best interests are defined under the Mental Capacity Act 2005, and staff are referred to the Trust's Consent Policy and the Act's Code of Practice for further detail. Where this decision is contrary to medical advice in relation to the mother's care and treatment, policy should be followed in relation to the mother's treatment (please refer to the discharge against medical advice policy [self discharge policy] on the trust intranet). If concerned contact the Safeguarding team for support/advice.

Procedure the management of Postnatal care, including: Early, Neonatal discharge & postpartum bladder care

Meta Data

| | |
|--------------------------------------|---|
| Guideline/procedure Title: | Early, neonatal postnatal Discharge |
| Guideline/procedure Sponsor: | Guideline Group Obstetrics & Gynaecology |
| Date of ratification: | 2 nd June 2016 |
| Effective from: | 20 th July 2016 |
| Review Date: | 20 th July 2019 |
| Related Policies/Topic/Driver | <ul style="list-style-type: none"> • Bereavement pathways • Consent policy (HEFT) • Examination of the newborn by midwives • Mental Health • Self-discharge policy (HEFT) • Surrogacy • Termination of pregnancy or intrauterine death • Vitamin K administration (NNU guideline) |

Revision History

| Version No. | Date of Issue | Author(s)/Reviewer(s) |
|---|---------------|---|
| 1 | May 2008 | S. Sharma M Dobson Philippa Sparrow |
| Reason for Issue: Merger & review | | |
| 2 | July 2016 | Suzanne Wilson – Midwife, Ward manager & Supervisor of midwives Hayley Butler – Midwife & Supervisor of midwives |
| Reason for Issue: Review & merger of PN care, early discharge & bladder care guidelines | | |
| <ul style="list-style-type: none"> • All 3 guidelines, as above, streamlined into 1 • Infant feeding assessments removed as in another guideline • Purple postnatal booklets removed – referred to as postnatal record for when IT records only used • VTE assessment added (RCOG,2015, MBRRACE-UK , 2015) • Postnatal bladder care only added – antenatal and intrapartum bladder care in other guidelines • Addition of the use of Instillagel for catheterisation • Updating of flowcharts 1 & 2 for discharge procedures and addition of flowchart 3 for postpartum bladder care by midwives | | |

Clinical Director:

Signed:



Name: Katherine Barber

Date: 20th July 2016