# Postnatal Care Guideline

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| **This document should be read in conjunction with:** | • Examination of the Newborn Guideline  
• Baby Tagging in the Maternity and Neonatal Unit Standard Operating Procedure  
• Maternity Early Warning Scoring System (MEWSS) |
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COMMON PATHWAY FOR POSTNATAL (POST-BIRTH) CARE

Philosophy of Care: Families benefit from a multiprofessional approach to care that meets their individual needs.

**Initial assessment of baby**
- Integrated Records
- NHS numbers for babies
- Birth notification

- Debrief labour experience
- Women should be offered information and reassurance on Normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (within 3 days)

**Contact by HV**
- Multiprofessional reassessment of needs
- Women should be offered information and reassurance on common health concerns as appropriate

**Family Attachment**
- Conducive Environment for positive parenting
  - Initiating skin to skin contact

**Examination of the newborn**
- Hearing screening
- Information for neonatal screening at 6-7 days (AN)
- Teach basic parenting skills.

**NICE Recommended**
- At each postnatal contact, ask the woman about her health and well-being and that of her baby
- Women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters.
- How long a woman stays in hospital after birth should be negotiated; consider the health and well-being of the woman and her baby and the level of support available following discharge.

**Initiate Infant Feeding**
- Promotion of Breastfeeding

- Prevention of haemorrhagic disease of newborn (Vitamin K)

- Assessment of immediate physical, social and emotional needs of mother
- Women should be offered information and reassurance on the physiological process of recovery after birth (within the first 24 hours)

- Women should be offered information and reassurance on Normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (within 3 days)

**Immunisation Schedule**

**Postnatal Guideline**

June 2013 version 3

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1.0 GENERAL INFORMATION

1.1 Introduction to the Postnatal Guidelines:

These guidelines have been developed with the aim of encouraging a consistent approach to the management of the puerperium by midwifery and medical staff. **They are not intended to be rigid rules but should be used in conjunction with clinical management tailored to individual requirements.** It is hoped that they will encourage both midwifery and medical staff to seek more experienced help when necessary. It is recognised that the puerperium is a physiological process and in the majority of cases will proceed normally without the need for medical assistance. However, problems do arise and on occasion result in critical situations. It is the duty of each team member to anticipate and identify such problems and take appropriate action. In order for the team to function effectively there must be good channels of communication and a clearly defined chain of command.

1.2 The lead professional for coordinating postnatal care will be a continuation of the multidisciplinary team responsible for care in the Antenatal and Labour periods, consisting of a Consultant Obstetrician & midwifery teams as documented on the antenatal notes.

2.0 COMMUNICATION AND DOCUMENTATION

2.1 Documentation of care given in the postnatal period should be documented in the postnatal care plan, although additional documentation can be made in the obstetric notes if appropriate. Where deviations from the norm, or problems are encountered, the documentation should include a clear identification of patient needs, and the action taken.

“Good communication with the woman, her relatives and member of staff is vital. Written documentation must be legible, contemporaneous and accurate. All records should be made in black ink, signed, dated and timed.” (NMC 2009).

2.2 All staff groups providing care should write contemporaneously, in chronological order in the hand held notes to provide a unified record.

2.3 The child Health Record Book will be given on the postnatal ward with a full explanation of its use and importance.

3.0 TELEPHONE REQUESTS FOR ADVICE

3.1 If a woman telephones the postnatal ward for advice or information regarding her antenatal care, or labour, the calls should be passed to Labour Ward. All telephone calls relating to the postnatal period where advice is given should be recorded on the advice slips, with an outline of the problem and the advice given. The advice slips should then be filed in the patients’ notes at the earliest opportunity (UKCC 1998).

3.2 Telephone Enquiries from Relatives:

Relatives calling the ward to enquire about a patient should be informed that, in the interests of patient confidentiality, patient details cannot be discussed. This policy is stated clearly in the ‘Information about the Maternity Unit’ leaflet, which can be given to both patients and their families. Relatives or friends should be encouraged to contact the patient’s partner, or messages can be passed on to patients as appropriate.

3.3 Discharge Calls from other Hospitals:
Postnatal discharges from other Maternity Units are collected via the voice mail box on a daily basis by the nominated out of area midwife and passed to the appropriate community team.

3.4 Discharge information to other Units:

If a woman is going home to another district the relevant hospital should be informed as soon as possible. The discharge coordinator will telephone/fax the receiving hospital with all the relevant information. The discharging midwife should ensure that the patient is given the telephone contact numbers for the relevant hospital in case she needs to call them for help or advice.

3.5 Discharge Information to Community Midwives:

When discharging a patient the Midwife should ascertain to which address the woman is going home. The discharge coordinator will page & leave a message with the named community midwife of the patient’s name, address and day first visit is required. Additional clinical information the midwife will be asked to ring the ward and speak to the discharging midwife.

3.6 Late Discharges:

Any late discharges should use the same system.

4.0 WARD ORGANISATION

4.1 Ward Rounds:

There should be regular ward rounds in accordance with the RCOG guidelines. During the week the doctor allocated to the postnatal ward should attend the ward each day and should see the following women:

- All women on their 1st day post-LSCS
- Any postnatal women that the Midwives feel need reviewing

4.1.1 At weekends the on-call obstetric team should attend the ward and see any postnatal patients that need reviewing.

4.1.2 In addition, any women that the SHO or midwives feel needs a senior review will be seen by the consultant allocated to the postnatal ward.

4.2 Communication:

In order to facilitate good communication between staff, and to ensure that the SHO sees all the appropriate patients, the Midwives on duty should record the names of any women that need reviewing on the integrated board, together with a brief indication of the patient’s history and the current concern.
5.0 WOMAN'S WELLBEING AND CARE

5.1 Daily Postnatal Checks:

5.1.1 All midwives will have access to and refer to the NICE guidance on postnatal care (quick reference guide at www.nice.org.uk/CG037distributionlist).

5.1.2 In order to maintain consistency of information all women should be given Birth to Five (2007 edition) which is an easy-to-use and practical guide for parents. It gives the latest advice and information on all aspects of child health, immunisation, healthy eating, childhood illnesses and child safety. www.dh.gov.uk/en/Publications

5.1.3 A documented, individualised postnatal care plan should be developed with the woman ideally in the antenatal period or as soon as possible after birth. This should include:

- relevant factors from the antenatal, intrapartum and immediate postnatal period
- details of the healthcare professionals involved in her care and that of her baby, including roles and contact details
- plans for the postnatal period.

This should be reviewed at each postnatal contact.

5.1.4 At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions and to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur.

5.1.5 At each postnatal contact, women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman’s normal pattern.

5.1.6 At each postnatal contact, parents should be offered information and advice to enable them to:

- assess their baby’s general condition
- identify signs and symptoms of common health problems seen in babies

5.1.7 Full postnatal checks should be performed daily on all women while they remain in hospital, and should be documented in their care plan.

5.1.8 First postnatal check

- Take the woman’s blood pressure and document the result within the first 6 hours.
- Measure and document the first urine void within the first 6 hours.
- Encourage gentle mobilisation.
- Provide an opportunity to talk about the birth.

5.1.9 Daily postnatal checks should cover the following:

- Baseline observations
- Condition of breasts (regardless of the method of infant feeding)
- Condition of uterus and the stage of involution
- Assessment of lochia
- Condition of the perineum. (If the perineal tears were sustained at delivery, or if the woman complains of any discomfort, the perineum should be examined)
• Examination of legs for any signs of DVT
• Assessment of general well-being (e.g. patient’s appetite, sleep pattern, emotional condition)
• Assessment of urinary and bowel function
• Examination of wound, or wound dressing (LSCS patients only)
• Discussion relating to infant feeding
• Discussion relating to postnatal exercises (as appropriate to stage of puerperium, and mode of delivery)

5.1.10 Where deviations from the norm are identified they should be recorded in the patient’s care plan, together with the action taken, and should be referred to the allocated postnatal obstetric SHO.

Ask about:

• resumption of sexual intercourse (within 2–6 weeks)
• resolution of baby blues (within 10–14 days).

5.2 Parent Education:

All women having their first baby, and others for whom it is appropriate, should be offered nappy changing and baby bath demonstrations, or offered the opportunity to perform these tasks with assistance or supervision.

5.3 Care of Women Post-LSCS:

5.3.1 Following LSCS women should be given regular and adequate analgesia, as prescribed. Women should be reviewed on the ward by the Anaesthetist, and in cases where pain control is inadequate advice can be sought from the Anaesthetist on-call. The women should also be seen by a doctor on the 1st or 2nd day post-delivery, and must be seen at least once prior to discharge.

5.3.2 The patient’s full blood count should be checked before discharge, usually on the 3rd post-operative day to allow for a more accurate result.

5.3.3 The surgeon’s operation notes should be referred to for any specific post-operative instructions such as when wound drains and urinary catheters can be removed. The wound dressing is usually removed on the 3rd day post-delivery. After this the wound can be inspected and the patient can be given appropriate hygiene advice.

5.3.4 Extra help with infant feeding and assistance with handling and caring for the baby should be offered, particularly in the initial post-operative period when the mother has limited mobility.

5.3.5 From the initial post-operative period onwards women should be shown appropriate postnatal exercises. Early mobilization is encouraged, and where problems are identified referrals can be made to the physiotherapist. Women should wear TED stockings until discharged home, and should be given daily prophylactic s/c enoxaparin, as prescribed, until discharged.

5.3.6 All women who have had an emergency caesarean section should be debriefed on the circumstances of the decision by the surgeon conducting the operation and discussions commenced regarding VBAC. This should be followed up as necessary (led by the woman).
5.4 Administration of Postnatal Anti-D:

5.4.1 For RhD negative mothers cord blood should be taken and sent for direct Coombs test (to establish the baby’s blood group). Maternal blood should be taken as soon as possible post-delivery (within at least two hours) and sent for Kleihauer in order to identify women who have had large fetomaternal haemorrhage and may need a higher dose of Anti-D immunoglobulin. The results of these tests will indicate whether a mother needs Anti-D immunoglobulin, and if so, which dose is appropriate.

5.4.2 All RhD negative mothers with RhD positive babies should be offered Anti-D immunoglobulin prophylaxis. It is important that women have all the necessary information, including the fact that Anti-D immunoglobulin is a blood product, to enable them to make an informed choice (RCOG 2002).

5.4.3 It is suggested that a standard dose of 1000 – 1500 units Anti-D immunoglobulin is appropriate for postnatal prophylaxis, and should be given within 72 hours of delivery (Letsky & De Silva 1994).

5.4.4 Anti-D immunoglobulin is best given into the deltoid muscle as injections into the gluteal region may only reach the subcutaneous tissue causing delayed absorption.

5.4.5 The patient should be monitored for approximately 20 minutes after the administration of Anti-D immunoglobulin as in rare cases an allergic reaction can occur. Details of the administration of Anti-D immunoglobulin should be recorded in the mother's notes. Similarly, if women declines Anti-D immunoglobulin, her decision and the information given should be documented clearly.

5.5 Checking Investigation Results in the Postnatal and Neonatal Period:

5.5.1 A full blood count is routinely performed on the third day following a Caesarean Section. The results should be accessed electronically prior to discharge, and acted upon accordingly. The results must be documented in the woman’s postnatal care plan.

5.5.2 If other investigations are required, then these should be accessed electronically and entered on the blood test result form which should be filed in the woman’s notes.

5.5.3 Results that come back after the woman has been discharged: if normal they must be signed, dated and filed in the woman’s notes.

5.5.4 In the case of abnormal results, the woman’s GP is informed, this is documented, dated, signed and filed in the woman’s notes. If the results are grossly abnormal then the registrar on call should be consulted in case the woman needs readmission. Checking of results must be carried out by a qualified practitioner i.e. Midwife or Doctor.

5.5.5 The practitioner who orders investigations either on a mother or baby is ultimately responsible for following up the results. If this is not possible due to leave or shift patterns then the fact that the investigation has been ordered should be handed over to another suitably qualified member of staff. This information may be passed on during ward handover, or when doctors hand over to each other at the end of their shifts.
6.0 BABY’S WELL-BEING AND FEEDING

- Don’t separate the woman and her baby within the first hour.
- Encourage skin-to-skin contact.
- Don’t ask about feeding method before skin-to-skin contact.
- Encourage initiation of breastfeeding within the first hour.
- Offer skilled breastfeeding support – including advice on positioning, attachment, ways to prevent concerns.
- Reassure women who leave hospital soon after birth about breastfeeding duration.
- Offer all parents intramuscular vitamin K IM for their baby. If IM dose is declined, offer oral.

6.1 Daily Checks

6.1.1 Carry out a full examination, by either a neonatal doctor or appropriately trained midwife (see guideline for Examination of the Newborn) within 72 hours of birth and explain its aims to parents.

6.1.2 Document this examination in the postnatal care plan and the personal child health record. Share the results with the parents.

6.1.3 Offer a newborn blood spot test when the baby is 5–8 days old.

6.1.4 In addition neonatal checks should be performed daily by the Midwife on all babies while they remain in hospital, and should be documented in the care plan. Daily neonatal checks should cover the following:

- Checking that the baby has two identification labels with the correct details, and a security tag.
- Assessment of the baby’s colour and temperature.
- Overall check covering fontanelles, eyes, mouth, cord / umbilicus, buttocks and condition of the skin.

6.1.5 The Midwife should also use this opportunity to discuss the method of feeding used, and how this is progressing, and also to check that the baby is passing urine and stools normally.

6.2 Emotional attachment


6.2.2 While the above list forms the basis of daily neonatal checks it is not meant to be exhaustive. The Midwife, using her clinical judgement, should use the opportunity to discuss or investigate any other concerns arising, or any problems the parents have identified. Where deviations from the norm are recognised they should be recorded in the care plan, together with the action taken, and should be referred to an appropriate practitioner.

6.3 Sudden infant death syndrome

6.3.1 Advise parents of Department of Health guidance: ‘The safest place for your baby to sleep is in a cot in your room for the first six months.’
6.3.2 Advise parents never to sleep on a sofa or armchair with their baby. If parents choose to share a bed with their baby, advise of increased risk of sudden infant death if either parent:
- is a smoker;
- has recently drunk any alcohol;
- has taken medication or drugs that make them sleep more heavily;
- or is very tired.

6.3.3 Use of a pacifier (dummy) should not be stopped suddenly.

6.4 **Successful breastfeeding – see Chelsea and Westminster Hospital Foundation Trust Infant Feeding Policy**

6.4.1 Offer additional breastfeeding support to women who have had a narcotic/general anaesthetic, a caesarean or delayed contact with their baby.

6.4.2 Ensure breast pumps are available for women who have been separated from their babies and give instruction on how to use them.

6.4.3 Encourage unrestricted breastfeeding frequency and duration.

6.4.4 Reassure women about breast milk supply and help them gain confidence.

6.4.5 Advise women that babies will stop feeding when satisfied.

6.4.6 Advise women of the signs that a baby is successfully feeding:
- swallowing is audible and visible
- there is a sustained rhythmic suck
- the arms and hands are relaxed
- the mouth is moist
- regular soaked/heavy nappies.

6.4.7 Review attachment and positioning if breastfeeding causes pain or discomfort.

6.4.8 All breastfeeding women should be taught how to hand express milk and how to store, freeze and warm it.

6.5 **Formula Feeding - see Chelsea and Westminster Hospital Foundation Trust Infant Feeding Policy**

6.5.1 Women who choose to feed their babies with formula milk must be given support.

6.5.2 If formula feeding, advise on how to prepare, store and warm formula and how to clean and sterilise bottles and teats.

6.6 **Care of Babies with Jaundice:**

6.6.1 Jaundice is a common physiological event occurring in approximately one in three term babies during the first week of life (P Johnston 1998). Physiological jaundice, caused by erythrocyte breakdown, usually appears 2-3 days after birth and begins to disappear towards the end of the first week. For the majority of babies with mild physiological jaundice no medical intervention is required if the baby continues to feed well and to behave normally. For these babies it is usually sufficient to observe the progress of the jaundice and to ensure that the baby feeds regularly. It is important however that the parents are reassured and given full explanations of the reasons for jaundice. If the baby is being discharged home the parents should also be made aware of the need for regular feeding and observing the baby for any worsening symptoms (such as drowsiness, excessive irritability or poor feeding).
6.6.2 The Community Midwife should also be informed so that appropriate follow-up can be arranged. The fact that jaundice has been observed, and the actions taken, must be documented clearly in the patient's notes.

6.6.3 In cases of more marked jaundice, or where there are other concerns such as poor feeding or drowsiness, the neonatal SHO should be asked to review the baby. In such cases, where the baby is symptomatic, or where the Paediatrician recommends it, the severity of the jaundice should be assessed by measuring the baby's serum bilirubin level. If poor feeding has been observed it may also be appropriate to check the baby's blood sugar at the same time. The SBR result should be charted and documented in the blue baby notes. If the result is above the treatment line the Paediatric SHO should be informed and appropriate treatment commenced (see 4.3) The Paediatrician should provide further instructions regarding the need and timing for further SBR checks, and should review the baby regularly.

6.6.4 Although physiological jaundice occurs frequently and usually resolves itself without treatment, neonatal jaundice can have many causes and can be a potentially serious condition. As a result, it is vital than when jaundice exceeds accepted normal limits appropriate help must be sought promptly, causes identified and treatment given.

6.7 Phototherapy

6.7.1 Phototherapy (using blue light of a specific wavelength to breakdown bilirubin into harmless metabolites) is the most commonly used treatment for neonatal jaundice. When phototherapy is required the baby should be nursed naked under the blue fluorescent lights, in a warm environment, with some protection for the eyes from the glare of the lights.

6.7.2 Parents should be fully informed of the need for phototherapy and should be given the opportunity to talk to the neonatal SHO on duty. They should also be encouraged to continue to participate in their baby’s care and to spend time with their baby especially if the treatment requires that mother and baby be separated.

6.7.3 The neonatologist should advise on when to commence phototherapy, when to recheck serum bilirubin levels, and when to discontinue the treatment. The Midwife should ensure that the baby feeds well and regularly. Additional fluids should not be required during phototherapy as long as the baby is feeding well. If there are concerns, a feeding chart should be used and the advice of the Paediatrician should be sought.

6.8 Transfer of Babies to SCBU: (see related guideline Admissions of Babies to the Neonatal Unit)

6.8.1 When babies require admission to SCBU from the Postnatal Ward, the events and reasons for transfer should be clearly documented. Parents should be kept fully informed and can, if appropriate, accompany their baby to SCBU. In rare cases where an unexpected, emergency transfer is required, an incident form should be filled out.

6.8.2 The Midwife responsible for transferring a baby to SCBU must ensure that it is correctly labelled, and should handover to the Neonatal Nurse assuming care. Parents should be encouraged to visit their baby as often as they would like. For women who have limited mobility after LSCS, visiting should be facilitated.

7.0 DISCHARGE HOME

7.1 Early Transfer to the Community:
7.1.1 Mothers requesting early discharge home can, if they have had a normal delivery and no immediate postnatal problems, be discharged as soon as they are clinically stable.

7.1.2 Follow up for neonatal check and hearing screening should be arranged.

7.2 Discharge from Hospital:

7.2.1 On discharge from the hospital, parents are usually given the following written information:

- Discharge Pack containing details on how to contact the hospital and the Community Office. The pack also includes details on the PKU test, and on travelling safely in cars with babies (Postnatal DVD)
- Postnatal exercise leaflet.
- Telephone contact numbers of local helplines and groups e.g. La Leche, NCT etc.
- Information booklet on cot death
- Leaflet on NHS numbers for babies (including baby's own NHS number)
- Leaflet on registering a birth
- A computer generated letter containing information on the pregnancy, birth and postnatal period to pass on to their Health Visitor
- Postnatal Care Plan

7.2.2 The Midwife and / or Student Midwife discharging the patient should take time to go through the written discharge information with the parents, giving them an opportunity to ask questions, or to raise any concerns they might have and complete the discharge check list in the postnatal notes.

7.2.3 The discharge coordinator will inform the community midwife, via pager, of discharge and when the first visit is expected.

7.2.4 Clinic follow up appointments should be arranged for women with:

- complicated medical problems
- peri partum loss
- 3rd/4th degree tears
- Complicated delivery (after review by postnatal consultant)

7.3 Transferring Postnatal Women to another Hospital:

See transfer of patient's guideline

7.4 Home Birth

It is essential for women who have had their baby at home that they have relevant contact details for health professionals before the delivering midwife leaves the home. The woman should have, clearly documented,

- The number of who to call in an emergency
- Telephone contact numbers of local helplines and groups e.g. La Leche, NCT etc.

8.0 POSTNATAL READMISSIONS:

8.1 Women re-admitted to the ward in the postnatal period should, for the purposes of infection control, be cared for in a side room.
8.1.1 She should be referred to her Obstetric Team, or if out of hours, should be assessed initially by the on-call team. Every effort should be made to keep the mother and baby together.

8.1.2 The Midwife caring for the patient should ensure that details of the patient’s admission are also passed to the relevant Community Midwife.

8.1.3 An incident form should be completed.

9.0 WARD SECURITY - Please see Baby Tagging in the Maternity and Neonatal Unit Standard Operating Procedure

9.1 On admission women and their relatives should be informed of the need for strict security on the ward. Both patients and their visitors should identify themselves using the door intercom system prior to being allowed entry to the ward. Likewise, visitors should be advised that when they enter the ward they should not let other people, who have not identified themselves to the ward staff, enter with them. Ideally, visiting should also be restricted to ward visiting hours. Written information on ward visiting hours, or the leaflet entitled “Information about the Maternity Unit” should be given to patients and visitors.

9.1.1 The Ward Census on Lastword (containing the names of all inpatients) should be kept as up-to-date as possible so that staff can, if the need arises, identify quickly how many women and babies are on the ward at that time.

9.1.2 With rare exceptions, babies should be kept with their mothers and should be cared for at their mother’s bedside.

10.0 MONITORING COMPLIANCE WITH THIS GUIDELINE

10.1 Compliance with this guideline will be audited on an annual basis in order to make recommendations for improvements in practice. The following criteria will be monitored

- Use of MEWSS Chart for all women
- Documentation of Postnatal Information given to women
- Documentation of Contact numbers given to women
- In high risk women, documentation of lead co-ordinating professional for ongoing care provision
- Documentation of Examination of the Perineum where perineal trauma has occurred.

10.2 Results will be presented in a multi-disciplinary forum meeting and subsequent action plans will be monitored through Maternity Outcomes Group.
11.0 REFERENCES

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