Postnatal Care Guideline (GL890)

Approval and Authorisation

<table>
<thead>
<tr>
<th>Approved by</th>
<th>Job Title or Chair of Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity Clinical Governance Committee</td>
<td>Chair Maternity Clinical Governance Committee</td>
<td>9th January 2015</td>
</tr>
</tbody>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Reason</th>
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<tr>
<td>1.0</td>
<td>January 2011</td>
<td>K Nash</td>
<td>Requirement within the Trust</td>
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<td>August 2011</td>
<td>A Weavers</td>
<td>Amended</td>
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<td>3.0</td>
<td>February 2012</td>
<td>K Nash</td>
<td>Revised</td>
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<td>4.0</td>
<td>December 2014</td>
<td>J Sangha (Matron for CMW &amp; Rushey)</td>
<td>Reviewed</td>
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<td>4.1</td>
<td>March 2015</td>
<td>M Whitfield/L Cox (Marsh &amp; Iffley Ward managers)</td>
<td>Point added on pg 7 re: care of babies whilst on PN wards</td>
</tr>
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<td>4.2</td>
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<td>Additional changes pg 7 &amp; pgs 11/12</td>
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1.0 Introduction

The purpose of this guideline is to assist Midwives and Maternity Support Workers (MSWs) involved in the provision of postnatal care to women and their babies. This guideline is relevant to all women and babies and aims to promote a consistent, efficient and evidence-based approach to the provision of postnatal care. It also provides a framework and schedule for the delivery of community postnatal care. It does not however replace individualised care and management.

1.1 Risk assessment

Risk assessment is an integral part of the role of the midwife. It is vital to ensure prompt recognition of the warning signs of abnormality in the mother/infant which necessitate prompt referral to medical colleagues and/or multi-agency referral. This Policy should be read in conjunction with the following Trust guidance:

- Baby weighing – indications for (GL790 - Tilbury, 2014)
- Bladder Care – Postpartum (GL792 – Street, 2014)
- Breast feeding – best practice in (GL798 - Tilbury, 2014)
- Communication between midwife and health visitor (GL808 - Valentine & Sangha, 2013)
- Care of the Term Newborn Infant (GL804 - Weavers, 2012)
- Child Protection Procedures (CG074)
- Domestic Abuse documentation and procedural framework (CG480 - Parris, 2014)
- Examination of the Newborn at the Royal Berkshire Hospital – guideline for performing the (GL403, B. Suryanarayanan, 2014)
- Identification of the Newborn (GL859 - Tuckey, 2012)
- Infant feeding policy (CG493 – Tilbury & Carter, 2014)
- Guideline for the Assessment and management of Perineal Wounds (GL885 – Haxton, 2014)
- Maternal Mental Health (CG497 - Valentine & Rough, 2012)
- Newborn Bloodspot Screening (CG498 - Young, 2014)
- Postnatal care, where and when leaflet (Sangha, March 2013)
- Skincare for term babies (GL915 - Weavers, 2012)
- Tears & Stitches leaflet (Weavers, 2014)
2.0 Principles of Postnatal Care

The postnatal period can be defined as the first 6 – 8 weeks after birth. Postnatal care should be a continuation of the care the woman has received through her pregnancy, labour and birth and take into account the woman’s individual needs and preferences. It should aim to create a supportive environment in which new families will be guided by professionals to learn how to care for their baby and themselves and be able to recognise and act upon any deviation from the normal (NCCPC, 2006).

Midwifery care may apply for the whole or part of the postnatal period. In the absence of any physical, emotional, social or psychological risk factors or concerns, it is anticipated that women will be discharged to the care of the GP and Health Visitor by day 10-14 following birth. It is important that care is planned according to the woman and her baby’s individual needs and these plans communicated to all relevant professional groups that may be involved with her care. These may include Neonatologists, Obstetricians, General Practitioners, Health Visitors and Maternity Support Workers.

3.0 Planning and Implementation of postnatal Care

The following should be observed when planning and implementing postnatal care:

3.1 During the Antenatal Period

- All women will be offered up to date information about the benefits and management of breastfeeding within the first 34 weeks of pregnancy. This should be backed up by leaflets or other written or visual information. This is aligned with the UNICEF Baby Friendly Initiative Action plan for the Royal Berkshire Hospital Foundation Trust (Tilbury, 2010).

- All women should be offered information about the schedule and locations of their community postnatal care within the antenatal period.

- The schedule of postnatal care should be interpreted flexibly by the midwife to allow for individual variations. Any individual needs or risk factors (e.g. safeguarding issues) should be assessed and communicated through the appropriate channels (follow link via Datix for child protection procedures).

- A coordinating health professional should be identified and documented within the postnatal notes for those women with multiagency or multidisciplinary needs. The woman should be informed of this and provided with the appropriate contact details. See links to other relevant Trust guidance within introduction on page 3.
3.2 Following Birth

- A documented postnatal care plan which takes into account both the suggested schedule of community postnatal care (see appendix A) and the woman’s individual needs and preferences should be developed with the midwife and the woman.

- This should include relevant factors from the antenatal, intrapartum and immediate postnatal period (outlined within p.4 of the postnatal and neonatal record) and details of the health professionals involved with the woman’s care and that of her baby’s including roles and contact details.

- The coordinating health professional should be clearly identified within the postnatal notes. Transfer of care to another health professional should also be clearly identified. See Lead Professional Communication GL866, (Rough & Tuckey, 2014) It is the midwife’s responsibility to ensure that she communicates within the wider multidisciplinary team e.g. with the GP and health visitor.

3.3 Community Postnatal Care

- All women will receive the first community postnatal visit by a midwife at home. This is to ensure the midwife has the opportunity to review any additional social or environmental needs that the woman and her family may have. Each woman should be aware of and be provided with the contact details for the coordinating health professional for their postnatal care. This is usually the midwife until transfer to the health visitor occurs.

- Communication with the woman and between health professionals is vital. Where possible the provision of postnatal care should be delivered by a small team of midwives and MSWs to facilitate communication and ensure continuity and consistency of care.

- Following the first community visit (and depending on individual circumstances and availability) women should be encouraged to attend the postnatal clinic or Children’s Centre for postnatal checks.

- All women should be provided with written information regarding the location of postnatal clinics, Children’s Centres, breast feeding support and other postnatal resources.

- MSWs will communicate with their buddy midwife (see section 6) about the women they have seen during the day. The midwife will make the final decision
regarding when and with whom the next visit will be with based on the information given (see section 6.3 Responsibility and Accountability).

- The provision of postnatal care will be delivered with the full involvement and participation of the woman in a way that ensures her and her baby’s safety, takes account of cultural sensitivity and facilitates clear communication with the woman, her partner and family (NCCPC, 2006).

- It is the responsibility of the discharging community midwife to ensure that communication with the Health Visitor has occurred [see Communication between Community Midwife, Health Visitor and Children’s Centre – GL808, Valentine & Sangha, 2013]

4.0 Ensuring maternal physical health and well-being

During the postnatal period women should be offered information and reassurance about their own health and wellbeing. The following outlines the minimum care that should be provided and has been informed by local and National guidance (NCCPC, 2006) and should include the following:

4.1 Within the first 24 hours of birth

- Women should be advised to contact their midwife if they have not passed urine within 6 hours of birth.

- A minimum of one blood pressure should be carried out and documented within 6 hours of birth.

- Any outstanding results should be obtained and action taken as appropriate.

- Anti D immunoglobulin should be offered to every non sensitised Rh-D negative woman within 72 hours following the delivery of an Rh-D positive baby.

- Women found to be sero-negative on antenatal screening for rubella should be offered an MMR vaccination following birth and before discharge from the maternity unit if they are in hospital. Women should be advised that pregnancy should be avoided for one month after receiving MMR, but that breastfeeding may continue.

- Women should be encouraged to mobilise as soon as appropriate following their birth.

- Women should be advised of the signs and symptoms of potentially life threatening conditions and to contact their health professional immediately or call
for emergency help if any signs and symptoms occur. This is outlined within p.8 of the postnatal and neonatal record.

- Women should also be offered information on the physiological process of recovery after birth, and that some health problems are common.

- During the woman's stay on the postnatal ward, her baby/babies must be cared for by the woman and/or her birthing partner in her bed space (rooming in) or the mother and baby room. Should a woman be unable to provide safe care for her baby/babies, or be required to leave the ward for any reason, her baby/babies should be admitted to SCBU, or a clinical member of staff allocated to baby sit 1:1, until the mother and/or her partner return. The baby/babies must not be left at the midwives station or mother and baby room alone at any time.

- Babies and mothers to be cared for in a bay when there are Child Protection issues unless there are maternal clinical exceptions which necessitate single room accommodation

- Women should be advised regarding suitable exercises to include pelvic floor exercises and Returning to fitness after birth – leaflets available on Trust website under M for Maternity

- The postnatal child health record should be given to all women as soon as possible after the birth and its use explained.

- Prior to discharge from hospital women should be advised regarding the schedule of postnatal community care and advised that postnatal contact from a midwife will be made within 24 hours. The Marsh Ward contact number should be provided meanwhile should they have any concerns or queries. (The Iffley Ward contact number may be provided instead if the woman has been discharged from Iffley ward).

### 4.2 At each Postnatal Contact

- 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. This will include reassurance about tiredness which is a normal consequence of new parenthood.

- Issues relating to general wellbeing should be explored further by the midwife in those women reporting of persistent tiredness. Underlying physical, psychological or social causes should be evaluated if persistent postnatal fatigue impacts on the woman’s ability to care for herself or her baby. It may be appropriate for the
midwife to evaluate the woman’s haemoglobin level should she experience persistent fatigue and have suffered a postpartum haemorrhage.

- Women should be provided with information about perineal hygiene and advised to contact a midwife should they have any concerns about the healing process of any perineal wound. This will include perineal pain or offensive odour. The midwife must strongly recommend that the woman’s perineum is assessed should any concerns be expressed by the women. In the event that the woman reports these symptoms to a MSW, the MSW should arrange for an urgent midwife review with the woman in order to undertake this assessment.

- Assessment of vaginal loss and uterine involution should be undertaken by a midwife should a woman report excessive or offensive vaginal loss, abdominal tenderness or fever. Should the woman report these symptoms to a MSW, an urgent midwifery review should be arranged.

- Women who have not had their bowels opened within 3 days of birth should have their diet and fluid intake assessed by a midwife who would offer advice on how to improve their diet. A gentle laxative may be recommended if dietary measures are not effective.

- Women should be asked about their emotional wellbeing and the family and social support that are available to them. Women and their families should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside the woman’s normal pattern.

- Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, time to rest, getting help with their baby, talking about their feelings and ensuring they can access social support networks.

- All healthcare professionals should be aware of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management.

### 4.3 At 10-14 day check

- Women should be asked about resolution or symptoms of baby blues. If symptoms have not resolved the midwife should arrange further support and communicate with the Health Visitor and GP regarding assessment for postnatal depression and further evaluation.

- Methods and timing of resumption of contraception should be discussed and proactive assistance provided to those women who may have difficulty accessing
contraceptive care. This includes providing contact details for expert contraceptive advice.

5.0 Promoting the infants health and wellbeing
During the postnatal period women should be offered information and reassurance about their infant’s health and wellbeing. Healthy babies should have normal colour for their ethnicity, maintain a stable body temperature, and pass urine and stools at regular intervals. They initiate feeds, suck well on the breast (or bottle) and settle between feeds. They are not excessively irritable, tense, sleepy or floppy. The information offered has been informed by local and National guidance (NCCPC, 2006) and should include the following:

5.1 Within the first 24 hours of birth.
(See also guidelines on Care of the Term Newborn Infant (GL804), Infant feeding policy (CG493) and Breastfeeding - best practice in (GL798)

- All parents should be offered vitamin K prophylaxis for their babies to prevent the rare but serious and sometimes fatal disorder of vitamin K deficiency bleeding (DH, 1998).
- Parents should be offered information about physiological jaundice including: that it normally occurs around 3–4 days after birth, reasons for monitoring and how to monitor, and advised to report to their healthcare professional urgently if jaundice develops within the first 24 hours after birth (British Columbia Reproductive Care Program, 2002).
- Prior to discharge from hospital or leaving a homebirth, parents should be offered information and given advice to enable them to assess their baby’s condition, identify signs and symptoms of common health problems seen in babies and how to contact a health professional or emergency service if required (outlined within p.17 of the postnatal and neonatal record).
- Every mother regardless of place of birth should be given the information leaflet ‘How do I know if my baby is well’. This should be recorded in the Postnatal Booklet
- A complete examination of the baby should take place within 72 hours of birth (see paediatric guideline for ‘Examination of the Newborn at the Royal Berkshire Hospital – guideline for performing’ - GL403).
The aims of any physical examination should be fully explained and the results shared with the parents and recorded in the postnatal plan and the personal child health record.

5.2 At following postnatal contacts

- The newborn blood spot test should be offered to parents when their infants are 5-8 days of age (UK Newborn Screening Centre, 2008).
- If jaundice develops in babies aged 24 hours and older, its intensity should be monitored as per Trust guidance and systematically recorded along with the baby’s overall well-being with particular regard to hydration and alertness.
- Parents should be offered information regarding their baby’s social capabilities as this can promote parent–infant attachment (NCCPC, 2006).
- Parents should be advised regarding nappy rash and to ensure frequent nappy changes and cleansing and exposure of the perianal area to help reduce babies’ contact with faeces and urine.
- Parents should be offered information regarding their baby’s bowel pattern which can take up to seven days to establish and advised to report any changes including hard stools that are difficult to pass or increased frequency of loose stools.
- Parents should be offered advice about infant safety and how to reduce accidents particularly scalds and falls.
- Parents should be advised how to keep the umbilical cord clean and dry and that antiseptic should not be used (Zupan et al, 2004).
- Parents should be given information in line with the Department of Health (DH) guidance about sudden infant death syndrome (SIDS) and co-sleeping (DH, 2009).

5.3 Babies requiring special care on Buscot ward

For those babies who require admission to Buscot ward (see paediatric patient information leaflet: welcome to Buscot ward information for parents and carers) parents should be supported and encouraged to visit their baby and participate in their care as soon as they feel able. It is important that the parents have the opportunity to discuss their baby’s condition and be provided with appropriate support and information. The
midwife and or/ MSW should provide support and advice about feeding and establishing lactation by hand and pump expressing depending on the woman’s wishes.

6.0 Postnatal Care Framework and Schedule for Community Postnatal Care

The Postnatal Care Framework and Schedule for Community Postnatal Care (see appendix A) aims to help ensure a consistent and efficient approach to the provision of postnatal care and should be referred to by all community team members. It does not however replace individualised care and management.

6.1 Role of the allocation midwife

Each community group will have an allocation midwife designated for each day which is incorporated within the off duty. The allocation midwife will be responsible for allocating and dispensing the workload for the day and will start the day in the team office in order to do this.

The allocation midwife will phone out the workload to the other members of the group on duty at the beginning of the day. It is the allocating midwife’s responsibility to ensure that tasks are delegated appropriately (see 6.3 Responsibility and Accountability). The MSW for the area will liaise with the allocated midwife in charge of community for that day.

6.2 Communication

A postnatal tracker will be created for all women discharged to the community. This will be used to plan the post natal visits on a daily basis. A separate phone communication sheet should be used for every phone call that is made instead of a planned postnatal visit. This postnatal tracker will be attached to the postnatal discharge summary received and kept in a folder at the relevant location. The folder will be divided into dates and the postnatal discharge summary and tracker is placed in the folder for this planned date.

The midwife organising the workload for the area should also ensure that any emails or telephone messages are checked and actioned appropriately.

The workload for each community area can be located on the W & C core drive under community folder. The allocated midwife for the day will take responsibility for ensuring this worksheet is updated with the workload for each area. The unit co-ordinator will liaise with the community co-coordinator to assess the workload for the community.
6.3 Responsibility and Accountability - The Scope of the MSW role, Nurse and Nursery Nurse

The NHS South Central Maternity Support Worker Governance Framework advises on the monitoring of standards of practice required of Maternity Support Workers (MSWs) by the South Central Strategic Health Authority, Trusts and PCTs across NHS South Central. It is intended to ensure that MSWs undertake their work in a safe, skilled and competent manner to ensure high quality and safe patient services, in the interest of public protection.

The role of the MSW is to carry out a delegated task to the agreed level of competence and to report back to a midwife following completion of a delegated task. The decision to delegate a task should be made by the midwife. The midwife will be accountable for ensuring that any delegation to a MSW is appropriate. The delegating midwife remains accountable to the NMC and her employer for the appropriateness of that delegation. It is important that the appropriate level of supervision has previously been provided to ensure MSW competence in carrying out the delegated task (NMC, 2008).

A midwife should also be responsible for reassessing the condition of the woman and baby under their care at appropriate intervals. Clear communication between the midwife and MSW is vital to enable the MSW to report clinical findings to the midwife which should be supported by clear written records. Thus the MSW should be allocated a midwife ‘buddy’ for their working day so that they are able to communicate back their findings to the midwife who will advise accordingly. This is because the Nursing Midwifery Council (NMC) is clear that although a registered midwife has the authority to delegate tasks to a competent MSW, the midwife will retain the responsibility and the accountability for that delegation.

If a midwife has delegated care to anyone other than another midwife, the delegating midwife retains the responsibility and must ensure that the MSW, Nurse or Nursery Nurse is aware of this and communicates any findings to the midwife.

7.0 Auditable Standards

1. All parents will receive written and verbal information to enable them to assess their newborn’s general condition and identify any signs and symptoms of common health problems. This will be evidenced by documentation of PIL “Well baby” or by fully completing “Feeling confident with your baby” staff checklist.

2. All parents will be given the contact details of the community midwives team and postnatal wards. This is documented in the postnatal booklet.
8.0 References


5. National Health Service Litigation Authority (NHSLA) (2009) Maternity Clinical Risk Management Standards (CNST) - Standard 5- Criterion 9: Postnatal Care Planning (Pilot Criterion) 139-140


9.0 Monitoring

The audit team that will audit the above auditable standards will be formed by:

- A midwife and/or a doctor and/or a maternity support worker
- Audit and quality midwife
- A clinical audit facilitator / assistant

The audit will compare results with previous audits, if applicable. The audit will review documentation stated in the maternal health records as evidence of compliance with standards.

The table below shows the plan to follow based on the audit results obtained. This would be subject to earlier re-audit if concerns are raised from risk management about this particular topic. Continuous and prospective audits might override this plan.

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<th>Results</th>
<th>Risk Priority</th>
<th>Minimum Plan</th>
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<td>If &lt; 75% compliance</td>
<td>1</td>
<td>Implement action plan and re-audit within 3 months from completion of report</td>
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<td>If ≥ 75% compliance and results ≤ than previous audit (when applicable)</td>
<td>2</td>
<td>Implement action plan and re-audit within 6 months from completion of report</td>
</tr>
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<td>If ≥ 75% compliance and results ≥ than previous audit (when applicable)</td>
<td>3</td>
<td>Implement action plan and re-audit next financial year from completion of report</td>
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The results will be disseminated depending on the risk priority.

<table>
<thead>
<tr>
<th>Risk Priority</th>
<th>Dissemination</th>
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</table>
| 1             | Reported in Maternity Audit Forum  
|               | Uploaded in Maternity Intranet page  
|               | RBHFT Maternity Newsletter  
|               | Special measures identified in action plan |
| 2             | Summary reported in Maternity Audit Forum  
|               | Uploaded in Maternity Intranet page  
|               | RBHFT Maternity Newsletter |
| 3             | Summary reported in Maternity Audit Forum  
|               | RBHFT Maternity Newsletter |

The dissemination on results and implementation of action plans and timely re-audit will be coordinated by the Audit and Quality Midwife and reported to the Maternity Clinical Audit Committee on a quarterly basis. This committee reports to Maternity Clinical Governance quarterly.
## Appendix A: Community Postnatal Care Framework and Schedule of Care

### Section one: Antenatal Preparation and information provision prior to discharge from hospital following birth

<table>
<thead>
<tr>
<th>By 34 weeks gestation</th>
<th>Information about the benefits and management of breastfeeding should be provided which is supported with written or visual information as appropriate.</th>
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<tbody>
<tr>
<td>From 36 weeks gestation</td>
<td>Postnatal information should be provided which is tailored to each woman’s individual needs. This should include the schedule and location of postnatal visits e.g. home, postnatal clinics and Children’s centres. Women should be informed that although the first visit will take place at home appointments will then usually be made for checks at postnatal clinics or Children’s Centres.</td>
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<tr>
<td>Within 24 hours of birth (prior to discharge from Hospital or leaving a home birth)</td>
<td>Women should be advised of the signs and symptoms of potentially life threatening conditions and to contact their health professional immediately or call for emergency help if any signs and symptoms occur <em>(outlined within p.8 of the postnatal and neonatal record)</em></td>
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</tbody>
</table>
| Prior to discharge from Hospital to community care or leaving a home birth | Parents should be offered information and advice to enable them to assess their baby’s condition, identify signs and symptoms of common health problems seen in babies and how to contact a health professional or emergency service if required *(outlined within p.17 of the postnatal and neonatal record)*. Parents should be offered information about the support available for breastfeeding within the community including how to contact both professional and voluntary sources of help. A documented postnatal care plan should be developed which takes into account both the suggested schedule of community postnatal care *(see section 2)* and the woman’s individual needs and preferences. The schedule of care is based on the following:

- Primiparous woman
- Multiparous woman

This should include relevant factors from the antenatal, intrapartum and immediate postnatal period *(outlined within p.4 of the postnatal and neonatal record)* and details of the health professionals involved with the woman’s care and that of her baby’s including roles and contact details *(outlined within p.6 of the postnatal and neonatal record)*. |

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**Author:** Jean Sangha  
**Date:** March 2015  
**Job Title:** Matron for Community & Rushey Birth Centre  
**Review Date:** January 2017  
**Policy Lead:** Director for Urgent Care  
**Version:** 4.2 March 2015 ratified 10th April 2015 Mat CG  
**Location:** Maternity CG Share drive/ Postnatal/ GL890

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### Section two: Schedule of Community Postnatal Care

<table>
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<th>Time Frame</th>
<th>Midwifery contact</th>
<th>Maternity Support Worker (MSW) contact</th>
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<tr>
<td>24 hours – 48 hours</td>
<td>First time mother</td>
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<td></td>
<td>Postnatal midwife visit and check at home by midwife within 24 hours.</td>
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<td></td>
<td>Ensure any outstanding results are checked and documented.</td>
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<td></td>
<td>Discussion re location and timing of next visit and arrange as appropriate.</td>
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<td></td>
<td>Obtain consent for Newborn Screening.</td>
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<td></td>
<td>Check appropriate for MSW visit day 3 e.g. no factors requiring early midwifery input.</td>
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<td></td>
<td>Second time (or more) mother</td>
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<td></td>
<td>Postnatal contact should be made within 24 hours and postnatal visit and check arranged at home for within 48 hours.</td>
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<td></td>
<td>Ensure any outstanding results are checked and documented.</td>
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<tr>
<td></td>
<td>Discussion re location of next visit and arrange as appropriate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obtain consent for Newborn Screening.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Check appropriate for MSW visit day 3 e.g. no factors requiring early midwifery input.</td>
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#### Day 3

<table>
<thead>
<tr>
<th>Choose one of two options</th>
<th>Home Visit or Clinic/Children’s Centre appt (MSW). Weigh baby and provide breast feeding/ artificial feeding support as necessary. Refer to guidelines for baby weighing and seek midwifery advice/support as necessary e.g. if concerns about weight or perineal check required by woman. Discussion re location and timing of next visit and arrange as appropriate. Communicate with buddy midwife.</th>
</tr>
</thead>
</table>

#### Day 5-6

| Home Visit or Clinic/Children’s Centre appt (MSW unless identified need for midwifery input). Ensure consent previously obtained by midwife and perform Newborn Screening. Check if further need for additional feeding support by MSW/midwife and arrange. Check if need for postnatal contact from MSW/midwife prior to discharge visit. Communicate with buddy midwife. |

#### Day 10 – 14

| Midwife discharge postnatal clinic/Children’s Centre (unless identified need for further midwifery input). Ensure contact/communication with Health Visitor in place. |

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**Author:** Jean Sangha  
**Date:** March 2015  
**Job Title:** Matron for Community & Rushey Birth Centre  
**Review Date:** January 2017  
**Policy Lead:** Director for Urgent Care  
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