Postnatal Care for Women and their Babies

University Hospitals of Leicester NHS Trust

Trust ref: C119/2011

Contents

Related documents;

Safer Sleeping and Reducing the Risk of Sudden Infant Death Syndrome LPT Midwifery and Neonatal Guidelines.
Infant Feeding Policy UHL LLR and Childrens Centre Services
Bottle Feeding UHL Obstetric Guideline
Breast Feeding Support UHL Obstetric Guideline
Weighing of Well Term Babies UHL Obstetric Guideline
Newborn Infant Physical Examination (NIPE) UHL Maternity and Neonatal Guideline
Newborn Blood Spot Screening For UHL and Community Midwives UHL Obstetric Guideline

1. Introduction and who the guideline applies to:

This guideline is based upon recommendations from the National Institute for Health and Clinical Excellence (NICE 2021) "Postnatal care". https://www.nice.org.uk/guidance/ng194

Postnatal care should be planned through a process of education, discussion and assessment of clinical need. Postnatal care should be structured to meet the requirements of each individual mother and baby in order to promote long term physical and emotional wellbeing for both. There should be effective systems of communication between all team members and disciplines as well as with parent(s) and their families.

There is a significant gap between the mortality rates for women from Black, Asian, mixed and white ethnic groups, with pregnant women and pregnant people from Black ethnic groups four times more likely to die than pregnant women and pregnant people from White groups. Pregnant women and pregnant people from Asian ethnic backgrounds are almost twice as likely to die in pregnancy compared to White pregnant women and pregnant people. Additionally pregnant women and pregnant people living in the most deprived areas are twice more likely to die, than those who live in the most affluent areas. With this risk in mind, the provision of postnatal care should be planned – in order to offer equitable outcomes, meeting the individual needs of all parents and families across the region.

This guideline is intended for the use of all Maternity Unit staff in both hospital and community settings.

Key points:

- A documented, individualised postnatal care plan is developed with pregnant women and pregnant people in the antenatal period or as soon as possible after birth, with MDT consultation where necessary.

- Pregnant women and pregnant people are offered relevant and timely information to enable them to promote their own and their babies' health and wellbeing and to recognise and respond to problems. Signpost to Health for Under 5s | For healthy, happy early years

- At the point of discharge, first postnatal contact and subsequent postnatal contacts, parents and carers are advised of the signs and symptoms of potentially life threatening conditions and advised to contact their healthcare professional immediately or call for emergency help if any signs or symptoms occur.

- **All maternity care providers (whether working in hospital or primary care) implement an externally evaluated, structured programme that encourages breast feeding, using the Baby Friendly Initiative (www.babyfriendly.org.uk) as a minimum standard.**

- At each postnatal contact, parents and carers are 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.

- At each postnatal contact, parents are 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
- Contact a healthcare professional or emergency service if required.
- Bed sharing, Crying babies (ICON), safer sleeping advice is discussed

- All information and advice discussed with the parents or carers, actions taken, referrals made and any management plans should be documented in the postnatal record. This discussion should include partner/others with parental responsibility.

- There are local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals which must be followed. E.g. transfer from obstetric led care to midwifery led care

- Where there is difficulty obtaining access to carry out a postnatal visit all reasonable attempts to do so must be made and documented in the health record.

What's new?

- Primary visit - If there are safeguarding concerns, and we cannot access on day 1, social care and the police should be informed.

2. Guideline standards & procedures

2.1 Individualised post-natal care plan

A documented, individualised postnatal care plan is developed with the pregnant woman or pregnant person ideally in the antenatal period or as soon as possible after birth. The standard schedule of postnatal care should be the basis of this.

- Documentation of handover of care from obstetric to midwifery led where applicable
- Documentation of handover of care from neonatal services to midwifery led care
- Documentation of any follow-up required for mother and or baby

- All parents or carers are asked about their and their baby's health at each postnatal contact
- All parents or carers are asked about infant feeding and any support required documented at each postnatal contact

- Provision of contact details of relevant health professionals.
- Provision of information about on-going care of themselves and their babies both verbally and shown how to access, the maternity website. The "Going Home Discharge Information" sheet and signs of infection babies leaflet must be provided.
- The information given is documented in the electronic transfer document forms and the discharge summary which is attached to the postnatal record.

- See Appendix 1 for postnatal schedule

Primary post natal visit:

At the first postnatal contact whether at home or in the hospital, all parents and carers are advised of the signs and symptoms of potentially life threatening conditions. They are advised to contact their healthcare professional immediately or call for emergency help if any signs or symptoms occur.

- The community midwifery primary visit should be face to face with a registered midwife within 36 hours of discharge. (NICE, 2021)

- See Appendix 3 and the postnatal notes

- During the primary visit in community an individualised plan of care will be agreed between the midwife and the parents or carers.

- At the primary visit the midwife should evaluate the health and wellbeing of the mother and baby and agree a plan for ongoing visiting. This should include assessment of suitability for the day 5 Newborn blood spot screening and weight assessment of the baby by a Maternity Support Worker:

Criteria for registered midwives to be required to perform the New-born Blood Spot test

If any of the following are present it would NOT be appropriate for MSW's to perform NBS's.

- Bruising or birth trauma to baby
- Below 37 weeks gestation at birth
- Known Medical problem requiring follow up or treatment
- Maternal concerns: significant perineal trauma, poor pain management, major PPH, PET or PIH.
- Any other concerns

Midwife 'X' discusses suitability for blood spot test to be performed by maternity support worker visit on day 5. This should be documented on the back page of the Baby P/N diary.

- The above should be documented in the postnatal record and fed-back to the community team.

- Any abdominal wound or perineal tear / episiotomy must be visualised at each contact with the midwife to monitor the healing process and make appropriate referral when there are signs of infection or where there are symptoms.

  - Where there is breakdown or infection of an abdominal wound the midwife should make a referral to the GP or the Maternity Assessment Unit
  - Repeated reports of pain/concern or any unresolved pain, should initiate a face to face consultation even if treatment is already underway.
  - Where there is breakdown or infection of the perineum the midwife should make a referral either to the GP or the UHL Perineal Clinic

- If seen by the GP and commenced on antibiotics, the midwife should call the woman or birthing parent at 72 hours post commencement and arrange telephone call or to see them at the end of this course of treatment
- If the perineum is then healing appropriately they will be discharged from midwifery care. If not, the midwife should refer them to the Perineal Clinic.
- If the they have been seen at the UHL Perineal Clinic there will be documented instructions re further visits and when to re refer if the perineum is still not healing satisfactorily

NB. Perineal pain is often overlooked, but it can cause significant maternal morbidity and lead to poor mental health (NICE, 2021). Pain which is not resolving or worsening, and/or where the woman or birthing parent reports an increasing need for pain relief, may warrant further investigation either via GP or perineal clinic.

2.2 Information health promotion

Relevant and timely information must be provided to enable promotion of their own and their babies' health and well being and to recognise and respond to problems. Written information is provided in the discharge paperwork, and contact details for any questions highlighted to parents.

- Skin-to-skin contact is encouraged following birth whatever the chosen method of feeding
- All parents and carers are given information about promoting health
- All parents and carers are given information about common health problems and how to recognise the signs and symptoms. (Appendix 2 and the postnatal record)
- All parents and carers are given information on how to manage fatigue with diet, exercise and planning activities
- All parents and carers are given information about health problems in babies and how to recognise the signs and symptoms. (Appendix 4)
- Intramuscular vitamin K (I mg IM) for their baby should be discussed and offered. If IM dose is declined, oral administration should be discussed and offered.
- Recommendation of Vitamin D supplementation if babies are exclusively breastfeeding.

2.3 Feeding support:

All maternity care providers (whether working in hospital or primary care) will implement an externally evaluated, structured programme that encourages breast feeding, using the Baby Friendly Initiative (www.babyfriendly.org.uk) as a minimum standard.

- The breast feeding policy (Joint Breast Feeding Policy for all NHS Trusts) is readily available to staff and they should be familiar with it.
- The breast feeding policy is communicated and implemented.
- New staff are orientated to the breast feeding policy within their first week of employment.
- New staff will participate in a practical skills review with the infant feeding team.
- Skin to skin contact is encouraged for 60 minutes following birth or until the baby has had a successful breast feed if this is the chosen method of feeding. Please

refer to the Reducing the Risk of Sudden Unexpected Postnatal Collapse of the Newborn UHL Obstetrics Guideline

- Breastfeeding support is available in all care locations.
- The mother or birthing parent and their baby are not separated within the first hour unless there is a clinical indication – mothers and birthing parents are to be encouraged to keep their baby with them at all times.
- There is privacy for mother's and birthing parents when they are breast feeding and expressing.
- Infant formula should not be given to breastfed babies unless clinically indicated or as a result of fully informed maternal choice.
- Mother's and birthing parents should be aware of the common breast feeding problems (Appendix 5 and the postnatal record)
- Mother's and birthing parents are encouraged to have adequate rest.
- Mother's and birthing parents should have ready access to food and drink.
- Commercial packs that contain formula milk or advertisements for formula are not distributed or displayed.
- On day 3, mothers and birthing parents who are breastfeeding should receive a phone call or visit by a midwife or MSW to support feeding.

2.4 Emotional assessment and support:

At each postnatal contact, parents and carers are 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.

Parents, carers and their families/partners are encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of their normal pattern. NICE recommend that parents and carers are given the opportunity to reflect on their birth experiences at each visit (2021).

- This should be recorded in the postnatal record at each visit.
- Further information is available in the postnatal diary which is given prior to discharge. This includes a telephone number for the Birth Reflections service, which should be highlighted to mothers and birthing parents during postnatal visits. They should be advised they can self-refer to this service, if they wish.

2.5 Newborn assessment and screening:

At each postnatal contact, parents or carers are 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
- Provide all parents with written information regarding spotting the signs of infections in babies prior to discharge home or on leaving the parents following a homebirth
- Contact a healthcare professional or emergency service if required

- An assessment of the baby's health and wellbeing is made and the postnatal record completed
- A Newborn hearing test will ideally be performed prior to discharge, however this can be offered in the community before the baby is two weeks old.
- Ideally prior to discharge from hospital, the baby should have its newborn infant physical examination (NIPE). If this is not possible then the parents should be

given an appointment to bring the baby back to a postnatal NIPE clinic at the hospital, or at St Marys Birth Centre. The national screening standard states the NIPE should be completed within 72 hours of birth. If the options above are not possible, some midwives in the homebirth and community teams are NIPE trained. These should be contacted to ascertain if they have capacity to perform the NIPE, to mitigate breaches of this recommendation

- Newborn bloodspot screening should be offered on Day 5. This may be performed later than day 5, but delaying this examination **should not** be routine practice.
- Parents or carers are directed to the National screening leaflet for further information
- Contact details for healthcare professionals are documented on the electronic version of the community transfer document

2.6 Post-natal referrals and follow-up:

All information and advice discussed with the mother, birthing parent, parents or carers, actions taken, referrals made and any management plans should be documented in the postnatal record.

- An individualised management plan is documented on the postnatal care plan at the back of the postnatal record
- The parents or carers also have the opportunity to write in the postnatal record any issues or concerns they might like to discuss with their Midwife which in turn may form the basis of the care plan

There are local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals

- A local safeguarding form is completed as early as possible in the case of any safeguarding issues and management plan in place if required. A referral should be completed via ICE and documented in the hospital notes.

- Mental health care plans are filed in the hospital notes if required.

- Both mother or birthing parent and baby transfer document are completed for all parents or carers prior to discharge electronically. Contact numbers are documented on the form and a copy is given to the parents or carers.

- Specific concerns and issues about the parents or carers or their baby are highlighted with the Community Midwife on the electronic transfer document and/or by telephone.

- Where multidisciplinary needs exist, these are identified on the electronic transfer records.

- The Community Midwife providing care in the post natal period will be the responsible professional for coordinating care and ensuring communication between other members of the multi-disciplinary team where required.

- The ‘Discharge of UHL Community Midwifery Care to Health Visitor’ form in the Red book is completed when the midwife transfers the families care to the Health Visitor.

This will include information regarding other agencies that may still be involved with the mother or birthing parent and their family.

- Parents and carers are signposted to discharge and postnatal information on the maternity website and given the 'Going Home Discharge information' on discharge.

- GPs should be made aware via E3 any TTO's mothers or birthing parents are prescribed on discharge.

2.7 Difficulty obtaining access or carryout post natal visits:

Where there is difficulty obtaining access to carry out a postnatal visit or newborn screening all reasonable attempts to do so must be made and documented in the health record.

See flowcharts below:

The following flow chart should be followed where access is unobtainable for the first and second visit:

Attempt at 1st visit – no access

↓

Community Midwife to check the woman's or birthing parent's details are correct with the ward of discharge

↓

Make contact with the woman or birthing parent by telephone to rearrange visit

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If unable to contact by telephone post a contact slip through the door informing the woman or birthing parent that someone will visit the next day and give the Community Office details in case the woman birthing parent wants to make contact sooner

If there are safeguarding concerns, and we cannot access on day 1, social care and the police should be informed.

↓

Ensure at this point that a further visit is arranged for the following day by informing the Community Team at the end of that working day

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Where there are safeguarding concerns if no access is gained on the second day contact the safeguarding team and social care. Also submit safeguarding form.

↓

If there is no access on the second day and there are no safeguarding concerns arrange to visit for a third day

↓

If no access on the third day post letter (Appendix 6) through the door informing the woman or birthing parent that further attempts will not be made. Ensure community office contact details are on the letter

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Send copy of letter in to the hospital for filing in the woman or birthing parent's health records

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Inform GP and Health Visitor.

The following flow chart should be followed where access is unobtainable for completion of the Newborn Blood Spot Screening Test:

Attempt visit on day 5 – no access

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Community Midwife to check the woman or birthing parent's details are correct with the ward of discharge

↓

Make contact with the woman or birthing parent by telephone to rearrange visit

↓

If unable to contact by telephone post a contact slip through the door informing the woman or birthing parent that someone will visit the next day and give the Community Office details in case the woman or birthing parent wants to make contact sooner

↓

Ensure at this point that a further visit is arranged for the following day by informing the community team at the end of that working day

↓

Where there are safeguarding concerns if no access is gained on the second day contact the safeguarding team and social care. Also submit safeguarding form.

↓

If there is no access on the second day and there are no safeguarding concerns arrange to visit for a third day

↓

If no access on the third day post letter through the door informing the woman or birthing parent that further attempts will not be made. Ensure community office contact details are on the letter

↓

Send copy of letter into the hospital for filing in the woman or birthing parent's health records

↓

Inform GP and Health Visitor and Screening Team

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Complete record of action

↓

If on gaining access the property is empty inform the safeguarding team and Bridge Park Plaza in order that they may attempt to track the woman or birthing parent

2.9 Safer sleeping advice

Please see - Safer Sleeping and Reducing the Risk of Sudden Infant Death Syndrome LPT Midwifery and Neonatal Guidelines

3. Education and Training

None

4. Monitoring Compliance

None

5. Key References

1. NICE Postnatal care NG194 (2021)
https://www.nice.org.uk/guidance/ng194/resources/postnatal-care-pdf-66142082148037
2. UHL Breast Feeding Policy
3. www.babyfriendly.org.uk
4. NHS (2021) Reduce the risk of sudden infant death syndrome (SIDS)

6. Key Words

Feeding support, Maternity support worker, Perineal, Screening, Visit

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Original author **Lead Officer:**	L Matthews (Q&S RM) & L Payne Snr RM Community Emily Wakelin – Community Matron	**Executive lead:** Chief Nurse

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
14.11.12	2	L Matthews	Minor corrections to reflect changes in electronic and paper documentation and audit personnel
30.10.13	3	L Matthews	Minor amendment to include examination of the perineum at each contact with the midwife
11.09.14	3	L Matthews and L Payne	Further clarification re requirements when perineal breakdown or infection
November 2017	3	L Payne and F Ford	Guidance on referral for infected abdominal wounds Blood spot screening to be done on day 5 up to day 8 at the latest. NIPE and hearing screening information added.
January 2018	3	C Wiesender, A Goodlife and C Dodd	Guidance added for action on systolic blood pressure on page 11
August 2019	4	L Matthews and S Taylor	Flow chart for no access amended as police do not attend anymore NIPE check section updated Letters updated to reflect practice
April 2021	4.1	H Archer and Flo Cox	SIDS information added. Common health problems in newborns updated.
May - August 2022 September 2022 October 2022	5	E Wakelin L Taylor Maternity Guidelines group Maternity Governance	Reference to gap in mortality rates for certain groups of women Updated advice re- bed sharing Signpost to ICON Assessment for suitability if MSW to conduct the day 5 PN check guidance and suitability criteria now included. Recognition and actions if persistent/worsening wound pain is reported Removed referral to GP NIPE assessment Approved
March 2025	6	E Wakelin A Foxwell L Taylor	Added; Primary visit - If there are safeguarding concerns, and we cannot access on day 1, social care and the police should be informed. Added sign post to health for under 5's website

Appendix 1: SCHEDULE OF POSTNATAL CARE

Visit	When	Who will visit	Care
Primary Visit	Day following discharge within 36 hours	Midwife face to face	• Assess wellbeing of woman or birthing parent and baby • Agree individualised plan of care
Second visit	Day 5-8	May be Midwife or Maternity Support Worker (MSW) for some low risk women or birthing parents	• Assessment of wellbeing of woman or birthing parent and baby & witness feed • Newborn Bloodspot Screening Test • Weigh baby
Final visit	Day 10 -14	Midwife	• Transfer to primary care • Signpost to other services
Extra support	As required	Midwife or MSW depending on reason for visit	• As appropriate

Appendix 2: COMMON HEALTH PROBLEMS IN WOMEN & BIRTHING PARENTS

Health problem	Action
Baby Blues	If symptoms are not resolved after 10-14 days, assess for postnatal depression, and if symptoms persist, evaluate further **(urgent action)**
Perineal pain, discomfort, stinging, offensive odour or dyspareunia	Offer to assess the perineum. Evaluate for signs of infection, inadequate repair, wound breakdown or non-healing **(urgent action)** Advise use of topical cold therapy and Paracetamol (if not contra-indicated), but if neither are effective consider oral or rectal non-steroidal drug (non-urgent action) Persistent pain is associated with prolonged morbidity
Dyspareunia	In cases of perineal trauma offer to assess the perineum. Advise use of water-based lubricant. If problem persist evaluate further (non-urgent action)
Headache	Advise women and birthing parents who have had epidural/spinal anaesthesia to report severe headache. For tension/migraine headaches offer advice on relaxation and avoiding factors associated with headache.
Persistent fatigue	Ask about general well-being and offer advice on diet, exercise and planning activities. If it affects the parents care of themselves or baby, evaluate underlying cause. Measure haemoglobin level and if low treat as appropriate
Backache	Give general advice on posture, lifting techniques and simple analgesia
Constipation	Assess diet and fluid intake. If changes in diet are ineffective advise use of a gentle laxative
Haemorrhoids	If haemorrhoids are severe, swollen or prolapsed, evaluate **(urgent action)** Otherwise advise dietary measures to avoid constipation
Faecal Incontinence	Assess severity, duration and frequency. If symptoms don't resolve, evaluate further **(urgent action)**
Urinary Incontinence	Teach pelvic floor exercises, and if symptoms don't improve or get worse, make referral to appropriate health professional
Urinary retention (within 6 hours of birth)	Advise methods of assisting urination such as taking a warm bath or shower. If this doesn't work, assess bladder volume and consider catheterisation**(urgent action)**

Urgent action – serious situation which requires appropriate action
Non-urgent action – continue to monitor and assess

Appendix 3 LIFE-THREATENING CONDITIONS IN WOMEN

Possible sign/symptom	Evaluate for	Action
Sudden or profuse blood loss, or blood loss and signs/symptoms of shock, including tachycardia, hypotension, hypo-perfusion, change in consciousness	Postpartum haemorrhage	**Emergency action**
Offensive/excessive vaginal loss, tender abdomen or fever, If no obstetric cause consider other causes	Postpartum haemorrhage/sepsis/other pathology	**Urgent action**
Fever, shivering, abdominal pain and/or offensive vaginal loss. If temperature exceeds 38°C repeat in 4-6 hours. If temperature still high or other symptoms and measurable signs evaluate further.	Infection/genital tract sepsis	**Emergency action**
Sever or persistent headache	Pre-eclampsia/eclampsia	**Emergency action**
Diastolic BP is greater than 100 mmHg or systolic more than 150mmHg and no other sign/symptom, repeat BP within 4 hours. If it remains above 100mm Hg after 4 hours, evaluate	Pre-eclampsia/eclampsia	**Emergency action**
Shortness of breath or chest pain	Pulmonary embolism	**Emergency action**
Unilateral calf pain, redness or swelling	Deep vein thrombosis	**Emergency action**

Emergency action – life threatening or potentially life threatening situation
Urgent action – potentially serious situation which needs appropriate action

Prompts for all of the above are included in the post natal record

Appendix 4: COMMON HEALTH PROBLEMS IN BABIES

Health problem	Action
Jaundice in first 24 hours	**STAT serum bilirubin and refer to neonatologist as Emergency action**
Jaundice in babies aged 24 hours or more	Record jaundice level by TCB or SBR, monitor overall wellbeing, hydration, output and alertness. Refer to Jaundice in Newborn Babies UHL Obstetric Guideline
Jaundice in babies starting aged 7 days or lasting longer than 14 days	Refer to local guideline Jaundice in Newborn Babies UHL Obstetric Guideline
Significantly jaundiced or unwell babies	Refer to local guideline Jaundice in Newborn Babies UHL Obstetric Guideline
Jaundice in breastfeeding babies	Advise frequent breastfeeding, waking the baby to feed if necessary, routine supplementation is not recommended. Refer to local guideline Jaundice in Newborn Babies UHL Obstetric Guideline
Thrush	Offer information and guidance on hygiene. If symptoms are causing pain to the woman an or baby treat with antifungal medication
Nappy rash	Consider hygiene and skin care, sensitivity, infection (for example, thrush)
Persistent painful nappy rash	Consider antifungal treatment. If it doesn't resolve evaluate further (non-urgent action)
No meconium in first 24 hours	**Emergency action**
Constipation in formula fed baby	Evaluate feed preparation, quantity, frequency and composition **(Urgent action)**
Diarrhoea	Evaluate **(Urgent action)**
Weight loss exceeding guidance within local policy	Refer to local policy "Weighing of the well term infant"
Excessive inconsolable crying, weak or high pitched cry	Reassure parents and assess general health, antenatal and perinatal history, onset and length of crying, nature of stools, feeding, any apparent jaundice, woman's diet if breastfeeding, family allergy, parent's response, factors making crying better/worse **(Urgent action)**
Colic	Advise parents that holding their baby during the crying episode and peer support may be helpful. Dicyloverine should not be used
Colic in formula fed babies	Offer advice and refer to GP if symptoms persist
Unwell baby	A full assessment, including physical examination, should be undertaken. Take temperature, and if it is below 36 or above 38°C evaluate cause **(Emergency action)**

Emergency action – life threatening or potentially life threatening situation
Urgent action – potentially serious situation which needs appropriate action
Non-urgent action – continue to monitor and assess

Appendix 5: COMMON BREASTFEEDING CONCERNS

Concern	Action
Cracked or painful nipples	Assess attachment and positioning, consider thrush
Engorged breasts	Advise frequent unlimited feeding, breast massage, hand expression, analgesia and that the woman has a well fitting bra. Review positioning and attachment.
Mastitis	Offer assistance with attachment and positioning and advise woman or birthing parent to continue breast feeding/hand expression, gently massage affected breast(s), take paracetamol and increase fluid intake. Advise to contact you urgently if it lasts more than a few hours.
Mastitis lasting more than a few hours	Consider antibiotics **(urgent action) Refer to GP**
Inverted nipples	Give extra breast feeding support
Breastfeeding concerns despite review of attachment and positioning	Evaluation for ankyloglossia by an appropriately trained professional
Perceived breast milk insufficiency	Reassure, review attachment and positioning and evaluate baby's health
Sleepy baby	Advise skin-to-skin contact or massage of baby's feet. If no improvement, assess general health

Urgent action – potentially serious situation which needs appropriate action

Appendix 6: Copy of standard letter for no access following 3 attempts

University Hospitals of Leicester NHS
NHS Trust

Dear ……

I left you a contact slip on …… informing you of a planned home visit as you were not available when I called. I have since tried to visit you again yesterday and today but you were still unavailable.

It is important that you have an assessment with your midwife, so that the health of you and your baby can be monitored and I am concerned that this has not been done.

I will not send you any further appointments. However postnatal care may be arranged for you if you contact us via the community office on: 0116 2584834 (Monday to Friday).

Yours sincerely

Community Midwife

Appendix 7: Copy of standard letter for no access after 2 visits and safeguarding issues

University Hospitals of Leicester NHS
NHS Trust

Dear ……

I left you a contact slip on …… informing you of a planned home visit as you were not available when I called. I have since tried to visit you again today but you were still unavailable.

It is important that you have an assessment with your midwife, so that the health of you and your baby can be monitored and I am concerned that this has not been done.

As I have been unable to contact you at this visit and you have not been in contact to make other arrangements a safeguarding form will be completed.

I will not send you any further appointments. However maternity services will always be available to provide care for you should you wish. I can be contacted via the community office on: 0116 2584834 (Monday to Friday).

Yours sincerely

Community Midwife

Appendix 8: Record of action for failed post natal visits

RECORD OF ACTION FOR FAILED POSTNATAL VISITS	
Patient Name: **Hospital Number:** **Date of Birth:** **Address:**	**Date of no access:** **(Please ring number)** ☐ **1st visit** ☐ **2nd visit** ☐ **3rd visit** ☐ **Visit for newborn bloodspot screening test**

Action taken:

	Yes	No	N/A
Demographics details correct			
1st failed visit – Woman or birthing parent telephoned and contact slip posted through door			
2nd failed visit			
2nd failed visit and safeguarding issued: Inform safeguarding Team Inform Social Care Team			
3rd failed visit – letter posted through door			
GP made aware of failed visits			
Health Visitor made aware of failed visits			
Screening Team informed if failed visit for blood spot screening test			
Copy of letter sent to hospital for filing in woman or birthing parents heath record			

Form completed by:…… Date:……

Designation:……