Aneurin Bevan University Health Board

Guidelines for Midwives Giving Care in Community Settings

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents:

1 Executive Summary

Childbirth is a social event that affects all family members and is based in the family context. Much midwifery care is given in settings which are close to or in the mother's home.

1.1 Scope of policy

These guidelines therefore, referral to all instances where midwifery care is given in community settings working within the framework of healthcare standards, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26.

The guideline specifically covers care during pregnancy. Intrapartum care in the community is covered by the All Wales Home Birth Guideline, and post natal care is covered by a separate hospital and community guideline.

1.2 Essential Implementation Criteria

1.2.1 Midwifery managers ensure safe systems and quality standards are embedded in the midwifery culture

1.2.2 Supervisors of midwives ensure that midwives are empowered to provide a quality service that encompass protection of the public

1.2.3 During a mother's pathway through the maternity services, care will be given in a variety of settings. The named midwife/deputy must ensure that prescribed maternity care is delivered.

1.2.4 In recognition of partnership working between women and the midwifery services, it is essential that women are involved in all aspects of service planning, provision and evaluation.

1.2.5 All midwives and student midwives need to be aware of the guideline.

2 Aims

This document provides midwives with the clear guidance they require to inform their daily practice.

3 Policy Statement

To provide equity of service throughout the organisation to enhance the health of mothers and babies

4 Responsibilities

The senior midwifery team and borough managers are responsible for the direct implementation and audit of these guidelines in community midwifery teams.

5 Training

Training will be cascaded through appropriate pathways, including mandatory days, team meetings and lead midwives to ensure all midwives are aware of the guideline and how to access the guideline via the intranet.

6 Monitoring and Effectiveness

Audit
The guideline's audit tool is attached, see appendix 10, community standards. This forms the basis of the community guidelines annual audit. The guideline will be reviewed on a triennial basis by the clinical effectiveness group.
Record of staff training will be kept by the specialist midwife for training and education.

The guideline will be reviewed on a triennial basis by the clinical effectiveness group.

7 References

A Strategic Vision for Maternity Services in Wales (2011) Welsh Government

All Wales Birth Centre Guidelines (2013)

Antenatal Screening Wales *Policy and Standards to support the provision of Antenatal Screening in Wales* December 2005

Ante Natal Care Routine care for the healthy pregnant woman Clinical guideline 6 2008.

Aneurin Bevan Maternity Services Strategy June 2009

Baby Friendly Initiative UNICEF United Kingdom

Confidential Enquiry into Maternal and Child Health Saving Mothers' Lives eighth report (2011)

National Service Framework for Children, Young People and Maternity Services in Wales (2005) Welsh Assembly Government.

Routine Post Natal care of women and their babies NICE 2006

NICE (May 2010) Clinical Guideline 98 Neonatal Jaundice

Routine Post Natal Care of Women and their Babies Guidelines NICE July 2006.

NICE Intrapartum Care Sept 2007

NICE Pregnancy and Complex Social Factors Sept 2010.

NICE Induction of Labour 2008

NMC Midwives Rules and Standards (2010),

NMC The Code, Standards of conduct, performance and ethics for nurses and midwives (2010)

NMC Record Keeping Guidance for nurses and midwives (2010).
National Service Framework, 2004.

See Also on Aneurin Bevan University Health Board Intranet

Nursing uniform/dress code Policy 4006

Lone Workers Policy & guidelines 0044.

Telephone Use Policy 0076.

Midwifery Led Care – Guideline for the provision of interpreters for women whose first language is not English 19/11/2009

Midwifery Led Care – Pathway into Maternity Services Referral letter 19/11/2009

Aneurin Bevan University Guidelines for Safeguarding. (2014)

Appendix 1 – Care in community Settings

Care in Pregnancy

Women should always be treated with kindness, compassion, respect and dignity. The views, beliefs and values of the woman in relation to her care and that of her baby should be sought and respected at all times. Treatment and care should take into account the woman's individual needs and preferences. It is appreciated that some pregnant women with complex social factors do not wish to use antenatal care services. Women should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. The midwife should ensure at least one occasion where the midwife and woman can discuss domestic violence and safeguarding issues on a one to one basis. Good communication is essential, supported by evidence based information, to allow women to reach informed decisions about their care. Accurate and contemporaneous records should be kept of all ante natal contacts.

Appointment schedule

In an uncomplicated pregnancy nulliparous women should receive 10 appointments over the course of the pregnancy and parous women should receive 7 appointments.

Ideally the booking appointment should be less than 10 weeks from the last menstrual period. (LMP)

More than one appointment may be needed for the initial appointment, especially for women who are pregnant for the first time.

Early appointments may need to be longer to allow the woman to discuss any concerns and to ensure enough time is available to give detailed information about screening and to allow informed decisions.

Women will be booked according to their level of need, bearing in mind that the name midwife remains as the co-ordinator of care eg

Home and community care
Midwifery led care
Consultant led care

Safety of Staff and Equipment

In order to safeguard staff, all staff working in the community must adhere to the lone worker policy.

Staff must not leave medical records, drugs or medical equipment in a car overnight. The situation must be risk assessed and a safe area of the midwife's home may be used for overnight storage. Medical records must be tracked from the hospital department, transported in a sealed envelope and tracked back to the hospital department in a timely manner.

Control of Infection

During a working period, staff will experience a wide variety of care environments. It is important that the principles of the control of infection are followed. Out door coats should be removed prior to direct patient contact. Staff must clean their hands by washing or using alcohol rub before and after any patient contact. During a pandemic episode, staff will adhere to control of infection directives.

Initial Contact of the woman with a community midwife

Ideally prior to 10 weeks from the LMP.
The initial contact must take place in a confidential area.
Obtain the woman's history including
Basic demographic information, including occupation to allow a risk assessment of working during pregnancy.
Medical, surgical and obstetric history
Family history
Mental health problems
Allergies
Alcohol, smoking and drug history.
Encourage the woman to use the Stop Smoking Wales service.

Physical Examination

Undertake base line examinations including:
Blood pressure (manual sphygmomanometer)
Urinalysis (mid stream specimen of urine)
Body mass index (BMI)
Any other relevant examinations, depending on her history
Estimate the expected date of delivery from the last menstrual period. (LMP)

Planned place of birth

In discussion with the woman, consider her choice of place of birth
Consider pre-existing conditions:

Cardiovascular disease, including hypertension
Renal disease
Diabetes and other endocrine disorders

Current psychiatric disorders or previous psychotic disorders
Venous thromboembolic disease
Known haemaglobinopathies(or haematological disorders)
Autoimmune disease
Epilepsy requiring anticonvulsants
Malignant disease
Severe asthma
Substance abuse, including alcohol abuse
HIV infection
Hepatitis B
Known genetic disorders
Identify women who have had female genital multilation (FMG)

Check for the following factors which may indicate that the woman requires additional support or consideration:

Lack of social support
Over age 40 years
Teenage pregnancy
Obesity (Body mass index more that 35kg/m²)
Underweight (BMI less than 18 kg/m²)
More than 6 pregnancies
Poor social support
History of or current domestic violence
Smoking
Use of recreational drugs (eg heroin, cocaine, ecstasy,)
Check for previous pregnancy related complications that require specialist care:
Three or more consecutive miscarriages
Fetal loss in second or third trimester
Neonatal death or still birth
Retained placenta on more than one prior occasion
Previous antepartum or post partum haemorrhage on two occasions
History of pre eclampsia or haemolysis, elevated liver enzymes, low platelets (HELLP) syndrome
Premature birth
Previous congenital anomaly
Previous intrauterine growth restriction
Previous baby weighing less than 2.5 kg or more than 4.5 kg
Rhesus isoimmunisation or other significant blood group antibodies
Uterine surgery including caesarean section, myomectomy or cone biopsy
Puerperal psychosis
Grand multiparity (More than six pregnancies)

Give specific information on antenatal screening, including the risks and benefits of the screening tests. Leave written information with the woman.

The woman should be informed of how she will be notified of her dating scan appointment.

Mental Health

Consider the possibility of ante natal depression or other mental health disorder (pre-existing of new) at an early stage following confirmation of pregnancy.

Women with emotional or mental distress associate with a previous traumatic birth experience should not routinely be offered a formal session to reconsider the experience; instead offer support and answer questions as required.

Refer women with diagnosed mental health disorders as defined by NICE guidance to the lead midwife for mental health and the mental health service for a care package to be developed. Ensure the condition is followed up at all subsequent ante natal contacts. Women with mental health conditions not covered by NICE guidance should be cared for in conjunction with the own GP.

If necessary arrange a consultation within one month of the initial assessment.

16 to 19 week appointment

Review the results of maternal ante natal screening and consider additional tests required. Check the individualised growth chart is within the hand held record

Measure the blood pressure and test for proteinurea.

Investigate haemoglobin levels below 11gd/l and consider iron supplements.

Check the woman knows the details of her anomaly scan appointment that will be in the time period of 18 to 20 weeks.

Inform the woman that she should feel fetal movements by 20 weeks. Any reduction of fetal movements needs to be reported to the maternity team.

28 week appointment

Measure the blood pressure and test for proteinurea.

Measure the symphysis fundal height and plot on the individualised growth chart.

Ask the women to describe her fetal movements. Auscultate the fetal heart.

Offer repeat testing for rhesus, blood groups and haemoglobin level.

Offer anti D immunoglobulin to rhesus negative women.

Check the women has enrolled onto a local parent education programme.
Document all findings in the hand held records and appropriate medical / IT records.

34 week appointment
Measure the blood pressure and test for proteinurea.
Measure the symphysis fundal height and plot on the individualised growth chart.
Perform an abdominal palpation to confirm fetal lie, presentation, engagement. Ascultate the fetal heart. Ask the women to describe her fetal movements.
Document all findings in the hand held records and appropriate medical / IT records.

By the 34th week appointment the woman and midwife should have discussed the birth plan including:

The woman's preferred place of birth
Birth companions
Type of birth
Birthing and any specialised equipment
Fetal monitoring in labour
Positions for labour
Requirements for an episiotomy
Delivery of the placenta
Any special considerations eg, customs, diets
Recognise active labour
Coping with pain
Feeding the baby, the benefits of breast feeding
Vitamin K
Routine post natal care
Attendance at ante natal classes.

36 week visit
Measure the blood pressure and test for proteinurea.
Measure the symphysis fundal height and plot on the individualised growth chart.
Perform an abdominal palpation to confirm fetal lie, presentation, engagement. Ascultate the fetal heart. Ask the women to describe her fetal movements.
Document all findings in the hand held records and appropriate medical / IT records. Welsh Government evaluate maternity care based on data returns from the initial community contact and the 36th

week contact. It is vital for the strategic direction of the maternity service that these data are recorded.

If on abdominal palpation a breech presentation is diagnosed, refer the woman for an ultrasound scan.
Women with confirmed breech presentation should be offered referral for consultant obstetrician clinic for external cephalic version (ECV) and return to midwifery led care if the ECV is successful.
By the 36th week appointment the woman and midwife should have discussed
Preparation for labour and birth
Recognition of active labour
Breastfeeding techniques
Care of the new baby
Vitamin K
Newborn screening tests
Post natal self care
Awareness of baby blues and post natal depression

38 week visit
Measure the blood pressure and test for proteinurea.
Measure the symphysis fundal height and plot on the individualised growth chart.
Perform an abdominal palpation to confirm fetal lie, presentation, engagement. Auscultate the fetal heart. Ask the women to describe her fetal movements.

If a breech presentation is diagnosed, refer the woman for an ultrasound scan.

Women should be informed that most women will labour spontaneously by 42 weeks
Offer information regarding prolonged pregnancy including
Membrane sweeps from term plus 7 days.
Induction of labour at term plus 12 days
Document all findings in the hand held records and appropriate medical / IT records.

41 weeks appointment
Measure the blood pressure and test for proteinurea.
Measure the symphysis fundal height and plot on the individualised growth chart.
Perform an abdominal palpation to confirm fetal lie, presentation, engagement. Auscultate the fetal heart. Ask the women to describe

her fetal movements. The importance of fetal movements must be stressed.
Document all findings in the hand held records and appropriate medical / IT records.
Offer a membrane sweep
Offer induction of labour for term plus 12 days.

42 week appointment
Measure the blood pressure and test for proteinurea.
Measure the symphysis fundal height and plot on the individualised growth chart.
Perform an abdominal palpation to confirm fetal lie, presentation, engagement. Auscultate the fetal heart. Ask the women to describe her fetal movements.
Document all findings in the hand held records and appropriate medical / IT records.

From 42 weeks, women who decline induction of labour should have twice weekly cardiotocograph (CTG) and examination of amniotic pool depth. Ask the women to describe her fetal movements. The importance of fetal movements must be stressed.

Appendix 2 On Call Guidelines

The following midwives participate in on call rotas,
Midwives working in community settings
Lead midwives
Midwife managers
Supervisor of Midwives

The purpose of this guideline is to give guidance for on call systems within the community setting.

All midwives working in community settings have access to:
A working mobile phone,
Appropriate equipment eg personal alarm

All midwives participating in the on call systems:
Follow the Health Board's Lone Worker Policy.
Keep a midwifery unit aware of their location, time of arrival and departure at a site.
Be responsible to ensure their mobile phone is working correctly at all times.
Submit timely and accurate records of their on call activity.
Have access to GPS and maps.
Access to the midwife responsible for maintaining the on call rota.
Adhere to the Sickness and Absence Policy

Central Switchboard
Has an up to date on call rota that covers all areas.

All Clinical Areas:
All on call rotas are kept in the off duty folder on B5, YYF and Labour ward at NHH.
Have record of current child protection issues.
Have a record of pending home births, with maps.

Appendix 3 Care of Pregnant Women with complex social factors

Four groups of pregnant women are identified as exemplars

- Women who misuse substances (alcohol and / or drugs)
- Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English
- Young women aged under 20 years
- Women who experience domestic abuse.

Midwives must work closely with the primary healthcare team, local agencies including social care and third sector agencies to coordinate ante natal care for these women.

For women who are pregnant and have not had a booking appointment: at their first contact with a health care professional, discuss the need for ante natal care, offer the woman a booking appointment as soon as possible, ideally before 10 weeks or offer referral to sexual health service.

For women who misuse substances: involve local agencies, including social care and third sector agencies to coordinate ante natal care. Midwifery support is through the specialist midwife.

For women who are recent migrants, asylum seeker or refugees, or who have difficulty reading or speaking English: provide information about pregnancy and antenatal services in a variety of formats, settings and languages. If a woman does not speak English, or her English is poor, do not use a family member for interpretation, ring Language Line. Midwifery support is through the specialist midwife.

For teenage women: consider one stop shops for ante natal education and ante natal appointments in peer groups in a variety of settings.

All of these women need clear care pathways and information for their pregnancy. The care pathway should include

1 Sources of help and support for domestic abuse, social services, the police, women's refuges.
2 Future care appointments and referrals.
3 Contact details of interpreter service
4 Contact details of her chosen support / next of kin.

The woman should provide a contact phone number on which it is safe to contact her.

Appendix 4 Guideline for Routine Screening.

Maternal Haematological Screening Offered in line with All Wales Ante Natal Screening Programme

At the initial visit, verbal and written information regarding ante natal ultrasound scans and haematological screening tests, are given to the woman.

1 A follow up appointment is made where after confirming the woman's choice and after seeking verbal consent, the midwife / phlebotomist takes blood for: **-**

- Blood Group and antibodies
- Rubella – antibodies present –immune. Mothers found to be susceptible should be offered post natal vaccination.
- Hepatitis B
- HIV after counselling
- Syphilis
- Full Blood Count
    - Haemoglobin less than 100g/l refer to Consultant for iron replacement
    - WBC normal range 5-11
    - Platelets 150-400
    - MCV 87-101
    - MCH 27-32

Other screening identified through booking history

- Sickle cell
- Thalassaemia
- Toxoplasmosis
- Cytomegalovirus
- MRSA
- Mothers with raise BMI >30 are offered glucose tolerance test at 28 weeks.

2. Between 15 weeks - 18 weeks 4 days ,maternal serum quad test screening for Down syndrome is offered

3. Repeat blood samples are taken at 28 weeks
    - Blood group and antibody screen
    - Full blood count.

Women are informed of their results by the Maternity Service within 15 working days of the sample being taken.
The midwives who arranged for blood to be taken **must** ensure all results are viewed and actioned.

It is imperative that results are followed through and actioned appropriately.
Results may be accessed via clinical work station at GP practice, ABUHB computer terminal, and if necessary Tertiary Centre.
Any abnormal screening result must be reviewed by the obstetric team, discussed with the mother and a plan of care put in place.

Ultrasonography
All mothers are offered ultrasound scans in line with Ante Natal Screening Wales (2006), dating scan is offered between 8weeks 5 days and 13 weeks, anomaly scan is offered between 18 to 20 weeks.

Urinary Retention
All mothers first void of urine following delivery is assessed in line with the Guideline for post natal care of mother and infant. If screen positive, then the guideline 'postnatal retention of urine' must be followed.

Neonatal Screening
All parents are offered examination of the new born in line with the Post Natal NICE guidance (2006).

All babies are observed for neonatal jaundice within the first 24 hours. NICE guidance Neonatal jaundice (2010)

Neonatal Hearing Screening
All parents are offered 'Neonatal hearing screening' in line with All Wales Newborn screening programme.

Neonatal Haematological Screening

All parents are offered 'Newborn blood spot screening' in line with the Policy for Newborn Blood spot Screening: results processing (policy no 2502)

Appendix 5 Equipment List For Midwives Working in the Community

Antenatal

Sphygmomanometer; Stethoscope**;** thermometer
Urine Pots; bili labstix; alcohol hand gel
Non stretch tape measure
Pinard stethoscope Doppler Sonic Aid ;Gel
General Health Promotion Leaflets
Vacutainers, Tourniquet, Syringes, Needles, Blood Bottles; Gloves; Medi Swabs; Cotton balls; Micropore
Path Bags Blood Forms

Intrapartum – additional requirements

Sterile gloves; lubricant jelly; Speculum; Light source; Incontinence Pads;
Sterile Delivery Pack; Sterile Swabs; Sanitary Pads; Large Artery Forceps Curved; Scissors; Stitch Holder; Toothed Forceps; Vicryl Rapide 2.0; Stitch Cutter; Sterile Tampon;
Jug; Plastic Draw Sheet; Plastic Aprons; 1 IV giving set
Venflon; Intravenous Giving set; Tegaderm Dressing; Yellow tiger (soiled dressings/waste) Yellow Placenta Bags; Goggles/Visor; Amnihook; indwelling and in out Urethral Catheters;
Baby Wrap; Plastic cord clamps; Tape Measure; Baby Books;
Continuation Sheets; Low Risk Pathway; Neonatal Resus Bags 500mls; Documentation; Tempadots; electronic baby scales (calibrated as manufacturer's recommendations); Swabs for Microbiology Sample;
General Info for Newborn Screening, Cot Death, etc

Post Natal

New born blood spot Forms and Bags Spot Plasters Uristix 3 neonatal lancets

Drugs

Syntometrine 1 mg; Ergometrine 500 microgrammes;
1 litre hartmans intravenous fluid
Lignocaine 1% 5 mls
500 mls normal saline for bladder filling
Vitamin K 2 mg in 0.2 ml;

Appendix 6 GUIDELINES FOR MIDWIVES IN THE EVENT OF A STILLBIRTH IN THE COMMUNITY – mother declines admission to hospital

If the mother declines an advised hospital admission for herself or the baby then:

1. Following confirmation of death by the GP, advise the family to contact a funeral director of their choice or advise regarding the Aneurin Bevan University Health Board funeral contract.

2. Contact the Maternity Department if you are unsure of the procedure to be followed in the event of a stillbirth, and carry out the procedures at home. (Weight, length etc.)

3 Midwives involved should consider contacting their supervisor of midwives for professional support. Staff should also consider using Aneurin Bevan University Health Board's staff support service.

Action to be taken if you <u>were not in attendance</u> at the time of birth:-

1. Record keeping should include the time of the initial call, and the time of your arrival.
2. Call medical aid, inform Supervisor of Midwives and midwifery manager on call / Head of Midwifery.
3. Call the police.
4. Do not move the mother or the baby (unless it is a medical emergency when emergency care / resuscitation of the mother must be given). Leave all blood products and clothing etc, until the area has been checked, and examined by the police.
5. Follow the procedures as outlined for still birth in the community guideline procedures once given police clearance.
6. As the attending professional the midwife may be called as a witness should a formal police investigation follow. Therefore, it is recommended to keep a personal record of events in addition to the clinical records and diary entries.
7. Advice and support should be sought from a Supervisor of Midwives before submitting any statements.
8 Complete a datex entry.
9 Midwives involved should consider contacting their supervisor of midwives for professional support. Staff should also consider using Aneurin Bevan University Health Board's staff support service.

Appendix 7 Guidelines for giving parents information regarding Vitamin K

1. All midwives should carry information sheets regarding the use of Vitamin K.

2. The information sheet should be given to the parent/parents during the antenatal period then discussed at the 30 week visit.

3. The written information should be explained verbally and clarified as required.

4. The midwife should record in the hand held records that the information has been given.

Appendix 8 Sepsis

All infection can be reduced if the attending midwife considers control of infection principals.

Prior to Clinical Examination

- The clinician's outer coat to be removed prior to clinical examination
- Clinician's arms to be bare below the elbow for any clinical examination / procedure for both baby and mother.
- Clinicians hands to be cleaned by washing or the use of alcohol jel.
- Following examination, the clinician must clean their hands again by washing or the use of alcohol jel.

Information

There is an increase in deaths due to community acquired beta haemolytic streptococcus Lancefield group A (streptococcus pyrogenes). Most of the deaths occur between December and April, and are preceded by a sore throat or upper respiratory tract infection. One third of the deaths occurred prior to 24 weeks. Most deaths occurred in the post natal period, more than half following caesarean section. Seven mothers died from sepsis following a vaginal birth. Sepsis in pregnancy is often insidious in onset but can progress very rapidly.

Early recognition, urgent transfer to hospital and prompt aggressive treatment saves lives. Tachapnoea, neutopaenea and hypothermia are all ominous signs. Diarrhoea is common with pelvic sepsis. In pregnancy, the combination of abdominal pain and suboptimal or absent fetal heart rate may be due to sepsis as well as placenta abruptio.

Requirements

- Early recognition and prompt management of genital tract sepsis
- Clear clinical leadership, multidisciplinary collaborative approach.
- Careful documentation of signs and treatment – use MEOWS chart
- Systemic antibiotic cover
- Careful fluid balance

All women must be advised of the signs and symptoms of infection and how to take steps to prevent its transmission.
Encourage women in these circumstances to seek urgent medical advice from their GP or the maternity service of they feel at all ill.
When a woman complains of feeling unwell, the midwife **must** take a set of observations including respiratory rate and effort, pulse, temperature. Observations must be clearly documented with any abnormal recordings reported to the consultant unit and admission to hospital arranged.

Appendix 9 On Call Staff Safety

If a midwife is called out on a visit out of hours, they must contact the agreed central point (Delivery Suite, YYF or ward B5) to notify their intention to conduct a visit in the community. The woman's details and reason for the visit must be recorded.
During out of hour visits the midwife must maintain 2 hourly contact with the agreed central point (Delivery Suite, YYF or ward B5). If this is communication is not maintained the hospital midwife will attempt to contact the community midwife on call via her mobile phone or the woman's land line. The midwife must contact the contact centre on his/her return home.

. If contact is not established; the hospital midwife will attempt to call the community midwife at home. If this fails, emergency procedure must be followed:

The incident must be reported to the following: -

- Supervisor of midwives on call
- Midwifery manager on call
- Head of Midwifery
- Police
- Midwife's Next of Kin (Contact file in the Community Midwives Office)

Appendix 10 Community Midwifery standards

No	Standard	Rationale	Process	Compiled	Review date
Diary Audit					
1	All entries to be recorded in BLACK ink	▪ NMC guidelines (2009) & Local Policy ▪ For reproduction purposes ▪ Records may be required for legal purposes ▪ Audit	▪ All diary entries will be written clearly in black ink ▪ All forms submitted must be legible and completed in black ink ▪ Only approved abbreviations should be used	2013	2016
2	Every diary entry must include the Personal details and contact telephone number of the woman	▪ Clear identity of the woman's detail ▪ A means of contacting the woman if required ▪ Compliance with NMC guidelines and Local Policy (2009) ▪ Audit purposes	▪ Name, Address and contact telephone number to be recorded in the midwife's diary at every visit ▪ All entries referring to a woman details must be contemporaneous ▪ Each visit must be communicated to the person responsible for the co-ordination of work in the Master File	2013	2016
3	All entries must clearly identify the reason for a home visit	▪ Clear identification to facilitate duty of care ▪ To plan daily work activity ▪ Audit ▪ NMC guidelines & Local Policy	▪ Each visit must identify antenatal gestation or postnatal day ▪ Each entry must include a brief account of clinical indication for visit ▪ Each visit the midwife must document a brief summary of any investigations undertaken ▪ Each visit the midwife must document if a referral is made stating the reason for the referral ▪ Each visit the midwife must document a plan for follow-up of care ▪ If called out for a home visit, the time of the call and time of return to home base should be clear documented in diary	2013	2016

4	The midwife's off-duty must be clearly be recorded in her/his diary	▪ To plan the team's and personal work activity ▪ Compliance with local Policy (2006) ▪ Audit	▪ Each midwife must clearly document off-duty in their diary, using approved abbreviations	2013	2016
5	All clinically related information relayed via mobile phone must be clearly recorded using the SBAR method	▪ To act as an *'aid-memoir'* for the midwife ▪ Compliance with Telephony Policy ▪ Audit	Mobile phone use for work purposes only ▪ Personal use of mobile phone must be registered and paid for by user ▪ All received calls must be recorded in Diary ▪ Texts from women must be discouraged ▪ Mobile phones must not have answer phone facilities	2013	2016
6	All Antenatal clinic activity must be clearly identified	▪ To collate clinical activity for monthly returns ▪ To ensure defaulters are appropriately followed-up ▪ Audit	▪ The GP surgery must be clearly identified ▪ The number of attendees expected must be recorded ▪ The number of attendees seen ▪ The number of defaulters clearly identified and the action taken to ensure midwifery care follow up	2013	2016
7	All midwives based within the community must submit monthly statistical returns	▪ For Workforce planning purposes ▪ Audit	▪ All statistical forms must be submitted to Team Leader by the *end of the day, 2nd Friday of the Month* ▪ All statistics will be shared with staff in order to assist consistency, compliance with guidelines and identify any development needs, on a rolling programme.	2013	2016

8	To minimise the risk to personal safety to Lone Workers in the Community	▪ To reduce the risk of hazards and maximise the safety to all staff working in the community ▪ To ensure compliance with the Lone Worker Policy ▪ Welsh Risk Pool Standard ▪ To identify a community midwife's location in an emergency ▪ ACPC & DA guidelines	The midwife to conduct a 'Risk Assessment' at Home Bookings ▪ The midwife must complete a risk assessment form for any additional risk issues identified in the antenatal period and all relevant documentation must be completed ▪ Any identified risk issues must be clearly document in the unit's 'Risk File' and details shared with relevant Healthcare Professionals ▪ The midwife must complete a further risk assessment on the first postnatal visit at home and this must be documented If there is a known risk with a woman/family, two staff members to conduct the visit ▪ A designated midwife will collate all daily visits for the team. Then this information must be re-laid as per individual midwife's caseload to a central point and recorded in the Master File. ▪ All daily visits should be identified in a chronological order in individual works diary ▪ Any additional visits that are handed to the community midwife during the working day, must be reported and documented in the 'Master File' ▪ The midwife must contact the Borough Manager or Community Midwife working in the hospital that their working day has ended. This must be recorded in the Master File.	2013	2016

9	Every community midwife must maintain a Register of her/his Caseload	▪ NMC Guidelines ▪ Local Policy ▪ Professional Accountability ▪ Audit	▪ The Named Midwife must maintain a record of all women 'booked' on a monthly basis in her register. The register may be electronic or paper based. (Name, address, telephone numbers, EDD and any concerns/conditions and the birth outcome. ▪ The community midwife must facilitate continuity of carer to her caseload ▪ The community midwife must maintain and up-date her register on a regular basis	2013	2016
10	Wherever possible, maternity bookings should be conducted in the woman's home or a venue of her choice	▪ To ensure privacy and confidentiality ▪ Community based access to maternity services	▪ Following the notification of the woman's pregnancy, the community midwife will make contact with the woman and arrange a mutually convenient appointment at the woman's home ▪ Using the information obtained from the Booking, the community midwife will risk assess the pregnancy and confirm the pregnancy pathway appropriate for the mother. ▪ Subsequent antenatal appointments will be arranged between community midwife and the woman in accordance with NICE and local guidelines ▪ Community midwife to provide the woman with details of contact numbers on a 24hr basis	2013	2016

11	Every woman during the antenatal period should be approached regarding the Routine Enquiry into Domestic Abuse	▪ Sign posting vulnerable women and children to appropriate services ▪ National and local policy ▪ Audit	▪ When appropriate, the community midwife should compile with the National and ABUHB guideline on Routine Enquiry for Domestic Abuse. On 2 occasions the RE question must be completed in the hand held records. ▪ If a disclosure is made, a DA2 form should be completed and then copied to the Child Protection midwife, the Health Visitor and filled into the hospital clinical notes. ▪ If the event of a DA2 disclosure the midwife must following the National and organisation's guidelines on Domestic Abuse.	2013	2016
12	Every midwife must provide written and verbal information on Antenatal Screening Tests to all woman	▪ To facilitate informed choice on Antenatal Screening for all women ▪ Code of Professional Conduct ▪ ASW Directive ▪ ASW Balance Score Card Audit ▪ organisation's Policy	▪ The woman must be given verbal and written pre-testing information and this should be recorded in the hand held records ▪ The woman's informed verbal consent is required for these tests and a record of her consent must be made in the hand held records ▪ Time must be allocated to facilitate questions by the woman and Partner ▪ All midwives must compile with organisation's policy when providing information regarding Antenatal Screening	2013	2016

13	All women who default antenatal appointments will be followed up by the midwife	▪ To establish a reason for non-compliance ▪ To facilitate an improvement in antenatal attendance	▪ The midwife will attempt to contact the woman via the telephone. If this fails, the midwife will visit the woman's home to establish contact or the midwife will arrange another appointment via a calling card ▪ If a problem is identified in accessing antenatal care, the midwife should discuss and organise an individualised plan of care ▪ Information relating to midwife's failure to make contact with the woman must be shared with the multidisciplinary team and other allied professionals ▪ All attempts at making contact with the woman must be clearly documented in midwife's diary and the woman's clinical records	2013	2016
14	All service users must have access to Parent Education	▪ All pregnant women and their partners should have information relating to the preparation for parenthood	▪ Preparation for parenthood education will be facilitated by a midwife on a one-to-one basis or via classes ▪ The Birth Plan in the hand-held records must be completed for all women by 36 weeks of pregnancy. ▪ Information on parent education classes will be provided by the midwife ▪ Any woman with complex needs will be signposted to relevant groups	2013	2016

15	Effective communication with the Primary Healthcare/Multidisciplinary Team	▪ To ensure there is effective two-way communication between multidisciplinary teams	▪ If a risk is identified relating to a woman and/or her family; this must be clearly communicated to the Primary Healthcare/Multidisciplinary Team and documented as per guidelines ▪ The named midwife or deputy to attend all Case Conferences ▪ A community midwife must attend the Primary Healthcare Team meetings	2013	2016
16	Continuity of Carer (Named Midwife)	▪ Continuity of Care ▪ Audit ▪ Meeting women's needs ▪ Quality assurance	▪ The named midwife should maintain continuity of carer whenever possible. ▪ The named midwife in partnership with the woman should document a plan of care ▪ During routine postnatal visiting, no more than three midwives should be providing care to mother and baby ▪ If another midwife is required to visit, the named midwife must communicate the identified plan of care ▪ The named midwife must provide a clear and concise hand over of care at the point of transfer to the Health Visitor. This must be documented in Postnatal records	2013	2016
17	Information on Infant Feeding will be provided for all women	▪ To encourage all women to Breast Feed ▪ Evidence demonstrates that Breast Feeding is the optimum method of feeding Newborns ▪ Maintenance of BFI Standards ▪ Compliance with ABUHB's Infant Feeding Policy	▪ All staff must comply with ABUHB's Policy in relation to Infant Feeding	2013	2016

18	Safe keeping of care records and audit / surveys	▪ To ensure all contemporaneous records are held centrally. ▪ To ensure surveys and audit returns eg SSI are available in a timely manner.	▪ All care records and surveys will be returned to the base unit within 24 hours of the final care episode	2014	2016
19	All service users must have an opportunity to comment on the standard of care they have received from Maternity Services	▪ To ensure all users participate in the provision and development of maternity services ▪ Health care Standards	▪ All women will be provided with a Maternity Care Evaluations form in the postnatal period ▪ Information regarding Patient Panels will be advertised ▪ Quarterly Newsletter will be available ▪ All midwives must be aware of the organisation's Complaints Procedure in order to advise women in the event of issues relating to care provision ▪ All woman should be provided with an opportunity to discuss their child birth experience ▪ If a community midwife is unable to resolve any issues raised by the woman relating to her care, this should be communicated to their line manager ▪ Use of graffiti boards	2013	2016
20	All midwives based in the community, must attend Mandatory Training	▪ Continuing Professional Development ▪ Welsh Risk Pool Standards ▪ Audit	▪ Each midwife based in community is professionally accountable and responsible for their own attendance at All Mandatory Training days provided by the Directorate on an annual basis ▪ Each midwife based in the community is professionally accountable and responsible for the completion of the on-line Mandatory Training provided by the health board	2013	2016

Aneurin Bevan University Health Board
Maternity Care in the Community
Monthly Audit of Work Diaries

The diary entries of two midwives for a period of 1 week will be examined by each borough manager.

	Midwife 1	Midwife 2		Action
All diary entries are legible in black ink				
Only approved abbreviations are used				
There is clear identification of the woman and a means of contacting her				
The reason for the visit is identified				
The reason date time and Venue for follow up is identified				
The midwife's shifts are written, with contacts with Lone Worker coordinator				
SBAR format is used for all phone calls				
ANC attended show Venue, number of attenders with defaulters and subsequent action				

Auditor ---------- Date ----------