Maternity Ward Discharge/Transfer Procedure (including SWAMS, Inland MGP and District Maternity Sites)

1. Guiding Principles

To ensure all women and neonates receive appropriate care and follow up postnatally for a minimum of five (5) days and up to four weeks postpartum upon leaving the hospital inpatient services.

Expected length of hospital stay is 6-24 hours following uncomplicated vaginal birth and 48-72 hours following uncomplicated caesarean section birth.

The minimum required 6 hours stay in hospital following a spontaneous vaginal birth excludes those women under the care of the Midwifery Group Practice whom are covered by separate procedures.

Upon planning for discharge or transfer of a woman and/or newborn to their local district site or service , SWAMS or it is essential that the receiving service is made aware of, and receives ISOBAR handover pertinent to the ongoing care of the mother newborn dyad.

The primary midwife shall initiate the discharge plan by discussing with the woman the expected date of discharge.

1.1 A woman and baby may be eligible for midwife-led discharge as per KEMH guidelines:
Discharge/Transfer of a Postnatal Woman to Home/visiting Midwifery Service/Care of General Practitioner
Discharge/Transfer of Healthy Infants from Postnatal Ward

2. Procedure

2.1 Visiting Midwifery Service

The Visiting Midwifery Service (VMS) is a home visiting service for postnatal women and neonates requiring the ongoing care of a registered midwife.

2.1.1 A woman may be eligible for VMS if:

- She has birthed at Bunbury Hospital and resides in the Bunbury region. If the woman resides close to district maternity site should be referred to that site for postnatal follow up.
- The discharging midwife has completed a home visit risk assessment form in PIARS and the patient is deemed to be low risk
- Mother and baby are documented as being medically clear for discharge home
- Postnatal discharge guidelines have been met for both mother and baby
- The woman agrees to remain at home between 1000-1600 for visits and is feeding independently or has a breast feeding management plan MR 76 in use.

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2.1.2 Once the mother and baby are suitable for VMS, please ensure that:

- The midwife has completed the **Stork VMS Summary** and discussed the reminders for discharge on the birth pathways.
- If risk factors are identified, ensure the **Special Child Health Referral** has been completed and emailed.
- The STORK database has been updated with all postnatal treatments for mother and baby and the **Stork Child Health Summary** has been confirmed with the mother and placed in the Child Health Book (purple)
- The patient address and phone numbers are confirmed with mothers as correct
- Specific directions for rural or difficult addresses are documented on VMS referral paperwork
- The Home Visit Risk Assessment form has been entered on Patient Information Activity Reporting System (PIARS) database.
- Ensure COVID-19 risk assessment questionnaire has been completed prior to discharge.
- Forms required for discharge to VMS:

  MR80 WACHS Vaginal Birth Care Plan

  MR81 WACHS Caesarean Birth Care Plan

  MR75 WACHS Newborn Care Plan

  Newborn Blood Spot Screening Test (NBST) card (if not done), Breastfeeding Management Plan MR 76

  STORK VMS Summary

  MR 8C WACHS-SW Maternal Postnatal Outpatient Form

  MR 8D WACHS-SW Neonatal Outpatient Form

  Outpatient mother/baby stickers are placed in a plastic sleeve and put in the VMS office tray.
- If specific reason for VMS visit, other than routine follow up, ensure documented on VMS Stork summary.
- Give medical record file to the ward clerk for scanning to BOSSnet.
- Give woman Maternity Ward – Bunbury Hospital VMS brochure ‘Some Reminders Prior to Discharge’

2.1.3 Recommended frequency of VMS visits:

- Frequency of visits by the VMS midwife is dependent upon many variables, with the overriding factor being the individual requirements of the mother and her baby.
- Mothers or babies requiring visits that extend beyond day five (5) must be discussed with the Clinical Midwife Specialist (CMS) / Clinical Midwifery Manager (CMM) and have the clinical reason for visits required beyond day five (5) documented in the diary and on either MR 8C or D or both.

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Spontaneous Vaginal Delivery

- Routine daily visits until day three (3) (72 hours) and then discharge visit on day five (5).
- Phone call and/or visit on Day four (4).
- If early discharge ≤ 6 hours (ie discharge before 12.00 midday) then phone woman on day of discharge. Visit the following day.

Operative Vaginal Delivery

- Routine daily visits until day five (5) postpartum.

Caesarean Section

- Routine daily visits until day five (5) postpartum.

2.1.4 The VMS visit responsibilities

- The midwife is to perform daily postnatal maternal observations and a daily neonatal assessment. The findings will be appropriately documented on MR 8C and 8D.
- VMS midwife returns MR 8C and D to ward clerk for entering to WebPAS and scanning to BOSSnet once woman discharged from VMS.
- The midwife is to complete the post-birth care plans, neonatal care plans prior to discharge from VMS
- The midwife is to provide education and supervision of parenting skills as required.
- Any identified maternal / neonatal abnormalities are to be documented and reported to woman's medical practitioner for further management.
- Immunisations are not to be performed in the home.

2.1.5 Other VMS midwife responsibilities

- Collect all NBST cards completed on ward, place in newborn screening envelope and send to PathWest by 10.00am daily.

2.1.6 Staffing of VMS

- If there are more than five (5) women to see:
  - phone local women and reallocate to Shared Care Clinic (if appointment slots available) or to Maternal Fetal Assessment Unit (MFAU).
  - attend ward during double staff time (1330-1530) over weekend/public holiday.
  - take a second staff member if available – this may be a senior student
  - >10 women to arrange second midwife and car.
  - Phone women and defer unnecessary visit to the following day.
  - Discuss with MGP re if women could be seen on their rounds if capacity.
  - Consider number of visits possible given travelling time and day of visit for woman and baby.
- If there are four (4) or less women to see:
  - discuss with ward coordinator/Clinical Midwifery Manager re when best to do visits i.e. morning or afternoon depending on ward activity/acuity.
  - if required to work on the ward, phone to see if is visit required and arrange visit for the following day.

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- On return from visits for the day, discuss planning for VMS shift the next day with pm coordinator i.e. number of visits, only two (2) patients, no need for full VMS etc.

2.1.7 Management of Neonatal Jaundice

- Use of the transcutaneous bilirubinometer may help to reduce the number of SBRs performed
- Infants requiring phototherapy may go home on a bilisoft® phototherapy unit at the discretion of the paediatrician/ GPO caring for the infant. It must be explained to the parents that the infant will require further blood tests to determine the effectiveness of the treatment.
- Infants discharged before 72 hours are likely to still have a rising total serum bilirubin level. The best documented method for assessing the risk of subsequent hyperbilirubinaemia is to measure total serum bilirubin and plot it on a nomogram.

2.1.8 Phototherapy at home

- Infants with moderate physiological jaundice can receive phototherapy at home via a loaned bilisoft®. This can be considered either as a continuation of phototherapy commenced in hospital or as a new treatment in babies who have gone home on early discharge. The need for phototherapy as a new treatment in the home must be discussed with the paediatrician.
- Babies who commence phototherapy at home should have the following investigations considered if they have not been done previously:
  - Full Blood Count
  - Baby blood group and direct antiglobulin (DAT/Coombs) test
  - G6PD in male babies of high risk ethnic groups (Asian, Middle Eastern, Mediterranean and African).
- The parents must be educated about the use of the bilisoft® prior to discharge or at home.
- The VMS diary completed with the date the bilisoft® is loaned out and a loan form with patient sticker (with correct address) is completed. The date the bilisoft is returned is documented on the loan form and the VMS diary.

2.1.9 Readmission to hospital from VMS

- If the patient requires urgent medical attention, call 000 for an ambulance.
- For review of maternal or neonatal readmissions contact medical officer under whom they were admitted as an inpatient ie GPO/Obstetric team/Paediatric team
- Liaise with the Maternity Coordinator to arrange re-admission and give ISOBAR handover.
- VMS paperwork is to be returned to the ward clerk for scanning to BOSSnet.
- If mother requiring readmission, baby is **well and ≤ 9 days old** admit mother to ward and baby to 'ward' nursery. In STORK perinatal database, enter mother's readmission to 'Woman Next Admit' and baby to 'Infant Next Admit'.

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- If baby readmitted and not requiring Special Care Nursery admission (deemed suitable for care on ward), the baby is to be admitted to the ward and the mother admitted as an essential boarder. If the mother is ≤ 5 days postnatal then perform postnatal check and document on MR 8C WACHS Outpatient Maternal Postnatal Assessment. In STORK perinatal database ensure ‘Infant Next Admit’ is commenced on admission to ward.
- If the baby is requiring admission to the Special Care Nursery, the mother can **reside at home and visit nursery or may be admitted as an essential boarder to a residential unit** if available. If ≤ 5 days postnatal the mother can be seen in Shared Care Clinic/MFAU for postnatal assessment to be documented on MR 8C WACHS Outpatient Maternal Postnatal Assessment. In STORK perinatal database ensure ‘Infant Next Admit’ is commenced on admission to Special Care Nursery.
- Complete a **Special Child Health Referral** for all babies re-admitted to ward or Special Care Nursery and email.
- On discharge, assess the need for further VMS follow up and provide information on referral.

2.1.10 Discharge eligibility criteria from ward to VMS

Maternal

- Seen by doctor at least once either at birth or post-delivery.
- Pain within comfortable levels.
- All Rhesus negative women are to have had FMH and cord blood collection and Anti D if required following review of neonatal blood group.
- MMR given to all women who are non-immune to Rubella.
- Postnatal observations within normal limits.
- Vaginal Blood loss within normal limits.
- Afebrile at discharge.
- Tolerating diet and fluids.
- Completed x 2 voids >150ml.
- Contraception discussed and organised.
- Mother crafting independently.
- Breastfeeding independently or if has identified breastfeeding issues must have Breastfeeding Management Plan MR76 in place and referral to postnatal breastfeeding classes (WACHSbirtheducation@health.wa.gov.au) and breastfeeding resources discussed.
- Supports established and offered community resources if identified lack of support.
- Social issues identified and referrals and community support in place.
- No ongoing treatments that require further hospital care.
- Advice given related to when and how to seek medical advice for herself or her baby.
- Discussed Safe Sleeping practices, documented in MR80 WACHS Vaginal Birth Care Plan, MR81 WACHS Caesarean Birth Care Plan, Stork postnatal discharge summary and consumer information provided.

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Neonatal

- Has had cephalocaudal examination by Midwife/GPO/Paed. If midwife only cephalocaudal examination (ie if no risk factors/well baby, early discharge) requires medical review within 24 hours by GP/Paed.
- Temperature stable.
- Passed urine.
- Bowels open.
- Breastfeeding well or breastfeeding variance in use.
- Vitamin K given or documented as declined.
- Hep B given or documented as declined.
- If > or = 48 hours old NBST done.
- If > 72hrs old weight loss <10%.
- Hearing screen attended prior to discharge or outpatient appointment made.
- Attend to pulse oximetry monitoring for CCHD prior to discharge.

2.1.11 Exclusion criteria for early discharge from ward

- Existing medical conditions requiring treatment and/or follow-up.
- Women who have birthed by Caesarean Section.
- Low Haemoglobin (Hb) of 100 g/L and / or symptomatic.
- Diabetes mellitus on insulin or oral hypoglycaemic medication.
- Hypertensive disease, both essential and pregnancy related, where:
  - Medication has been required either antenatally or postnatally
  - There has been a **sustained and significant** increase in BP which **required** medical review during labour or the postpartum period.
- PPH ≥ 1000mL or symptomatic.
- Maternal or neonatal pyrexia requiring treatment.
- Baby weight ≤ 2500gm
- Positive TPHA.
- Urinary problems requiring medical intervention.
- Women who have had a:
  - 3rd and 4th degree tear
  - fetal death in utero/ stillbirth / neonatal death (if woman would like early discharge discuss with Obstetric team and perform medical review).
- Women with a current history of Drug and/or Alcohol use.
- Psychological problems requiring medical intervention or any current or past history of depression unless cleared by treating doctor.

2.1.12 VMS radius inclusion zone

- VMS midwife can visit women within a 40 km radius.
- Consideration must be given to the number of visits possible when confirming the distance to be travelled. Discuss with ward coordinator/CMM/CMS when deciding upon those suitable to be seen and those that can be given phone

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call/delayed to following day/reviewed by ward or MGP/second midwife available if necessary to visit.

- All other women will be referred to a district maternity site for follow up postnatal care.

2.1.13 VMS Role and Responsibilities

- **Ensure Home Visit Risk Assessment form (PIARS) is completed prior to undertaking first visit**.
- **At commencement of shift present to morning shift coordinator to discuss planning needs for visits and the ward for the day**.
- Midwives working on VMS are required to comply with following WACHS policies that related to working alone in the community.
  - Working in Isolation - Minimum Safety Standards for All Staff Policy
  - Working Alone - SPOT GPS Tracker Activation Procedure
  - Working Alone - Staff Movement Sheet
- It is essential to carry the mobile phone at all times for security reasons.
- All midwives working on VMS are registered with Autocentral Car Booking
- Midwife must carry mobile phone (charged) at all times
- Midwife to call ward clerk or CNM-AH after each visit and have visit attendance logged on Working Alone - Staff Movement Sheet
- Midwives working on VMS are to be familiar with the WA Health MP 0052/17 Motor Vehicle Fleet Policy in relation to responsibilities for the vehicle
- Car keys are kept in the VMS tray on Maternity Ward
- Complete the vehicle logbook daily.
- Return the vehicle to the designated VMS parking space in the secure compound at the end of the working day.

2.1.14 Circumstances deemed unsuitable to visit (current domestic violence, known or suspected armed/unarmed offender, current criminal proceedings, police present at home, known drug use)

Refer to Working in Isolation - Minimum Safety Standards for All Staff Policy (5. Indications for Minimum Standard of Safety and Security)

Do not enter home if offender still present (call the police).

If the offender has left the scene:

- give aid to the victim
- call ambulance / police as required
- contact medical officer and inform of incident
- do not leave the woman and/or siblings unattended
- arrange a safe environment and carers or transport the woman to hospital in private car or ambulance (as required)
- contact the Emergency Department if the woman to be transferred to hospital
- document the incident and record the events.

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1.1 Discharge to SWAMS

Discharge to care of SWAMS midwives

- Women who have received antenatal care through SWAMS can be referred to care of a SWAMS midwife for postnatal care.
- This can occur **Monday to Friday only**.
- Women who have received antenatal care from SWAMS requiring postnatal care on a weekend will be referred to VMS.
- **Call** SWAMS midwife **(97 26 6000)** to provide ISoBAR clinical handover.
- Inform woman that midwife from SWAMS will review at home.
- SWAMS midwife will complete own home visiting risk assessment.
- Give woman copy of Stork Labour and Birth summary MR 15A, Postnatal Discharge summary MR 15B, Stork CHN summary (with any further instructions regarding follow up of mother or baby, include if a Special Child Health Nurse Referral has been made).
- If woman requiring visit on weekend, SWAMS will call VMS midwife to refer woman back to VMS. SWAMS midwife will give VMS midwife ISOBAR clinical handover to be documented on MR 8E Postnatal Clinical Advice Form. If unable to contact VMS midwife, call Maternity ward coordinator (9722 1275)
- Any information that is regarded as sensitive can be **faxed** to SWAMS separately marked 'Attention SWAMS midwife' to (**9791 7655).**
- SWAMS will document visits in own medical record document, Communicare.
- SWAMS are not limited by distance and will visit all women in our region therefore can refer all women who have received antenatal care from SWAMS.
- Give Maternity Ward- Bunbury Hospital 'Some Reminders Prior to Discharge brochure which includes both Maternity Ward and SWAMS contact number.

1.2 Discharge/Transfer to Inland Midwifery Group Practice (Warren/Blackwood, Collie)

All midwifery care for Inland (as above) is provided via the Midwifery Group Practices. Handover is required to occur verbally to the MGP team.

- For hospital transfers call site CNM or hospital coordinator to ensure bed availability. Enter woman onto Enterprise Bed Management (EBM) once accepted for transfer.
- Ensure GP/O medical acceptance of care has occurred prior to transfer to district site (Obstetric team to give handover of maternal condition and Paediatric team to give handover of neonatal condition).
- Call MGP midwife directly to give ISoBAR handover regarding discharge home or transfer to hospital (see Maternity Ward for contact numbers).
- Send MR 184C Interhospital Transfer Form (Maternal) and MR 184P Interhospital Transfer Form Neonatal/Paediatric with woman who is being transferred to Inland site. Include if a Special Child Health Referral was made.
- If going home include Stork Postnatal discharge summary MR 15B documenting any additional follow-up requirements.

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- Inform woman of discharge/transfer of care to MGP midwife and ensure she has contact details for her midwife.
- Discuss transport arrangements back to site (private or SJA transfer).
- Ensure Stork completed and discharged from Bunbury.
- For transfer to Inland hospitals give all patient medical records to ward clerk (or admissions clerk on weekend/public holiday) to batch and send for priority upload to BOSSnet for transfer site to view.

2.4 Discharge/Transfer to Coastal district sites

Busselton

- If woman **going home** call Busselton Health Campus Maternity Ward to request referral to Visiting Midwifery Service for postnatal/neonatal assessment and give ISoBAR clinical handover.
- Include Stork Postnatal discharge summary MR 15B documenting any additional follow-up requirements. Include if a Special Child Health Referral has been made.
- Inform woman of follow up arrangements and provide Busselton Health Campus Maternity Ward contact details.
- For **hospital transfers** call site CNM or hospital coordinator to ensure bed availability. Enter woman into EBM once accepted for transfer.
- Ensure GPO medical acceptance of care has occurred prior to transfer to district site (Obstetric team to give handover of maternal condition and Paediatric team to give handover of neonatal condition).
- Call midwife directly to give ISoBAR handover regarding transfer.
- Send MR 184C Interhospital Transfer Form (Maternal) and MR 184P Interhospital Transfer Form Neonatal/Paediatric with woman.
- Include if a Special Child Health Referral was made.
- Discuss transport arrangements back to site (private or SJA transfer).
- Ensure Stork completed and discharged from Bunbury.
- For transfer to Busselton Hospital give all patient medical records to ward clerk (or admissions clerk on weekend/public holiday) to batch and send for priority upload to BOSSnet for transfer site to view.

Margaret River

- If woman going home call Margaret River Hospital to request postnatal/neonatal assessment and follow up and give ISoBAR clinical handover.
- Include Stork Postnatal discharge summary MR 15B documenting additional follow up requirements.
- Include if a Special Child Health Referral has been made.
- Inform woman of time to arrive at Margaret River Hospital for appointment and provide Margaret River Hospital contact details.
- For **hospital transfers** call site CNM or hospital coordinator to ensure bed availability. Enter woman into EBM once accepted for transfer.
- Call midwife directly to give ISoBAR handover regarding transfer.

- Send Interhospital Transfer Form (Maternal) and MR 184P Neonatal with woman.
- Discuss transport arrangements back to site (private or SJA transfer).
- Ensure Stork completed and discharged from Bunbury.
- For transfer to Margaret River Hospital give all patient medical records to ward clerk (or admissions clerk on weekend/public holiday) to batch and send for priority upload to BOSSnet for transfer site to view.

2. Definitions

VMS	Visiting Midwifery Service
SBR	Serum Bilirubin
MGP	Midwifery Group Practice
MFAU	Maternal Fetal Assessment Unit
CNM AH	Clinical Nurse Manager After Hours
CMS	Clinical Midwifery Specialist
CMM	Clinical Midwifery Manager

3. Roles and Responsibilities

4.1 Clinical Nurse Manager After Hours (CNM AH)

The VMS midwife calls the CNM-AH mobile 0439073424 to text in and out of home visits. The CNM AH ensures the safety of the VMS midwife by then completing the attendance at visits in PIARS on weekends and public holidays.

4.2 Ward Clerk

The VMS midwife calls the Maternity Ward Clerk to alert to attendance in and out of home visits. The Ward Clerk ensures the safety of the VMS midwife by completing the attendance at visits in PIARS on weekdays

4.3 All Staff

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

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Those who fail to comply with this procedure may face disciplinary action and, in serious cases, termination of their employment or engagement.

5. Evaluation

Monitoring of compliance with this document is to be carried out by Clinical Nurse Manager – Maternity.

- Review it in three (3) years or sooner if required.
- Monitor number of clinical incidents in relation to the procedure

6. Standards

National Safety and Quality Health Service Standards
Clinical Governance Standard: 1.1, 1.2, 1.3, 1.7, 1.7, 1.30
Partnering with Consumers Standard: 2.1
Comprehensive Care Standard: 5.5, 5.10, 5.11
Communicating for Safety Standard: 6.7, 6.8, 6.9, 6.10
Recognising and Responding to Acute Deterioration Standard: 8.1, 8.4, 8.6, 8.7, 8.8, 8.9, 8.10, 8.11, 8.12, 8.13.

7. References

KEMH discharge policies:

Postnatal Care: Discharge/Transfer of a Postnatal Woman to Home/Visiting Midwifery Service/Care of a General Practitioner
Discharge/Transfer of Healthy Infants from Postnatal Ward
Jaundice

8. Related Forms

Patient Information Activity Reporting System (PIARS) database for Home Visit Risk Assessment
MR80 WACHS Vaginal Birth Care Plan
MR81 WACHS Caesarean Birth Care Plan
MR75 WACHS Newborn Care Plan
MR 8C WACHS-SW Maternal Postnatal Outpatient Form
MR 8D WACHS-SW Neonatal Outpatient Form
MR 76 Breastfeeding Management Plan

9. Related Policy Documents

WACHS Working in Isolation - Minimum Safety Standards for All Staff Policy
WACHS Working Alone - SPOT GPS Tracker Activation Procedure

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10. Policy Framework

Clinical Governance, Safety and Quality Policy Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Clinical Maternity Specialist Bunbury Hospital		
Directorate:	Operations South West	EDRMS Record #	ED-CO-14-7610
Version:	3.00	Date Published:	4 May 2021

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