Government of Western Australia
North Metropolitan Health Service
Women and Newborn Health Service

OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Discharge/Transfer of a Postnatal Woman to Home/Visiting Midwifery Service/Care of General Practitioner

Scope (Staff):	All midwifery and obstetric staff
Scope (Area):	Obstetric wards

This document should be read in conjunction with the Disclaimer.

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Aim

All well patients and babies shall be transferred into the community safely, in optimal postnatal health. This guideline should be read in conjunction with the Women and Newborn Health Service (WNHS) Discharge of a Patient Policy.

Risk

Non-compliance with this guideline will impact on patient safety and quality of patient care.

Key Points

- Discharge planning commences from the booking visit throughout the antenatal period and at time of admission and is discussed with the patient and their family and support people.
- Length of stay and VMS care discussions need to be commenced in the antenatal period to create shared realistic expectations and goals.
- All patients need a clear plan for ongoing care following discharge from hospital/birth centre discussed with them and documented on the Postnatal Clinical Pathway MR249.60 (KEMH) / MR72.1 (OPH)

Discharge eligibility and processes.

Refer to the WNHS Policy Discharge of Patient for information regarding eligibility for discharge.

Discharge to Home / General Practitioner (GP)

Patients and/or Babies discharged home with no further postnatal follow up should be advised:

- To book an appointment with their GP for themselves and baby at six weeks postpartum (or earlier if clinically indicated)
- The Child Health Nurse will contact the patient upon discharge to arrange a visit to review the baby. If there are concerns or worries about the health of the patient or baby, to attend a GP earlier than planned or attend their local emergency department.

All patients should receive a discharge summary (STORK) and a copy should be provided to the GP.

See the WNHS Clinical Handover Policy for further details regarding discharge summaries.

Visiting Midwifery Service (VMS)

VMS – a home visiting service

VMS care is available in the patients own environment if they fulfill the inclusion criteria for home visiting (See Appendix 1).

VMS care is available to patients who:

- Are discharged prior to Day 5, or require additional care post Day 5
- Birthed at KEMH or OPH or were transferred to KEMH / OPH during their labour or postnatal period.
    - Wherever possible, patients from other sites should be referred back to their booking hospital for follow up care – see *Peripheral Hospitals*
- Require midwifery care services only – see KEMH *Emergency Centre follow up (Medical or Neonatal Review) and Medical/ Neonatal review at OPH occurs in OPH Assessment Unit (AU)*
- Do not have a baby in the Special Care Nursery – see KEMH *VMS Hospital Clinic and* OPH patients who have a baby in OPH NNU or PCH 3B can be seen at OPH AU
- VMS is also available to Antenatal and Gynaecology patients that do not fulfill criteria for HITH / Silverchain but require some follow up in their home.
- VMS is available as an option for patients who have had spontaneous or planned abortion post 14 weeks from EC or Ward 6. Generally, a phone appointment post discharge by VMS though a home visit is an option if further support required.
- All patients over 20 weeks though PLS or PCAC service offered VMS visiting at home or clinic even if more than 5 days post-delivery.

VMS Hospital Clinic

- Patients who are ineligible for home visiting as per Appendix 1 or have a baby in the SCN may access the VMS Hospital clinic located on Ward 4.
- Patients who may have come through the PCAC service and would like postnatal care but not in the home.
- OPH patients who have a baby in OPH NNU or PCH #B can be seen at OPH Assessment Unit (AU)
- Patients requiring medical or neonatal review are unable to attend the VMS Hospital Clinic and instead are to be booked to the Emergency Centre - **see Emergency Centre Follow Up** - or for OPH patients in OPH AU Midwifery Group Practice (MGP), Community Midwifery Program (CMP), Endorsed or Privately Practicing Midwives (E/PPM) and Midwifery Antenatal Postnatal Service (MAPS) at OPH.
- Patients booked to MAPS (OPH) MGP, CMP or receiving care by an Endorsed or Privately Practising Midwife will be referred back to the service post discharge for care to be continued with their relevant services.

MAPS (OPH)

- MAPS Midwives will see all their patients

MGP & CMP

- For patients booked to MGP and CMP, the inclusion / exclusion criteria for Home Visiting (Appendix 1) applies.

EPPM

- For patients booked to EPPM, it is at the discretion of the EPPM as to whether home visiting is appropriate, refer for care by EPPM.

Other Services

Referral methods for postnatal follow up are noted in the Postnatal Pathways to Community Transfer document for all services listed below.

Emergency Centre follow up (Medical or Neonatal)

If a patient requires medical/O&G or neonatal follow up, this must be arranged in the Emergency Centre or OPH AU for OPH patients.

Perth Childrens Hospital

- There are midwives available to see patients who are admitted to Ward 3B parent accommodation for postnatal cares up to and including Day 5.

Adolescents

- All patients booked to the Adolescent Service to have post discharge follow up with the Adolescent midwifery service. This includes patients who are past Day 5 (Adolescent Service provides extended VMS)

Overseas Visitors declining VMS.

- Overseas visitors may decline VMS care due to cost (e.g. no insurance)

- Encourage these patients to attend an Emergency Department or GP if there are any concerns.
- Overseas patients can access free NBST at PathWest – provide the patient with a prefilled NBST card prior to discharge.

Regional Patients residing in Perth temporarily.

- Local VMS is available for patients from outside the metropolitan area but residing in Perth temporarily.
- Ensure the address listed on the VMS tab of Stork reflects the address the patient is residing as whilst staying at Perth. NB: this address must be within the VMS catchment area to receive WNHS VMS services. If outside catchment area, refer to *Peripheral Hospitals* below.

Peripheral Hospitals

- For patients requiring post discharge care from peripheral hospitals, refer to the Postnatal Pathways to Community Transfer document for specific processes.

Referral process for postnatal follow ups

1. **If patient is for a home visit -** Ensure the patient lives in the VMS area and is appropriate for referral.
    a. Complete the Home and Community Visit Risk Assessment (MR255.04 – KEMH, MR30.5 - OPH) to assess suitability for VMS.
    b. If unsure, discuss with the Ward Coordinator or Clinical Midwifery Consultant or Clinical Midwife Specialist.
2. Generate and print a VMS referral through one of the following methods.
    a. Postnatal – Stork VMS Referral
    b. Visiting Midwifery Service Referral - Gynaecology MR255.02
    c. Visiting Midwifery Service Referral - Antenatal MR255.01
    d. Visiting Midwifery Service Referral – Special Care Nursery MR255.03
3. Place the patient UMRN label into the VMS / Discharge Book located on each ward.
    a. Include relevant information if postnatal visits are required >Day 5
    b. Note which clinic / service the follow up visits are occurring (i.e.. MGP / CMP / VMS / Adolescents/ MAPS, etc).
4. The hospital clinical manager (HCM) will collect the referrals each evening and send referrals to the assigned clinics for visits the following day.
    a. If patients are discharged after and require VMS follow up the next day, contact the A/H HCM and handover over the VMS referral.
    b. OPH referrals are sent to the KEMH HCN by scanner.
5. **Specific documentation and communication instructions for different follow up services are identified on the Postnatal Pathways to Community Transfer document.** This document is regularly updated to reflect service changes and referral requirements.

Related policies
WNHS Policy: Discharge of a Patient
NMHS Policy: Discharge Summary
WNHS Policy: Clinical Handover at WNHS
WNHS Policy: Neonatal Special Referrals to Child Health Services

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Version History

Version Number	Date	Summary
1.0	September 2002	First version
2.0	Aug-Oct 2024	• Review of all content, with the inclusion of Osborne Park Hospital services • Update of the 'Postnatal Pathways to the Community Transfer" document – including OPH Assessment Unit. • Reference to woman/women changed to patient throughout document .

The health impact upon Aboriginal people has been considered, and where relevant incorporated and appropriately addressed in the development of this policy.

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

Appendix 1: Home visiting inclusion / exclusion criteria

Inclusion Criteria

- Resides within 40km VMS radius of the hospital
- Gynaecology patients who are discharged home but not referred to Hospital in the Home (HITH) or Silver Chain and require follow up in the community.
- PLS patients 14 weeks post FDIU/Top if requested.
- Completion of the Home and Community Visit Risk Assessment MR 255.04 (KEMH) / MR30.5 (OPH), and answered 'Yes' to questions 1-4.

Exclusion Criteria

- Patients requiring intravenous antibiotics (these patients are to be referred to Silverchain / HITH)
- Patients with a peripherally inserted central catheter (PICC) who require drug administration through the PICC, removal of a PICC or flushing of a PICC. These patients are to be referred to Silverchain / HITH
- Patients with specialised wound dressings (e. g. VAC dressings). Refer to Clinical Guideline- Wound Care
- Patients living outside catchment area – see *Peripheral Hospitals*
- Patients from environments where there is known aggression or domestic violence – see *VMS Hospital Clinic*
- Patients deemed not suitable for home visiting midwifery services for another reason not listed – See *VMS Hospital Clinic*