Playing by the rules

In the first article of this new series, ANTHONY CARR puts the case for standardised nursing policies and describes the guidance given to midwives by Newcastle Health Authority.

IN LARGE organisations, there is always a need for policies to be established for the benefit of staff working in that industry. Nursing is no different, although recent views are beginning to challenge what is seen as the rigid "tram lines" of policy.

It depends to a large extent on whether the individual sees written policies as a restriction on the use of her knowledge and experience. Some people will react in this way, but policies will, if written properly, allow scope for interpretation. Other policies, if written at all, have, by the nature of the subject, to be laid out in precise terms – for example, an isolation policy for diphtheria.

The reasons for establishing a policy system are to enable nurses to care safely for patients and to protect those same nurses from complaints of unsafe practice.

It is important that nurses are given an opportunity to say that, because of circumstances arising on the ward or department, they are unable to carry out a certain policy.

A paragraph has been inserted in the local Newcastle instructions which allows sisters or charge nurses to cover themselves legally and professionally. It states: "Should any sister/charge nurse, or nurse in charge of a ward or department, find themselves in a position of not being able to correctly carry out a policy contained in this file, they should immediately inform their nursing officer, senior assistant director of nursing or director of nursing of the situation and confirm the reasons in writing later if necessary. Unless this action is taken senior nurse management will assume that any policy contained in the file is capable of being carried out by the staff. It should be remembered that disciplinary action could result from failure to carry out these policies correctly."

It is important that an effective system of storage and accessibility for policy notes be established. A red policy folder is issued to every ward, nursing department and health or school clinic in my district. The school of nursing has copies available for learners. Nursing officers also have their own copies.

Each new policy that is issued contains a space at the bottom for the sister or charge nurse to sign. The signature indicates that the statement has been read by all those staff who have an interest in the subject. In addition, all new staff should have their attention drawn to those policies that will affect them.

Nursing officers are required to check that the folder is easily accessible and that staff know the appropriate policy.

During the next few weeks selected policies will be reproduced, suitably edited where necessary, to convey the substance of the policy without the complicated detail that may be required in the operational situation.

Midwives

Some time ago it was felt necessary to issue guidance to midwives working in the community. It became the standard of practice required by the health authority. The policy covers antenatal and postnatal care and is required reading for all community midwives and student midwives.

Antenatal care. All pregnant women should be seen regularly by a doctor or a midwife. Guidelines to the minimum number of visits in a normal pregnancy would be: one each month until about the twenty-sixth week; two each month until about the thirty-fourth week; then one visit weekly until delivered.

The antenatal care may be at a clinic, GP surgery or the home, but there must be an efficient system of follow-up of defaulters. Any patient failing to attend on the appointed day must be visited at home as soon as possible when the opportunity to carry out a full antenatal examination should be taken.

It is essential that all information cards are completed and that every visit is recorded. If the patient is out, a visiting card must be left. Make sure that the woman has full investigations, that is blood tests, and see that she has the names and telephone numbers of the booked doctor and the midwives, including details of how to obtain a midwife should her own particular midwife not be on duty. This information should include the telephone number of the senior assistant director of midwifery (community midwifery) office and the local ambulance station.

Home assessments. In addition to patients booked for home confinements, midwives will be asked by the hospitals to visit all antenatal patients. This must be done as soon as possible and the appropriate form completed and returned to the senior assistant director of midwifery immediately after the visit.

The opportunity should be taken during this first visit of not only assessing home and social conditions, but also discussing the pregnancy. Emphasis should be placed on general health, parentcraft education, infant feeding, requirements of postnatal care and family planning, and the need for someone to look after the family during the postnatal period. Arrangements for attendance at parentcraft education classes could be made at this time. A second home visit should be made about four weeks before delivery to ensure that the arrangements for postnatal care are satisfactory, and that no change in circumstances has occurred.

Unbooked emergencies. Whenever possible, the patient should be admitted to hospital for delivery. Where the patient has had no antenatal care and no blood investigations, a specimen of cord blood must be taken and sent to the laboratory of the blood transfusion service or to hospital if the patient is admitted there. As much information as possible should be given and the specimen labelled: "For urgent Coombs' test, mother not tested antenatally." The patient's general practitioner should be notified and arrangements made for transfer to hospital for postnatal care if necessary.

Home confinement. The decision as to where a patient's confinement shall take place is normally taken by the patient and the doctor. Any patient who approaches a midwife for a home confinement booking should be referred immediately to the general practitioner concerned.

Once a patient has been accepted by her doctor for home delivery, he should inform the individual midwife concerned. The midwife must visit the patient's

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home and, provided home and social conditions are suitable, she will confirm with the patient and the doctor that the patient is booked for home confinement.

The midwife should record the arrangements made for medical coverage throughout the pregnancy. The senior assistant director of midwifery should also be notified of the booking by using the appropriate form.

When home conditions are unsuitable, the matter should be discussed with both the general practitioner and the senior assistant director.

The director of midwifery and senior assistant director must be kept informed of all requests for home confinement, particularly when a general practitioner is not available.

Two midwives – in certain cases a midwife and student – will attend the patient and keep a detailed record of all antenatal visits and counselling given to the mother.

The community midwife may call on the emergency obstetric service if she requires medical assistance. Non-urgent treatment, such as the suture of an episiotomy or tear, will be carried out in hospital and an ambulance ordered to transport the mother and baby accompanied by a midwife. Patients should be persuaded to attend a consultant antenatal clinic at least once at about 34–36 weeks. Patients who request a home confinement could be offered, as an alternative, a system of admission to hospital for delivery followed by return home within six to eight hours of delivery provided the mother and baby are fit.

Emergency

If a patient is in preterm labour, the midwife should, whenever possible, transfer her to hospital for delivery and notify the general practitioner. Should delivery occur at home and an infant require resuscitation, the Blease resuscitation and Sparklet oxygen apparatus are the most effective methods. Every baby who has had difficulty or delay in establishing or maintaining respirations should be examined by a doctor as soon as possible.

Should paediatric help be required, a request should be made for the paediatric emergency service.

In an obstetric emergency a doctor must be summoned. If the situation is grave, do not waste time but call the obstetric emergency service by contacting the relevant hospital on call.

When sending messages, make sure that there is no confusion between a request sent to a general practitioner for assistance and an urgent call for the obstetric emergency service. The information given should include the nature of the complication, the name of the midwife and exact directions on how to get to the house.

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– Anthony Carr

Postnatal care. All postnatal patients must be visited twice each day during the first three days of the puerperium and daily thereafter up to and including the tenth postnatal day. The decision as to when, following the tenth day, the mother and child are transferred to the health visitor is made by the midwife in charge of the case. Full information about the patient's conditions, including the discharge letter, should be given to the health visitor.

Whenever it is not possible to make a scheduled call, the senior assistant director of midwifery must be notified.

A doctor must be consulted when there is any deviation from normal of mother or baby. When seeking advice from a general practitioner, the midwife must speak to the doctor himself, or leave a written message for him, whenever possible. In an emergency, make sure that the person taking the message gives this correctly, adding that it is a maternity case.

These matters must be notified to the senior assistant director of nursing (community midwifery) in person as soon as possible:

- if the midwife is a source of infection, for example, colds, influenza, cold sore;
- contact with infection, for example, communicable diseases;
- illness – if the midwife is unable to carry on with her work;
- preterm or low birth weight infants;
- illness or abnormality of infant;
- call on obstetric or paediatric emergency service;
- transfer of any patient to hospital;
- disappearance of patient or change of address;
- unsuitable home conditions;
- illness of patients;
- abortion, stillbirth, death of mother or child.

The first midwife to receive any message about a pregnant woman *must* deal with it herself. In every case she must either visit the patient immediately or pass the message on to another midwife in person. Patients, relatives, doctors, receptionists, ambulance drivers and so on must not be told to get another midwife unless the first midwife is ill and incapable of reaching a telephone.

There appears to be an increase in women who are away from home when midwives call. Check that it is the correct address, either by asking a neighbour or by telephoning the office or hospital; and put a visiting card through her door indicating the time of the next visit.

Inexperienced

Remember that student midwives undertaking midwifery training are very inexperienced when they first start their community care programme. They must not make visits unaccompanied during their first eight weeks and thereafter only at the discretion of the individual teaching midwife and following assessment by the senior assistant director. Student midwives are allocated to one teaching midwife and as far as possible their off-duty periods should coincide.

In the case of stillbirth, arrangements can be made for the health authority to accept responsibility for payment of funeral expenses. If parents wish to avail themselves of this, arrangements should be made through the unit administrator, community health services □

Next week: Cutbacks in resources.