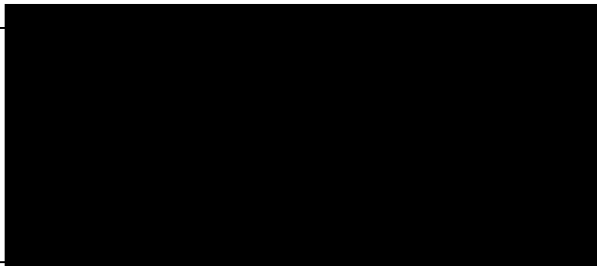


**IN THE MATTER OF THE ROYAL COMMISSION  
INTO FAMILY VIOLENCE**

**ATTACHMENT FD-21 TO STATEMENT OF FRANCES MARIE DIVER**

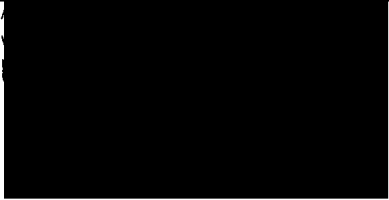
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This is the attachment marked '**FD-21**' produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.



Before



Attachment FD-21

health

Postnatal Care Program  
Guidelines for Victorian  
Health Services



Postnatal Care Program  
Guidelines for Victorian  
Health Services

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# 1. Introduction

The postnatal period is defined as the period after the delivery of the baby, usually the first six weeks after birth (Commonwealth of Australia, 2011). Postnatal care may be provided in the acute and community healthcare sectors or in the woman's home.

Care may include routine clinical examination and observation of the woman and her baby, routine baby screening to detect potential disorders, support for infant feeding, and ongoing provision of information and support (Demott et al., 2006). Postnatal care may be provided by a number of health professionals, including registered midwives, registered and enrolled nurses, obstetricians, general practitioners (GPs) and Aboriginal health workers.

Postnatal care begins immediately after birth and the primary aims are to provide:

- recuperation from the birthing process
- breastfeeding education and support
- parenting education and support
- clinical care to promote the physical and psychological health and wellbeing of the woman and her baby.

The *Postnatal care program guidelines for Victorian health services* (the guidelines) focuses on the immediate postnatal period of care in hospital and in the woman's home. This period of time is dependent on the individual needs of the woman, the woman's geographical location and the health service configuration.

The time that women spend in hospital following childbirth has steadily declined. In 2009–10, the average length of stay for a public hospital birth episode was two days for an uncomplicated vaginal birth and four days for a caesarean section without major complications (Department of Health, 2012). This reflects improvements in acute care and the development of alternative and appropriate care settings, including the woman's home.

Whether the setting for care is the hospital or a woman's home, the focus should be on the most appropriate care setting for each woman. As a result, the average length of hospital stay following childbirth may continue to decrease. Whether postnatal care is provided in hospital or in the woman's home, it is imperative that the care provided is of the highest standard and meets the needs of the individual.

These guidelines outline the Victorian Government's expectations of public health services, including Koori Maternity Services, in the delivery of postnatal care to ensure best quality care is provided to all women and their babies.

The guidelines further the aims outlined in the *Victorian Health Priorities Framework 2012–2022*, in particular:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- implementing continuous improvements and innovation
- increasing accountability and transparency.

The Department of Health has developed the guidelines in consultation with the following stakeholders:

- Maternity and Newborn Clinical Network
  - Department of Education and Early Childhood Development
  - associated professional groups
  - representatives from metropolitan, rural and regional health services.
-

## 2. Purpose

The guidelines provide direction to support continued reform of all Victorian public health services responsible for the delivery of maternity and newborn care, to ensure the needs of the community are met now and into the future.

It is widely recognised that demand for maternity and newborn care is growing. The guidelines are intended to assist health services to deliver improved health outcomes for the Victorian community.

Current service delivery and coordination are discussed to inform health services and the health service system of the factors that may impact on the delivery of postnatal care.

The guidelines identify key priority areas for improving maternity and newborn care and access in Victoria's public hospitals. Each of the priorities outline initiatives already underway and further actions required into the future.

The key objectives of the guidelines are to:

- promote good practice in the delivery of postnatal care to women and their families
- identify the responsibilities of health services, community-based providers and women
- improve communication between women, health services and community-based providers
- improve continuity of care for women across the full range of maternity services
- provide scope, direction and authority for local policy and procedure development.

Public health services are responsible for ensuring compliance with the guidelines.

This includes putting processes in place to:

- implement the guidelines
- identify and provide appropriate education and training opportunities to health service staff who fulfil the roles and carry out the tasks required by the guidelines
- regularly review individual health service performance
- validate the accuracy and integrity of reported data.

Each section of the guidelines includes information to support implementation. Health services should view the sections collectively and, where appropriate, develop their own local policies and procedures that comply with the guidelines.



### 3. Scope

The guidelines provide direction for all Victorian public health services that are responsible for the delivery of maternity and newborn services. For the purpose of this document, 'public health service' refers to all public hospitals and denominational hospitals, public health services and multi-purpose services established under the *Health Services Act 1988*.

The guidelines outline the Victorian Government's expectations of public health services in the delivery of the immediate postnatal period of care in hospital and in the woman's home. This period of time is dependent on the individual needs of the woman, the woman's geographical location and the health service configuration. As the average length of hospital stay following childbirth decreases, health services should ensure appropriate services are provided to women in their home.

While the care provided by GPs, maternal and child health (MCH) services and other community-based providers during the postnatal period is not included in the scope of the guidelines, the links between these and public health services are important and are included in this document.

## 4. Principles

The following principles underpin the guidelines and are designed to enable delivery of best available, evidence-based interventions to optimise the health of the woman and her baby

- Postnatal care will be woman-centred to enable women to participate in informed decision making regarding their own care and the care of their baby.
- Postnatal care will be provided by an appropriately qualified midwife, GP or MCH nurse, supported by a multidisciplinary team.
- Health services will facilitate timely and equitable access to postnatal care with women able to access services as close to home as possible.
- Postnatal care will be culturally appropriate and culturally safe.
- Postnatal care will be responsive to the often complex, multifaceted needs of women from culturally and linguistically diverse (CALD) backgrounds.
- Health services will work in a collaborative and coordinated way with other health services and community-based providers of maternity and newborn services to optimise women's experiences and postnatal care outcomes.
- Health services will ensure women have timely and consistent access to services across the continuum of care according to their needs.
- Health services will promote safe and high-quality outcomes for women and their families.
- Health services will collect and report accurate data on women's access to postnatal care.

## 5. Key priorities

### i. Woman-centred care

Many women report lower levels of satisfaction with the care and support they receive during the postnatal period than at any other phase of their maternity care (Forster et al., 2005). Feeling listened to and well supported, and receiving timely and consistent information are important factors contributing to women's satisfaction with their postnatal care.

Providing information and education relating to the normal physiological changes associated with childbirth, breastfeeding and parenting is a key component of postnatal care that is aimed at giving women and their families the confidence to manage the care of their baby.

For a number of first-time parents, the reality of caring for a baby can be overwhelming and often differs from their expectations. The provision of timely and effective postnatal care and support can have a significant impact on the long-term health and wellbeing of women and their families.

Postnatal care should be delivered in the most appropriate setting, whether that is in hospital or in the woman's home. Irrespective of the postnatal care setting, it is imperative that the care provided is of the highest standard and meets the needs of the individual.

#### Principles

Postnatal care will be woman-centred to enable women to participate in informed decision making regarding their own care and the care of their baby.

Postnatal care will be culturally appropriate and culturally safe.

#### Program guidelines

1. Health services should provide postnatal care that is woman-centred.

Woman-centred care focuses on a woman's unique needs, expectations and aspirations; recognises her right to self-determination in terms of choice, control and continuity of care; and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations (Australian Nursing and Midwifery Council, 2006).

2. Postnatal care planning should commence as early as possible, preferably during the antenatal care period.
3. Irrespective of the postnatal care setting, health services must ensure that care is woman-centred, safe and of the highest quality.
4. Health services should plan for postnatal care in partnership with women and their families or significant others, as determined by the woman herself.
5. Health services must provide women with timely, appropriate and consistent written information and education to enable informed decision making.
6. Health services must ensure that women have an individualised home-based postnatal care plan prior to discharge from hospital that provides information on the care they will receive.
7. Health services should provide breastfeeding advice and support according to the 'Ten Steps to Successful Breastfeeding' as specified in the *Baby Friendly Health Initiative* (World Health Organization, UNICEF, 2009).

## Implementation guidance

### Information and education

Women should be given appropriate and consistent written and verbal information and education relating to the postnatal period. This enables women to make informed decisions regarding their care and the care of their baby, and can increase women's confidence and satisfaction with the care provided (Newburn & Bhavnani, 2010).

The information provided by health services should be given to women as early as possible, preferably during the antenatal period. It should be easy to understand and communicated in the woman's primary language. Women should also be given the opportunity to discuss and ask questions about the information provided with a midwife and/or doctor.

The following information should be provided and discussed with women to support decision making regarding the provision of postnatal care and beyond:

- the birth experience
- psychological and social adjustment to parenthood (for example, expectations, mood, self-care, child safety, relationship with partner, contraception)
- care of the baby (for example, feeding, bathing, handling and sleep/settling babies)
- maternal physical adjustments (for example, fatigue, sleep, breastfeeding, breast and body changes, sexual health)
- family adjustments (for example, care of the baby, siblings' acceptance of the baby)
- family environment (for example, housing, employment, safety)
- social support and local networks.

Where appropriate and determined by the woman, written information and education should be provided to her family and/or significant others.

### Planning

Planning for the postnatal period and beyond should be undertaken in partnership with women as early as possible. Planning initiated during the antenatal care period can benefit women and lead to higher levels of satisfaction with the care provided (Three Centres Consensus Guidelines on Antenatal Care, 2001).

A written record of planning should be kept by both the woman (Victorian Maternity Record) and the health service (patient record). The Victorian Maternity Record prompts health professionals to discuss planning for postnatal care, and includes a section to document the woman's preferences after birth.

At a minimum, a woman's postnatal care plan should include information relating to:

- the woman's preferred location of care
- timing of care
- the woman's expectations of care
- contact details of the health services' postnatal care coordinator or midwife
- central contact details of a MCH service, close to the woman's home, to which the birth notice has been sent
- roles and responsibilities of both the woman and the care provider(s).

Health services should ask women who they would like to be involved in planning for and delivering care throughout the postnatal care period, and where this care should be provided.

### **Breastfeeding**

Providing mothers with accurate information about the importance of breastfeeding to the health of their baby can result in changes in infant feeding decisions. Health promotion efforts should emphasise the importance of breastfeeding for normal growth and development, and the risks and costs associated with premature weaning (Berry & Gribble, 2008).

The World Health Organization (WHO) recommends exclusive breastfeeding for babies up to six months of age, with breastfeeding continuing alongside complementary foods for up to or beyond two years of age, as this contributes to optimal physical growth and mental development (WHO, UNICEF, 2009).

There are a number of reasons why women are less likely to breastfeed, including less family support for breastfeeding, less ability to seek help with breastfeeding problems, less flexibility with working arrangements, and concerns about breastfeeding in public. Women with lower measures of education, income and occupational status; younger women; women who are overweight/obese and women who are smokers are also less likely to breastfeed (Amir & Donath, 2008).

According to the 2010 *Australian National Infant Feeding Survey* (Australian Institute for Health and Welfare (AIHW), 2011), almost all Australian babies commence breastfeeding but most do not continue as long as recommended. Although 96 per cent of babies were initially introduced to breastmilk, 61 per cent were exclusively breastfed for less than one month and this progressively decreased to 15 per cent at around six months of age (AIHW, 2011).

According to the AIHW survey, the main reasons why mothers gave their baby breastmilk were that it was 'healthier for child', 'convenient' or 'helps with mother-baby bonding'. 'Wanting to share feeding responsibilities with their partner' and 'previously unsuccessful breastfeeding experiences' were the two most common reasons for not breastfeeding. Many women also felt that formula was just as good as breastmilk (AIHW, 2011).

The *Baby Friendly Health Initiative* (BFHI) developed by the WHO and UNICEF sets out 'Ten Steps to Successful Breastfeeding', which provide the global accreditation standards for health services providing maternity and newborn care (WHO, UNICEF, 2009). In 2009–10, 26 public hospitals in Victoria were BFHI accredited (Victorian Government Department of Health, 2012).

The *Australian national breastfeeding strategy 2010–2015* recognises the biological, health, social, cultural, environmental and economic importance of breastfeeding and provides strategies to promote breastfeeding and complementary foods to 12 months of age and beyond (Commonwealth of Australia, 2009a).

## Caesarean section

For women who have undergone a caesarean section, postnatal care is important to prevent and, where necessary, treat infection and post-birth complications.

The rate of caesarean section is growing both in Victoria and nationally. This can be explained, in part, by factors such as maternal age and medical conditions such as obesity, diabetes and hypertension (Commonwealth of Australia, 2009b).

In 2008–09, the rate of caesarean section was 27.9 per cent of all deliveries in Victorian public health services compared with 39.4 per cent in private hospitals. This rate increased in public health services to 28.2 per cent in 2009–10 and 28.4 per cent in 2010–11. The WHO recommends a caesarean section rate of 15 per cent (WHO, 1985).

Caesarean sections performed following an appropriate medical indication are potentially life-saving procedures. At the same time, in many settings, women are increasingly undergoing caesarean sections without any medical indication (Souza et al., 2010).

The World Health Organization Global Survey on Maternal and Perinatal Health (WHOGS) provides evidence on the relationship between mode of delivery and maternal and perinatal outcomes. Findings indicate that an increase in rates of caesarean delivery is associated with increased use of antibiotics postpartum, greater maternal morbidity and mortality, and higher fetal and neonatal morbidity, even after adjustment for demographic characteristics, risk factors, general medical and pregnancy associated complications, type and complexity of institution, and proportion of referrals (Villar et al., 2006). The need for evidence-based counselling about the risks and benefits of caesarean section for women and their babies is imperative (Boutsikou et al., 2011).

When compared with vaginal delivery, emergency and elective caesarean deliveries are associated with a decreased rate of exclusive breastfeeding. In general, separation of the mother and baby, post procedure immobility and wound pain may attribute to some women's inability to breastfeed comfortably (and therefore exclusively) following a caesarean section (Bodner et al., 2011).

This emphasises the importance of appropriate breastfeeding education and support for these women in the immediate postpartum period.

## ii. Culturally appropriate care

Women and their families should always be treated with compassion, respect and dignity. The views, beliefs and values of the woman and her family in relation to her care and that of her baby, should be sought and respected at all times. The woman should be fully involved in the planning of postnatal care so that care is flexible and tailored to meet her and her baby's needs (Demott et al., 2006).

Cultural awareness is an appreciation of cultural, social and historical differences. Cultural safety builds on the concept of cultural awareness and is based on the basic human rights of respect, dignity, empowerment, safety and autonomy (Phiri et al., 2010). Culturally appropriate and culturally safe care recognises diversity and the dynamic nature of culture.

A culturally competent healthcare system will support efforts to increase the capacity of the system to design, implement and evaluate culturally and linguistically competent services to address health disparities among populations from CALD backgrounds and to promote health and mental health equity (Department of Health, 2011).

### Principles

Postnatal care will be culturally appropriate and culturally safe.

Postnatal care will be woman-centred to enable women to participate in informed decision making regarding their own care and the care of their baby.

Postnatal care will be responsive to the often complex, multifaceted needs of women from CALD backgrounds.

Health services will collect and report accurate data on women's access to postnatal care.

### Program guidelines

1. To ensure equitable access, postnatal care must be:
  - culturally appropriate; with readily obtainable translated health information (for example, telephone interpreters, written material sensitive to differing cultures and levels of literacy)
  - culturally responsive; delivered by culturally competent staff with knowledge of health issues impacting upon different population sub-groups, experience in comprehensive assessment and awareness of support services available for referral.
2. Health services should ensure that registered midwives and other health professionals providing postnatal care are sensitive to the individual needs of women from CALD backgrounds.
3. Health services should provide women from linguistically diverse backgrounds with readily obtainable, translated health information, including appropriate interpreting services (face-to-face or telephone), during each postnatal care appointment including home-based visits.
4. Postnatal care must be appropriately coordinated, with good connection to support services and streamlined processes for referral.
5. Postnatal care should be innovative and flexible, to meet the complex, multifaceted needs of women from CALD backgrounds.

## Implementation guidance

### Cultural competence

Cultural competence requires an understanding and respect for a woman's culture, and a commitment to provide care that appropriately responds to her values, practices and beliefs.

For example, some Aboriginal and Torres Strait Islander women do not want a prolonged stay in hospital following the birth of their baby. Health services should ensure systems are strengthened so that women who discharge early are appropriately supported in the postnatal period. In some instances, this support may be best provided by an Aboriginal Community Controlled Health Service, which has an established relationship with the woman.

Health services should provide regular and ongoing training to ensure cultural competency of all staff. Health services should also embed cultural competence within their quality improvement framework to build organisational capacity.

### Accountability

Health services will ensure comprehensive and consistent monitoring and management of maternal and neonatal outcomes data to improve health service planning and delivery for women irrespective of their cultural, linguistic and socioeconomic background.

This will include improved identification of Aboriginal or Torres Strait Islander status in key administrative data sets by routinely asking and reporting whether either or both parents of the baby are of Aboriginal or Torres Strait Islander descent.

### Interpreting services

Health services should provide women with access to appropriate interpreting services (face-to-face or telephone). It is the responsibility of health services to arrange an interpreter for required postnatal care appointments, including home-based visits. This is necessary to ensure that information provided is understood and to enable women and their families to ask questions and seek additional advice.

The *Department of Human Services language policy* outlines the requirements for providing access to professional interpreting and translating services in Victoria (Department of Human Services, 2005).



### iii. Collaborative and coordinated care

The coordination of maternity and newborn services across the care continuum and throughout the postnatal period is important to ensure that women and their families are able to access timely and appropriate care that optimises their health and wellbeing and supports family functioning and child development.

#### Public health services

The current system of maternity and newborn services in Victoria includes three hospitals with tertiary services (plus a fourth tertiary service dedicated to neonatal and paediatric services) and a range of metropolitan, large regional and local rural hospitals, providing primary and secondary maternity care services, as outlined in the *Capability framework for Victorian maternity and newborn services* (Department of Health, 2010).

Victorian public health services are responsible for providing postnatal care to women both in hospital and for the immediate period following the woman's discharge. This period of time is dependent on the individual needs of the woman, the woman's geographical location and the health service configuration.

#### Maternal and child health services

It is a requirement under the *Child Wellbeing and Safety Act 2005* (Office of the Child Safety Commissioner, 2005) that a birth notice is sent by health services to the appropriate local government authority within 48 hours of the birth.

Local government, in partnership with the Department of Education and Early Childhood Development, is responsible for providing community-based MCH services. These services offer support, information and advice regarding parenting and child health and development to families with children up to six years of age.

Upon discharge from hospital, women are referred to their local MCH service. The MCH service is required to contact women to offer and arrange a home visit. In most cases, a MCH nurse will visit a woman within seven to 14 days of their discharge from hospital.

### Principles

Health services will work in a collaborative and coordinated way with other health services and community-based providers of maternity and newborn services to optimise women's experiences and postnatal care outcomes.

Health services will facilitate timely and equitable access to postnatal care with women able to access services as close to home as possible.

Health services will ensure women have timely and consistent access to services across the continuum of care according to their needs.

Health services will promote safe and high-quality outcomes for women and their families.

## Program guidelines

1. Health services must establish and maintain effective linkages with other health services and community-based providers of maternity and newborn care to enable women to access appropriately qualified and skilled health professionals.
2. Health services must ensure MCH services are appropriately notified of infants and children that are vulnerable, including those known to Child Protection, Placement and Family Services.
3. Health services must ensure MCH services are appropriately notified of women who are vulnerable or disadvantaged or who have high needs. Health services must take measures to ensure continuity of care, a seamless transition between services and that there is no gap in care provision.
4. Health services must clearly document the provision and outcomes of postnatal services in the woman's patient record and Child Health Record to ensure seamless referral and transfer of care.
5. The Child Health Record must provide the woman with sufficiently detailed information to take with her to her first MCH appointment.
6. Health services must refer women to other services, where appropriate, that will meet their individual healthcare needs.
7. Health services must respect women's privacy. Health services must operate within the parameters of the *Health Records Act 2001* with regards to the management, release and sharing of health information between health service providers.
8. Health services should work collaboratively with a woman's lead maternity care provider(s) to ensure early identification and management of physical, emotional, psychological and social factors that may impact on the health and wellbeing of the woman or her family during the postnatal period and beyond.
9. Health services should provide comprehensive assessment and treatment of psychosocial factors, where indicated, throughout the antenatal and postnatal periods. Health services will provide support/onward referral for mothers experiencing postnatal depression and other health problems.
10. Women should be offered access to postnatal care, irrespective of Medicare or financial status. Health services should notify women who are ineligible for access to Medicare subsidised healthcare.

## Implementation guidance

### Collaborative and coordinated care

Health professionals who may be involved in the provision of care during the postnatal period include registered midwives, registered and enrolled nurses, obstetricians, paediatricians, GPs, Aboriginal health workers, allied health professionals and lactation consultants. Care may be provided by an appropriately qualified midwife, GP or MCH nurse, and be supported by a number of individual health professionals forming part of a multidisciplinary team. Care may also include team consultations.

Health services should promote continuity of care throughout the maternity care pathway and should therefore work collaboratively with a woman's lead maternity care provider(s). Continuity of care has been shown to lead to a woman-centred approach to care and consistency in the information and support provided. As a result, women report higher levels of satisfaction with their care and a greater sense of control and safety during the postnatal period (Fereday et al., 2009).

Collaboration between health professionals and organisations providing care to women and their families during the postnatal period is necessary to facilitate timely access to care that meets individual needs and expectations (Homer et al., 2009). Successful collaboration is based on the following elements:

- shared vision and values
- agreement and commitment to common goals
- sound governance and leadership
- recognition and valuing of health professionals' individual roles and responsibilities
- willingness to share risks
- effective communication
- mechanisms to share information.

### Assessment of women's health and wellbeing

There is an increasing awareness of the impact of psychosocial factors on the health and wellbeing of women and their families, including the behaviour and cognitive development of children (Williamson & McCutcheon, 2004).

Health services should ensure that there is a comprehensive assessment process in place addressing the physical, emotional, psychological and social factors that may impact on the health and wellbeing of women and their families during the postnatal period and beyond (NSW Department of Health, 2009). The assessment process, where possible, should be initiated during the antenatal care period and should be ongoing to ensure that new and emerging needs are identified and managed in a timely manner. The outcomes of assessment should contribute to planning for the postnatal care period.

Health services should work collaboratively with a woman's lead maternity care provider(s) to ensure early identification and management of physical, emotional, psychological and social factors that may impact on her health and wellbeing during the postnatal period and beyond.

### **Postnatal depression and anxiety**

The incidence of clinically significant symptoms of depression during the postnatal period is estimated to range between 10 and 15 per cent (Commonwealth of Australia, 2009b). Postnatal depression can start within one or several months of giving birth. About 40 per cent of women with postnatal depression had symptoms that started in pregnancy (Matthey et al., 2004).

Risk factors for postnatal depression include a history of mental illness, recent life stressors (for example, bereavement, relationship issues) and past or current physical, sexual or psychological abuse (NICE, 2007). Depression during the postpartum period is distinguished from 'baby blues' by duration and intensity of mood symptoms. Baby blues occurs in 80 per cent of women, with symptoms resolving within 7–10 days of childbirth with minimal or no treatment (Pearlstein, 2008).

Recent studies examining anxiety across the antenatal and postnatal periods suggest that as many as 30 per cent of women may experience significant symptoms of anxiety (Britton, 2008).

Women with a previous history of a serious mental illness have an increased risk of developing a recurrence of symptoms during pregnancy or following childbirth. For example, a woman with a history or family history of bipolar affective disorder has an overall risk of recurrence of mood symptoms during pregnancy of 71 per cent. Those who cease taking mood stabiliser medication during pregnancy are at double the risk (Viguera et al., 2007).

### **Support vulnerable and at risk children**

Health professionals may encounter vulnerable children and families who are at risk of child abuse or neglect, or may witness abuse or neglect that has already occurred or children who are at risk of significant harm.

Under the *Children Youth and Families Act 2005*, some professionals, such as medical practitioners, nurses, police officers and school teachers, are legally obliged to report suspected child abuse. In addition, any person who believes on reasonable grounds that a child needs protection can make a report to the Victorian Child Protection Service.

Health services providing postnatal care have a key role to play in the care and protection of vulnerable children through early identification of child abuse and neglect. By working with community services, Child Protection and the justice system, health services can contribute to the provision of early intervention to help meet the needs of vulnerable babies, children and young people at risk of harm.

The Department of Health has produced and distributed a best practice framework, *Vulnerable babies, children and young people at risk of harm: Best practice framework for acute health services* (Department of Health, 2006), that provides information and guidance for health services on issues relating to children and young people at risk of abuse and neglect.

*Health professionals working together to keep children safe* (Victorian Forensic Paediatric Medical Service) is an online resource designed to assist health professionals working in Victorian hospitals and community settings to identify vulnerable children; respond to situations where abuse or neglect is suspected; and understand the child protection service system.

### **Medicare ineligible patients**

Medicare ineligible patients are individuals within Australia who are not eligible for Medicare and are unable to receive free public hospital services under the National Healthcare Agreement and the National Health Reform Agreement. Medicare ineligible patients are generally temporary entrants to the country, including tourists, international students and temporary workers.

Medicare ineligible patients seeking treatment for maternity care can access treatment at a public hospital as a private patient. Women seeking care should be encouraged to discuss the likely fees with the hospital.

The National Health Reform Agreement (COAG, 2011) allows states and territories to charge Medicare ineligible patients for services provided by public hospitals. Current Department of Health policy advises that fees for ineligible patients be set to achieve full cost recovery. Health services may charge Medicare ineligible patients at the full cost recovery rate and manage debt processes to ensure appropriate revenue is collected to recover costs.

Under current Department of Health policy, Medicare ineligible asylum seekers are classified as public patients and hospitals are unable to charge these patients. Medicare ineligible asylum seekers are provided with the full medical care they require and health services are paid the relevant public price by government for their treatment.

### **Patient consent and confidentiality**

Health services should obtain a woman's consent\* for referral and ensure that she has been given adequate information regarding the nature of the referral.

Health services must respect women's privacy and must operate within the parameters of the *Health Records Act 2001* with regards to the management, release and sharing of a patient's health information between health service providers.

### **Referral guidelines**

Women who would benefit from other specialist services (for example, physiotherapy, psychology, lactation consultants) during the postnatal period and beyond should be referred to an appropriate service provider located as close as possible to the woman's home.

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\* Consent may be express or implied. Signing a consent form is one form of express consent. Consent is implied from a person's actions, such as when rolling up a sleeve to receive a flu vaccine.

A referral or transfer of a woman's care to another health service or community-based service provider should be written and should contain relevant and sufficient information to appropriately prioritise and manage a woman's wait for services and her care at the first appointment (Department of Health unpub). The following is suggested as the basic content that should be included in a referral:

- the woman's demographics (for example, contact details, date of birth, and information about special needs)
- referrer details
- primary maternity care provider(s) (for example, GP, specialist obstetrician, registered midwife)
- health service discharge summary including relevant history, current medications, postnatal care plan and reason for referral
- relevant investigation results
- priority for care, if relevant.

The Service Coordination Tool Templates (SCTT) (Department of Health, 2009) were developed to facilitate and support service coordination. The SCTT support the collection and recording of initial contact, needs identification, referral and care planning information in a standardised way. This can improve communication and information sharing to support better outcomes for women and their families.

### **Record keeping**

Health services should keep comprehensive written records of postnatal care, including a woman's consent for care. This is important to ensure consistency of information provided and timely transfer and follow-up of care.

Guidance on the collection and storage of patient information is available from the Public Records Office of Victoria (<http://www.prov.vic.gov.au>).

## iv. Access to home-based postnatal care

Postnatal care, irrespective of setting, is focused on the needs of the mother and supporting her to care for her baby. Postnatal home-based care should be provided by a registered midwife from the birth hospital where possible, and supported by a number of individual health professionals forming part of a multidisciplinary team. However, home-based care may be transferred to the service of a different hospital, a Koori Maternity Service, the Royal District Nursing Service or a private nursing agency to better suit the individual needs of a woman, particularly when located closer to the woman's home.

Home-based models of postnatal care are becoming increasingly important in assisting women to transition from hospital to home, and for providing them with care and advice in the most appropriate care setting for their needs. For many women, home can also be a more relaxed, convenient and private environment for recovery from childbirth and for the establishment of breastfeeding.

As a minimum requirement, following discharge, public health services should offer women at least one postnatal visit in her home. Additional home visits are provided on the basis of individual clinical and psychosocial needs.

### Principles

Health services will facilitate timely and equitable access to postnatal care with women able to access services as close to home as possible.

Health services will work in a collaborative and coordinated way with other health services and community-based providers of maternity and newborn services to optimise women's experiences and postnatal care outcomes.

Health services will promote safe and high-quality outcomes for women and their families.

Health services will collect and report accurate data on women's access to postnatal care.

### Program guidelines

1. Health services providing intrapartum care must offer women home-based postnatal care prior to their discharge home.
2. Health services will ensure the health and safety of all staff members providing home-based care, in accordance with relevant legislation.
3. Following discharge home from hospital, a suitably qualified health professional, preferably a registered midwife, should provide at least one postnatal home-based visit tailored to the individual requirements of the woman. For many women, this visit will be required within 24 hours of discharge.
4. Health services must provide multiple postnatal home-based visits to women with identified clinical and psychosocial needs during the immediate postnatal period of care. This includes local health services that are sub-contracted to provide postnatal home-based care. The period of time and the number of visits required is dependent on the individual needs of the woman, the woman's geographical location and the health service configuration.

5. Women who should be considered for multiple postnatal home visits include:

- first-time mothers
- young women, including teenagers
- women without a support network
- Aboriginal and Torres Strait Islander women
- women with a disability
- women with substance abuse issues
- women known to child protection
- women who experienced birth or post-birth complications
- women experiencing breastfeeding difficulties
- women who have not yet received antenatal care
- women with psychosocial issues.

6. Sub-contracted health services, including Aboriginal Community Controlled Health Organisations with a Koori Maternity Service, are responsible for arranging appropriate remuneration with the birthing hospital for any services provided.

## Implementation guidance

### Failure to be present at the time of visit

Health services should make reasonable attempts to contact women who are not present on the day of an agreed postnatal home-based visit. At a minimum, health services should attempt to contact the woman and her nominated GP to arrange another visit.

Women may choose to decline postnatal home-based care following discharge home from hospital. Where care is declined, health services should document this in the woman's patient record. Health services should exercise discretion to avoid disadvantaging women in the case of hardship, misunderstanding and other extenuating circumstances.

### Access in rural and regional areas

Advances in information and communication technologies have improved access to healthcare and advice for geographically dispersed individuals. Where a face-to-face home-based visit is not possible, health services should consider alternative models of service delivery when providing postnatal care to women in rural and regional areas. For example, providing women with the ability to access support via telephone in conjunction with home-based visits has been shown to improve breastfeeding duration and exclusivity and decrease symptoms of postnatal depression (Dennis & Kingston, 2008; Fereday et al., 2009).



### **Sub-contracting service delivery**

Health services may restrict service delivery to individuals residing within a geographical area. Health services should, however, demonstrate flexibility to accommodate the exceptional needs of women residing outside of this area.

Where health services determine that a woman lives outside of their feasible geographical area, the provision of postnatal home-based care should be sub-contracted to a local health service, private provider or district nursing service. Sub-contracted health services, including Aboriginal Community Controlled Health Organisations with a Koori Maternity Service, are responsible for arranging appropriate remuneration with the birthing hospital for any services provided.

In some cases, sub-contracting of postnatal home-based care should be arranged to maintain continuity of care and/or carer. Continuity of care refers to a consistent organisational structure around which care is provided (for example, team based model of maternity care). Continuity of carer refers to care provided by a primary midwife whom the woman has previously met and is familiar with (for example, caseload model of maternity care) (Homer et al., 2002).

## v. Safe and high-quality care

Health services should ensure women and their babies have access to safe, high-quality maternity services. Whether postnatal care is provided in hospital or in the woman's home, it is imperative that the care provided is of the highest standard and meets the needs of the individual.

In addition to ensuring the health and safety of women accessing postnatal care, health services should also consider the occupational health and safety of all health professionals responsible for providing postnatal care.

### Principles

Health services will promote safe and high-quality outcomes for women and their families.

Health services will collect and report accurate data\* on women's access to postnatal care.

### Program guidelines

1. Health services must provide postnatal care within a sound quality and safety framework.
2. Health services must promote evidence-based practices.
3. Health services must provide staff with access to regular and ongoing education and training that supports their scope of practice.
4. Health services must collect and report data on women's access to postnatal care including home-based care.
5. Health services must provide health professionals delivering postnatal home-based care with the necessary equipment and training to protect their own health and wellbeing and enable the delivery of timely and appropriate care.
6. Health services must comply with accepted legislation, including the *Occupational Health and Safety Act 2004*.
7. In determining appropriate care for women with co-morbid conditions, health services should ensure appropriate physical and service delivery capabilities, including appropriate workforce capability and risk management strategies.

### Implementation guidance

#### Policies and procedures

Health services should have written policies and procedures that address occupational health and safety considerations that could impact on health professionals responsible for providing postnatal care, including home-based visits (for example, driving in hazardous weather conditions, bushfire training and the use of a car as an emergency vehicle).

Health services should also have written protocols relating to the treatment of women and their families during the postnatal care period.

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\* data elements specified under Performance reporting

## Education and training

Health services should ensure that health professionals employed to deliver postnatal care are appropriately qualified and credentialled. A qualified and skilled workforce is imperative to the provision of safe and high-quality postnatal care that reflects current, evidence-based practices.

Health services should ensure that all health professionals providing postnatal home-based care have undertaken adequate training to make decisions regarding the safety of the environment in which they are to provide care.

## Performance reporting

Health services should report annually against the Department of Health's maternity services performance indicators (Department of Health, 2012). The performance indicators relevant to postnatal care are:

- Maternity Indicator 6 – Rate of women referred to postnatal domiciliary care or hospital-in-the-home in Victorian public hospitals
- Maternity Indicator 8 – Number of WHO Ten Steps to Successful Breastfeeding achieved in Victorian public hospitals

The following three indicators are in development and will replace the current breastfeeding support indicator (Maternity Indicator 8):

- Maternity Indicator 8b – Breastfeeding initiation in Victorian public hospitals
- Maternity Indicator 8c – Use of infant formula in Victorian public hospitals
- Maternity Indicator 8d – Final feed being taken exclusively from the breast in Victorian public hospitals

It is expected that all women will be referred to postnatal home-based care or hospital in the home (HITH). Women eligible for HITH must meet the criteria of the *Victorian hospital admission policy* (Department of Health, 2011b).

Health services in scope to collect specialist (outpatient) clinic data through the Victorian Integrated Non-Admitted Health (VINAH) data set should report this to the Department of Health as per the specifications (Victorian Government Health Data Standards and Systems). The VINAH data collection was rolled out to outpatient clinics on 1 July 2011 for implementation from 1 July 2012.

## Risk factors associated with pregnancy

The most common pregnancy complications are obesity, hypertension, diabetes mellitus, cardiovascular disease (CVD) and placental abnormalities (Segev et al., 2011). Uncontrolled conditions such as gestational diabetes and chronic hypertension can increase the risk of maternal and fetal/neonatal complications.

Many women who need assisted reproductive technology because of infertility are older than the average pregnant woman and the risks for chronic diseases such as obesity, diabetes mellitus, chronic hypertension, CVD and malplacenta greatly increase with maternal age.

Women who are overweight or obese have increased risks of experiencing pregnancy complications such as gestational diabetes, pregnancy-induced hypertension and wound infection. Overweight and obese women are also at greater risk of giving birth to a preterm baby (less than 37 weeks) or low birth weight baby (less than 2500g) compared with women of normal weight range (McDonald et al, 2010).

In recognition of the additional risks posed by factors such as obesity during the postnatal period, specific measures of routine care may be required, such as weight management strategies.

Health services should work to strengthen systems for health protection, health promotion and preventive healthcare, including appropriate assessment and management of women with risk factors and their baby.

### **Occupational health and safety**

Health services should have written policies and procedures that address occupational health and safety considerations that could impact on health professionals responsible for providing postnatal care, including home-based visits (for example, driving in hazardous weather conditions, bushfire training and the use of a car as an emergency vehicle).

Specifically, health services should ensure:

- promotion of appropriate standards in occupational health and safety and welfare and injury management
- use of effective prevention strategies and injury management practices
- integration of occupational health and safety across all aspects of business operations, systems of work and procedures (Department of Human Services, 2003).

The *Occupational Health and Safety Act 2004* (OHS Act) highlights the principles that all employers and employees should apply in building and maintaining safe workplaces.

WorkSafe Victoria, a statutory authority of the Victorian State Government, works with employers and employees to ensure the appropriate information, guidance and assistance is available to support compliance with the OHS Act.

- *Working safely in visiting health services* (WorkSafe Victoria, 2011a) is a publication developed for healthcare providers involved in the assessment and treatment of clients in their homes and other community settings. The publication covers health and safety basics, with a focus on occupational violence and manual handling.
- *Home care – occupational health and safety compliance kit* (WorkSafe Victoria, 2011b) describes the seven most common hazardous tasks that cause workplace injuries in the home care sector. It includes seven health and safety solutions to outline ways to control the risks associated with these tasks.

Information includes measures for identifying hazards and risks, and implementing control measures to eliminate, isolate or substitute the source of the risk. When a client's home is deemed to be unsafe, advice is provided for suspending visits or providing visits in a safer environment such as at a local hospital outpatient clinic.

## Appendix. Policy context

There are a range of state and national policy frameworks that provide guidance to health services on the principles underpinning maternity and newborn care including postnatal care.

### Victorian context

#### Victorian Health Priorities Framework 2012–2022

In May 2011, the Victorian Government released the *Victorian Health Priorities Framework 2012–2022*, which provides the blueprint for planning and development of priorities for the Victorian healthcare system for the coming decade.

The framework is the basis for three supporting plans: the Metropolitan Health Plan, Rural and Regional Health Plan and Health Capital and Resources Plan.

The framework establishes the key outcomes, attributes and improvement priorities for the Victorian healthcare system across seven priority areas:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and experiences
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- utilising e-health and communications technology.

#### Metropolitan Health Plan

The Victorian Government published the *Metropolitan Health Plan* in May 2011. The plan articulates the long-term planning and development priorities for metropolitan Melbourne and statewide health services throughout the next decade. It indicates that a *Refugee Health and Wellbeing Plan* will be developed and available in 2012, which will increase the capacity of the healthcare system to design, implement and evaluate culturally and linguistically competent services to address health disparities among populations from CALD backgrounds.

#### Rural and Regional Health Plan

The Victorian Government published the *Rural and Regional Health Plan* in December 2011. This plan will drive the development of key actions that will deliver services in rural and regional Victoria that are more responsive to people's needs and are rigorously informed and informative.

#### Health Capital and Resources Plan

The *Health Capital and Resources Plan* will be available in 2012 and will apply the overarching *Victorian Health Priorities Framework 2012–2022* to the specific context and challenges of rural and regional Victoria.

#### Victorian Public Health and Wellbeing Plan 2011–2015

The *Victorian Public Health and Wellbeing Plan* aims to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government. The plan is a companion document to *Victorian Health Priorities Framework 2012–2022*.

### **Future directions for Victoria's maternity services**

*Future directions for Victoria's maternity services* (2004) provides the policy framework that sets the direction for the provision of maternity care in Victoria. The policy reflects the belief that birthing is a normal process and, where possible, should be located close to the mother's home.

The principles underpinning the policy are:

- Women have informed choice, continuity and safety in their pregnancy, birthing and postnatal experiences.
- Primary maternity care is the most appropriate model of care for the normal life events of pregnancy and birthing.
- Access to appropriate specialised care when required is integral to providing safe, high-quality maternity care.
- A collaborative, multidisciplinary team approach to the provision of maternity care requires education, training and development.

### **Capability framework for Victorian maternity and newborn services**

The *Capability framework for Victorian maternity and newborn services* (2011) delineates the role of maternity and newborn services and defines the minimum standards required to deliver different levels of care. There are six levels of care, which can be broadly grouped as:

- Primary maternity care services (levels 1, 2 and 3) provide care to women with low or normal risk pregnancies and births.
- Secondary maternity care services (levels 1–3, 4 and 5) provide care to women with medium risk pregnancies and births with moderate complications.
- Tertiary maternity care services (levels 1–5 and 6) provide care to women with complex pregnancies and births requiring neonatal intensive care.

### **Perinatal Emotional Health Program**

In 2010, the Department of Health established the Perinatal Emotional Health Program to improve early identification and treatment of women at risk of or experiencing depression during the antenatal and postnatal periods. The program currently employs 16 mental health nurses or equivalent across rural and regional Victoria to provide clinical assessment and treatment in maternity services, MCH services or in women's homes. A pilot of a similar program for metropolitan Melbourne is planned for 2012.

### **Continuity of Care: A communication protocol for Victorian Public Maternity Services and the Maternal and Child Health Service**

*Continuity of Care: A communication protocol for Victorian Public Maternity Services and the Maternal and Child Health Service* (2004) provides a framework to support effective communication between health services, MCH services and other services providing care to women and their families. The framework was developed through a partnership between the departments of Education and Early Childhood Development, Health and Human Services, and the Municipal Association of Victoria.

### **Programs to support vulnerable and disadvantaged women**

In Victoria, a number of programs have been established to support vulnerable and disadvantaged pregnant women and their families during the postnatal period. These include:

- *Healthy Mothers Healthy Babies* program which supports access to appropriate services during the antenatal and postnatal care period, and provides key health promotion messages to support healthy behaviours in pregnancy and beyond. The program is available to women up to six weeks post-childbirth.
- Koori Maternity Services provide culturally appropriate maternity care and support to Aboriginal and Torres Strait Islander women with the principle focus of increasing access to antenatal care and postnatal support, and liaising with public maternity services. There are currently 11 Aboriginal community controlled health organisations providing the service.
- Enhanced MCH Service responds to the needs of children and families at risk of poor outcomes. The service provides a more intense level of support than the universal MCH service to families with one or more risk factors, including drug and alcohol issues, mental health issues, family violence issues, homelessness and low income, socially isolated and single-parent families (Department of Education and Early Childhood Development, 2011).

### **Care of the obese pregnant woman and weight management in pregnancy clinical guideline**

*Care of the obese pregnant woman and weight management in pregnancy* clinical guideline aims to promote and facilitate standardisation and consistency in practice in the care of obese women in pregnancy. The guidelines recognise the:

- potential complications associated with obesity in pregnancy
- importance of appropriate weight management in pregnancy
- need for consistency of practice in managing obesity in pregnancy
- need for appropriate workforce and workplace capability to manage obesity in pregnancy.

## **National context**

### **National Maternity Services Plan**

The *National maternity services plan* (2010) recognises the importance of maternity services within the health service system and provides a strategic national framework to guide policy and program development across Australia over the next five years. The plan is underpinned by the following principles:

- Maternity care places the woman at the centre of her own care. Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial and clinical needs close to where they live.
- Maternity care enables all women and their families to make informed and timely choices in accordance with their individual needs. The planning and provision of maternity care is informed by women and their families.
- Women and families in rural and remote Australia have improved and sustainable access to high-quality, safe, evidence-based maternity care which incorporates access to appropriate medical care if complications arise.

- Governments and health services work to reduce the health inequalities faced by Aboriginal and Torres Strait Islander mothers and babies or other disadvantaged populations.
- Maternity services offer continuity of care across the pregnancy and birthing continuum as a key element of quality maternity care for all women and their babies.
- Maternity care will be provided for all women and their babies within a wellness paradigm, utilising primary healthcare principles whilst recognising the need to respond to emerging complications in an appropriate manner.
- The potential of maternity health professionals is maximised to enable the full scope of their specific knowledge, skills and attributes to contribute to women's maternity care.
- Maternity services provide high-quality, safe, evidence-based maternity care within an expanded range of sustainable maternity care models.
- Maternity services are staffed by an appropriately trained and qualified maternity workforce sufficient to sustain contemporary evidence-based maternity care.
- Maternity services operate within a national system for monitoring performance and outcomes and guiding quality improvement.

### **Australian National Breastfeeding Strategy**

The *Australian national breastfeeding strategy 2010–2015* (2009) recognises the biological, health, social, cultural, environmental and economic importance of breastfeeding and provides a framework of priorities for Australian governments at all levels to protect, promote, support and monitor breastfeeding. The objective of the strategy is to increase the percentage of babies who are fully breastfed from birth to six months of age, with continued breastfeeding and complementary foods to 12 months of age and beyond.

### **National Perinatal Depression Initiative**

The National Perinatal Depression Initiative aims to improve prevention, early detection and treatment of antenatal and postnatal depression. The initiative provides routine and universal screening for depression for women during the perinatal period; follow-up treatment and support for women who are at risk of or experience perinatal depression; training and development of health professionals to assist them in screening and identifying women at risk of experiencing perinatal depression; and research and data collection into prevention activities and the provision of services to meet women's needs.

As part of this initiative, the National Health and Medical Research Council *Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period* (2011) were developed by beyondblue to assist health professionals working in primary and maternity care to identify and treat mental health problems in the perinatal period.



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