

Guideline 16

PLANNED MATERNITY DISCHARGE FOLLOWING TERM BIRTH

INTRODUCTION

In British Columbia most mothers and their infants are currently being discharged within 2.3 days (55 hours) of a normal vaginal delivery and within 3.3 days (79 hours) of an uncomplicated Caesarean birth (BCRCP, 1996).

Preparation for discharge should be considered part of the normal antenatal education of all expectant mothers (and families), including information on infant feeding and detection of such neonatal problems as dehydration and jaundice. These issues should be reinforced during the short hospital stay (CPS, 1996).

Benefits associated with a short maternity stay with an adequate community follow up program include:

- family-centred postpartum adjustment in the family home environment
- 1:1 teaching/support in the home geared to family needs
- decreased iatrogenic infections
- reduction in hospital costs

Without adequate assessment prior to hospital discharge and, without an appropriate community follow-up program in place, a shortened length of stay may pose risks to some mothers and newborns. Hospitals and communities will need to develop their own standards of care related to length of maternity stay depending upon the availability of follow-up resources and the time frames in which these resources are consistently available.

Care for mothers and babies should be individualized and family-centred. With many uncomplicated births, a stay of 12 to 48 hours is adequate, provided the mother and baby are well, the mother can care for her baby, and there is proper nursing follow-up in the home. In the absence of these requirements, mothers should be offered the opportunity to stay in hospital with their baby for a minimum of 48 hours after a normal vaginal birth. Women with complicated births, including Caesarean section, may require a longer hospital stay (SOGC, CPS, 1996).

Hospitals with early discharge programmes should partner with community health agencies in the development, implementation and ongoing management of these programmes. Audit outcomes for mothers and babies should be available to ensure guidelines for early discharge are *appropriate* and are *being used* appropriately.

The mother needs appropriate information in her language regarding follow-up care for herself and her baby. This should include:

- advice on positioning baby (i.e. supine sleeping)
- when she/baby should first be seen by the doctor/midwife
- when she can expect a contact/visit from the community health nurse or hospital nurse
- how she can access community services and resources (with phone numbers)
- whom to contact if there are problems/concerns with herself or baby, e.g., excessive bleeding, baby feeding poorly

Risks associated with a short maternity stay without an adequate community follow-up program may include:

- decreased time for staff to teach mother about postpartum self-care
- decreased time for staff to teach about and assist with breastfeeding and baby care
- increased risk of early breastfeeding failure/termination
- increased risk of illness from dehydration and hypernatremia in breastfeeding babies
- delayed diagnosis and management or treatment of neonatal problems, i.e. jaundice, sepsis, etc.
- delayed diagnosis and management of postnatal maternal problems
- increased hospital re-admission

DETERMINANTS OF LENGTH OF STAY

1. The length of stay should be calculated from the time of birth of the baby and not by admission of the mother, and take into account the labour, complications and postpartum course.
2. The length of stay after a Caesarean birth will take into account the labour, complications and the postpartum course.
3. A 12 to 24 hour stay is only acceptable when women have a proper home environment in place and there is community nursing follow-up in the home (seven days a week). Newborn and postpartum clinics should be available to provide emergency access for patients.
4. Home care services (community health nursing) implies a minimum of one home visit within the first 24 to 48 hours of discharge by a qualified health professional when discharge occurs less than 48 hours after birth (SOGC, CPS, 1996).

CRITERIA FOR COMMUNITY HEALTH NURSING

Rationale

Relying on new mothers to travel to a clinic or office may result in many families being inadequately followed. The home visit is not intended to replace a complete evaluation by a physician or midwife, but should focus on those aspects that require early attention (e.g., feeding problems, jaundice, signs of infection, etc.). When discharge occurs before 48 hours after birth, there must be a programme that ensures appropriate ongoing assessment of the mother and baby. This evaluation should be carried out by a qualified professional with education and experience in maternal/newborn care and all aspects of breastfeeding.

Ongoing assessment should include referral information from the hospital to the community, i.e. HLTH 1589 *Postpartum Nursing and Community Health Record*.

Program staff should be able to assess and offer advice on (including on weekends):

- adequacy of infant feeding and hydration
- support for the mother in the feeding of her infant
- the baby for jaundice and other abnormalities that may require further investigation and/or assessment by a physician/midwife earlier than expected
- the need for screening tests and/or other investigation as required
- maternal physical and emotional status with regard to the normal involutinal processes after birth
- signs of postpartum depression (mood disorders)

Planned Maternity Discharge Following Term Birth

* BCRCP *

- the integration of the baby into the home environment
- plans for future health maintenance and care, including routine infant immunizations, identification of illness, and periodic health evaluations
- the family's need for other sources of support (e.g., social services, parenting classes, lactation consultants) as necessary

In addition:

Hospitals with early discharge programmes should work with community health agencies to audit outcomes for mothers and babies to ensure guidelines for early discharge are appropriate and being effectively utilized.

READMISSION

When readmission of the baby to hospital occurs within seven days after birth, the baby should be admitted to the hospital with accommodation for the mother so as to maintain the maternal/child dyad and maintain breastfeeding. When readmission of the mother is required, there should be opportunity for the newborn baby to be with her, if appropriate.

CRITERIA FOR DISCHARGE LESS THAN 48 HOURS AFTER BIRTH (SOGC, CPS, 1996)

The following criteria should be considered for all mothers and newborns, but particularly adhered to when the length of stay is 48 hours or less.

There is a requirement for:

- Strong and effective communication and cooperation between all caregivers and agencies – particularly the hospital and community health unit (i.e., referrals must be timely)
- Follow up professional support must be skilled in all aspects of maternal/newborn postpartum assessment, breastfeeding, and newborn care.

MATERNAL	NEWBORN
<p>Purpose: to ensure postpartum mothers are safely discharged following the birth of their baby; they should meet basic criteria and have appropriate arrangements for ongoing care. Prior to discharge, the following criteria should be met:</p>	<p>Purpose: to ensure newborn infants are safely discharged, they should meet basic criteria and have appropriate arrangements for ongoing care. The baby should be healthy in the clinical judgment of the physician or midwife, and the mother should have demonstrated an appropriate ability to care for the newborn.</p>
<ul style="list-style-type: none"> • Vaginal delivery • Vital signs stable • Perineal tear, or episiotomy is clean and intact • No intrapartum or postpartum complications that require ongoing medical treatment or observation • No evidence of venous thrombosis • Mother is mobile with adequate pain control • Bladder and bowel functions are adequate • Receipt of Rh immune globulin and/or rubella vaccine, if eligible • Demonstrated ability to feed the baby properly at two consecutive feeds • Demonstrated ability of mother to put the baby to breast with proper latch and suckle • If bottle feeding, mother can demonstrate proper formula feeding technique and understands procedure for preparation of formula • Advice regarding contraception and resources is provided • Physician who will provide ongoing care is identified and, where necessary, notified • Parents have approved infant car seat • Satisfactory home environment (safety, shelter, support, communication) and family accessible for follow-up visits • Mother is aware of, understands, and will be able to access community and hospital support resources • Mother is aware of and understands necessity for, and timing of, any health checks for baby or herself 	<ul style="list-style-type: none"> • Vitamin K and eye prophylaxis has been given • No evidence of sepsis • No significant jaundice • Temperature stable in cot (auxiliary temperature of 36.1°C to 37.2°C) • No apparent feeding problems (at least two successful feedings documented) • Physical examination of the baby by physician or other qualified health professional within 12 hours prior to discharge indicates no need for additional observation and/or therapy in hospital • Baby has normal voiding and stool patterns • Parents aware of normal voiding and stool patterns • No bleeding at least two hours after circumcision • Receipt of necessary medications and immunization (e.g., hepatitis B) • Metabolic screen completed (at 24 hours of age) or satisfactory arrangements made • Weight loss <7 to 10% of birth weight • Mother is able to provide routine infant care (e.g., of the cord) and is knowledgeable about signs of illness and other infant problems • Arrangements are made for the mother and baby to be evaluated within 48 hours of discharge • Physician responsible for continuing care is identified with arrangements made for follow-up within one week of discharge
<ul style="list-style-type: none"> • Mothers should NOT be discharged until stable, if they have had: <ul style="list-style-type: none"> - significant postpartum haemorrhage or ongoing bleeding greater than normal - temperature of 38°C (taken on two occasions at least one hour apart) at any time during labour and after birth - other complications requiring ongoing care • Full-term healthy infant (37-42 weeks) 	<ul style="list-style-type: none"> • Infants requiring intubation or assisted ventilation, or infants at increased risk of sepsis should be observed in hospital for at least 24 hours or until healthy for discharge

NOTE: Individual hospitals may identify more specific criteria according to the needs of their populations, regions and geography.

RECOMMENDED RESPONSIBILITIES

Physician/Midwife

- Assess the mother and her infant as to the appropriateness of discharge.
- Ensure that the infant will be assessed by physician, midwife or nurse within 48 hours of discharge.
- Provide routine or necessary postpartum obstetrical and newborn follow-up.

Hospital Nursing/Liaison Nursing

1. Provide instruction and assistance to mothers to enable them to meet discharge criteria.
2. Providing the following information:
 - details of community support programme (Early Discharge Program), when to expect the first home visit and how to access service 24 hours per day, if necessary
 - details of symptoms which require immediate medical care (e.g. significant postpartum haemorrhage or infant respiratory distress) and symptoms which should be reported to the professional who is providing postpartum follow-up (e.g. increased vaginal flow, urinary problems, or breastfeeding concerns)
 - provision of 24 hour phone contact (will vary by community)
 - provide take home information with resource listing and phone numbers
 - refer parents to *Baby's Best Chance*
3. Communicate concerns re: mother's readiness for discharge to physician/midwife.

Community Health Nursing

- Provide maternal postpartum and newborn assessment including breastfeeding/infant nutrition assessment.
- Provide adequate liaison with the hospital to help identify mothers and recognize special needs.
- Assist in coordination and/or provision of and referral to other Public Health programmes, breastfeeding support, and postpartum support groups.
- Ensure that a home visit/contact* is made within 24 hours when hospital discharge is <48 hours.
- This visit should include assessment of the mother and infant, including assessment of feeding.
- Advise the mother when to contact physician/midwife or community health nurse.
- Ensure availability of *Baby's Best Chance*.

*Note: Some mothers may not want a home visit. In this case a thorough telephone assessment should be attempted.

These recommendations include current policy statements from The Society of Obstetricians and Gynaecologists of Canada and The Canadian Paediatric Society and are consistent with current nursing and medical literature.

National guidelines, such as the 1996 National Breastfeeding Guidelines for Health Care Providers, present comprehensive information on shortened length of stay and infant nutrition (CICH, 1996). (Appendix I Erratum)

REFERENCES

BCRCP, 1996 Biannual Hospital Perinatal Survey

Canadian Institute of Child Health, 1996, National Breastfeeding Guidelines for Health Care Providers, 1996, Ottawa

The Society of Obstetricians and Gynaecologists of Canada, 1996, and the Canadian Paediatric Society, 1996, Early Discharge and Length of Stay for Term Birth.

Paediatric Child Health, Vol. 1, No. 2, Fall 1996, Facilitating Discharge Home Following a Normal Term Birth.

SUGGESTED READING

Arnold, L.S., Bakewell-Sachs, S. Models for perinatal home follow-up. *J. Perinat. Neonatal Nurs.* 1991; 5: 18-26.

Braverman, P., Egerter, S., Pearl, M., Marchi, K., Miller, C. Problems associated with early discharge of newborn infants. *Early discharge of newborns and mothers: A critical review of the literature. Paediatrics* 1995; 96: (4 Pt 1), 716-26.

Burnaby Health Department Preventative Services, *Healthy Beginnings 1997. 24 Hour Telephone Assessment Guidelines.*

Committee on Fetus and Newborn. *Hospital Stay For Healthy Term Newborns. Paediatrics* 1995; 96: 788-90.

Farbman Moran, C., Holt, V., Martin, D. What do women want to know after childbirth? *Birth* 24:1, March, 1997.

Lee, K.S., Permian, M., Ballantyne, M., Elliot, L. The association between duration of neonatal hospital stay and readmission rate. *J. Pediatr.* 1995; 127:758-66.

Rush, J. Early hospital discharge of mothers and newborns. *Child Action, Canadian Institute of Child Health, Dec., 1996.*

Waldenstrom, U. Early discharge as voluntary and involuntary alternatives to a longer postpartum stay in hospital – effects on mothers' experiences and breastfeeding. *Midwifery* 1989; 5:189-96.

ERRATUM

National Breastfeeding Guidelines for Health Care Providers
Canadian Institute of Child Health, 1996

Please see third paragraph (beginning Mycostatin ...) on page 84 and replace the second sentence with the following:

However, alternative agents such as Clotrimazole cream (Canesten), twice daily or Gentian Violet (0.5-1%), swabbed once daily around the inside of the baby's mouth and applied to mother's nipples once daily for 3-4 days, are also recommended.

**EARLY DISCHARGE OF NEWBORN INFANTS –
A GUIDE FOR PARENTS**

WHEN SHOULD EARLY DISCHARGE (LESS THAN 48 HOURS) BE CONSIDERED FOR A NEWBORN INFANT?

Babies can be safely discharged from hospital before they are 48 hours old if they are born at full term and are physically well, as determined by a complete physical examination. The baby should have had a normal temperature and at least two successful normal feedings. He or she should have passed urine at least once and received all necessary medications, such as vitamin K and antibiotics to prevent eye infection. If any immunization is needed (for example, for hepatitis), this should have been performed. Screening tests to detect certain problems, such as PKU (a disease where the body cannot use phenylalanine usually), should have been done or appropriate arrangements made for these to occur after discharge. The mother herself should be well, able to recognize illness in the baby and be comfortable with care of her baby at home.

WHAT SHOULD BE DONE BEFORE A BABY IS DISCHARGED AT LESS THAN 48 HOURS OF AGE?

The new mother should be provided with preparation for the baby at home. This should include advice and information about feeding, the detection of jaundice, dehydration and infection. This should have occurred before the baby is delivered and should be reinforced after delivery. Plans should have been made for the baby's future health care. The mother should know how to access community services for routine baby care, for breast feeding support and for the treatment of any emergency.

WHAT SHOULD BE DONE AFTER THE BABY IS DISCHARGED?

The baby should have a physical assessment performed at home, in the office or in a hospital clinic within 48 hours of discharge. This should be done by a qualified health professional and should include the assessment of jaundice, feeding and general health. Any screening tests that require completion should be checked and the appropriateness of the home environment confirmed.

If an infant is discharged from hospital, but must be readmitted in the first week of life, the mother should always have the opportunity to have a room with or near the baby so as to continue breast feeding and to facilitate the ongoing development of the mother-child relationship.

The information contained in this publication should not be used as a substitute for the medical care and advice of your physician. There may be variations in treatment that your physician may recommend based on individual facts and circumstances.

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Information for Patients

YOUR BABY IN THE FIRST WEEK AFTER BIRTH

WHAT DO I NEED TO KNOW?

You should be aware of a number of concerns that might need attention in the first week after your baby is born. If you have any questions about the following points, please call your doctor or pediatrician:

1) **Timing of feedings.** If your baby feeds less than six times a day or more than 12 times a day, consider talking to your doctor or someone from your local hospital. If you are breastfeeding, you may wish to speak with someone from your local LaLeche League.

2) **Sucking.** Your baby should not be sucking with rapid, nibbling and shallow sucking movements. The baby's mouth should open with each suck, pause and then close.

Your baby should not be falling asleep on your breast or on the bottle, then waking up crying soon after being taken off. Also, if your baby falls asleep when feeding at your breast or with the bottle in his or her mouth *without drinking* and does not wake up, speak with your doctor.

3) **Throwing up.** Large amounts of vomit (not "spitting up"), frequent vomiting or a green content in the vomit could indicate a problem.

4) **Wet diapers and bowel movements.** It is not a good sign if your baby does not produce:

- wet diapers within the first two days of life
- more than two wet diapers on day three
- more than four heavy, wet diapers every 24 hours between days four and six.

There may also be a problem if:

- your baby's stool stays dark green and does not get lighter and yellow on days three to six

- your baby is producing three or four dollar-coin-sized stools on days three to six
- there is blood in your baby's stool
- your baby's stools are watery and last for a few hours (watery stools during or after feeds, however, are normal if you are breastfeeding and your milk is just coming in).

5) **Skin colour and condition.** There could be a problem if your baby's skin looks yellow, blue or pale either all the time or every so often with breathing difficulty. Also, if your baby has skin blisters, bruising or areas of redness, swelling or heat rash, see your doctor.

6) **Temperature and breathing.** It is not a good sign if your baby has a fever, a low temperature or is sweating a lot. Notice any fast, difficult or noisy breathing – especially if your baby's breathing has changed from the way it usually is.

7) **Sleepiness or irritability.** Contact your doctor if your baby is overly sleepy, refuses to wake and feed and has a weak cry. Being irritable or hard to console may also be a sign of a problem.

8) **Strange movements.** Unusual movements of your baby's arms and legs (especially rhythmic ones) and arching of the back are not normal.

9) **Swollen belly.** A large belly, or a belly that is tender to touch, could indicate a problem.

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May be copied and distributed to patients.

**A Joint Policy Statement by the Canadian Paediatric Society
and the Society of Obstetricians and Gynaecologists of Canada**

EARLY DISCHARGE AND LENGTH OF STAY FOR TERM BIRTH

To View this Guideline please go to: <http://www.sogc.org>

Clinical Practice Guidelines

**Obstetric Number 56:
Early Discharge and Length of Stay for Term Birth:
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