

BRITISH COLUMBIA
REPRODUCTIVE CARE PROGRAM

REPORT ON THE FINDINGS OF
A CONSENSUS SYMPOSIUM ON
THE PROVISION OF POSTPARTUM
SERVICES IN BRITISH COLUMBIA

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Background

The British Columbia Reproductive Care Program (BCRCP) is a provincial program whose mission is to optimise Maternal/Fetal/Newborn health. The program's mandate includes consultation with perinatal care providers, promotion of education and perinatal care networks, the development of guidelines for perinatal care and the management of the British Columbia Perinatal Database Registry.

The BCRCP has historically facilitated the process of the formulation of Provincial Perinatal Guidelines and associated documentation tools, including care-paths, in BC. This process of development and revision is done by a multidisciplinary committee with provincial representation. The last BCRCP Perinatal forms revision occurred in 1998 and included the creation of postpartum hospital and community documentation tools and care-paths. During this development process, it became apparent that there was much variation in both postpartum service delivery and care practices across the province. The most pressing issue that emerged is that currently, there are no generally accepted, multidisciplinary standards for the delivery of postpartum care in BC.

The goal of postpartum services is to achieve optimal newborn, maternal and family health in the short- and long-term, not only to prevent occurrences such as hospital readmission or rare adverse events. Outcomes reflecting important measures of health and well-being for newborns, mothers, and families include:

- initiation and continuation of breastfeeding;
- timely use of preventive and curative services;
- the occurrence and severity of postpartum depression;
- the mother's physical comfort, overall functioning, and sense of competence with parenting; and
- the adoption of healthy lifestyles.

(Early Postpartum Discharge; Recommendations from a Preliminary Report to Congress, in *Pediatrics*, vol 107 no2 Feb 2001).

Given these goals of postpartum services and the apparent variation of service delivery and care practices across BC, the BCRCP identified two key questions on which to focus the consensus symposium:

1. What are the 'best practices' that can be recommended for postnatal and postpartum care, based on existing knowledge and considering the optimal attainable health of newborns, mothers and families, rather than only the prevention of rare adverse events ?
2. What are the essential health services (including either clinical evaluation or health promotion or both) that mothers and newborns should receive from the point of physiologic stability to self-care (care-by-parent) ?
 - How and when should these services be delivered ?
 - How can interdisciplinary communication be facilitated ?

Trends

The postpartum period (also known as the puerperium, postnatal period or fourth trimester) covers a critical transitional time for a woman, her newborn and her family on a physiological, emotional and social level (World Health Organisation, 1998). Whether health care professionals are involved in education, research or clinical practice, postpartum care has tended to be the least-emphasised component of the entire childbearing cycle (Albers & Williams, 2002). It has only been within the last decade that practitioners and researchers have begun to question many aspects of postpartum care.

According to generally accepted standards of maternity care, the postnatal/postpartum health care needs of the newborn and mother are not confined to the immediate post-delivery period. These needs include, but are not limited to, monitoring of the infant to support the physiologic adaptation to an extra-uterine environment, assessment of major medical risk factors for mother and baby, instruction in breastfeeding and lactation support and teaching on infant and self care (Early Postpartum Discharge; Recommendations from a Preliminary Report to Congress, in *Pediatrics* vol 107 no2 Feb 2001).

The afore-mentioned postpartum needs of clients are identified in order to prevent potential complications. For the mother, the most common include postpartum hemorrhage (the single most important cause of maternal death in the world) infections, thromboembolic disease, injury to the urinary tract, perineum and vulva and psychological complaints. Frequently occurring infant complications in the postpartum period include infection, respiratory morbidities, birth trauma, disturbances in thermoregulation and jaundice. Both the identified needs and the potential complications necessitate some level of postpartum intervention.

Over time, the provision of postpartum care has been affected by various trends. The most significant trend in recent years has been the decrease in hospital length of stay after childbirth. This trend has occurred over the past 20 years, initially in response to public demand to demedicalise childbirth, but increasingly in response to cost containment pressures. This trend has not only raised concerns about the potential consequences of reduced hospital stays, but has also resulted in the transfer of responsibility for much of the postpartum recovery period to community care providers. In BC, these services are managed by a variety of health care providers (physicians, midwives, nurses, lactation consultants and outreach workers) in a variety of settings (clinics, community facilities and the clients' homes).

Prevailing expert opinion has also recommended earlier and more rigorous follow-up for newborns discharged early from institutional care. However there are no well-accepted standards for addressing the follow-up needs of mothers and infants. In response to these concerns, the American College of Obstetricians and Gynecologists (ACOG) the Canadian Pediatric Society (CPS) and the Canadian Society of Obstetricians and Gynecologists (SOGC) have all published guidelines for early discharge and length of stay for uncomplicated term deliveries (Appendix H). Discharge within 48 hours of birth is defined as early discharge, and discharge < 24 hours is defined as very early discharge (ACOG, 1992).

Prior to the Postpartum Consensus Conference, the BCRCP surveyed primary care givers and nurses from health care facilities in an attempt to create a “snapshot” of prevailing practice (Appendix D). One-third of respondents indicated that no discharge criteria existed or they were unsure if any existed in their facility. Although a variety of formal guidelines and recommendations have been written, they have not been acted upon in a systematic way and there are no structures in place to ensure implementation and compliance (Ontario Public Health Association, 1998).

To date, medical science, hospital policies and related legislation addressing concerns about the delivery of health care after childbirth have focussed primarily on the number of hours postpartum (or post hospital stay). There has been a dearth of good research on the physical and psychosocial needs of the mother and newborn and on the content and quality of the care they should receive. To some extent, this focus on the timing of discharge undoubtedly reflects the lack of consensus in the literature, on the effectiveness of many of the services routinely provided. Current scientific knowledge does not provide conclusive evidence about the ideal post delivery length of stay, or the post discharge services that should be available to the general population of mothers and infants. Postpartum outcome data is very limited and formal evaluation of programs, in many cases, is lacking. However current knowledge about important physiological and psychological changes that occur in the first few days after birth, does indicate that the third or fourth postpartum day is critical (Early Postpartum Discharge; Recommendations from a Preliminary Report to Congress, in *Pediatrics*, vol. 107 no.2, Feb. 2001). Apart from clinical evaluation and timely intervention, routine health promotion and early screening for psychosocial problems are also crucial components of care for healthy newborns, mothers and families.

The currently available evidence on different approaches to care does not identify any single model of care as being “best practice”. Due to the lack of evidence on best practices for postpartum care, the BCRCP Consensus Symposium was convened to discuss standards for postnatal/postpartum care in BC (in the context of the trend towards shorter hospital stays) and to make recommendations. The consensus was grounded in the existing body of scientific knowledge (Appendix I) but not limited to formal studies.

Consensus Process

The BCRCP convened a consensus symposium to explore these questions and with input from the appropriate stakeholders, work towards a solution that would guide both administrative and practice decisions. This took the format of a two-day intensive “think tank”. Day one provided formal sessions from experts in the field, followed by brainstorming in focus groups to explore options for six identified areas (Appendix G); day two focussed on the consensus-building process, culminating in the production of a series of statements (recommendations) that can be used to establish province-wide standards of care.

Attendance was by invitation with the purpose of bringing together those health care professionals who were best able, by formal education, skills and experience, to actively contribute to the consensus process. Fourteen delegates per health region in BC were invited (two from each profession) from the following: Physicians representing the specialties of Obstetrics, Pediatrics and Family Practice, Registered Nurses from Hospital

and Community (PHN) settings, Midwives and Pregnancy Outreach Program providers. Regional delegates were joined by invited faculty from UBC and BCIT, representatives of the Ministries of Health and Health Planning, Health Canada and other expert stakeholders. A complete list of delegates is provided in Appendix K.

Definition of Terms

Time frames :

According to Western textbook definitions, the postpartum period begins shortly after the birth of the placenta and ends around six weeks following birth (World Health Organisation, 1998). The period represents the time of the most physiological change for mother and baby. With an increasing emphasis on the psychosocial issues in this postpartum period, some health care providers are extending the working definition to any where from 3 months up to one year following the delivery of the baby (Health Canada 2000 – FCG).

The scope of the consensus symposium limited the time frame under discussion to the period from the attainment of **postpartum physiologic stability** to the (restored) capacity for **self care (mother) or care-by-parent (infant)**.

Physiologic Stability:

The normal full term infant adapts to extra-uterine life within 8-12 hours of birth. Maternal physiological stability is generally attained within two hours following birth.

Self-care :

The Oxford English Dictionary defines Self-care as:

“...the ability to use one’s own resources to undertake the activities of daily living, to independently supply one’s own needs, and to solve one’s own problems.”

The members of the Consensus Conference adopted the following standard criteria for assessing when a woman is ready to move towards self-care:

- Mother is mobile with adequate food and fluid intake
- Mother recognises normal postpartum physical changes, e.g. fundus, vaginal flow, and will inform caregiver of abnormal findings
- Mother responds appropriately to newborns needs, i.e. diapering, feeding, settling
- There are support systems in place – partner/family
- Mother verbalises understanding of postpartum adjustment and postpartum “blues”

The members of the Consensus Conference adopted the following standard criteria for assessing when the infant is ready to move towards care-by-parent:

- Baby presents with normal newborn examination and no major CNS concerns
- Mother recognises normal newborn physical findings, e.g. voiding and stooling patterns, onset of jaundice, and will inform care giver of abnormal findings
- Mother able to successfully initiate and complete feedings, breast or bottle
- Mother responds appropriately to newborn cues/needs, i.e. diapering, feeding, settling
- Mother has support systems in place – partner/family

The current *Neonatal Resuscitation Guidelines* of the American Academy of Pediatrics (AAP) and the American Heart Association (AHA) provide additional information on the newborn transition period (AAP/AHA, 2000).

“Hands-on” versus “self-report”

“Hands-on” assessment is the actual physical review by the health care practitioner.

“Self-report” signifies that the mother has been asked about the assessment item and that she verbally reported her/the baby’s condition.

Discharge

The term discharge refers to either discharge from hospital or discharge to self-care. The terms are not synonymous and are specified throughout the report as to which is being used.

Global Assessment

A global assessment includes the physical, emotional, and psychosocial health of the woman, and her learning needs for her own self care as well as care of her infant. For the infant, global assessment includes a physical and a feeding assessment.

Guiding Principles

During the consensus-building process, it became evident that guiding principles were required prior to the development of the consensus statements. Seven “guiding principles”, representing global values and goals to which all practitioners would subscribe, were developed based on input from the symposium delegates. All recommendations arising from consensus assume these “norms” as inherent.

#1 Health & Well-being

Perinatal and Women’s health is well-suited to self-care because childbearing is essentially health focussed, women are usually well when they enter the system and postpartum visits provide the opportunity for health as well as illness interventions. The literature indicates that the goal of Women’s health care is to help women improve health and reduce the risks associated with poor lifestyle adjustments. Areas such as nutrition education, improvement of social supports and parenting education have been suggested.

Therefore the goal of postpartum (mother) and postnatal (infant) care should be good health and well being, not only the prevention of rare adverse events.

- Both short- and long-term outcome measures must reflect important measures of health for newborns, mothers and families.

#2 Spectrum of Services

A full range of accessible postpartum services is necessary in all jurisdictions to support clinical practice standards. We must ensure the delivery of the essential health care regardless of length of stay or place of birth

- Practitioners (physicians, midwives, registered nurses) must be skilled in all aspects of maternal/newborn postpartum assessment, breastfeeding and newborn care
- Postpartum support services must be available/accessible 7days a week

#3 Client-centered Focus

We must broaden the focus of concern beyond the issue of length of hospital stay to the multiple factors affecting maternal and infant postpartum adaptation.

- Services must be tailored to the individual family's socioeconomic, psychosocial and environmental circumstances as well as biomedical risk factors, and must be culturally appropriate.

#4 Evidence-based Care

The physical needs of the mother and newborn, as well as the psychosocial needs of the mother and family, should be addressed using evidence-based guidelines for postpartum care

- “Best practices” must be supported by the literature, giving consideration to clinical effectiveness, patient satisfaction and financial constraints; other models of care should also be evaluated for “best practices”.

#5 Excluded Topics

Investigations/treatments that are mandated by legislation or accepted clinical practice guidelines have been classified as “givens” and therefore are not included in the consensus discussion.

For the mother, these are:

- Rhogam, where applicable in women who are Rh–ve
- Hepatitis B prophylaxis/treatment where indicated
- Any other required treatment of/screening for, infectious diseases, e.g. Herpes.

For the newborn these are:

- Vitamin K and eye prophylaxis
- PKU and Thyroid screening
- Hepatitis B prophylaxis, where indicated
- Vitamin D supplementation, where indicated
- Immunisation

#6 Baby Friendly Initiative

Support for the adoption of the UNICEF/WHO Baby Friendly Initiative.

#7 Family-centered Maternity Care

Support for the “*Principles of Family-Centered Maternity and Newborn Care*”, as presented in Health Canada's National Guidelines, 2000.

Consensus Recommendations

Maternal

Consensus statement #1

*Maternal postpartum physiologic stability for vaginal delivery at term is defined as:

- Vital signs (T,P,R, BP) stable
- Perineum intact or repaired as needed
- No postpartum complications requiring ongoing observation, e.g. hemorrhage
- Bladder function adequate, i.e. has voided
- Skin-to-skin contact with baby as appropriate

*Adapted from : *“Early Discharge and Length of Stay for Term Birth”* a joint policy statement by the CPS and the SOGC, #22, October 1996.

Consensus statement #2

There is a lack of evidence that the routine practice of taking maternal vital signs and screening for venous thrombosis after the period of stability improves maternal outcomes. Therefore these practices should not routinely be carried out.

Consensus statement #3

Care-givers should complete a “hands-on” global assessment at 12 hours and 24 hours postpartum. Women should be taught how to independently check their own fundus and lochia so that they can self-report these parameters after 24 hours.

Consensus statement #4

Self-medication is recommended, in the event that the postpartum woman requires analgesia, laxatives and/or vitamin supplementation.

Consensus statement #5

Psychosocial assessment of the woman and family should commence in the prenatal period and continue into the postnatal period.

Consensus statement #6

Prior to **hospital discharge**, a global assessment must be completed based on the criteria identified in the SOGC/CPS Policy Statement: “Early Discharge and Length of Stay for Term Birth” (Appendix F). This should be a hands-on assessment.

Consensus statement #7

Prior to discharge **to self-care**, a global assessment must be completed. Appropriate referrals should be made at this time.

Consensus statement #8

Prior to hospital discharge or the move to self-care, women need written information about when to seek professional help. Where and who to call in critical situations should be clearly documented. Caregivers should provide a summary of community resources.

Consensus statement #9

Recognising that significant maternal morbidity, e.g. post-partum depression, pelvic floor dysfunction, may not be identified within ten days postpartum, there needs to be periodic contact with the woman and her family for a period of one year. A system of ongoing assessment, support, and education must continue throughout this year.

Consensus statement #10

In keeping with adult learning principles, it is recognised that a continuum of educational opportunities occurs in the perinatal period. Current information should be available in a variety of formats, based on needs and stage appropriateness.

Newborn

Consensus statement #11

*Infant physiologic stability following term vaginal delivery is defined as:

- Respiratory rate between 40-60/min. and a regular respiratory pattern with no evidence of distress, i.e. grunting or in-drawing
- Axillary temperature of 36.1C to 37.2C and stable heart rate (120 – 160bpm)
- Suckling/rooting efforts and evidence of readiness to feed
- Physical examination reveals no significant congenital anomalies
- No evidence of sepsis
- No developing (<24 hrs.) jaundice

*Adapted from : *“Early Discharge and Length of Stay for Term Birth”* a joint policy statement by the CPS and the SOGC, #22, October 1996.

Consensus statement #12

After newborn stability is established, a global assessment must be completed between 12 and 24 hours.

- If discharged to care-by-parent at 24 hours of age, phone contact should be made within 24 hours of discharge and a visit scheduled for day 2 or 3 of life.
- Regardless of time of discharge, global assessments should occur at 3-4 days and at 7-10 days.

Consensus statement #13

Weight, elimination and hydration status should be components of the feeding assessment. After stability is established, the newborn is weighed at 3-4 postnatal days and around 7 postnatal days.

Consensus statement #14

A full physical examination should be repeated by the primary care provider or designate (MD, RM or NP) around 7 days of age.

- The assessment component should include appropriate instruction for the mother, partner and family on parenting, well baby care and behavioral norms.

Consensus statement #15

Newborn care includes an emphasis on behaviors and practices that have demonstrated long-term benefits for health outcomes, e.g. infant stimulation. Therefore a system of ongoing education and support to facilitate parenting must continue after the newborn period through the first year of life.

Maternal and Newborn

Consensus statement #16

Breastfeeding :

- Observe, within 24 hours of birth, two independent assessments of effective latching at breast; ensure that the woman understands what constitutes an effective feed.
- Achieve two effective feeds without assistance prior to moving to self-care. Assessment (hands-on) should be repeated at 3-4 postnatal days and again at 7-10 postnatal days, regardless of parity.

Consensus statement #17

To facilitate continuity of care, a standardised tool for feeding assessment in the hospital and the home should be developed and adopted

- Each newborn requires an individualised feeding plan

Consensus statement #18

Timely sharing of appropriate information is key. There is a requirement for effective verbal and written communication and cooperation between all care givers and agencies, particularly the hospital and community health unit (e.g. referrals) and between those in shared practices, e.g. midwives and physician groups.

- A single standard of care should be reflected in a single documentation tool to support the continuum of care
- A woman-carried communication passport is recommended

Consensus statement #19

Postpartum care should be redirected from those activities that have little evidence of benefit towards those that improve maternal outcomes.

- As new evidence becomes available, practice should be modified.

Consensus statement #20

Science, policy and legislation addressing concerns about health care after childbirth have focussed primarily on length of (hospital) stay. This needs to be broadened to reflect a population health perspective

- Studies must shift the focus from “early discharge” to “appropriate discharge” with the emphasis on optimal attainable health of mothers and newborns.

Discussion from the Consensus Process

“Good judgement suggests that..... standards should be set for appropriately timed postnatal/postpartum care that represents “best practice”, without waiting for conclusive evidence on the most effective and efficient approach.”

(Early Postpartum Discharge ; Recommendations from a Preliminary Report to Congress, in *Pediatrics* vol 107 no 2 Feb. 2001).

Many of the consensus statements are self-explanatory and require little explanation or supplementation of information to comprehend their intent or the decision making process that occurred to arrive at consensus. However, some issues required considerable discussion and debate. It may be helpful to illuminate some of the discussion where issues occurred to provide background and clarification.

Postpartum Stability

The notion of when a woman or her infant achieves stability and what criteria needs to be achieved in order to say a woman or her infant is “stable” evoked considerable discussion. The agreed upon goal was to identify those women and infants who would fit into a broad “norm”, in order to capture the majority of women and infants who would be receiving postpartum follow-up in the early postpartum period. The resulting definition does not presuppose that women who fall outside the criteria of the definition can not be considered stable (e.g. women who were delivered by caesarian section).

It is acknowledged that issues still exist regarding initial management of mothers and newborns that may require an additional consensus process to standardize. Although it was difficult to exclude the care that may be required to achieve stability in the context of postpartum follow-up (e.g. NRP), it was agreed by the conference planning committee that the goal of this consensus conference process needed to focus on the limited period between stability and self care in order to address the overwhelming concerns of varying practices and overlapping postpartum services in the hospital and community.

The definition of postpartum stability for both the mother and her newborn was initially discussed and produced as background data to the conference participants by the consensus conference planning committee members. Conference participants then ratified each definition as a consensus statement.

Evidence

There was no literature found to support taking routine, ongoing maternal vital signs once physiologic stability has been attained. The *Family Centered maternity and Newborn Care Guidelines (Health Canada 2002)* do not mention routine vital signs. The World Health Organisation states that after the initial point of stability, temperature measurement should be done “only if there is a reason to suspect infection”. There is mention of taking blood pressure readings only in the first 6-12 hours postpartum. Current practice in BC has been that once mothers are discharged from hospital, vital signs are only done in cases where there are indicators to do so. This practice appears to be fairly consistent for general practitioners, midwives and community nurses.

Hospital discharge

There was considerable discussion around the issue of hospital discharge related to postpartum follow-up care. The goal of the consensus conference was to identify an appropriate standard of postpartum follow-up regardless of place of care or care provider. However, medical legal issues around requirements prior to hospital discharge (e.g. discharge exam by primary care provider) and specific, existing hospital policies (e.g. newborn discharge weight) and professional practice guidelines (SOGC/CPS discharge criteria) complicated the discussion.

The consensus statements are a result of the participants’ attempt to maintain clarity regarding the actual needs of postpartum women and their infants, trying to stay away from existing hospital practices as much as possible. However, it needs to be acknowledged that assessments in addition to the recommended follow-up may be required for those women choosing to deliver in hospital and for whom the timing of hospital discharge does not fit neatly into the suggested recommendations of the consensus conference. Should the consensus conference recommendations become accepted practice, it may be a future goal to look at how existing hospital practices/standards can be modified.

Resources

Within each of the breakout groups, there was emphasis on the importance of a continuum of postpartum teaching/education opportunities for mothers and families. Current information should be provided in a variety of formats, based on needs and stage appropriateness. The delegates supported using a variety of methods and educational resource materials already developed, such as “*Baby’s Best Chance*” and “*Toddler’s Next Steps*”, produced by the BC Ministry of Health.

The importance of psychosocial follow-up for mothers and families was also discussed. The use of available, valid screening tools, such as the ALPHA and PPDI was recommended.

The work of the conference participants’ focus groups resulted in recommendations of each group regarding appropriate follow-up for the mother and newborn. In synthesizing the data, several commonalties evolved. These commonalties are reflected in the consensus statements, however the statements themselves do not provide a *broad* overview of what the course of postpartum follow-up might look like taking into account the what, when, who and how.

The following suggested template (Appendix A) was developed and shown to the conference participants during the consensus process and was met with general approval. It is shown here to provide a broad synthesis and overview of the findings as a beginning step in understanding the potential changes to the current system.

Appendix A

Maternal-Newborn Postpartum Care Stability to Self Care *Suggested Template for Follow-up

When	Visit or Telephone Contact	Hands On or Self-Report	Communication	Who
12-24 hours	Visit	Hands – On (Maternal and Newborn)	<ol style="list-style-type: none"> 1. Passport 2. Common Care Path 3. Feeding Plan 	RM or RN/CHN with PP/NB Assessment Skills
72 hours	Visit	Self – Report (Maternal) Hands – On (Newborn)	As Above	RM or RN/CHN with PP/NB Assessment Skills
7 days	Visit	Self – Report (Maternal) Hands - On (Newborn)	As Above	MD/RM and CHN as needed

* This template reflects the commonalities of timeframe as a result of synthesizing the information in the consensus statements. It is a potential visual representation of what postpartum follow-up might look like. The actual consensus statements will need to be referred to for identification of the range of timeframes suggested. All timeframes are in postnatal hours/days.

APPENDIX B
MATERNAL/NEWBORN SCHEMATA

MOTHER

	When	How	Hands-on vs self-report	Self-care
Physical Assessment				
Emotional needs				
Hygiene and healing				
Teaching – self and newborn				

INFANT

Physical assessment				
Feeding – breast and bottle				
Health and healing				
Infant behavior/safety				

APPENDIX C

Postpartum Symposium Questions Primary Care Giver

Optional:

Name of person(s) completing this questionnaire _____

Phone # _____

1. Please identify your professional designation

- GP Midwife Obstetrician Pediatrician Other

2. Hospital(s) where you have admitting privileges _____

3. Average number of deliveries you care for per year:

- 1-10
 11-30
 31- 50
 51-70
 71-99
 >100
 N/A

For pediatricians:

Average number of infants you care for per year:

- 1-10
 11-30
 31- 50
 51-70
 71-99
 >100

4. Generally, when is your **first** follow-up visit after postpartum hospital discharge?

a) mothers discharged under 48 hours:

- seen within 48 hours of discharge
 seen between 48-96 hours after discharge
 seen between 4-7 days postpartum
 seen after 7 days postpartum
 other _____

N/A as I do not follow-up mothers

b) mothers discharged over 48 hours:

- seen within 48 hours of discharge
 seen between 48-96 hours after discharge
 seen between 4-7 days postpartum
 seen after 7 days postpartum
 other _____

N/A as I do not follow-up mothers

c) newborns discharged under 48 hours:

- seen within 48 hours of discharge
 seen between 48-96 hours after discharge
 seen between 4-7 days postpartum
 seen after 7 days postpartum
 other _____

N/A as I do not follow-up newborns

d) newborns discharged over 48 hours:

- seen within 48 hours of discharge
 seen between 48-96 hours after discharge
 seen between 4-7 days postpartum
 seen after 7 days postpartum
 other _____

N/A as I do not follow-up newborns

5. Generally, what is your pattern of postpartum follow-up **after the initial postpartum visit** up to 6 weeks postpartum? (please check all that apply)

a) for **mom**

seen daily to _____ days postpartum

seen weekly to _____ weeks postpartum

one visit at 6 weeks postpartum

it depends on the following factors (please identify): _____

N/A as I do not provide maternal follow-up

b) for **baby**

seen daily to _____ days postpartum

seen weekly to _____ weeks postpartum

one visit at 6 weeks postpartum

it depends on the following factors (please identify): _____

N/A as I do not provide newborn follow-up

6. Who do you feel is the most appropriate person to provide postpartum follow-up for the normal, healthy mother and baby within 72 hours of hospital discharge?

- primary caregiver
- community nursing
- either
- both
- other (please specify) _____

7. Does your community have a hospital/community postpartum home follow-up program in which nurses provide follow-up to the family after discharge?

- yes no not sure in development

If yes, what best describes the program? (check all that apply)

- follow-up occurs for hospital discharges <48 hours postpartum only
- follow-up occurs for all discharges
- follow-up occurs for primips only
- follow-up occurs for at-risk only
- unsure when follow-up occurs
- other _____

8. a) Does the hospital(s) in which you practice have postpartum discharge criteria?

- yes no not sure

b) Which hospital postpartum discharge criteria are utilized?

- SOGC/CPS
- BCRCP guidelines
- facility specific
- other _____
- not sure

c) Do you find your hospital postpartum discharge criteria useful?

yes no

If no, why

not? _____

d) What factors contribute to keeping mothers and babies in hospital for a longer period than normal protocol in the postpartum period? Please identify the **top two reasons** in order of priority.

maternal/family choice

the postpartum discharge criteria are not met

maternal/newborn complications

maternal family/home situation

beds and staff are available to keep mothers/babies for a longer period

other _____

N/A because we normally do not keep mothers/babies in hospital for a longer period than our normal protocol

e) What factors contribute to mothers and babies being discharged prior to the official postpartum discharge criteria being met? Please identify the **top two reasons** in order of priority.

the need for hospital beds

family/client choice

short-staffed

the community postpartum program provides competent follow-up for these moms and babies

other _____

N/A because mothers and babies in the facility(s) I work in always meet the postpartum discharge criteria

9. a) Do you routinely complete a physical **maternal** assessment on the day of hospital postpartum discharge?

yes no N/A as I do not provide follow-up care to mothers

it depends on the situation (please

describe) _____

b) Do you routinely complete a physical assessment of the **newborn** on the day of hospital discharge?

yes no N/A as I do not provide follow-up care to newborns

it depends on the situation (please

describe) _____

10. How would you describe hospital/community health/primary giver partnerships and communication in relation to postpartum care in your community?

excellent good satisfactory poor

Please describe any innovative practices that have contributed to care.g.iver cooperation in the delivery of postpartum care in your community.

Newborns <48hrs.	seen within 48	= 7 (23%)
	48 – 96	= 9 (29%)
	4 – 7 days	= 5 (16%)
	after 7 days	= 2 (6%)
	other	= 4 (13%)
	N/A	= 5 (16%)
Newborns > 48hrs.	seen within 48	= 1 (3%)
	48 – 96	= 6 (20%)
	4 – 7 days	= 9 (30%)
	after 7 days	= 7 (23%)
	other	= 2 (6%)
	N/A	= 5 (17%)

Question 5. Pattern of Follow-up after Initial Visit

This question yielded variable patterns of postpartum follow –up and is difficult to analyze, especially for the newborn. Bracketed qualifiers were added by the respondents.

Mom = Daily (<i>to 2-3 days</i>)	= 2 (6%)
Weekly (<i>to 3 weeks, 1 – 2 weeks, 3 – 4 weeks</i>)	= 2 (6%)
One visit at 6 weeks	=14 (45%)
It depends (<i>numerous qualifiers listed</i>)	=10 (32%)
N/A	= 3 (10%)
Baby = Daily (<i>to 2-3 days</i>)	= 2 (6%)
Weekly	= 6 (19%)
(<i>to 1 – 2 weeks, 2 weeks, 3 weeks, 3 – 4 weeks, 6 weeks</i>)	
One visit at 6 weeks	=8 (26%)
It depends (<i>numerous qualifiers listed</i>)	=12 (39%)
N/A	= 5 (16%)

Question 6. Most Appropriate Person to Provide Postpartum Follow-up

n=28	
Primary care.g.iver	= 6 (21%)
Community nursing	= 8 (29%)
Either	= 4 (14%)
Both	= 10 (36%)
Other	= 0 (0%)

Question 7. Hospital/Community Postpartum Follow-up Program

Yes	= 26 (84%)
No	= 2 (6%)
Not sure	= 0 (0%)
In development	= 2 (6%)

If yes, what best describes program?

All discharges <48 hrs.	= 8 (26%)
All discharges	= 16 (52%)
Primips only	= 1 (3%)
At risk only	= 2 (6%)
Unsure	= 0 (0%)
Other	= 3 (1%)

Question 8. Hospital Postpartum Discharge Criteria**a) Have discharge criteria?**

Yes	= 19 (63%)
No	= 8 (27%)
Not sure	= 3 (10%)

b) Which criteria utilized?

SOGC/CPS	= 3 (10%)
BCRCP	= 10 (33%)
Facility	= 3 (10%)
Other	= 0 (0%)
Not sure	= 7 (23%)
N/A	= 7 (23%)

c) Useful? n=27

Yes	= 14 (52%)
No	= 5 (19%)
N/A	= 8 (30%)

d) Rationale for keeping mothers and babies:

(Most respondents did not prioritize, therefore data collapsed to total numbers - percentages calculated on n=62))

Maternal/family choice	= 5 (8%)
Criteria not met	= 11 (18%)
Mat/NB complications	= 29 (47%)
Home situation	= 12 (19%)
Beds and staff available	= 1 (2%)
Other	= 1 (2%)
N/A	= 2 (3%)

Of those who prioritized (n = 8):

#1	Mat/NB complications	= 7 (88%)
	Criteria not met	= 1 (13%)
#2	Mat/Family choice	= 4 (50%)
	Home situation	= 4 (50%)
	Mat/NB complications	= 1 (13%)
	Bed/staff available	= 1 (13%)

e) Rationale for discharging prior to criteria met:

Need for beds	= 7
Family/client choice	= 23
Short-staffed	= 1
Competent follow-up program	= 10
Other	= 0
N/A	= 7

Of those who prioritized (n = 6):

#1	Family/client choice	= 3 (50%)
	Need for beds	= 1 (17%)
	Competent follow-up	= 1 (17%)
#2	Need for beds	= 2 (33%)
	Competent follow-up	= 2 (33%)
	Family/client choice	= 1 (17%)

Question 9. Physical Assessment Day of Discharge

Maternal assessment	Yes	=21 (68%)
	No	= 1 (3%)
	N/A	= 3 (10%)
	It depends	= 6 (19%)
Newborn assessment	Yes	=26 (84%)
	No	= 1 (3%)
	N/A	= 3 (10%)
	It depends	= 0

Question 10. Hospital/Community Health Primary Caregiver Partnerships

Excellent	=11 (35%)
Good	=13 (42%)
Satisfactory	=2 (6%)
Poor	=0
Excellent – Good	=3 (10%)
Sub-optimal	=1 (3%)

Appendix E Postpartum Symposium Questions Facilities and Community Health Units

Hospital/CH unit _____

Address _____

Postal Code _____

Phone

_____ Fax# _____

Name of person(s) completing this
questionnaire: _____

Date _____

Title _____ Phone# _____

General Information

Hospital respondents please answer questions 1 – 3

Community respondents please go to question 4

1. In the last calendar year (Jan.1st – Dec 31st 2000) approximately how many births took place at your facility? _____

2. In the last calendar year (Jan.1st – Dec 31st 2000) approximately how many obstetric re-admissions (within 28 days post discharge) have you had? _____

N/A

Please rank the top 3 by number, in the boxes provided

Reasons: Postpartum hemorrhage Postpartum infection
 Postpartum depression Breastfeeding difficulties
 Other (specify) _____

3. In the last calendar year (Jan.1st – Dec 31st 2000) approximately how many newborn re-admissions have you had? _____

N/A

Please rank the top 3 by number, in the boxes provided

Reasons: Jaundice Feeding problems Dehydration Sepsis
 Congenital anomaly Other (specify) _____

Note: Questions 4 and 5 are for Health units only

4. In the past year how many postpartum/maternal referrals has your health unit received?
Please estimate #s per month _____

In the past year how many postpartum/new-born referrals has your health unit received?
Please estimate #s per month _____

5. What were the primary reasons for referral back to the hospital/doctor/midwife ?
Please rank the top 3 by number, in the boxes provided

Maternal: Postpartum hemorrhage Postpartum infection
 Postpartum depression Breastfeeding difficulties
 Other (specify) _____

Newborn: Jaundice Feeding problems Dehydration Sepsis
 Congenital anomaly Other (specify) _____

Planned Maternity Discharge

All respondents please complete this section

6. Does your community have a hospital / community postpartum home follow-up program?
 yes no in development

Please complete the following graph as it describes your program :

Follow-up occurs for (check all that apply):	Who provides the community postpartum follow-up?	Type/Time frame of the follow-up after hospital discharge
<input type="checkbox"/> Discharge < 48 hrs after delivery	<input type="checkbox"/> Hospital nurses to postpartum day _____ <input type="checkbox"/> Community nurses <input type="checkbox"/> Other _____	<input type="checkbox"/> Initial telephone call within 24h <input type="checkbox"/> Initial telephone call within 24-48h <input type="checkbox"/> Initial telephone call after 48h <input type="checkbox"/> Initial home visit within 24h <input type="checkbox"/> Initial home visit in 24-48h <input type="checkbox"/> Initial home visit after 48h <input type="checkbox"/> None of the above (please comment below)

<input type="checkbox"/> All discharges	<input type="checkbox"/> Hospital nurses to postpartum day _____ <input type="checkbox"/> Community nurses <input type="checkbox"/> Other _____	<input type="checkbox"/> Initial telephone call within 24h <input type="checkbox"/> Initial telephone call within 24-48h <input type="checkbox"/> Initial telephone call after 48h <input type="checkbox"/> Initial home visit within 24h <input type="checkbox"/> Initial home visit in 24-48h <input type="checkbox"/> Initial home visit after 48h None of the above (please comment below)
<input type="checkbox"/> Primips only	<input type="checkbox"/> Hospital nurses to postpartum day _____ <input type="checkbox"/> Community nurses <input type="checkbox"/> Other _____	<input type="checkbox"/> Initial telephone call within 24h <input type="checkbox"/> Initial telephone call within 24-48h <input type="checkbox"/> Initial telephone call after 48h <input type="checkbox"/> Initial home visit within 24h <input type="checkbox"/> Initial home visit in 24-48h <input type="checkbox"/> Initial home visit after 48h <input type="checkbox"/> None of the above (please comment below)
<input type="checkbox"/> At-risk	<input type="checkbox"/> Hospital nurses to postpartum day _____ <input type="checkbox"/> Community nurses <input type="checkbox"/> Other _____	<input type="checkbox"/> Initial telephone call within 24h <input type="checkbox"/> Initial telephone call within 24-48h <input type="checkbox"/> Initial telephone call after 48h <input type="checkbox"/> Initial home visit within 24h <input type="checkbox"/> Initial home visit in 24-48h <input type="checkbox"/> Initial home visit after 48h <input type="checkbox"/> None of the above (please comment below)

Comments:

7. How would you describe postpartum follow-up and support services in your community?

- excellent
 good
 satisfactory
 poor

Comments:

8. Please indicate the postpartum services/support in place in your community (check all that apply) :

- community health nurse/unit
- breastfeeding centre/clinic
- breastfeeding support group, i.e. La Leche League
- postpartum support group
- parenting group
- Lactation Consultant/expert
- mother/newborn hotline
- POPS program
- other (specify): _____

9. What is the average length of maternity hospital stay (post delivery) for all healthy mothers and babies in your community?

- Spontaneous vaginal delivery
- | | | | |
|----------------------------------|----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> 0-6 h | <input type="checkbox"/> 6-12 h | <input type="checkbox"/> 12-24 h | <input type="checkbox"/> 24-48 h |
| <input type="checkbox"/> 48-72 h | <input type="checkbox"/> 72-96 h | <input type="checkbox"/> > 4 days | |
- Caesarean section
- | | | | |
|----------------------------------|-----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 0-6 h | <input type="checkbox"/> 6-12 h | <input type="checkbox"/> 12-24 h | <input type="checkbox"/> 24-48 h |
| <input type="checkbox"/> 48-72 h | <input type="checkbox"/> 72-96 h | <input type="checkbox"/> 4 days | <input type="checkbox"/> 5 days |
| <input type="checkbox"/> 6 days | <input type="checkbox"/> > 7 days | | |

10. Which discharge criteria are utilised in your planned maternity discharge program?

- | | |
|---|---|
| <input type="checkbox"/> SOGC/CPS | <input type="checkbox"/> Facility specific (please enclose) |
| <input type="checkbox"/> BCRCP guidelines | <input type="checkbox"/> None |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> Other (please specify) _____ |

11. Approximately what % of women met these discharge criteria ?

- 0 – 25%
- 26 – 50%
- 51 – 75%
- 76 – 100%
- Don't know

Please comment : _____

12. Approximately what % of new-borns met these discharge criteria ?

- 0 – 25%
- 26 – 50%
- 51 – 75%
- 76 – 100%
- Don't know

Please comment : _____

13. How are referrals from hospital to community initiated for postpartum families? (check all that apply)

- seen by a community health liaison nurse in hospital
- hospital nurse makes the referral
- relevant information is faxed to health unit by hospital
- Community Care Linkage (PDR)
- other (specify): _____

14. Is the referral process effective?

- yes
- no

Please explain:

15. How would you describe hospital / community health partnerships in your community, as they relate to postpartum maternal/newborn care?

- excellent
- good
- satisfactory
- poor

Comments:

16. How is Postpartum care documented ? (Check all that apply)

- BCRCP hospital care paths
- BCRCP community care paths
- Electronic patient documentation
- Narrative charting system
- Hospital specific documentation tool
- Regional C.H. documentation tool
- Other (please specify)_____

17. Would you be in favour of a single hospital/community documentation tool that reflects the standard of postpartum care regardless of the setting or care provider ?

- yes
- no

If no, why not ?

Appendix F Hospital and Community Survey Results

N = 68

Question 1. Facility Size

0-49	13	(19.5%)
50-249	19	(27.5%)
250-499	11	(16.5%)
500-999	10	(14.5%)
1000-1499	10	(14.5%)
1500-2499	1	(1.5%)
2500-4999	2	(3%)
>5000	1	(1.5%)
No response	1	(1.5%)

Question 2. Obstetrical Re-admissions in past year:

Range: 1 – 190
Average 16

- Rank: 1. Postpartum hemorrhage
2. Breastfeeding Difficulties
3. Postpartum Infections

Question 3. Newborn Re-admissions in past year:

Range: 1 – 217; average 20

- Rank: 1. Jaundice
2. Feeding Problems
3. Sepsis

Question 4. Maternal / postpartum referrals received by health unit:

Range: 1 – 217
Average: 30

Question 5. Primary reasons for referral back to hospital/primary care giver:

- Maternal: Rank: 1. Breastfeeding Difficulties
2. Postpartum Infection
3. Postpartum Depression

- Newborn: Rank: 1. Jaundice
2. Feeding Problems
3. Dehydration

Question 6: Does community have hospital/community p.p. follow-up program?

Yes: 58 (94%)

No: 4 (6%)

- > 90% have postpartum follow-up for all mothers
- Majority of the time it is the community health nurse providing the follow-up
- > 45% provided initial telephone call within 24 hours
- > 45% provide initial telephone call 24 – 48 hours

Question 7: Ranking postpartum follow-up and support services in community:

Excellent: 29 (43%)

Good: 27 (40%)

Satisfactory: 10 (15%)

Poor: 1 (2%)

Question 8: Services available in community:

Rank: Community Health Nurse	65 (97%)
Breastfeeding Support Groups	44 (67%)
Parenting Groups	44 (67%)
Lactation Consultant	40 (59%)
POPS Program	32 (47%)
Breastfeeding Center / Clinic	25 (37%)
Postpartum Support Group	23 (34%)
Mother-Newborn Hotline	23 (34%)

Question 9: Average length of stay:

Spontaneous vaginal delivery:

12-24 h 4 (6%)

24-48 h 34 (50%)

48-72 h 23 (34%)

Missing 7 (10%)

Caesarean Section:

48-72 h 23 (34%)

72-96 h 24 (35%)

4 days 4 (6%)

5 days 4 (6%)

Missing 13 (19%)

Question 10: Discharge Guidelines:

BCRCP	30 (44%)
Don't Know	15 (22%)
SOGC/CPS	11 (16%)
Facility specific	6 (9%)
None	5 (7%)

Question 11: % of women meeting discharge criteria:

Don't know	24 (47%)
76-100%	14 (28%)
51-75%	11 (21%)
26-50%	1 (2%)
0-25%	1 (2%)

Question 12: % New-borns meeting discharge criteria:

Don't know	24 (47%)
76-100%	14 (28%)
51-75%	11 (21%)
26-50%	1 (2%)
0-25%	1 (2%)

Question 13: How postpartum referrals are initiated:

Seen by a community health liaison nurse in hospital	43 (63%)
Relevant information is faxed to health unit by hospital	43 (63%)
Hospital nurse makes the referral	26 (38%)
Community Care Linkage (PDR)	3 (5%)

Question 14: Is the referral process effective?

Yes:	61 (90%)
No:	3 (5%)
Unsure:	3 (5%)

Question 15: Rate hospital / community partnerships:

Excellent:	23 (37%)
Good:	24 (38%)
Satisfactory	16 (25%)
Poor	0

Question 16: Documentation of Postpartum care:

BCRCP Community Care Paths	32 (47%)
BCRCP Hospital Care Paths	31 (46%)
Electronic patient documentation	26 (38%)
Narrative charting system	20 (16%)
Hospital specific documentation tool	11 (16%)
Regional C.H. documentation tool	9 (13%)

Question 17: Favor a single hospital / community documentation tool?

Yes:	46 (68%)
No:	12 (18%)
Unsure:	6 (9%)
Missing	4 (5%)

Questions 18: Problems with the delivery of care in your community.

Yes:	38 (63%)
No:	21 (37%)

Appendix G

Summary of Focus Group Questions

Maternal

Preamble:

In considering which aspects of maternal/newborn care should be considered for assessment, we have deliberately excluded certain parameters that we have classified as “givens”. These are investigations/treatments that are mandated by legislation or accepted clinical practice guidelines.

For the mother, these are:

- Rhogam, where applicable in women who are Rh–ve
- Hepatitis B prophylaxis/treatment where indicated
- Any other required treatment of, or screening for, infectious diseases, Herpes etc

Question #1

“Assuming these are the desired parameters, when should these maternal assessment parameters be assessed ?”

1. Assessment of physiologic status:
 - Temperature, pulse and respirations
 - BP
 - Fundus and lochia
 - Bladder and bowels
 - Breasts
2. Assessment of emotional needs:
 - Maternal attachment/family interaction
 - Emotional support from partner
 - Sexuality and contraception
 - Protection from abuse/violence
 - Screening for PPD
3. Hygiene and healing :
 - Pain relief
 - Nutrition
 - Perineum/peri-care
 - Legs/DVT
4. Teaching
 - Self-care
 - Newborn care/feeding
 - Newborn security/safety
 - Care seat safety
 - Poison control, etc.

Question #2

“How should these maternal parameters be assessed and communicated ?”

Hands-on versus self-report ?

1. Direct contact
 - Hospital physician/midwife visit
 - In person home/clinic visit with hands-on assessment
 - Doorstep visit : explanation of PHN role and determination of when a home visit might be needed
2. Indirect contact
 - In home visit with verbal report only
 - Phone call to client, with thorough verbal assessment
 - Telephone contact with a household member, indicating how client may access PHN services
3. When contact cannot be made by phone
 - A letter package may be left indicating how to access services

Communication with/between care providers : What, when and how ??

Question #3

“How do we assess optimal postpartum care along a time continuum ?”

We are trying to establish standards of care that will provide optimal health for mothers, newborns and their families, i.e. not only the avoidance of adverse perinatal events but also the attainment of healthy families. We therefore need to focus our attention on those interventions that are of proven long-term benefit, e.g. breastfeeding support.

Hence the focus on “appropriate discharge” versus “early discharge”. We need to look beyond 48 hrs., to postpartum days three and four and beyond. The focus then is on family assessment and facilitating the shift in the relationship (with the care-giver) from protective ie avoidance of adverse events, to one of health promotion/wellbeing.

Question #4

“What criteria should be utilised to determine if a woman is ready for self-care ?”

Suggest :

- Mother is mobile with adequate food and fluid intake
- Recognises normal postpartum physical changes, e.g. fundus, vaginal flow, and will inform caregiver of abnormal findings
- Responds appropriately to newborns needs, i.e. diapering, feeding, settling
- Support systems in place – partner/family
- Verbalises understanding of postpartum adjustment and postpartum “blues”

Newborn

Preamble:

As with the mother, there are certain “givens” in the treatment/assessment of newborns. These are:

- PKU and Thyroid screening
- Hepatitis B prophylaxis
- Vitamen D supplementation
- Immunization

Question #5

“When should the newborn assessment parameters be assessed ?”

1. Assessment of Physiologic status :
 - Temperature, heart rate and respirations
 - Skin colour, turgour
 - Extremeties/tone
 - Reflexes
 - Cry
2. Feeding
 - Latch and suck
 - Frequency and duration
 - Amount and tolerance
 - Feeds on cue, content between feedings
3. Elimination
 - Urine output
 - Stools
4. Health and Healing
 - Cord care
 - Circumcision care if appropriate
 - Weight monitoring, to maintain loss <10% of birth weight
 - Behaviour – normal wake/sleep patterns
 - Immunization, as a discussion topic only
5. Full newborn examination. When should the first exam be done ? Is a repeat discharge exam necessary at 48 hrs ? When should a well newborn visit be scheduled ?

Question #6

***“How should these newborn parameters be assessed and communicated ?”
Hands-on versus self-report ?***

4. Direct contact
 - Hospital visit by physician/midwife
 - In person home visit with hands-on assessment
 - Doorstep visit : explanation of PHN role and determination of when a home visit for the baby might be needed
5. Indirect contact
 - In home visit with verbal report only
 - Phone call to client, with thorough verbal assessment re newborn
 - Telephone contact with a household member, indicating how client may access PHN services for newborns

6. When contact cannot be made by phone
A letter may be left indicating how to access services for the newborn

Communication with/between care providers : What, when and how ??

Question #7

“How do we assess optimal newborn care along a time continuum ?”

We are trying to establish standards of care that will provide optimal health for newborns and their families, i.e. not only the avoidance of adverse perinatal events but also the attainment of healthy families. We therefore need to focus our attention on those interventions that are of proven long-term benefit, e.g. position for sleeping and SIDS prevention.

Hence the focus on “appropriate discharge” versus “early discharge”. We need to look beyond 48 hrs., to postpartum days three and four and beyond. The focus then is on family assessment and facilitating the shift in the relationship (with the care giver) from protective i.e. avoidance of adverse events, to one of health promotion/wellbeing.

Question #8

“What criteria should be utilised to determine if a newborn is ready for care-by-parent alone ?”

Suggest :

- Baby presents with normal newborn examination and no major CNS concerns
- Mother recognises normal newborn physical findings, e.g. voiding and stooling patterns, onset of jaundice, and will inform caregiver of abnormal findings
- Mother able to successfully initiate and complete feedings, breast or bottle
- Mother responds appropriately to newborn cues/needs, ie diapering, feeding, settling
- Support systems in place – partner/family

APPENDIX H

Summary of Key Guidelines and Policy Statements on Early Discharge Follow-up

Organization	Title	Summary of Content
Canadian Institute of Child Health, 1996	Early Hospital Discharge of Mothers and Newborns	-outlines strategies for consideration of early discharge program development
Canadian Institute of Child Health, 1996	National Breastfeeding Guidelines for Health Care Providers	-criteria for follow-up if discharge under 48 hours including contact by telephone or home visit within 24 hours, physical examination of mother and infant within 48 hours of discharge, exam by newborn by a physician at 7-10 days, services in evenings and weekends, providers be skilled in the assessment and management of breastfeeding
Canadian Paediatric Society (CPS) & the Society of Obstetricians and Gynaecologists of Canada (SOGC), 1996	Early Discharge and Length of Stay for Term Birth	-with many uncomplicated births, a stay of 12 to 28 hours is adequate provided that mother and baby are well, that the mother can care for her baby and that there is proper nursing follow-up in the home (7 days per week) -if discharge <48 hours, it must be part of a program that ensures appropriate ongoing assessment of the mother and baby. This evaluation should be carried out by a physician or other qualified professional with training and experience in maternal/infant care. A personal assessment in the home is preferred for all mothers and babies. Programs should ensure availability of assessment including weekends. -hospitals with early discharge programs should work with community health agencies to audit outcomes to ensure that guidelines are being used effectively.
National Association of Childbearing Centres, 1996	Position Statement on Early Discharge	-the timing of discharge should be made by the new mother and her team of health care professionals -decisions regarding length of stay should be research-based -early discharge is appropriate only as part of a comprehensive program of care which includes intensive prenatal education and close postpartum and newborn follow-up -communities have a responsibility to develop and fund a network of support systems which assist families in their critical role of parenting -health care providers have a responsibility to provide services in a cost-effective manner

Government of the United States, 1996	The Newborns' and Mothers' Health Protection Act	<ul style="list-style-type: none"> -sets federal standards for minimum length of stay for mothers and their newborns – 48 hours for a vaginal delivery -the timing of discharge should be made by the attending provider in consultation with the mother -the length of inpatient care should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health/stability of mom and baby, the ability and confidence of the mother to care for her infant, the adequacy of support systems at home and the access of the mother and infant to appropriate follow-up care
American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 1997	Guidelines for Perinatal Care (4 th Ed.)	<ul style="list-style-type: none"> -the hospital stay should be long enough to allow identification of problems and to ensure that the mother is sufficiently recovered and prepared to care for herself and baby at home -the timing of discharge should be the decision of the physicians in consultation with the family -a shortened hospital stay (<48 hours) for healthy term infants can be accomplished, but is not appropriate for every mother and neonate – each dyad should be evaluated individually to determine optimal time of discharge -minimal maternal and newborn discharge considerations are provided (physical, social, emotional) -all newborns with a shortened hospital stay should be examined by experienced health care providers within 48 hours of discharge
BC Reproductive Care Program, 1998	Perinatal Guideline: Planned Maternity Discharge	Based on the CPS/SOGC guideline.
World Health Organization, 1998	Postpartum Care of the Mother and Newborn: A Practical Guide	<ul style="list-style-type: none"> -a healthy mother and newborn need not be in a hospital. If the birth took place in a health facility, she may stay there for a while, however, the quality of the care is not dependent on the duration of the stay in a health care facility. -there is no consensus about the optimal number and timing of home visits by a caregiver during the first week postpartum. There is no general agreement about the precise purpose of home visits and about their frequency and effectiveness. -with limited resources, a contact with the health care system at least during the first 24 hours and before the end of the first week would be most effective.
Health Canada, 2000	Family-Centred Maternity and Newborn Care: National Guidelines	<ul style="list-style-type: none"> -identifies maternal indicators of postpartum adjustments including physiological and emotional and newborn indicators including physiological and safety -also identifies maternal and newborn support outcomes and community support strategies -the success of the early discharge programs rests on: parental choice/involvement in the decision re length of stay; appropriate screening; strong community-support follow-up; and professional staff experienced in maternal/newborn care and in community health.

APPENDIX I

Postpartum Literature Review

BREASTFEEDING

- Meyers, D. **American Family Physician**, 64(6): 931-932, September 15, 2001
Promoting and supporting breastfeeding
- Sinusas, K. & Gagliardi, A. **American Family Physician**, 64(6): 981-988, September 15, 2001
Initial management of breastfeeding
- Janson, S. & Rydberg, B. **Birth**, 25(4): 222-225, December 1998
Early postpartum discharge and subsequent breastfeeding
- Moxley, S. **Canadian Nurse**, 94(7): 35-9, August 1998
Breastfeeding and shorter hospital stays
- Unknown. ACOG educational bulletin. **International Journal of Gynaecology & Obstetrics**, 72(2): 217-232, August 2000
Breastfeeding: Maternal and infant aspects
- Winterburn, S. & Fraser, R. **Journal of Advanced Nursing**, 32(5): 1152-7, November 2000
Does the duration of postnatal stay influence breast-feeding rates at one month in women giving birth for the first time? A randomized control trial
- Saslow, J., Pride, K. & Imaizumi, S. **Journal of Maternal-Fetal Medicine**, 4: 252-256. 1995
Early discharge of breastfed infants – a potentially dangerous combination
- Quinn, A., Koepsell, D. & Haller, S. **Journal of Obstetric, Gynecologic & Neonatal Nursing**, 26(3): 289-289, May-June 1997
Breastfeeding incidence after early discharge and factors influencing breastfeeding cessation
- Locklin, M. & Jansson, M. **Journal of Obstetric, Gynecologic & Neonatal Nursing**, 28(1), 33-40, January-February 1999
Home visits: Strategies to protect the breastfeeding newborn at risk
- Johnson, T., Brennan, R. & Flynn-Tymkow, C. **Journal of Obstetric, Gynecologic & Neonatal Nursing**, 28(5):480-485, Sept.-Oct. 1999
A home visit program for breastfeeding education and support
- Sheehan, D., Krueger, P., Watt, S., Sword, W. & Brindle, B. **Journal of Human Lactation**, 17(3): 211-219, 2001.
The Ontario mother and infant survey: Breastfeeding outcomes
- Scott, J., Landers, M., Hughes, R. & Binns, C. **Journal of Paediatrics & Child Health**, 37: 254-261, 2001
Factors associated with breastfeeding at discharge and duration of breastfeeding

Biancuzzo, M. **Journal of Perinatal and Neonatal Nursing**, 11(2), 10-22, 1997
Breastfeeding education for early discharge: A three-tiered approach

Ertem, I., Votto, N. & Leventhal, J. **Pediatrics**, 107(3): 543-548, March 2001
The timing and predictors of early termination of breastfeeding

ECONOMICS

Lu, M., Lin, Y., Prietto, N., & Garite T. **American Journal of Obstetrics & Gynecology**, 182(1, Part 1): 233-239, January 2000
Elimination of public funding of prenatal care for undocumented immigrants in California: A cost/benefit analysis

Raube, K. & Merrell, K. **American Journal of Public Health**, 89(6): 922-3, June 1999
Maternal minimum-stay legislation: Cost and policy implications

Calhoun, B., Gries, D., Barfield, W., Kovac, C & Hume, R. **Australian New Zealand Journal of Obstetrics and Gynaecology**, 39(1), 35-40. 1999
Cost consequences of implementation of early obstetrical discharge programme in a military teaching hospital

Roberts, J. Sword, W., Watt, S., Gafini, A., Krueger, P., Sheehan, D. & Soon-Lee, K. **Canadian Journal of Nursing Research**, 33(1): 19-34, June 2001
Costs of postpartum care: Examining association from the Ontario Mother and Infant Survey

Gazmararian, J. & Koplan, J. **Clinics in Perinatology**, 25(2): 483-497, June 1998
Economic aspects of the perinatal hospital stay

EMJA, 167, 236-327, 1997.
Counting the costs of early discharge after childbirth

Morrell, C., Spiby, H., Stewart, P., Walters, S. & Morgan, A. **Health Technology Assessment**, 4(6): 2000
Costs and benefits of community postnatal support workers: A randomised controlled trial

Fleschler, R. & King, B. **Journal of Perinatal and Neonatal Nursing**, 9(2): 21-28, 1995
Perinatal outcomes management: Balancing quality with cost

*Buist, A. **The Medical Journal of Australia**, 167: 236-237, 1997
Counting the costs of early discharge after childbirth

GENERAL

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Are we providing adequate postnatal services?

Thompson, J., Roberts, C. & Ellwood, D. **Birth**, 26(3): 192-5, September 1999
Early discharge after childbirth: Too late for a randomized trial?

- Young, D. **Birth**, 23(2): 61-62, June 1996
Early discharge – whose decision, whose responsibility?
- Perlman, M. **Canadian Journal of CME**, 65-75, July 1996
Are newborns being sent home too early?
- E.g.arter, S., Braveman, P. & Marchi, K. **Clinics in Perinatology**, 25(2): 471-479, June 1998
Follow-up of newborns and their mothers after early hospital discharge
- Brumfield, C. **Clinical Obstetrics & Gynecology**, 41(3): 611-25, September 1998
Early postpartum discharge
- Margolis, L. **Clinical Pediatrics**, 34(12): 626-634, 1995
A critical review of studies of newborn discharge timing
- Raddish, M & Merritt, T. **Clinics in Perinatology**, 25(2): 499-518, June 1998
Early discharge of premature infants: A critical analysis
- Hiebert-White, J. **Health Progress**, 76(7): 12-15, September-October 1995
Early postpartum discharge a public policy issue?
- Reid, M. **Hospital Medicine** (London), 61(11): 758-9, November 2000
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Postpartum home care in the United States
- Martell, L. **Journal of Obstetric, Gynecologic & Neonatal Nursing**, 30(5): 496-506, 2001
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APPENDIX J

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Dr. Duncan Farqueharson, Speaker & Planning Committee Member
Dr. Carrie Fitzsimons, Speaker
Ms. Lily Lee, Speaker
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Ms. Barbara Selwood, Speaker
Dr. Elizabeth Shaw, Speaker
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