



CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM  
PROGRAMME RÉGIONAL DES SOINS À LA MÈRE  
ET AU NOUVEAU-NÉ DE CHAMPLAIN

# Postnatal Hospital Discharge Experiences Workgroup Report



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on behalf of the

*CMNRP Postnatal Discharge Experiences Workgroup*

February 2017 v2

## Contents

Acknowledgements.....	4
Workgroup Members.....	4
Executive Summary.....	5
Introduction .....	6
Part 1 - Discharge Processes .....	8
Part 2 - Length of Postnatal Hospital Stay .....	10
Part 3 - Surveys .....	15
Survey Design & Dissemination Strategies .....	15
Data Collection.....	15
Data Analysis.....	15
Part 3a - New Parent Survey .....	16
Participants .....	16
Recruitment .....	16
Learning During the Prenatal Period.....	19
Methods of Learning to Care For Mom and Baby .....	19
Best Time and Method for New Parents to Learn .....	20
Important Topics to Discuss During Hospital Stay.....	21
Readiness for Discharge.....	22
Follow-up Care for Baby.....	24
Follow-up Care for Mothers.....	25
Advice from New Parents .....	25
Part 3b - Perinatal Care Provider Survey .....	26
Participants .....	26
Access to Services /Primary Care Providers.....	27
Public Health .....	28
Primary Health Care Providers.....	28
Midwifery Care.....	29
Models for Follow-up Care .....	29
Information / Teaching .....	30
Lack of Parental Knowledge.....	30
Communication/Collaboration .....	31
Greater Understanding of Roles and Responsibilities of Perinatal Care Providers .....	32
Discussion.....	32

Parental Knowledge Gap.....	32
Preferred Methods of Learning .....	34
Importance of Prenatal Parental Preparation for Postnatal Period .....	34
Timing for Learning .....	35
Follow-up Care .....	36
Follow-up Care Providers.....	37
Project Limitations .....	38
Recommendations .....	40
Next Steps .....	41
Conclusion.....	41
References .....	42
Appendices.....	43
Appendix A - Length of Stay Literature Review Summary .....	43
Appendix B – New Parent Experiences Survey .....	45
Appendix C - Perinatal Care Provider Survey .....	50
Appendix D - Advice from New Parents to Other New Parents .....	52

**Please note:** Although significant effort has been made to ensure the accuracy of the information presented in this report, neither the authors nor CMNRP, BORN Ontario or any other parties make any representation or warranties as to the accuracy, reliability or completeness of the information contained herein.

## Acknowledgements

We wish to thank all the parents and perinatal care providers who took the time to participate in the various initiatives associated with this project, including completing the online surveys.

We especially wish to acknowledge the workgroup members and the organizations that supported them in serving on the workgroup. The members' input and expertise were critical to the work and enhanced the quality of this regional workgroup's deliverables.

We also want to acknowledge **Margaret Sampson**, Manager of Library Services at the Children's Hospital of Eastern Ontario, for her assistance with the literature search.

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## Executive Summary

In January 2016, the Champlain Maternal Newborn Regional Program (CMNRP) formed a regional workgroup to explore the process of hospital discharge and the experiences of new parents and perinatal care providers navigating postnatal discharge in the South East and Champlain Local Health Integration Networks (LHINs).

There has been a global trend where hospital postnatal length of stay has been decreasing in an effort to provide the right care in the right place at the right time. We obtained **postnatal length of stay (LOS) data from the Better Outcomes Registry Network (BORN) of Ontario** for all hospitals in our region. When examining the regional data over the last three fiscal years, **there is a trend towards a shorter LOS**, despite maternal parity or type of birth. In our region, the mean LOS, although decreasing, remains higher than the provincial average.

We examined **hospital discharge practices and processes** across the region and **surveyed new parents and healthcare providers** who had recently experienced a hospital discharge or who were routinely involved in postnatal discharge. We found that new parents often feel overwhelmed with the information given to them in the immediate postnatal period. Furthermore, health care providers and new parents told us that new parents are often under-prepared for discharge home with their newborns, have a lack of insight into the importance of timely follow-up and underestimate the importance of community supports (including how to access them). Workgroup findings clearly demonstrate that there needs to be a shift from the postnatal period to the prenatal period - in both parent learning and planning for follow-up care.

We identified a need to focus on strategies to **share consistent, evidence-based information** by interprofessional team members across the continuum of perinatal care. Clearly identifying the discharge process, follow-up standards as well as ensuring clear communication pathways between hospital and community will facilitate a smooth transition from hospital to home.

The following **recommendations** have been developed based on the work of the postnatal hospital discharge workgroup for consideration by the regional network:

1. Raise parental awareness about the importance of building knowledge in the prenatal period.
2. Identify prenatally the follow-up care providers for mothers and newborns for the immediate postnatal period and confirm/verify this prior to hospital discharge.
3. Increase prenatal screening of women for Healthy Babies Healthy Children (HBHC) so those with risk are identified early and can be properly supported to plan for parenting.
4. Ensure 100% of women in the postnatal period are offered the HBHC screen and ensure that those who decline the screen are captured as “declined”.
5. Enhance health care provider education on infant nutrition best practices, according to the Baby Friendly Initiative, to ensure consistency in recommendations and information being shared with parents.
6. Support the creation or maintenance of transition clinics for follow-up postnatal maternal and newborn care that are accessible and close to home, regardless of the family’s primary care provider.

Moving forward, the **next steps** include to:

- Form a regional workgroup to develop, pilot and evaluate a “*postnatal plan*”;
- Finalize the recommendations from this report in collaboration with the final findings of the Care Mapping Workgroup;
- Continue to monitor postnatal hospital LOS data; and
- Support regional organizations in the implementation of the PCMCH *Standards of Postnatal Care* when they are released in the spring 2017.

## Introduction

The landscape of perinatal care has been changing across the province of Ontario for the last several years. One of the many significant changes affecting health care providers and new families is the decrease in postnatal length of stay (LOS) (time from the birth of a baby until the mother-baby dyad is discharged home from the hospital). Historical trends have seen decreasing postnatal LOS in response to increasing pressure to reduce hospital care costs and an increasing desire to shift care of “normal births” to the community. Today’s decrease in LOS is multifactorial and more complicated than in the past when close family and community supports were more readily available. Hospitals are looking for efficiencies and healthy term, low-risk mothers and babies provide a potential opportunity for cost savings. Furthermore, new parents are eager to be discharged home from the hospital into the comfort of their home.

These opportunities to decrease the postnatal LOS seem symbiotic and relatively speaking are perceived as being without risk. In the midwifery model of care, women may choose to birth at home, in a birth centre or in the hospital and barring any complications, are often eligible to return to their home environment within 4-8 hours of the birth. The midwifery model includes follow-up care after birth - in the hospital, the home and the community. Many families not under the care of midwives desire similar experiences of going home quickly following birth with adequate community follow-up. As such, hospitals are seeing new parents requesting early discharges home with their new baby, however, each community has different capacities to safely follow these new mothers and babies once they are discharged home.

This decrease in postnatal LOS presents concerns to perinatal care providers as discharge from the hospital to the home/community is a key point of transition. If supports are not in place, not easily accessible, or not available, safety of the new mother and newborn are at risk. The potential cost savings associated with early discharge may be negated by increased visits to the local emergency department for non-emergent and emergent care and potential re-admissions.

*Transition in care* is defined by Accreditation Canada as “a set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings)” (2015, p. 5). Some examples of transition-related Accreditation Canada’s Obstetrical Service Standards include the following:

- 8.6 A comprehensive and individualized care plan is developed and documented in partnership with the client and family.
- 8.7 Planning for care transitions, including end of service, are identified in the care plan in partnership with the client and family.
- 9.16 Information relevant to the care of the client is communicated effectively during care transitions (Note: this is a Required Organizational Practice).
- 13.0 Clients and families are partners in planning and preparing for transition to another service or setting.

13.8 The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

By exploring the process of transition and subsequent experiences with transition on a regional level, CMNRP hospital and community partners can use this information to meet the standards put forth by Accreditation Canada.

As recognized in this region almost twenty years ago, *“the important issue is not when we discharge mother and baby but rather whether we have in place the criteria and programs to meet their needs”* (Walker, Watters, Nadon, Graham & Niday, 1999, p. 315). Recognizing that significant program and funding challenges have occurred over the past two decades, we need to find new ways to better prepare parents-to-be, give them consistent information and engage health care providers in meeting the ongoing needs of our new families, while being cognizant of the ever-changing service landscape in each individual community.

In January 2016, CMNRP formed a regional workgroup to explore the process of postnatal hospital discharge and the experience of new parents and perinatal care providers navigating this transition point in the South East and Champlain Local Health Integration Networks (LHINs). This was in alignment with one of CMNRP’s strategic imperatives for 2015-2018 aimed at addressing the transition of maternal-newborn care from hospital to the community across our region. One component of this imperative included the need to examine regional postnatal discharge processes and experiences to identify strengths, gaps and areas for improvement.

Working together regionally to examine the current state of postnatal discharge and transition into the community is a very complex process. Each community within the region is working to enhance transition on an individual level; however broader system-level change and a paradigm shift in perinatal health and perinatal health care may influence key decision-makers on how best to move forward in a continually evolving system.

It is anticipated that by having a clear understanding of the current state of discharge planning in our region, we can identify strategies to streamline discharge practices, facilitate transition processes and improve families’ readiness to go home from the hospital. In addition, we will be well positioned to implement the *Standards of Postnatal Care* from the Provincial Council for Maternal and Child Health (PCMCH), expected to be announced in spring 2017.

Activities of the workgroup were guided by a Project Charter and are summarized in this report in the following 5 parts:

- Part 1 - Discharge Processes
- Part 2 - Length of Stay Data
- Part 3 - Surveys
- Part 4 - Recommendations
- Part 5 - Next Steps

## Part 1 - Discharge Processes

The hospital discharge processes, in conjunction with new parent and health care provider experiences of the current postnatal discharge environment across the region, present fundamental information needed to determine whether the current landscape of postnatal care is meeting the needs of new parents and health care providers in the Champlain and South East LHINs. The **information** (topics covered, materials given on discharge) and **processes** used for educating new parents were reviewed. Significant variations in the tools used by hospitals (even within larger urban areas) led to the decision to review the topics covered in educational tools provided to new parents (either following the birth of their baby, upon admission to a postnatal unit or upon discharge).

**Maternal care topics** routinely covered in regional hospitals in the postnatal period include:

- Breastfeeding basics
- Pumping and storing breastmilk
- Breast care
- Postnatal pain management
- Baby blues & perinatal mood disorders
- Wound care
- Exercise and mobility
- Maternal diet
- When to seek help
- Maternal fever
- Increased per vaginal (PV) loss
- Foul smelling PV discharge
- Increased vaginal tenderness
- Passing clots
- Difficulty voiding and stooling
- Signs of mastitis
- Signs of preeclampsia
- Perinatal mood disorders

**Newborn care topics** routinely covered in regional hospitals after birth include:

- Newborn breathing
- Newborn lethargy
- Thermoregulation
- Jaundice
- Feeding, output and dehydration
- Crying
- Umbilical cord care
- Group B Streptococcus (GBS)
- Newborn Screening Ontario and Newborn Hearing Screen
- Car safety
- Vitamin supplementation and introduction to solids
- Newborn registration

**Methods for providing the education** varied between centres throughout the region. Many centres provide opportunities for educational discussions based on checklists; while others focus on the self-identified needs of new parents in the immediate postnatal period. All hospitals in the region provide some sort of information for parents to take home with them following their discharge. Interestingly, some hospitals request that parents sign a form indicating that they received the education outlined in the discharge instructions document. Others provide a printed copy of discharge instructions to parents and verbally review the information.

Public health units throughout the region collaborate with the hospitals to ensure all new parents are given accurate information. Of note, there have been recent changes in the information provided to postnatal parents upon discharge with some public health units providing a link to electronic resources versus providing paper handouts.



Parents are routinely sent home with documents specific to their hospital stay and although the specific documents vary by centre, the purpose is common: to ensure accurate and timely information for the health care provider (HCP) who will be following up with the new family in the community. There is significant variability in the information that is being shared with follow-up care providers and how this information is shared. Throughout the region, physicians (obstetricians, family physicians, pediatricians and neonatologists), registered midwives and nurse practitioners are responsible for postnatal discharge of mothers and newborns. Care plans/pathways are also commonly used to guide postnatal care of mothers and newborns. No centres within the region identified that they have medical directives that provide nursing staff with the opportunity to discharge families home. Some hospitals use whiteboards in patient rooms to communicate and help coordinate care during the hospital stay, prepare parents for discharge (timing), and ensure appropriate follow-up after discharge has been or will be arranged.

## Part 2 - Length of Postnatal Hospital Stay

Length of postnatal hospital stay (LOS) is closely monitored by many hospitals across the region, working toward decreasing it as a cost-saving measure. However, many of the region's level-1 hospitals, though not actively seeking to decrease their postnatal LOS, are seeing a decrease in LOS as many families desire to go home as soon as possible after birth to settle into their home environment and new family life. This desire to be discharged home as soon as possible was confirmed by family members who completed the survey (which is discussed later in the report).

In 2015, we conducted a **literature review on postnatal LOS** (see Appendix A). Discussions following the dissemination of the review highlighted that, at the organizational level, the length of hospital stay data is collected differently. Finding a common way to track this data was identified by CMNRP's Advisory Committee as an important priority in monitoring LOS.

Regionally, the decision was made to examine LOS data using the BORN information system. For the purposes of our review, postnatal LOS is defined as the time from birth until the mother and newborn are discharged home; however, we also obtained data on postnatal LOS for mothers when their newborns remained in hospital. We requested fiscal year data from BORN for the years 2013-2014, 2014-2015 and 2015-2016 to provide an opportunity to examine trends in discharge times over the past three fiscal years, exploring key indicators which might impact the LOS: parity and type of birth. Consultations with key stakeholders led to the decision to obtain data grouped within specific timeframes, chosen strategically to be in line with various CMNRP partners working towards decreasing their LOS.

### **KEY FINDINGS**

***When examining all the regional data, there is a trend towards shortened lengths of stay in Champlain and South East hospitals and in Ontario, regardless of maternal parity or type of birth.***

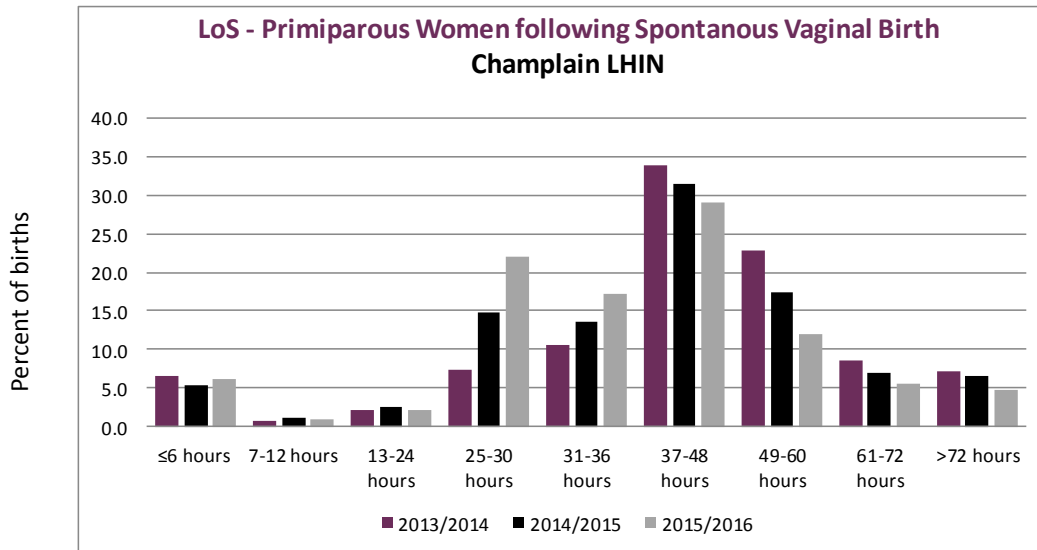
The graphs below highlight some of the key findings. The data is at times presented separately for the Champlain and South East LHINs to help delineate the differences in practices based on geography. Provincial level data is provided as an additional comparator.

### **Champlain LHIN – Primiparous women, vaginal birth**

Over the past three fiscal years:

- Primiparous women who had a vaginal birth have been discharged most frequently between 37–48 hours following birth (Graph 1)
- LOS between 25-30 hours postnatally increased from 7% of new moms and newborns being discharged in this time frame in 2013-2014, compared to almost 15% in the 2014-2015 fiscal year and 22% in 2015-2016. This represents a three-fold increase in number of discharges in this timeframe between the first and last fiscal years.

**Graph 1**

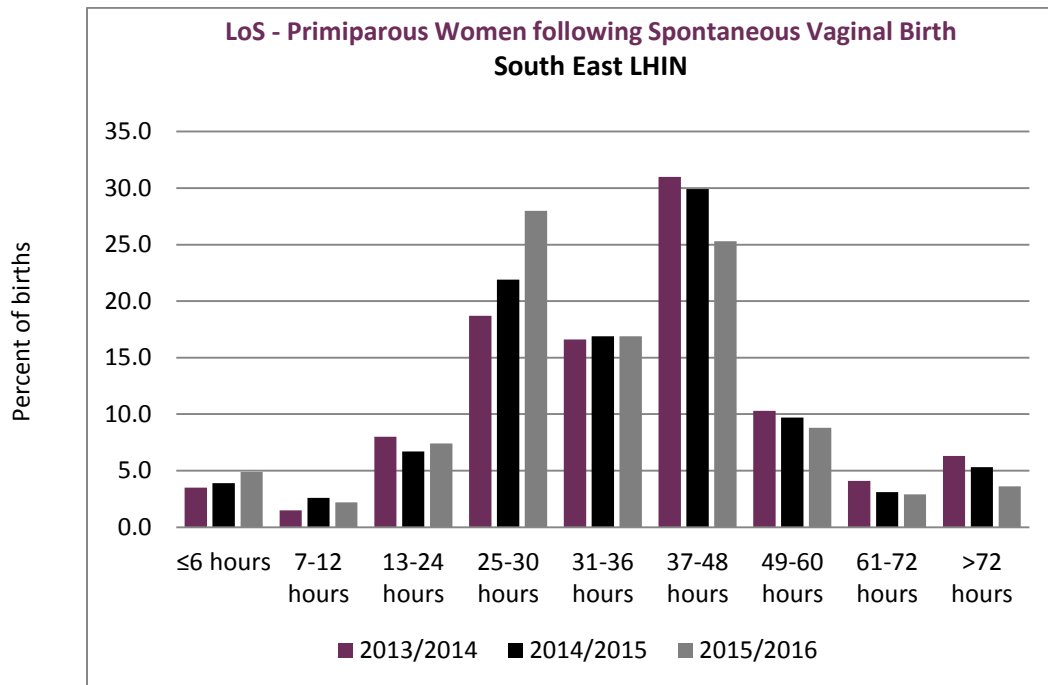


BORN, 2016

**South East LHIN - Primiparous women, vaginal birth**

- Primiparous women who had a vaginal birth were most frequently discharged home between 37-48 hours, with the trend decreasing over the three fiscal years (Graph 2).
- LOS between 25-30 hours postnatally increased from 18% of new moms and newborns being discharged in this time frame in 2013-2014, compared to 22% in the 2014-2015 fiscal year and 27.5% in 2015-2016. This demonstrates a similar trend in discharge times across both LHINs over the fiscal years reviewed.

**Graph 2**

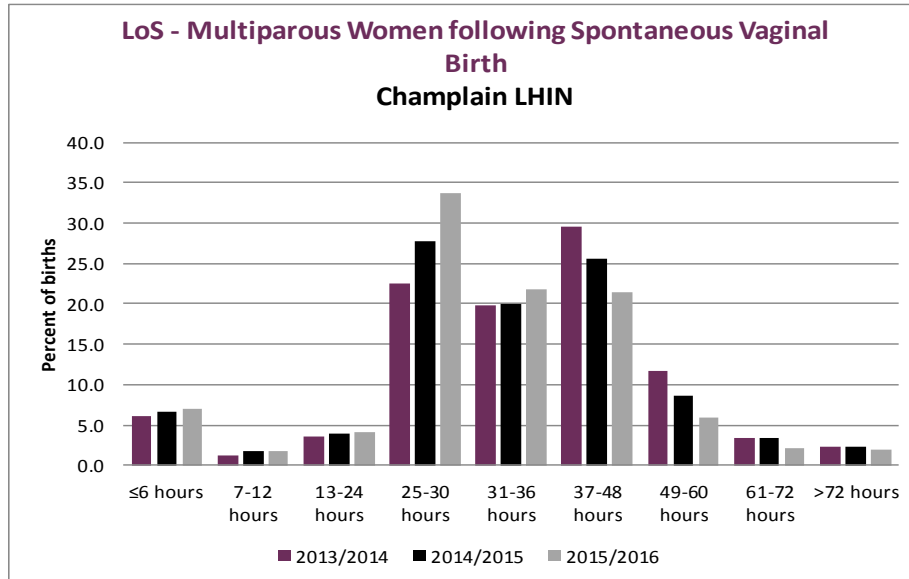


BORN, 2016

### Champlain LHIN – Multiparous women, vaginal birth

- Between 2013 and 2016, a shift in discharge time frames from 37-48 hours to 25-30 hours can be seen (Graph 3).
- One-third (34%) of multiparous women who experienced spontaneous vaginal birth in 2015-2016 were discharged home with their newborns between 25-30 hours postnatally. This represents a 12% increase in comparison to the 2013-2014 fiscal year.

Graph 3

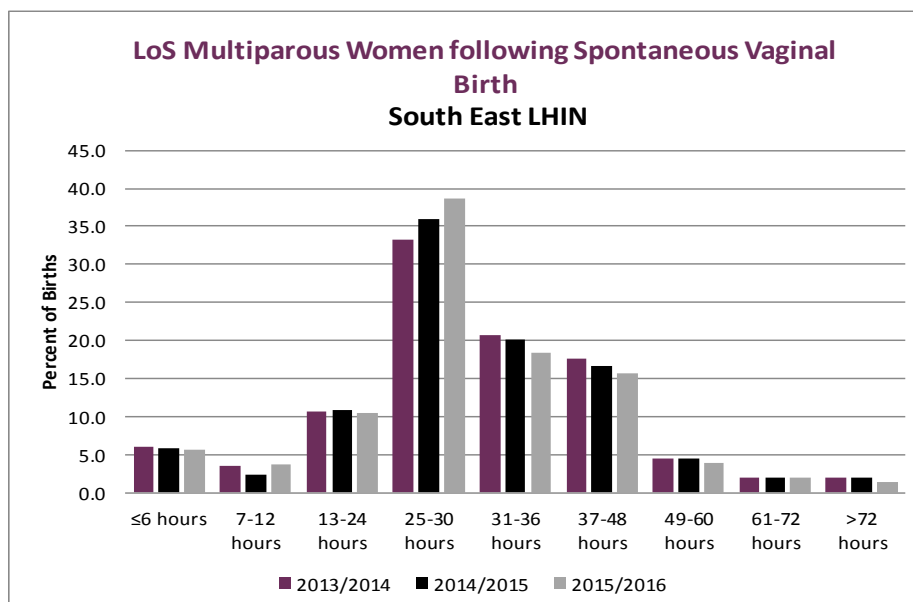


BORN, 2016

### South East LHIN - Multiparous women, vaginal birth

- Discharged most frequently between 25-30 hours following birth (Graph 4).
- Approximately 20% of the multiparous women in the South East LHIN are being discharged home prior to 24 hours following birth, as compared to 13% of the same population in the Champlain LHIN in 2015-2016.

Graph 4

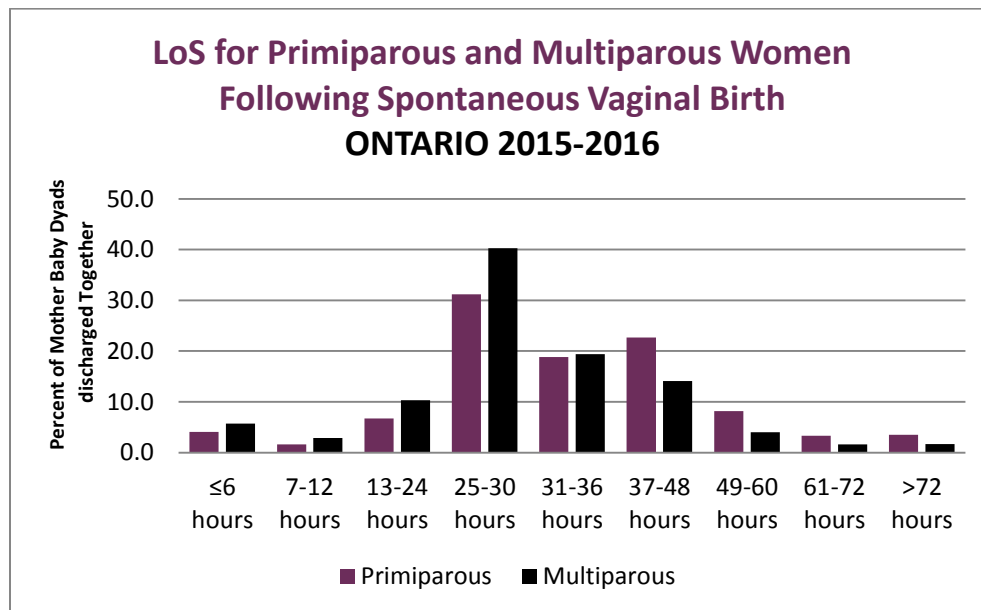


BORN, 2016

## Ontario – 2015-2016

- Provincially, the majority of women who experience **spontaneous vaginal birth** are being discharged home from hospital between **25-30 hours**, regardless of parity (Graph 5).
- Approximately 40% of multiparous women in Ontario are discharged in this timeframe, as compared to the South East and Champlain LHINs at rates of 38% and 34%, respectively.
- Primiparous women were discharged home between 25-30 hours at a rate of 31% in Ontario, 22% in the Champlain LHIN and 34.5% in the South East LHIN.
- Women discharged between **31-36 hours** following birth were discharged at a rate of 19% across the province, 18% the South East LHIN 17% and in the Champlain LHIN.
- For the discharge time period of **37-48 hours**, the discharge rate was 22.5% provincially, 19% in the South East LHIN and 29% in the Champlain LHIN.

Graph 5



BORN, 2016

## LOS by type of birth – 2015-2016

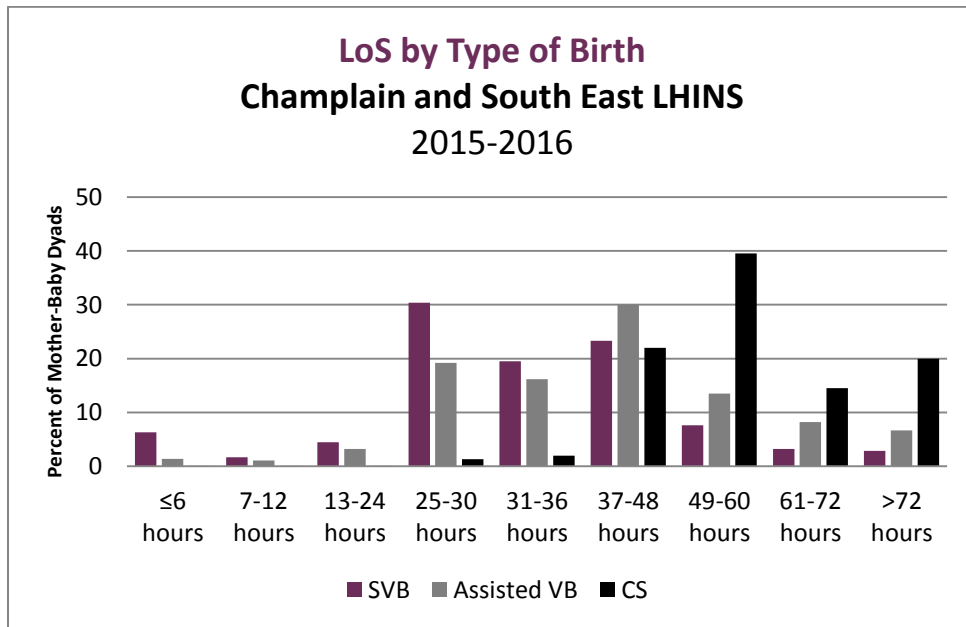
Provincial and regional rates are relatively comparable.

- Women who experience **spontaneous vaginal births** throughout the province and region are sent home most frequently between 25- 30 hours. Provincially, more women (11% overall) who experience a spontaneous vaginal birth will go home between 13-24 hours than women who give birth in the region (combined Champlain and South East LHINs = 4.5%).
- Women who experience **assisted vaginal births** (either vacuum-assisted, forceps-assisted or a combination of vacuum and forceps) are most frequently discharged home between 25-30 hours in Ontario (32%). Regionally, these women are most frequently discharged between 37-48 hours (30%), and 19% being discharged between 25-30 hours and 16% between 31-36 hours.
- **Cesarean section (CS)** discharge times are closely aligned across the region and the province, regardless of parity. Nearly half (42.5%) of women who experience CS across the province are discharged home between 49-60 hours; regional data is similar with almost 40% of women being

discharged in that time period. Approximately 27% of mothers who experience CS are discharged home between 37-48 hours provincially and 22% regionally.

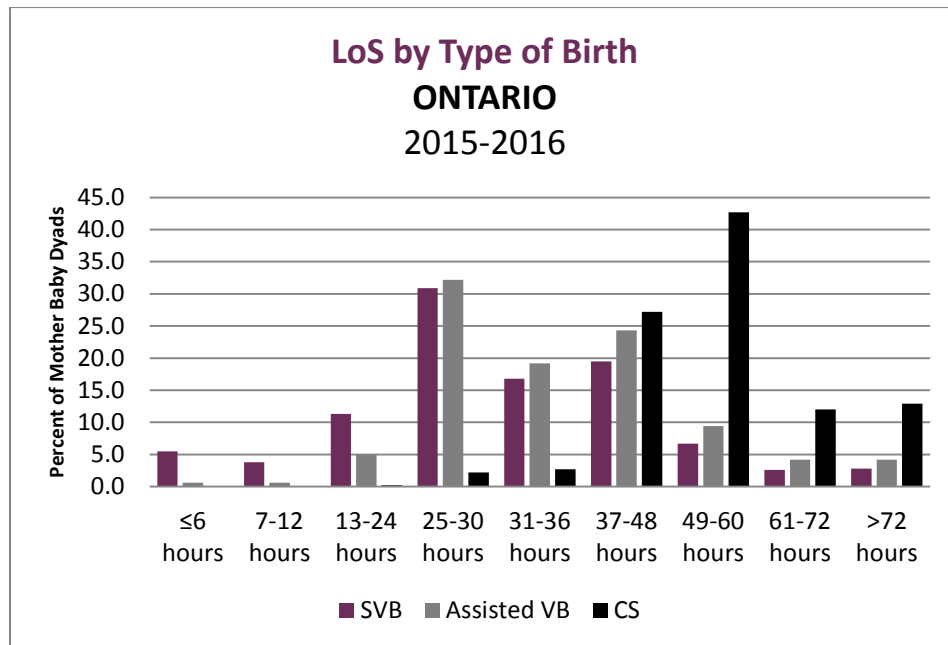
Graphs 6 and 7 show combined regional and provincial data about length of stay by type of birth, regardless of parity.

**Graph 6**



BORN, 2016

**Graph 7**



BORN, 2016

## Part 3 - Surveys

We engaged new parents and perinatal care providers in describing their experiences of the hospital discharge process through online surveys designed to identify the current system's strengths, gaps (on both a community and regional level) and opportunities for improvement to streamline maternal-newborn hospital discharge.

### Survey Design & Dissemination Strategies

Two surveys were developed by CMNRP's Postnatal Discharge Experiences Workgroup. Questions on the New Parent Survey included brief demographics, details of their last pregnancy and birth, ways they prepared to care for themselves and their baby, the extent to which they felt prepared to go home from hospital, advice they received regarding follow-up appointments for mother and baby, and their ability to book and attend follow-up appointments (See Appendix B - *New Parent Survey*). Questions on the Perinatal Care Provider Survey were largely open text questions exploring current postnatal hospital discharge strengths, gaps and opportunities for hospital- and community-level and regional system improvement (See Appendix C - *Perinatal Care Provider Survey*).

Both surveys were translated into French, converted to an online format and administered via FluidSurveys. Bilingual social media messages for Facebook and Twitter were created and partners and family advisors were asked to help disseminate the survey link through their personal and professional networks. Information regarding the New Parent Survey was included on CMNRP's website page "For Parents". The Perinatal Care Provider Survey was largely disseminated via email through our partner organizations' leadership teams requesting that the survey be forwarded to frontline healthcare providers involved in hospital discharge. Information was also included in the "Ways to Engage" page of the CMNRP website. Both surveys were promoted through the CMNRP Weekly News email (approximately 1,000 recipients).

### Data Collection

The surveys were administered in July and August of 2016. The New Parent Survey was launched first, with the Perinatal Care Provider Survey following. Data was collected under the auspices of a regional quality improvement initiative as determined by the workgroup following extensive discussion and individual assessment of the proposed project using the Ottawa Health Science Network Research Ethics Board tool "*Is your project Research or Quality Improvement? – Guideline & Checklist*". The decision was finalized by group consensus.

### Data Analysis

Initial data analysis was completed by CMNRP secretariat staff on behalf of the workgroup. Data analyzed included both qualitative and quantitative data. Demographic data were collected in an attempt to determine the relative representation of survey respondents and provide insight into potential sample bias. Open-text responses were analyzed using thematic analysis and coded with an initial theme by one reviewer. To ensure validity of themes, a second reviewer verified the themes or suggested a new code, and a third reviewer confirmed the themes.

## Part 3a - New Parent Survey

### Recruitment

Our recruitment strategy involved engaging parent representatives to share the survey link through their social media networks as well as CMNRP community partners such as community health centres and public health units who have a mandate to provide services to childbearing families across all socioeconomic groups. Respondents were asked to identify the first three digits of their postal codes. This information provided LHIN delivery rates and allowed families who live outside of our LHINs but who delivered within one of our hospitals to respond. Data received was proportionally representative of the number of births in each of the LHINs.

Concerted efforts were made by the workgroup to ensure that we heard from a diverse group of new parents across the region. The workgroup was cognizant of the varying issues relating to sociodemographic status and geography, and as such, we hoped to hear from young parents, families with low income, and families who had issues with accessing services.

### Participants

The survey was designed to capture the experiences of new parents who delivered a baby at one of the 12 hospitals in the Champlain or South East LHINs in the last 12 months (n=248). We limited the respondents to those who had births in the last year to ensure that we captured families who had or were experiencing care within the current health care reality given the many changes in discharge practices and follow-up supports over time.

Respondents who indicated their baby had been born more than a year ago (13.9%) were directed to a thank you page. A small portion of respondents did not complete the survey (6%). The final number of respondents who completed the New Parent Survey was approximately 190-200 (see Table 1 - Demographics).

**Table 1 Demographics of New Parent Respondents \***

Descriptor	Category	n	%
Age n=202	<20	1	0.5%
	21-25	15	7.4%
	26-35	153	75.7%
	36 and older	33	16.3%
Number of children n=200	0	1	0.5%
	1	105	52.5%
	2	69	34.5%
	3	15	7.5%
	4 or more	10	5%
Marital Status n= 201	Single	2	1.0%
	Married	154	76.6%
	Common-law	43	21.4%
	Not living with partner	2	1.0%
Primary Language n=200	English	167	83.5%
	French	29	14.5%
	Other	4	2.0%
	Health Care Provider n= 201	Obstetrician	95
Family Physician		34	16.9%
Midwife		69	34.3%
Nurse Practitioner		1	1%
Birth Type n= 201		Vaginal	152
	Cesarean	49	24.4%
Health Issues n=200	No	118	59%
	Yes	82	41%

*\*Numbers are variable as not all respondents answered all questions*



## Income Level

The social determinants of health would suggest that respondents from lower socioeconomic statuses may have challenges related to financial or transportation issues that could impact their ability to attend health care appointments. Therefore, we wanted to determine the percentage of low-income families who responded to our survey. Low income was determined by looking at the number of people living in a household and the total yearly household income. The cut-off number for low income households was based on the Ottawa Snowsuit Fund calculation, and for the purposes of this quality improvement initiative, it provides a rough estimate of potential for health inequities (see Table 2. Low Income Cut-Offs).

**Table 2 – Low Income Cut-Off (2015)**

Size of Family Unit	Minimum Necessary Income
1 person	\$23, 861
2 persons	\$29, 706
3 persons	\$36, 520
4 persons	\$44, 340
5 persons	\$50, 290
6 persons	\$56, 718
7 persons	\$63,147
More than 7 persons, for each additional person add:	\$6, 429

Source: Snowsuit Fund Low-Income Cutoffs <http://snowsuitfund.com/category/clients/>

Table 3 shows that the majority of our survey respondents considered themselves to be middle to high income. Approximately 10% were considered low-income however this proportion may possibly be higher given that 12.8% of respondents chose not to include their income bracket.

**Table 3 - Respondents Who Were Considered Low Income**

Considered Low Income	Number	Percentage
No	158	77.8%
Yes	19	9.4%
Unknown	26	12.8%
Total	203	100%

## Access to Care

To determine if we accessed parents with potential risk, we decided to look at barriers to accessing perinatal care. Responses indicated that 4.5% of the survey population were not able to get to their appointments (no transportation), and that 11.5% found that not having child care for other children was prohibitive. Approximately 12.5% of respondents indicated that they had difficulty attending health care appointments because they were unable to get time off of work. Financial restrictions, access to transportation and non-flexible employers or clinic times were all recognized as limitations. The majority of the survey respondents (77%) indicated that they did not experience any difficulties in attending health care appointments.

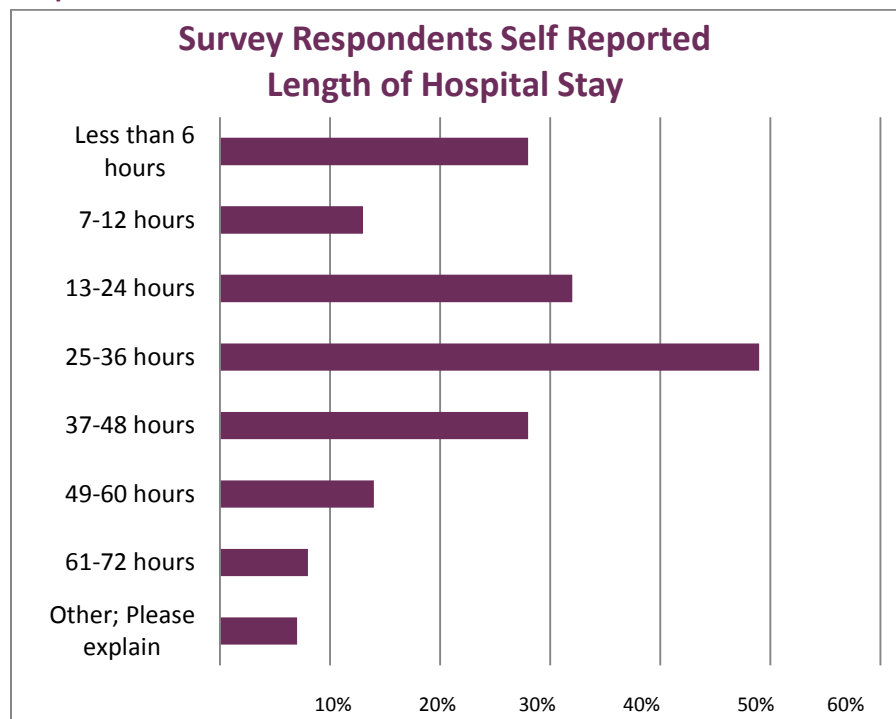
## Health Issues

Almost half of the respondents (41%) identified a health issue either during pregnancy, in labour or for their baby, with some respondents identifying multiple health issues. Diabetes and hypertensive disorders of pregnancy were identified as the most common pregnancy related health concerns. Of the 152 women who had vaginal births, 9.9% indicated that they experienced an instrumental delivery (4.6% vacuum; 5.3% forceps). No participants required both a vacuum and forceps.

## Length of Stay

Participants were asked about their length of stay following the birth of their baby. The majority (67.5%) of new parents who completed the survey identified that they were discharged home before or near 36 hours following birth. A third of families (28%) indicated they were discharged between 25-36 hours. Of note were the 14% who stayed in hospital less than 6 hours; these families are most likely midwifery clients. However, one cannot assume that some new parents who are not under the care of midwifery would not choose to leave the hospital as soon as possible following the birth of their baby. Eight respondents identified that they stayed longer than 72 hours, with the range in extended length of hospital stay being from 80 hours to 7 days postnatally. Those who stayed longer than 72 hours experienced difficulties in the immediate postnatal period necessitating a longer stay for the safety of mom and/or newborn. Survey respondents self-reported LOS is summarized in Graph 8.

Graph 8



Two thirds of respondents (61.3%) identified that the decision to go home was made collaboratively with their health care provider(s). A subset of respondents (10.6%) made the decision that they wanted to go home, and in some cases wanted to go home as early as possible. Contrasting this, open text comments indicated that some respondents felt pushed out of the hospital before they were ready.

The majority of respondents' newborns were discharged home with their mothers (91.5%). The initial intention of the workgroup was to exclude families with a baby who had an extended hospital stay (> 6

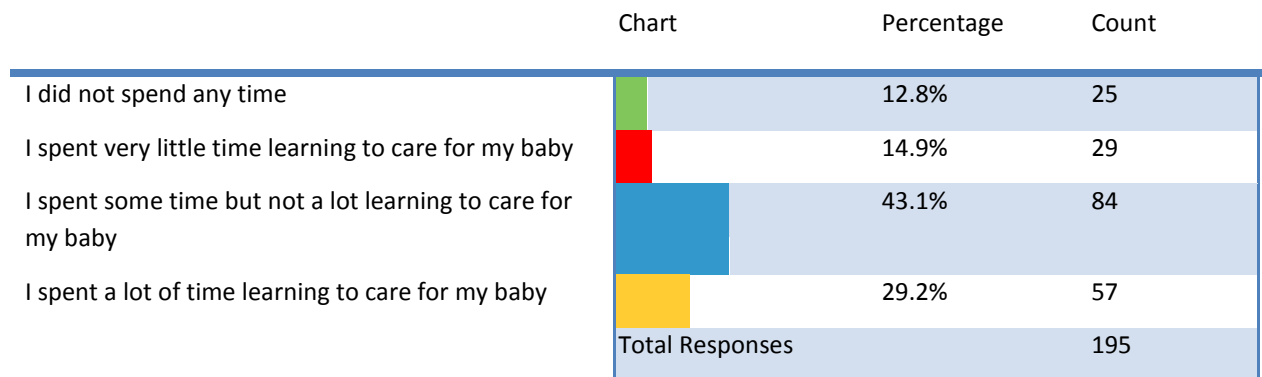
hours) in the Special Care Nursery/Neonatal Intensive Care Unit (SCN/NICU). However, given that transitions from hospital to home will still occur, and the group of families needing SCN/NICU care is small, the decision was made to include all new parents, including those discharged home without their baby.

Respondents who indicated their newborns were not discharged home with them (8.5%) were asked to provide further information about their newborn’s discharge delay. The main reasons identified included NICU admissions (preterm births and complications) and hyperbilirubinemia.

## Learning During the Prenatal Period

Respondents were asked “During your pregnancy, how much time did you spend learning to care for your baby once you got home?”. Forty-three percent of respondents spent some time but not a lot learning to care for baby, nearly one-third spent a lot of time and another third did not spend any time (12.8%) or very little time (14.9%) (Graph 9).

**Graph 9 - Learning During the Prenatal Period**

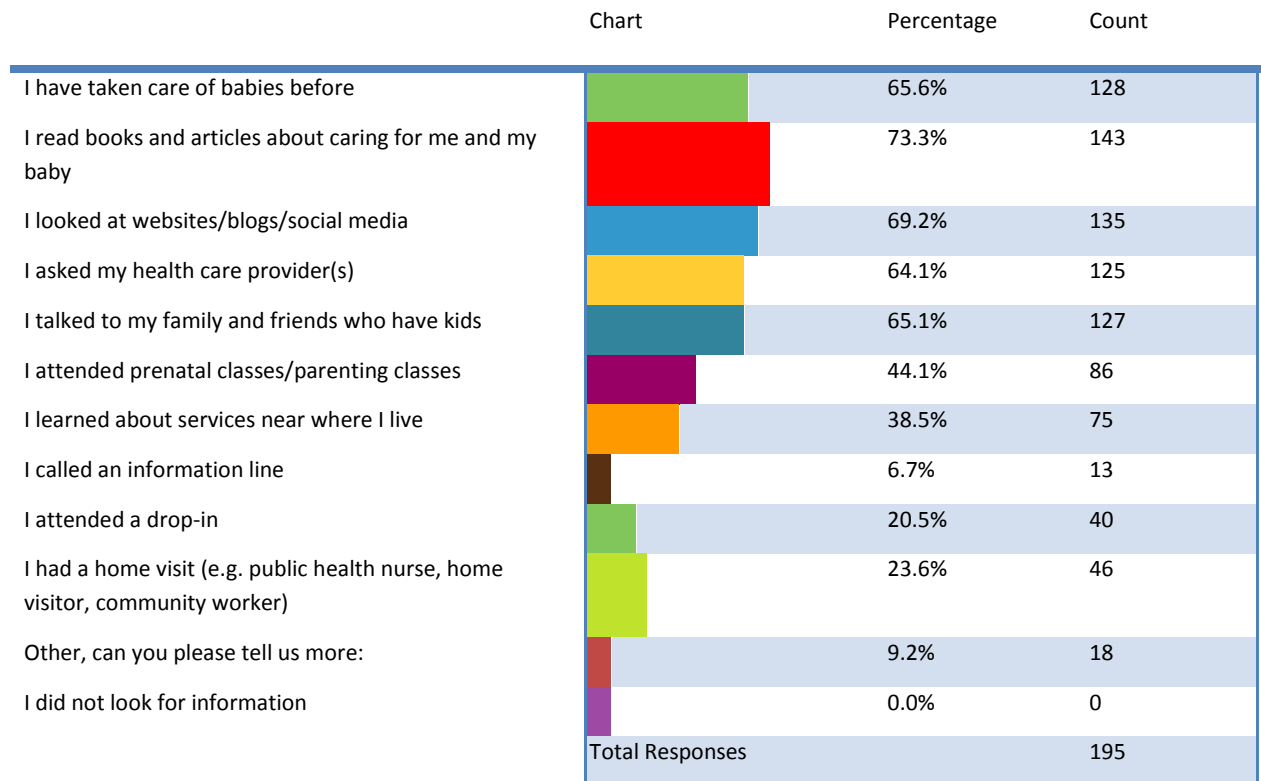


## Methods of Learning to Care For Mom and Baby

Respondents were asked “How did you learn to care for you and your baby after going home from the hospital?”. Respondents were able to select multiple answers and make additional comments. The majority of respondents read books or articles, or looked at websites, blogs or other social media (Graph 10). A few respondents provided comments pertaining to other sources of information: having personal experience in caring for babies, attending community programs/services, receiving home visits by midwives, or receiving information from health care providers or family members.

Retrospectively, the wording of this question may not have been clearly understood and may not have reflected what was intended, which was: “In getting ready for the birth of your baby, how did you learn to care for you and your baby?”

**Graph 10 - Methods of Learning**



### Best Time and Method for New Parents to Learn

The majority of respondents (71.9%) retrospectively felt that the **best time to learn** about postnatal care of mom and baby **was during pregnancy**. Only 14.3% felt that the best time for learning was during the hospital stay. We advise caution when interpreting this information as the opinions may not necessarily be representative of the opinions of expectant parents but rather parents who reflect back on their experience. Nonetheless, this needs to be explored further as currently with the lack of expectant parents accessing prenatal education beyond that provided at their antenatal appointments, the majority of postnatal self-care and newborn care teaching is provided during the short postnatal hospital stay.

We asked respondents to identify the **best way for new parents to learn information** about how to care for themselves and their baby after birth. The following summarizes the most frequently selected options: prenatal or parenting classes (27.7%), home visits (24.6%), teaching from health care providers (17.9%), and information from other parents (13.3%) (e.g. peer support groups, postnatal parent support groups). The least preferred methods included electronic resources (e.g. websites, social media, apps) and written information (e.g. pamphlet, handout, booklet) (8.7% and 4.6% respectively).

Some respondents felt that **a variety of education strategies** tailored to individual learning needs should be available to accommodate different learning styles:

*“I think all of these options are valuable. Home visits would be especially useful for doctor and OB patients.”* *“All [options listed] above - Everyone learns differently and has had different experiences.”* *“It depends on the individual.”* Additionally one respondent suggested a combination of methods, such as *“Written info with support drop-in or some sort of contact person/group”*.

## Important Topics to Discuss During Hospital Stay

The topics discussed during the hospital stay that were the most valuable to new parents included:

- **Breastfeeding** (breastfeeding support, including Lactation Consultant support in hospital, and practical information like latching, initiation & continuation, pumping)  
*"...what is normal in terms of milk coming in after a couple of days and that day 2-3 is really tough. Knowing ahead of time made it easier to cope"*
- **Newborn care** (in particular bathing, diapering) and **newborn health & safety** (e.g. normal patterns of elimination)  
*"Signs to look for in myself or my baby that could indicate something may be wrong (blood clots, not enough wet diapers, info on bowel movements etc.)"*
- **Maternal self-care and recovery**  
*"What to watch for in terms of bleeding and blood clots...This information ended up saving my life I believe"*

Respondents commented that they did not remember information given to them in the hospital in the postnatal period. One parent shared *"I barely remember anything"* and another parent shared that she learned how to pump but *"... otherwise, I was in a fog and don't remember much of my stay"*. Written information was important to reinforce knowledge: *"I actually found all the other information we got a bit overwhelming and was glad that it was written down so I could refer back to it when we were home (e.g. what to watch for when caring for myself and the baby)"*

Respondents identified similar topics that were not discussed with them that would have been helpful to them after going home from the hospital:

- **Breastfeeding** (managing complications, troubleshooting)  
*"Breastfeeding was so hard and no one seemed to be able to help. The nurses did not seem very trained, they offered little help and simply would latch the baby on themselves then leave. They all seemed to have different information on breastfeeding which was confusing. There needs to be a lot more focus on breastfeeding and warning about complications and how to relieve engorgement once milk comes in since the milk comes in once you are home. There needs to be follow-up at home"*
- **Maternal self-care** (including care after cesarean section)  
*"How to care for myself. No one gave me stool softener so I didn't know about it. No one told me about the healing process or what to expect or how to manage the discomfort/pain"*  
*"How to care for your newborn while recovering from a cesarean, bending to lift him was painful, so tips to care for baby while recovering yourself would be helpful. As well what you can and can't do and when. We did not receive much information at all on how to manage post surgery"*
- **Mental health** (more discussions about emotions, depression and perinatal mood disorders)
- **Newborn care and behaviour** (bathing, managing crying, safety, and sleep)

*“More hands on demonstrations about how to care for the babe. We were in hospital for such a short time that we didn’t get a chance, but our midwife came to our house and was able to answer our questions”*

It is essential for parents to know about available community services and programs as this serves as an important aspect of a smooth transition from hospital to home. Nearly 65.7% of respondents were told by someone during pregnancy about community services or programs that were available after discharge and nearly 70% of respondents were told by someone at the hospital about such services.

Additionally, they were asked about the information packages given in the hospital. The majority of respondents (77%) reviewed this information whereas 11.8% did not remember getting a package.

Reasons for not looking at the information package included:

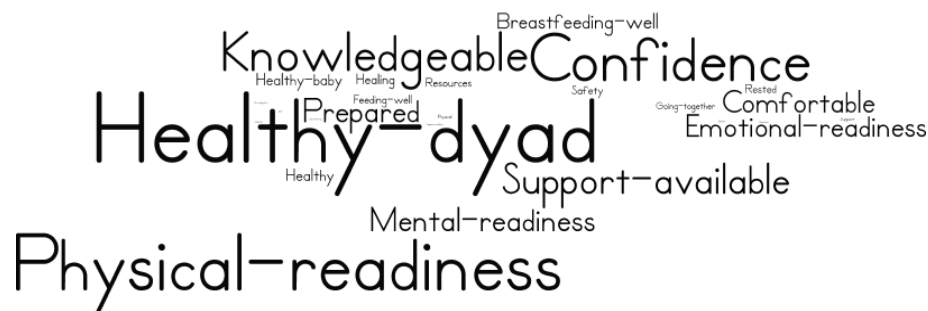
- **Didn’t find it helpful/ didn’t bring it home** (often because they were multiparous women)  
*“This was my second baby and I was better prepared and he is a very easy baby so I didn’t need as much help”*
- **Things were going well and didn’t feel they needed it**  
*“I have a strong support network and reached out to services I knew existed”*
- **Didn’t have time to read it**  
*“No time to read hard copy, holding baby!”*

A lack of information pertaining to formula feeding and preparation was identified by some respondents. One respondent commented that there was no information in the parent education packages on formula feeding, stating: *“it mostly contained information about breastfeeding and I opted to formula feed due to complications”*. Another new parent shared that in hospital teaching on formula was lacking, including *“Les types de formules qui sont les meilleures pour un enfant non allaité. Je comprends l’idée d’encourager l’allaitement mais il ne faudrait pas non plus négliger et priver de ressources les mamans qui n’allaitent pas”*. As a parent identifying an unmet need, this feedback is very important, and health care providers are required to provide this information on a one-to-one basis as needed, as per the Baby Friendly Initiative and the WHO Code of Breastmilk Substitutes.

## Readiness for Discharge

Respondents were asked *“What does ‘being ready to go home with your new baby’ mean to you?”* The word cloud below (Diagram 1) illustrates the common themes from their responses.

**Diagram 1 - “Readiness to Go Home”**



We wanted to explore parents' perception of their level of readiness to go home with their baby (Graph 11). More than 2/3 of survey respondents indicated they were "definitely ready to go home". We had hypothesized, based on workgroup members' personal lived experiences that some families would think that they were ready to go home when in the hospital, but would later realize that, in fact, they were not ready. The results show that 15.1% of respondents fell into this category. Another 15.1% "did not feel ready" or "were sort of ready" to be discharged.

**Graph 11 - Feelings of Readiness to Go Home with Baby when Discharged**

Response	Chart	Percentage	Count
I was not ready		5.6%	10
I was sort of ready		9.5%	17
I thought I was ready, but I got home and realized that I wasn't ready		15.1%	27
I was definitely ready		69.8%	125
Total Responses			179

An open-text option was available for respondents to explain why they chose the answer they chose. In the interest of brevity, we are only reporting a summary of open-text comments pertaining to "definitely ready" and "not ready" to go home to demonstrate the differences between groups.

**Respondents indicated that they were "definitely ready" to be discharged home** when they:

- Were parenting other children
- Felt physically ready
- Had in-home support from a midwife, doula or public health
- Felt well prepared and well supported at home by their family and friends
- Felt breastfeeding was going well and maternal pain control was satisfactory

Additional factors influencing respondents' perception of their readiness to be discharged home included:

- Lack of sleep/comfort in the hospital
- A need to be in their own homes and have their own space
- Having perceived the birth of their baby as uncomplicated

The subset of respondents who indicated they were definitely ready to go home due to the lack of comfort within the hospital environment potentially presents bias within the results of this question as it is possible some of them went home unprepared and unsupported, but preferred to be in their home environment over the unfamiliar hospital environment.

A variety of reasons were provided to explain why some parents perceived that **they were "not ready to go home"**:

- Difficulties with pain and ambulation  
*"I was in a lot of pain, wasn't able to walk very well and was very weak due to postnatal hemorrhage"*  
*"... felt completely pushed out of the door by hospital staff when I couldn't even walk. I had a really bad labor experience that brought back awful memories for the first few months"*

- Having a premature or ill newborn
- Elevated blood pressure or another medical reasons
- Newborn feeding problems

***New parents' perception of readiness for hospital discharge is largely influenced by previous parenting experience, birth experience, postnatal pain and ability to physically care for their newborn.***

## **Follow-up Care for Baby**

Participants were asked **who they were planning to take their baby to for health care** after hospital discharge: Family Doctor (56.7%), Midwife (33.9%), Pediatrician (8.9%), and Nurse Practitioner (0.6%).

We asked the respondents to identify **when they were told to have a follow-up appointment for their baby**: 62.8% were told within 1-2 days of going home, 22.2% within 2-3 days of going home and 10 % within one week of going home. Reassuringly, only 1.1% were not told about follow-up appointments. A small portion of respondents indicated that they were told something else, some of whom indicated that they were midwifery clients whose midwives came to their homes to examine the newborn. Some respondents from this smaller group required more frequent follow-ups (due to hyperbilirubinemia), or their babies were not discharged at the same time as the mother.

One respondent indicated that they had been discharged on the Friday of a long weekend with instructions to see their physician in two days. When they brought up the long weekend to the health care provider who discharged them, they were told to wait until Tuesday, causing the new parent great anxiety as the newborn had a high bilirubin on discharge. The respondent shared *"This was way too long. The most stressful weekend ever."*

Approximately 92.7% of the respondents were **able to book the appointment for their newborn** as instructed at discharge and 99.4% of these were able to attend this appointment. Respondents indicated that they were thankful for additional supports available in their communities, such as the Monarch Centre in Ottawa and midwifery follow-up care at home. The remaining respondents experienced a multitude of complicating factors in booking this appointment for their new baby including: weekend delays, inability to register newborn with the physician office until the baby was born, having breastfeeding complications and newborn weight loss, and needing help sooner than the booked appointment.

When asked to recall if the hospital health care provider was worried about anything in particular about the baby requiring follow-up in a specific time frame (beyond normal newborn follow-up), 42.2% of infants required follow-up appointments for the following: breastfeeding, weight loss, jaundice, musculoskeletal issues, follow-up ultrasound scans, cardiac issues and positive newborn screen samples.



## Follow-up Care for Mothers

We asked the respondents to identify **when they were told to have a follow-up appointment for the new mother/parent**:

- 50.8% were told within six weeks of going home
- 24% within 2-4 days
- 7.3% within one week
- 2.2% within 4-5 days
- 5.6% for another timeframe and pertained to the midwifery follow-up care schedule

A few respondents shared that their physician inquired about maternal health during a baby visit and thus they felt their needs were met.

The majority of respondents (93.4%) were **able to book a postnatal follow-up appointment for themselves** as instructed at discharge. The reasons for *not* booking an appointment included receiving midwifery care, scheduling issues (e.g. no family physician, lack of timely clinic appointments for obstetrician, lack of coverage during absence of physician), attending an earlier appointment due to complications (infection), or personal reasons (e.g. transportation barriers, forgetting to book the appointment, or not feeling that it was necessary):

*"[I was] too tired to travel by bus"*

*"[I] didn't feel as though I needed it so I didn't make the appointment"*

Of concern are the 10.1% of respondents who were **not told about follow-up appointments**. This postnatal check-up is important for women's health and should be routinely communicated to all postnatal women.

## Advice from New Parents

An open-text comment field was available for parents to identify **advice that they would share with other new parents**.

Identifying their new priorities was the central theme in a variety of comments reflecting the "push and pull" that new parents feel

- Taking time for self-care was the most common topic identified by parents, with comments focusing on sleeping/resting, eating and drinking
- Importance of taking the time to foster a nurturing relationship with the baby, including spending time skin-to-skin and holding the baby close
- Establishing social supports while at the same time managing/limiting visitors and not worrying about housework. It was important to find the help needed and to accept help offered

Overall, advice focused on having realistic expectations and enjoying the moment

See Appendix D for quotes from new parents about their advice to other new parents.

## Part 3b - Perinatal Care Provider Survey

In addition to exploring the discharge process and experience from the perspective of new parents, our workgroup also wanted to capture the experiences of perinatal care providers (PCPs) who were directly involved in hospital discharge following birth; to do this an online survey was created.

### Participants

Similar to the inclusion criteria for new parents, we sought out the experiences of HCPs who had been working within perinatal care and conducting hospital discharge over the last 12 months from at least one of the health care organizations in the Champlain or South East LHINs. The dissemination strategy was previously described in the report.

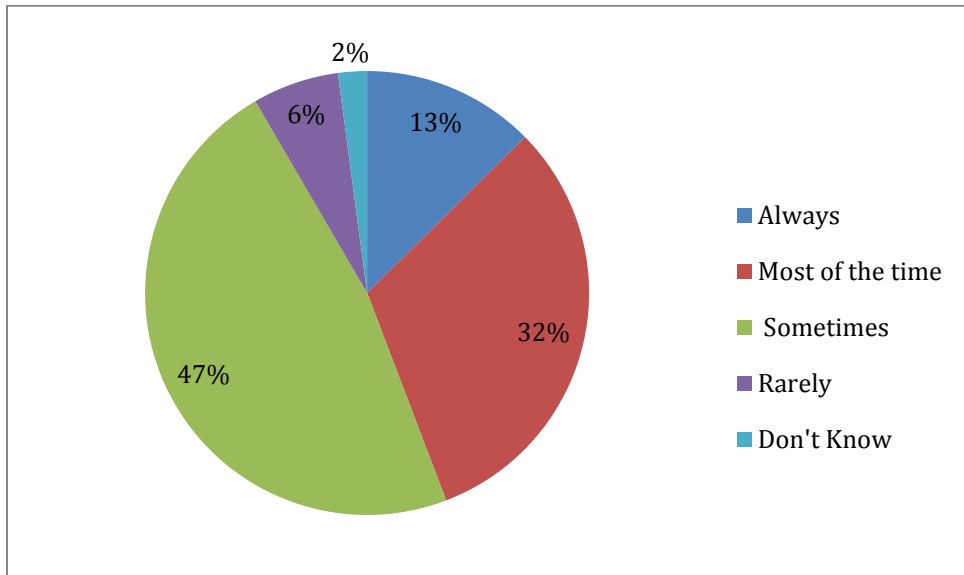
A total of 153 individuals accessed the health care provider survey link, of whom 17 were not directly involved in discharging postnatal families from the hospital in the last 12 months and 9 did not work at one of the health care organizations in the Champlain or South East LHINs. These individuals were automatically directed to a thank you page, leaving a total of **118 respondents** (see Table 4).

**Table 4 - Demographics of Perinatal Care Provider Respondents**

		n	%
<b>Type of Organization</b>	Hospital	76	64.4
	Clinic/Community Practice	29	24.6
	Public Health Unit	13	11
<b>Role</b>	Hospital Nurse (labour & birth, postnatal, lactation consultant)	47	39.8
	Pediatrician/Neonatologist	15	12.7
	Family Physician	15	12.7
	Registered Midwife	11	9.3
	Obstetrician	9	7.6
	Public Health Nurse (HBHC)	9	7.6
	Administrative Leader (Director, Manager)	3	2.5
	Social Worker	2	1.7
	Other	6	5.1

Providers were asked *“In your opinion, on admission to hospital, are parents aware of the early follow-up care required for their newborn?”* The results were mixed with almost half of the respondents perceiving that parents were “sometimes” aware and 45% of the respondents who perceived that parents were “always” or “most of the time” aware of the early follow-up requirements. See graph 12.

**Graph 12 – Providers’ Perception of Parental Awareness of Early Follow-up Requirements**



Providers were also asked about their practices regarding **confirming with parents whether they have booked (or were planning to book) follow-up appointments**. Approximately three quarters of survey respondents (76.8%) indicated that they “always” or “most of the time” *personally* confirmed that a newborn follow-up appointment had been booked prior to their discharge home.

Additionally, we asked respondents to indicate their **level of knowledge of available community services and programs** aimed at new parents. Most respondents were familiar with many (67.4%) or some (32.6%) programs in their community; however the survey did not explore the PCPs’ knowledge of the variety and breadth of programs and services available.

A significant portion of the survey included open-text questions. We asked perinatal care providers to identify, in their opinion, what is working well in the current process of maternal-newborn discharge, what barriers and gaps families faced in their experience of transition from hospital to community, how the discharge process could be improved, and current or new/innovative strategies to help enhance transition. Three themes emerged from the survey responses;

- 1. Access to Services / Primary Care Providers**
- 2. Information / Teaching**
- 3. Communication / Collaboration**

### **Access to Services /Primary Care Providers**

**Lack of services** was identified as the **most significant barrier to seamless transition**. Specifically, lack of breastfeeding services and support were the most frequently identified barriers to ensuring a smooth transition from the hospital to the community. Lack of access to lactation consultants in both the hospital and community settings was brought forward; further to this, PCPs felt that new parents experienced difficulty accessing these services outside of regular business hours and on weekends.

*“Breastfeeding support is challenging to access for many who cannot afford a private lactation consultant”*

*“Lack of breastfeeding support IN THE HOME”*

*“Difficulty finding drop in lactation consultant/breastfeeding clinics”*

*“Access to lactation consultant/breastfeeding support close to home”*

*“Inadequate breast feeding support in the community (no home support)”*

Other services identified as either lacking entirely or limited to specific populations included home visiting, Healthy Babies Healthy Children (HBHC) Public Health follow-up at home, newborn weight checks and well-baby check-ups in the community. Respondents identified the need for a one-stop location for follow-up care/support that is close to home. Increased access to these types of community services could contribute to reducing visits to emergency departments.

*“We need community labs that will do STAT bilirubins on newborns”*

*“We need home visits from [Public Health]...within 3 days [of discharge] for all women identified as being in need”*

## **Public Health**

Respondents highlighted a close collaboration with Public Health as a **facilitator of hospital discharge**. Many respondents identified the value of in-hospital Healthy Babies Healthy Children (HBHC) screening that is offered in some communities.

*“The [public health nurse] comes to the hospital Monday-Friday to meet families and complete the Healthy Babies Healthy Children Screen with them. I think this blends in-hospital care with community care very nicely”*

A gap in care was noted in relation to **follow-up screening on weekends** and the role that hospitals need to play in helping to ensure safe follow-up is available on an outpatient basis. Respondents valued the HBHC program’s ability to support clients after discharge. Specifically, the respondents indicated that they felt that the in-home support offered was of great benefit and very important. This led to a substantial concern for the workgroup as significant changes have been made to the HBHC programs across the region and home visits and even Public Health nurse phone calls are limited to only those families who screen as “with risk” and needing further assessment. Other families who deliver in our region may receive a letter in the mail (and/or during their hospital stay) containing information on services available in their community. It is important to note that in communities where Public Health is involved in screening in the hospital, they are not responsible for screening all patients, but rather their presence is meant to be a support. More education for providers is needed regarding the HBHC screening process and a greater emphasis needs to be put on making referrals to the HBHC program during the prenatal period.

## **Primary Health Care Providers**

A **lack of access to Primary Health Care Providers (PHCP)** was the **second most identified barrier** from our survey. Respondents identified this as a concern given the need for hospitals to ensure appropriate follow-up in the community. This challenge is further complicated by unclear processes and geography, with some communities within our region struggling with this more than others. Further investigation into this concern is required.

*“Some patients have not been able to find a Family Doctor and therefore have no care for their newborn so we are scrambling to make sure the newborn is followed within the first week”*

**Timely access to newborn follow-up** was also identified. Newborns discharged home less than 48 hours following birth require early follow-up in the community with a PHCP regardless of risk factors. This presents unique challenges to PHCP schedules as these appointments cannot be booked prior to birth and often clinic space is booked weeks in advance.

*“Many families do not have or cannot access a primary care physician who can provide timely follow-up care”*

## Midwifery Care

The comprehensive care provided by midwives, especially the timely in-home follow-ups in the early postnatal period, were acknowledged as beneficial both by midwives who responded as well as other perinatal care providers who responded to the survey. There was a desire for all families to have access to this type of service/support.

*“All women, regardless of whom they see for antenatal care, deserve access to breastfeeding/postnatal support in their home if they choose, not just those who see midwives”*

*“For midwifery clients, the follow-up care in the community is especially good, seeing them on day 1, 3, 5, wherever they are with follow-up phone calls in between; and being on call 24/7 makes midwives very accessible. By day 10, clients come to the clinic and see us again at 3 weeks and 6 weeks when we transfer care to their family doctor”*

*“Discharge works really well for midwifery clients who remain under midwifery care in hospital”*

However, there appears to be a lack of understanding regarding the midwifery scope of practice as it pertains to newborn care. Education and clear communication between perinatal care providers is required in order to prevent confusion for families and reduce duplication of services.

## Models for Follow-up Care

Survey respondents identified a need to create and/or maintain innovative ways for families to access needed services following discharge home from hospital. The concept of *Transition Clinics* was brought forward by several respondents indicating how highly valued these services are for health care providers discharging new mother-baby dyads home and highlighting overall that new parents are pleased with their experiences within these types of clinics.

Lack of access to services on weekends and outside of normal business hours was identified numerous times as being a significant gap in the current system. Home support was identified as an important aspect to consider for non-midwifery clients. A combination of greater access to services as well as clear communication with and between services is essential to achieve consistency in care and promote a smooth transition.

There were many different models described for providing follow-up (e.g. outpatient bilirubin clinics, immediate pediatric follow-up).

*“We have a jaundice clinic and breastfeeding clinic open 7 days/week for families in the first 3 weeks postpartum - it really helps for follow-up of the common neonatal issues in the first few weeks of life”*

*“We have a follow-up clinic at the [hospital] for jaundice and a drop in breast feeding clinic available all days of the week, weekends and holidays - this is essential for early follow-up”*

## Information / Teaching

### Lack of Parental Knowledge

Some perinatal providers perceived a lack in parental knowledge regarding the postnatal discharge processes, early follow-up care requirements for newborns and available community services as the **third most significant barrier to discharge**.

*“About 80% of our patients do not take prenatal classes. (I think this limits their knowledge of the process)”*

*“Lack of good prenatal preparation so that women know what services they will need and what is available to them”*

*“Education of parents of the importance of follow-up, even if their initial efforts to make appointments don't succeed”*

Respondents identified that **more teaching/education should be provided during the prenatal period** in order to be better prepared for the postnatal period. Knowledge gaps related to the need to identify a follow-up provider prior to birth, newborn follow-up requirements, timeliness of the follow-up, and awareness of available community resources. One respondent shared *“It is helpful when women are already connected with services prior to delivery.”*

To reduce this knowledge gap, **perinatal care providers need to share consistent and comprehensive information** during prenatal visits. Creating a postnatal planning tool and encouraging parents to complete this during pregnancy has been suggested as a strategy to better prepare families for the postnatal period.

*“Public education about the importance of having a “newborn care plan”... It is more important than having a “birth plan”*

*“Some parents are not aware of when to seek medical help for their newborn”*

*“Parents are going home before they are aware of what they don't know”*

*“Most parents are going home before the second night and have had very little sleep and do not retain the information that we are teaching them in the hospital. This could be affecting breastfeeding rates”*

A **lack of consistency in postnatal information** communicated to parents was identified by a number of respondents with a specific concern regarding *“... non-evidence based information [being] told to parents on discharge”*. In fact, consistency in teaching was identified as being particularly important, as sharing consistent, evidence based key messages prevents parental confusion.

*“We talk to the mom about understanding discharge plans, i.e. when mom is due back to see dr. and baby. We go over wet diapers etc.”*

*“We have postnatal Teaching list which we review with the parents prior to discharge and all parties sign. An Information Folder which includes the booklet “Breast Feeding Matters” is given to all our patients”*

Respondents identified the **importance of the interprofessional team clearly and consistently communicating the discharge process** as well as follow-up requirements.

*“Our hospital provides the new parents with a handout package full of up-to-date best practice guidelines with regards to baby care. We also provide them with a discharge summary outlining their follow-up appointments and when to call the doctor or return to the hospital. I always ensure the client is leaving the hospital with confidence and understanding of the next steps”*

As the above quote exemplifies, standardized communication tools have been suggested by multiple respondents as an important strategy to facilitate the communication between hospital providers as well as between hospital and community providers following discharge.

**Streamlining paperwork/e-documentation** and having documents that are given to the family to share with their care provider have been suggested. Of importance is ensuring that parents attend follow-up appointments. One respondent shared that *“Les parents ont toujours des [rendez-vous] après leurs congés mais il arrive quelque fois qu'ils ne se présentent pas ou décident d'annuler eux-mêmes”*. An established transition process and consistent communication pathway may help to encourage attendance at follow-up appointments.

## Communication/Collaboration

**Lack of communication between health care providers** was another barrier identified throughout the survey responses.

*“Lack of communication to care providers in the community about care received in hospital”*

*“Lack of a timely discharge summary”*

*“Delay in discharge information reaching the family doctor”*

Centres throughout the region have varying discharge summary sheets as well as varying methods for transmitting key information to the primary health care providers.

Respondents indicated the importance of **strong collaboration between hospitals and the community**. Of importance were suggestions about an interprofessional approach to discharge planning and follow-up, and clear communication pathways so that all providers are aware of pertinent medical/social information and any established plans of care. One respondent identified the need for a *“process to facilitate communication between sectors beyond large organizations”*. Suggested communication strategies included a comprehensive discharge summary (written or electronic) and a phone call between PCPs prior to discharge.

*“Discharge summaries are great to let them know everything about their stay since they may have missed details”*

*“A standardized discharge document with all the prenatal, delivery and postnatal hospital information that gets forwarded or brought to the primary care office (for example I often have to chase down blood type, blood work, relevant hospital info that the family is not aware of”*

*“Speaking with community MD before discharge, particularly for more complex patients. Organizing home care needs for complex patients, especially outside Ottawa. Identifying a paediatrician to assume care when family MD cannot or won't, especially in more remote areas”*



There appears to be a lack of awareness by some community providers about the importance of early follow-ups which has created delays in follow-up. One respondent shared that “*community outreach to primary providers about the importance of early [follow-up] for mom and baby*” is required. An increased awareness of the importance of timely follow-up for both mothers and babies may facilitate the booking of appropriate postnatal appointments.

### **Greater Understanding of Roles and Responsibilities of Perinatal Care Providers**

There were multiple comments reflecting confusion about midwifery scope of practice, especially regarding follow-up newborn care.

*“Lack of understand[ing] of a midwife's role or involvement especially when babies discharged from NICU”*

*“Midwifery clients are followed for 6 weeks postnatal by the midwife but rarely consent to involvement from the Public Health Unit, nor do they arrange for a timely well baby visit by their family physician”*

Additionally, there was confusion noted among parents as well as care providers as to the follow-up care providers and services available.

*“The community (including family physicians) often misunderstands (and therefore misinforms parents) of what post-discharge care the hospital offers, e.g., with respect to bilirubin testing. This leads to confusion and frustration for the parties involved”*

A need to increase awareness about Public Health services and programs was noted with one respondent stating “*...doctors should know and refer to HBHC as a more cost effective support to postnatal clients*”.

Perinatal care providers agree that parental preparation for the transition to parenting, including increased education on the challenges new parents will face in the immediate postpartum period, is essential. The importance of prenatal preparation for parenting needs to be emphasized with expectant families to significantly impact smoother transition from hospital to home following birth and enhance parents’ perceptions of readiness to be discharged home.

## **Discussion**

### **Parental Knowledge Gap**

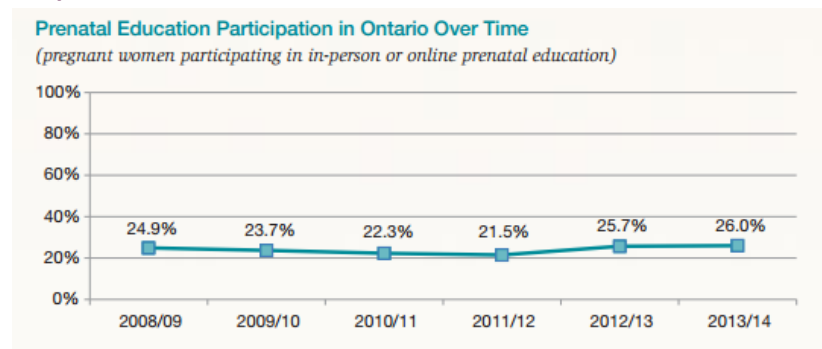
Respondents in both surveys identified that parental knowledge is a gap, specifically newborn and postnatal maternal care, timelines for follow-up appointments and available community resources post discharge. Our survey revealed that 44% of respondents attended prenatal classes (data not stratified by parity); this is considerably higher than the 26% of primiparous and multiparous women who attended prenatal classes in Ontario in 2013-2014 (Best Start Resource Centre (BSRC), 2015). BSRC defines prenatal classes as “any prenatal education classes during the current pregnancy, including online education requiring registration or enrolment as well as in-person classes.”

A cohort study of 511 pregnant women in Ontario attending one of seven Public Health prenatal classes revealed a significant increase in mean knowledge scores after finishing classes ( $p < .01$ ) (Godin et al., 2015); demonstrating that prenatal education is an effective strategy to increase parental knowledge (BSRC, 2015). However, rates of prenatal education have been consistently low in the province - less



than 26% since 2008 (see Graph 13) (BSRC, 2015). BORN data (2013-2014) for the indicator “prenatal education” shows that only 46.3% of nulliparous pregnant women in Ontario and 26% of all pregnant women who had a hospital birth attended online or in-person prenatal classes (BSRC, 2015). Consequently, these data demonstrate that prenatal classes are not a guaranteed avenue to share information with all parents.

### Graph 13 Trend in Prenatal Education in Ontario



Source: Best Start Resource Centre, 2015

The Champlain LHIN had the highest prenatal education participation rate in the province at 41.0% and South East LHIN at 23.9% (BSRC, 2015). Some health units have prenatal education participation rates that are almost double that of the province, including Perth (50.3%) and Ottawa (45.9%) (BSRC, 2015). It is important to interpret these results with caution given that women who received prenatal education other than from traditional group prenatal education classes might have indicated that they did not receive any prenatal education. Nonetheless, it is evident that rates of prenatal education vary considerably across our region. This potentially creates disparities as **higher participation in prenatal education** in Ontario tends to be associated with the following demographic groups (BSRC, 2015):

- Nulliparous women
- Young mothers
- Mothers who lived in neighbourhoods with: higher educational levels, higher incomes, lower unemployment rates, lower concentrations of immigrants, and lower concentrations of visible minorities

It is evident that parents spent time learning information during pregnancy but based on the survey findings, it appears that the focus of their preparation is on the labour and birth. Furthermore, how expectant parents learn this information varies greatly. This is consistent with the findings from an online parent survey conducted by the Best Start Resource Centre in 2014. This survey looked at 753 Ontario residents (men and women) who were planning a pregnancy, were currently pregnant or had a baby in the last 2 years. Results demonstrated that women accessed a **variety of sources** when learning about pregnancy, labour and newborn care with the top sources being the following: websites, friends, family and colleagues, health care providers, books, magazines and other printed materials, as well as prenatal education programs (BSRC, 2015). Nearly all women who identified that they accessed these sources found them to be very useful or somewhat useful. However, foreign-born mothers were significantly more likely to consider friends, family and colleagues as their preferred source of information. Health care providers were the source found to be the most trustworthy by women, followed by family, friends and colleagues and then prenatal education programs (BSRC, 2015). These findings are reassuring to health care providers; but are cause for concern based on our survey findings indicating that often HCP are providing out-of-date or contradictory information.

## Preferred Methods of Learning

Analysis of our regional survey identified a discrepancy in the way that parents preferred to learn about maternal and newborn care and how they actually learned. Preferred methods of learning included prenatal or parenting classes, home visits, teaching from health care providers, and learning from other parents (e.g. peer support groups, postnatal parent support groups). According to our survey, the least preferred method was accessing electronic resources. This contrasted with the most frequently reported ways they actually learned information: reading books, looking at websites/blogs/social media, and talking with family/friends that had babies. In 2009, a review was conducted on antenatal education and the findings confirmed women's preference for a small-group learning environment in which they can talk to each other and with the educator and can relate the information discussed to their individual circumstances (Nolan, 2009).

## Importance of Prenatal Parental Preparation for Postnatal Period

It is evident that future efforts should focus on conveying the importance of **prenatal preparation** for the postnatal period. The workgroup identified creating a “push” to expectant parents to emphasize the need to learn this information while still pregnant. *“You don’t know what you don’t know”* was a frequent catchphrase of workgroup members. It has been reported elsewhere that approximately one quarter of parents who didn’t take prenatal classes retrospectively wished that they had. The top reasons for not taking prenatal classes were the belief that the information could be accessed through other sources, a lack of time and a lack of awareness (BSRC, 2015).

## Breastfeeding

Parents who completed the regional survey identified that breastfeeding was the most important topic discussed by health care providers in the hospital. When parents were asked which topic they would have preferred to talk more about, breastfeeding was once again identified, indicating that trouble shooting and managing breastfeeding complications were the topics needing more explanation or information. The workgroup discussed whether it is reasonable to educate all new parents on these advanced breastfeeding topics; especially considering the shortened length of postnatal hospital stays. This paradox may be interpreted as a parental knowledge gap specifically relating to how parents are accessing supportive care in their community in the postnatal period. This highlights the need for hospitals and community service agencies to recommend and direct families to resources and supports in the community to address these learning needs and breastfeeding concerns.

A community-based prenatal breastfeeding education initiative in Ottawa with 282 women demonstrated an 81% increase in parental breastfeeding confidence as well as an 83% increase in knowledge of community resources and intention to use them (Szollos, 2016). Breastfeeding peer support has also been identified as an effective strategy to support breastfeeding mothers and should be explored further (BSRC, 2015; Renfrew, McCormick, Wade, Quinn, & Dowswell, 2012).

## Normal Newborn Behaviour & Care

The findings of our survey indicated that parents reported that information on newborn care such as bathing, diapering, and newborn health and safety (e.g. normal patterns of elimination) were extremely valuable during hospitalization. In addition, parents wished they received more information on normal newborn behaviour (e.g. sleeping and crying). The workgroup discussed at length the difference between learning skills and parenting behaviours. The survey comments demonstrated that new parents are often preoccupied with learning skills relating to the physical care of their newborn, but this must be

considered within the larger context of their transition to parenting. Bonding and connecting with a newborn are very important aspects, which were mentioned by survey respondents to a lesser degree.

In 2012, the CMNRP Family Advisory Committee reviewed available parent resources in the region. Findings indicated that there are significant differences in the information provided to postnatal families across the Champlain and South East LHINs. The Family Advisory Committee's recommendation was to have one standardized provincial resource that contained current evidence-based information that was easy to access for families. The Best Start Resource Centre created a parent resource regarding what to expect in the first three months (2016); one limitation of this resource is its reliance on web-links.

The literature confirms parental lack of preparation. Deave and associates (2008) completed an exploratory survey of 24 women and 20 partners in South West England. Women were recruited at 28 weeks gestational age and interviewed in the third trimester. They were then contacted at three to four months postnatally for a follow-up interview. Knowledge about transition to parenting was poor with a specific knowledge gap regarding parenting and baby care as well as the change in the relationship with their partners (Deave, Johnson, & Ingram, 2008).

The onus should not be on parents, in the first days post-discharge, to find health care information about their own or baby's health. Provision of and access to current information and resources would benefit both families and PCPs. Comprehensive discharge information, ideally generated through a system such as BORN, would be prepopulated during the hospital stay and accessed electronically by all primary HCPs.

## Timing for Learning

The question remains - when is the best time to provide parenting education? In our regional survey, we found that the majority of parents (71.9%) retrospectively felt that the best time to learn about postnatal care was **during pregnancy**. Many new parents identified not remembering the information taught to them following the birth of their baby. Parents are exhausted following labour and birth; this is not an ideal time to learn.

Not surprisingly, the results of the BSRC parent survey (2015) identified that the most common timing to attend prenatal courses was the second or third trimester. BSRC concluded their report with recommendations for reaching future parents. They identified that "prenatal information should be shared through a range of channels including prenatal education classes, websites, health care providers, and printed materials, using consistent evidence-based messages" (p. 32). A limitation of many studies on prenatal education is that the evaluations tend to be conducted after the intervention but before the birth of the baby.

There is likely a direct association between parental knowledge and **readiness for discharge**. We found that one-third of respondents identified that they did not feel ready to go home at the time of discharge, or once home, realized they in fact were not ready. This finding is supported by the literature. A USA study of 131 mothers of healthy singleton or twin infants, born via cesarean or vaginal birth, identified predictors and outcomes of postnatal mothers' perception of their readiness for hospital discharge. It found that mothers who reported low readiness had greater difficulty coping at home (Weiss & Lokken, 2009). The quality of teaching provided to participants in this study was important. If mothers in the study received poor quality discharge teaching they had more urgent/emergent visits for newborn problems (Weiss & Lokken, 2009).

A prospective observational study conducted by Bernstein and associates (2013) of 4300 mother-infant dyads in the US found that length of hospital stay was not “an independent predictor of health care outcomes or utilizations among mothers and their healthy newborns” (p. 36). Rather, readiness for discharge was important. This was defined as “the agreement of the mother, pediatrician, and obstetrician that both the mother and infant were ready to be discharged” (p. 28). The authors reported that 16% of mother-baby dyads were considered “unready” by maternal, pediatrician, and obstetrician ratings. Unready dyads made more calls to HCPs during first 2 weeks post discharge and had more symptom days for both the mother and the baby. Symptoms days were defined as the total number of days with documented maternal concerns (an 8.5% increase) and infant concerns (an 8.7% increase), both of which were statistically significant ( $p < .01$ ). Unready mothers also had lower mean physical and mental health status scores at 4 weeks post discharge. Of note, cesarean delivery was associated with a greater number of calls concerning mental health matters and poorer maternal physical health status score (Bernstein et al., 2013).

## Follow-up Care

**Planning for transition** between the hospital and community is an important aspect of high quality perinatal care. According to Accreditation Canada, involving families in this transition planning is essential to ensure continuity of service: “Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations” (2015, p. 48).

In our survey, 7.3% new parents experienced difficulty in **booking a follow-up appointment** for their newborn. There were many comments regarding the importance of timely follow-up care that is close to home and accessible 24/7, regardless of the provider. Commonly, babies are being seen by a primary care provider in an office, however parents identified multiple barriers to this (e.g. receptionist not allowing parent to book an appointment in 1-2 days as directed by the hospital, and providing instead a 1-week appointment).

Survey respondents identified the need to create or maintain follow-up transition clinics for postnatal maternal and newborn care that are close to home and accessible, regardless of the primary care provider. Respondents highlighted **examples of successful models of follow-up care including:**

- In-hospital follow-up clinics,
- Midwifery care,
- The Monarch Centre in Ottawa.

In hospital follow-up clinics were cited as beneficial from the perspective of the care providers working within those organizations. Midwifery care was repeatedly highlighted as an ideal model due to the capacity for midwives to provide in home support in the early postnatal days. The Monarch Centre was also mentioned as an effective strategy to facilitate the transition home while ensuring necessary follow-up for breastfeeding and bilirubin screenings were completed. A randomized control trial of postnatal support offered at the Monarch Centre showed increased rates of exclusive breastfeeding at 12 weeks (66.1 vs 60.5% in controls) and less emergency room visits as compared to controls (11.4 vs 15.2%; OR = 0.69; 95% CI: 0.39–1.23) (Laliberté et al., 2016). Although the exclusive breastfeeding results were not statistically significant, they are clinically meaningful. Importantly, high parental satisfaction rates in the new interdisciplinary model were noted (OR= 1.96; 95 CI: 3.50-6.88).

The LOS reported by new parents in the survey was similar to the data received from BORN. Any reduction in hospital LOS cannot be safely achieved without first ensuring appropriate community follow-ups are in place.

In Rome, Italy, De Carolis and associates (2014) evaluated the safety of early discharge followed by an individualized follow-up program, and the efficacy in promoting breastfeeding initiation and duration. Infants were eligible for early discharge if they were  $\geq 37$  weeks' gestational age and had a birth weight  $\geq 2,500$ g. There were 1,045 infants who were eligible for early discharge, however only 419 (40.1%) babies were discharged early (defined as the infant being 48-63 hours old after a two-night hospital stay). The follow-up program interventions were dependent on bilirubin levels and degree of weight loss at time of hospital discharge. Following a clearly defined algorithm for discharge, the authors reported that no babies required readmission for hyperbilirubinemia or weight loss in the first 28 days of life. Breastfeeding rates were 90.6%, 75.2%, and 41.5% at 1, 3 and 6 months of life respectively. Parent satisfaction with early discharge was high (90.1%). Follow-up was available for the majority of infants (97.4%), with the remaining 11 families unable to return to the follow-up program. These families were evaluated by a medical home service so there were no gaps in care. Of the infants that received follow-up care, only 10.4% required a second or subsequent visit (De Carolis et al., 2014).

Although one model will not work for all organizations, it is important to ensure that services are available in the evening, on weekends and during the holidays. These gaps, noted by survey respondents, were also found in the literature. O'Donnell et al. (2014) reported that 44% of newborns received a follow-up visit beyond three days of hospital discharge. Newborns discharged on the weekend were four times more likely to have delayed follow-up visit (OR 4.39, CI 3.66, 5.27,  $p < .0001$ ). Having an appointment date and time recorded on the nursery record or first appointment with a home nurse booked before discharge decreases the odds of a delayed follow-up visit.

It is evident that a variety of models for early follow-up exist but there is great variability across the region and follow-up best practices are not always adhered to. The Provincial Council for Maternal & Child Health (PCMCH) Standards of Postnatal Care Expert Panel will be making recommendations regarding timelines for follow-up care which will help to ensure consistency across the region and across providers (PCMCH, 2016).

## Follow-up Care Providers

A current gap is the **identification of the postnatal follow-up care provider during pregnancy**. During the hospital stay, postpartum nurses are often involved in helping families find a health care provider. Nursing time can be better utilized for parent teaching if the follow-up provider had already been identified during pregnancy, having confirmed his/her willingness to accept the baby as a new patient and his/her capacity to schedule an appointment within the recommended timeframe. Parents who have the name and phone number of this provider should book this appointment while in hospital, thereby increasing confidence that appropriate follow-up will take place.

Having the contact information for follow-up care providers is important. Women in Australia who had a care provider's 24-hour contact details were more satisfied with care received (AOR 3.64, 95%CI 3.00-4.42) and felt more confident being discharged home (APR 1.34, 95% CI 1.08-1.65) (Brodribb et al., 2015).

Additionally, it is essential to **consider the family's circumstances when planning follow-up care**. Darling and associates (2016) conducted a study investigating bilirubin follow-up in a cohort of babies

born at 35 weeks gestation or older between 2003 and 2011 in Ontario (n= 711,242), and discharged home within three days. Universal bilirubin screening was associated with an increase in follow-up from 29.9% to 35% (adjusted RR [aRR] = 1.11; p= .047). However, 40% of the increase in follow-up was attributable to the highest socioeconomic quintile and 0% was attributable to the lowest quintile. Therefore, low socioeconomic status is a barrier to obtaining follow-up care. Darling stated “improved coordination of care between hospitals and community care providers is needed so that follow-up appointments in the community are booked before newborns leave the hospital ...having a process in place is necessary to ensure access to a follow-up visit for newborns whose parents have not been able to find a primary care provider for their newborn” (as cited in Offit, 2016).

Some of our survey respondents suggested that parents sign a carbon copy **discharge teaching sheet** upon discharge from the hospital. One copy stays on the hospital chart and the family takes the other copy. There is evidence to support increased parental retention of information when they sign the discharge teaching sheets. When both the nurse and the mother sign the discharge letter, mothers have an increased understanding of the instructions (82%) and ability to recall the discharge instructions (88%) as compared to mothers who did not sign the discharge letter (58%, p = .002 and 73%, p=.022 respectively). The statistical difference was maintained following adjustment for independent variables. This study was conducted with mothers of 219 singleton term newborns (> 37 wks) with a birth weight >2.5kg who had an uneventful neonatal course in hospital.

**Communication between hospitals and community agencies** is currently lacking. The Canadian Medical Protective Association (CMPA) identified keys to effective interprofessional care. Following their review of 135 cases, they found that when medical-legal difficulties arise “they are frequently a consequence of poor coordination of care and inadequate communication brought about by a lack of clarity of roles and responsibilities or due to interprofessional conflict” (CMPA, 2016). The CMPA encourages providers to “consider using a structured communication tool for sharing information during handovers”. Of concern, respondents in the regional survey identified a lack of understanding of the roles of providers, in particular those related to the scope of midwifery practice. The CMPA advises providers to “be familiar with the scope of practice, qualifications, experience, training, and liability protection of other healthcare providers who you know will be involved in the patient’s care” (CMPA, 2016).

Jenkinson, Young and Kruske (2014) conducted a review of current discharge practices in Queensland, Australia in order to identify **mechanisms to minimize fragmentation in care during transition** from hospital-based postnatal care to community-based health care. Upon reviewing survey results of 52 hospitals, the authors found that although many providers used discharge summaries, these were not consistently provided to all follow-up care providers (more likely to be sent to general practitioners versus other follow-up providers) nor were they provided in a timely manner (often 1 week and even up to 6 weeks post-hospitalization or not at all). Only 29% provided a discharge summary on the day of discharge. Additionally, the authors found that information on the baby was lacking (e.g. outcomes of routine screening tests were not universally included) as well as psychosocial information on the mother.

The survey findings echoed the literature reviewed. Regionally, work now needs to focus on taking the themes identified throughout the survey to work on enhancing parental understanding of the importance of preparing for parenting before baby’s arrival. Creating tools and strategies to assist expectant parents in preparing for parenting will be essential. Collaboration between hospitals and community agencies is also essential to ensure optimal access to resources available to new



families. Finally, enhancing consistency in information provided with and across health care agencies will enhance parental confidence in their readiness for discharge.

## Project Limitations

It is important to note that although approximately 200 new parents completed the survey, 19,274 births occurred across the region in the fiscal year 2015-2016; this means that the survey captured the experiences of approximately 1% of the parents of the total births across the region.

Although targeted dissemination strategies were developed to reach diverse populations, sample bias occurred and most respondents were well educated, married and with higher socioeconomic status.

Additionally, new parents completed the survey and retrospectively reflected on the birth that took place up to one year before. Therefore, their ability to recall the information accurately may have been reduced with time. For example, self-reported LOS discharge times were not consistent with the 2015-2016 BORN LOS data. Nonetheless, their input did provide valuable insight into the needs of new parents in the region.

Dissemination of the survey link to front-line perinatal care providers was primarily facilitated by hospital managers, educators or directors. It was also disseminated via the CMNRP weekly news and Twitter. Given that it was distributed during the summer months, many providers may not have had the chance to complete the survey. We were also aware that some sub-regions were reluctant to share or participate in the survey as research ethics board approval had not been obtained.

We attempted to gather more detailed information regarding hospital postnatal discharge practices, but received limited information from regional partner organizations. There is great variability in practices between hospitals and for that reason, we cannot generalize findings and suggest this be explored further.

## Recommendations

Recommendations for consideration from the Postnatal Discharge Experiences Workgroup include:

1.	<b>Raise parental awareness about the importance of building knowledge in the prenatal period.</b> <i>Specifically education about newborn care &amp; maternal self-care, and available community resources post discharge.</i>
2.	<b>Identify <u>prenatally</u> the follow-up care providers for mothers and newborns for the immediate postnatal period and confirm/verify this prior to hospital discharge.</b> <i>Emphasize the need to see the identified care provider as recommended by discharge instructions and/or provincial standards.</i>
3.	<b>Increase <u>prenatal</u> screening of women for Healthy Babies Healthy Children (HBHC) so those with risk are identified early and can be properly supported to plan for parenting.</b>
4.	<b>Ensure 100% of women in the postnatal period are offered the HBHC screen and those who decline are captured as declined.</b>
5.	<b>Enhance health care provider education on infant nutrition best practices, according to the Baby Friendly Initiative, to ensure consistency in recommendations and information being shared with parents.</b>
6.	<b>Support the creation or maintenance of transition clinics for follow-up postnatal maternal and newborn care that are close to home and accessible despite the primary care provider.</b>



## Next Steps

The workgroup suggests that the next steps involve:

1. The development of a *postnatal plan*. This has been proposed to help parents prepare for the transition from hospital to home. CMNRP applied for and received grant money from Women's Xchange to develop such a tool. The creation of an interprofessional regional workgroup is recommended, ideally co-led by a parent representative, with the goal of designing, piloting and evaluating this innovative strategy.
2. Linking the recommendations from this report to CMNRP's Care Mapping Workgroup recommendations. The combined recommendations will be brought forward to the Advisory Committee, Network Council and Communities of Practice to determine feasibility and prioritization of regional initiatives.
3. Continued surveillance of regional hospital length of stay data. Partners have identified that this data is most helpful at an organizational level. Consideration should be given to exploring in more detail various aspects of the data that may be informative to discharge practices (e.g. Robson 1 & 2 and the link to LOS). Furthermore, it will be important to capture emergency department visits and readmission data to explore the safety of reduced postnatal hospital stay in the region.
4. CMNRP regional partners adopt and implement the PCMCH *Standards of Postnatal Care Expert Panel* when released in spring 2017. Given the understanding we now have regarding the strengths and gaps in our current system, we are better prepared to support the implementation of these standards.

## Conclusion

Successful transition after birth cannot start at birth. Expectant parent need to start planning for the arrival of a newborn in the prenatal period and perinatal care providers need to regularly reinforce the need to plan before birth.

As hospitals in our region continue to engage in efforts to decrease their postnatal length of stay, it is imperative that innovative ways to engage parents in planning for their postnatal experience and transition to parenting are created and supported.

Helping new parents to better prepare themselves prior to or during pregnancy is a key point in facilitating postnatal transition. Having a clear understanding of the services available to new parents in any given community and ensuring that parents know what and how to access these services is imperative. Furthermore, all health care providers working in perinatal care should know the range of services available in their community so they can refer families appropriately. The recommendations from this project are actionable and realistic. Working with pregnant women and new parents, we can move forward to help enhance the transition to parenthood.

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# Appendices

## Appendix A - Length of Stay Literature Review Summary



CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM  
PROGRAMME RÉGIONAL DES SOINS À LA MÈRE  
ET AU NOUVEAU-NÉ DE CHAMPLAIN

### POSTPARTUM LENGTH OF STAY Literature Review Summary for CMNRP's Advisory Committee

#### Purpose

1. To determine the current postpartum length of hospital stay (LOS) for low risk mothers and newborns.
2. To define “shortened length of stay”.
3. To examine the impact of early discharge on maternal and newborn outcomes.

#### Historical Background & Clinical Practice Guidelines

The issue of minimum LOS is controversial. In Canada, we have seen an ongoing trend over the past 30 years to decrease the length of postpartum hospital stay as a means to save healthcare dollars. Hospital LOS following an uncomplicated vaginal delivery in Ontario can range from 4 – 48 hours postpartum. In the United States, the Health Protection Act mandates that all women have the right to stay in hospital for up to 48 hours following the birth of their baby to ensure they have received adequate support (Mosen et al., 2002).

The World Health Organization, the Society of Obstetricians and Gynecologists of Canada, the Canadian Paediatric Society, the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists and the National Institute for Health and Care Excellence all focus their position statements around ensuring that both the mother and newborn are physically stable, that newborn feeding is being managed well and that there has been adequate time for education and identification of any maternal or newborn health issues prior to discharge. These organizations emphasize the importance of ensuring that appropriate follow-up has been arranged and is accessible. Ultimately, the timing of discharge should be a collaborative decision between health care providers and the family.

#### Literature Review

The literature reviewed was *inconsistent* in defining a cohort of women and newborns who would be considered eligible for **early discharge**. There was little to no consistency in defining a normal postpartum LOS and as a result, the literature did not clearly identify the timeframe for a shortened LOS. Consistently, the literature reviewed included evaluation of the following variables: neonatal readmission; hyperbilirubinemia and breastfeeding (BF).

**Neonatal readmission rates** varied in the literature. Habib (2013) found that newborns who were discharged early (defined as before 48 hours of life) were significantly more likely to be readmitted than their later discharged counterparts (1.45% vs 0.81%,  $p = 0.017$ ) with an overall readmission rate of 1.3%. Oddie, Hammal, Richmond and Parker (2005) reported that 2.8% of babies were readmitted to hospital. In this study, readmission rates varied significantly by hospital of birth but not by timing of discharge. Babies at greatest risk for readmission included those with a birth weight <2500g (AOR 1.95, 95% CI 1.16 to 3.28) and babies born at or between 35–37 weeks gestation (AOR 1.72, 95% CI 1.15 to 2.57). Mosen et al. (2002) found that neonatal readmission rates were significantly lower within 7 days of life following the introduction of a 48-hour minimum LOS in the US (OR 0.61; 95% CI 0.40, 0.95). Gries (2000) reported no statistical difference in number of readmissions after implementing an early discharge program. The studies reviewed included a variety of care models to provide or enhance follow-up care.

The most common reasons for neonatal readmission following discharge were hyperbilirubinemia (Gries, 2000; Lain 2015; Mosen et al., 2002) and sepsis (Gries, 2000; Habib, 2013; Oddie et al., 2005). Hyperbilirubinemia requiring readmission (in the first 29 days of life) following early discharge ranged from 1.8% (Lain et al., 2015) to 26.5% (Habib, 2013).

Results were mixed regarding the **impact of shortened LOS** on breastfeeding duration and exclusivity. Breastfeeding complications were addressed by Goulet, Fall, D'Amour & Pineault (2007) who found that despite high breastfeeding rates at discharge, women living in rural regions were at significant risk of stopping breastfeeding before their baby was one month of age ( $p = 0.05$ ). This finding was despite the fact that the majority of women (77%) in this study received breastfeeding education during home visits.

In a study **comparing early discharge with home care versus standard in-hospital postpartum care**, Askelsdottier et al. (2013) reported no difference in exclusive BF rates at one month of age; however at 3 months, more women in the control group were exclusively BF (p= .021). It was noted that the intervention group had mothers with lower education levels than the control group in this study. No other differences in sociodemographic variables were noted. Lieu et al. (1998) found no difference in breastfeeding duration following the implementation of a revised model of postpartum service delivery.

**Barriers to and facilitators of early discharge** are largely community dependent although several studies identified the need for education, specifically having enough time to provide education to mothers and families. **Strategies to shorten LOS** included patient education; clearly identified discharge criteria; easy access to follow-up care; scheduled follow-up care prior to discharge from hospital; follow-up telephone calls and/or home visits, and appointments at clinics and Community Health Centres (D'Amour et al., 2003; Gries, 2000; Lieu et al., 1998; Oddie et al., 2005).

### **Regional Initiatives**

Moving forward regionally, awareness, consistency and communication are paramount. Consideration for the varying and varied community services across the region needs to be taken into account. Mothers and families need to be aware of the services that are available to them. A plan to ensure that this information is available, ideally prior to birth, but at the least, prior to discharge should be developed. Evaluation or consideration of the barriers that families may encounter in accessing services needs to be taken into account through the lens of a family-centred care model.

Furthermore, regionally there may be inconsistencies in determining LOS (measurement of LOS from maternal admission or from birth, measured in hours versus a 24-hour day versus overnight sleeps). In order to better track our current LOS in the region, it is recommended that a standardized formula for measuring hospital LOS be utilized.

*“Policies and guidelines for professional practices associated with reducing the length of hospital stays are crucial, but not sufficient. The success of changes related to the ambulatory shift depends on organization’s ability to collaborate and to capitalize on their interdependence. The new division of labour provides a context in which the health professionals depend on each other to optimize the quality of care provided. Among other things, these major changes require competent leadership, and above all, the capacity for bringing together skills which were once isolated. There must now be a system of direct collaboration among professionals, among services and among organizations which used to be independent of each other”* (D'Amour et al., 2003, p. 403).

Please contact Lauren Rivard ([larivard@cmnrc.ca](mailto:larivard@cmnrc.ca)) or Christina Cantin ([ccantin@cmnrc.ca](mailto:ccantin@cmnrc.ca)) for further details and a list of references.

## Appendix B – New Parent Survey



CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM  
PROGRAMME RÉGIONAL DES SOINS À LA MÈRE  
ET AU NOUVEAU-NÉ DE CHAMPLAIN

### Going Home from Hospital after Birth: New Parent Experiences

#### Introduction

Did you have a baby in the last year?

Was your baby born in a hospital in Eastern Ontario?

#### **If yes, this survey is for YOU!!!**

The Champlain Maternal Newborn Regional Program wants to better understand the experiences of families being discharged from the hospital after they have had a baby.

We want to hear about your own experience after your delivery until you returned home with your baby. The results of the survey will help the health care providers and hospitals in your community serve families better.

This survey should take about 15 minutes to complete. Your answers are confidential.  
Your feedback is valuable!

If you have any questions or concerns about this survey, please contact the Champlain Maternal Newborn Regional Program offices at 613-737-2660 ext. 3246 (Ottawa) or 613-549-6666 ext. 4960 (Kingston) or by email at [larivard@cmnrp.ca](mailto:larivard@cmnrp.ca).

Please tell us about yourself:

What are the first three digits of your postal code?

Did you deliver your baby at one of the following hospitals in the region:

- Almonte General Hospital
- Brockville General Hospital
- Cornwall Community Hospital
- Hôpital général de Hawkesbury and District General Hospital
- Hôpital Montfort
- Kingston General Hospital
- The Ottawa Hospital (Civic or General)
- Pembroke Regional Hospital
- Perth & Smiths Falls District Hospital
- Queensway-Carleton Hospital
- Quinte Health Care (Belleville)
- Winchester District Memorial Hospital

- Yes
- No [*skip to termination/thank you page*]

How long ago was your baby born?

- Less than 6 months ago
- 6-12 months ago
- More than a year ago [*skip to termination/thank you page*]

How old are you?

- Less than 20
- 21-25
- 26-35
- 36 years or older

How many children do you have (including your new baby)?

How many people live in your house (including yourself)?

What is your total yearly household income?

- Less than \$25 000
- \$25 000 - \$39 999
- \$40 000 - \$54 999
- \$55 000 - \$69 999
- \$70 000 - \$100 000
- More than \$100 000
- I prefer not to answer

What is your marital status?

- Married
- Living with a partner (common-law)
- Have a partner (Not living together)
- Single
- Separated/divorced/widowed

What language do you speak most often at home?

- English
- French
- Other, please describe:

Please identify any difficulties your family has in getting to health care appointments (select all that apply):

- Not being able to get there (no transportation)
- No childcare for my other children
- Not being able to get time off work
- Other, please describe: (open text)
- My family does not have any difficulties

#### YOUR LAST PREGNANCY AND BIRTH

The health care provider who cared for you the most during your last pregnancy (this may not be the person who delivered your baby) was:

- Family Doctor
- Obstetrician
- Midwife
- Nurse Practitioner
- Other, please describe:

How was your baby born?

- Vaginal birth
- Caesarean birth

You indicated vaginal birth. Were any instruments used to help your baby be born?

- No
- Yes, a vacuum
- Yes, forceps
- Yes, a vacuum and forceps (both)

Did you have any health issues with your pregnancy, labour, birth and/or baby?

- No
- Yes, can you tell us more?

How long did you stay in hospital after your baby was born?

- Less than 6 hours
- 7-12 hours
- 13-24 hours
- 25-36 hours
- 37-48hours
- 49-60 hours
- 61-72 hours
- Other, please tell us how long you stayed in hospital after the birth:

Whose decision was it to go home at this time?

- Mine
- My health care provider(s) (doctor, midwife and/or nurse)
- We decided together (my health care provider(s) and I)

Was your baby discharged home at the same time as you?

- Yes
- No, can you tell us more?

#### GETTING READY TO CARE FOR YOU AND YOUR BABY

During your pregnancy, how much time did you spend learning to care for your baby once you got home?

- I did not spend any time
- I spent very little time learning to care for my baby
- I spent some time but not a lot learning to care for my baby
- I spent a lot of time learning to care for my baby

How did you learn to care for you and your baby after going home from the hospital? (*select all that apply*)

- I have taken care of babies before
- I read books and articles about caring for me and my baby
- I looked at websites/blogs/social media
- I asked my health care provider(s)
- I talked to my family and friends who have kids
- I attended prenatal classes/parenting classes
- I learned about services near where I live
- I called an information line
- I attended a drop-in
- I had a home visit (e.g. public health nurse, home visitor, community worker)
- Other, can you please tell us more:
- I did not look for information

In your opinion, when would be the best time for new parents to learn about how to care for mom and baby after birth?

(*Please choose one*)

- During pregnancy
- During the hospital stay
- After returning home

In your opinion, what would be the best way for new parents to learn information about how to care for mom and baby after

birth? (*Please choose one*)

- Teaching from health care providers
- Prenatal or parenting classes
- Information from other parents (e.g. peer support groups, postnatal parent support group)
- Written information (e.g. pamphlet, handout, booklet)
- Electronic resources (e.g. websites, social media, apps)
- Telephone support
- Drop-ins
- Home visits
- Other, please describe:

## GETTING READY TO GO HOME FROM THE HOSPITAL

Of the topics discussed with you during your hospital stay, which were most valuable to you?

Were there topics not discussed in hospital that would have been helpful to you after you got home?

## GOING HOME WITH YOUR BABY

What does “being ready to go home with your new baby” mean to you?

Did you feel you were ready to go home with your baby when you were discharged?

- I was not ready (please explain):
- I was sort of ready (please explain):
- I thought I was ready, but I got home and realized that I wasn't (please explain):
- I was definitely ready (please explain):

Please share any advice you have to help new parents in the first few days after returning home with their new baby.

When you left the hospital, who were you planning to take your baby to for health care?

- Family Doctor
- Midwife
- Nurse Practitioner
- Pediatrician
- I didn't have a health care provider for my baby. Please tell us more:

Were you told to have a follow-up appointment for your baby (with a doctor, nurse or midwife)?

- Yes, within 1-2 days of going home
- Yes, within 2-3 days of going home
- Yes, within 1 week of going home
- Other, please tell us more:
- No, I was not told about a follow-up appointment for my baby [*skip next question*]

Were you able to get this appointment?

- Yes
- No, please tell us more:

Was your hospital health care provider worried about anything in particular about your baby that needed follow-up in a specific time frame (beyond normal newborn follow-up, for example follow-up testing for jaundice or breastfeeding support)?

- No
- Yes, please tell us more:

Were you able to attend a follow-up appointment for your baby?

- Yes
- No

## TAKING CARE OF THE MOTHER/BIRTH PARENT FOLLOWING BIRTH AND DISCHARGE

When were you told to have a follow-up appointment for yourself?

- Within 2-4 days of going home
- Within 4-5 days of going home
- Within 1 week of going home
- At about 6 weeks after giving birth
- Other, please tell us more:
- I was not told about a follow-up appointment [*skip next question*]

Were you able to get this appointment?

- Yes
- No, please tell us more:



Were you able to attend a follow-up appointment?

- Yes
- No, please tell us more:

#### SERVICES AND PROGRAMS FOR NEW FAMILIES

During your pregnancy, did someone tell you about community services or programs that were available to you after discharge?

- Yes
- No

In the hospital, did someone tell you about community services or programs that were available to you after discharge?

- Yes
- No

Since your return home from the hospital, have you looked at the information package you were given in the hospital?

- Yes
- No, can you tell us why:
- I don't remember getting an information package

Would you be interested in participating in a focus group to discuss your experience of being discharged home from hospital after birth?

- No
- Yes

## Appendix C - Perinatal Care Provider Survey



CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM  
PROGRAMME RÉGIONAL DES SOINS À LA MÈRE  
ET AU NOUVEAU-NÉ DE CHAMPLAIN

### Postnatal Discharge: Survey of Health Care Providers

#### Introduction

The Champlain Maternal Newborn Regional Program is exploring transition of families along the maternal newborn continuum of care.

The purpose of this survey is to explore the experiences of health care providers who are currently (within the last 12 months) directly involved in the process of postnatal discharge from hospitals in Eastern Ontario (Ottawa/Champlain region - LHIN 11 - and Kingston/South East region – LHIN 10). The goal is to identify strengths, gaps and opportunities for improvement to streamline maternal newborn hospital discharge.

Your feedback is valuable to help our regional network understand how the current discharge processes can be enhanced to support health care providers and better serve families.

The survey will take approximately 15 minutes to complete. All answers will be confidential.

If you have any questions or concerns about this survey, please contact the Champlain Maternal Newborn Regional Program offices at 613-737-2660 ext. 3246 (Ottawa) or 613-549-6666 ext. 4960 (Kingston) or by email at [larivard@cmnnp.ca](mailto:larivard@cmnnp.ca).

Have you been directly involved in discharging postnatal families from the hospital in the last 12 months?

- Yes
- No [skip to terminate/thank you page]

Do you work at one or more health care organizations in the Ottawa/Champlain region (LHIN 11) or Kingston/South East region (LHIN 10)?

- Yes
- No [skip to terminate/thank you page]

Please identify the type of organization in which you work the majority of time:

- Hospital
- Public Health Unit
- Clinic or Community Practice

Please identify your role:

- Hospital Nurse (labour & birth, postnatal, lactation consultant)
- Public Health Nurse (HBHC)
- Nurse Educator, Advanced Practice Nurse (NP, CNS)
- Hospital Administrative Leader (Clinical Director, Manager)
- Obstetrician
- Pediatrician/Neonatologist
- Family Physician
- Registered Midwife
- Social Worker
- Other, please specify:

Accreditation Canada defines "Transition in care" as:

*A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care provider or location (within, between, or across settings).*

When considering current maternal-newborn hospital discharge processes in your organization, please answer the following questions:

In your opinion, on admission to hospital, are parents aware of the early follow-up care required for their newborn?

- Always
- Most of the time
- Sometimes
- Rarely
- Never
- Don't know
- Not Applicable

Do you personally confirm with parents prior to discharge that a newborn follow-up appointment has been booked?

- Always
- Most of the time
- Sometimes
- Rarely
- Never
- Not Applicable

How familiar are you with community services and programs for new parents in your area?

- I am aware of many
- I am aware of some
- I am not aware of any

From your perspective, what is working well in the current process of maternal-newborn discharge?

What do you think are the top 3 barriers/gaps to seamless transition in care from hospital to community following birth?

How can the hospital discharge process be improved?

Can you identify 2-3 strategies (current or new/innovative) that may help to enhance seamless transition in care?

Would you like to make any other comments or suggestions regarding postnatal hospital discharge?

Would you be interested in participating in a focus group to discuss this topic further?

- Yes
- No

## Appendix D - Advice from New Parents to Other New Parents

In the parent survey, an open-text comment field was available for parents to provide the advice they wanted to share with other new parents. Below is a summary of the themes as well as selected quotes.

❖ **Take time for self-care** was the most common topic identified by parents, with comments focusing on sleeping/resting, eating and drinking.

❖ **Foster a nurturing relationship with baby.** Parents provided advice about the importance of taking the time to foster a nurturing relationship with the baby including spending time skin-to-skin, and holding baby close.

❖ **Establish social supports** while at the same time managing/limiting visitors and not worrying about housework.

*“Don't worry if you have no clue what you are doing. Many people don't. Don't be afraid to ask a friend, family member, or even an online support group. They are great, especially in the middle of the night”*

*“No visitors unless it is someone you can see in your PJs. Have them hold the baby while you nap or shower. Get them to vacuum, unload the dishwasher etc. Tell everyone else they can visit and meet the baby once she/he is a month old (or 6 weeks). You need rest and NOT pressure to clean, visit and host”*

❖ **Find help needed and accept help offered.** In fact 24 respondents identified accepting help as the most important advice they would offer other new parents. *“Accept as much help as you can. There is no shame in needing it”*

*“There's always someone who can help. If you are feeling in over your head- call and ask someone for help”*

*“Ask for help, mothers, family, friends, spouse, partner, don't try to do it all on your own, and use any resource available to you, public health drop ins, support groups to help you connect with other new moms”*

*“Be easy on yourself, accept all help offered”*

*“Don't wait to get help. Call a lactation consultant or La Leche League helpline right away for answers to all your questions (you will have a lot). Call an expert”*

*“Accept any offer of help! Give yourself time to get to know the baby's routine, don't be too hard on yourself”*

*“Take it easy. Spend time bonding with your baby. Don't be afraid to ask for help”*

❖ **Enjoy the moments.** Parent also advised to *“Relax! Enjoy the moments more than anything”* and *“Most of all, enjoy being a parent!”*

❖ **Have realistic expectations**

*“It is tough! But it gets better. The first few days and weeks are rough”*

*“People say you'll know your baby's cries and know what they'll need, but it's not instant and sometimes you just don't know!”*

*“All babies are different. It's ok to have questions & utilize the resources around you”*

*“Expect it to be the toughest 5 days of your life. There will be times when you question if it was all worth it. But this period doesn't last and you'll get past it. Try not to have unrealistically high expectations for yourself; just do the best you can and ask for help when you find it getting to be too much.”*