

Healthy Babies, Healthy Families:

Postpartum & Postnatal Guidelines

A report prepared by the Reproductive Care Program of Nova Scotia



**REPORT OF THE POSTPARTUM/POSTNATAL
SERVICES REVIEW WORKING GROUP**

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EXECUTIVE SUMMARY

In January 2002, the Department of Health, Public Health/Health Promotion, asked the Reproductive Care Program of Nova Scotia (RCP) to:

“Develop ...Department of Health minimum acceptable standards for initial postpartum contact (0-6 weeks) in Nova Scotia”

RCP established a Postpartum Services Review Working Group with representation from hospital and community nursing, nursing education, family practice, public health, obstetrics and pediatrics to assist them with this important task. This report represents the findings of the Postpartum Services Review Working Group and recommends a series of guidelines intended to ensure that postpartum/postnatal services are provided in an informed and consistent way across Nova Scotia.

Between March and November 2002, the Working Group met seven times and completed a scan of the literature; reviewed postpartum practices in a number of other Canadian and international jurisdictions; reviewed relevant statistics and current service delivery approaches in Nova Scotia; and derived a set of recommended guidelines to support the delivery of quality postpartum/postnatal care to mothers and babies in Nova Scotia. The proposed guidelines address a number of the issues relating to physiologic stability of mother and baby; infant feeding/nutrition and growth monitoring; psychosocial/family adjustment; parent-child attachment and parenting; building on capacities and strengths; transition to home and community; family access to community support; healthy lifestyles and environments; collaborative practice; and professional competency. Developing an implementation plan for these guidelines will require a multi-disciplinary approach and cross-sectoral collaboration. The report was approved by the Action Group of the Reproductive Care Program of Nova Scotia on December 5, 2002 and by the Program Delivery Group of the Department of Health on December 18, 2002.

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1. INTRODUCTION

As signatories to the September 2000 First Minister's Communiqué on Early Childhood Development, Nova Scotia made an agreement with the Government of Canada to invest in an early childhood development strategy. Three priority areas for investment in early childhood were identified:

- Establish a comprehensive home visiting program (led by Department of Health)
- Stabilize and enhance the current childcare system (led by Department of Community Services)
- Develop a coordinated system of early childhood development (led by Department of Community Services).

Public Health/Health Promotion, which is part of the Department of Health's Integrated Population and Primary Health Division, is the lead organization for the enhanced home visiting program called 'Healthy Beginnings'. A Provincial Steering Committee was formed in September 2001 to provide leadership and support for the development, implementation and evaluation of the Healthy Beginnings:

Enhanced Home Visiting Initiative. Early in their work members of the Steering Committee identified the need for development of a standardized approach to postpartum, post-discharge care. In January 2002, the Department of Health, Public Health/Health Promotion, asked the Reproductive Care Program of Nova Scotia (RCP) to:

“Develop...Department of Health minimum acceptable standards for initial postpartum contact (0-6 weeks) in Nova Scotia” using an approach based on (a) a review of the literature, (b) identification of current practice in Nova Scotia and (c) a scan of the provinces/territories. The review of the literature should also include information about the 6 weeks to 6 months period, where this is available. Following this, a draft “Department of Health minimum standards for initial postpartum contact 0-6 weeks in Nova Scotia, acknowledging realistic resource capacity” should be developed. (Terms of Reference - Attachment 1)

2. APPROACH

In response to the request from the Department of Health, Public Health Services, the Reproductive Care Program of Nova Scotia established a Working Group to assist with the task of developing acceptable standards. The Working Group had representation from hospital and community nursing, nursing education, obstetrics, pediatrics, family practice and public health.

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The Group's first tasks were to define two of the key concepts of its mandate, namely 'postpartum' and 'standard'. According to the literature, these terms have a variety of meanings and definitions.

'Postpartum' lacks a specific, recognized definition and can mean a time period that extends between six weeks to one year following the birth of a baby.¹ Based on the terms of reference for the project, the Working Group chose to focus on concerns from zero to six weeks after birth, recognizing that pregnancy and birth-related issues extend well beyond that time frame.

Similarly, the meaning of the word "standard" varies widely, depending on its context and intended use. Professional practice depends heavily on experience and clinical judgement, as well as the needs of the individual patient/client. Given the relative inflexibility implied by the application of specific standards, RCP's past approach has been to develop guidelines for adoption and adaptation by health care professionals. Therefore, the Working Group considered that developing guidelines would provide health professionals and the District Health Authorities with sufficient guidance but enough flexibility to develop approaches and programs to address the unique needs of women, infants, their families, and communities.

The Working Group then:

- **completed a scan** of the **literature**,
- **reviewed practices** in other Canadian provinces, the United States, the United Kingdom and New Zealand,
- arranged for a representative to attend a **Postpartum Consensus Symposium** in British Columbia, hosted by the B.C. Reproductive Care Program, on May 31 to June 1, 2002,
- **reviewed relevant maternal/newborn statistical information** in Nova Scotia, and
- **compiled an overview of service delivery approaches in Nova Scotia.**

The Working Group met seven times over a nine month period. The Group completed much of its work and background research by electronic means of communication, to maximize the use of professionals' valuable time. In addition to the full committee meetings, several Working Group members agreed to draft or revise particular sections of the guidelines for review and approval by the Working Group as a whole. Guideline 2, 'Infant feeding/nutrition and growth monitoring', was developed by the Provincial Baby-Friendly Initiative (BFI) Committee. This group was able to provide expertise regarding the clinical content of the guideline

1. AWHONN & Johnson & Johnson Consumer Products, Inc., *Compendium of Postpartum Care*.
M. Myles, *Textbook for Midwives*.
Stedman's Medical Dictionary 25th Edition.

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as well as ensure consistency of the recommendations with the developing provincial breastfeeding and baby-friendly policies.

2.1 Literature Scan

The purpose of the literature scan was to provide a 'broad-brush' overview of some of the key issues related to postpartum care and to provide a context for the following specific topics identified in the Postpartum Service Review Working Group's terms of reference:

- discharge criteria used to plan for transition to the community
- timing of the initial postpartum contact related to length of stay
- criteria for ongoing follow-up of families in the first six weeks
- program activities (education, assessment, anticipatory guidance) conducted during home visits
- capacity-building approaches to work with new families - building on what families already know and what they feel they need to learn
- identification of key health issues (mother, infant) in the first six weeks
- existing and related policies identified in the literature for public health, obstetrics, pediatrics, etc.

The strategy for the scan was thorough in approach, although not strictly a comprehensive literature search in the academic sense. The initial scan began with a search through the Medline database, via the Dalhousie University on-line system, and involved the following combinations of terms: postnatal care **AND**

- standards
- hospitalization
- patient discharge

The resulting articles were limited to those published in English and a scan of abstracts identified those that appeared most relevant to the Working Group's task. Although the search elicited a number of articles from nursing and midwifery journals, the major proportion of the literature articles were medical in focus. The on-line literature search was supplemented by a variety of other sources such as journal references, bibliographies, information supplied by committee members and other researchers, and existing professional practice guidelines. The search was further strengthened by an exchange of bibliographic information between RCP of Nova Scotia and their colleagues in the British Columbia Reproductive Care Program, who were researching the same issues.

The literature identified the following key trends affecting postpartum care in recent years (Literature Scan with Bibliography - Attachment 2):

- shorter postpartum lengths of stay

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- shift of early postpartum care to the home setting
- variety of care providers and services
- need for emphasis on 'appropriate' versus 'early' discharge
- limited amount of research on the postpartum period

The review also revealed that:

- Postpartum care is an under-researched and largely ignored period of maternal and infant care.
- The literature on postpartum care tends to present issues from the perspective of specific health care professions (e.g. the challenges for, or the role of, the postpartum nurse or the family physician) rather than focusing on system-wide issues.
- Other developed countries (such as the United States, United Kingdom, New Zealand and Australia) are also struggling with:
 - the lack of reliable, definitive information based on rigorous research, about the exact nature, scope and effectiveness of postpartum care being provided, and
 - lack of a clear definition of patients' needs during this time.
- In many countries, postpartum care after discharge from hospital is the responsibility of midwives. For example, in the United Kingdom, midwives currently have a statutory obligation to attend women for a minimum of 10 days, up to a maximum of 28 days after delivery. In New Zealand, the Handbook of Practice for midwives requires that the midwife conduct an assessment every 24-48 hours postpartum until the woman feels confident in her home environment.²
- Reduced lengths of hospital stay for childbirth in recent years have resulted in limited in-hospital opportunities for patient/client education and support. Women no longer remain in hospital "until their milk comes in" and they are "rested". These changes have shifted the responsibility of ensuring that breastfeeding is well established and that the mother has received all of the early postpartum care and support she needs from hospital staff to community-based care providers, family members and community programs. The future implications of these changes require close monitoring to ensure that past gains in maternal and infant health outcomes are not eroded or

² D. Bick, C. MacArthur, H. Knowles, H. Winter, *Postnatal Care: Evidence and Guidelines for Management*, page xv.
Midwives Handbook for Practice 2000

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reversed.

- The focus of postpartum care has traditionally centred on adverse medical events which, due to advances in maternal and child care, are today increasingly rare occurrences.
- Issues relating to mental health, parenting adjustment and social isolation are becoming increasingly important in the postpartum period.
- At the systems level, health providers are facing a marked shift away from a focus primarily on medical/clinical care and the accompanying emphasis on adverse events, towards a more community-based approach to care. However, models of care that are based on the philosophies of 'primary care' and 'population health' are still developing compared to established hospital-based models for delivery of care. Both the medical and the population-based approaches are equally important but the transition between the two is not always smooth. The challenge for postpartum care lies in bridging these two realities.

2.2 Canadian Perspective

A cross-country survey of selected key informants in other Canadian provinces showed that all provinces are struggling with the same issues relating to postpartum/postnatal care. No province has a single, consistent, standardized, province-wide approach to the delivery of postpartum/postnatal care. There is a wide variation between, districts, regions, and provinces, as well as variation within these geographic areas.

The province of British Columbia is facing the same challenge as Nova Scotia. To begin the work of developing consistent approaches to postpartum care in their province, the British Columbia Reproductive Care Program hosted an intra-provincial Consensus Symposium in Vancouver from May 31 to June 1, 2002. The background information and the work of the two-day symposium proved extremely useful to the Nova Scotia Working Group's subsequent discussions (Shared Bibliography: British Columbia Reproductive Care Program and Reproductive Care Program of Nova Scotia - Attachment 3).

There are two key Canadian documents on postpartum care: a system-focused set of guidelines issued by Health Canada, and an early postpartum discharge policy/guideline developed by The Society Of Obstetricians and Gynaecologists of Canada/Canadian Pediatric Society (SOGC/CPS). The document "Family-Centred Maternity and Newborn Care. National Guidelines" (Health Canada, 2000), was produced by 70 individuals and consumers through a lengthy and exhaustive, three-stage process in collaboration with many leading Canadian medical, nursing and

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health-related organizations. The purpose of these National Guidelines is "to assist hospitals and other health care agencies in planning, implementing and evaluating maternal and newborn programs and services".

The National Guidelines reflect a systems perspective, bringing together community and institutions in one seamless system, and address consumer and family participation in health care, i.e. 'Family-centred care'. The National Guidelines are designed for policy-makers, health care professionals (physicians, nurses, midwives), parents, and program planners. While not clinical practice guidelines, the National Guidelines address a wide range of topics and refer to, and abstract from, clinical practice guidelines throughout the document. ("Family-Centred Maternity and Newborn Care. National Guidelines" can be downloaded from the Health Canada web site: <http://www.hc-sc.gc.ca/english/index.html>.)

The SOGC/CPS policy statement on "Early Discharge and Length of Stay for Term Birth" provides clinical direction for postpartum/postnatal programs across the country (SOGC/CPS policy statement on "Early Discharge and Length of Stay for Term Birth" - Attachment 4). For those mothers and infants discharged from hospital before 48 hours post-delivery, SOGC/CPS recommends at least one in-home follow-up visit by a health care professional with maternal-child training and experience, within 48 hours of discharge. This recommendation applies to all mothers and infants who are discharged in this time frame, including those who would require a home visit on the weekend. In the absence of these requirements, the document recommends that "mothers should be offered the opportunity to stay in hospital with their baby for a minimum of 48 hours after a normal vaginal birth".

This document is recognized as the 'professional standard' for early discharge in Canada. The SOGC/CPS recommendations have been endorsed and adopted by a number of programs and organizations, including the Manitoba College of Physicians and Surgeons and the Child Health Work Group of the Ontario Public Health Association. The SOGC/CPS policy statement was formally endorsed by the Reproductive Care Program of Nova Scotia in 1997. However, a recent study in Nova Scotia showed that the "SOGC/CPS guidelines for physician follow-up after early neonatal discharge and for anticipatory guidance (were) not being followed consistently" and that "the guidelines were disseminated without reinforcement".³

³. L.K. Purcell, T.J.T. Kennedy, K.A. Jangaard, Early neonatal discharge guidelines: Have we dropped the ball? *Paediatric and Child Health*. 2001; 6: 769-772.

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3. POSTPARTUM CARE IN NOVA SCOTIA

3.1 Context for care

In recent years, maternity and postpartum/postnatal care in Nova Scotia have occurred within the larger health system context of rapid change and multiple challenges, such as ongoing health reforms, constant changes in the provincial organization of health care, severe fiscal restraint, constrained resources, demands for cost containment and a significant reduction in the availability of hospital beds.

In Nova Scotia, labour and birth take place almost exclusively in a health care facility providing maternity services. In 2002, 12 hospitals in the province offer maternity services. However, between 1990 and 2001, 16 community hospitals in Nova Scotia eliminated their maternity services or closed entirely. It has been suggested to RCP that in some areas local care providers have lost interest and confidence in providing pregnancy and early infant care. As a result there are now several Nova Scotian communities where there is either limited, or no, access to local prenatal and postpartum/postnatal care provided by physicians.

3.2 Postpartum/Postnatal Services in Nova Scotia

Virtually all births in the province take place in a hospital setting attended by a physician and hospital nurses. Between 1988 and 2000, there was a 58% reduction in the number of family physicians attending deliveries. Shortages of physicians and nurses in many communities and practice choices among professionals have resulted in increasing pressure on those working in the maternal-newborn field. There is also concern that families' difficulties with access to maternity and newborn care have not been adequately quantified.

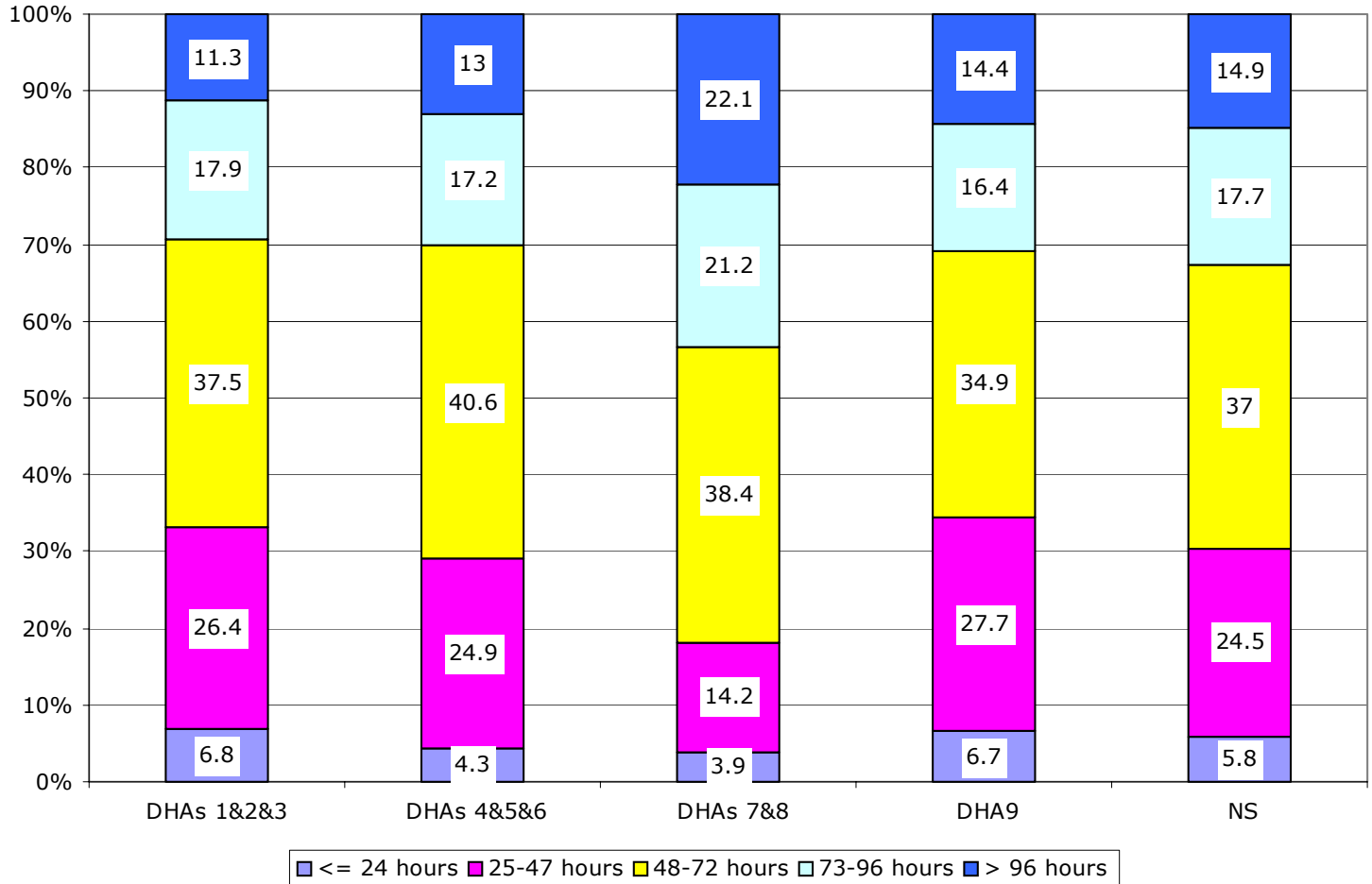
Care and support for mothers and babies in the immediate postpartum/postnatal period is provided by hospital staff. The hospital stay for mothers and babies is brief, with almost 1/3 discharged at < 48 hours and more than 2/3 (67.3%) discharged on or before 3 days postpartum (70% discharged at < 73 hours in most areas of the province, see Figure 1).⁴

Following hospital-based postpartum/postnatal care, women and their infants receive community-based postpartum/postnatal care mainly through family practitioners, Public Health Services, hospital-based clinics in some areas and, for eligible women in the Capital District Health Authority, the "Mother and Baby Leave Early" (MABLE) Program (Map of the District Health Authorities - Attachment 5).

4. Nova Scotia Atlee Perinatal Database, 2000.

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**Figure 1
Postpartum Length of Stay by Shared Service Area (2000)**



3.2.1. Family Physician Postpartum/Postnatal Services

Family physicians provide the majority of 'well infant' medical care in Nova Scotia and a large proportion of the 'well woman' medical care in the first six weeks postpartum. This care includes at least daily visits during postpartum hospitalization, a comprehensive newborn physical exam to rule out congenital anomalies and to assess the need for ongoing care, and maternal assessments that include psychosocial adjustment as well as monitoring for physical problems related to breastfeeding, perineal healing and uterine involution. These assessments form the basis for decisions about readiness for discharge from hospital.

After discharge, women see their primary care physician within one to two weeks in

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most areas of the province. This contact provides an opportunity to assess the mother's and the baby's physical and emotional condition, with particular attention to newborn feeding and growth patterns and maternal/family adjustment to the new baby. If infant or maternal health concerns arise outside office hours, families will likely seek assessment and care at the closest Emergency Room or Outpatient Department. Some physicians have practice arrangements that include evening and weekend availability but this varies considerably across the province.

At six weeks postpartum, women are seen to assess physical recovery from pregnancy and birth and on-going psychosocial/emotional adjustment. This contact also provides an opportunity for cervical screening (Pap smear) and reinforcement of issues related to resumption of intercourse and birth control. If any infant health concerns are identified, they will be addressed at this appointment. However, many family physicians provide infant immunizations in their offices so they will see babies at two, four, six, twelve and eighteen months to immunize them and to assess growth and development. (Note: Immunizations are provided by public health nurses in some parts of the province.)

Although the timing of the usual postpartum/postnatal physician assessments is fairly consistent, the availability of maternity care varies across the province. Hospital-based maternity care in Nova Scotia is now offered mostly in regional and tertiary centres and the number of family physicians who attend deliveries has decreased. Many physicians share care with, or refer maternity care to, one of their colleagues in their own or a different community. Therefore, the physician who provides prenatal care and attends labour and birth may not be the one who provides ongoing care for the family.

The provincial medical reimbursement system for maternity care has specific parameters for prenatal, delivery and postpartum/postnatal care. The current fee structure allows for one 'well infant' visit. Therefore, any physician contact between the well baby visit at one to two weeks of age and the first infant immunization at two months of age is problem-based.

3.2.2. Public Health Services

Public Health Services across Nova Scotia are offered through four Shared Service Areas that consist of District Health Authorities 1-3, District Health Authorities 4-6, District Health Authorities 7-8, and District Health Authority 9. Using a population health/health promotion approach, Public Health Services provides postpartum/postnatal services for all families across Nova Scotia. Although a slight variation exists across the province, postpartum/postnatal practice is guided by Public Health targets and standards as outlined in the Nova Scotia Health Standards 1997 (Excerpts from the Nova Scotia Health Standards - Attachment 6). New families are contacted by telephone and/or home visit. Criteria for offering families a

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home visit, and responding to requests for home visits in the early postpartum period, include breastfeeding challenges, parenting concerns, postpartum adjustment, etc. Families can also be referred for home visiting by hospital staff, the family physician or self-referral. In Districts 7 and 8, Public Health Services offers every new family a home visit following hospital discharge. Families not receiving home visits are contacted by telephone for support, health assessment, health education and to facilitate linkage to community resources. If a concern is identified through the telephone contact, a home visit is offered. Due to fiscal and human resources constraints, the ability to provide support via home visits is usually limited to the first six weeks. There is limited weekend phone coverage by public health nurses in Nova Scotia, through the breastfeeding support line in Capital District Health Authority.

In partnership with the Department of Community Services, Public Health Services offers the Healthy Baby Program. This initiative contributes toward enabling pregnant and new mothers, who are recipients of Provincial Income Assistance, achieve a healthy birth outcome through the provision of a nutritional allowance and counseling services. Beginning in the prenatal period, the program continues until three months postnatal age.

Public Health Services throughout Nova Scotia offers many opportunities for new families to link with their staff through avenues such as, telephone support lines, well baby clinics, breastfeeding and parenting support groups, etc. Public Health Services embraces a community development and capacity building model and works in partnership with many community agencies and groups. Resources such as Canada Prenatal Nutrition Programs (CPNP) and Family Resource Centres offer many supports to new families including home visiting.

During the 2002-2003 fiscal year, Public Health Services will begin a phased-in implementation of the 'Healthy Beginnings: Enhanced Home Visiting Initiative'. Under this program, a standardized screening and assessment process will identify families who may potentially benefit from additional support. Many circumstances including age, geographic isolation, limited education, no family or community support, low income, etc., may place an additional burden on families during the early weeks, months and years of their new baby's life. This additional burden has been shown to have an impact on parents' confidence, parenting skills and parents' ability to support their child's optimal health and development. These families will be offered enhanced home visiting by public health staff and lay home visitors for the first three years of their child's life.

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3.2.3. Postpartum Clinics

Seven of the twelve facilities with active maternity services offer breastfeeding support and consultation through an on-site breastfeeding/postpartum clinic, usually located on or near the maternity unit. The majority of these clinics are open Monday to Friday during 'day-time' hours and are staffed by a lactation consultant. Two of these clinics provide all breastfeeding women and their infants with an appointment to return within 48 hours of discharge.

Women looking for 'after-hours' consultation regarding a self-care or infant care issue or a breastfeeding problem often call or visit the maternity unit or the hospital emergency/outpatient department.

3.2.4. Mother and Baby Leave Early (MABLE) Program

The MABLE Program is offered to healthy mothers and babies who are discharged from the IWK Health Centre prior to 48 hours following vaginal birth, or 72 hours following cesarean section. The woman must reside within a specified geographical location - generally defined as being within a 30 minute drive of the IWK Health Centre. The Program is also available to women who have had babies with special care needs (e.g. infants admitted to the Special Care Nursery), women who have placed their children for adoption and those who have had stillbirths. Nursing assessments and family wishes are often instrumental in initiating admission to the Program. When all the criteria apply, admission to the Program remains voluntary. The initial contact is made by telephone within 24 hours of discharge from the IWK and a visit time is arranged, based on identified need.

Since November 2001, a nurse does not automatically visit all women who enter the MABLE Program. All mothers are still contacted by telephone but, if a visit is deemed unnecessary, women are made aware of the services available through Public Health Services and the IWK Health Centre's Mother and Baby Clinic. The Mother and Baby Clinic is open to all women who give birth at the IWK Health Centre, regardless of whether they were enrolled in the MABLE Program. This clinic is open seven days a week from 11:00 am to 6:00 pm, operating on both scheduled and 'drop-in' appointments.

4. WORKING GROUP ASSUMPTIONS

The Working Group reviewed the information available to them and suggested a series of guidelines to enhance and support the provision of quality care to Nova Scotian women, their babies and their families in the immediate (six weeks) postpartum period. The Group viewed postpartum care as one stage within the larger continuum of maternal/child care which, in common with all health programs,

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should have clearly articulated goals and objectives.

In the absence of a pre-existing, over-arching goal statement for provincial maternal/child care, the Working Group suggested that the goal of postpartum and postnatal services might be:

" to achieve optimal newborn and maternal health in the short-term and the long-term, and to ensure the physical, emotional and social well-being of the mother and baby."⁵

This would then support the goals of the 'Healthy Beginnings: Enhanced Home Visiting Initiative' which are to:

- 1. Promote the optimal level of physical, cognitive, emotional and social development of all children in Nova Scotia***
- 2. Enhance the capacity of parents to support healthy child development***
- 3. Enhance the capacity of communities to support healthy child development***
- 4. Contribute to a coordinated, effective system of child development services and supports for children and their families.***

In developing their guidelines, the Working Group made the following assumptions:

1. Guidelines should not over-ride the exercise of professional judgment by the health care provider.
2. Given the constantly evolving nature of evidence and changing practice recommendations, these guidelines must regularly be re-visited, reviewed, revised and updated to integrate new evidence.
3. Postpartum care should be redirected away from those activities with little evidence of benefit e.g . the routine practice of taking maternal vital signs after the period of stability has been achieved, towards activities that improve maternal outcome. As new evidence becomes available, practice should be modified appropriately.
4. While there must be a reasonable balance between expectations and resources, the development of clinical standards/guidelines for patient/client care should not be dictated by the availability of resources.
5. Postpartum/postnatal contact/support/assessment services must be available

⁵. *British Columbia Reproductive Care Program Consensus Symposium on the Provision of Postpartum Services in British Columbia. 2002.*

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- seven days a week, from a variety of sources and use a number of strategies such as home visits, discharge clinics, hospitals, telephone contact, parent help-lines, etc. The approach and type of support should be based on the assessed need, as identified by the parent and the health professional, and the services available in their area.
6. Health professionals should maintain a family-centred approach to the care of the woman, her baby and her family, rather than simply comply with a list of requirements for care.
 7. Postpartum care in Nova Scotia should build on, or adapt, those assessment tools currently in use which have demonstrated their utility. Where necessary, new tools or assessment processes should be introduced. These could include a care plan/care path/mother-infant passport, a feeding assessment tool or format, a prenatal psychosocial assessment tool, and a postpartum depression screening tool or process.
 8. The following recommended guidelines are targeted to generally healthy women and infants. For those women or infants who have experienced significant intrapartum or postpartum/postnatal complications, many of the recommendations may be relevant once physiological stability of the mother and/or baby has been achieved. In those instances where a greater level of care in hospital is required, an appropriate and timely referral should be made for a home visit after discharge.
 9. Developing an implementation plan for these guidelines will require a multi-disciplinary approach and cross-sectoral collaboration.

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5. RECOMMENDED GUIDELINES

The Working Group used the following categories for grouping their recommended guidelines - ***Physiologic stability (mother, baby); Infant feeding/nutrition and growth monitoring; Psychosocial/family adjustment; Parent-child attachment/parenting; Building on capacities and strengths; Transition to home and community; Family access to community support; Healthy lifestyles and environments; Professional competency; and Collaborative practice.***

1. Physiologic stability

Successful feeding, parent-child attachment, psychosocial adjustment, and successful transition from hospital to home and community are enhanced by a mother and baby who are physiologically stable.

Maternal and newborn assessments should take place at specified times and these assessments documented (Examples of a Care Plans/Care Paths - Attachment 7). Follow-up will be individualized, based on these assessments.

1.1 The stability of both mother and baby needs to be established. "The immediate postpartum period is a time of significant physiological adaptation for both the mother and baby. Women experience significant physical adjustment..; involving all of their body systems, they require a significant expenditure of energy. The adjustments include losses in circulating blood volume, diaphoresis, weight loss and the displacement of internal organs." ⁶ Assessment of maternal stability includes the following:

- vital signs
- uterine tone
- lochia
- fundal height
- condition of perineum
- bladder function
- breasts and nipples
- bowel function
- physical comfort.

"The baby's respiratory, cardiovascular, thermoregulatory and immunological systems undergo significant physiologic changes and adaptations during the transition from fetal to neonatal life. Successful transition requires a complex

⁶. Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*, Chapter 6.

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interaction between those systems.”⁷ To ensure that they are safely cared for following delivery and the transfer to self-care, newborn infants should, in the clinical judgement of the physician, be healthy and the mother should demonstrate an appropriate ability to care for her newborn. Assessment of newborn stability includes the following:

- normal respiratory pattern with no evidence of distress i.e. grunting or in-drawing
 - temperature (axillary temperature of 36.5C to 37.5C)
 - heart rate (120-160 beats per minute) and perfusion
 - colour (no evidence of significant jaundice or cyanosis)
 - physical examination that reveals no significant abnormalities
 - suckling/rooting efforts and evidence of readiness to feed.
- 1.2 A comprehensive global newborn physical assessment should be done at birth and prior to discharge. A physical exam should be repeated at approximately seven to ten days of life.
- 1.3 A maternal assessment that includes physical and emotional issues, and identified learning needs should be done prior to discharge/transition to self-care. The Nova Scotia Healthy Beginnings Enhanced Home Visiting screening tool will help to identify families with immediate needs for support as well as those who will benefit from a more comprehensive assessment.
- 1.4 Infant feeding should be assessed and documented on each work shift during the hospital stay and prior to discharge/transition to self care (see Guideline 2 - Infant feeding/nutrition and growth monitoring).
- 1.5 Throughout all physical examinations of the newborn, there should be careful assessment for jaundice.
- 1.6 Discharge of mother and baby from hospital within 48 hours of birth should comply with the criteria identified by the SOGC/CPS in their policy statement on early discharge and length of stay following birth at term.⁸ This document specifies time-sensitive examinations and provides advice on communication and service delivery, as well as clinical care. Based on available data, these guidelines should apply to approximately one-third of all women giving birth annually in the province of Nova Scotia.

7. K.R. Simpson & P.A. Creehan, *Perinatal Nursing: Care of the Childbearing Woman/Neonate*, p. 290.

8. Canadian Pediatric Society and Society of Obstetricians and Gynaecologists of Canada, *Joint Policy Statement No. 56: Early Discharge and Length of Stay for Term Birth*, (Ottawa: Author, 1996).

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2. Infant feeding/nutrition and growth monitoring

Practices of health care providers, relevant policies and program guidelines should protect, promote and support optimal infant feeding assessment, intervention and support strategies.

Breastfeeding has been identified as the optimal method of infant feeding worldwide because of the proven nutritional, immunological, social benefits, the psychological benefits of the breastfeeding process for mothers and infants, and the economic benefits for families and the overall health system. Consistent with the World Health Organization (WHO), UNICEF and other international authorities, in Nova Scotia exclusive breastfeeding is recommended for the first six months of life, followed by the introduction of nutritionally adequate, safe and appropriate, complementary foods, in conjunction with continued breastfeeding for up to two years of age or beyond, to promote optimal health.

The health system and its partners play a key role in supporting women/parents in making decisions that optimize their infant's nutritional health. The Baby Friendly Hospital initiative⁹ and the Baby Friendly Initiative in Community Health Services¹⁰ outline key steps to facilitate the creation of conditions in which all women will be supported in their efforts to breastfeed their babies.

In Nova Scotia, the rate of breastfeeding at hospital discharge is 65%.¹¹ Public Health Services has established population targets of 75% breastfeeding initiation and 60% breastfeeding duration at 4 months by 2007.¹²

2.1 Health care agencies, including District Health Authorities, maternity care facilities, Public Health Services and other partners, are strongly encouraged to develop, implement, communicate and evaluate a breastfeeding policy, consistent with the guidelines of the WHO/UNICEF Baby-Friendly Initiative. In addition to adhering with the *Ten Steps to Successful Breastfeeding*,¹³ (WHO Ten Steps - Attachment 8) and the International Code of Marketing of Breast-milk Substitutes,¹⁴ policies developed by District Health Authorities

9. UNICEF, *Programme Manual*, 1992.

10. Breastfeeding Committee for Canada, *Canadian Implementation Guide*, 2002.

11. Nova Scotia Atlee Perinatal Database, 2000.

12. Nova Scotia Department of Health, *Nova Scotia Health Standards*, 1997.

13. WHO/UNICEF, Joint Statement, 1989.

14. WHO/UNICEF, *International Code*, 1981.

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- should clearly identify referral/communication process(s) for mothers experiencing breastfeeding challenges (Sample Breastfeeding Policy - Attachment 9).
- 2.2 Capacity building related to breastfeeding knowledge needs to start early in the prenatal period and continue to be reinforced throughout the birth and postpartum experience. The hospital environment should enhance/enrich the breastfeeding experience through its commitment to the Baby Friendly Initiative.¹⁵
- 2.3 Breastfeeding care prior to discharge and following transition to self-care must be guided by health care providers who demonstrate competence in implementing the *Ten Steps to Successful Breastfeeding*¹⁶ and in breastfeeding assessment and counseling.
- 2.3.1 Health care providers working with breastfeeding families must demonstrate competence in the following key areas: positioning and latch, evidence of swallowing and transfer of milk, hunger/satiation cues, hydration, voiding/stooling, potential difficulties such as breast engorgement or sore nipples. Professional competence in these areas includes the ability to observe the mother and baby and listen for the mother's descriptions of what she sees, hears and experiences during a feeding.
- 2.3.2 Consistent with Step 2 of the *Ten Steps to Successful Breastfeeding*, health care providers must be given the opportunity to obtain the education and competencies to implement the *Ten Steps to Successful Breastfeeding*.
- 2.4 All other health care staff (i.e. those who do not provide clinical care to breastfeeding mothers) who have contact with infants and new parents should be oriented to their organization's breastfeeding policy, thereby demonstrating an understanding of the *Ten Steps to Successful Breastfeeding*.¹⁷
- 2.5 Prior to discharge and the transition to self-care, the following infant feeding/breastfeeding 'milestones' should be achieved:

15. UNICEF, *Programme Manual*, 1992.

16. UNICEF, *Programme Manual*, 1992.

17. WHO/UNICEF, Joint Statement, 1989.

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- 2.5.1 Establishment of 'effective breastfeeding' demonstrated by two consecutive feedings managed independently by mother and baby (see assessment outlined in 2.3.1).
 - 2.5.2 Assessment and documentation of infant feeding at least once on each work shift during the hospital stay and prior to discharge/transition to self-care.
 - 2.5.3 Determination of infant weight gain/loss within the generally accepted normal range. Initial weight loss during the first ten days of up to 10% of birth weight can be normal. However, it is generally accepted practice that a weight loss of 7% during the first week warrants a close assessment of the breastfeeding situation.¹⁸
 - 2.5.4 Infants should return to their birth weight by two to three weeks of age.
 - 2.5.5 Assessment of the family's knowledge regarding adequate hydration as well as when and how to access help when needed (Breastfeeding Assessment Charts - Attachment 10).
 - 2.5.6 Development of a breastfeeding/feeding plan, including planned referral and follow-up, based on an individualized, comprehensive, standardized breastfeeding/feeding assessment, and giving consideration to the following accessibility factors: transportation, distance, child care coverage, language capabilities and telephone access. This feeding plan needs to be carefully developed and used appropriately so as not to make a very normal, natural process more complicated than is necessary.
- 2.6 Based on the individualized, comprehensive feeding assessment and breastfeeding/feeding plan, all parents will be contacted within one to three days of discharge/transition to self-care to determine ongoing needs/supports required to contribute to a successful feeding experience. The feeding assessment and plan should dictate the type of contact (home visit, office/clinic visit, telephone call) and the timing of the contact, which may be within twenty-four hours of discharge/transition to self-care but will be no longer than three days following discharge/transition to self-care. Note: The nurse must confirm the telephone number for contact in this time frame with the parent.

¹⁸. Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*.

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- 2.7 Building on the individualized, comprehensive standardized breastfeeding/feeding assessment, a plan for ongoing monitoring of the baby's growth and feeding will be determined by the health professional and the parents. As a suggested guideline, the baby's growth (i.e. height and weight) may be monitored at three to seven days of age, ten to fourteen days of age, and one month of age.
- 2.8 A standardized breastfeeding/feeding assessment tool should be developed/identified and used by all providers and in all settings/contacts (i.e. hospital, phone, home). A copy of this assessment tool and breastfeeding/feeding plan, developed with the parents, must be sent home from hospital with the family.
- 2.9 The booklet "*Breastfeeding Basics*"¹⁹ must be provided to all breastfeeding families in Nova Scotia as the consumer health information standard on breastfeeding. Parents should be made familiar with this resource in hospital and referred to "*Breastfeeding Basics*" during subsequent contacts with the family at home.
- 2.10 Health care agencies, including District Health Authorities, maternity care facilities, Public Health Services and other community partners should develop programs and services that promote, protect and support exclusive breastfeeding for the first six months of life. Exclusive breastfeeding should be followed by the introduction of nutritionally adequate, safe, and appropriate complementary foods in conjunction with continued breastfeeding until the child is two years of age or older, to promote optimal health.
- 2.11 Although breastfeeding is promoted and supported as the optimal method of infant feeding, some parents may chose to use artificial infant milk. These parents will need individual counseling regarding safe use of artificial infant formula (i.e. proper mixing, temperature safety, choking hazards, etc.) As a suggested guideline, infant feeding and growth (i.e. height and weight) may be monitored at three to seven days of age, ten to fourteen days of age and one month of age.

¹⁹. Nova Scotia Department of Health, Public Health Services and District Health Authorities, *Breastfeeding Basics*.

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3. Psychosocial/family adjustment

Practices of health care providers, relevant policies and program guidelines should support healthy psychosocial adjustment, assessment and intervention strategies.

Supporting healthy emotional and relationship adjustment to pregnancy and birth has a positive impact on parenting confidence/satisfaction and ultimately on healthy child development.

- 3.1 A comprehensive psychosocial assessment should begin in the prenatal period and continue into the postnatal period. Using a standardized tool or tools, psychosocial assessment includes, but is not limited to: maternal factors (prenatal care, self-esteem, emotional history), family factors (social support, couple relationship, stressful life events), substance abuse and family violence²⁰ (Example of a Psychosocial Assessment Tool - Attachment 11).
- 3.2 The psychosocial assessment, should be re-visited prior to discharge/transition to self care. Assessment results may indicate the need for a home visit/community referral for the family. The Nova Scotia Healthy Beginnings Enhanced Home Visiting screening tool will help to identify families with immediate needs for support as well as those who will benefit from a more comprehensive assessment.
- 3.3 Special care and vigilance is indicated for women with a previous history of severe mental illness.²¹
- 3.4 Parents' perceptions of the birth experience should be explored prior to discharge and after the transition to self care, as the birth experience has a powerful effect on women with the potential for permanent or long-term positive or negative impact.²²
- 3.5 All women should be assessed for the risk of, or the presence of, postpartum depression. A standardized postpartum depression

20. A.J. Reid, A. Biringer, J.C. Carroll, D. Midmer, L.M. Wilson, B. Chalmers, D.E. Stewart, Using the ALPHA form in practice to assess antenatal psychosocial health, *CMAJ*, 1998; 159:677-84.

21. G. Lewis, *Why mothers Die. The Confidential Enquiries into Maternal Deaths in the United Kingdom 1997-1999*.

22. Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*.

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screening tool could be used.²³ (Postpartum Depression Screening Tools - Attachment 12)

- 3.6 Any contacts with the health care system can offer an opportunity to assess psychosocial concerns identified in the prenatal period (as per 3.1) and monitor ongoing emotional adjustment. Currently, these contacts occur at one to two weeks after birth (infant assessment), six weeks postpartum (maternal postpartum check), and at two, four, and six months of age (infant immunizations).
- 3.7 The issue of family violence should be discussed with all women prenatally and postnatally. The National Clearinghouse on Family Violence recommends asking every woman about abuse prenatally and after birth; not only women whose situations raise suspicions of abuse.²⁴ Information regarding community resources should be widely available (e.g. posters, printed information left in women's washrooms, etc.).

4. Parent-child attachment/parenting

Practices of health care providers, relevant policies and program guidelines should promote and support healthy parent-child attachment.

The first five years are pivotal in a child's ability to learn and create, to love, to trust and to develop a strong sense of themselves. This process begins from the moment of birth through parent-child attachment.²⁵

- 4.1 Preparation of mothers and families for parenting and the postpartum period should begin in the prenatal period.
- 4.2 Parenting confidence can be enhanced by an understanding of infant behavior, infant cues and appropriate responses.²⁶ Practices that help support the attachment process include: direct skin-to-skin contact between mother/father and baby, supporting breastfeeding during the first hour after birth and keeping babies and parents together in

23. Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*.

24. Health Canada, Population and Public Health Branch, The National Clearing House on Family Violence.

25. F. Mustard & M. Norrie McCain, *Early Years Study - Reversing the Real Brain Drain*.

26. K. Barnard & G. Sumner, *Keys to Caregiving*.

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hospital. Corresponding policies that promote attachment within the hospital setting should be developed.

- 4.3 Health care providers should reinforce the beginnings of attachment e.g. talking/singing to baby, touching, responding to cues and help parents understand the relationship between these early experiences and brain development.²⁷ This area has been identified as a key competency area for health care providers involved in the care of postpartum families.
- 4.4 Health care providers should be sensitive to cultural differences and understanding the influences of culture on child raising practices, family relationships and communication style.²⁸
- 4.5 Parents should receive information on key safety issues for newborns, e.g. prevention of Sudden Infant Death Syndrome and Shaken Baby Syndrome, car seat safety, and avoiding exposure to second-hand smoke.

5. Building on capacities and strengths

Practices of health care providers, relevant policies and program guidelines should support building on family capacities and strengths.

A strengths-based approach focuses on strengths rather than deficits or problems. By adopting this approach, health care providers promote parents' confidence and skill.²⁹

- 5.1 Families must be involved in all aspects of care planning.
- 5.2 Screening, assessment and intervention processes used by all health care professionals in all settings should use a strengths-based approach.
- 5.3 Capacity-building related to parenting knowledge and skill needs to start in the prenatal period and continue to be reinforced throughout the birth and postpartum experience.

^{27.} G. Sumner & A. Spietz, *NCAST Caregiver/Parent - Child Interaction Feeding Manual*.

^{28.} Great Kids, Inc., *Program Planning Guidebook, Home Visitation Programs for Families with Newborns*.

^{29.} Family Service Canada (Not-for-profit, national, voluntary organization representing the concerns of families and family service agencies across Canada.)

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- 5.4 The mother should receive information and resources in the very early postpartum stage about the resumption of intercourse and contraception measures.
- 5.5 New mothers and their families have many learning needs, starting in the prenatal period, and progressing through the phases of postpartum adaptation. Health care providers can assist in this process by facilitating the necessary learning and development via a learner-based approach. The five principles anchoring the facilitation of a learner-based approach are (1) setting a comfortable climate for learning, (2) sharing control of both content and process, (3) building self-esteem, (4) ensuring that what the parents learn applies to their home situation, and (5) encouraging self-responsibility.³⁰
- 5.6 In keeping with a learner-centred approach, education tools such as ready access to reading materials, web-based information, telephone support lines, etc. should be available throughout the continuum.
- 5.7 Innovative community programs and initiatives to support mothers and their families in the prenatal and postnatal periods should be considered. The following are examples of existing community programs across Canada: weekend parent-baby information help-lines, telephone support lines, routine follow-up, phone help by hospitals on a 24-hour basis, well baby 'drop-in' centres, prenatal and parenting classes, family resource centres, La Leche League.

6. Transition to home and community

Practices of health care providers, relevant policies and program guidelines should support a seamless continuum of care from community to hospital to community.

Postpartum care and a successful transition to the community are central to promoting healthy new beginnings for the family³¹.

- 6.1 Mothers/fathers should participate in all aspects of their care, including planning for transition to the community following birth. A care plan or care path could assist the health care professional and family in following this progress and in addressing learning needs. The care plan should make reference to the following areas: physiologic stability,

³⁰. Health Canada, *Postpartum Parent Support Program: Implementation Handbook*.

³¹. Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*.

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infant feeding/nutrition and growth monitoring, psychosocial/family adjustment, parent-child attachment/parenting, building on capacities and strengths, transition to home and community, family access to community support, healthy lifestyles and environments. The care plan would help to identify when the mother is ready for self-care, and care of her infant³². Prior to the move to discharge/transition to self-care, health professionals should make sure that the family is aware of the appropriate action to take, the resources that are available and who to contact if a critical situation should arise.

- 6.2 Community follow-up of the family should be based on the care plan, i.e. individual assessment and identified needs. The care plan should follow the family to the community and continue to be used by the health care professionals. Suggested time lines for monitoring progress are outlined in this document (see Guidelines 1.2, 2.7, 2.11, 3.6).
- 6.3 Planning for transition to the community should include discussion and provision of written information regarding how to access:
 - physician (primary care provider)
 - community supports and resources
 - emergency services.

7. Family access to community support

Practices of health care providers, relevant policies and program guidelines should support linkage of families to community services and supports.

Social support is recognized as one of the determinants of health. Ensuring accessible postpartum/postnatal support for families within their communities is essential in supporting health outcomes for women/children and families.

- 7.1 Programs and services for families at the community level must occur within an effective system linking all partners.
- 7.2 Postpartum/postnatal support services must be available and accessible seven days a week to families through a coordinated network of appropriate services and providers. The capacity to assess mother and/or baby face-to-face must be available.
- 7.3 Accessibility and availability of community support can be enhanced by offering services in a variety of settings including the home,

³². Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines*.

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clinic/office, through telephone contact and parent help-lines. Factors such as distance, transportation, child care needs for older siblings, etc. should be considered when planning follow-up care.

- 7.4 Families need to be aware of resources available to them in the community. These can be reviewed verbally, with a written copy provided for home use. If this information is available electronically, it can be shared with families.
- 7.5 Direct referral and community follow-up will be necessary for families experiencing 'at-risk' issues including, but not limited to, substance abuse, child protection, and family violence.
- 7.6 Families who are identified through a comprehensive, psychosocial assessment as having limited family/community support, would benefit from early home visiting follow-up.

8. Healthy lifestyles and environments

Practices of health care providers, relevant policies and program guidelines should promote and support healthy lifestyles, primary prevention and address the determinants of health.

Viewing health as a resource for everyday living and not merely the absence of disease encourages health promotion strategies that can enhance the health of the family. The entire range of factors and conditions that determine health (determinants of health) must be considered³³.

- 8.1 Determinants of health, such as adequate housing, food security, income, education, employment should be assessed and considered when working with postpartum families.
- 8.2 A family's health will benefit from information and support to adopt and maintain healthy lifestyles, e.g. good nutrition, healthy body image, smoking cessation, maintaining physical activity, healthy relationships.
- 8.3 Health care providers should discuss the serious effects of environmental tobacco smoke (second-hand smoke) on children's health. Maternal smoking during pregnancy and/or exposure to second-hand smoke are significant risk factors for Sudden Infant Death Syndrome. Young children exposed to second-hand smoke are more

³³. Health Canada, *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*.

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vulnerable to respiratory illnesses such as bronchitis, asthma and ear infections. Health care providers should ask parents who smoke if they are interested in receiving information on smoking cessation.

- 8.4 Families should receive anticipatory guidance, at appropriate learning opportunities, regarding, but not limited to: injury prevention, growth and development, early language development, sibling rivalry. Information should also be provided about the need for, and timely use of, preventive and curative services including, but not limited to: contraception, cervical screening, newborn screening, immunization, vision and hearing screening.

9. Collaborative practice

Practices of health care providers, relevant policies and program guidelines should promote and support collaborative practice.

*"The vision for primary health care in Nova Scotia, with respect to providers within that system, is that collaboration among primary health care professionals, other care providers, community organizers, individuals and families is supported by structures that foster trust, support for shared decision-making and respect for professional autonomy"*³⁴

- 9.1 Communities should explore unique and new strategies to address the needs of prenatal and postpartum families through collaborative practice.
- 9.2 Service and support to women/children and families should reflect a team approach with team members providing service within their scope of practice. Interdisciplinary planning and collaborative work would ensure appropriate support with minimal duplication/gaps in service.
- 9.3 Effective interdisciplinary communication is essential. The requisite communication systems should be in place, including between and among health care providers and communities. There should be strong and effective communication and cooperation between all caregivers and agencies, particularly among hospitals, community health units, primary care providers and other non-professional groups.
- 9.4 Referrals must be timely, with increased emphasis on referrals for prevention of problems. A process should be in place for urgent referrals and appropriate follow-up.

³⁴. Nova Scotia Department of Health, *Vision for Primary Health Care*.

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- 9.5 A single documentation tool could be used to ensure a single standard across the continuum of care and to improve inter-agency collaboration. A 'woman-carried' communication passport would improve communication among health professionals, and encourage patient autonomy related to aspects of self-care and infant care. As technology develops, there is potential for using an electronic means of communication to support this initiative.
- 9.6 Collaborative practice would be enhanced by joint professional development and education opportunities.

10. Professional competency

Policies and program guidelines must support and ensure ongoing professional development for health care providers. Health care providers have a professional obligation to ensure competence in their practice and identification of professional development needs.

Ongoing professional development supports competent and evidence-based practice and contributes to better health outcomes for women, children, and families.

- 10.1 District Health Authorities and their partners have a responsibility to support the maintenance of staff competence and identified professional development needs.
- 10.2 Key competency areas need to be identified and supported for health care providers involved in the care of postpartum families, to support the successful implementation of these guidelines. These competency areas include, but are not limited to:
- breastfeeding benefits, management and support (refer to section 2.3)
 - Baby Friendly Initiative (BFI)
 - Nursing Child Assessment Satellite Training (NCAST)
 - parent-child attachment

 - maternal and newborn assessment (including physical, emotional, psychosocial)
 - family violence
 - cultural sensitivity
 - capacity-building
 - learner-based approach to education

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- 10.3 Opportunities for multi-disciplinary, collaborative professional development and education should be explored within District Health Authorities.

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6. CONCLUSION

This report was approved by both the Action Group of the Reproductive Care Program and by the Department of Health in December 2002. It recommends a series of guidelines intended to facilitate the provision of postpartum and postnatal services in an informed and consistent way across Nova Scotia, ultimately to improve health outcomes for women, infants, and families. A successful implementation strategy for these guidelines will require close collaboration among key local clinicians and health care planners as well as District Health Authorities and the Department of Health. Members of the Postpartum/Postnatal Services Working Group also emphasized the need for structures, processes and strategies to ensure dissemination and monitoring of these guidelines. The RCP and the Department of Health acknowledged the necessity to plan these processes, and as a result, the development of an implementation and monitoring strategy is underway. The Public Health Information Technology Strategy, once developed, will be one source of valuable data, building on existing acute care information systems (e.g. patterns of physicians' office visits, hospital readmission rates).

Healthy Babies, Healthy Families: Postpartum & Postnatal Guidelines supports women, infants and families in Nova Scotia by **promoting evidence-based**, family-centred, collaborative practice.

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Attachment 1

TERMS OF REFERENCE (22/02/02)

Title: Working Group on Postnatal Follow-up

Authority: Reproductive Care Program of Nova Scotia (RCP)

Reporting to: Action Group (RCP)

Membership:

Dr. Minoli Amit, Pediatrician (Antigonish)
Ms. Janet Braunstein Moody (Senior Director, NS Department of Health)
Ms. Judy Cormier, Faculty of Nursing, St. Francis Xavier University (Antigonish)
Dr. Beth Guptill, Family Practitioner (Bridgewater)
Ms. Karen Lewis, Public Health Services (Annapolis)
Ms. Mona Turner-McMahon, MABLE Program (Halifax)
Ms. Wanda Nagle, Public Health Services (Capital District Health Authority)
Dr. Joan Wenning, Department of Obstetrics & Gynaecology (Halifax)

Project leaders/co-chairs:

Becky Attenborough, (RCP)
Elizabeth Barker (Project Consultant)

Additional members added:

Cathy Chenhall (Core Programs, NS Department of Health)
Kathy Inkpen (Healthy Beginnings, NS Department of Health)

Goal: "Development of a recommendation for a Department of Health minimum, acceptable standard(s) for initial postpartum contact (0-6 weeks) in Nova Scotia".

Specific Objectives:

Phase 1:

- A)** Literature review examining (a) the immediate postpartum period 0-6 weeks and (b) 6 weeks - 6 months. The review will build on the *Home Visiting Literature Review* by the Population Health Research Unit (Dalhousie University) currently in progress to inform the Enhanced Home Visiting Program. This review will include current, relevant published and unpublished studies to provide "evidence-based" information. The key issues to be identified in the literature are:
- discharge criteria used to plan for transition to the community
 - timing of initial postpartum contact related to length of stay
 - criteria for ongoing follow-up of families in the first 6 weeks

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- program activities (education, assessment, anticipatory guidance) conducted during home visits
 - capacity-building approaches to work with new families - building on what families already know and what they feel they need to learn
 - identification of key health issues (mother, infant) in the first 6 weeks
 - existing and related policies identified in the literature for public health, obstetrics, pediatrics, etc.
- B)** Identification of current practice in the province of Nova Scotia, including existing services and gaps. This post-discharge scan will involve all maternity facilities and community-based postpartum standards, including Public Health Services, family physicians, etc. and will identify length of stay, discharge criteria, current providers or service (who and when)
- C)** Scan of provinces/territories to identify postpartum standards currently in place and trends in service delivery.

Phase 2 will include the development of the draft Department of health minimum, acceptable standards for initial postpartum contact (0-6 weeks) in Nova Scotia, acknowledging realistic resource capacity. During this phase, the project will

- A.** Identify existing/new committee to review the evidence and recommend the standards
- B.** Review the report from Phase 1
- C.** Identify proposed approach for articulation of postnatal standards
- D.** Develop Department of Health minimum standards for initial postpartum contact
- E.** Build consensus with partners regarding standards (Note: although the Department of Health has identified "consensus-building" as part of Phase 2, the project leaders doubt whether the allotted time-frame is sufficient for the completion of this key consultative step. It is more likely that the project group will recommend a process/strategy to follow RCP's recommendations to the Department of Health.)

Deliverable: Final report outlining recommendation(s) for submission to Nova Scotia Department of Health, Public Health Section.

Deadline for report: June 31st, 2002 (to be confirmed)
Attachment 2

**REVIEW OF LITERATURE
(May, 2002)**

Purpose

The purpose of the literature scan was two-fold. It was intended, first, to provide a “broad-brush” overview of some of the key issues related to post-partum care and, second, to help provide some context for the following specific topics, as identified in the “Postnatal Service Review Working Group’s” terms of reference:

- discharge criteria used to plan for transition to the community
- timing of the initial post-partum contact related to length of stay
- criteria for ongoing follow-up of families in the first 6 weeks
- program activities (education, assessment, anticipatory guidance) conducted during home visits
- capacity-building approaches to work with new families - building on what families already know and what they feel they need to learn
- identification of key health issues (mother, infant) in the first 6 weeks
- existing and related policies identified in the literature for public health, obstetrics, pediatrics, etc.

Search strategy

The strategy for the scan was thorough, although not strictly a comprehensive literature search in the academic sense. The initial scan began with a search through the Medline database, via the Dalhousie University on-line system, and involved the following combinations of terms:

- postnatal care
- **AND**
- standards
- hospitalization
- patient discharge

The resulting articles were limited to those published in English. A scan of abstracts identified those that appeared most relevant to the Group’s task. The formal literature search was supplemented by a variety of other sources such as journal references, professional practice guidelines, information from other researchers, etc. Although the search elicited a limited number from nursing and midwifery journals, most of the resulting literature articles were medical in focus.

Findings

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The literature scan quickly revealed the postpartum period to be an overlooked aspect of the childbirth continuum, particularly in terms of primary exploration and research. The published literature also provided little guidance on what could be construed as a basic acceptable standard of care, based on sound evidence of effectiveness, during this important period of the mother's and baby's lives.

Apart from the purely clinical/medical issues, the literature on the postpartum period focussed mainly on the following significant issues affecting the postpartum care of mothers and newborns in recent years:

1. **shorter postpartum lengths of hospital stay**
2. the absence of clear definition of **the scope of postpartum care**
3. the **changing role of hospitals and communities** (with the associated shift to care in the community)
4. the meaning and duration of "**postpartum**" care

Shorter Postpartum lengths of hospital stay

Many developed countries have witnessed a gradual decline in postpartum length of hospital stay for mothers and newborns. Evident throughout the latter half of the last century, this trend has accelerated in recent years (Raube,1999;Jacobson, 1999; Martell,2000; Mandl 2000). In the **United States**, for example, the average postpartum length of stay(LOS) between 1970 and 1992 declined from (approximately) 4 days to 2.1 days for vaginal births and 7.8 days to 4 days for Caesarean section.(Brumfield,1998; Jacobson, 1999).

Since 1992, even shorter lengths of stay (e.g. one-day or less) occurred. During the 1990s, escalating healthcare costs and changing third-party reimbursement costs generated pressure on physicians and hospitals to shorten the length of stay and to discharge mothers and babies from hospital as quickly as possible (Gagnon,1997; Brumfield,1998; Johnson 1999). Some insurance companies even began refusing payment for a hospital stay that extended 12-24 hours after an uncomplicated vaginal delivery (Brumfield, 1998).

Widespread concern about these "drive-through deliveries" prompted US federal legislation in 1996 (the Bradley Bill) which mandated insurance coverage of a follow-up visit either at home or in clinic for both the mother and newborn within 48 hours, if the postpartum stay was less than 48 hours (Lieu, 2000). Since then, more than 43 States enacted legislation or reached voluntary agreements with insurance payers to provide coverage for in-hospital postpartum stays (Brumfield,1998; Eaton, 2001).

However, many critics believed that the heated debate in the United States on the

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optimal postpartum length of stay and the legislative responses of mandated minimum stays took place in the absence of relevant data regarding the health outcomes and effects of any changes (Volpp, Bundorf 1999; Mandle, 2000; Hyman, 2001).

Canada also witnessed a decline in postpartum length of stay. Between 1989 and 1997, the average length of hospital stay for childbirth declined from 4.0 to 2.3 days for vaginal births and from 6.7 to 4.5 days for Cesarean births, excluding Quebec, Nova Scotia and Manitoba (Canadian Perinatal Health Report, 2000). During the same period, the **neonatal hospital readmission rate** increased significantly from 2.8 per 100 live births (in Canada) in 1989 to 4.0 per 100 live births in 1997. The most common reasons for these neonatal re-admissions were neonatal jaundice, feeding problems, sepsis, dehydration and inadequate weight gain. The authors of this report stated that *"although many factors may contribute to neonatal readmission, the practice of early discharge of newborns without the application of guidelines may be related to the recently increasing neonatal readmission"*.

The Canadian Perinatal Health Report (2000) supported the findings of at least 2 earlier published Canadian studies. Lee et al (1995) demonstrated an association between length of postpartum stay at birth hospitals and neonatal readmission rates for jaundice and dehydration during the first 2 weeks of life. As length of stay decreased from a mean of 4.5 days to 2.7 days, the re-admission rate during the first post-natal week increased two-fold. Another report (Lock and Ray, 1999) showed that *"an even smaller change in length of stay from 2.1 to 1.9 days was associated with a more substantial rise in the neonatal readmission rate from 5.2% to 10.4% at one Toronto hospital"*. However, as Lee et al pointed out, *"while it is not feasible to keep all mothers in hospitals for 1 week to reduce readmission rates, it does mean that efforts should be made to identify cases at risk for readmission and either to prolong hospital stay or to provide extra follow-up"*

The 3 month **maternal readmission rate** in Canada following vaginal birth has remained fairly stable from 1990-1997, ranging from 2.4% to 2.7% of deliveries. Readmission rates for Cesarean births increased from 3.2% of deliveries in 1990 to 3.9% of deliveries in 1997, excluding Nova Scotia, Quebec and Manitoba (Canadian Perinatal Health Report 2000).

Controlled studies on the safety and efficacy of early maternal/neonatal discharge have been relatively few, despite more than a decade of rapid change and fierce debate. Braveman et al.(1995), in a review of the literature on early discharge between 1975 and 1994, noted that published research provided little knowledge of the medical consequences of shorter mother and newborn stays for the general population. The situation has changed little since then and the "early discharge of

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mothers from hospital after childbirth (remains) one intervention that has been widely adopted but has not been fully evaluated in randomized controlled trials" (Thompson 1999).

In response, some Canadian jurisdictions developed professional recommendations and guidelines in relation to lengths of stay. In October 1996, the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Canadian Pediatric Society (CPS) issued a joint policy statement on "Early Discharge and Length of Stay for Term Birth" which was intended to provide clinical direction for postpartum programs across the country. For an early hospital discharge, SOGC/CPS recommended in-home follow-up at least once, by a health care professional with maternal-child training and experience, within 48 hours of discharge, including weekends.

This document has been recognized as the professional standard for early postpartum discharge in Canada. The SOGC/CPS recommendations have been endorsed by many programs and organizations, including the Manitoba College of Physicians and Surgeons' Guideline "*Planned Obstetrical Discharge Following Uncomplicated Term Birth*" (1997) and the Child Health Work Group of the Ontario Public Health Association which produced "*Early Postpartum Discharge Position Paper: November 1998*".

In Spring 1997, the Reproductive Care Program of Nova Scotia endorsed the policy statement for practitioners in the province. However, a study of family physicians providing prenatal and/or newborn care in a large Nova Scotia community served by a tertiary care hospital found that there was no significant difference in the scheduling of the follow-up by physicians for babies who were part of an Early Discharge Program compared with those who were not (Purcell et al., 2001). The study demonstrated that the use in practice of clinical policies and/or guidelines depend on an effective implementation strategy for dissemination, uptake monitoring and the requisite enabling conditions.

The scope of postpartum care

There was wide variation between countries on what constituted appropriate postpartum care. Initially, in the **United States**, when a number of hospital organizations (eg. Kaiser Permanente) introduced early discharge, this option included a prescribed program of daily follow-up visits by a perinatal nurse practitioner for 4 days, plus additional visits as necessary and close collaboration with the family (Temkin, 1999). However, in the 1980s, when the prospective payment system in the US made Early Discharge an insurance-driven system rather than a consumer-driven option, the home visit portion of the short-stay package disappeared. (Temkin, p 594).

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There was limited information on the scope, content and frequency of visits to mothers and babies in the US in the postpartum period. The standard of care for new mothers, as described by AAP and ACOG, was one (MD) office visit at 4-6 weeks. (Albers, 2002) There have been efforts in the US to implement alternative models of post-partum care, few of which have been standardised or studied systematically (Albers , 2002).

The currently available evidence on how different approaches to routine postpartum care is limited, in large part because this area has been relatively neglected as a focus for rigorous research. Until studies of adequate design are directed to questions about routine postpartum care, no single model of in-hospital and post-discharge services can be defined as "best practice"(Eaton, 2001,p.401).

Current guidelines, according to Escobar et al.(2001), provided scant guidance on how routine follow-up of newly-discharged mother-infant pairs should be performed. National guidelines focused primarily on the prevention of catastrophic morbidity (eg. severe hyperbilirubinemia, dehydration). They provided less guidance on how, where and by whom routine follow-up of newly-discharged mother-infant pairs should be performed to achieve optimal health needs (Escobar 2001, p.719).

In the **United Kingdom**, a recent review of the (UK) midwife and community-based literature, published between 1970 and 1998, found that, while ante-natal and intra-partum care had attracted a great deal of attention, the postnatal period was relatively under-researched (Dowswell et al,2001). In the UK, present community postnatal care is generally said to consist of 7 home visits by the midwife to 10-14 days after birth although this can continue up to the 28th day. Care is then provided by the Health Visitor, who is a community nurse with enhanced preparation in maternal/pre-school child health (Hewison et al, 2001). However, a survey of different models of maternity care associated with primary care practices in England and Wales found that the timing and the content of postnatal care by midwives was very variable (Hewison et al,2001).

MacArthur et al.(2002) stated that much postpartum physical and psychological morbidity was not addressed by the present system of UK care, which tended to focus on routine examinations. One of the authors' underlying assumptions was that many women have experienced, but did not report, physical and emotional disorders after childbirth, some of which are persistent. MacArthur et al's cluster, randomised, controlled trial in the West Midlands, involving 1087 women, used symptom checklists, derived from evidence-based guidelines, and the Edinburgh Postnatal depression scale. The trial showed that a re-designed community postnatal care program was associated with positive psychological health outcomes in women at 4 months postpartum, although physical health measures did not

differ.

This assessment has been reinforced by emerging statistics indicating that suicide is now the leading cause of death in the postpartum period in the United Kingdom. In the UK, as in other developed countries, maternal **mortality** rates are low. However, the recently published Report of the Confidential Enquiries into Maternal Deaths in the UK entitled "*Why Mothers Die 1997-1999*" found that deaths due to psychiatric causes, including suicide, were the leading cause of maternal deaths. Although the number of reported deaths from suicide and psychiatric causes was small (28 over 3 years), closer examination proved the actual number to be significantly higher than reported. The logical assumption is that the incidence and prevalence of psychiatric illness in the pregnancy, intrapartum and postnatal periods greatly exceeds what is now reported.

To date, "science, policy and legislation addressing concerns about healthcare after childbirth have focused primarily on the number of hours postpartum stay, rather than on the needs of the mother and newborn and on the content and quality of the care they receive" and "current scientific knowledge does not provide conclusive evidence about ... post-discharge services for the general population of infants and mothers" (Eaton p.401).

In 2000, Health Canada produced the document "***Family-Centred Maternity and Newborn Care. National Guidelines***" with the purpose of "assisting hospitals and other health care agencies in planning, implementing and evaluating maternal and newborn programs and services". The document represented the end-product of a lengthy and exhaustive 3-stage process in collaboration with many leading Canadian medical, nursing and health-related organizations.

These National Guidelines reflect a more systems perspective, bringing together community and institutions into one system, and address "family-centred care". They are designed for use by policy makers, healthcare professionals (physicians, nurses, midwives), parents, program planners and other health providers. Although not clinical practice guidelines, the National Guidelines address a wide range of topics, referring to, and abstracting from, clinical practice guidelines throughout.

Changing Roles for Hospital and Community

Shorter lengths of hospital stay after birth have raised concerns about the potential consequences of reducing the length of time in which necessary care can be delivered to newborns and their mothers in the hospital setting (Eaton, 2001). In the hours immediately following delivery, mothers experience post-delivery fatigue, sleep deprivation and sensory overload (Ruchala, 2000). The opportunities for hospital staff to interact with the mother and baby are severely limited.

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This has, in turn, shifted the setting for much of the immediate postpartum recovery from the hospital to the community. Services that previously were provided in the hospital, such as assessment, support and teaching of the new mother, must now be provided after discharge, either in an out-patient clinical setting or at home (Eaton, 2001).

The re-thinking of how nurses (and physicians) deliver care for maternity patients has given rise to the use of critical pathways and case management approaches. Many jurisdictions in Canada have developed this type of care plan in an effort to provide continuity of postpartum patient care.

The meaning and duration of "post-partum care"?

The terms "***postnatal***" and "***postpartum care***" were often used interchangeably in the literature and appeared to lack a specific recognized definition. "Postnatal" more often pertains to the infant while "postpartum" refers to the mother. Postnatal and postpartum care, although part of the larger continuum of care for mother and baby within the family unit, varied in scope and intensity, depending on whether the client was the mother or the baby and whether the "need" was for healthcare or psychosocial services.

"Unlike prenatal and intrapartum care, where clear standards are usually available, explicit aims and objectives are often lacking in postpartum care. Sometimes, this results in isolated actions, valuable as they may be, for immunization, contraception or other goals. Postpartum care all too often does not incorporate all the essential elements required for the health of a woman or her newborn in a comprehensive package. Postpartum care must be a collaboration between parents, families, caregivers, health professionals, planners, administrators, community groups, policy makers and politicians"
Postpartum Care of the mother and newborn: a practical guide. World Health Organization (WHO)

Traditionally, the "postpartum period" has ended at 6 weeks, although most jurisdictions recognised the need for ongoing support after this time. Despite the absence of rigorous supporting evidence, there appeared to be "crucial" moments when contact with the health system/informed caregiver could be instrumental in identifying and responding to needs and complication. WHO offered the following formula - which must not be interpreted too rigidly - for identifying these moments as "6 hours, 6 days, 6 weeks and 6 months". The underlying assumption for this approach was that there is already some form of continuous attention to the woman and her newborn for the first few hours immediately after birth.

According to the World Health Organization, there was no consensus about the

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optimal number and timing of home visits by a caregiver during the first week postpartum. In both developed and developing countries, there was no general agreement about the precise purpose of home visits and their frequency and effectiveness. This assumption was borne out by the existing literature (Dowswell et al, 2001; McCarthy 2002)

The responsibilities of healthcare providers in the extended postpartum period were to meet the needs of the mother and baby which generally included:

for the woman

- information/counselling on baby care and breast-feeding;
- bodily changes, self-care, signs of possible problems, hygiene and healing, sexual life, contraception and nutrition
- support from healthcare providers, partners and family, emotional and psychological
- healthcare problems
- time to care for the baby
- help with domestic tasks
- maternity leave
- social reintegration into family and community
- protection from abuse/violence

for the newborn infant

- easy access to mother
- appropriate feeding
- adequate environmental temperature
- safe environment
- parental care
- cleanliness
- observation of body signs by someone who cares and can take action if necessary
- access to healthcare for suspected or manifest complications
- nurturing, cuddling, stimulation
- protection from disease, harmful practices, abuse/violence
- acceptance of sex, appearance, size
- recognition by the state e.g. registration

(World Health Organization, 1998)

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Attachment 3

**SHARED BIBLIOGRAPHY
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SOGC Joint Policy Statement October 1996.

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Important Note:

This bibliographic list has integrated the lists previously compiled for the Reproductive Care Program of Nova Scotia and our colleagues in the Reproductive Care Program of British Columbia, and has adopted the format adopted by British Columbia. Both organizations have collaborated in sharing their bibliographic resources.

Attachment 4

**JOINT POLICY STATEMENT:
EARLY DISCHARGE AND LENGTH OF STAY FOR TERM BIRTH**

Reprinted with permission from:

**The Society of Obstetricians and Gynaecologists of Canada (SOGC)
744 Promenade Echo Drive
Ottawa, ON
K1S 5N8**

**SOGC CLINICAL PRACTICE GUIDELINES
POLICY STATEMENT No. 56, October 1996**

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

EARLY DISCHARGE AND LENGTH OF STAY FOR TERM BIRTH

This Statement supersedes SOGC Policy Statement No. 20, published in April 1996 (Clinical Practice Guidelines for Obstetrics series)

Over the past two decades there has been a trend toward shorter hospital stays for maternal/newborn care. This occurred partially because of a need to curtail hospital costs and has been paralleled by shortened hospital stays for other patients. Discharge of the mother and baby from hospital within **48** hours after birth began first, as a consumer initiative and, subsequently, as an initiative of health care providers (primarily hospitals and insurance agencies). Mothers choosing early discharge were more likely to be multiparous, interested in rooming in, relied more on themselves than others and to had learned about early discharge **from** printed information rather than from clinic staff.' Early discharge with home follow-up has been reported as a safe and effective use of health care **resources**²⁻⁷ and may offer psychological benefits to **families**.^{8,9} Although short maternal/newborn hospital stays are a common occurrence in many Canadian centres, published research provides little knowledge of the consequences for large populations.¹⁰ In the US, the American Academy of Pediatrics has published guidelines" and is currently trying to facilitate legislation to require insurance companies to pay for care of mother and baby for at least 48 hours after a vaginal birth and 96 hours

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after a Caesarean **birth**.¹² The purpose of this statement is to provide guidelines for physicians and other health care personnel to influence policy and practice related to discharge of healthy term babies and mothers from hospital and subsequent follow-up in the community.

Babies undergoing a normal six-hour postnatal transition are far less likely to have problems requiring hospitalization in the first three days of life than those who have an abnormal transition **period**.⁴ The importance of individualized assessment in preparation for potential early discharge has been emphasized.⁵ Women who are discharged “involuntarily” are more likely to be dissatisfied and have more problems than women discharged voluntarily.¹³ This importance of choice related to childbirth has been addressed in other aspects of obstetrical **care**.¹⁴

After early discharge following a normal term birth, women are less likely to have problems requiring readmission to hospital (up to **1.8 %**, primarily for infection) than babies (up to 10.9%,² more commonly 2 to 3%¹⁵) whose most prevalent reason for re-hospitalization is neonatal jaundice. Recent Canadian data indicate that a reduction in hospital stay **after** delivery **from** 4.5 to 2.7 days without community follow-up is associated with increased readmission to hospital, especially for hyperbilirubinemia and dehydration, after which at least two infant deaths occurred.¹⁶ Establishing neonatal feeding could decrease the need for readmission of the baby, since inadequate breast-milk intake is associated with increased neonatal jaundice.” Education and support must be provided to breastfeeding mothers. Successful early discharge programmes have strong outpatient components with community support.^{15,18-22} Models of home follow-up have been described, including details of home assessments for the mother and baby.” In keeping with the principle of family-centred care²³ and the ongoing facilitation of breast-feeding, it is important that babies and mothers remain together if one or the other needs readmission to hospital. Hospitals should ensure their admission policies facilitate readmission of babies for at least the first seven days of **life**. This may require the development of hostel facilities for mothers whose babies are hospitalized.

Policy Statements:

This policy reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. To enquire about ordering additional copies, please contact the SOGC information and documentation centre. None of the contents may be reproduced in any form without prior written permission of SOGC.

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In a study by **Norr**,²² low income mothers discharged with their infants 24 to 47 hours after birth showed no increased maternal or infant morbidity within 15 days after birth compared with previous patients who stayed in hospital 48 to 72 hours after birth. Not surprisingly, mothers discharged without their babies had more concerns and less satisfaction. Mothers electing early discharge (24 to 48 hours after delivery) are reported to show better postpartum adjustment than mothers who stayed in hospital for five to seven days.²⁴

Despite the increasing prevalence of early discharge programmes, controlled studies are relatively few. (Studies of early discharge of low-birth-weight babies are not relevant to these guidelines.) Waldenstrom reported a randomly allocated study of discharge 24 to 48 hours after birth with subsequent midwifery visits compared to traditional hospital stays (six days after delivery).²⁵ Although the study may be biased since patients had to desire early discharge to enter the study, parents had a more positive experience with early discharge. They also rated this more highly than parents who did not enter the study and had traditional hospital care. A separate report indicated that infant morbidity and prescribed medications in the first six months after birth were no different with early discharge than with traditional hospital **care**.²⁶ A similar study by Carty reported that discharge of mothers and babies between 12 and 48 hours after birth was associated with increased maternal satisfaction and breast-feeding without **supplementation**.²⁷ While no differences in maternal or infant morbidity were seen, it was noted that the sample size was too small to detect significant differences in outcome. The need for further research has been documented," and trials with larger numbers to address this issue are currently under way.

Discharge of healthy mothers and term babies before 48 hours **after** birth (often within 24 hours of birth) is a reality in many areas. **Common** components of most successful programmes include:

- a normal vaginal birth with the baby having a normal adaptation to extrauterine life, and neither the mother nor the baby having ongoing problems requiring hospitalization;
- adequate preparation of the family for early discharge and access to community services after delivery, which may include home visits by health care personnel with maternal/infant experience and additional home care assistance as required;
- facilitation of maternal/infant contact in hospital, with decisions regarding early discharge individualized for both the baby and the mother.

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Further research is required into support for the mother and baby in the home environment and to validate these (or other) discharge guidelines. It is the collective responsibility of physicians and other health care personnel, including administrators and funding agencies, to ensure early discharge after birth is implemented in a safe and effective manner.

Recommendations

1. Care for mothers and babies should be individualized and family-centred. With many uncomplicated births, a stay of 12 to 48 hours is adequate, provided the mother and baby are well, the mother can care for her baby, and there is proper nursing follow-up in the home. In the absence of these requirements, mothers should be offered the opportunity to stay in hospital with their baby for a minimum of 48 hours after a normal vaginal birth. Women with complicated deliveries, including Caesarean section, may require a longer hospital stay (see Table 2).
2. With discharge from hospital prior to 48 hours after birth, the guidelines in Table 1 should be followed. Individual hospitals may identify more specific criteria according to the needs of their populations and regions.
3. When discharge occurs before 48 hours after birth, this must be part of a programme that ensures appropriate ongoing assessment of the mother and baby. This evaluation should be carried out by a physician or other qualified professional with training and experience in maternal/infant care. A personal assessment in the home is preferred for all mothers and babies. Relying on newly delivered mothers to travel to a clinic or office may result in many families being inadequately followed due to lack of compliance. This visit is not intended to replace a complete evaluation by a physician, but should focus on those aspects that require early intervention (e.g., feeding problems, jaundice, signs of infection, etc.). Programmes should ensure availability of assessment, including on weekends, to:
 - assess infant feeding and hydration with support of the mother in the nutrition of her infant ;
 - evaluate the baby for jaundice and other abnormalities that may require further investigation and/or assessment by a physician earlier than anticipated;
 - complete screening tests and/or other investigation as required;
 - evaluate maternal status with regard to the normal involutinal processes after delivery;

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- assess and support integration of the baby into the home environment;
 - review plans for future health maintenance and care, including routine infant immunizations, identification of illness, and periodic health evaluations; and
 - link the family with other sources of support (e.g., social services, parenting classes, lactation consultants) as necessary.
4. Preparation for discharge should be considered part of the normal antenatal education of all expectant mothers (and families), including information on infant feeding and detection of such neonatal problems as dehydration and jaundice. These issues should be reinforced during the short hospital stay.
 5. Hospitals with early discharge programmes should work with community health agencies to audit outcomes for mothers and babies to ensure guidelines for early discharge are appropriate and being effectively utilized.
 6. When readmission of the baby to hospital is required within seven days after birth, the baby should be admitted to the hospital of birth with accommodation for the mother to maintain the maternal/child dyad. When readmission of the mother is required, there should be opportunity for the newborn baby to be with her, if appropriate.

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Criteria for discharge less than 48 hours after birth	
Maternal	Newborn
<p>Purpose: To ensure postpartum mothers are safely discharged following the birth of their baby, they should meet basic criteria and have appropriate arrangements for ongoing care. Prior to discharge, the following criteria should be met.</p>	<p>Purpose: To ensure newborn infants are safely discharged, they should meet basic criteria and have appropriate arrangements for ongoing care. The baby should be healthy in the clinical judgment of the physician, and the mother should have demonstrated a reasonable ability to care for the child</p>
<p>Vaginal delivery</p> <ul style="list-style-type: none"> • Care for the perineum will be ensured • No intrapartum or postpartum complications that require ongoing medical treatment or observation* • Mother is mobile with adequate pain control • Bladder and bowel functions are adequate • Receipt of Rh immune globulin, if eligible • Demonstrated ability to feed the baby properly; if breast-feeding, the baby has achieved adequate "latch" • Advice regarding contraception is provided • Physician who will provide ongoing care is identified and, where necessary, notified • Family is accessible for follow-up and the mother understands necessity for, and is aware of, the timing for any health checks for baby or herself • If home environment (safety, shelter, support, communication) is not adequate, measures have been taken to provide help (e.g., homemaking help, social services) • Mother is aware of, understands, and will be able to access community and hospital support resources <p>.....</p> <ul style="list-style-type: none"> • Mothers should NOT be discharged until stable, if they have had: 	<ul style="list-style-type: none"> • Full-term infant (37-42 weeks) with size appropriate for gestational age • Normal cardiorespiratory adaptation to extrauterine life* • No evidence of sepsis* • Temperature stable in cot (axillary temperature of 36.1°C to 37°C) • No apparent feeding problems (at least two successful feedings documented) • Physical examination of the baby by physician or other qualified health professional within 12 hours prior to discharge indicates no need for additional observation and/or therapy in hospital • Baby has urinated • No bleeding at least two hours after the circumcision, if this procedure has been performed • Receipt of necessary medications and immunization (e.g., hepatitis B) • Metabolic screen completed (at >24 hours of age) or satisfactory arrangements made • Mother is able to provide routine infant care (e.g., of the cord) and recognizes signs of illness and other infant problems • Arrangements are made for the mother and baby to be evaluated within 48 hours of discharge • Physician responsible for continuing care is identified with arrangements made for follow-up within one week of discharge <p>.....</p> <ul style="list-style-type: none"> • Infants requiring intubation or assisted ventilation, or infants at increased risk for sepsis should be observed in hospital for at least 24 hours

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LENGTH OF STAY FOLLOWING TERM BIRTHS

Type of Delivery	Number of Days - without home care nursing service	Number of Days - with home care nursing services
Normal vaginal labour and delivery	2	1 -2
Complicated labour and vaginal delivery	3+	2+
Caesarean Section	4+	3

Note:

1. The length of stay should be calculated from the time of birth of the baby and not since admission of the mother.
2. The length of stay after a Caesarean Section will take into account the complexity of labour and postpartum course.
3. A 12 to 24-hour stay is only acceptable when patients have a proper home environment in place and the community has a home care nursing programme (seven days a week). Newborn and postpartum clinics should be available to provide emergency access for patients.
4. Home nursing visits by a qualified health professional, with maternal-child training and experience, and home care services imply a minimum of one home visit within the first 24 to 48 hours of discharge.

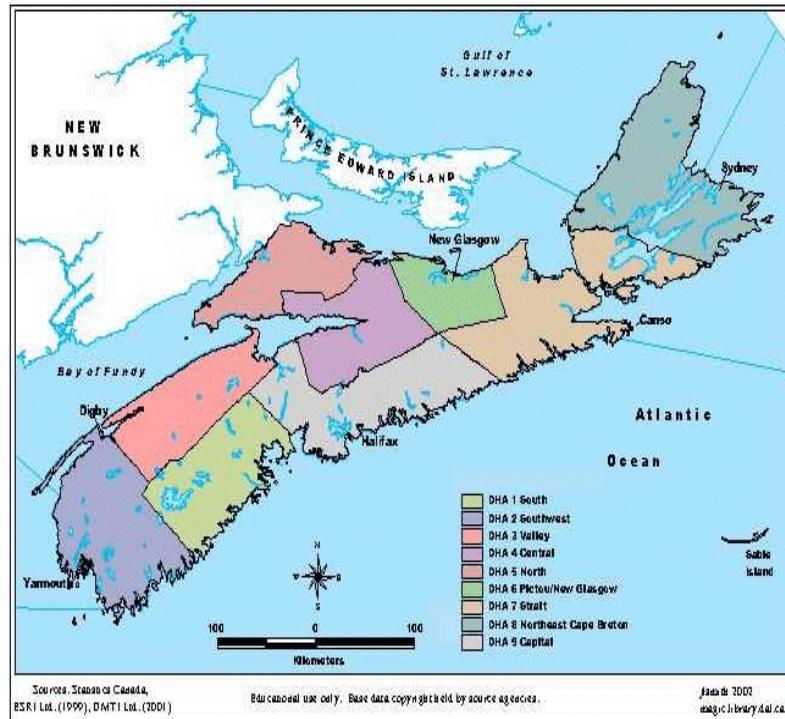
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Map of District Health Authorities



Attachment 6

EXCERPTS FROM THE NOVA SCOTIA HEALTH STANDARDS

**Core Service: Non-Communicable Disease Prevention
(Healthy Beginnings)**

Changes to lifestyle choices involve changing knowledge, attitudes, behaviours, and often values. This takes time to do and time to being about an effect. Realistic time lines for observable effects of risk factor reduction on chronic disease outcomes tend to be a minimum of 10 years. As a result, risk factor reduction is an investment in future health and health care.

- Component:**
- * Family Benefits Act
 - * Tobacco Act
 - * Day Care Act
 - * Health Act
 - * Municipal Legislation
 - * Motor Vehicle Act
 - * Environment Act
 - * Occupational Health & Safety Act
 - * Labour Standards Code

- Key External Partners:**
- * Family Resource Centre
 - * Family and Children Services/Community Services
 - * Family Physicians
 - * Hospitals/clinics
 - * NGOs with mandates - provincially, nationally and internationally

- Focus Population:**
- * Infants (preconception to 18 months) and their parents and caregivers.

Outcomes: Communities, families and individuals will take action leading to health babies and healthy families (preconceptual to 18 months).

- Targets:** **The following targets are a combination of population and operational due to the fact that population targets and data area not available for some areas at this time:**
- * To reduce the low birth weight rate from 5.8% to 5.0% by the year 2005.

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- * To decrease the rate of teenage pregnancies from 44.5/1000 population to 41/1000 by the year 2005.
 - * To increase breastfeeding initiation rates from 62% to 75% by the year 2007.
 - * To control, reduce or eliminate communicable disease vaccine preventable diseases (see CDC core service targets).
 - * To decrease the rate of overall smoking in pregnancy from 20% to 27% by the year 2007.
 - * To reduce the percent of postpartum women overall who resume smoking from 60% to 50% by the year 2007.
 - * To decrease the rate of smoking in women <20 years of age in pregnancy from 48% to 45% by the year 2007.
 - * To reduce the percent of women 20 years of age who resume smoking postpartum from 60% to 50% by the year 2007.
 - * 60% of women of childbearing age will consume a daily folic acid supplement by the year 2007.
 - * 85% of families will receive information on the cause and prevention of nursing bottle syndrome by the year 2007.
 - * 85% of families will receive information on proper daily mouth care for their infant by the year 2007.
- Standards:**
- * Each Region will provide nutrition education according to approved Department of Health policies and guidelines (4, 5,7,8,9,10,11,15,17,25).
 - * Each Region will provide infant dental education and services according to approval Department of Health Children's Oral Health Policy and guidelines (4,10,11,18,19).
 - * Each Region will support the goals and objectives of the Family Violence Prevention Initiative of Nova Scotia (20).

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- * Each Region will ensure coordination and collection of the minimum data set on preconception, prenatal, postpartum, and infancy (21).
- * Each Region will support prenatal education to all primiparas according to approved Public Health prenatal guidelines (3,4,7.8,9.11,14).
- * Each Region will offer prenatal and postpartum services/supports, based on needs, to high risk families, according to approved Department of Health Guidelines (4,5,6,7.8.9.10,11,2,14,16,25).
- * Each Region will provide Public Health tobacco reduction initiatives aimed at prevention of prenatal and postpartum smoking (26).
- * Each Region will provide, in partnership with Community Services, prenatal and postpartum nutrition education and counselling according to Family Benefits Act Regulations (4,5,6,7,8,9,10,11,12,14,15).
- * Each Region will protect, support and promote breastfeeding initiation and continuation to at least 4 months of age (8,9,12).
- * Each Region will support healthy sexuality initiatives aimed at healthy decision making and self-esteem (13).
- * Each Region will develop, procure and manage health education resources according to the established Department of Health, Health Education Resource Policy.
- * Each Region will provide and administer publicly funded vaccines within the Regions according to the approved Department of Health policy and schedules (1,2,3).
- * Each Region will maintain Public Health Services' staff competencies in the area of preconceptional prenatal postpartum, and infancy (1,2,3,4,5,,7,8,9,10,11,12,13,14).

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- * Each Region will ensure that the concept of injury prevention is incorporated into all healthy beginnings education initiatives.
- * Each Region will promote service delivery that supports the Public Health Services model of health promotion.

Measurement:

- * Atlee Perinatal Database (Reproductive Care Program)
- * Child Health Database (Canadian Institute of Child Health)
- * Vital Statistics Database (Business and Consumer Affairs)
- * Hospital Database (Canadian Institute of Health Information)
- * Immunization Database (Public Health)
- * Healthy Baby Program Database (Public Health; Community Services)
- * Antenatal Screening Database (Reproductive Care Program; Public Health)
- * Postpartum Screening Database (Public Health)
- * Infant Feeding Database (Periodic Survey - Public Health)
- * CHIRRP
- * MSI

Supporting Documents:

1. CDC Manual: Department of Health
2. Immunization Services and Schedule: Department of Health
3. Anaphylaxis: Canadian School Boards Association
4. Prenatal Guidelines (A New Life): Department of Health
5. Healthy Baby Program Manual: Department of Health and Department of Community Services
6. Healthy Baby Program Evaluation Report: Department of Health
7. Folic Acid Policy Statement: Department of Health
8. Breastfeeding Protocol: Grace Maternity Hospital
9. National Breastfeeding Guidelines for Health Care Providers: Canadian Institute of Child Health
10. Year One: Food for Baby: Department of Health
11. After Year One: Food for Children: Department of Health
12. Breastfeeding Your Baby: Department of Health
13. National Sexual Health Guidelines: Health Canada
14. Nobody's Perfect Program Manual: Health Canada
15. Iron Fortified Formula Policy
16. Guidelines for Prenatal and Postpartum Screening: Department of Health

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17. Canada's Food Guide to Healthy Eating: Health Canada
18. Children's Oral Health Program Policy: Department of Health
19. Children's Oral Health Survey
20. Family Violence Prevention Initiative Policy: Government of Nova Scotia
21. Healthy Babies Minimum Reporting Requirements: Department of Health
22. Terms of Reference for Provincial Non-communicable Disease Prevention Advisory Committee
23. Terms of Reference for Regional Non-communicable Disease Prevention Advisory Committee
24. Terms of Reference for Joint Management Committee - Public Health and Health Promotion
25. Terms of Reference for Provincial Dental Advisory Committee
26. Provincial Guidelines for Perinatal Health Care: Department of Health and Reproductive Care Program
27. Preventing Smoking Relapse Among Pregnant and Postpartum Women: Start Quit, Stay Quit, University of Ottawa
28. Canadian Task Force on Periodic Health Exam

- Standing Committees:**
- * Joint Management Committee - Public Health and Health Promotion (24)
 - * Non-communicable Disease Prevention Advisory Committee (Provincial and Regional) (22,23)
 - * Provincial Dental Advisory Committee (25)
 - * Provincial Working Groups on an as needed basis

Source: Nova Scotia Department of Health, Public Health Services and Drug Dependency. *Nova Scotia Health Standards, Edition 1*. (Halifax: Author, 1997), pp. 180-185.

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Check Box, initial item when completed
 * (Asterisk) indicates narrative note written
 N/A – not applicable
 Initial all additions and changes to the carepath.

Date and Time of Birth: _____ Blood Group and Rh: _____

Focus	Date/Nurse	0-24 hours		24-48 hours		48-72 hours		Outcomes for discharge
		D	N	D	N	D	N	
Assessment	VS	<input type="checkbox"/> Q15 min IN PACU <input type="checkbox"/> Q1h x 3 <input type="checkbox"/> Resp Q1h x 15 for EpiMorph <input type="checkbox"/> BP Q4 h while awake		<input type="checkbox"/> BID		<input type="checkbox"/> BID		<input type="checkbox"/> VS WNL <input type="checkbox"/> No S&S of Infection or excessive bleeding <input type="checkbox"/> Normal involution
	PP Assessment	<input type="checkbox"/> Q15 IN PACU <input type="checkbox"/> Q1h x 3 <input type="checkbox"/> Pain		<input type="checkbox"/> Pain		<input type="checkbox"/> Pain		
Activity/Safety		Received from BU @ _____ Rm# _____ <input type="checkbox"/> Bedrest <input type="checkbox"/> Ambulate with assistance @ _____ <input type="checkbox"/> Assist with self care and infant		<input type="checkbox"/> Ad lib <input type="checkbox"/> Assist with self care and infant <input type="checkbox"/> Independent care of self and infant		<input type="checkbox"/> Ad lib <input type="checkbox"/> Independent care of self and infant		<input type="checkbox"/> Moving towards usual activity levels <input type="checkbox"/> Able to care for self and baby
Tests		<input type="checkbox"/> Kleihauer if Rh neg						<input type="checkbox"/> Rh neg status documented on chart <input type="checkbox"/> Results available
Medications/Immunizations		IV <input type="checkbox"/> Post Epi-morph orders or PCA		IV <input type="checkbox"/> Bedside medications		<input type="checkbox"/> MMR Lot# _____ <input type="checkbox"/> WinRho # _____		<input type="checkbox"/> Pain managed with po analgesia <input type="checkbox"/> Triplicate prescription (narcotics) <input type="checkbox"/> MMR documented <input type="checkbox"/> WinRho documented
Nutrition		<input type="checkbox"/> Ice chips progress to DAT <input type="checkbox"/> Food Allergies		<input type="checkbox"/> DAT		<input type="checkbox"/> DAT		<input type="checkbox"/> Tolerates diet
Elimination	Voiding	<input type="checkbox"/> Foley Catheter <input type="checkbox"/> Foley D/C 18-24 h post-op @ _____ <input type="checkbox"/> Voided @ _____ <input type="checkbox"/> Bowel sounds present		<input type="checkbox"/> Voiding qs <input type="checkbox"/> Passing flatus		<input type="checkbox"/> Voiding qs <input type="checkbox"/> Passing flatus <input type="checkbox"/> Bowel Movement		<input type="checkbox"/> Voiding without difficulty <input type="checkbox"/> Knowledge of normal bowel function resumption
	Bowels							
Psychosocial/Spiritual	Attachment Feeding Interaction	<input type="checkbox"/> Skin to skin touching <input type="checkbox"/> En face positioning <input type="checkbox"/> Breastfeeding 4-12/24h <input type="checkbox"/> Bottle feeding q3-4 hr		<input type="checkbox"/> Dressing removed @ _____ <input type="checkbox"/> Incision Care <input type="checkbox"/> Fleet enema prn		<input type="checkbox"/> Incision Care <input type="checkbox"/> Fleet enema prn <input type="checkbox"/> Staples removed @ _____		<input type="checkbox"/> Evidence of parent-infant attachment <input type="checkbox"/> Reciprocal response to social cues <input type="checkbox"/> Responds to feeding cues <input type="checkbox"/> Latches with smooth motion, swallowing, 8-12 feeds/24h
	Maternal Tasks	<input type="checkbox"/> Taking-in <input type="checkbox"/> Debrief birth experience		<input type="checkbox"/> En face positioning <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24h <input type="checkbox"/> Bottle feeding q3-4 hr		<input type="checkbox"/> En face positioning <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24h <input type="checkbox"/> Bottle feeding q3-4 hr		<input type="checkbox"/> Expresses feelings about birth experience, progressing through interdependent stage <input type="checkbox"/> Family prepared to take on parenting roles at home <input type="checkbox"/> Mother and partner/support person understand range of normal postpartum emotional response
	Role Attainment	<input type="checkbox"/> Assess family strengths, coping strategies <input type="checkbox"/> Assess cultural and individual expectations for postpartum		<input type="checkbox"/> Assess emotional status/risk for PP depression		<input type="checkbox"/> Assess emotional status/risk for PP depression		
Teaching/Learning	Self-Care	<input type="checkbox"/> Orient to room and unit <input type="checkbox"/> Mobility/positioning in bed <input type="checkbox"/> Normal involution <input type="checkbox"/> Pericare <input type="checkbox"/> Fundal massage <input type="checkbox"/> Lochia		Identify learning needs <input type="checkbox"/> Exercise Pamphlet <input type="checkbox"/> Breast Care		Identify learning needs <input type="checkbox"/> Normal involution <input type="checkbox"/> Sleep and fatigue <input type="checkbox"/> Activity <input type="checkbox"/> Nutritional needs <input type="checkbox"/> Sexuality and birth control		<input type="checkbox"/> Knowledge of normal PP course <input type="checkbox"/> S & S of wellness and illness for mother and infant (esp. jaundice, dehydration, sepsis) <input type="checkbox"/> Manage common breastfeeding problems - eg sore nipples, engorgement <input type="checkbox"/> Knowledge of breastfeeding resources
	Infant Feeding	<input type="checkbox"/> Feeding cues <input type="checkbox"/> Positioning <input type="checkbox"/> Latching <input type="checkbox"/> Breaking suction <input type="checkbox"/> Burping <input type="checkbox"/> LATCH tool		<input type="checkbox"/> Positioning <input type="checkbox"/> Latching <input type="checkbox"/> Breaking suction <input type="checkbox"/> Burping <input type="checkbox"/> LATCH tool		<input type="checkbox"/> Breast care - strategies to manage engorgement <input type="checkbox"/> Formula preparation		<input type="checkbox"/> Demonstrates basic techniques for infant feeding <input type="checkbox"/> Formula preparation understood
	Infant Care	<input type="checkbox"/> Keys to Caregiving <input type="checkbox"/> Elimination <input type="checkbox"/> Baby bath <input type="checkbox"/> Cord/skin care <input type="checkbox"/> Newborn patterns of behaviour - sleep, hunger, crying <input type="checkbox"/> Signs of wellness and illness <input type="checkbox"/> Jaundice and dehydration		<input type="checkbox"/> Keys to Caregiving <input type="checkbox"/> Elimination <input type="checkbox"/> Baby bath <input type="checkbox"/> Cord/skin care <input type="checkbox"/> Newborn patterns of behaviour - sleep, hunger, crying <input type="checkbox"/> Signs of wellness and illness <input type="checkbox"/> Jaundice and dehydration		<input type="checkbox"/> Infant car seat		<input type="checkbox"/> Knowledge of newborn behaviour <input type="checkbox"/> Demonstrated confidence and competence of self-care and infant care <input type="checkbox"/> Keys to Caregiving Pamphlets
Consults		<input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Social Work <input type="checkbox"/> Lactation Consultant <input type="checkbox"/> Other _____						
Discharge Process		<input type="checkbox"/> Live birth registration completed <input type="checkbox"/> Information package given and explained <input type="checkbox"/> Physician hospital d/c order on chart <input type="checkbox"/> Mother/Baby bands checked <input type="checkbox"/> Read to Me!		<input type="checkbox"/> A feeding plan <input type="checkbox"/> Adequate supplies/home preparation <input type="checkbox"/> Family Safety <input type="checkbox"/> Knows how to access after hours medical care <input type="checkbox"/> Car seat		<input type="checkbox"/> A feeding plan <input type="checkbox"/> Adequate supplies/home preparation <input type="checkbox"/> Family Safety <input type="checkbox"/> Knows how to access after hours medical care <input type="checkbox"/> Car seat		Discharge Date: _____ Time: _____ <input type="checkbox"/> MABLE <input type="checkbox"/> Early PHN

POSTPARTUM AND POSTNATAL GUIDELINES



Caesarean Birth Carepath (1)

Legend	Breast	S = soft	F = filling	E = engorged
	Nipple	N = normal	B = blistered	C = cracked

Patient Name: _____ Unit #: _____

Date/Time												
Breasts												
Nipples												
Fundus (f.b. ↑ or ↓)												
Lochia												
Episiotomy Incision/drsg												
Mood												
Initials												
Time												
BP ∨												
∧												
Pulse ●												
Respirations												
Pain (0-10)												
T E M P E R A T U R E												
Initials												

Signature/Status	Print Name	Initials

Signature/Status	Print Name	Initials

POSTPARTUM AND POSTNATAL GUIDELINES

L/L-neck box, initial item when completed
 * (Asterisk) indicates narrative note written
 N/A – not applicable
 Initial all additions and changes to the carepath.

Date and Time of Birth: _____

Focus	Date/Nurse	72-96 hours		96-120 hours		120-144 hours		Outcomes for discharge	
		D	N	D	N	D	N	D	N
Assessment	VS	<input type="checkbox"/> BID		<input type="checkbox"/> daily		<input type="checkbox"/> daily		<input type="checkbox"/> VS WNL	
	PP Assessment	<input type="checkbox"/> daily		<input type="checkbox"/> daily		<input type="checkbox"/> daily		<input type="checkbox"/> No S&S of infection or excessive bleeding <input type="checkbox"/> Normal involution	
Activity/Safety	Pain	<input type="checkbox"/> Ad lib		<input type="checkbox"/> Independent care of self and infant		<input type="checkbox"/> Independent care of self and infant		<input type="checkbox"/> Moving towards usual activity levels <input type="checkbox"/> Able to care for self and baby	
		<input type="checkbox"/> Independent care of self and infant							
Tests								<input type="checkbox"/> Rh neg status documented on chart <input type="checkbox"/> Results available	
Medications/Immunizations								<input type="checkbox"/> Pain managed with po analgesia <input type="checkbox"/> Triplicate prescription if necessary <input type="checkbox"/> MMR documented <input type="checkbox"/> WinRho documented	
Elimination		<input type="checkbox"/> DAT		<input type="checkbox"/> DAT		<input type="checkbox"/> DAT		<input type="checkbox"/> Tolerates diet	
Treatments		<input type="checkbox"/> Voiding qs		<input type="checkbox"/> Voiding qs		<input type="checkbox"/> Voiding qs		<input type="checkbox"/> Voiding without difficulty <input type="checkbox"/> Knowledge of normal bowel function resumption	
		<input type="checkbox"/> Bowel movement		<input type="checkbox"/> Bowel movement		<input type="checkbox"/> Bowel movement			
Psychosocial/Spiritual		<input type="checkbox"/> Incision care		<input type="checkbox"/> Incision care				<input type="checkbox"/> Incision intact and dry <input type="checkbox"/> Staples removed	
		<input type="checkbox"/> Supportive bra							
	Attachment Feeding Interaction	<input type="checkbox"/> Feeding interaction <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24hr <input type="checkbox"/> Bottle feeding q3-4hr		<input type="checkbox"/> Feeding interaction <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24hr <input type="checkbox"/> Bottle feeding q3-4hr		<input type="checkbox"/> Feeding interaction <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24hr <input type="checkbox"/> Bottle feeding q3-4hr		<input type="checkbox"/> Evidence of parent-infant attachment <input type="checkbox"/> Reciprocal response to social cues <input type="checkbox"/> Responds to feeding cues <input type="checkbox"/> Latches with smooth motion, swallowing, 8-12 feeds/24h <input type="checkbox"/> Expresses feelings about birth experience; progressing through interdependent stage <input type="checkbox"/> Family prepared to take on parenting roles at home <input type="checkbox"/> Mother and partner/support person understand range of normal postpartum emotional response	
Maternal Tasks	<input type="checkbox"/> Assist mother through maternal tasks - taking hold <input type="checkbox"/> Assess family strengths and coping strategies		<input type="checkbox"/> Taking hold						
Role Attainment	<input type="checkbox"/> Assess emotional status/risk for PP depression		<input type="checkbox"/> Assess emotional status/risk for PP depression						
Teaching/Learning	Self-Care	Identify learning needs <input type="checkbox"/> Normal involution <input type="checkbox"/> Breast care - strategies to manage engorgement <input type="checkbox"/> Breastfeeding - positioning, latching, breaking suction, burping, LATCH tool		Identify learning needs		Identify learning needs		<input type="checkbox"/> Knowledge of normal PP course <input type="checkbox"/> S&S of wellness and illness for mother and infant (esp. jaundice, dehydration, sepsis) <input type="checkbox"/> Manage common breastfeeding problems - e.g. sore nipples, engorgement <input type="checkbox"/> Knowledge of breastfeeding resources <input type="checkbox"/> Demonstrates basic techniques for infant feeding <input type="checkbox"/> Formula preparation understood <input type="checkbox"/> Knowledge of newborn behaviour <input type="checkbox"/> Demonstrated confidence and competence of self-care and infant care <input type="checkbox"/> Keys to CaregiverG pamphlets	
	Infant Care	<input type="checkbox"/> Feeding cues <input type="checkbox"/> Elimination <input type="checkbox"/> Baby-bath <input type="checkbox"/> Cord/skin care <input type="checkbox"/> Newborn patterns of behaviour - sleep, hunger, crying <input type="checkbox"/> Signs of wellness and illness <input type="checkbox"/> Jaundice and dehydration <input type="checkbox"/> Formula preparation							
Consults		<input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Social Work <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Other							
Discharge Process		<input type="checkbox"/> Live birth registration completed <input type="checkbox"/> Information package given and explained <input type="checkbox"/> Physician hospital d/c order on chart <input type="checkbox"/> Mother/Baby bands checked <input type="checkbox"/> Read to Me!		<input type="checkbox"/> A feeding plan <input type="checkbox"/> Adequate supplies/home preparation <input type="checkbox"/> Family Safety <input type="checkbox"/> Knows how to access after hours medical care <input type="checkbox"/> Car seat <input type="checkbox"/> Variance form completed		Discharge Date: _____ Time: _____		<input type="checkbox"/> MABLE <input type="checkbox"/> Early PHN	
		Length of stay: <input type="checkbox"/> < 48 <input type="checkbox"/> 48-72 <input type="checkbox"/> 72-96 <input type="checkbox"/> > 96							
Signature	Signature/Status	Printed Name		Initials		Signature/Status		Printed Name	

POSTPARTUM AND POSTNATAL GUIDELINES

= care component, initial and/or time
 asterisk (*) = see progress note
 initial = changes, additions, outcomes to carepath
 line out and initial = not applicable
Date & Time of Birth:

Focus	Date	0-24 hrs. after delivery (NB Day 1)	24-48 (Day 2)	48-72 (Day 3)	72-96 (Day 4)	96-120 (Day 5)	Outcomes for Discharge	I	M
Assessment V/S Assessment Weight MD Assess. Circumcision		q1h x4, pre/post bath then QD q1h x 4 then q4h Head-to-toe, Gest.Assess. Admission physical	QD q4h visual QD q30 min x2	QD q4h QD QD	QD q4h QD QD	QD q4h QD	V/S stable: T36.5-37.5; P100-160; R30-60 No significant jaundice (bili<100mmol/L @24hrs) No S&S of infection Weight loss <10% of birth weight Physical exam completed		
Activity/Safety Position Identification Bath		Side/back Ma/baby ID bands in place Admission bath	Side/back Verify leg/arm bands Bath prn				Mother verbalizes, demonstrates safe & appropriate newborn activities Identification bands present & match, Verified @ D/C		
Medications/ Immunizations		Erythromycin Vitamin K Hepatitis B prn Immunoglobulin prn					Eye prophylaxis within 4 hours of birth Vitamin K within 4 hours Hepatitis B vaccine & immunoglobulin within 12 hours of birth		
Tests		Cord Blood sent Yes <input type="checkbox"/> No <input type="checkbox"/> Chem strips Blood glucose prn Hearing & speech form	PKU/TSH Bilirubin level prn				Results obtained on babies of Rh neg mothers Metabolic screening completed MD notified of lab results		
Nutrition Breast Bottle		Initiates feeding in 1st h LATCH assessment Observed latch: 07-19 19-07 8-12 feedings/24h Initial bottle feeding 4-6h (15-30cc)	8-12 feedings/24 hrs Observed latch: 07-19 19-07 Bottle feeding 30cc minimum q4h	8-12 feedings/24 hrs Observed latch: 07-19 19-07	8-12 feedings/24 hrs Observed latch: 07-19 19-07	8-12 feedings/24 hrs Observed latch: 07-19 19-07	Breast feeding on cue with no supplements; demonstrated latch, sucking & swallowing Parent verbalizes knowledge of lactation follow-up & has plan for feeding Nipples well, tolerates formula		
Elimination Voiding Bowels		1st voiding 1st stool (meconium)	2-3 wet diapers 2 or more stools	4-6 wet diapers 2-5 stools			Voiding 4-6 wet diapers/24 hrs 2-5 stools/24 hrs Knowledge of usual elimination patterns		
Treatments		Cord care Skin care	Cord care Skin care				Cord drying Cord clamp removed Skin integrity intact		
Psychosocial/ Spiritual		Assess response to maternal cues					Evidence of parent-infant attachment Responds to cues		
Consults PRN									
Discharge Planning		MD notified of delivery Review of discharge plan, home preparation - car seat, clothing, supplies Appointment with doctor within 1 week Ready for discharge Yes <input type="checkbox"/> No <input type="checkbox"/>	Review discharge plan, home preparation - car seat, clothing, supplies Ready for discharge Yes <input type="checkbox"/> No <input type="checkbox"/>				Adequate home preparation Knowledge of community resources Car Seat available Physician hospital discharge on chart Plan to make appt. Following appointment for baby. D/C @ MABLE		
Sign/Print/Initial	0700 - 1900								
	1900 - 0700								

POSTPARTUM AND POSTNATAL GUIDELINES

Check Box, initial item when completed
 * (Asterisk) indicates narrative note written
 N/A – not applicable
 Initial all additions and changes to the carepath.

Date and Time of Birth: _____ Blood Group and Rh: _____

Focus	Date/Nurse	0-4 hours		4-24 hours		24-48 hours		48-72 hours		Outcomes for discharge
		D	N	D	N	D	N	D	N	
Assessment	VS	Q20 min x q1h, then <input type="checkbox"/> Q1 x q3h		<input type="checkbox"/> TPR daily <input type="checkbox"/> BP Q 4h while awake		<input type="checkbox"/> daily		<input type="checkbox"/> daily		<input type="checkbox"/> VS WNL <input type="checkbox"/> No S&S infection or excessive bleeding
	PP Assessment	Q20 min x q1h, then <input type="checkbox"/> Q1 x q3h <input type="checkbox"/> Pain		<input type="checkbox"/> daily <input type="checkbox"/> Pain		<input type="checkbox"/> daily <input type="checkbox"/> Pain		<input type="checkbox"/> daily <input type="checkbox"/> Pain		
Activity/Safety		Ambulate with assistance Received 1m BU @ _____ Rm # _____		<input type="checkbox"/> Assist care of mother & infant		Ad lib <input type="checkbox"/> Independent care of self & infant		Ad lib <input type="checkbox"/> Independent care of self & infant		<input type="checkbox"/> Moving towards usual activity levels <input type="checkbox"/> Able to provide care for self and infant
Tests				<input type="checkbox"/> Kleihauer if Rh neg						<input type="checkbox"/> Rh neg status documented on chart <input type="checkbox"/> Results available
Medications/Vaccines		IV		IV <input type="checkbox"/> Bedside Medications <input type="checkbox"/> MMR Lot # _____ <input type="checkbox"/> WinRho # _____		IV				<input type="checkbox"/> Pain managed with po analgesia <input type="checkbox"/> Triplicate prescription - narcotics <input type="checkbox"/> MMR documented <input type="checkbox"/> WinRho/Rh neg documented
Nutrition		<input type="checkbox"/> DAT <input type="checkbox"/> Food Allergies		<input type="checkbox"/> DAT		<input type="checkbox"/> DAT		<input type="checkbox"/> DAT		<input type="checkbox"/> Tolerates diet
Elimination		<input type="checkbox"/> Voided <input type="checkbox"/> cath prn		<input type="checkbox"/> Voiding qs <input type="checkbox"/> cath prn				<input type="checkbox"/> BM/Passing flatus		<input type="checkbox"/> Voiding without difficulty <input type="checkbox"/> Knowledge of normal bowel function resumption
Treatments		<input type="checkbox"/> Ice to perineum prn		<input type="checkbox"/> Ice to perineum prn <input type="checkbox"/> Sitz bath prn <input type="checkbox"/> Supportive bra prn		<input type="checkbox"/> Sitz bath prn		<input type="checkbox"/> Sitz bath prn		<input type="checkbox"/> Episiotomy/laceration dry & clean
Psychosocial/Spiritual	Attachment Feeding Interaction	<input type="checkbox"/> En face positioning <input type="checkbox"/> Skin to skin touching		<input type="checkbox"/> En face positioning <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 4-12x/24h <input type="checkbox"/> Bottle feeding Q3-4h		<input type="checkbox"/> En face positioning <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24h <input type="checkbox"/> Bottle feeding Q3-4h		<input type="checkbox"/> En face positioning <input type="checkbox"/> Soothes infant <input type="checkbox"/> Breastfeeding 8-12/24h <input type="checkbox"/> Bottle feeding Q3-4h		<input type="checkbox"/> Evidence of parent-infant attachment <input type="checkbox"/> Reciprocal response to cues <input type="checkbox"/> Responds to feeding cues <input type="checkbox"/> Observed latches <input type="checkbox"/> Family prepared to take on parenting roles
	Maternal Tasks	<input type="checkbox"/> Taking-in, debrief birth experience		<input type="checkbox"/> Taking-in <input type="checkbox"/> Assess family strengths, coping		<input type="checkbox"/> Taking in/hold <input type="checkbox"/> Assess emotional status, risk for PP depression				<input type="checkbox"/> Expresses feelings about birth experience, progressing through dependent stage
	Role Attainment			<input type="checkbox"/> Cultural & individual expectations for PP						<input type="checkbox"/> Mother and partner/support person understand range of usual PP emotional responses
Teaching/Learning	Self-Care	<input type="checkbox"/> Fundal massage <input type="checkbox"/> Lochia <input type="checkbox"/> Body mechanics for feeding		Identify learning needs <input type="checkbox"/> Normal involution <input type="checkbox"/> Pericare <input type="checkbox"/> Kegel exercises <input type="checkbox"/> Activity <input type="checkbox"/> Sleep & fatigue <input type="checkbox"/> Exercise Pamphlet		Identify learning needs <input type="checkbox"/> Nutritional needs <input type="checkbox"/> Breast care <input type="checkbox"/> Sexuality & birth control		Identify learning needs		<input type="checkbox"/> Knowledge of normal PP course <input type="checkbox"/> S & S of wellness and illness for mother and infant (esp jaundice, dehydration, sepsis) <input type="checkbox"/> Manage common breastfeeding problems - eg sore nipples, engorgement <input type="checkbox"/> Knowledge of breastfeeding resources
	Infant Feeding	<input type="checkbox"/> Positioning <input type="checkbox"/> Latching <input type="checkbox"/> Breaking suction burping		<input type="checkbox"/> Positioning <input type="checkbox"/> Latching <input type="checkbox"/> LATCH tool <input type="checkbox"/> Feeding cues <input type="checkbox"/> Keys to Caregiving <input type="checkbox"/> Elimination <input type="checkbox"/> Baby-bath <input type="checkbox"/> Cord/skin care <input type="checkbox"/> Newborn patterns of behaviour - sleep hunger crying <input type="checkbox"/> Signs of wellness & illness <input type="checkbox"/> Jaundice & dehydration		<input type="checkbox"/> Strategies to manage engorgement <input type="checkbox"/> Formula preparation				<input type="checkbox"/> Demonstrates basic techniques for infant feeding <input type="checkbox"/> Formula preparation understood <input type="checkbox"/> Knowledge of newborn behaviour
	Infant Care	<input type="checkbox"/> Orientation to room/unit				<input type="checkbox"/> Infant car seat safety				<input type="checkbox"/> Demonstrated confidence and competence of self-care and infant care <input type="checkbox"/> Keys to Caregiving pamphlets
Consults PRN		<input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Social Work <input type="checkbox"/> Lactation Consultant <input type="checkbox"/> Public Health Nurse		<input type="checkbox"/> Other _____						
Discharge Process		<input type="checkbox"/> Live birth registration completed <input type="checkbox"/> Information package given and explained <input type="checkbox"/> Physician hospital d/c order on chart <input type="checkbox"/> Mother/Baby bands checked <input type="checkbox"/> Read to Me! Length of stay: <input type="checkbox"/> < 48 <input type="checkbox"/> 48-72 <input type="checkbox"/> 72-96 <input type="checkbox"/> > 96				<input type="checkbox"/> A feeding plan <input type="checkbox"/> Adequate supplies/home preparation <input type="checkbox"/> Family Safety <input type="checkbox"/> Knows how to access after hours medical care <input type="checkbox"/> Car seat <input type="checkbox"/> Varianco form completed				Discharge Date: _____ Time: _____ <input type="checkbox"/> MABLE <input type="checkbox"/> Early PHN

POSTPARTUM AND POSTNATAL GUIDELINES

Attachment 8

TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

-
- Step 1: Have a written breastfeeding policy that is routinely communicated to all health care staff.
-
- Step 2: Train all health care staff in skills necessary to implement this policy.
-
- Step 3: Inform all pregnant women about the benefits and management of breastfeeding.
-
- Step 4: Help mothers initiate breastfeeding within a half-hour of birth.
-
- Step 5: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
-
- Step 6: Give newborn infants no food or drink other than breast milk, unless medically indicated.
-
- Step 7: Practise 24-hour rooming-in.
-
- Step 8: Encourage breastfeeding on cue.
-
- Step 9: Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
-
- Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
-

Source: WHO/UNICEF. *Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services*. A Joint WHO/UNICEF Statement, Geneva, 1989.

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B. PURPOSE:

In keeping with the spirit of the mission and vision statements of the IWK Health Centre and Public Health Services, C.D.H.A.:

1. Breastfeeding is recommended as the optimal way of feeding infants and small children because of the nutritional and immunological, social, and psychological benefits afforded by the breastfeeding process for the mother and infant as well as the economic benefits to the family and the health care system.
2. It is the shared responsibility of all health care professionals and their governing bodies in collaboration with women, their families, and communities to promote, support and protect breastfeeding. By doing so they will create a supportive physical and social environment which enables parents to make an informed choice to breastfeed.

C. PROTOCOL:

- 1.0 Families will receive support according to the breastfeeding policy unless contraindicated by the health status of the infant and/or mother (see Appendix A); or individual **informed choice** (see glossary for definition).

Evaluation Method:	Chart review, family surveys, peer review.
Target:	100%
Threshold:	100%

- 2.0 Families will be offered assistance by health care providers who have knowledge, skills and attitudes to fully support breastfeeding (exceptions: see Appendix A).

- a) A welcoming atmosphere will be provided for breastfeeding families. All healthcare providers are accountable for attitude they present regarding breastfeeding.
- b) Orientation and continuing education, which enables healthcare providers to be consistent and constructive in their support to breastfeeding families, is the mandate of the Organizations.

- 1.3 All healthcare providers are required and supported to increase their breastfeeding knowledge and skills within the context of their practice.

Evaluation method:	Chart review, family surveys, peer review.
Target:	100%
Threshold:	100%

- 3.0 All women and their families will receive information regarding the benefits and management of breastfeeding whenever feeding decisions are being made and throughout the breastfeeding experience.

- a) Feeding options other than breastfeeding are **not promoted** (see glossary) within the

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IWK Health Centre and the Public Health Services of the C.D.H.A.

- b) The IWK Health Centre and Public Health Services of the C.D.H.A. encourage exclusive breastfeeding for six months with appropriately timed introduction of complementary foods and continued breastfeeding for up to two years and beyond, consistent with the recommendations of WHO/UNICEF (1990).
- c) Parents will have access to ongoing breastfeeding education and support during the decision making process regarding infant feeding choices.
- d) Families will receive consistent, current, and accurate breastfeeding information from all healthcare providers within the organizations governed by this policy throughout the continuum of the breastfeeding experience.
- e) Principles of community development and adult learning are used when assessing and meeting individual families' and communities' needs for breastfeeding information.
- f) Families will receive information that will enable them to identify, access and utilize available community resources.

Evaluation method: Chart review, family surveys, peer review.
Target: 100%
Threshold: 80%

4.0 Families will receive information on the benefits of skin-to skin contact and will be provided with the opportunity for this to occur within one-half hour of birth. They will be supported to initiate breast-feeding within the first hour of the baby's life, unless mother's or baby's health doesn't make it possible.

- 3.1 Families will receive information on the benefits of early initiation of skin-to-skin contact with the baby and its positive impact on breastfeeding.
- 3.2 Families experiencing cesarean birth will be provided with the opportunity for skin-to skin contact within one hour of birth and will be supported to initiate breastfeeding within 2 hours of birth.
- c) Description of the skin-to-skin contact and the initiation of breastfeeding will be documented for all families.

Evaluation method: Chart review, Family surveys, peer review.
Target: 100%
Threshold: 90%

5. Breastfeeding families are supported in learning to breastfeed on baby's **hunger cues** (for more information see glossary).

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- A. Families are provided with information on infant feeding cues.
- b) No restrictions are placed on the frequency or length of feedings.
- c) In the first 24 hours it is not unusual that babies feed as few as 2-4 times or as many as 12 or more times in 24 hours. Encourage mothers to offer breast each time babies arouse or begin to cue.
- d) After first 24 hours mothers are encouraged to breastfeed babies on cue, waking babies if not cuing.
- e) When milk comes in feeding on hunger cue from baby is desired.
- f) Every breastfeeding mother and baby will be encouraged and supported to remain together to learn how to interact with each other and understand each other's cues.

Evaluation method: Chart review, Family surveys, peer review.
Target: 100%
Threshold: 100%

6.0 The IWK Health Centre and the Public Health Services, C.D.H.A, will support families to initiate and maintain breastfeeding, throughout their breastfeeding experience.

- a) Families have access to a variety of types of breastfeeding support.
- b) All breastfeeding mothers will be shown how to manually express breast milk.
- c) All mothers and babies who are unable to feed at the breast within 6-12 hours of birth are provided with assistance and information on how to maintain lactation.
- d) All mothers and babies who are unable to feed at breast at any age are provided with assistance and information on how to maintain lactation.
- e) Families who experience breastfeeding challenges, will receive support where necessary through the use of specific referrals to **appropriate resources** (see Appendix B).

Evaluation method: Chart review, Family surveys, peer review.
Target: 100%
Threshold: 80%

7.0 Breastfeeding families are not provided with artificial means of feeding, unless medically indicated during hospitalization, upon discharge, or in the community.

- a) Families are informed of the ways artificial teats (nipples) and pacifiers (dummies) may

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interfere with early, effective breastfeeding, and thus teats and pacifiers are not provided to breastfeeding babies unless medically indicated.

- b) Families are informed of the impact of supplemental feeding (infant formula, water, and glucose) on lactation.

Evaluation method:	Chart review, Family surveys, peer review.
Target:	100%
Threshold:	80%

Rationale for not meeting any one aspect of breastfeeding protocol is documented.

Evaluation method:	Chart review, Family surveys, peer review.
Target:	100%
Threshold:	100%

- 8.0 Variations in the evaluation process will occur depending on the context of care/practice in which the policy is implemented. The responsibility for evaluation rests with the individual Organizations.

GLOSSARY OF TERMS

Informed Choice:

All families will be provided with evidence-based information regarding benefits and management of breastfeeding and potential risks of formula feeding. This information will enable families to make informed decision regarding how they wish to feed their infant (Wong, 2000).

Infant Cues:

Infant cues are the many ways infants have of expressing themselves and communicating their needs and wants.

- Hunger Cues include fussy behavior, mouthing, rooting, and putting hand-to mouth, sucking movements, and turning towards the caregiver.
- Satiation Cues include behaviors such as falling asleep, fingers, arms and legs extended and relaxed, lack of facial movements, and decreased suckling (Keys to Caregiving, 1998).

Promotion of Breastfeeding:

Measures that promote and support breastfeeding, including:

- Informing pregnant women of the benefits and management of breastfeeding.

POSTPARTUM AND POSTNATAL GUIDELINES

- Providing opportunity for skin-to-skin contact within 30 minutes of birth and assisting with breastfeeding within the first hour of birth for all mothers and babies whose health permits so.
- Giving breastfed babies no infant formula or other drinks, such as 5% glucose and water or sterile water, **unless medically indicated**.
- Practicing rooming-in and encouraging healthy mothers and babies to remain together 24 hours a day.
- Feeding on cue and giving no artificial teats or pacifiers to breastfed infants unless medically indicated.
- No free samples of formula and /or related products or literature given to pregnant or new breastfeeding mothers during postpartum hospitalization or upon discharge.

APPENDIX A

There are medical indications that require individual infants be given fluids or food in addition to, or in place of, breast milk, such as in the following situations:

- HIV positive mothers should not breastfeed.
- Ill babies who are medically compromised will be in special care unit. Their feeding must be individualized with appropriate consideration of their particular requirements and functional capabilities. Breast milk is preferred and recommended whenever possible.

Some situations which may require fluids or food in addition to or in place of breastmilk include:

- Infants with very low weight who are born pre-term, at less than 1500 grams or 34 weeks gestational age.
- Infants at risk for severe hypoglycemia, or who require therapy for mild hypoglycemia and who have not improved through increased breastfeeding or by being given breast milk.
- Infants with inborn errors of metabolism (e.g. galactosaemia, phenylketonuria, maple syrup urine disease).
- For infants who are well enough to be with their mothers, there are very few indications for supplementation. Some examples include:
 - Infants whose mothers have severe illness (e.g. psychosis, eclampsia, or shock).
 - Infants whose mothers take medications which are contraindicated when breastfeeding (e.g. cytotoxic drugs, radioactive drugs, and anti-thyroid drugs other than propylthiouracil).
 - Infants who are dehydrated or malnourished and too weak to feed at the breast (Infant Feeding: The Physiological basis, 1989).
 - Infants of mothers who are hepatitis C positive and have bleeding nipples should not be breastfed until nipples are healed.
 - Infants of mothers who have herpes on nipple/areola should not breastfeed until herpes lesions disappear.

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APPENDIX B

Referrals:

To facilitate the referrals at the IWK Health Centre contact Public Health Liaison at 420-6668.

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F. REFERENCES:

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Keys to Caregiving (1998). Seattle: University of Washington NCAST Publications.

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World Health Organization/UNICEF (1990). Innocenti Declaration on the protection, promotion and support of breastfeeding. Breastfeeding in the 1990s: Global Initiative. Florence: WHO/UNICEF.

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Attachment 10

BREASTFEEDING ASSESSMENT GUIDES

WHEN TO GET HELP

All parents should know when to get immediate breastfeeding help. They should be made aware of the following signs. While it is possible that a healthy breastfeeding baby may have a few of these signs, a thorough assessment of the situation is still warranted, especially in the early days and weeks, to determine if the baby is feeding effectively.

- The baby has fewer than two soft stools daily, during the first month.
- The baby has dark urine and/or fewer than one or two wet diapers daily for the first three days, or fewer than six wet diapers by days four to six.
- The baby is sleepy and hard to wake for feedings.
- The baby is feeding less than approximately eight times in 24 hours.
- The mother has sore nipples that have not improved by day three to four.
- The mother has a red, painful area of the breast accompanied by fever, chills, or flu symptoms.

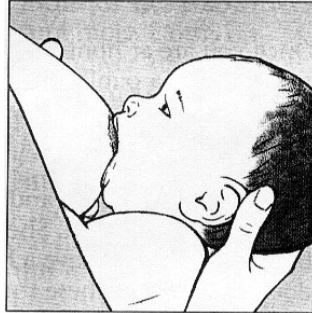
Source: Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines* (Ottawa: Minister of Public Works and Government Services, 2000.), p. 7.16.

POSTPARTUM AND POSTNATAL GUIDELINES

How to tell that breastfeeding is going well

You know that breastfeeding is going well when

- You can hear baby swallowing at the breast.
- Baby is gaining weight, feels heavier, and fills out newborn clothes. Baby needs to gain at least 4 ounces a week, 1 pound a month. In metric, that's about 100 grams a week, 450 grams a month. Most babies regain their birthweight within 10 to 14 days of birth.
- Baby is content after most feedings.
- Your breasts feel softer after feeding. They are never completely empty, because you continue to make milk while the baby is feeding.
- Baby begins to stay awake for longer periods.



You don't need to measure what baby is taking in to know that she is getting enough milk. If you are concerned, you can keep track of what is coming out. This can reassure you that your baby is getting enough

milk.

Here are the numbers to watch for:

Age	Wet diapers per day*	Bowel movements per day
Days 1 to 2	2 or more per day.	1 or more sticky, dark green or almost black (meconium).
Days 3 to 4 (milk coming in)	3 or more per day, pale urine, diapers feel heavier.	3 or more brown/green/yellow changing in colour.
Days 5 to 6 (milk in)	5 or more per day, pale urine, heavy wet diapers.	3 or more, becoming more yellow in colour. At least 3 are the size of a dollar coin ("loonie").
Days 7 to 28	6 or more per day, pale urine, heavy wet diapers.	3 or more yellow in colour.
After day 28	5 or more per day, pale urine, heavy, wet diapers.	1 or more, soft and large. Some babies may sometimes go several days without a bowel movement.

*If you are unsure diapers are wet when changing baby, place a paper towel inside the clean diaper and check for wetness next change.

Source: Nova Scotia Department of Health, Public Health Services and District Health Authorities, *Breastfeeding Basics* (Halifax: Nova Scotia Department of Health, 2001).

Attachment 11

ANTENATAL PSYCHOSOCIAL HEALTH ASSESSMENT (ALPHA)

Reprinted with permission from:

**Dr. June Carroll
Department of Family and Community Medicine
University of Toronto**

Source: Dr. J. Carroll Department of Family and Community Medicine, University of Toronto.

POSTPARTUM AND POSTNATAL GUIDELINES

ANTENATAL PSYCHOSOCIAL HEALTH ASSESSMENT (ALPHA)

Antenatal psychosocial problems may be associated with unfavorable postpartum outcomes. The questions on this form are suggested ways of inquiring about psychosocial health. Issues of high concern to the woman, her family or the caregiver usually indicate a need for additional supports or services. When issues of some concern are identified, follow-up and/or referral should be considered. Additional information can be obtained from the ALPHA Guide.*
Please consider the sensitivity of this information before sharing it with other caregivers.

Addressograph

ANTENATAL FACTORS	COMMENTS/PLAN
FAMILY FACTORS	
Social support (CA, WA, PD) <ul style="list-style-type: none"> • How does your partner/family feel about your pregnancy? • Who will be helping you when you go home with your baby? 	
Recent stressful life events (CA, WA, PD, PI) <ul style="list-style-type: none"> • What life changes have you experienced this year? • What changes are you planning during this pregnancy? 	
Couple's relationship (CD, PD, WA, CA) <ul style="list-style-type: none"> • How would you describe your relationship with your partner? • What do you think your relationship will be like after the birth? 	
MATERNAL FACTORS	
Prenatal care (late onset) (WA) <ul style="list-style-type: none"> • First prenatal visit in third trimester? (check records) 	
Prenatal education (refusal or quit) (CA) <ul style="list-style-type: none"> • What are your plans for prenatal classes? 	
Feelings toward pregnancy after 20 weeks (CA, WA) <ul style="list-style-type: none"> • How did you feel when you just found out you were pregnant? • How do you feel about it now? 	
Relationship with parents in childhood (CA) <ul style="list-style-type: none"> • How did you get along with your parents? • Did you feel loved by your parents? 	
Self esteem (CA, WA) <ul style="list-style-type: none"> • What concerns do you have about becoming/being a mother? 	
History of psychiatric/emotional problems (CA, WA, PD) <ul style="list-style-type: none"> • Have you ever had emotional problems? • Have you ever seen a psychiatrist or therapist? 	
Depression in this pregnancy (PD) <ul style="list-style-type: none"> • How has your mood been during this pregnancy? 	

ASSOCIATED POSTPARTUM OUTCOMES

The antenatal factors in the left column have been shown to be associated with the postpartum outcomes listed below. ***Bold, Italics*** indicates **good** evidence of association. Regular text indicates fair evidence of association.

CA - Child Abuse CD - Couple Dysfunction PI- Physical Illness PD - Postpartum Depression WA - Woman Abuse

POSTPARTUM AND POSTNATAL GUIDELINES

ANTENATAL FACTORS	COMMENTS/PLAN
<p>SUBSTANCE USE</p> <p>Alcohol/drug abuse (WA, CA)</p> <ul style="list-style-type: none"> • How many drinks of alcohol do you have per week? • Are there times when you drink more than that? • Do you or your partner use recreational drugs? • Do you or your partner have a problem with alcohol or drugs? • Consider CAGE (Cut down, Annoyed, Guilty, Eye opener) 	
<p>FAMILY VIOLENCE</p> <p>Woman or partner experienced or witnessed abuse (physical, emotional, sexual) (CA, WA)</p> <ul style="list-style-type: none"> • What was your parents' relationship like? • Did your father ever scare or hurt your mother? • Did your parents ever scare or hurt you? • Were you ever sexually abused as a child? 	
<p>Current or past woman abuse (WA, CA, PD)</p> <ul style="list-style-type: none"> • How do you and your partner solve arguments? • Do you ever feel frightened by what your partner says or does? • Have you ever been hit/pushed/slapped by a partner? • Has your partner ever humiliated you or psychologically abused you in other ways? • Have you ever been forced to have sex against your will? 	
<p>Previous child abuse by woman or partner (CA)</p> <ul style="list-style-type: none"> • Do you/your partner have children not living with you? If so, why? • Have you ever had involvement with a child protection agency (ie Children's Aid Society)? 	
<p>Child discipline (CA)</p> <ul style="list-style-type: none"> • How were you disciplined as a child? • How do you think you will discipline your child? • How do you deal with your kids at home when they misbehave? 	

FOLLOW-UP PLAN:		
<input type="checkbox"/> Supportive counselling by provider	<input type="checkbox"/> Homecare	<input type="checkbox"/> Assaulted women's helpline / shelter / counseling
<input type="checkbox"/> Additional prenatal appointments	<input type="checkbox"/> Parenting classes / parents' support group	<input type="checkbox"/> Legal advice
<input type="checkbox"/> Additional postpartum appointments	<input type="checkbox"/> Addiction treatment programs	<input type="checkbox"/> Children's Aid Society
<input type="checkbox"/> Additional well baby visits	<input type="checkbox"/> Smoking cessation resources	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Public Health referral	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prenatal education services	<input type="checkbox"/> Psychologist / Psychiatrist	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Psychotherapist / marital / family therapist	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Community resources / mothers' group		

COMMENTS:

Date Completed

Signature

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*The ALPHA Guide is available through the Department of Family and Community Medicine, University of Toronto.

Attachment 12

POSTPARTUM DEPRESSION SCREENING TOOLS

Edinburgh Postnatal Depression Scale

Name:

Address:

Baby's age:

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed:

I have felt happy

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
 - As much as I always could
 - Not quite so much now
 - Definitely not so much now
 - Not at all

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2. I have looked forward with enjoyment to things
 - As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
 - Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never

4. I have been anxious or worried for no good reason
 - No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often

5. I have felt scared or panicky for no very good reason
 - Yes, quite a lot
 - Yes, sometimes
 - No, not much
 - No, not at all

6. Things have been getting on top of me
 - Yes, most of the time I haven't been able to cope at all
 - Yes, sometimes I haven't been coping as well as usual
 - No, most of the time I have coped quite well
 - No, I have been coping as well as ever

POSTPARTUM AND POSTNATAL GUIDELINES

7. I have been so unhappy that I have had difficulty sleeping
Yes, most of the time
Yes, some of the time
No, not very often
No, not at all
8. I have felt sad or miserable
Yes, most of the time
Yes, quite often
No, not very often
No, not at all
9. I have been so unhappy that I have been crying
Yes, most of the time
Yes, quite often
No, only occasionally
No, never
10. The thought of harming myself has occurred to me
Yes, quite often
Sometimes
Hardly ever
Never

Source: Cox JL, Holden JM, Sagovsky R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-876.

Postpartum Depression Screening Scale (PDSS)

POSTPARTUM AND POSTNATAL GUIDELINES

The Postpartum Depression Screening Scale (PDSS) was developed by Cheryl Tatano Beck, D.N.Sc. and Robert K. Gable, Ed. D.. The PDSS contains 35 items that can be completed in 5-10 minutes. There are seven sub-scales which permits assessment of sleeping/eating disturbances, anxiety/insecurity, emotional lability, mental confusion, loss of self, guilt/shame, and suicidal thoughts. The first 7 questions, while not a separate instrument, can be completed in 1-2 minutes and scored to determine overall symptoms of postpartum depression. Copies of the PDSS Manual and Screening Tools can be obtained from:

Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, CA
90025-1251

