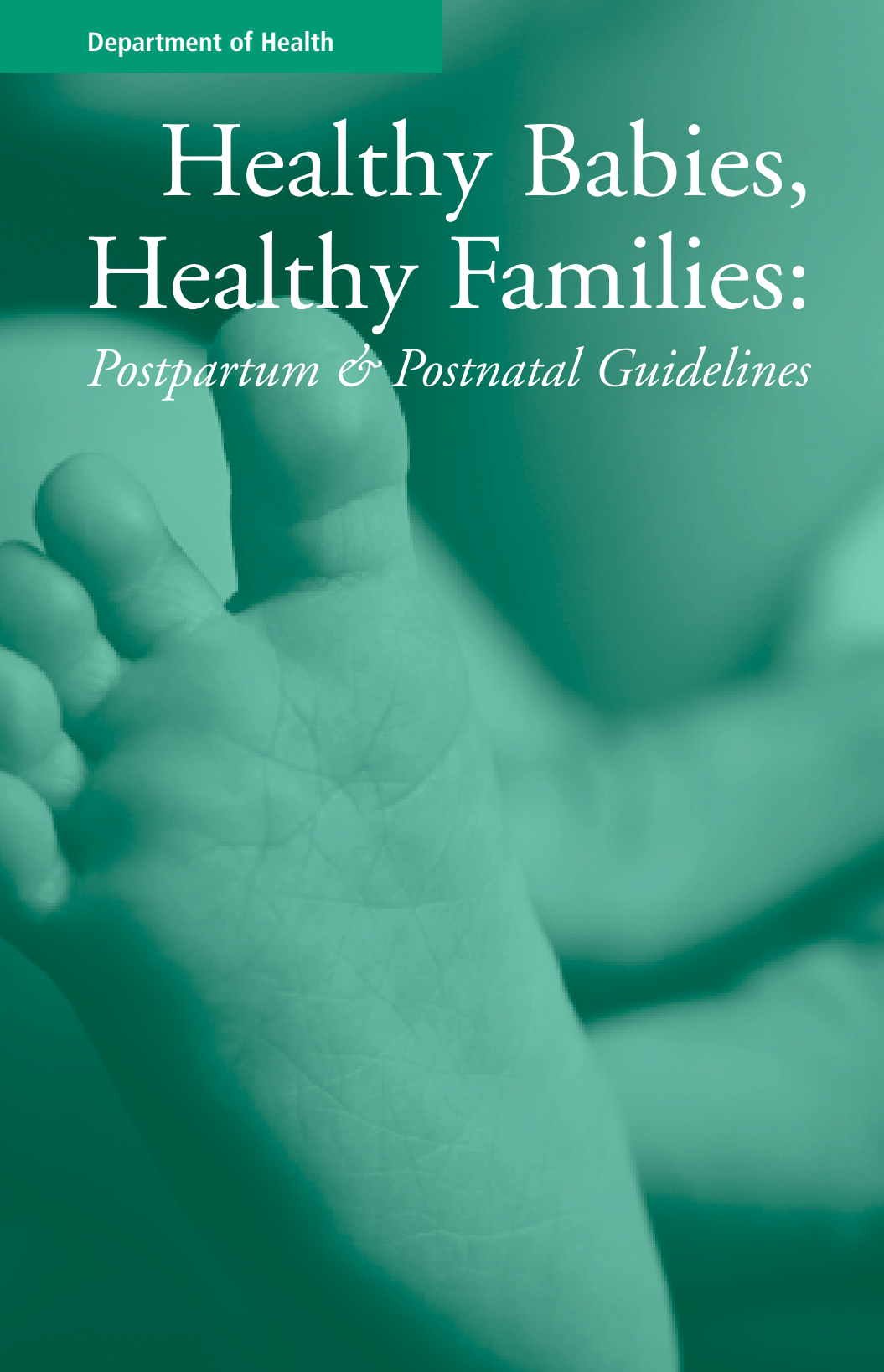
Department of Health

Healthy Babies, Healthy Families:

Postpartum & Postnatal Guidelines



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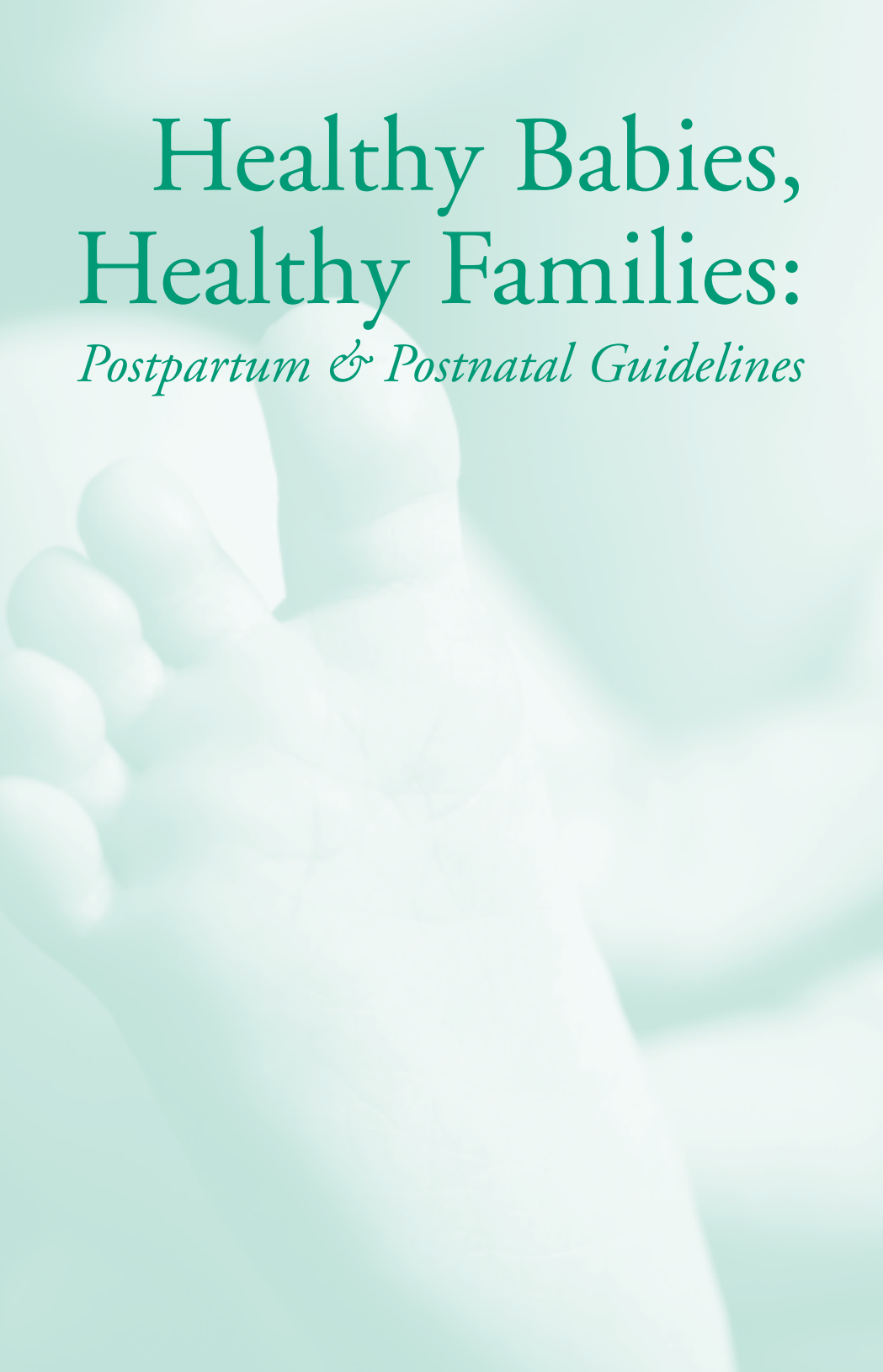

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NOVA SCOTIA
Department of Health

Reproductive Care Program of Nova Scotia
RCP

Introduction

AS PART OF THEIR COMMITMENT to supporting women, infants, and families, Nova Scotia health professionals identified the need for a standardized approach to postpartum, post-discharge care. In response to this need, *Healthy Babies, Healthy Families: Postpartum & Postnatal Guidelines* was developed to facilitate a smooth transition from hospital to home and to ensure that health care professionals can provide optimal care following birth. These guidelines were developed by a committee of health professionals organized through the Reproductive Care Program of Nova Scotia (RCP) and informed through a review of the literature and a cross country survey of selected key informants in other Canadian provinces. This review identified a number of key issues as noted below:

- Postpartum lengths of stay have decreased and care in the early postpartum has shifted from hospitals to the home setting.
- There is a need to focus on 'appropriate' versus 'early' discharge.
- There is a variety of care providers and services available in the postpartum period.
- No province has a single, consistent, standardized, province-wide approach to the delivery of postpartum/postnatal care.

- 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
  - the lack of a clear definition of needs during this time.

- Postpartum care is an under-researched and largely ignored period of maternal and infant care.

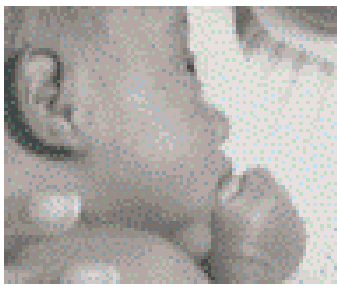
- The literature on postpartum care tends to present issues from the perspective of specific health care professions (e.g. the challenges for, or the role of, the postpartum nurse or the family physician) rather than focusing on system-wide issues.

- 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 care 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.

The document *Healthy Babies, Healthy Families: Postpartum & Postnatal Guidelines* has been approved by the RCP Action Group and the Department of Health. These guidelines are being made available to health care providers and planners to support the provision of postpartum/postnatal services in an informed and consistent way across Nova Scotia. It is recognized that developing an implementation plan for these guidelines will require a multi-disciplinary approach and cross-sectoral collaboration to meet local needs. The full report is available in all health care facilities with maternity services and through Public Health Services. It can be downloaded from the Department of Health website at: http://www.gov.ns.ca/health/Publichealth/.



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, 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." [1]

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.

[1] British Columbia Reproductive Care Program Consensus Symposium on the Provision of Postpartum Services in British Columbia. 2002.

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 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.

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;
- Collaborative practice; and
- Professional competency.

Physiologic stability

1

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. Follow-up will be individualized, based on these assessments.

Stability of both mother and baby should be established by comprehensive assessments at specific times.

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."[2] 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.

assessment

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

"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 interaction between those systems." [3]
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 36.5°C to 37.5°C)
- 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.

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

supports transition

1.3 A maternal assessment that includes physical and emotional issues, and identifies 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.[4] 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.

[4] 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).

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.

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 Initiative**[5] and the **Baby Friendly Initiative in Community Health Services** [6] outline key steps to facilitate the creation of conditions in which all women will be supported in their efforts to breastfeed their babies.

[5] UNICEF, Programme Manual, 1992. [6] Breastfeeding Committee for Canada, *Canadian Implementation Guide*, 2002.

In Nova Scotia, the rate of breastfeeding at hospital discharge is 65%.[7] Public Health Services has established population targets of 75% breastfeeding initiation and 60% breastfeeding duration at 4 months by 2007.[8]

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**,[9] and the **International Code of Marketing of Breast-milk Substitutes**,[10] policies developed by District Health Authorities should clearly identify referral/communication process(s) for mothers experiencing breastfeeding challenges.

collaboration

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.[11]

[7] Nova Scotia Atlee Perinatal Database, 2000. [8] Nova Scotia Department of Health, *Nova Scotia Health Standards,* 1997. [9] WHO/UNICEF, Joint Statement, 1989. [10] WHO/UNICEF, *International Code,* 1981. [11] UNICEF, Programme Manual, 1992.

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.

2

professional development

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**[12] 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**.[13]

[12] UNICEF, *Programme Manual*, 1992. [13] WHO/UNICEF, Joint Statement, 1989.

2.5 Prior to discharge and the transition to self-care, the following infant feeding/breastfeeding 'milestones' should be achieved:

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.[14]

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.

[14] Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines.*

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.

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.

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).

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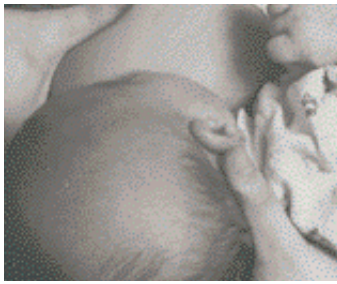

assessment

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.

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

collaboration

2.9 The booklet "**Breastfeeding Basics**"[15] 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.

[15] Nova Scotia Department of Health, Public Health Services and District Health Authorities, *Breastfeeding Basics.*

Psychosocial/family adjustment

3

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.

Healthy emotional and relationship adjustment to pregnancy and birth has a positive influence on parenting confidence and 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 violence.[16]

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.

[16] 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.

3

3.3 Special care and vigilance is indicated for women with a previous history of severe mental illness.[17]

3.4 Parents' perceptions of the birth experience should be explored prior to discharge and 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.[18]

3.5 All women should be assessed for the risk of, or the presence of, postpartum depression. A standardized postpartum depression screening tool could be used.[19]

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).

assessment

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.[20] Information regarding community resources should be widely available (e.g. posters, printed information left in women's washrooms, etc.).

[17] G. Lewis, *Why mothers Die. The Confidential Enquiries into Maternal Deaths in the United Kingdom 1997-1999.* [18] Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines.* [19] Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines.* [20] Health Canada, Population and Public Health Branch, The National Clearing House on Family Violence.

Parent-child attachment/ parenting

4

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.[21]

Parent-child attachment, beginning at the moment of birth, has a critical impact on all aspects of child development.

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

capacity building

[21] F. Mustard & M. Norrie McCain, *Early Years Study - Reversing the Real Brain Drain.* [22] K. Barnard & G. Sumner, *Keys to Caregiving.*

4

capacity building

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.[23] 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.[24]

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.

[23] G. Sumner & A. Spietz, *NCAST Caregiver/Parent - Child Interaction Feeding Manual.* [24] Great Kids, Inc., *Program Planning Guidebook, Home Visitation Programs for Families with Newborns.*

Building on capacities and strengths

5

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.[25]

Health Care providers can enhance parents' confidence and skills by focusing on family strengths.

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.

5.4 The mother should receive information and resources in the very early postpartum stage about the resumption of intercourse and contraception measures.

[25] Family Service Canada (Not-for-profit, national, voluntary organization representing the concerns of families and family service agencies across Canada).

5

collaboration

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.[26]

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.

[26] Health Canada, *Postpartum Parent Support Program: Implementation Handbook.*

Transition to home and community

6

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 key to promoting healthy new beginnings for the family.[27]

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 heath 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, 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 infant.[28] Prior 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.

[27, 28] Health Canada, *Family-Centred Maternity and Newborn Care: National Guidelines.*

6

support transition

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 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.

Family access to community support

7

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 heath. Ensuring accessible postpartum/postnatal support for families within their communities is essential in supporting health outcomes for women/children and families.

Accessible postpartum support within their communities is essential for 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, 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.

collaboration

7

supports transition

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.

Healthy lifestyles and environments

8

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

Health promotion strategies should 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 considered.[29]

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.

capacity building

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

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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 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.

Collaborative practice

9

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".[30]

Primary health care in Nova Scotia must be based on inter-sectoral collaboration.

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.

collaboration

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.

[30] Nova Scotia Department of Health, *Vision for Primary Health Care.*

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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.

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.

Professional competency 10

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

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

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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