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

Postnatal Hospital Discharge Experiences Workgroup Report

Executive Summary

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CMNRP Postnatal Discharge Experiences Workgroup

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Executive Summary

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

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

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

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

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

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

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

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