Discharge Planning During Antenatal Visits

Guidelines	Level of Evidence	References
All women should be given appropriate written information regarding length of stay, discharge procedures and caring for themselves and their baby when they return home, and be given an opportunity to discuss these issues with their midwife or doctor. Hospitals should ensure consistent information is given to women and that shared care providers are included in planning.	IV	2,11
Good Practice Notes		
Discharge planning initiated during antenatal visits appears to benefit women. There is some evidence it may increase satisfaction with care. However, the evidence is insufficient to recommend the content and timing of routine planning prior to admission.		
Innovations in discharge planning should be introduced with concurrent evaluation of maternal and infant outcomes.		
In terms of breastfeeding advice, NHMRC guidelines recommend midwives and doctors offer women a range of useful, easy-to-read literature on breastfeeding, including contact points for local support groups. An antenatal discussion should cover the importance of exclusive breastfeeding for the first four to six months, including the nutritional and protective benefits of breastfeeding. Education about basic breastfeeding management and coping with minor problems is also important. Education programs should acknowledge the role of partner and relatives in creating a supportive environment for breastfeeding.		12

Aim

The aim of these guidelines is to assist midwives and doctors on antenatal discharge planning for women assessed as low obstetric risk in order to reduce maternal anxiety, maternal and neonatal morbidities and increase satisfaction with care.

Evidence

Discharge planning refers to techniques that assist women to identify anticipated needs for themselves, their newborn and other household members following discharge from hospital and interventions to address anticipated needs. Techniques may include informal questions, formal assessment tools or targeted visits. The needs identified may be physical (including issues such as physical self-care and breastfeeding), or social (including issues such as housing or the impact of a new baby on family relationships). Interventions usually include referral to support agencies, advice and written information. The emphasis in Australia appears to be on planning for the immediate physical needs of the baby and the mother. There is no consensus on what should be covered during planning, though it will generally include discussion of what to bring to hospital, when to come to hospital, infant feeding safety and length of stay.

Midwives and doctors undertake antenatal discharge planning in the belief that it is associated with positive outcomes for mother and baby, and as part of a general duty of care to prepare women for the transition from hospital to home. Although the Victorian Ministerial Review of Birthing Services (1990) recommended that planning for the postnatal period be an integral part of maternity services, the techniques and frequency of discharge planning vary greatly between hospitals, and between models of care within hospitals [1]. The 1999 Review of Shared Care in Victoria indicates that, although attempts have been made to plan for postnatal discharge during booking and preadmission visits, most planning occurs post-delivery [2]. Formal antenatal discharge planning at the centres was only introduced to standard care in the last 1-4 years and is largely driven by hospital policies surrounding early discharge and, in some cases, women's responses to these policies. Two of the Three Centres offer a third trimester 'discharge planning' or 'preadmission visit' with midwives. While individual doctors and midwives may have always undertaken discharge planning, midwives do most formal planning.

There is a paucity of evidence addressing the effectiveness of discharge planning conducted antenatally. Almost all the published literature focuses on planning that occurs in the immediate postpartum period [3-10]. A recent Cochrane review concludes there is some evidence that discharge planning may result in reduced length of stay, reduced readmission rates and increased satisfaction with care, but overall this assumption has not been directly addressed or systematically evaluated [8]. A 1995 US review found little high level evidence to guide discharge planning for most apparently well newborns and their mothers [9]. Consequently, there is no published evidence to indicate whether a single antenatal visit focused on discharge planning is more beneficial than planning undertaken throughout the antenatal period. Neither is there direct evidence to suggest when planning should occur, if and how questions should be asked, or who should do the asking. No research compares midwife led planning with other providers. However, there is good evidence to suggest women value consistent information and shared care providers should be involved in discharge planning [11]. Further research is necessary to address each of these issues.

NHMRC guidelines on infant feeding recommend midwives and doctors discuss the benefits and management of breastfeeding and feeding choices with women during pregnancy. They recommend the discussion (to assess the woman and her partner's attitudes and expectations, knowledge and experience of infant feeding) should take place during the initial visit, following a routine breast check [12]. However, the initial visit may not be the optimal time for proper discussion of feeding choices.

Surveys of recent mothers in Victoria (Level IV evidence) establish that satisfaction with care is associated with women feeling they have been properly informed, supported and prepared [4]. However it is still unclear whether the current techniques and interventions associated with discharge planning are effective to this end. Current survey research underway at Southern Health maternity facilities on Women's Experiences of Childbirth Services (EPOCS) may address the lack of evidence. In 1999 Southern Health initiated a survey of 1,922 women who had given birth at one of the four sites prior to implementing changes to discharge planning. Two thirds (66.4 per cent) of the 1,249 respondents reported they received written information about going home from hospital. However, large numbers of women reported they would like more information about life with a new baby (40.4 per cent), their own health and recovery following birth (37.4 per cent) and about the hospital stay (20.4 per cent). Initiatives including the revision of written information to women, a specific antenatal visit designed for postnatal planning and a program of education and support for midwives working in the antenatal setting were designed to address the issues raised. These were complemented with an added focus on discharge planning during the postnatal hospital stay and a hospital based domiciliary service. A post implementation survey to evaluate the impact of the initiatives will conclude mid 2001 [6].

Methods of Search and Appraisal

Three strategies were used to search and appraise evidence relating to discharge planning.

I. Search on Defined Questions (February 2001)

A research team from the Department of Perinatal Medicine at the Royal Women's Hospital used the OVID interface to search Premedline/Medline (1985 to current), CINAHL (1992 to December 2000), Best Evidence (1991 to December 2000), ClinPsyc (1989 to December 2000), and the Cochrane Database (2001 Issue 1) to address:

1. What evidence exists to indicate a universal postnatal discharge planning conducted antenatally is beneficial in terms of readmission rates, satisfaction with care, breastfeeding, and maternal and infant morbidity?

2. What evidence exists to indicate a single antenatal visit focused on discharge planning is more beneficial than postnatal discharge planning undertaken throughout the antenatal period?

3. What information should be obtained from women antenatally to assist with discharge planning?

4. How should questions about postnatal planning be asked?

5. When in pregnancy should discharge planning be undertaken?

6. Who should women see regarding discharge planning?

7. What evidence exists to indicate a universal third trimester postnatal planning visit is beneficial to women compared with no planning visit at all?

The search terms included postnatal or postpartum and discharge planning, prenatal, antenatal or antepartum with discharge planning, preadmission and surgical, preadmission, planning and preparation. The following outcome measures were used: readmission rates, satisfaction with care, breastfeeding rates, maternal and infant morbidity.

The initial search yielded 59 citations, from which 14 key citations were identified. Two citations were identified by hand search of the bibliographies. The 13 citations included a Level I Cochrane systematic review, a Level II RCT, 2 Level III-2 studies and nine Level IV studies/documents. The coordinator searched grey literature and journals for additional evidence published between March and August 2001.

II. Consultation with Experts to Identify Evidence and Practice Wisdom.

III. Search of Related Fields

Electronic databases (listed above) were searched for articles on preoperative education and surgical preadmission clinics relevant to preadmission clinics for pregnant women.

References

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4. Brown S, Lumley J. *Survey of recent mothers. Women's views and experiences of maternity care.* Centre for the Study of Mother's and Children's Health, La Trobe University, Melbourne 1997. Level IV

5. Brown S, Darcy MA, Bruinsma F, and Lumley J. *Postnatal Care in Hospital Time to Reassess and Rethink.* Paper 149 presented at Perinatal Society of Australia and New Zealand Conference Canberra, March 2001. (available from www.psanz.org) Level IV

6. Krastev A, Yelland J and Brown S. *Looking Ahead-Postnatal Discharge Planning.* Paper 150 presented at Perinatal Society of Australia and New Zealand Conference, Canberra, March 2001. (available from www.psanz.org) Level IV

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9. Braveman P, Egerter S, Pearl M, Marchi K, Miller C. Early discharge of newborns and mothers: A critical review of the literature. *Pediatrics* 1995;96(4): 716-725. Level IV

10. Braveman P, Kessel W, Egerter, S, Richmond J. Early Discharge and evidence-based practice: good science and good judgment. *JAMA* 1997;278(4): 334-336. Level IV

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12. NHMRC. *Infant feeding guidelines for health workers*. NHMRC, Canberra 1996. Level I