

# **Maternity Services and the Discharge Process: A Review of Practice in Queensland**

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## ABBREVIATIONS

<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation
<b>ACSQHC</b>	Australian Commission on Safety and Quality in Healthcare
<b>AMS</b>	Aboriginal Medical Service
<b>CFHN</b>	Child Family Health Nurse
<b>CNC</b>	Chief Nurse Consultant
<b>DON</b>	Director of Nursing
<b>EDS</b>	Enterprise Discharge System
<b>GP</b>	General Practitioner
<b>MW</b>	Midwife
<b>MUM</b>	Midwife Unit Manager
<b>NGO</b>	Non-Government Organisation
<b>NMSP</b>	National Maternity Services Plan
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>NUM</b>	Nurse Unit Manager
<b>PHR</b>	Pregnancy Health Record
<b>QMPQC</b>	Queensland Maternity and Perinatal Quality Council
<b>SMO</b>	Senior Medical Officer
<b>VMO</b>	Visiting Medical Officer

## EXECUTIVE SUMMARY

Research indicates that early parenting can be overwhelming and difficult (Nelson, 2003; Schmied et al., 2010) and yet the transition between hospital-based maternity care and community-based child and family health services has received little attention. Despite universal access to community-based child and family health services in Queensland, the effectiveness of those services is limited by inadequate transfer and referral processes (Brodribb et al., 2012). The fragmentation of services may have a significant negative impact during a vulnerable time for women and families (Homer et al., 2009, p. 65).

### Aim

This project aimed to review current practices around postnatal transfer of care from Queensland birthing facilities to community-based services.

### Objectives

In order to achieve the identified aim, the project included the following elements:

- A review of the literature focusing on discharge processes and documentation, including published academic papers and grey literature discussion papers, government policies and guidelines.
- An online survey of postnatal transfer of care practice in all Queensland birthing facilities.
- A review of the process, content and distribution of discharge summaries in Queensland birthing facilities.
- Identification of recommendations to improve the quality of information transfer from maternity services in Queensland.

### Findings

#### Literature review

Shortcomings in the quality and process of information transfer in all disciplines of health care in Australia and internationally are well documented. Issues reported in the literature include content errors, omissions and delays in creation and dissemination of discharge summaries. Similar concerns have been raised in maternity services research, particularly around the potential for poor quality or delayed discharge summaries to contribute to fragmentation of care. To date, studies aimed at improving the quality of discharge communication have focused on interventions related to electronic generation and standardisation of content. However, there has been relatively little attention given to defining the content or design of high quality discharge summaries in healthcare generally, and none in maternity specifically.

#### Survey

A total of 55 Queensland birthing facilities (public N=40 and private N=15) were invited to participate in an online survey seeking information about their discharge summary practices. Fifty-two of the 55 (95%) facilities (public N=38, 95% of public facilities; private N=14, 93% of private facilities) responded. Electronic discharge summaries were in common use (N=34, 65%), but information for the summary was typically generated from a review of the woman's paper-based client records (N=30, 58%). The Enterprise Discharge Summary (EDS), which is an electronic system for the creation of discharge summaries in hospitals and their distribution to General Practitioners (GPs) (Office of the Deputy Premier and Minister for Health, 2010) does not appear to have been widely adopted in maternity services.

Discharge summaries are most often completed by postnatal ward midwives (N=16, 31%) and resident doctors (N=14, 27%), with the remainder completed by other midwives, registrars or consultants. Participants reported that discharge summaries were usually sent either at discharge (N=15, 29%) or within one week (N=30, 58%), usually to a woman's GP (N=43, 83%), and less commonly to Child Family Health Nursing Services (N=27, 52%). Few facilities reported sending discharge summaries to other agencies such as Aboriginal Community Controlled Health Organisations (ACCHOs), or non-government agencies, even though these agencies provide important services to women in the early postnatal period. Furthermore, distribution was more likely to be directed by routine practice, than by the needs of the individual woman.

The findings indicated a lack of collaboration with women in the process of information sharing and transition of care to community agencies. Only 10% (N=5) of the respondents reported that their facility had a process for women to check accuracy of their discharge summary. Less than half of the participants reported that their facility (N=25, 48%) routinely provided women with a copy of their discharge summary. One in five facilities did not consult women to inform them or seek their consent for the disclosure of their information (N=10, 19%).

### Analysis of discharge summaries

Of the 52 facilities who completed the survey, 25 (48%) provided QCMB with a copy of a de-identified postnatal discharge summary in use in their facility. This yielded eight different discharge summaries, with two of the templates being used across 16 facilities. Content analysis of these documents revealed deficiencies associated with the use of generic forms (not specific to maternity) and significant variation in the nature, content and application of otherwise similar discharge summary forms. Moreover, there was a heavy focus on bio-physical information, minimal data relating to psychosocial status and gaps in information about postnatal services and post-discharge care advice.

## Recommendations

The Queensland Government has made a significant investment in postnatal care through the "Mums and Bubs" policy to increase women's access to postnatal care. Our recommendations strengthen and improve on this investment for the benefit of women, babies and families. We recommend that:

1. Queensland Health, through an executive sponsor, such as the Chief Nursing and Midwifery Officer in partnership with Queensland Centre for Mothers and Babies, develop a standardised discharge summary template for use across maternity services.
2. All discharge summaries include information on both the woman's and the baby's bio-physical history and outcomes as well as psychosocial and cultural needs and the impact these may have on the family following discharge (see also Appendix B).
3. Discharge summaries be produced via electronic health records to facilitate generation and reduce human error.
4. Each maternity service identify appropriate personnel to be responsible for the coordination of the discharge process, including completion and distribution of the discharge summary.
5. Processes be developed to ensure each woman is involved in the development and review of her discharge summary and receives a copy of it upon discharge.
6. Discharge summaries be created and distributed when the woman is discharged from the maternity service (including any domiciliary midwife home visits).

7. With the woman's consent, discharge summaries be distributed to a wide group of support services including GPs, CFHNs, NGOs, ACCHOs, and other relevant support services.
8. Further research into maternity discharge communication be undertaken.



## 1. PROJECT BACKGROUND

Women's experiences of the transition into motherhood have received significant research attention. Consistently, this research reports that early parenting can be an overwhelming and difficult time for many women (Nelson, 2003; Schmied et al., 2010) with a number of health issues emerging (e.g., low confidence, anxiousness, depression, extreme tiredness, backache) (Brown & Lumley, 1997; Miller et al., 2011; Thompson et al., 2002). The value of additional support at this vulnerable time is well documented (Fenwick et al., 2010; Myors et al., 2013; O'Connor, 2001; Zadoroznyj, 2007), but Australian research finds that women often feel isolated and are particularly dissatisfied with their postnatal care (Guest & Stamp, 2009; Prosser et al., 2013).

This dissatisfaction with postnatal care has led to scholarly evaluation of the impact of the trend towards early postnatal discharge and consideration of other ways of providing support to women and families. In Queensland, attempts were made to increase postnatal support for women following hospital discharge through the Universal Postnatal Contact Service (AHMAC, 2011). Evaluations of that initiative call for improved referral mechanisms and collaboration between birthing facilities and community services such as child health services and General Practitioners (GPs), as well as mechanisms to extend the service to women who birth in private care (Brodribb et al., 2012).

Greater integration of the services available for families from pregnancy through early childhood is needed to improve the effectiveness of these services. Currently there is limited research into best practice for supporting families through this transition, with the majority of 'transition of care' research being conducted in health areas outside of maternity care. Furthermore, little is known about the processes currently in place to manage this transition of care in Queensland maternity services. This project sought to explore the transition from hospital-based maternity services to either community-based health services or other agencies who offer important support to women and families in the first weeks and months of parenting.

## 2. PROJECT AIM

This project aimed to review current practice around postnatal transfer of care and information from Queensland birthing facilities to community health and other services. To meet this aim, we conducted the following:

- A review of the literature focusing on discharge communication, including published academic papers and grey literature (i.e., discussion papers, government policies and guidelines).
- An online survey of postnatal transfer of care practice in all Queensland birthing facilities.
- A review of the process, content and distribution of discharge summaries in Queensland birthing facilities.
- Identification of recommendations to improve the quality of information transfer from maternity services in Queensland.

### **3. LITERATURE REVIEW**

#### **3.1. Discharge summaries**

Concern about the quality of discharge summaries in all disciplines of health care is not new. A 1975 study (Tulloch et al., 1975) of discharge summaries in English hospitals identified the need for improvements in both timeliness and content. Much of the literature examining discharge summaries is drawn from geriatric and psychiatric care. This reflects the complex care needs of geriatric and psychiatric health consumers and the involvement of both community and acute care settings, making care vulnerable to fragmentation and an associated decrease in quality (Coleman, 2003). A 2011 study (Coit et al. (2011) found that less than 25% of discharge summaries included discharge instructions, information on follow-up care, or a discharge medication list. Kind et al. (2012) found that delayed creation of discharge summaries, or completion by less experienced care providers was associated with the omission of critical information. Similarly, Kripalani et al. (2007) identified deficits in communication and information transfer at hospital discharge.

#### **3.2. Discharge summaries in maternity care**

Maternity services research has reported similar concerns about the potential for fragmentation and poor quality care after discharge from hospital. Australian research identified a lack of consistency in processes for transition of care in maternity services, despite it being an “ideal time to ensure women are linked into services and support agencies... [and] also the time that fragmentation of services can potentially have a deleterious effect” (Homer et al., 2009, p. 65).

The consequences of fragmentation may be most profound in the care of women from rural and remote areas. Bar-Zeev et al. (2012) called for improvements in discharge processes as a key component of improving the standard of care for remote-dwelling mothers and their infants. Although not a maternity patient, the gravity of the risk created by miscommunication at discharge for remote dwelling Australians is demonstrated by the case of the preventable death of an elderly Aboriginal man after he was left at a Northern Territory airstrip following his discharge from hospital (Chalmers, 2007). Josif et al. (2012, p. 402) undertook a participatory action research project to address such “fragmented and dangerous discontinuities in a postnatal health care discharge system”. The project resulted in a new ‘length of stay and discharge policy’, a redesigned discharge summary, designation of a health professional at each remote community to receive discharge summaries, as well as training to support the computer generation of discharge summaries.

#### **3.3. Australian health policy**

The policy direction at a national level in Australia is clear. The National Safety and Quality Health Service Standards (2011, p. 45) call for “timely, relevant and structured clinical handover that supports safe patient care”, which involves standardised processes and information sets. Similarly, the National Maternity Services Plan (NMSP) stipulates that the “transition from maternity care into child and family health care should also provide continuity of care through a robust system of early referral and information transfer in the postnatal period” (AHMAC, 2011, p. 14). The NMSP prioritises the development of a “nationally consistent approach to information transfer and referral from maternity care to child and family health care”, including sharing of standardised information (p. 50).

Although some Australian states have developed comprehensive strategies to integrate services for families (Department of Education and Early Childhood Development Victoria, 2004; NSW Department of Health, 2009), the Victorian protocol appears to be the only one which attempts to address seamless transition from maternity services to family and child health services by specifying how information should be shared at key junctures in maternity care. Nonetheless, the Victorian protocol does not extend to women who birth in private care or who wish to seek private child and family health care through their GP. Moreover, there are few published evaluations of these integrated models of service delivery (Schmied et al., 2010).

### **3.4. International health policy**

Just as in Australia, international guidelines and government strategies acknowledge the importance of seamless transitions from maternity care to child and family health care services. In Canada, government strategies aim to create a “seamless continuum of care from community to hospital to community” (Perinatal Services BC, 2011, p. 29), because “postpartum care and a successful transition to the community are key to promoting healthy new beginnings for the family” (p. 31). This has been addressed in British Columbia, Canada with the development of a standardised process to support continuity of care which focusses on a structured, logical and standardised manner of communication. Similarly, in the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) guidelines establish a minimum data set (NICE, 2006). In the USA, the Joint Commission on the Accreditation of Healthcare Organisations stipulates mandatory elements for inclusions in discharge summaries, although these elements are not directly aligned with maternity services nor do they have agreed definitions (Kind & Smith, 2005).

### **3.5. Improving discharge summaries**

To date, studies aimed at improving the quality of discharge communication have centred on interventions related to electronic generation and standardisation of content through various means (Hesselink et al., 2012). Such studies (eg. Kripalani et al., 2007; Lissauer et al., 1991; Maslove et al., 2009; Myers et al., 2006; Rao et al., 2005; van Walraven et al., 1999) have consistently found that electronic generation of discharge communications and standardisation of content were favourably associated with completeness, timeliness and accuracy.

Scant attention has been given to defining the content of high quality discharge summaries. Three studies (Balla & Jamieson, 1994; Meara et al., 1992; van Walraven & Rokosh, 1999) make recommendations about discharge summary content relevant to general hospital admissions, while a fourth study's focus (Coleman, 2003) is on geriatric care. The valued content of discharge summaries in these studies related to diagnosis, examinations and test results, complications, medications and ongoing medical care needs. This is consistent with their focus on general hospital discharge, where patients have received care for sickness or injury.

The relevance of these definitions of discharge summary content to maternity discharge summaries is limited. In maternity services, discharge summaries provide information, in most cases, about well women and their babies. The appropriate emphasis for maternity discharge summaries may well be different; however, there is no literature to illuminate how. We were unable to locate any studies that evaluated the content of maternity discharge summaries specifically. One Australian state government program (Department of Health

Victoria, 2012) does recommend minimum content for maternity discharge summaries, but its advice is brief and focussed on the discharge summary as part of a specific referral.

Nonetheless, the value of psychosocial information is evident, both in discharge from general hospital care and maternity care. Meara et al. (1992) found that GPs sought the inclusion of more information about patient's social, not just medical, needs. Similarly, van Walraven and Rokosh (1999) identified the value of information about the patient's ongoing social needs and Kripalani et al. (2007) raised concerns over the frequent omission of information related to patient or family counselling. A study of women's dissatisfaction with postnatal care (Wray and Davies (2007) reported that women want more and better advice about contraceptive options, as well as more information about local support groups. Given that suicide is one of the leading causes of maternal death in Queensland, the Queensland Maternity and Perinatal Quality Council (QMPQC) has also called for greater emphasis on the psychosocial wellbeing of women after their discharge from hospital (QMPQC, 2012).

Some studies have made recommendations about the length and format of discharge summaries, although these are not specific to maternity services. The findings of van Walraven and Rokosh (1999) support the selection of relevant information, rather than 'over-including' all information and found that discharge summaries were most highly regarded when they did not exceed two pages. Papers from Sandler et al. (1989) and van Walraven and Rokosh (1999) report that discharge summaries in a structured form were preferred over letters or narrative styles.

The need for accurate, reliable, timely and complete discharge communication is clear. What this means for maternity care has yet to be thoroughly explored in research. Australian and international guidelines and government strategies offer some insights, but further clarity is needed.

## 4. SURVEY METHODOLOGY

An online survey was created to assess the discharge processes of Queensland birthing facilities (N=55<sup>a</sup>). A copy of the survey is in Appendix A. The draft survey was refined on the basis of feedback from the Queensland Maternity and Neonatal Clinical Network, and piloted with two midwives. A web link to the final version of the survey was then distributed to the Director of Midwifery in each Queensland birthing facility, together with a cover letter from the Queensland Health Midwifery Advisor. The cover letter stated the purpose of the survey and requested that if the Director of Midwifery was not the most suitable person to complete that survey, that it be passed on to someone who was more suited. Participants received an email reminder at two weeks and telephone follow-up at three weeks after receiving the survey.

Sixteen items were included in the final survey, five of which asked for demographic information. The remaining items assessed the facility's discharge process, the woman's role in this process, and ideas for improvement. The survey also requested a copy of the facility's discharge summary to be emailed or posted to QCMB.

## 5. SURVEY FINDINGS

### 5.1. Participants

Fifty-two (95%) of the 55 Queensland birthing facilities completed the survey. Of the facilities that responded, 38 (73%) were in the public sector (95% of all public birthing facilities) and 14 (27%) were in the private sector (93% of all private birthing facilities).

Participants predominately held positions of either Nurse Unit Manager (NUM; N=22, 42%) or Director of Nursing (DON; N=10, 19%; see Figure 1).

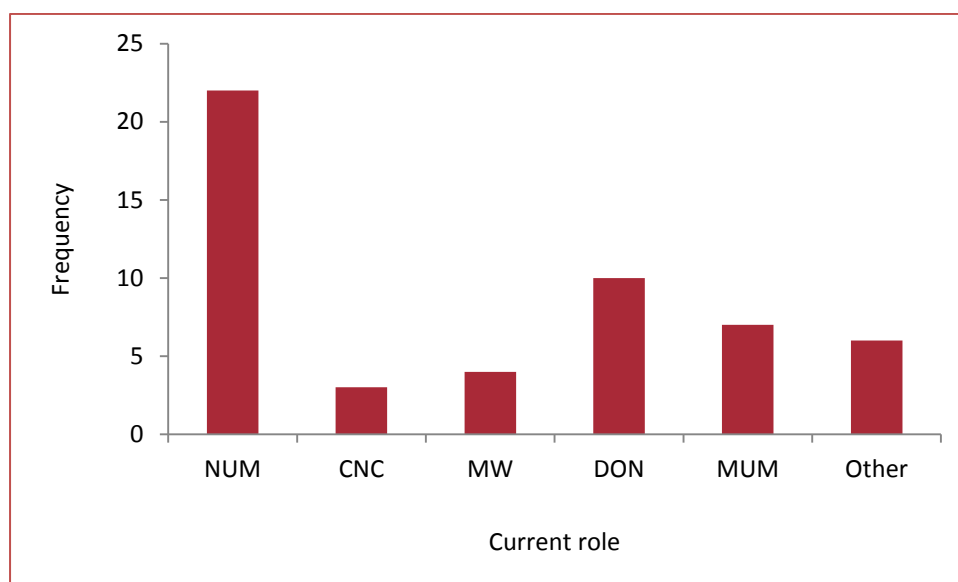


Figure 1. Current roles of participants

<sup>a</sup> Birth centres were not separately assessed from their attached hospital facility.

## 5.2. The discharge summary

The two most common forms of discharge communication used in Queensland facilities were an electronic discharge summary (N=34, 65%; public N=28, 74%; private N=6, 43%) and the Queensland Health Postnatal Discharge/Referral Form (N=13, 34% public). Handwritten paper summaries were less commonly used (N=11, 21%; public N=2, 5%; private N=9, 64%). One public facility reported using a letter and another three facilities reported using their own locally-developed discharge summary. Twelve facilities (23%, public N=9, 24%; private N=3, 21%) reported using the Queensland Perinatal Data Collection form, although this is not intended as a discharge communication document; it is a health statistics collection tool.

Information to complete the discharge summary was typically generated from a review of the woman's paper-based client records (N=30, 58%; public N=24, 63%; private N=6, 43%) or an electronic database (N=18, 35%; public N=12, 32%; private N=6, 43%). Databases varied between facilities and included Matrix, Obstetric, Enterprise Discharge Summary, Meditech, and the Perinatal Data Collection. 'Other' (N=4, 8%; public N=2, 5%; private N=2, 14%) responses included pathology and ultrasound results.

## The discharge process

### 5.3.1. Who completes the discharge summary?

The care provider reported as typically completing discharge summaries was different in public and private hospitals. Participants from private hospitals reported that midwives completed discharge summaries in all cases, and most often it was postnatal ward midwives (private N=12, 86%). In public hospitals, resident doctors (public N=14, 37%) were most frequently identified as typically completing women's discharge summaries (see Figure 2). Respondents selecting 'other' outlined that Senior Medical Officers (SMO) or a combination of both midwives and doctors often completed the discharge summaries.

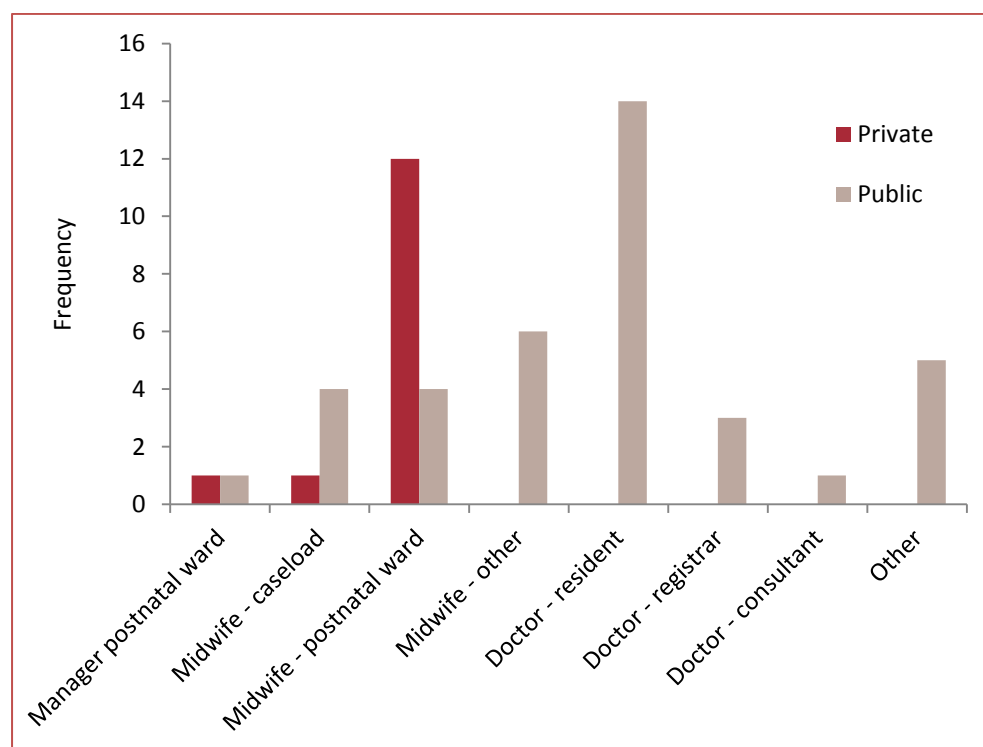


Figure 2. Health care providers who complete postnatal discharge summaries

### 5.3.2. To whom are discharge summaries distributed?

It was more common for facilities to send a copy of a woman's discharge summary to her GP (N=43, 83%; public N=36, 95%; private N=7, 50%), than it was for it to be sent to the local Child Family Health Nurse (CFHN) (N=27, 52%; public N=19, 50%; private N=8, 57%; see Figure 3). 'Other' responses included sending the discharge summary to the community midwife, Universal Postnatal Contact Initiative (UPNC) midwife and Royal Flying Doctor Service.



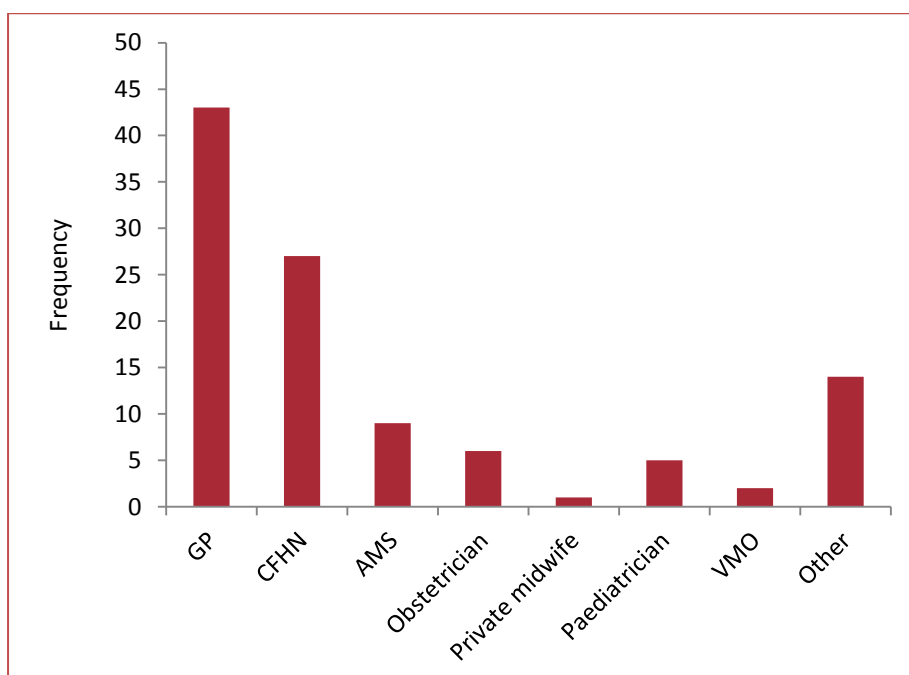


Figure 3. Health care professionals who receive women's discharge summaries

Participants indicated a variety of ways in which Queensland facilities determined the distribution of a woman's discharge summary, using an open-text response question in the survey. Analysis of responses indicated three different ways that Queensland birthing facilities determined who should receive women's discharge summaries. These were 'routine practice', 'assessing needs' and 'asking women'.

#### 5.3.2.1. Routine practice

Routine practice was identified as a determining factor in the distribution practices of 27 Queensland birth facilities (52%; public N=21; 55%; private N=6, 43%), as seen in the following quotations from participants.

*Standard practice is to send discharge summary in the mail to nominated GP.*  
Regional public hospital

*Automatically send information to all 4 [GP, CFHN, Paediatrician, Visiting Medical Officer (VMO)]*  
Regional private facility

In five of the 27 'routine practice' responses, it was also possible to identify one of the other two themes describing the facility's practice for determining the distribution of discharge summaries. This is demonstrated in the following quotations from participants:

*The mother is asked which services she would like referrals to and copies are sent. All discharge summaries are sent to the woman's GP and the CHN [Child Health Nurse].*  
(combines 'asking women') Rural public facility

*Decisions would be based on outcomes from preg and birth. Routine care - Summary to woman and (+/- GP). If non-routine summary to any other relevant specialists or those to whom the woman has been referred e.g. CFHN, Paed, psychologist etc.*  
(combines 'assessing needs') Metropolitan private facility

### 5.3.2.2. Assessing needs

Sixteen participants (31%; public N=11, 29%; private N=5, 36%) described that their facility's approach to determining the distribution of women's discharge summaries was dependent on assessment of the woman's needs. This included the practice of sending discharge summaries back to referring care providers, distributing discharge summaries to care providers to whom a woman had been referred postnatally, and other individualised assessments.

*Caseload midwife determines women's needs post birth.*

Rural public facility

*The summary is sent to any health practitioner who has or will be involved in that particular woman's care.*

Metropolitan private facility

### 5.3.2.3. Asking women

Explicitly seeking the preferences of women regarding who should receive their discharge summary was identified in the responses of participants from 12 facilities (23%, public N=7, 18%; private N=5, 36%). This group included 6 responses indicating that women were asked (public N=6, 16%; private N=0), and a further 6 responses indicating that women were given their discharge summary to distribute as they chose (public N=1, 3%; private N=5, 36%).

*We discuss with the woman during her stay. If she was share caring or sees a usual GP we gain consent for a discharge summary to be sent to her nominated provider. All women are offered community health follow up with child health. Child health visits the mother in hospital, mothers consent is obtained to fax a copy of discharge summary to child health. The women are advised that community health will contact them to see how they are going and arrange an appointment if required.*

Small regional public facility

*One copy is given to the Client who in turn is asked to pass it onto the GP.*

Regional private facility

### 5.3.3. When are discharge summaries sent?

Facilities typically distributed a woman's discharge summary either on the day of discharge or within a week (see Figure 4). Of the 15 facilities that indicated discharge summaries were usually sent on the day of discharge, seven were private hospitals (50% of private hospitals) and eight were public hospitals (21% of public hospitals). Of the 30 facilities that reported sending discharge summaries within a week, 24 were public hospitals (63% of public hospitals) and six were private (43% of private hospitals). Of the two hospitals that reported discharge summaries not being sent until at least six weeks postnatally, one provides caseload midwifery care until six weeks and so discharge summaries are created upon discharge from that model of care.

Participants selecting the 'other' category responded that they were either unsure or that the time varied between women. One participant reported that discharge summaries were rarely completed in their facility. This occurred because of a culture that considered discharge summaries to be the legal responsibility of doctors, and given the high rotation of locum doctors and a lack of resources to orientate them to the process, summaries were not usually completed.

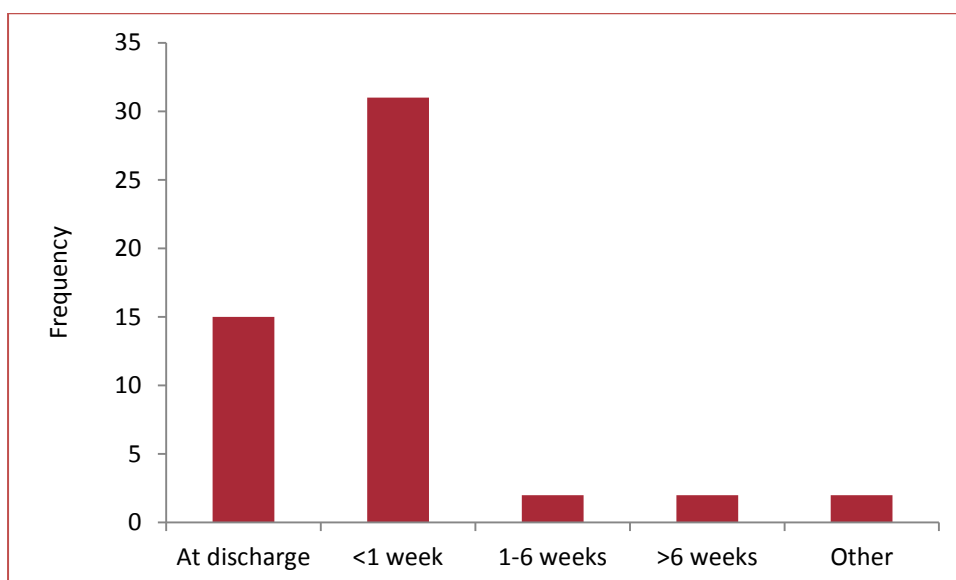


Figure 4. Time taken for facilities to send a woman's discharge summary to relevant parties

### 5.3. The woman's role in the development of her discharge summary

The majority of facilities reported obtaining women's consent before distributing the woman's discharge summary. Consent was more likely to be received verbally (N=22, 42%; public N=18, 47%; private N=4, 29%), than in writing (N=10, 19%; public N=5, 13%; private N=5, 36%) or by other methods (e.g., both verbal and written; N=3, 6%; public N=1, 3%; private N=2, 14%). Nineteen per cent (N=10; public N=9, 24%; private N=1, 7%) of facilities did not obtain women's consent prior to their discharge summary being distributed to relevant parties. A further four facilities (8%, public N=1, 3%; private N=3, 21%) responded that gaining the woman's permission was not necessary as they only give the discharge summary to the woman (and she is responsible for its distribution), or that it is the responsibility of either the obstetrician or paediatrician to gain the women's permission.

Only five facilities (10%, public N=2, 5%; private N=3, 21%) reported that they had a process in place that allowed women to check the accuracy of their postnatal discharge summary. Such processes included the midwife going through the discharge summary with each woman at discharge or at a postnatal visit. Thirty-one facilities (60%; public N=22, 58%; private N=9, 64%) reported that they had no process for women to check the accuracy of their discharge summary. A further 16 facilities (31%, public N=14, 37%; private N=2, 14%) indicated that they provided women with a copy of their discharge summary only (without any specific discussion or review opportunity) or that women were free to make enquiries about the content of their discharge summary after they have left hospital. For the purposes of this study, these responses were not coded as having a process for checking discharge summaries.

Less than half of facilities reported 'always' providing women with a copy of their discharge summary (N=25, 48%; public N=16, 42%; private N=9, 64%). A further 25% of facilities provided it to the woman 'sometimes' (N=7, 13%; public N=6, 16%; private N=1, 7%), or only when requested by the woman (N=6, 12%; public N=6, 16%; private N=0). Fourteen facilities (27%, public N=8, 21%; private N=4, 29%) did not provide women with a copy of their discharge summary.

Participants were also asked whether women were given a copy of their Pregnancy Handheld Record (PHR) upon discharge. The majority of facilities provided women with a

copy (N=12, 23%; public N=11, 29%; private N=1, 7%) or were willing to do so if the woman requested it (N=23, 44%; public N=18, 47%; private N=5, 36%). A further 12% (N=6; public N=5, 13%; private N=1, 7%) provided women with a copy sometimes and 21% (N=11, public N=4, 11%, private N=7, 50%) not at all.

#### **5.4. Differences in discharge communication in public and private hospitals**

The use of electronic discharge summaries was more commonly reported in public hospitals than in private hospitals (public N=28, 74%; private N=6, 43%), with handwritten paper summary correspondingly more likely in private hospitals (public N=2, 5%; private N=9, 64%).

Nonetheless, private hospitals were more likely to create the discharge summary from a review of an electronic database (public N=12, 32%; private N=6, 43%) rather than the woman's paper-based client record (public N=24, 63%; private N=6, 43%).

Midwives, specifically postnatal ward midwives, more frequently completed women's discharge summaries in private hospitals than in public hospitals (public N=4, 11%; private N=12, 86%). In public hospitals, responsibility for completing postnatal discharge summaries varied between facilities, but was most often the province of resident doctors (public N=14, 37%, private N=0).

Public hospitals were more likely than private hospitals to send a woman's discharge summary to her GP (public N=36, 95%; private N=7, 50%). In both sectors, discharge summaries were reportedly only sent to local CFHN services about half the time (public N=19, 50%; private N=8, 57%).

It was more common for women in private hospitals to give their consent to the distribution of their discharge summary (public N=24, 63%; private N=11, 79%), and correspondingly more likely for public facilities to report not seeking consent prior to distributing discharge summaries (public N=9, 24%; private N = 1, 7%).

Processes for enabling women to check the accuracy of their discharge summaries were rare in both sectors, with only five facilities (10%) having an established process. Nonetheless, private hospitals were more likely to report the implementation of a checking process than public hospitals (public N=2, 5%; private N=3, 21%).

Women in private hospitals were more likely to routinely receive a copy of their discharge summary (public N=16, 42%; private N=9, 64%), but also slightly more likely to not be given a copy of it (public N=8, 21%; private N=4, 29%).

#### **5.5. Suggestions for improvement**

The final question of the survey was an open text response and asked participants how they thought the discharge summary process could be improved. Responses were relatively consistent with six main themes being identified: women, content, resources, process, staff input and summary format.

##### **5.6.1. Women**

Numerous participants commented that women should be more involved in the discharge summary process and should have better access to their discharge information.

*Women should be more involved in the process as the D/C summary has information which is incorrect however this is only noticed after the woman is at home and had chance to go read it.*

Metropolitan private facility

*Giving all women a copy of the PDC [perinatal data collection] and PHR [pregnancy handheld record].*

Regional public facility

### 5.6.2. Content

Many participants believed discharge summaries should include data from the perinatal data collection forms.

*Linking of the perinatal data to EDS [Enterprise Discharge Summary database] as this would combine the work of the midwife and the medical practitioner.*

Regional public facility

Participants also believed that all information systems used to collect patient data should be better integrated with that used to generate discharge summaries to minimise data errors.

*Better integration between existing systems so that transcription errors can be eliminated i.e. birth weight, sex, time etc as recorded on the PDC (electronic document).*

Metropolitan public facility

### 5.6.3. Resources

Some participants noted that their ability to have an efficient postnatal transfer of care system was impeded by a lack of necessary resources within their facility.

*Individually at this site we need more computers on the unit to complete discharge.*

Regional public facility

*Discharge summary could be completed by midwife electronically but would need funds to assist in capturing wireless networks etc...*

Regional public facility

### 5.6.4. Process

Several comments related to the process by which postnatal transfer of care occurs. Comments generally pertained to the need for discharge summaries to be produced in a more timely manner and for there to be more consistency across external health institutions with regards to their discharge information requirements.

*Prompt completion of the electronic discharge summary. Same day would be good.*

Rural public facility

*Some doctors do use electronic discharge EDS, others use carbon copy paper DCS. All using EDS would be better.*

Rural public facility

### 5.6.5. Staff input

Many participants believed that there should be multidisciplinary contribution to each discharge summary.

*More diversity in persons able to fill the summary out.*

Regional public facility

*Doctors input into chart more.*

Metropolitan private facility

### 5.6.6. Summary format

Participants commonly cited the need for discharge summaries to either be made electronic or for the paper form to be improved.

*Think an electronic record would be fantastic, a lot of medical centres will not accept emailed or scanned copies of discharge summaries. Finding an easy to read and fill out form that is on one page and addresses all the required info is difficult. Many GPs state they just chuck our discharge summaries in the bin as too busy or too simple. Format and ease of reading appears to be a big issue.*

Rural public facility

### 5.6.7. Positive comments

Some participants believe their facility's current system to be adequate, and as such did not deem improvements to be necessary.

*This is a small rural facility and all services including GP regularly communicate so if there is an issue then we contact each other.*

Rural public facility

*We think that printing out to the health centre printers, and not to a nominated person works well. Women have their own copy, to distribute. Copy left in notes, for future reference.*

Remote public facility

*For us (private facility) what we do now works extremely well.*

Regional private facility

## 5.6. Analysis of discharge summaries

### 5.7.1. Discharge summaries received

Twenty-five of the 52 facilities (48%) who completed the survey (public N=24, 63%; private N=1, 7%) forwarded a scanned copy of their facility's postnatal discharge summary. Many facilities used the same form. Eight different discharge summaries were received in total<sup>b</sup>, with two versions representing the discharge summary form used by 16 facilities.

These discharge summaries were deemed to represent those used in the majority of Queensland public birthing facilities. Only one discharge summary was received from a private hospital.

### 5.7.2. Content of discharge summaries reviewed

Irrespective of the format used, there was marked variation in the content of discharge summaries. Significant gaps in the useful information communicated by discharge summaries were evident. Importantly, all discharge summaries communicated information only about the woman's stay in hospital, and omitted any information about postnatal care provided in the context of domiciliary midwife home visits offered by the hospital.

#### 5.7.2.1. About the woman

Discharge summaries typically included extensive information about the bio-physical outcomes of birth and largely omitted potentially useful information about the woman's psychosocial wellbeing. Information about whether the woman's labour was induced or augmented, the type of birth she had, what pain relief she accessed, the amount of blood

<sup>b</sup> Although a small number of discharge summaries were received, these documents represented what the majority of Queensland birthing facilities reported using as a discharge summary in other areas of the survey.



she lost, any perineal trauma and the need for sutures were universally included. Similarly, the woman's blood group and the administration of Anti-D (when given) were found in almost all discharge summary forms. Screening information for depression and anxiety was identified in the discharge summaries used in 11 public hospitals (29%), but was usually restricted to an indication that an Edinburgh Postnatal Depression Scale (EDPS) had been completed, rather than the score or any further follow up or intervention if required. Information such as the extent of family and community support available to the woman, her exposure to intimate partner violence, her use of alcohol, tobacco and other drugs and the impact of other stressors (financial, housing) were included infrequently and, if present, only as a 'tick box'. It was unclear exactly what the tick box conveyed, either that the screening had been completed or that screening had flagged a particular concern. If it was the latter, then there was no space to provide details or to identify if and how referral to appropriate services was indicated or provided.

Discharge summaries were also found to frequently omit important aspects of the woman's personal information. All discharge summaries reviewed communicated the woman's basic personal details (name, unique identification number, contact information), but most were found not to contain information about the woman's destination upon discharge or provide alternative temporary contact details for her. Most discharge summaries did not identify the woman's cultural background or the family's need for an interpreter.

The capacity of discharge summaries to contribute to a range of public health strategies also appears to be under-utilised. Information about whether the woman was breastfeeding was universally included; however, her previous breastfeeding experience and current need for support were often not identifiable. Advice to women and their primary care providers about the woman's vaccination status (usually Rubella, but less commonly Pertussis and Hepatitis B) was identified in a minority of discharge summary forms. Similarly, information about the woman's pre-pregnancy body mass index (BMI), indication for postnatal glucose-tolerance testing and contraceptive advice were not routinely evident in discharge summary forms reviewed.

#### **5.7.2.2. *About the baby***

Information about the baby contained in the reviewed discharge summaries also tended to focus on the bio-physical health at the time of birth. Information such as birth weight, length and head circumference, along with Apgar scores were universally included in the sample discharge summaries. Similarly, the outcomes of routine screening tests were usually indicated. In the discharge summaries reviewed, there was little space to relay information relevant to the care of sick babies or to provide information sensitive to the needs of families experiencing the death of a baby in the perinatal period.

In the discharge summaries reviewed, the baby was primarily identified by its unique identification number, sex, date and time of birth. Space for the baby's name was included in one discharge summary form used by five public hospitals (13%). The baby's cultural background was identified in one discharge summary form reviewed.

#### **5.7.2.3. *About support services in hospital***

Most discharge summary forms did not include information about the range of support services a woman had accessed in hospital. In some cases, the name of the admitting doctor, hospital care provider, midwife, or discharging clinician was recorded. However, the discharge summary forms reviewed did not include scope to give details of other clinicians

that a woman or her baby may have received care from, such as paediatricians, physiotherapists, and lactation consultants.

#### **5.7.2.4. About post-discharge care**

The reviewed discharge summaries did not consistently include advice to women about accessing health care after their discharge from hospital. Discharge summaries most frequently documented advising the women to see her GP between 5-10 days hence and again at 6 weeks, but this advice was not universal. There was little capacity to record what written information had been given to women on topics such as breastfeeding, contraception, safe infant sleep and early parenting. There was also little evidence of women being routinely given advice about wound care or indications for urgent return to hospital.

Most discharge summaries included some scope to refer women to other services. These services most commonly included child health and lactation consultant services, and less commonly to women's health, mental health or physiotherapy. The option of a postnatal home visit was identified in most, but not all, discharge summaries (despite the Universal Postnatal Contact Service being a Queensland Health initiative at the time of the survey). Only two discharge summary forms reviewed included scope for the woman to indicate her consent for the disclosure of her information. In a minority of discharge summaries there was evidence of advice about the role of community organisations, such as the Australian Breastfeeding Association.

#### **5.7.3. Queensland Health discharge summary**

The most widely used discharge summary is entitled "Queensland Health Discharge Summary". Versions of it were submitted by 10 public hospitals that use it in an electronic format and one public hospital who reported using it in a handwritten format. This document was designed for discharge from general hospital admissions and is not specific to maternity care. De-identified completed discharge summaries demonstrated how hospitals work within the template to include maternity-specific information in the "Principal diagnosis" or "Inpatient Clinical Management" fields. However, important information related to maternity care was difficult to identify and there was very minimal information on post-discharge care. Very few discharge summaries received for review included details on postnatal services (e.g., contact and referral details) or care instructions for mother and baby once at home (e.g., how to care for a caesarean wound).

#### **5.7.4. Queensland Health perinatal discharge and referral form**

The next most common discharge summary used was the "Queensland Health Perinatal Discharge and Referral Form". Versions of this form were submitted by a further five public hospitals. These were universally handwritten one page documents with numerous 'tick boxes' and small comment fields. As a document specifically designed for the perinatal period, the content includes a more comprehensive range of maternity-specific information, including psychosocial and lifestyle information. It includes opportunity for referral to a range of postnatal support services (e.g., GP, CFHN, social work, postnatal home visiting programs, local drop in services, etc.) and, in some cases, space to record a woman's consent to disclosing her information to those services. One facility submitted a highly customised version of this form that reflected the local cultural context. In adhering to a single page format these documents, to varying degrees, compromise readability due to small font sizes and crowding.



### 5.7.5. Divergent use of similar discharge summary forms

Despite different facilities using the same discharge summary forms, it was evident that their implementation varied between facilities. For example, some facilities report using the general Queensland Health discharge summary and while some facilities simply wrote what they could under the sections relevant to maternity care (e.g., “Recommendations to GP”), others were more comprehensive and inserted information beyond what the section called for (e.g., copying perinatal data and pathology results into the “Care Plan Summary” section). Further, many facilities used more than one kind of discharge summary. For example, one facility used a letter generated from information in an obstetric database and also attached the birth summary page from the Pregnancy Health Record. Overall, there was little consistency across facilities in how they used similar discharge summary documents.

### 5.7.6. Electronically generated discharge summaries

With increasing use of electronically generated discharge summaries, it is worthwhile comparing the nature of these documents to their handwritten counterparts. Of the discharge summaries reviewed, 27% were handwritten and 73% were electronically generated. As already mentioned, the time consuming nature of handwritten documents, as well as their vulnerability to human error limits their effectiveness. The potential for human error and labour intensiveness were both minimised by the use of tick-boxes and small comment fields, however this also minimised the available space to communicate information relevant to individual women. A benefit of electronically generated documents was that some fields are only included if populated with data, potentially resulting in a more brief and personalised discharge summary.

Electronically generated documents are also only as accurate as the data that are entered. Our review of de-identified sample discharge summaries identified frequent use of generic statements in discharge summaries. This may have indicated the use of ‘comment banks’. Much like tick boxes, comment banks may increase the likelihood of indicating that routine processes have been followed, but without offering any real insight into the needs or understandings of the individual woman. Involving women in completing and reviewing their discharge summaries could help ensure the veracity of the information (see also sections 5.4 and 6.3).

### 5.7.7. Readability of discharge summaries

Another issue identified in the analysis of the sample discharge summaries relates to their readability. All forms tended to rely heavily on abbreviations and medical jargon. Single-page handwritten forms were often crowded and used small font sizes. Electronically generated discharge summaries tended to use small font sizes also, but readability was further complicated by the over-use of capitals and large blocks of text.

Electronically generated discharge summaries tended to be very long. The average length of discharge summaries received of this type was four pages. Perhaps as a consequence of the relative ease with which very detailed accounts of a woman’s labour and birth can be electronically generated, electronic discharge summaries tended to include very detailed accounts of the physiological aspects of a woman’s labour and birth, often at the expense of psychosocial or cultural information.

## 6. DISCUSSION

### 6.1. The discharge summary

Most Queensland facilities reported using an electronic discharge summary. However, a small portion, predominately private facilities, used handwritten paper summaries. Despite the frequent use of electronic discharge summaries, facilities most often sourced information for the discharge summaries from a review of women's paper records, rather than a database. This is a time consuming and non-standardised process, that is susceptible to human error (Kripalani et al., 2007). This finding may reflect a lack of resources to enable electronic transfer of information to the discharge summary, or a lack of training amongst staff to use such resources. Any investigation of the accuracy or completeness of completed discharge summaries was beyond the scope of this study, but would be useful further research.

There was little mention of the Enterprise Discharge Summary system recently introduced into the majority of Queensland Health facilities (Office of the Deputy Premier and Minister for Health, 2010), with only three facilities reporting that they use it. This may be due to the lack of maternity specific information available in the summaries generated by the system, or the fact that the system only distributes discharge summaries to GPs, leaving other postnatal care providers unable to access it.

The analysis of the discharge summary documents received revealed a number of limitations in their quality and usefulness. Unlike many other reasons for hospital admission, birth is not an illness and the majority of women do not have serious complications (AIHW et al., 2012). As such, the information needs of the woman and her care providers differ significantly from other hospital patients and their care providers. Unfortunately, the discharge summaries received did not reflect this, with many failing to include sufficient maternity-specific information to adequately support women transitioning from hospital care to the community. Particularly where discharge summary forms are not specific to maternity or where they are generated electronically, there was a tendency to focus on physiological aspects of labour and birth, at the expense of psychosocial information or postnatal care planning. In many cases, the readability of documents was diminished due to small font sizes, crowded single pages, blocks of text, the over use of capitals or the over-inclusion of information and text in electronically generated documents.

Efforts to standardise discharge communication need to be undertaken carefully. Great variation was noted both in the type of summaries used across facilities, and in how different facilities used the same document. Such inconsistencies may compromise communication with postnatal care providers, such as GPs and CFHNs, who have to decipher many different discharge summaries in order to provide efficient care. Care must be taken however, not to revert to standardised tick-box forms and the use of comment banks in electronic forms, as these often failed to communicate sufficiently personalised information. Electronic forms that only print populated fields would appear to have the most potential for communicating relevant information without becoming overly long.

The information needs of community-based health care providers involved in postnatal care are an under-investigated area. Homer et al. (2009) identified communication as a barrier to effective collaboration between midwives and CFHNs in the postnatal period. Beyond that study, our review of academic literature did not identify any Australian studies that have

examined the information needs of GPs and CFHNs or their views on current discharge communication practices.

## 6.2. The discharge process

In public facilities, resident doctors were more likely to be identified as the care provider usually completing a woman's discharge summary, whilst in private facilities this function was exclusively undertaken by midwives, most commonly postnatal ward midwives. Some participants indicated that there was confusion about whose responsibility it was to complete discharge summaries. Some responses also indicated that two discharge summaries may be created for each woman: one medical, one midwifery. Greater role clarity and a multidisciplinary contribution to a single discharge summary would seem both more efficient and capable of better reflecting the care the woman received.

Discharge summaries were most commonly reported as being sent to women's GPs (83%). The relative infrequency with which private hospitals (compared to public hospitals) send discharge summaries to GPs may reflect the ongoing care provided by the woman's private obstetrician and that communication with the GP might occur at discharge from obstetric care at six weeks postnatally. However, given that women often don't see their private obstetrician between discharge from hospital and 6 weeks, there is a significant delay in supporting women to access community-based health services.

It was also less common (in both sectors) for discharge summaries to be sent to CFHNs (52%). This may well be a product of 'routinisation' of practice rather than adopting systems which respond to the needs and preferences of individual women. It would appear to be consistent with the apparent rarity of seeking input from women about the distribution of their discharge information, especially since Queensland women visit CHFNs an average of 2.73 times in the first four months after having a baby (Prosser et al., 2013). This routinised approach risked missing many vital postnatal services (e.g., social worker, psychologist, lactation consultant). Furthermore, with programs such as the Enterprise Discharge System only distributing information to GPs, there may be a lack of infrastructure to support information distribution to a wider variety of postnatal services.

Significantly fewer facilities reported sending discharge summaries to care providers such as ACCHOs, non-government organisations or private midwives. This finding indicates a real lack of promotion for, and possibly understanding of, the importance of community postnatal services amongst hospital staff. As above, it may also reflect the infrequency with which women direct who they would like their information shared with. Furthermore, it is in direct contrast to the recommendations of the National Maternity Services Plan for all facilities to refer all women to their local CFHN, and for women to have increased access to midwifery postnatal services, and continuity of midwifery care during pregnancy, birth and beyond (AHMAC, 2011).

Discharge summaries were typically sent within a week of discharge from the facility. However, 45.4% of women see their GP within the first seven days after discharge (Prosser et al., 2013), meaning that this contact may occur without formal communication about the woman's labour, birth and early postnatal care. Moreover, many women (49.6%) receive domiciliary midwifery services at home for 7-10 days after discharge (Prosser et al., 2013) and in some models of care, this midwifery care may continue for up to six weeks. Care information, advice given and referrals made during this time are not routinely collected and communicated at the end of such programs. This represents a significant discontinuity in the care of women receiving these home visits.

A small number of facilities reported taking up to six weeks for discharge summaries to be sent. This length of time is problematic as it does not allow for timely communication with care providers in order to ensure a smooth transition between hospital and community care. Furthermore, with a number of serious health issues potentially developing in the early postnatal period, this lack of information could result in care providers missing serious health issues in the mother and baby.

### **6.3. The woman's role in the development of her discharge summary**

Approximately one fifth of Queensland birthing facilities did not obtain women's consent prior to sending her personal information to other care providers. This does not allow women any control over who receives their confidential information, nor does it facilitate conversation around what options the women has for postnatal care once at home. Queensland Health Confidentiality Guidelines (Queensland Health, 2012) do permit the disclosing of confidential information if doing so is required for the person's ongoing care. This provision extends to the disclosure of relevant confidential information both to other health professionals employed by Queensland Health (such as CFHNS) and to relevant people outside Queensland Health (such as GPs, private midwives, employees of Aboriginal Medical Services). Consent is not legally required for such disclosures; however, the guidelines stipulate that "disclosing confidential information with the consent of the person concerned has always been (and will continue to be) the most common and preferable mechanism for disclosure" (Queensland Health, 2012, p. 5).

More widespread adoption of processes to involve women in the development, checking and distribution of their discharge summary would also support women's informed consent for that disclosure of confidential information. Despite Queensland Health guidelines describing best practice as including "discuss[ing] ... with the patient prior to the disclosure to ensure the patient is fully informed, and is aware of what is going to happen with their information"(Queensland Health, 2012, p. 9), approximately three fifths of Queensland birthing facilities reported not having a process for women to check the accuracy of their discharge summaries prior to its distribution. Furthermore, 12 facilities did not provide women with a copy of their own discharge summary. Given the high use of medical terms and abbreviations identified in discharge summaries received, and the complicated layout of many of the forms, it is unlikely that women find the information easy to interpret. These factors further exclude women from giving informed consent to the disclosure of their confidential information, and can contribute to the transfer of incorrect information and consequently, to inadequate postnatal care, as well as compromising care in future pregnancies. It is also inconsistent with the recommendations of the National Safety and Quality Health Services Standards which call for health services to "establish mechanisms to include patients and carers in clinical handover processes" (ACSQHC, 2011, p. 44).

International research and guidelines also support the practice of giving women their discharge summaries. The NICE guidelines endorse the use of hand-held records, discharge care plans and personal child health records to promote communication with women (NICE, 2006). Ross and Lin (2003) tentatively concluded that providing patients with access to medical records (as would be the case with providing women their discharge summary) supported enhanced communication and was attended by minimal risk. Similarly, Sandler et al. (1989) found that providing discharge information to patients upon discharge, to share with their GP, improved communication and satisfaction of participants. Likewise, Wäckerle et al. (2010) found that providing maternity notes (including discharge information) to

pregnant women on a USB stick contributed positively to patient empowerment, satisfaction and safety (compared to conventional hospital-held notes).

This study did not examine the reasons for hospitals' apparent reluctance to provide discharge summaries to women.

#### **6.4. Suggestions for improvement**

Several suggestions were made by participants to improve the current discharge summary process. These comments centred around the need to increase women's involvement in the process, better linking of information from databases into discharge summaries, improving available resources (e.g., technology infrastructure), improving the discharge process itself, increasing multidisciplinary contribution to discharge summaries, and to improve the format of discharge summaries to either be electronic or more easily read paper forms.

#### **6.5. Strengths and limitations of this study**

This review of current practices around postnatal transfer of care from Queensland birthing facilities to community-based health services faced a number of limitations. Sixty-two per cent of participants reported not completing discharge summaries as part of their current role and the veracity of their feedback about the strengths and weaknesses of the processes may have been limited by this. However, this review was strengthened in that it was the first study of its kind in Queensland, with no others examining postnatal transfer of care practice in all of the birthing facilities. The review also achieved a notably high completion rate ensuring that practices of Queensland birthing facilities were well represented.

## 7. RECOMMENDATIONS

The Queensland Government has made a significant investment in postnatal care through the “Mums and Bubs” policy to increase women's access to postnatal care. Our recommendations strengthen and improve on this investment by helping to ensure women and their infants are safely and effectively supported in the transition from hospital-based postnatal care to community-based family and child health care. We recommend that:

1. Department of Health Queensland, through an executive sponsor, such as the Chief Nursing and Midwifery Officer in partnership with Queensland Centre for Mothers and Babies, develop a standardised discharge summary template for use across maternity services.

This study identified a significant number of facilities that did not provide postnatal maternal discharge summaries, either because they inappropriately used perinatal data capture forms for this purpose or because of reported lack of compliance. Both practices undermine the safety and quality of care for women in the postnatal period.

Furthermore, this study identified clear limitations to the use of general hospital discharge summaries. The information needs of women and babies, and their care providers, are quite distinct from other hospital patients and their care providers. A maternity-specific discharge summary should:

- Treat the woman and her baby as a pair, and support post-discharge health and wellbeing of both.
  - Document the care provided in her recent birth and include appropriate opportunities to discuss her feelings about that birth. It should also advise the woman of post-discharge support available to her should she wish to further discuss her birth experiences.
  - Provide for the development of an individualised postnatal care plan for each women, and ensure women have continuous access to care and are aware of local community-based health care services and support organisations relevant to their own and their baby's needs.
  - Support the provision of consistent, evidence-based advice to women regarding key health topics such as breastfeeding, safe sleeping, child health, early parenting and contraception.
2. All discharge summaries include information on both the woman's and the baby's bio-physical history and outcomes as well as psychosocial and cultural needs and the impact these may have on the family following discharge.

Maternity discharge summaries must include relevant cultural, physiological and psychosocial information. This study has reviewed the data currently collected in Queensland birthing facilities and found significant gaps, particularly in the psychosocial and cultural information. This study also reviewed the data called for in relevant Australian and international policies and guidelines, with a view to how that might inform a more comprehensive discharge summary in Queensland. Based on this review, we have developed Appendix B: Recommended Content of Discharge Summaries in Maternity Services.



### 3. Discharge summaries be produced via electronic health records to facilitate generation and reduce human error.

Maternity-specific electronic systems to generate discharge summaries, linked with relevant hospital databases would minimise human errors and maximise efficiency, making accurate completion of comprehensive discharge summaries more likely. The use of fields which only appear in the discharge summary if relevant and populated with data would prevent discharge summaries from being unnecessarily long. Electronic creation of discharge summaries would also make the creation of a comprehensive summary, containing all of the elements recommended in Appendix B, feasible.

Electronic generation of discharge summaries would also support the timely communication of important information.

There is an electronic system already available in Queensland public hospitals for the creation of discharge summaries. Known as Enterprise Discharge Summary (EDS), it is not specific to maternity services and this study found limited evidence of its use for maternity discharge. Further investigation is needed to identify modifications required to make the EDS system more relevant for use in the maternity sector.

### 4. Each maternity service identify appropriate personnel, responsible for the coordination of the discharge process including completion and distribution of the discharge summary.

This study identified great variation in the timing and completion of discharge summaries. There were examples of discharge summaries not being completed, as well as being completed more than once for each woman. Safe and high quality care requires clear lines of responsibility for coordinating the discharge process of each woman, and for documenting that in her discharge summary. In the context of continuity of midwifery carer, this role may be most appropriately assumed by the woman's primary midwife. In other circumstances, it may be useful to identify a liaison role to support effective and timely communication during the transition from hospital to community-based health care services in the postnatal period.

### 5. Processes be developed to ensure each woman is involved in the development and review of her discharge summary and receives a copy of it upon discharge.

Engaging women in the development of their discharge summary would have several benefits. The literature reports issues regarding the frequency of errors and omissions in discharge summaries and enabling women to verify the information would provide an additional check on its accuracy. However, such checking processes were notably rare in Queensland birthing facilities. Engaging women in developing and reviewing their discharge summaries would also provide opportunities for each woman to discuss her feelings about her birth experience with care providers and offer care providers further insight into a woman's psychosocial wellbeing. Furthermore, engaging women in the development and review of their discharge summary would enable the woman to direct and consent to the disclosure of her confidential information. It follows from these processes, that women should routinely be provided with a copy of their discharge summary and their Pregnancy Health Record.

### 6. Discharge summaries be created and distributed when the woman is discharged from the maternity service (including any domiciliary midwife home visits).

Many facilities reported that discharge summaries captured information only until women left the hospital. Many women however, leave hospital within 24–48 hours of birth and are

visited by domiciliary midwives employed by the maternity service at home for a further 7–10 days. In caseload models of care, midwives employed by the health service may continue to provide postnatal care for up to six weeks. The lack of systems to capture information about midwifery care provided after discharge from hospital presents a significant discontinuity in communication and could potentially lead to duplication of care by child and family health services, GPs and maternity services.

Other reported delays in the distribution of discharge summaries may also compromise the quality of care through the transition from hospital-based maternity care to community-based child and family health care. Most birthing facilities reported that discharge summaries are usually distributed within one week of discharge from hospital. This may not allow the information to be available to the woman's GP to whom she is referred for follow up one to five days after discharge or sooner if concerns arise. Longer reported delays of up to six weeks, although unusual, represent a significant weakness in the transition of care.

The most appropriate timing for the creation and distribution of discharge summaries may vary depending on the model of maternity care accessed by the woman, but should coincide with the woman's final discharge from the maternity service. Where women receive post-discharge domiciliary or caseload midwife visits, the discharge summary process should reflect both the initial discharge from hospital and subsequent care provided by the domiciliary midwife. This will ensure that information is available to all care providers whom the woman has contact with in the vulnerable early postnatal period.

**7. With the woman's consent, discharge summaries be distributed to a wide group of support services including GPs, CFHNs, NGOs, ACCHOs, and other relevant support services.**

This study found that discharge summaries were usually distributed to GPs and less commonly to CFHNs, and that distribution was more often directed by routine practice, rather than the needs of each woman. Other important care providers were omitted from the communication, potentially creating barriers to women's access to care. With the woman's consent, maternity discharge summaries should be shared with all care providers relevant to the woman's ongoing care and those identified by the woman. Guidelines defining indications for referral should be developed to support consistent referral of women to appropriate services. These services may include GPs, CFHNs, private midwives, ACCHOs, social workers, psychologists, physiotherapists, lactation consultants etc. Local service directories should be developed to support the referral process.

**8. Further research into maternity discharge communication be undertaken.**

The Australian literature on the topic of maternity discharge communication is scant. Further study, using the data set recommended in Appendix B, is now needed to better understand the information needs and preferences of women, GPs and CFHNs.

It was beyond the scope of this study to investigate the post-discharge care practices for women with adverse outcomes. It follows for the recommendations above that alternative maternity discharge summaries need to be developed that better reflect the needs of women following neonatal deaths, stillbirths, miscarriage and termination of pregnancy.



## 8. CONCLUSION

This project was the first to review current practice around postnatal transfer of care from birthing facilities to community health services in Queensland.

Our analysis of discharge summaries used in Queensland found a lack of consistency in their content and format, as well as an over-emphasis on bio-physical information, often at the expense of psychosocial information. We have therefore made recommendations that provide for greater consistency and completeness in maternity-specific discharge summaries. We are aware that work to develop a “nationally consistent approach to information transfer and referral from maternity care to child and family health care” (AHMAC, 2011, p. 50) commences this year under the National Maternity Services Plan. We are confident that this report will make a positive contribution to that work.

We also found that women in Queensland were afforded little opportunity to review their discharge summaries or consent to their distribution. Not only was this inconsistent with the National Safety and Quality Health Service Standards (ACSQHC, 2011) and Queensland Health guidelines (Queensland Health, 2012), it also missed a significant opportunity to discuss birth experiences with women, verify the accuracy of information and engage women, and families, with their post-discharge care options.

We have also identified several areas which were beyond the scope of this study but which are worthy of further investigation. We investigated neither the accuracy nor completeness of currently used documents, nor the post-discharge information needs of community-based care providers and women. Both of these would be fruitful lines of further inquiry. Further, this study did not examine current transition of care practice for women following adverse pregnancy outcomes. Doing so should underpin any future work on the development of post-discharge care planning for these women.

## 9. REFERENCES

- AHMAC. (2011). National Maternity Services Plan. Canberra: Australian Health Ministers Advisory Council, Commonwealth of Australia.
- AIHW, Li, Z., Zeki, R., Hilder, L., & Sullivan, E. (2012). Australia's Mothers and Babies 2010 *Perinatal statistics series no. 27. Cat. no. PER 57*. Canberra: AIHW.
- Australian Commission on Safety and Quality in Healthcare (ACSQHC). (2011). National Safety and Quality in Health Service Standards. Sydney: ACSQHC.
- Balla, J. I., & Jamieson, W. E. (1994). Improving the continuity of care between general practitioners and public hospitals. *MJA*, 161(11-12), 656.
- Bar-Zeev, S. J., Barclay, L., Farrington, C., & Kildea, S. (2012). From hospital to home: The quality and safety of a postnatal discharge system used for remote dwelling Aboriginal mothers and infants in the top end of Australia. *Midwifery*, 28(3), 366-373.
- Brodribb, W., Zadaroznyi, M., Dane, A., & Price, T. (2012). Evaluating the Implementation of the Universal Postnatal Contact Services in Queensland: The Experiences of Health Care Providers and Mothers. Brisbane, QLD: Queensland Centre for Mothers and Babies, The University of Queensland.
- Brown, S., & Lumley, J. (1997). Reasons to stay, reasons to go: results of an Australian population-based survey. *Birth*, 24(3), 148-158.
- Chalmers, E. (2007). Report of the Investigation into the disappearance and subsequent death of an elderly gentleman transferred from Katherine Hospital to Kalkaringi in August 2006. *Katherine West Health Board and Department of Health and Community Services*.
- Coit, M. H., Katz, J. T., & McMahon, G. T. (2011). The effect of workload reduction on the quality of residents' discharge summaries. *J Gen Intern Med*, 26(1), 28-32.
- Coleman, E. A. (2003). Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs. *J Am Geriatr Soc*, 51(4), 549-555.
- Department of Education and Early Childhood Development Victoria. (2004). *Continuity of Care: A communication protocol for Victorian public maternity services and the Maternal Child Health Service*. Melbourne, Victoria: Community Care Division, Victorian Government Department of Human Services. Retrieved from <http://www.health.vic.gov.au/maternitycare/>.
- Department of Health Victoria. (2012). *Postnatal Care Program Guidelines for Victorian Health Services*. Melbourne: State Government of Victoria.
- Fenwick, J., Butt, J., Dhaliwal, S., Hauck, Y., & Schmied, V. (2010). Western Australian women's perceptions of the style and quality of midwifery postnatal care in hospital and at home. *Women Birth*, 23(1), 10-21. doi: <http://dx.doi.org/10.1016/j.wombi.2009.06.001>
- Guest, M., & Stamp, G. E. (2009). South Australian rural women's views of their pregnancy, birthing and postnatal care. *Rural Remote Health*, 9(3), 1101.
- Hesselink, G., Schoonhoven, L., Barach, P., Spijker, A., Gademan, P., Kalkman, C., . . . Wollersheim, H. (2012). Improving Patient Handovers From Hospital to Primary Care: A Systematic Review. *Ann intern med*, 157(6), 417-428.
- Homer, C. S., Henry, K., Schmied, V., Kemp, L., Leap, N., & Briggs, C. (2009). 'It looks good on paper': Transitions of care between midwives and child and family health nurses in New South Wales. *Women Birth*, 22(2), 64-72.
- Josif, C., Barclay, L., Bar-Zeev, S., Kildea, S., & Brittin, M. (2012). How participatory action research supported improvements to the postnatal discharge summary system used for remote dwelling Aboriginal mothers and infants in the Top End of Australia. *Action Research*, 10(4), 387-405.
- Kind, A., Sattin, J., Walz, S., & Smith, M. (2012). Provider Characteristics, Clinical-Work Processes and Their Relationship to Discharge Summary Quality for Sub-Acute Care Patients. *J Gen Intern Med*, 27(1), 78-84.

- Kind, A., & Smith, M. (2005). Documentation of mandated discharge summary components in transitions from acute to subacute care. *Advances in Patient Safety: New Directions and Alternative Approaches*, 2, 1-10.
- Kripalani, S., LeFevre, F., Phillips, C. O., Williams, M. V., Basaviah, P., & Baker, D. W. (2007). Deficits in communication and information transfer between hospital-based and primary care physicians. *JAMA*, 297(8), 831-841.
- Lissauer, T., Paterson, C., Simons, A., & Beard, R. (1991). Evaluation of computer generated neonatal discharge summaries. *Archives of disease in childhood*, 66(4 Spec No), 433-436.
- Maslove, D. M., Leiter, R. E., Griesman, J., Arnott, C., Ophyr Mourad, M., Chi-Ming Chow, M., & Bell, C. M. (2009). Electronic versus dictated hospital discharge summaries: a randomized controlled trial. *J Gen Intern Med*, 24(9), 995-1001.
- Meara, J. R., Wood, J. L., Wilson, M. A., & Hart, M. C. (1992). Home from hospital: a survey of hospital discharge arrangements in Northamptonshire. *Journal of Public Health*, 14(2), 145-150.
- Miller, Y., Thompson, R., Porter, J., & Prosser, S. (2011). Findings from the Having a Baby in Queensland Survey, 2010. *Brisbane, QLD: Queensland Centre for Mothers & Babies, The University of Queensland*.
- Myers, J. S., Jaipaul, C. K., Kogan, J. R., Krekun, S., Bellini, L. M., & Shea, J. A. (2006). Are discharge summaries teachable? The effects of a discharge summary curriculum on the quality of discharge summaries in an internal medicine residency program. *Academic Medicine*, 81(10), S5.
- Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2013). Collaboration and integrated services for perinatal mental health: an integrative review. *Child Adolesc Ment Health*, 18(1), 1-10.
- National Institute for Health and Clinical Excellence (NICE). (2006). *Postnatal Care: Routine postnatal care of women and their babies*. Manchester, UK: NICE Retrieved from [www.nice.co.uk](http://www.nice.co.uk).
- Nelson, A. M. (2003). Transition to motherhood. *J Obstet Gynecol Neonatal Nurs*, 32(4), 465-477.
- NSW Department of Health. (2009). *NSW Health/Families NSW Supporting Families Early Package - maternal and child health primary health care policy*. Sydney: NSW Department of Health, Retrieved from [www.health.nsw.gov.au](http://www.health.nsw.gov.au).
- O'Connor, P. (2001). Supporting mothers: Issues in a community mothers programme. *Community Work Fam*, 4(1), 63-85.
- Office of the Deputy Premier and Minister for Health. (2010). *New discharge summary improve continuity of care [press release]*. <http://statements.qld.gov.au/Statement/Id/70592>.
- Perinatal Services BC. (2011). *Perinatal Forms Guidelines 8: A Guide for the Completion of the British Columbia Community Liason Records - Postpartum & Newborn*. Vancouver: Perinatal Services BC Retrieved from [www.perinatalservicesbc.ca](http://www.perinatalservicesbc.ca).
- Prosser, S. J., Miller, Y. D., Armanasco, A., Hennegan, J., Porter, J., & Thompson, R. (2013). Findings from the Having a Baby in Queensland Survey, 2012. *Brisbane, QLD: Queensland Centre for Mothers & Babies The University of Queensland*.
- Queensland Health. (2012). *Health Services Act 1991 Part 7 Confidentiality Guidelines (Vol. Version 6)*. Brisbane: Queensland Health.
- Queensland Maternal and Perinatal Quality Council. (2012). *Maternal and Perinatal Mortality and Morbidity in Queensland: Queensland Maternal and Perinatal Quality Council Report 2011*. Brisbane: Queensland Health Retrieved from [http://www.health.qld.gov.au/chi/AIS/qmpqc\\_publications.asp#2011](http://www.health.qld.gov.au/chi/AIS/qmpqc_publications.asp#2011).
- Rao, P., Andrei, A., Fried, A., Gonzalez, D., & Shine, D. (2005). Assessing quality and efficiency of discharge summaries. *American Journal of Medical Quality*, 20(6), 337-343.
- Ross, S. E., & Lin, C.-T. (2003). The effects of promoting patient access to medical records: a review. *Journal of the American Medical Informatics Association*, 10(2), 129-138.
- Sandler, D. A., Heaton, C., Garner, S. T., & Mitchell, J. (1989). Patients' and general practitioners' satisfaction with information given on discharge from hospital: audit of a new information card. *BMJ: British Medical Journal*, 299(6714), 1511.

- Schmied, V., Mills, A., Kruske, S., Kemp, L., Fowler, C., & Homer, C. (2010). The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *J Clin Nurs*, 19(23-24), 3516-3526.
- Thompson, J. F., Roberts, C. L., Currie, M., & Ellwood, D. A. (2002). Prevalence and persistence of health problems after childbirth: associations with parity and method of birth. *Birth*, 29(2), 83-94.
- Tulloch, A., Fowler, G., McMullan, J., & Spence, J. (1975). Hospital discharge reports: content and design. *Bmj*, 4(5994), 443.
- van Walraven, C., Laupacis, A., Seth, R., & Wells, G. (1999). Dictated versus database-generated discharge summaries: a randomized clinical trial. *Canadian Medical Association Journal*, 160(3), 319-326.
- van Walraven, C., & Rokosh, E. (1999). What is necessary for high-quality discharge summaries? *Am J Med Qual*, 14(4), 160-169.
- Wäckerle, A., Blöchliger-Wegmann, B., Burkhardt, T., Krähenmann, F., Kurmanavicius, J., & Zimmermann, R. (2010). Notes on a stick: use and acceptability of woman-held maternity notes. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 153(2), 156-159.
- Wray, J., & Davies, L. (2007). What women want from postnatal care. *Midwives*, 10(3), 131.
- Zadoroznyj, M. (2007). Postnatal care in the community: report of an evaluation of birthing women's assessments of a postnatal home-care programme. *Health Soc Care Community*, 15(1), 35-44.

## 10. APPENDICES

### Appendix A: Online survey distributed to Queensland birthing facilities

The Queensland Centre for Mothers and Babies (QCMB) is currently reviewing discharge summary practices within Queensland birthing facilities. Specifically, we are interested in how care is transferred from the hospital to community services and agencies. Such information will assist in the identification on how to improve services to more effectively meet women and care providers' needs.

Thank you for your time. Your contribution is very much appreciated.

#### Q1 Who typically completes a woman's discharge summary?

- ☐ Manager of postnatal ward
- ☐ Midwife - Caseload or team
- ☐ Midwife - Postnatal ward
- ☐ Midwife - Other, please specify: \_\_\_\_\_
- ☐ Doctor - Resident
- ☐ Doctor - Registrar
- ☐ Doctor - Consultant
- ☐ Other, please specify: \_\_\_\_\_

#### Q2 In what form is a woman's discharge summary? Please tick all that apply.

- ☐ Electronic
- ☐ Handwritten paper copy - Queensland Health Postnatal Discharge/Referral Form
- ☐ Handwritten paper copy - other
- ☐ Letter
- ☐ A copy of the Queensland Perinatal Data Collection (PDC) form
- ☐ Other, please specify: \_\_\_\_\_

#### Q3 Where is the information for the discharge summary generated from?

- ☐ Database - Matrix
- ☐ Database - Obstetrix
- ☐ Database - Other, please specify: \_\_\_\_\_
- ☐ A review of the woman's paper-based client records
- ☐ Other, please specify: \_\_\_\_\_

#### Q4 Which health care professional/s typically receive a copy of a woman's discharge summary? Please tick all that apply.

- ☐ General practitioner (GP)
- ☐ Child family health nurse (CFHN)
- ☐ Aboriginal Medical Service
- ☐ Obstetrician
- ☐ Private midwife
- ☐ Paediatrician
- ☐ Visiting Medical Officer (VMO)
- ☐ Other, please specify: \_\_\_\_\_

#### Q5 How does your service determine which health care professional/s to send a woman's discharge summary to?

**Q6 On average, when does the discharge summary get sent to the relevant health care professional/s following a woman's discharge from hospital?**

\_\_\_\_\_ Days  
\_\_\_\_\_ Weeks  
\_\_\_\_\_ Months

Other, please specify: \_\_\_\_\_

Additional comments: \_\_\_\_\_

**Q7 Do women provide their consent for their discharge summary to be sent to relevant parties?**

- ☐ Yes - Verbally
- ☐ Yes - Written
- ☐ Yes - Other, please specify: \_\_\_\_\_
- ☐ No
- ☐ Sometimes
- ☐ Other, please specify: \_\_\_\_\_

**Q8 Is there a process in place that allows women to check the accuracy of their discharge summary?**

- ☐ Yes, please specify: \_\_\_\_\_
- ☐ No

**Q9 Do women receive a copy of their discharge summary for their personal record?**

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Only when requested by the woman
- ☐ Other, please specify: \_\_\_\_\_

**Q10 Upon discharge, do women receive a copy of their Pregnancy Hand Held Record for their personal record?**

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Other, please specify: \_\_\_\_\_

**Q11 In your opinion, how do you think the discharge summary process could be improved?**

**Q12 What is the name of the facility for which you are filling out this survey for?**

**Q13 Is this facility public or private?**

- ☐ Public
- ☐ Private

**Q14 What is your current role?**

**Q15 Do you personally complete discharge summaries?**

- ☐ Yes
- ☐ No
- ☐ Other, please specify: \_\_\_\_\_

**Q16 Can we contact you if we have any further questions?**

- ☐ Yes, please provide your email address: \_\_\_\_\_
- ☐ No

Please email or post a copy of your facility's discharge summary form to the following address:

*Email address*

Kate Young: k.young2@uq.edu.au

*Postal address*

Attn: Kate Young

The Queensland Centre for Mothers & Babies

The University of Queensland St Lucia QLD 4072

In doing so, we hope to better understand what features of a discharge summary are consistently used across Queensland, and what is most useful to care providers and women. If you have any queries or concerns about this request or the survey please email our Director, Professor Sue Kruske, at sue.kruske@uq.edu.au.

Thank you for your time and effort in completing this survey. Your contribution is very much appreciated.

## Appendix B: Recommended content of discharge summaries in maternity services

NOTE: Adapted from *Perinatal Forms Guideline 8, A Guide for Completion of the British Columbia Community Liaison Record – Postpartum & Newborn*

*This following is intended for inclusion in the discharge summary of a woman following the birth of a live baby/ies. Alternative discharge summaries better reflecting the needs of women following either the death of their baby in the neonatal period or the birth of a stillborn baby, a miscarriage or a termination of pregnancy should be developed.*

### Demographic information of woman

Label	Description
Place of birth	Document the name of the hospital, birth centre or place (e.g. home) where the woman gave birth.
Name/s (given, middle, surname, maiden)	Document the woman's legal names.
Unique Identifier	Document the unique identifier used by facility e.g. URN, MRN.
DOB	Document woman's date of birth.
Next of kin	Document the name and relationship of the next of kin.
Woman's Nationality	Identify the woman's nationality and cultural background: <ul style="list-style-type: none"><li>• Australian<ul style="list-style-type: none"><li>– Aboriginal</li><li>– Torres Strait Islander</li><li>– Both: Aboriginal and Torres Strait Islander</li><li>– Australian South Sea Islander</li></ul></li><li>• Other: _____ (list country/ies)</li></ul>
Baby's Nationality	Identify the baby's nationality and cultural background: <ul style="list-style-type: none"><li>• Australian<ul style="list-style-type: none"><li>– Aboriginal</li><li>– Torres Strait Islander</li><li>– Both: Aboriginal and Torres Strait Islander</li><li>– Australian South Sea Islander</li></ul></li><li>• Other: _____ (list country/ies)</li></ul>
Interpreter	Document if interpreter is required and the communication language required.

### Contact information

Label	Description
GP contact details	Document GP contact details for postnatal contact.
Other primary care providers contact details.	Document contact details for other primary carers identified by the woman. These may include a private midwife, Aboriginal health worker etc.
Mother's contact details (permanent and temporary, as applicable)	Document Mother's details for postnatal contact. 'Permanent' required for long and short term postnatal contact. 'Temporary' applicable to those women who travelled to give birth and plan to stay somewhere other than their usual home immediately after discharge etc. Include information about whose home the mother is going to and length of stay.
Baby's details (if different to mothers) Permanent	Document baby's details <b>only if different</b> to Mother's details (above) *Note: if mother has given birth to two or more babies, and



<ul style="list-style-type: none"> <li>• Address</li> <li>• Phone Number</li> </ul> Temporary <ul style="list-style-type: none"> <li>• Address</li> <li>• Phone Number</li> </ul>	baby/ies will be residing in different locations, please indicate where <i>each</i> baby will be residing, along with comments.
Admitting Doctor and/or Midwife	Document the name and designation of the admitting care provider/s.
Hospital consultation/referral	If there was a consult or referral made during the hospital stay, document the details of the consultant/referral person. Document details separately for the baby, if needed.

### ***Previous obstetric history***

<b>Label</b>	<b>Description</b>
Gravida	Document previous pregnancies a woman has had. Include the years, and where relevant, type of birth, complications, and other relevant information. Indicate most recent birth (include time of birth).
Ages of other children	When a woman has other children in her care, indicate their ages.
BMI	Indicate pre-pregnancy weight and BMI.
Blood group Rh	Document the woman's blood group and Rh factor. If Rh negative, Indicate if the woman had anti-D during pregnancy.
Current medications	Indicate if the woman is currently taking any medications, including over-the-counter medications and alternative remedies.
Allergies	Indicate if the woman has any allergies. If yes, specify any allergies and reaction.
Antenatal education	Indicate if the woman access antenatal education during this pregnancy. If yes, specify.
Antenatal care	Indicate how many antenatal visits the woman has had, and whether the first one was before 20 weeks gestation.

### ***Current maternal and birth details***

<b>Label</b>	<b>Description</b>
Plurality	Document if this pregnancy is a singleton, twin or other multiple pregnancy.
Onset of labour	Indicate whether onset of labour was spontaneous or induced. If induced, specify how and indication for induction.
Augmentation	Indicate if labour was augmented. If so, specify how and indication for augmentation.
Type of Birth	Indicate the type of birth, for each baby: <ul style="list-style-type: none"> <li>• Spontaneous Vaginal Delivery (SVD)</li> <li>• Vaginal Birth After Caesarean (VBAC)</li> <li>• Assisted Vaginal: <ul style="list-style-type: none"> <li>• Vacuum</li> <li>• Forceps: outlet, low, mid, rotation</li> </ul> </li> <li>• Caesarean Section (C/S) <ul style="list-style-type: none"> <li>– elective</li> <li>– emergency</li> </ul> </li> </ul>
Perineum	Indicate the condition of the perineum: <ul style="list-style-type: none"> <li>• Intact</li> <li>• 1<sup>st</sup> degree tear</li> </ul>

	<ul style="list-style-type: none"> <li>• 2<sup>nd</sup> degree tear</li> <li>• 3<sup>rd</sup> degree tear</li> <li>• Episiotomy</li> <li>• Repaired – indicate if the tear or episiotomy was repaired, or if repair was declined</li> </ul>
EBL (Estimated Blood Loss)	<p>Indicate the woman's estimated blood loss from this intrapartum episode of care.</p> <ul style="list-style-type: none"> <li>• &lt;500mL</li> <li>• 500-1000mL</li> <li>• &gt;1000mL</li> </ul>
Intrapartum analgesia/anaesthetic	Indicate if the woman received intrapartum analgesia or anaesthesia. If yes, specify.
Antibiotics	Indicate if the woman received antibiotics in labour or postpartum. If yes, specify. Indicate if antibiotics were indicated, but declined.
Complications	Indicate if there were any complications affecting the woman's labour and birth.
Rubella status	Indicate the woman's rubella status and whether MMR vaccination was given.
Anti D	For Rh negative women, document if she has been given Anti D or if Anti D was declined.
Other communicable diseases	Document if the woman was given vaccination for pertussis Heb B, HPV or other locally relevant vaccines.
Additional information	Indicate any other information, concerns, medications etc. If yes, specify including plans and/referrals.

### ***Mother's psychosocial health***

<b>Label</b>	<b>Description</b>
Emotional health and wellbeing	<p>Document the woman's current, or history of mental illnesses:</p> <ul style="list-style-type: none"> <li>• History of mental illness</li> <li>• Experience depression this pregnancy</li> <li>• Is on any medications for her emotional health.</li> </ul> <p>Comment: Document any pertinent information for the woman's emotional health and wellbeing, including appropriate postnatal care plans and referrals.</p>
Depression (EPDS score)	Document the woman's depression score based on the Edinburgh Depression Scale. Record outcomes of antenatal and postnatal screening.
Other stressors	<p>Document if the woman is experience any other stressors:</p> <ul style="list-style-type: none"> <li>• Age &lt;18 or &gt;45</li> <li>• Physical/intellectual disability</li> <li>• Financial stress</li> <li>• Housing issues</li> <li>• Other</li> </ul>
Domestic Violence	Document concerns about domestic violence, including referral as appropriate.
Substance use	Document the types of substances the woman uses, and the frequency of this use, and the date/time of her most recent use. Including appropriate postnatal care plans and referrals as appropriate.
Alcohol use	Document the types of alcohol consumed, and the frequency of consumption. Indicate if non-drinker, quit before pregnancy, quit during pregnancy, current use and binge

	drinking.
Tobacco	Document the frequency of tobacco use. Indicate use as: non-smoker, quit before pregnancy, cut down during pregnancy, quit during pregnancy (include gestation when quit), or current smoker.

### ***Baby's medical health***

<b>Label</b>	<b>Description</b>
Baby Name	Document the legal names of the baby.
Unique Identifier	Document the baby's unique identifier as used by facility e.g. URN, MRN.
Baby 1 DOB and time	Document baby's date and time of birth: <ul style="list-style-type: none"> <li>• dd/mm/yyyy</li> <li>• hh:mm</li> </ul>
Baby 1 Gestational age	Document baby's gestational age.
Baby 1 Sex	Indicate the sex of the baby: Male, Female or undifferentiated.
Baby 1 birth type	Indicate the type of birth, for each baby: <ul style="list-style-type: none"> <li>• Spontaneous Vaginal Delivery (SVD)</li> <li>• Vaginal Birth After Caesarean (VBAC)</li> <li>• Assisted Vaginal: <ul style="list-style-type: none"> <li>• Vacuum</li> <li>• Forceps: outlet, low, mid, rotation</li> </ul> </li> <li>• Caesarean Section (C/S): <ul style="list-style-type: none"> <li>– elective</li> <li>– emergency</li> </ul> </li> </ul>
Baby 1 Presentation	Indicate baby's presentation at birth: <ul style="list-style-type: none"> <li>• Vertex</li> <li>• Breech</li> <li>• Face</li> <li>• Brow</li> </ul>
Baby 1 Apgar scores	Document baby's Apgar scores from 1 minute, 5 minutes, and 10 minutes. Includes comments/follow-up advice as appropriate.
Baby 1 Weight	Document baby 1 birth weight in kilograms (kg).
Baby 1 Length	Document baby 1 body length in centimetres (cm).
Baby 1 Head circumference	Document baby 1 head circumference in centimetres (cm).
Baby 1 Vaccinations	Indicate if baby has received vaccinations for: <ul style="list-style-type: none"> <li>• Vitamin K (including if oral or intramuscular)</li> <li>• Hep B (yes, deferred to 8 weeks or declined)</li> <li>• Pertussis</li> <li>• Other locally relevant vaccinations</li> </ul>
Skin-to-skin	Indicate if mother and baby had uninterrupted skin-to-skin contact for the 1 hour after birth. Indicate if first breastfeed was initiated during this time.
Feeding	Document what liquids have been given to baby during hospital stay: <ul style="list-style-type: none"> <li>• Exclusive breastfeeding</li> <li>• Expressed breast milk (donated or mothers)</li> <li>• Partial breast milk (breast milk and one or more supplements of breast milk substitute, specify kind)</li> <li>• Breast milk substitute only (specify kind)</li> </ul>

	<ul style="list-style-type: none"> <li>• Water</li> </ul>
Healthy Hearing Screen	Document if the baby has had a Health Hearing Screen, the outcome and any referrals arising.
Neonatal Screening Test	Document if the NNST has been performed.
Complications	Document if any complications arose during the baby's hospital stay. Document any NICU or SCN admission, including length of stay.
Congenital anomalies	Document any congenital anomalies detected. Include follow up advice/referral as appropriate.

\*Note: repeat all the above for Baby 2, 3, 4 etc.

### **Summary and postnatal care plan – important information**

*This section summarises important postnatal information for postnatal care providers. Includes at home support, community resources, type of education provided to the woman.*

<b>Label</b>	<b>Description</b>
Seen by hospital resources	<p>Indicate if woman was seen by:</p> <ul style="list-style-type: none"> <li>• Lactation consultant</li> <li>• Social worker</li> <li>• Psychologist</li> <li>• Other (specify)</li> </ul> <p>Include name and contact details for each. Indicate if follow up is required and specify the type of follow up.</p>
Support at home	Specify the type and extent of support and support person/s available to the woman in her home environment after the birth.
Community resources, follow-up, and how to access	<p>Indicate if the woman is aware of relevant local community resources, follow-up, and how to access them, including (as relevant):</p> <ul style="list-style-type: none"> <li>• Health services: GP, CFHN, Aboriginal Medical Service</li> <li>• Community organisations: playgroups, ABA, SANDS, PIPA, multiple birth associations (as relevant)</li> <li>• Specific if other agencies are supporting the family</li> </ul>
Additional psychosocial health information	Additional psychosocial information not covered in other fields.
Contraception	Document advice given to the woman regarding contraception. Indicate the woman's preferences for contraception, including actions arising.
Pap Smear	Indicate if the woman will be due for a pap smear postnatally.
Information provided	<p>Document the printed information and resources that have been given to the woman, for example:</p> <ul style="list-style-type: none"> <li>• Safe Sleeping and SIDS information</li> <li>• 13Health</li> <li>• Raising Children website information</li> <li>• Baby's personal health record ('Red Book')</li> <li>• Information about CFHN services and other relevant local services</li> </ul>
Discharge Summary distribution	<p>Indicate who the discharge summary will be sent to:</p> <ul style="list-style-type: none"> <li>• GP</li> <li>• CFHN</li> <li>• ACCHO</li> <li>• ATODS</li> <li>• Social work</li> <li>• Mental health</li> </ul>

	<ul style="list-style-type: none"> <li>• Other</li> </ul> Document date, and medium (fax, paper copy, electronic), and the woman's consent to this disclosure.
Baby's discharge weight	Indicate if the baby (or babies) is being discharged with the woman. If yes, document the infant's weight at discharge. If not, document reason.
Feeding	Document the woman's previous breastfeeding experience. Indicate feeding intentions at time of discharge <ul style="list-style-type: none"> <li>• Exclusive breast milk</li> <li>• Partial breast milk (breast milk and one or more supplements of breast milk substitute)</li> <li>• Breast milk substitute only (specify kind)</li> </ul>
Discuss and review by woman	Provide space for the woman to confirm that she has had the opportunity to discuss and review her discharge summary. Record the name and designation of the care provider who discussed the discharge summary with the woman.
Post-discharge care.	Document advice given to the woman about: <ul style="list-style-type: none"> <li>• causes for concern and need for immediate care</li> <li>• post-discharge follow up care</li> </ul>
Date and time of discharge	Document the date and time the woman was discharged from hospital. <ul style="list-style-type: none"> <li>• dd/mm/yyyy</li> <li>• hh:mm</li> </ul>
Discharged by	Record the signature, name and designation of the care provider discharging the woman.
Discharge summary sent	Document the date, time and mode of distribution, as well as all recipients of the woman's discharge summary.



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