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# Maternity services and the discharge process: A review of practice in Queensland

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ABSTRACT

*Background:* Efforts to increase postnatal support available to women and families are hampered by inadequate referral mechanisms. However, the discharge process in maternity services has received little research attention.
*Aim:* To review current discharge practices in Queensland, in order to identify mechanisms to minimise fragmentation in the care of women and families as they transition from hospital-based postnatal care to community-based health and other services.
*Methods:* A survey of discharge practices in Queensland hospitals that offer birthing services ($N = 55$) and content analysis of discharge summary forms used by those hospitals.
*Findings:* Fifty-two Queensland birthing hospitals participated in the study. Discharge summaries were most commonly sent to General Practitioners (83%), less commonly to Child and Family Health Nurses (CFHNs; 52%) and rarely to other care providers. Discharge summaries were usually disseminated within one week of discharge (87%), but did not capture any information about care provided by domiciliary services. Almost one-fifth (19%) of hospitals did not seek women's consent for the disclosure of their discharge summary and only 10% of hospitals had processes for women to check accuracy. Significant gaps in the content of discharge summaries were identified, particularly in psychosocial and cultural information, and post-discharge advice. The format of discharge summaries diminished their readability.
*Conclusion:* Discharge summaries (format and content) should be consistent, comprehensive and specific to maternity services. Discharge summaries should be generated and disseminated electronically at the time of discharge from the maternity service. Women should review their discharge summaries and direct and consent to its dissemination.


## 1. Introduction

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[1,2] with numerous health issues emerging (e.g., anxiousness, depression, extreme tiredness, backache).[3–5] The value of additional support at this vulnerable time is well documented.[6–9] Efforts to increase postnatal support are hampered by inadequate referral mechanisms and collaboration between birthing hospitals and community services such as Child Family Health Nurses (CFHNs) and General Practitioners (GPs).[10]

Concern about the quality of information transfer via discharge summaries in all disciplines of health care is not new. A 1975 study of discharge summaries in English hospitals identified the need for improvements in both timeliness and content,[11] and similar concerns have been raised in contemporary health care.[12] Despite concerns about the potential for fragmentation and poor quality care after discharge from maternity care,[13,14] the majority of 'transition of care' research has been conducted in health areas outside of maternity care.[15–18]

Both in Australia and internationally, the importance of discharge communication features in health policy, guidelines and government strategies. Australia's National Safety and Quality Health Service Standards call for "timely, relevant and structured clinical handover that supports safe patient care", which involves standardised processes and information sets.[19] Similarly, Australia's National Maternity Services Plan 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.[20] Similarly, international

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health guidelines and government strategies from Canada,[21] the UK,[22] and the USA[23] acknowledge the importance of discharge communication in safe, high quality healthcare.

To date, studies aimed at improving the quality of discharge communication have centred on interventions related to electronic generation and standardisation of content.[12] Scant attention has been given to defining the content of high quality discharge summaries. Three studies[24–26] make recommendations about discharge summary content relevant to general hospital admissions, while a fourth study's focus is on geriatric care.[15] The relevance of this research to maternity discharge summaries is limited because unlike other hospital admissions, childbirth is not an illness.[27] Therefore, in maternity services discharge summaries provide information, in most cases, about well women and their babies. The appropriate emphasis for maternity discharge summaries should therefore be different. However no studies examine those differences or evaluate the content of maternity discharge summaries.

Australia has a system of universal public health care provision, as well as a parallel private hospital system that is accessed by 30% of women for maternity care.[28] Maternity services in Queensland have followed the trend towards early postnatal discharge,[29] with increasing emphasis on community-based postnatal care. Post-discharge care is available to women and babies via midwives, CFHNs, obstetricians, and General Practitioners (GPs).[1,10,30] Midwives and CFHNs are employed in the public health sector and in Aboriginal Community Controlled Health Organisations (ACCHOs) and provide free maternal and infant health services. Women can also access post-discharge care from private midwives, GPs, and obstetricians; however, these may involve out-of-pocket fees.

This study aimed to review current discharge communication practices in Queensland, Australia, in order to identify mechanisms that minimise fragmentation in the care of women and families as they transition from hospital-based postnatal care to community-based health and other services.

## 2. Methodology

This study involved a survey of discharge practices in Queensland hospitals that offer birthing services and a content analysis of discharge summary forms used by them. The survey was distributed to the Director of Midwifery in each Queensland birthing hospital ($N = 55$) via the Queensland Midwifery Advisor. Participants received an email reminder after two weeks, and telephone follow-up after three weeks.

The survey, developed for this study, included 16 items. Five items sought demographic information about the survey respondent, their role within the hospital and their involvement with discharge summaries. Hospital sector (public/private) was also collected. The remaining items assessed the hospital's discharge process, the woman's role in this process, and ideas for improvement. The survey also requested a de-identified copy of a sample discharge summary.

Survey data was analysed using simple descriptive statistics in SPSS Statistics version 17.01.[31] Responses to open text items from the survey were analysed thematically. Discharge summary forms received were grouped by form style and a directed content analysis undertaken.[32] This analysis compared the elements of each discharge summary form with British Columbian guidelines.[21] The British Columbian guidelines were the most expansive guidelines identified in our literature review and encompass a comprehensive range of maternal and infant biophysical and psychosocial information.

The survey followed normal ethics protocol and no confidential data were received. Completion of the survey was taken as an indicator of consent to participate. Ethics approval was granted by the University of Queensland Behavioural and Social Sciences Ethical Review Committee.

## 3. Results

### 3.1. Participants

Fifty-two (95%) of the 55 Queensland birthing hospitals completed the survey, with excellent representation of both public (95%) and private sector (93%) hospitals (see Table 1).

### 3.2. The discharge process

The care provider reported to typically complete discharge summaries was different in public and private hospitals. Private hospitals reported that midwives completed discharge summaries in all cases, usually postnatal ward midwives ($N = 12$, 86%). In public hospitals, resident doctors ($N = 14$, 37%) and midwives (postnatal ward, caseload or other; $N = 14$, 37%) were equally likely to complete women's discharge summaries. Information to complete discharge summaries 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%).

It was more common for hospitals 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 CFHN ($N = 27$, 52%; public $N = 19$, 50%; private $N = 8$, 57%). It was uncommon for the discharge summary to be sent to other community-based care providers, such as Aboriginal Community Controlled Health Organisations ($N = 9$, 17%; public $N = 9$, 24%) or private midwives ($N = 1$, 2%; public $N = 1$, 3%).

Most hospitals distributed a woman's discharge summary either on the day of discharge from the hospital ($N = 15$, 29%) or within a week ($N = 30$, 58%). One hospital reported taking up to six weeks and a second hospital reported taking more than six weeks.

**Table 1**
Participant sample.

| | Public ($N = 40$) | | Private ($N = 15$) | | Total ($N = 55$) | |
|---|---|---|---|---|---|---|
| | *N* | % | *N* | % | *N* | % |
| Hospital sector | 38 | 95 | 14 | 93 | 52 | 95 |
| Position held by survey respondent | | | | | | |
| Nurse Unit Manager | 14 | 37 | 8 | 57 | 22 | 42 |
| Director of Nursing | 9 | 24 | 1 | 7 | 10 | 19 |
| Chief Nurse Consultant | 3 | 8 | 0 | 0 | 2 | 4 |
| Midwife | 4 | 11 | 0 | 0 | 3 | 6 |
| Midwife Unit Manager | 6 | 16 | 1 | 7 | 6 | 12 |
| Other | 2 | 5 | 4 | 29 | 5 | 10 |
| Survey respondent completed discharge summaries in current role | 12 | 32 | 8 | 57 | 20 | 38 |
| De-identified sample discharge summary submitted | 24 | 63 | 1 | 7 | 25 | 48 |