Hospital obstetrics — extending care into the community

By D.W.M. Juzwischin and D.L. Paddon

A problem often identified in health care literature is the absence of a link between a hospital and the follow-up care in the community. This paper describes a service which has attempted to reduce this discontinuity of care by encouraging increased communication between the Royal Alexandra Women’s Hospital and four other Edmonton hospital obstetric units with the Edmonton Local Board of Health (ELBH).

In order to provide information to new mothers while in the hospital, in the 1960s, public health nursing staff started visiting each of the five city hospitals once a week to inform mothers about the ELBH’s community maternal/child services. The visits were increased to two per week in 1980. Postpartum patients in each hospital were invited to gather in a lounge for a half-hour discussion about public health community services during which pamphlets were distributed and a question and answer period was held. Attendance records revealed that the public health nurse saw only nine mothers out of a possible 35, or 26.7 percent. One of the major objectives of the visit was to contact the mother of a first baby, but it is interesting to note that only 31 percent of the total attending were first-time mothers.

To be more effective, the program needed to reach more of its clients. With further research, it was determined that the reasons for the poor attendance included: an unsuitable lounge setting due to cigarette smoke (some mothers did not wish to be in a “smoke-polluted” area); frequent interruptions by visitors or health care workers; and conflicting activities for patients such as doctor’s visits, treatments, physiotherapy and exercise periods.

In late 1983, the ELBH nursing consultant met with the Royal Alexandra Women’s Hospital administrative, nursing and social service staff to discuss a modified hospital-community liaison. The improved service would provide the option of a continuity of care to all mothers and newborns discharged from the hospital to the community.

A protocol, with input from nursing, social service and administration, was agreed upon by the hospital and the public health agency. Because of its successful implementation at the Royal Alexandra Women’s Hospital, the protocol and service were duplicated at the other four hospitals in Edmonton in 1984.

**Service launched**

A public health liaison nurse visits each weekday at a mutually agreed upon time. She consults with the nurse in charge to collect a prepared list of patients for possible discharge within 24 to 48 hours. Also unit staff identify any health problems or concerns expressed by patients which may require early follow-up or support upon discharge.

The liaison nurse averages about 6.5 minutes at each bedside, offering pamphlets, asking the address the mother will go home to initially, and whether the family would like a visit earlier than the routine public health nurse visit they can expect in nine to 12 days.

The liaison nurse attempts to ascertain the familial support the new mother will have on discharge, her knowledge base, as well as addressing her concerns, if appropriate. The hospital staff or liaison nurse may feel the family would benefit from a home visit sooner than the normal nine to 12 days after discharge. In that case, the liaison nurse will so advise the appropriate clinic regarding the concern and recommended contact time. The hospitalized mother gives her permission for this information exchange to take place.

**Initiation problems**

Whenever a new service is proposed, change is an obvious result. Change is unsettling to some and this service was no exception. Hospital nurses were concerned that their nursing care and teaching role might differ from public health nursing philosophy — social service staff perceived that there might be an overlap into patient social welfare issues such as child abuse, child protection, adoption and other social problems. The concerns of hospital administration and physicians related to the confidentiality of information exchange. Public health administration was concerned about the cost and stress factors of this new nursing service.

Continued on page 28
grandparent visiting, and mother-baby care. A number of institutions have examined birthing beds and are embracing the birthing room concept for families with no identified perinatal risk.

Resuscitation trays and equipment are examined frequently by staff and revisions have been made in many centres. The tertiary centre has facilitated standardization of items and minimized the waste of bulk purchase of items that are infrequently used by enabling the hospitals to purchase from small quantities of endotracheal tubes, mucus extractors and other small items.

A number of changes have been made with regard to the general care of the laboring mother. Two hospitals have started to certify their nurses in performing vaginal examinations where they previously were not allowed to examine the labor patient rectally or vaginally.

The use of the Friedman partogram in assessing progress of labor is gradually gaining acceptance. Infusion pumps have been purchased for use with oxytocin inductions and three hospitals purchased fetal monitors for antenatal screening and for use with the labor patient.

Nursing care is changing as hospitals adopt an attitude of family-centered care. Six isolates were purchased and two hospitals implemented Dextrostix as a screening tool in their nursery. The level of nurses’ knowledge of perinatology was found to be in need of attention, results of pre- and post-test evaluations of updating courses will be discussed in a future article.

The field of perinatal outreach is challenging and diverse. Because the primary aim of the program is prevention of avoidable illness in mothers and babies, tangible results are few, but we are very encouraged by the responses we have received. The medical and nursing staff is generally enthusiastic and especially appreciate the regular, direct interpersonal contact with the visiting nursing-physician team from the tertiary centre. Change takes time slowly and with measured steps, but change is occurring. The warmth and encouragement we receive from the community centres is gratifying.

The program itself is continually evolving. It has no mandate for access to community hospitals, but is dependent upon mutual goodwill. With few role models to follow, growth has often been by trial and error. There are many areas we wish to pursue in future such as standardization of chart forms and formation of policy manuals for the region. The potential and scope of the program is great and continuing reduction in perinatal mortality and morbidity is our imperative to continue. We believe the program may be a model for continuing education in other aspects of health care for community hospital nurses and physicians, especially those in rural and isolated communities.

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Footnotes

Extending care into the community (Continued from page 23)

The real cost of stress on the liaison nursing staff must be considered. First there is pressure of time. ELBH staff nurses are generalists; that is, each nurse is responsible for a district which includes carrying out all public health nursing programs as well as participating in clinics for immunization and well-child counselling in the area. To offer a hospital liaison service, in times of budget restraint, necessitates reducing the ELBH nurse’s district by half for each hospital served and adding portions of the unserved half to other district nurse case loads. The designated liaison nurse then can allocate one-half of her day to hospital liaison duties and the other half to her district work.

On paper this works. In practice it means a liaison nurse is constantly juggling demands from her district with her responsibilities at the hospital. The liaison nurse must state the same information repeatedly to each mother at each bedside. In a large obstetric facility, such as the Royal Alexandra Women’s Hospital which recorded 6,039 deliveries in 1983-84, this entails 20 to 25 visits per day. Stemming from these factors is the possibility of burn-out.

Evaluation
Although no formal evaluation has taken place, the maternal child nursing consultant responsible for the hospital liaison nursing service, in discussion with the ELBH research division, agreed that an interview with the hospital’s director of Nursing be undertaken. The protocol agreement with the Royal Alexandra Women’s Hospital was reviewed point by point and the service judged to be very advantageous. Client satisfaction has been reported positively by phone to the clinics. New mothers say they saw the public health nurse in the hospital and that the visit was helpful.

The improvement in the program was based on modifying the method by which mothers in hospital were approached, and although more labor-intensive, it does improve the opportunity for concerns to be identified prior to discharge. The success of the program is also based on the importance of physicians, nurses and social workers identifying and communicating the mother’s needs through rounds, risk screening and referrals, all of which are a collaborative responsibility. Knowledge of each other’s services has also been enhanced as a result of the communication and interchange taking place within the program.

Footnotes