Postpartum Safety and Satisfaction Following Early Discharge

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Recommended Citation
Postpartum Safety and Satisfaction Following Early Discharge

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The length of hospital stay (LOS) has decreased dramatically over time in Ontario. In the 1920s and 1930s, when hospital births became more common, a stay of 12 to 14 days was typical.1 The average LOS in 1992 was approximately 3.0 days.2 Early discharge (ED) has been defined as hospital discharge within 48 hours after a normal birth. Programs that included ED have been introduced to provide more family-centred care,3,4 in response to parental preferences,5,6 to provide alternative forms of care7,8 and also as a response to other economic and political factors.9

With regard to patient safety and satisfaction, ED programs in the literature appear to have resulted in positive outcomes. However, the majority of these studies were descriptions of single groups, and sample sizes tended to be small. Four randomized trials have been completed to date,10-14 and they have shown that when compared with the group given late discharge, women discharged early showed similar rates of hospital readmission10,12,14 and of referral to a physician or nurse13,14 and experienced equivalent or higher levels of satisfaction.3,14

Given that many of the ED programs were being used by fewer than 10% of eligible women,9,15 the Ontario Ministry of Health invited agencies to submit proposals for pilot projects or evaluations of existing programs. Hospitals, public health units, colleges, universities and other agencies were invited to participate, and two Ontario sites were chosen for the demonstration project.

A representative from the Ministry of Health (JR), members of the evaluation team (EH, JW) and various health professionals in the two sites worked together to develop, implement and evaluate this ED program. Throughout the program, an attempt was made to provide flexibility and choice to new families while ensuring safety to mother and baby.

Safety was measured by the number of visits to a physician or hospital emergency department and reports of hospital readmission, and satisfaction was measured through a mailed postpartum questionnaire. It was hypothesized that the early discharge group would show improvement or at least be comparable to two comparison groups on the outcomes of interest.

METHOD

Subjects
Subjects were recruited in the two study sites mainly through hospital postpartum units. Site 1 was located in northeastern and site 2 in southwestern Ontario. Site 1 consisted of a single hospital (hospital 1) and site 2 included three county hospitals (hospitals 2, 3 and 4). Eligibility was restricted to those women without previous medical or obstetrical complications who had or were expected to have a normal vaginal birth.

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The program

The hospitals involved, together with the local health units, the Home Care Program, the Victorian Order of Nurses, Visiting Homemakers and other agencies and consumers, developed and implemented the early discharge protocol at each site. Early discharge was defined as discharge from the hospital as early as six hours after the delivery. Criteria (Appendix A) were developed to assess eligibility at the time of discharge.

In order to maintain the flexible nature of the program, mothers could decide either pre- or postnatally whether they wished to participate. For a high proportion of mothers (42%), the decision was made during their postpartum stay.

Community services available to the mother and her family in the ED program included a lactation consultant, home visits by a nurse, a homemaker, a 24-hour hospital telephone line, and information about community-based resources for parents. Mothers decided which services they felt they would need in the immediate postpartum period at home. Homemaking could be provided without the provision of professional nursing services. A nurse-coordinator at each site was responsible for assessing patient eligibility and coordinating community-based services.

Study design

The design was chosen by members of the Women’s Health Bureau of the Ontario Ministry of Health. The interrupted time series design included a comparison between the ED and concurrent comparison group as well as an additional preprogram comparison group for whom early discharge was not an option.

In phase one, the preprogram phase, those women who would have been eligible for ED and who agreed to participate were asked to sign a consent form. Approximately two and a half weeks later, they received a self-administered questionnaire to complete and return. The questionnaire was adapted from that used by Carty and Bradley\(^1\) and was rated at a grade 4 to 5 literacy level by the Grammatik IV software program (Reference Software International, San Francisco, CA). The questionnaire asked mothers about their satisfaction with their hospital stay, their needs during the first week postpartum, the help they received and breastfeeding. The questionnaire was pretested on a voluntary group consisting of ante- and postpartum women, interested consumers and members of the planning group from site 1.

During the second phase, the women who had agreed to participate and were discharged early were mailed the postpartum questionnaire and became the ED group. Those who opted for the traditional LOS and consented to fill out the questionnaire became the concurrent group.

Data collection instruments were submitted for ethics approval by the hospitals involved prior to study implementation.

Analysis

In all analyses, women enrolled in this project remained in their original study group regardless of their LOS. Descriptive statistics were calculated to compare the three study groups on demographic characteristics; chi square analyses were used for categorical data, and analysis of variance was used for interval data. Tukey's B test was used for any post-hoc comparisons of group means.

Multiple classification analysis (MCA) was used to measure differences in satisfaction levels across groups while controlling for differences due to the site or the individual hospital, and the Mantel-Haenszel procedure was used for the stratified analysis of categorical data.

The analysis involved a two-part approach. Initially, comparisons were made between the ED and concurrent groups, and in the case of a significant finding, a comparison was also made between the ED and preprogram groups. Unless otherwise indicated, a two-tailed significance level was set at 0.05.

RESULTS

Enrollment and response rates

During phase one, 1,886 births occurred, and 1,378 (73%) mothers were eligible to participate (Figure 1). Approximately 74% chose to participate, and 542 usable questionnaires were returned, for an overall response rate of 53%. These respondents represent the preprogram group. Response rates differed across the two sites, with 83% of questionnaires returned from site 1 and 40% from site 2.

During phase two, 2,217 births occurred in the two communities, and 1,400 of the women (63%) were eligible for ED.
Figure 1. Flow chart of the two phases in the evaluation of an early discharge (ED) program

### TABLE III

<table>
<thead>
<tr>
<th></th>
<th>Preprogram</th>
<th>Concurrent</th>
<th>ED A1</th>
<th>F value</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total satisfaction</strong></td>
<td>69.4 (40-108)</td>
<td>90.7 (46-108)</td>
<td>91.4 (44-108)</td>
<td>3.3</td>
<td>0.04</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>86.7 (40-108)</td>
<td>91.9 (46-108)</td>
<td>90.4 (44-108)</td>
<td>31.3†</td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>Site 1</strong></td>
<td>86.7 (40-108)</td>
<td>91.9 (46-108)</td>
<td>90.4 (44-108)</td>
<td>31.3†</td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>Site 2</strong></td>
<td>93.8 (40-108)</td>
<td>94.0 (46-108)</td>
<td>90.9 (44-108)</td>
<td>24.0‡</td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>97.1 (40-108)</td>
<td>95.8 (46-108)</td>
<td>95.7 (44-108)</td>
<td>24.0‡</td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>Hospital 4</strong></td>
<td>89.0 (40-108)</td>
<td>88.9 (46-108)</td>
<td>90.9 (44-108)</td>
<td>24.0‡</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

* Mean ± standard deviation (range); ED score significantly greater than preprogram group score
† ANOVA after controlling for the effects of site; p<0.05 for the comparison across study groups
‡ ANOVA after controlling for the effects of hospital; p<0.05 for the comparison across study groups

Among this group, 384 (27%) chose to enrol in the ED program. An additional 1,016 women agreed to complete the questionnaire but chose the routine LOS, and became the concurrent comparison group.

Clinical data from hospital records were obtained for 319 (83%) of those who enrolled in the ED group and for 456 (45%) of those in the concurrent group.

**Description of the study groups**

All of the women in the groups were similar in age, and the majority (86%) were married or living in a common-law relationship (Table I). Most were English-Canadian (73%) and had an average of 13.5 (SD=2.8) years of formal education.

**Hospital and clinical outcomes**

The average postpartum LOS in the hospital was significantly shorter for the ED group: 2.7 days for mothers and 2.7 for their babies, compared with the concurrent group (3.5 and 3.4 days) and the preprogram group (4.2 and 4.1 days).

Approximately 50% of women had some postpartum contact with a physician, and the proportions were not different across the study groups (Table II). The Mantel-Haenzel (M-H) odds ratio (OR) for the two sites was 1.1 (95% confidence interval: 0.8-1.4) with an M-H chi square of 0.06, which was not significant. When stratified by hospital, the adjusted M-H OR comparing the ED and concurrent groups was 1.1 (0.8-1.5) which was also nonsignificant.

There were no significant differences across groups in terms of readmission rates of mothers or their babies (Table II).

**Postpartum services received**

Approximately 42% of ED mothers had a telephone conversation with a public health nurse, compared with 33% in the concurrent control group and 35% in the preprogram group, a difference that was statistically significant. The proportion of ED mothers receiving a home visit by a public health nurse was also significantly higher than that in the other two groups (ED: 38%, concurrent: 22%, preprogram: 23%). This was also true for visits (13%, 2%, 1%) and telephone conversations (33%, 11%, 7%) with nurses from the Victorian Order of Nurses, use of a special hospital phone number for new mothers (32%, 13%, 9%) and homemaking services (18%, 3%, 2%).

**Satisfaction**

The questions about satisfaction with postpartum care involved three main areas: confidence in newborn care, evaluation of postpartum care and evaluation of the hospital environment. The Cronbach's alpha
reliability coefficient was found to be 0.90 for both phase one and two, indicating a high degree of internal consistency. An overall satisfaction score was created by summing across individual questions. A higher score indicated a higher level of satisfaction.

Analysis of variance showed an overall significant difference in mean group scores (p=0.04), and Tukey’s B was significant at the 0.05 level when the preprogram and ED groups were compared (Table III). Thus, the ED group was significantly more satisfied than the preprogram comparison group according to this summary measure, although the actual magnitude of the difference (two points) was quite small. Multiple classification analysis revealed that satisfaction was significantly different across sites and hospitals, but did not vary by study group.

DISCUSSION

The purpose of this project was to evaluate an ED program in terms of its relative safety and patient satisfaction. The ED program was unique in many ways. For example, the program provided women with the flexibility to enrol either pre- or postnatally, it did not require that women choosing to receive homemaking also receive visits from a nurse, it did not require an initial home assessment, and it provided new families with a range of community-based and other services from which to choose. The entire process was geared to the needs and interests of the new family and differed from many previous programs, in which the intervention was predetermined and often inflexible.

Patient satisfaction in this project was comparable across groups and was found to be quite high, since 80% said they would choose the same type of care during a subsequent pregnancy. Although these values appear to be encouraging, it has been shown that women tend to prefer the care they have received, regardless of what the care involved.16

Making comparisons across studies with regard to satisfaction is problematic, as the instruments used are often very different.17 Carty and Bradley18 found higher satisfaction scores among those discharged within 48 hours, with mean differences ranging from 12 to 17 points, differences more pronounced than in the current project. However, these differences in satisfaction may be partially explained by the fact that their questionnaire was much longer than the one used in this study, and their study design included random allocation to ED.

We did not collect information on the nonrespondents, and it is possible that they differed from the women who returned completed questionnaires. This may have important implications for our measurement of satisfaction: as Ferris et al.17 have pointed out, those returning completed questionnaires tend to be more satisfied than those who do not. The women in the ED group had a higher response rate than the controls; however, their overall satisfaction score of only two points higher implies that response bias may have been adequately controlled.

This type of clinical manoeuvre is subject to a number of discharge criteria, which are intended to ensure safety yet at the same time restrict eligibility. As well, personal preferences play an important role, since certain women value ED more than others and for different reasons.18 These results can be generalized to women having a normal, uncomplicated vaginal birth, who in fact represent the majority of childbearing women in Ontario.

In conclusion, the ED program with home follow-up appears to provide a feasible, safe and effective alternative to traditional discharge procedures. Although the study sites represent only two Ontario communities, it is highly possible that early discharge programs could be implemented province-wide. This type of program could be highly successful if the necessary components of cooperation, flexibility, consumer involvement, community follow-up and support are put in place by all those involved.

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MARCH – APRIL 1996

CANADIAN JOURNAL OF PUBLIC HEALTH

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Received: June 27, 1995
Accepted: December 8, 1995