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Hospital postnatal discharge and sepsis advice; perspectives of women and midwifery students

Abstract

Postnatally, women are increasingly discharged home from hospital earlier. There is little evidence examining the postnatal hospital discharge process and how this may impact on the health of women and babies. An example is advice on sepsis prevention. This is the biggest direct cause of maternal mortality, with increased number of women re-admitted postnatally with the condition.

This qualitative study explored women's and senior student midwives' perceptions of the postnatal hospital discharge, focusing on maternal sepsis prevention advice. Three focus group interviews were undertaken involving nine senior student midwives and 14 women attending paid NCT or specialist classes for vulnerable migrant women. All participants believed that the postnatal hospital discharge process was inadequate; being rushed, with too much inconsistent information provided. Sepsis advice was patchy and the condition underplayed. It is argued that cost effective, time efficient and innovative ways to impart vital information are required to support the postnatal hospital discharge process.

Introduction and background

The length of the postnatal hospital stay has fallen over the last 30 years, and there continues to be pressure on health services to reduce this further (Bowers and Cheyne, 2016). With the emphasis on enhanced recovery, many women are now discharged home within 24 hours of giving birth, including following caesarean section (WHO, 2013).

Shortened hospital stays in the postnatal period has implications for maternal and neonatal outcomes therefore good quality postnatal care is essential.

Recent surveys have found dissatisfaction with the current provision of postnatal care, both among mothers and midwives (WHO, 2013, Bhavnani and Newburn, 2010, Royal College of Midwives, 2013). Midwives report particular challenges, including a lack of time at the postnatal hospital discharge to impart vital health information, such as hand hygiene, and maintaining maternal well-being (RCM, 2013). The National Institute of Clinical Excellence (NICE, 2013) outlines the myriad of information mothers should receive at the first postnatal contact and the postnatal hospital discharge requires women to have received this vital public health information and tailored advice (NICE, 2013). In addition, language barriers could further compound communication difficulties in women with low levels of spoken English. Evidence suggests that trained interpreters are not consistently used in maternity services (Haith-Cooper, 2014, Phillimore, 2015).

Hospital readmission

Unplanned maternal readmission to hospital within 42 days postpartum is an undesirable maternal outcome. In 2013/4 the mean rate of emergency readmission following normal birth in England was 1.9% and 3% following caesarean section (RCOG, 2016). The definition of emergency maternal readmission has changed recently from 30 to 42 days and therefore a direct comparison is difficult to make, however there appears to have been an increasing rate of maternal readmissions over the past 5-10 years (RCOG, 2013).

Infection continues to be one of the main reasons for postnatal hospital readmission and sepsis remains a significant cause of maternal death in the UK, with higher rates in women

from black or minority ethnic groups (Acosta et al., 2014). Approximately 1 in 1000 women will develop sepsis (Knowles et al., 2015) and between 2011-2012 a UKOSS study reported 365 women with sepsis, 5 of whom died. For each death, approximately 50 women have life-threatening morbidity (Acosta et al., 2014). There is considerable variation in readmission rates between Trusts which may depend on how well prepared women are at the postnatal hospital discharge for example including clear information regarding care of surgical wounds to prevent infection (RCOG, 2013).

The postnatal hospital discharge process

There is a lack of information regarding what constitutes the essential elements of the postnatal hospital discharge process (Bick et al., 2011b) and a systematic literature review revealed no published literature related to this. Providing simple public health messages to help prevent sepsis and reduce maternal morbidity is an example of advice required at the postnatal hospital discharge, consequently a study was undertaken with the aim to explore women's and student midwives' perceptions of the postnatal hospital discharge and the advice and information offered, in particular relating to postnatal maternal sepsis prevention.

Methods

An interpretivist tradition was adopted to understand how women and senior student midwives made sense of the postnatal hospital discharge and the meaning they attach to it (Topping, 2011). This involved a hermeneutic phenomenological approach (Todres and Holloway, 2011); seeking to understand the lived experiences of both student midwives and women of the postnatal hospital discharge process.

A purposive sample of participants was recruited as follows:

1. Nine year three student midwives as they have recent experience of the entire maternity journey
2. Nine women who paid for NCT parent education classes currently attending a postnatal support group and had a baby in the last year
3. Five vulnerable migrant women attending a specialist NCT funded postnatal support group who had a baby in the last year. This was to ensure a broad socioeconomic, ethnic and cultural background of the participants

Three focus groups were undertaken, lasting an hour each. These provided the opportunity to explore in depth how the postnatal hospital discharge was conceptualised and negotiated by the participants (Mason, 2005). Questions focused on the postnatal discharge in general and then more specifically on sepsis advice and information that the participants had seen provided or had received (See table 1). The focus groups were audio recorded and transcribed verbatim by a professional external agency. Refreshments were provided and the women reimbursed for their travel

Ethical issues

Ethical approval was obtained from the University Ethics Panel 06/03/17 Ref:E596. Women attending the NCT groups who expressed an interest had their contact number taken by the group facilitator (NCT researcher). They received an information sheet and were phoned by the principal investigator. English language ability was assessed by the NCT researcher. She is also the group facilitator and very experienced working with women with language barriers). No

women required an interpreter. Student midwives received an information sheet and explanation in class and emailed a researcher if they wished to volunteer to participate.

Informed consent was gained at the beginning of the interviews. This was written consent for the student midwives and members of the 1st women's focus group. Verbal audio recorded consent was gained from the vulnerable migrant women in case of a fear of providing a signature due to immigration status. Anonymity and confidentiality were assured and requested by participants. They were advised to avoid recalling personal specific care experiences that may reveal substandard care. If this occurred the midwife researcher could have a conflict of interest between her role as a researcher and that of a health professional. There could be a dilemma as to whether the research process should continue or be terminated and confidentiality breached to report such practice.

For the migrant women, it was stressed that the researchers had no link with the Home Office and the data would only be used for research purposes. There was the potential that participants could become stressed or upset during the focus groups for an unconnected or unforeseen reason. The participants were advised that they could withdraw from the focus group, debriefing would be offered by the NCT researcher and the option to signpost the participant to relevant support services e.g. 3rd sector counselling. Participants were informed that they could withdraw their consent within a week of the focus group. Transcripts were stored in a password-protected computer file accessible only to the researchers and transcribers and once transcribed, audio-recordings were destroyed.

Data analysis

The data were subject to thematic analysis (Braun and Clarke, 2006). This was undertaken by hand, using 'Microsoft Word' and on screen different colour highlighting. This involved reading and re-reading the transcripts, then coding the data and grouping codes together to form themes. To ensure rigour, the themes were discussed by the research team to ensure they were true to the data.

Findings

Three key themes emerged from the data; 'It's all a rush', 'too much to remember' and 'a lack of consistency'. The transcribers could not differentiate individual contributions so the findings are classified by interview order for the women's contributions i.e. W1 or W2 and SMW For student midwives

'It's all a rush'

Rushing was a concept discussed in all three interviews and this was felt to affect the quality of the information provided or received at the postnatal hospital discharge. Rushing was felt to be an issue related to the midwife undertaking the discharge process:

W2 My midwife she's just in hurry, she just ask quick, quick, quick question and say, "okay, you are good...you can go home"

This led to concerns that the midwives were not providing all the information needed.

W1 But it means it's all a rush and you think what if they missed something.

Midwives rushing was also acknowledged as an issue by the student midwives:

SMW There's so much, and when you're rushing doing a discharge and you're trying to get TTOs together and all the rest of it...

It was perceived by the women that midwives were rushing because they needed the bed quickly for the next woman and that they felt part of a 'standard, conveyor-belt, process.'

W1 it felt like it was quite standard that everybody's out at a certain time ready for the next lot to come, that's, I felt like it was like a hotel checkout, everybody was flying out

The concept of rushing was not believed to be all midwife led. Some women felt that midwives took their time but the women just wanted to get home quickly and consequently did not take advantage of the information provided at the discharge:

W1 I was rushing it because I just wanted to go...yes to every question, okay brilliant, yeah, go go go, but I don't think the person doing it was rushing at all, so that was good.

The women wanting to go home quickly was frequently blamed on delays to the hospital discharge process. Women had to wait until late in the day to be seen by a midwife, then had lost interest in the information provided by this point in time.

'Too much to remember'

What was said at the postnatal hospital discharge formed a large part of the discussion both in terms of general information provided and specifically sepsis prevention advice. It was generally agreed that there was too much verbal information to remember specific details. However, there were specific topics women did remember being discussed, most frequently

relating to contraception and breastfeeding. No participants recalled a conversation specifically around sepsis prevention, many participants stating they had never heard of it. Infection was a concept that women were aware of. However, women could not recall infection prevention being discussed at discharge. Conversely, some student midwives felt that this was discussed with women.

SMW I have heard people say infection postnatal can happen really, really quickly and it's imperative that you do ring us straightaway but not everybody would do that.

Women and student midwives could recall specific advice that would be given to prevent infection such as handwashing, personal hygiene, wound care and frequently changing sanitary pads. However, the women did not appear to appreciate the link between this and preventing sepsis. They also did not seem to understand when to be concerned about whether their wound may be infected or what generalised symptoms to watch out for.

W2 ...I didn't realise this happen also with the women, they get infected with this, because I also got stitches and they say it's going to be dissolved a few days and I don't, because I was getting pain and that whenever I sit and hold my baby because I was trying to give him breastfeeding but I didn't realise it was going to harmful for me also.

Similarly, the student midwives acknowledged that the advice given was not provided in the context of sepsis prevention and that they didn't believe enough information was provided to prevent sepsis at the postnatal discharge.

'A lack of consistency'

A lack of consistency of information was discussed at all the focus groups. There appeared to be a lack of consistency about how the information was provided, what was provided and when it was provided.

This lack of consistency included the use of leaflets, with some midwives verbally providing key messages and providing leaflets for women to read later to reinforce the message. Other women reported not receiving verbal messages but being provided with too many leaflets to read at home; most of which were not read or the content not remembered.

No women could recall receiving a leaflet about sepsis (or infection) prevention, symptoms or advice.

W2 so many leaflets and so many advice and information but I don't remember exactly about this...

However, one student midwife had sourced a leaflet about sepsis prevention, although none of the other student midwife had seen this.

Another area of inconsistency at the hospital discharge was overcoming language barriers when giving information and advice. This wasn't discussed during the women's focus groups but created discussion amongst the student midwives. Some had seen a professional interpreter used, however other students found that midwives appeared to rely on relatives to communicate the information.

SMW It's normally a younger sister or, like, her equivalent. I've seen, they mostly they would pass the information onto female relatives and it tends to be sort of like the second...generation so a female relative, so they maybe were born in the UK and are native speakers, if you can get the closest to that you can get really...

However, difficulties were experienced with women who were not supported by an extended family with English speaking relatives.

SMW ...within the Asian culture they often have a lot of family members around them and you can give that information to them but I've noticed with eastern European women, for instance, they're often there with just a husband and he might not speak English either and then you're really stuffed and what do you do? You do your best and you're waving your hands around but how much of that information is actually going in, you just have no way of knowing.

The consistency of the translation was another aspect discussed by the student midwives when relying on relatives to interpret at the postnatal hospital discharge.

SMW ...the strength of the translation is in the truth of the translator...if you give the information to a relative they might think that they know what you mean and just sort of shorten it.

Telephone interpreting services were discussed but they were rarely used due to the cost but also the time taken to organise the phone call.

SMW ...when you're under pressure and then, like, when a discharge doing and the woman wants to go home ...I've seen people be like, well we could go get it but that'll take another half an hour, hour plus, so what we'll do is we'll do our best.

In addition, women who experienced language barriers were generally only provided leaflets written in English:

SMW But they're not offered any written information that they can understand themselves either, so it is, it is inadequate isn't it?

Inconsistency also related to the way that sepsis was (or was not) talked about at the postnatal discharge. Language use appeared to vary and the participants expressed concern that the seriousness of the condition was played down when it was discussed:

W1 But I think I didn't know that sepsis was like such a big killer and things like that, so I think if they opened with that it would stick more because you're more, oh this is a real problem

In addition, the words used to describe sepsis were inconsistent with some women being informed they may just experience flu like symptoms. Other women were told that they may have a localised infection or feel under the weather. The words 'blood poisoning' was not generally used. One student midwife blamed this inconsistency on changes to terminology over time:

SMW people used to talk about septicaemia and they understood that as a very serious disease and that terms seems to have gone out the window and healthcare professionals understand what sepsis is and talk about it all the time, but the general population isn't

hearing sepsis, septicaemia, they're just hearing infection, oh an infection's alright, that's just like having a whitlow or something.

The final discussion around lack of consistency related to the timing of sepsis advice. Participants discussed how the advice that they were given around infection or sepsis was provided at different points in the maternity journey. This ranged from the booking appointment up until the 1st or 2nd home postnatal visit rather than at the postnatal hospital discharge.

SMW And I've seen it more, yeah, done in community which is sometimes too late rather than it should be done at discharge, yeah

Discussion

This study confirms that both women and student midwives experience difficulties with the postnatal hospital discharge process. The quality of advice and information received is negatively affected by midwives rushing to get the woman discharged but also the woman rushing to go home. In addition, having too much information to impart or remember and this information being imparted in an inconsistent way is also perceived to influence the quality of postnatal hospital discharge process. These findings add to the current evidence, albeit limited around hospital postnatal care (WHO, 2013, Bhavnani and Newburn, 2010, Royal College of Midwives, 2013, Bick et al., 2011a), where midwives were perceived to be rushing due to shortages of midwives. The NCT survey found that this led to delays in women going home. Some women had self-discharged due to frustration at having to wait for a midwife to undertake the postnatal hospital discharge process (Bhavnani and Newburn, 2010).

This study also found that in some areas trained interpreters were not used at the postnatal hospital discharge. There was an over reliance on family members to interpret for the woman. This supports previous evidence where the use of interpreters in maternity care is patchy (Haith-Cooper, 2014, Phillimore, 2015). It is concerning that using family members is still practiced when previous work has highlighted problems such as potential translation errors (Dysart-Gale, 2007) and also a breach of confidentiality (Meddings and Haith-Cooper, 2008).

This study is limited, with a small local sample of women obtained from two specific postnatal forums with no women requiring an interpreter. If women with language barriers had been included in the study, it may have been revealed how these affected the experience of the postnatal hospital discharge. However, the women and student midwives represented postnatal experiences from four different NHS Trusts which increases the likelihood that these findings are transferable to other NHS sites. but they add to the evidence base around postnatal care in general and have implications for practice. In addition, no other research could be found focusing on the postnatal hospital discharge and specifically the advice provided to prevent maternal sepsis.

It would appear that more specific information is required at the postnatal hospital discharge, to prevent maternal sepsis. This includes providing the information in a timely manner to ensure women's interest is not lost. We would argue that this information would need to include advice about prevention, early symptoms and who to contact if the woman develops symptoms of sepsis. Using the term sepsis rather than infection and explaining what this is could help to re-enforce the importance of the advice offered. As this

information needs to be provided in a time efficient and content consistent way, in the woman's spoken language, we argue that an innovative approach could be developed, such as using digital technology, to impart the information. More research is needed to test whether this would be a feasible approach and whether ultimately using an innovation such as health technology could result in a reduced incidence of postnatal sepsis in women.

Conclusions

The postnatal hospital discharge process is an important transition in care and its quality can affect the risk of maternal and neonatal morbidity. However, there is little research focusing specifically on the postnatal hospital discharge process. This study found that student midwives and women believe that the discharge process is rushed with too much information provided. The advice offered around maternal sepsis prevention is inconsistent and the use of interpreters patchy. With increasing budget cuts in the NHS and a chronic shortage of midwives, it is necessary to consider the development of time saving, innovative ways of presenting information. This could be using digital technology. However, any technology would need to be thoroughly tested in practice. An improvement in the postnatal discharge process could ultimately contribute to the reduction of the incidence of sepsis in postnatal women.

Key points

- There is evidence that there are an increasing number of women re-admitted postnatally with sepsis.
- Women are being discharged home earlier postnatally and it is vital that this transition in care includes information and advice to maintain a healthy mother and baby.

- This study found that the postnatal hospital discharge process is rushed, information provided is inconsistent and there is a lack of information specifically around sepsis prevention.
- A cost effective, time saving, means of providing vital sepsis prevention information is needed.

Table 1: Questions asked at the focus group interviews

Focus group 1 (midwifery students)

Tell me about your experiences of the postnatal hospital discharge and the information and advice offered to women

Probes

- General topics covered
- Positives about the PN discharge
- Negatives
- Advice to prevent/ detect and act on maternal sepsis
- Any additional advice that you think should be provided? If so what?

Focus group 2 and 3

Please think back to when you were about to go home from hospital after having your baby and tell me about the advice you received from the midwife at discharge

- General topics covered
- Positives about the PN discharge
- Negatives
- Advice given to help prevent yourself getting an infection
- Advice given about how you would know if you had an infection
- Advice was given about how to get medical help if you think you had an infection
- Was the word sepsis explained to you? If so, can you remember what you were told about sepsis?
- Any additional advice that you think should be provided? If so what?

References

- ACOSTA, C., KURINCZUK, J., LUCAS, D., TUFFNELL, D. & SELLERS S, E. A. 2014. *Severe Maternal Sepsis in the UK, 2011–2012: A National Case-Control Study*. [Online]. Available: <http://www.plosmedicine.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pmed.1001672&representation=PDF> [Accessed 2014].
- BHAVNANI, V. & NEWBURN, M. 2010. *Left to your own devices: The postnatal care experiences of 1260 first-time mothers*. London: NCT.
- BICK, D., ROSE, V., WEAVERS, A., WRAY, J. & BEAKE, S. 2011a. Improving inpatient postnatal services: midwives views and perspectives of engagement in a quality improvement initiative. *Health Services Research*, 11.
- BICK, D. E., ROSE, V., WEAVERS, A., WRAY, J. & BEAKE, S. 2011b. Improving inpatient postnatal services: midwives views and perspectives of engagement in a quality improvement initiative. *BMC Health Services Research*, 11, 293.
- BOWERS, J. & CHEYNE, H. 2016. Reducing the length of postnatal hospital stay : : implications for cost and quality of care.
- BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- DYSART-GALE, D. 2007. Clinicians and medical interpreters. Negotiating culturally appropriate care for patients with limited language ability. *Family Community Health*, 30, 237-246.
- HAITH-COOPER, M. 2014. Mobile translators for non-English speaking women accessing maternity services. *British Journal of Midwifery*, 22, 795-803.
- KNOWLES, S., O'SULLIVAN, N., MEENAN, A., HANNIFFY, R. & ROBSON, M. 2015. Maternal sepsis incidence, aetiology and outcome for mother and fetus: a prospective study. *BJOG* 663-671.
- MASON, J. 2005. *Qualitative Researching*, London, SAGE.
- MEDDINGS, F. & HAITH-COOPER, M. 2008. Culture and Communication in Ethically Appropriate Care. *Nursing Ethics*, 15, 52-61.
- NICE. 2013. *NICE Quality Statements on postnatal care* [Online]. Available: <https://www.nice.org.uk/guidance/qs37/chapter/list-of-quality-statements> [Accessed July 2013].
- PHILLIMORE, J. 2015. Delivering maternity services in an era of superdiversity: the challenges of novelty and newness. *Ethnic and Racial Studies*, 38, 568-582.
- RCOG 2013. *Patterns of maternity care in English NHS trusts 2011/2*. London: The Royal College of Obstetrics and Gynaecology.
- RCOG 2016. *Patterns of maternity care in English NHS trusts 2013/14*. London: The Royal College of Obstetricians and Gynaecologists.
- ROYAL COLLEGE OF MIDWIVES. 2013. *Postnatal Care Planning: Pressure Points* [Online]. Available: <https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf> [Accessed August 2013].
- TODRES, L. & HOLLOWAY, I. 2011. Phenomenological Research. In: K, G. & LACEY, A. (eds.) *The Research Process in Nursing*. 6th ed. Chichester: Wiley-Blackwell.
- TOPPING, A. 2011. The Quantitative-Qualitative Continuum. In: GERRISH, K. & LACEY, A. (eds.) *The Research Process in Nursing*. 6th ed. Chichester: Wiley-Blackwell.
- WHO. 2013. *WHO recommendations on postnatal care of mother and newborn* [Online]. Available: http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf [Accessed October 2013].

