Provincial Council for Maternal and Child Health

building a brighter future

Standards of Postnatal Care for Mothers and Newborns in Ontario:

Birth to one-week postnatal period

REPORT | MAY 2018

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Table of Contents

About the Provincial Council for Maternal and Child Health

The Provincial Council for Maternal and Child Health has two distinct roles. First, it generates information to support the evolving needs of the maternal-child health care system in Ontario. Second, it is a resource to the maternal-child health care system in Ontario to support system improvement and to influence how services are delivered across all levels of care.

Vision

The best possible beginnings for lifelong health.

Mission

- Be the provincial forum in which clinical and administrative leaders in maternal and child health can identify patterns and issues of importance in health and health care delivery for system support and advice.
- Improve the delivery of maternal and child health care services by building provincial consensus regarding standards of care, leading practices, and priorities for system improvement.
- Provide leadership and support to Ontario's maternal and child health care providers, planners, and stewards in order to maximize the efficiency and effectiveness of health system performance.
- Mobilize information and expertise to optimize care and contribute to a high-performing system therefore improving the lives of individual mothers and children, providers, and stewards of the system.

Introduction

Approximately 140,000 babies are born in Ontario each year.[1] In the context of early hospital discharges, rising health care costs, and constraints on resources, there is concern that the quality of postnatal care for the mother*-baby dyad during this transition period may be compromised. The Standards of Postnatal Care for Mothers and Newborns Expert Panel was established with the objectives to:

1. Articulate the provincial standards for postnatal care;
2. Review the literature and identify strategies to facilitate the implementation of the standards;
3. Develop an evaluation framework to monitor the implementation of these standards; and
4. Identify or develop parent education tools to assist with the communication of the standards to families.

Firstly, the panel reviewed the standards against existing research evidence and best practice guidelines, in order to ensure that they were up-to-date. The panel then administered a provincial survey to identify innovative models or methods that were currently in use or being adopted for providing and/or coordinating postnatal care, and concurrently performed a literature review to identify models of care that could potentially be used at local and provincial levels to coordinate and implement the postnatal standards. Finally, the panel identified a number of indicators to be included in the evaluation framework for this initiative.

About the Report

This report articulates the standards of postnatal care for mothers and newborns in the first seven days following birth. The expert panel focused on articulating the standards where coordination of postnatal care activities may be required once families are discharged from the hospital. Part two of this report outlines models and methods for coordinating postnatal care that should be considered for adoption in Ontario, and proposes recommendations for the standards that should be prioritized for monitoring.

*Please note that the term 'mothers' described in this report is meant to refer to all birth parents regardless of gender or gender identity.

[1] Statistics Canada. No date. Table 102-4503, Births and total fertility rate, by province and territory. CANSIM (database). Last updated October 26, 2016. Retrieved from: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth85a-eng.htm (Accessed November 2016).

Standards of Postnatal Care for Mothers and Newborns in Ontario

VISION

Coordination of quality postnatal care for all mothers and newborns in Ontario during the birth to one week postnatal period

Standards of Postnatal Care

Newborn Standards	
1.	**JAUNDICE AND HYPERBILIRUBINEMIA SCREENING** All newborns receive bilirubin screening between 24-72 hours of life (if not clinically indicated and performed earlier) via Total Serum Bilirubin (TSB) or Transcutaneous Bilirubin (TcB) measurement.
2.	**NEWBORN BLOODSPOT SCREENING** The newborn bloodspot screen is collected between 24 and 48 hours after birth and sent to Newborn Screening Ontario (NSO) via courier within 24 hours of collection.
3.	**PULSE OXIMETRY SCREENING for CRITICAL CONGENITAL HEART DISEASE** Pulse oximetry screening for critical congenital heart disease (CCHD) includes both pre- and post-ductal oxygen saturations and is done between 24 and 48 hours after birth as per Newborn Screening Ontario's algorithm.
4.	**INFANT HEARING SCREENING** Newborns not at risk of permanent hearing loss receive an initial Automated Distortion Product Optoacoustic Emissions (ADPOAE) screening prior to hospital discharge if possible or in the community by an Infant Hearing Program (IHP) hearing screener. ADPOAE screening should not be done within 15 hours of birth for vaginal deliveries or 22 hours of birth for caesarean section deliveries.
5.	**NEWBORN EXAM** The expert panel recommends that newborns receive a complete physical exam by a physician or midwife within 24 hours of birth, and again within 24-72 hours after discharge from the hospital. For out-of-hospital births, newborns should receive a complete physical exam by a midwife during the birth visit within 24 hours of birth, with a second complete physical exam being performed within 24-72 hours of the first complete physical exam.

Maternal and Newborn Standards	
6.	**BREASTFEEDING INITIATION AND SUPPORT** Unless there are medical indications for delayed or interrupted skin-to-skin contact for the purpose of breastfeeding, newborns are placed in uninterrupted skin-to-skin contact with their mothers immediately following birth for breastfeeding initiation for at least one hour, until completion of the first feeding, or as long as the mother wishes. Breastfeeding support is provided to mothers and newborns throughout the first week postpartum to facilitate exclusive breastfeeding.
7.	**SAFE SLEEP** The expert panel affirms the position of the Canadian Paediatric Society (CPS) and other provincial and national bodies regarding safe sleep practices. The safest position for the baby to sleep is on his or her back in a crib, cradle, or bassinet that meets Canadian regulations and in a room shared with a parent or caregiver. Breastfeeding should be encouraged and exposure to tobacco smoke should be prevented.
8.	**HEALTHY BABIES HEALTHY CHILDREN SCREEN** The Healthy Babies Healthy Children (HBHC) screen should be offered to all mothers. For those who are identified as at risk, follow-up contact is made with the mother within 48 hours of discharge from hospital or birth (for home births) and a home visit by a Public Health Nurse is offered. Mothers are referred to the Aboriginal HBHC program as appropriate.
Maternal Standards	
9.	**MATERNAL PHYSICAL ASSESSMENT** The expert panel recommends that a thorough postnatal maternal physical assessment be completed for all mothers prior to discharge or within the immediate postnatal period for home births. An early follow-up assessment should be arranged in the community for mothers with pre-existing health conditions or for those who have been identified as high-risk for developing complications.
10.	**MATERNAL MENTAL HEALTH** The expert panel recommends that the Healthy Babies Healthy Children (HBHC) Screen be used as an initial screening tool for identifying maternal mental health concerns in the immediate postnatal period. If a more comprehensive follow-up assessment is required, the Edinburgh Postnatal Depression Scale (EPDS) should be used.

Jaundice and Hyperbilirubinemia Screening

Standard: All newborns receive bilirubin screening between 24-72 hours of life (if not clinically indicated and performed earlier) via Total Serum Bilirubin (TSB) or Transcutaneous Bilirubin (TcB) measurement.[2]

Implementation Considerations

Jaundice and hyperbilirubinemia screening responsibility chart

	Initial screening	Interpretation of results	Coordination of follow-up if required
Responsibility	Nurse or midwife	Nurse practitioner, midwife, or physician	Nurse, midwife, or physician

It is important to build on and leverage existing relationships with the HBHC Program (Ministry of Children and Youth Services), Healthy Kids Strategy (Ministry of Health and Long-term Care), and Ontario Baby Friendly Initiative to improve hyperbilirubinemia screening and monitoring across the province.[3] It is also essential to consider the family's circumstances when planning follow-up care (e.g. considering factors such as transportation). Darling et al (2016) conducted a study investigating bilirubin follow-up in a cohort of babies born at 35 weeks gestation or older between 2003 and 2011 in Ontario (n = 711,242), and discharged home within three days.[4] Universal bilirubin screening was associated with an increase in follow-up from 29.9% to 35% (adjusted risk ratio = 1.11; p= 0.047). However, 40% of the increase in follow-up was attributable to the highest socioeconomic quintile and 0% was attributable to the lowest quintile. Therefore, low socioeconomic status is a barrier to obtaining follow-up care. The authors state "improved coordination of care between hospitals and community care providers is needed so that follow-up appointments in the community are booked before newborns leave the hospital …having a process in place is necessary to ensure access to a follow-up visit for newborns whose parents have not been able to find a primary care provider for their newborn."

Resources

Parent Education

- Provincial Council for Maternal and Child Health. (2017). Jaundice parent education brochure. Retrieved from: http://www.pcmch.on.ca/health-care-providers/maternity-care/pcmch-strategies-and-initiatives/standards-post-natal-care/

Other

- Provincial Council for Maternal and Child Health and Ministry of Health and Long-term Care. (2013). Quality-based procedures clinical handbook for hyperbilirubinemia in term and late pre-term infants (≥35 weeks). Retrieved from: http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_jaundice.pdf
- Provincial Council for Maternal and Child Health. (2015). Quality-based procedures clinical handbook for hyperbilirubinemia in term and late pre-term infants (≥35 weeks): Webinar questions and answers. Retrieved from: http://www.pcmch.on.ca/wp-content/uploads/2015/07/Hyperbili-QA_vFINAL.pdf

[2] Provincial Council for Maternal and Child Health and Ministry of Health and Long-term Care. (2013). Quality-based procedures clinical handbook for hyperbilirubinemia in term and late pre-term infants (≥35 weeks). Retrieved from: http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_jaundice.pdf
[3] Provincial Council for Maternal and Child Health and Ministry of Health and Long-term Care. (2013). Quality-based procedures clinical handbook for hyperbilirubinemia in term and late pre-term infants (≥35 weeks). Retrieved from: http://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_jaundice.pdf
[4] Darling, E. K., Ramsay, T., Manuel, D., Sprague, A. E., Walker, M. C., & Guttman, A. (2016). Association of universal bilirubin screening with socioeconomic disparities in newborn follow-up. Academic Pediatrics, 17(2), 135-143.

- Healthcare Insurance Reciprocal of Canada. (2016). Failure to identify/manage hyperbilirubinemia. Retrieved from: https://www.hiroc.com/getmedia/e8000f85-293a-42ee-a403-3ec28fdb7184/14_Failure-to-Identify-Manage-Hyperbilirubinemia-without-OBS.pdf.aspx?ext=.pdf

Newborn Bloodspot Screening

Standard: The newborn bloodspot screen is collected between 24 and 48 hours after birth and sent to Newborn Screening Ontario (NSO) via courier within 24 hours of collection.[5]

Implementation Considerations

Newborn bloodspot screening responsibility chart

	Setting standards or guidelines	Initiation of screening	Testing, referral to specialist care, and follow-up	Coordination of follow-up and feedback to NSO
Responsibility	NSO	Birthing hospitals and midwives	NSO	Regional Treatment Centre

Ensuring that every infant born in Ontario is screened and that every affected infant receives appropriate treatment and follow-up requires the coordinated efforts of three main groups of health care providers: birthing hospitals and midwives, NSO, and Regional Treatment Centres.

Implementation Tips

- To improve the timeliness of detection for critical diseases on the panel that present very early, the optimal collection time is 24-48 hours of age. Samples collected after 48 hours are considered acceptable, but may introduce a delay in identification of a screen positive infant.
- Infants discharged prior to 24 hours of age should have a sample taken prior to discharge, but a repeat collection should be arranged within the optimal collection time frame.
- If an infant is transferred to another hospital, ensure there is communication between hospitals regarding the responsibility for obtaining the newborn screen.
- When an alert of a potential missed screen is received from BORN Ontario, NSO will contact the birthing hospital or midwife to follow-up on missed screens if a sample is not received by 14 days of age. NOTE: BORN does not received real-time information about all births, so alerts may be delayed. Institutions and health care providers should institute their own policies and systems to ensure newborns are screened.

Resources

General

- Newborn Screening Ontario. (No date). Newborn screening and your baby: A healthy start leads to a healthier life. Retrieved from: https://www.newbornscreening.on.ca/en/about-screening/screening-resources
    - Patient education resources found in the manual (Section 6)
    - Main website: www.newbornscreening.on.ca

[5] Newborn Screening Ontario. (2015). Newborn screening manual: A guide for newborn care providers. Retrieved from: https://www.newbornscreening.on.ca/en/health-care-providers/submitters

Pulse Oximetry Screening for Critical Congenital Heart Disease

Standard: Pulse oximetry screening for critical congenital heart disease (CCHD) includes both pre- and post-ductal oxygen saturations and is done between 24 and 48 hours after birth as per Newborn Screening Ontario's algorithm.

Implementation Considerations

Pulse oximetry screening for CCHD responsibility chart

	Setting standards or guidelines	Initial screening	Management of abnormal results	Coordination of follow-up for abnormal results
Responsibility	NSO	Nurse, midwife, or other trained professional	Physician (including paediatrician or paediatric cardiologist); NSO will conduct a secondary review to ensure all screen positives are identified	Physician (including paediatrician or paediatric cardiologist); NSO will conduct a secondary review to ensure follow-up is initiated

Pulse oximetry screening for CCHD is a simple, non-invasive, point of care test that measures the level of oxygenation in the arterial blood. The screen is quick to perform (approximately 5 minutes) and the results of the screen are available right away.

Implementation Tips

- Newborns in the well-baby unit or under the care of a midwife should be screened for CCHD via pulse oximetry between 24 and 48 hours after birth or prior to discharge (if discharged <24 hours) by a health care provider.[6]
  Optimal: Performed between 24-48 hours of age;
  Delayed: Performed between 48-72 hours of age;
  Missed: Not done by 72 hours of age.
- In the case of early discharge, an arrangement should be made to ensure newborns are screened within the optimal time frame.

Resources

General

- Newborn Screening Ontario. (No date). CCHD screening implementation. Retrieved from: https://www.newbornscreening.on.ca/en/health-care-providers/cchd-screening-implementation
  - Main website: www.newbornscreening.on.ca

[6] Provincial Council for Maternal and Child Health and Better Outcomes Registry and Network. (2014). Newborn screening for critical congenital heart disease using pulse oximetry. Toronto, ON: Canada.

- Education resources: https://www.newbornscreening.on.ca/en/health-care-providers/submitters/cchd-screening-implementation/education-resources
- Newborn screening manual - a guide for newborn care providers: https://www.newbornscreening.on.ca/en/health-care-providers/submitters

Infant Hearing Screening

Standard: Newborns not at risk of permanent hearing loss receive an initial Automated Distortion Product Optoacoustic Emissions (ADPOAE) screening prior to hospital discharge if possible or in the community by an Infant Hearing Program (IHP) hearing screener*. ADPOAE screening should not be done within 15 hours of birth for vaginal deliveries or 22 hours of birth for caesarean section deliveries.[7]

* If a complete ADPOAE screen is not achieved prior to discharge, "Did Not Test" can be marked on the IHP hearing screening form and these newborns will be followed up in the community within 2-4 weeks.

Implementation Considerations

Infant hearing screening responsibility chart

	Setting standards or guidelines	Initial screening	Reporting results to parents	Coordination of follow-up
Responsibility	IHP (Ministry of Children and Youth Services)	IHP Hearing Screener	IHP Hearing Screener	IHP Lead Agency

Screening before hospital discharge has the advantage of easy access to the mother and baby, which facilitates high screening coverage of the newborn population as well as the earliest start on a path to intervention if permanent hearing loss is present. Refer rates tend to be lower when screening is done after discharge from hospital, and the logistical, family contact, and appointment attendance challenges with universal post-discharge hearing screening are substantial. Generally, however, it is better to screen with a modest refer rate than not to screen at all.

Implementation Tips[8]

- A successful ADPOAE screen is a "Pass" or "Refer" in any individual ear. A complete screen is a successful screen in both ears. A quiet environment, a sleeping baby or one that is resting quietly, a properly fitting probe, a gentle massaging of the ear to open the ear canal(s), and the removal of obvious ear debris will all help ensure a successful screen.
- A "Refer" result in any ear must be followed by a repeat screen of that ear with the maximum number of attempts limited to 3 on any given ear. Multiple attempts beyond this are not acceptable.
- Regardless of whether the screening attempt was successful or not, the parent or legal guardian must be made aware of what occurred, the results, and next steps. Even if the baby passes the screening, the importance of monitoring speech and language development must be stressed.
- Newborns with a "Refer" result on the ADPOAE require further screening by automated auditory brainstem response (AABR) testing before discharge when available, which can be done at any time before 8 weeks corrected age, if not immediately. The meaning of the "Refer" and the rationale for the AABR should be explained to the parent/ legal guardian by the IHP Hearing Screener. If further screening is needed, these newborns will be followed up in the community within 2-4 weeks.
- Newborns not screened by ADPOAE before discharge may be screened directly by AABR in the community.

[7] Ministry of Child and Youth Services. (2013). Ontario infant hearing program: hearing screening protocol & support document. Toronto, ON: Canada.
[8] Ministry of Child and Youth Services. (2013). Ontario infant hearing program: hearing screening protocol & support document. Toronto, ON: Canada.

Resources

General

- Ministry of Children and Youth Services. (No date). Newborn hearing screening: Parents are important partners. Retrieved from: http://www.children.gov.on.ca/htdocs/english/earlychildhood/hearing/moreinfo.aspx
    - Main website: http://www.children.gov.on.ca/htdocs/english/earlychildhood/hearing/index.aspx
    - Infant hearing program locations: http://www.children.gov.on.ca/htdocs/English/earlychildhood/hearing/where.aspx

Newborn Exam

Standard: The expert panel recommends that newborns receive a complete physical exam by a physician or midwife within 24 hours of birth, and again within 24-72 hours after discharge from the hospital. For out-of-hospital births, newborns should receive a complete physical exam by a midwife during the birth visit within 24 hours of birth, with a second complete physical exam being performed within 24-72 hours of the first complete physical exam.

Implementation Considerations

Newborn exam responsibility chart

	Initial newborn assessment at birth	Complete newborn exam within 24 hours of birth	Follow-up complete newborn exam
Responsibility	Nurse, midwife, or physician If the results of the initial newborn assessment are abnormal, the most responsible provider should be consulted immediately, as required (e.g. family physician, midwife, nurse practitioner, paediatrician, or neonatologist)	If the results of the initial newborn assessment at birth are normal, the newborn's most responsible provider should complete the newborn exam within 24 hours of birth prior to discharge (for hospital births) or during the birth visit (for out-of-hospital births)[9]	If the results of the complete newborn exam within 24 hours of birth are normal, the nurse or midwife should help coordinate the follow-up newborn exam with the most responsible provider

The follow-up newborn exam is performed to assess the baby's physical health (including weight), check for signs of jaundice, and provide feeding support. The timing of when the follow-up newborn exam is completed may differ slightly between women who deliver in the hospital with a physician, and those who deliver at the hospital, birth centre, or at home with a midwife, due to the differences in the model of care. In addition to the complete physical exam of the newborn by the most responsible provider while in-hospital, it should be standard practice for the newborn to be periodically monitored by designated health care providers throughout the hospital stay. Education should also be provided to the parents prior to hospital/ birth center discharge or at birth (for homebirths), so that if the parents are concerned with their baby's wellbeing they know where they can access emergent care in advance of the scheduled follow-up visit.

Resources

General

- Reproductive Care Program of Nova Scotia. (2012). Physician newborn examination. Retrieved from : http://rcp.nshealth.ca/sites/default/files/chartforms/chartform08.pdf
- Rourke, L., Leduc, D., Rourke, J. (2014). Rourke Baby Record. Retrieved from: http://rourkebabyrecord.ca/pdf/RBR2011Nat_Eng.pdf
- Canadian Pediatric Society. (2014). When should I take my baby for a first doctor's visit? Retrieved from: http://www.caringforkids.cps.ca/handouts/bringing_baby_home

[9] American Academy of Pediatrics and The American Congress of Obstetricians and Gynecologists. (2012). Guidelines for perinatal care-7th ed. Washington, DC.

- Association of Ontario Midwives. (1999). Physical assessment of the newborn. Retrieved from: http://www.aom.on.ca/files/Health_Care_Professionals/Clinical_Practice_Guidelines/No_1_-_Physical_Assessment_of_the_Newborn.pdf
- American Academy of Pediatrics and The American Congress of Obstetricians and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village (IL): AAP; Washington, DC: The American Congress of Obstetricians and Gynecologists; 2012. p. 109-110, 160, 192-194, 248.

Breastfeeding Initiation and Support

Standard: Unless there are medical indications for delayed or interrupted skin-to-skin contact for the purpose of breastfeeding, newborns are placed in uninterrupted skin-to-skin contact with their mothers immediately following birth for breastfeeding initiation for at least one hour, until completion of the first feeding, or as long as the mother wishes. Breastfeeding support is provided to mothers and newborns throughout the first week postpartum to facilitate exclusive breastfeeding.[10,11,12]

Implementation Considerations

Breastfeeding initiation and support responsibility chart

	Breastfeeding initiation	Coordinating/ providing breastfeeding support while families are in the hospital	Coordinating breastfeeding support when preparing for discharge from the hospital
Responsibility	Nurse, midwife, or physician	Nurse, midwife, physician, or lactation consultant	Midwives or hospital staff such as nurses, physicians, or lactation consultants are responsible for ensuring mothers who require extra support know where to receive it

Hospital practices that support breastfeeding include mother-baby dyad care that:[13]

- Allows the newborn unrestricted access to mom's breasts at birth through uninterrupted skin-to-skin contact so baby can start breastfeeding within the first hour, until after the first feed, or as long as the mother wishes
- Initiates feeding early, within one hour of birth
- Facilitates rooming-in with baby
- Teaches mothers baby's feeding cues so feedings are baby-led
- Teaches mothers hand expression
- Teaches mothers how to position and latch the baby
- Promotes frequent breastfeeding or as often as baby will drink to develop good milk supply
- Promotes exclusive breastfeeding with no supplements, bottles or artificial teats
- Provides access to professional support in hospital and/or community

[10] Pound, C.M., Unger, S.L., Canadian Paediatric Society Nutrition and Gastroenterology Committee, Hospital Paediatrics Section. (2012). Paediatr Child Health, 17(6), 317-21. Retrieved from: http://www.cps.ca/en/documents/position/baby-friendly-initiative-breastfeeding
[11] Health Canada. (No date). Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada. Retrieved from: http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php
[12] Breastfeeding Committee for Canada. (2017). The BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services. Retrieved from: http://breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf
[13] Health Canada. (No date). Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada. Retrieved from: http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php

Implementation Tips

- The "BFI 10 Steps and WHO Code Outcome Indicators for Hospitals and Community Health Services" provides a useful guide to practices known to ensure effective support for mothers who wish to breastfeed (Please see Appendix A).
- Peer support and professional support are associated with greater breastfeeding initiation and longer duration.[14,15,16]
- The following supports are important for breastfeeding women and their families:[17]
  - Skilled support from a combination of professionals and trained peers or laypeople helps breastfeeding mothers and infants as they transition between the hospital and community services and beyond.
  - Peer support groups and community networks, such as La Leche League Canada, give mothers and families the opportunity to share breastfeeding practices and experiences. Such networks enhance their knowledge and confidence about breastfeeding.
  - International Board Certified Lactation Consultants and Public Health Nurses provide support to breastfeeding mothers in the community with home visits, counselling, and resource referrals.
  - Community health programs, such as those funded through the Canada Prenatal Nutrition Program, provide breastfeeding education and support, and have also been shown to improve initiation and maintenance of breastfeeding among their participants.
  - The community at large can further support breastfeeding as the normal way of feeding infants "anytime and anywhere". Community support helps to protect breastfeeding mothers and infants from discrimination and harassment. Members of the community can be made aware that restrictions on breastfeeding may be grounds for complaints on the basis of gender or sex discrimination under the Canadian Charter of Rights and Freedoms or provincial, territorial or federal human rights legislation.

[14] Patnode, C. D., Henninger, M. L., Senger, C. A., Perdue, L. A. & Whitlock, E. P. (2016). Primary care interventions to support breastfeeding. Updated evidence report and systematic review for the US preventive services task force. JAMA, 316(16), 1694-1705.
[15] Lumbiganon, P., Martis, R., Laopaiboon, M., Festin, M.R., Ho, J.J., & Hakimi, M. (2016). Antenatal breastfeeding education for increasing breastfeeding duration. Cochrane Database of Systematic Reviews, Issue 12. Art. No.: CD006425. DOI: 10.1002/14651858.CD006425.pub4.
[16] McFadden, A., Gavine, A., Renfrew, M.J., Wade, A., Buchanan, P., Taylor, J.L., Veitch, E., Rennie, A.M., Crowther, S.A., Neiman, S., & MacGillivray, S. (2017). Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub5.
[17] Health Canada. (No date). Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months: A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada. Retrieved from: http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php

Step 10 of the Baby Friendly Initiative:

10.1	**Strategies which promote family, peer and professional support matter for breastfeeding success.**
10.1.1	Mothers and babies benefit from consistent support, evidence-informed care and appropriate interventions
10.1.2	Mothers and families benefit from evidenced-informed information provided throughout all community programs and services
10.1.3	Mothers and babies benefit from peer support networks
10.2	**A culture supporting the Baby-Friendly Initiative protects, promotes and supports breastfeeding and responsive parenting.**
10.2.1	The creation of a culture supporting BFI should be promoted in all health care settings and community settings
10.2.2	A culture supporting BFI provides support to mothers, partners and babies
10.3	**The determinants of health should be considered when counseling mothers regarding breastfeeding**
10.3.1	Mother who are more at risk for not breastfeeding, or shorter duration require more support and information that should be tailored to their situation

The expert panel encourages all hospitals providing maternal/ child health services, Public Health Units and Community Health Centres to work towards the Baby Friendly Initiative designation.[18]

Resources

Parent Education

- http://www.ontarioprenataleducation.ca/breast-feeding/
- http://www.beststart.org/resources/rep_health/pdf/low_lit_book_fnl_LR.pdf
- https://www.beststart.org/resources/breastfeeding/pdf/BreastfeedingMatters_2013_low_rez_reference.pdf (Available in multiple languages)
- http://www.breastfeedingresourcesontario.ca
- http://www.omama.com/en/late-pregnancy/BREASTFEEDING.asp?_mid_=97246
- http://www.breastfeedinginfoforparents.ca
- Locate breastfeeding services near you: http://ontariobreastfeeds.ca/services

Other

- PCMCH breastfeeding resource: http://www.pcmch.on.ca/health-care-providers/maternity-care/pcmch-strategies-and-initiatives/breastfeeding-services-and-supports/

[18] The Provincial Council for Maternal and Child Health. (No date). Work group recommendations regarding practice standards for direct services. Retrieved from: http://www.pcmch.on.ca/wp-content/uploads/2015/07/Recommendations_Revised-May-16_13v.2.pdf

- PCMCH mother-baby dyad care resource: http://www.pcmch.on.ca/wp-content/uploads/2015/07/MBDC_Report_2011FEB06.pdf
- McKenna, J. J., Ball, H. L., & Gettler, L. T. (2007). Mother–infant cosleeping, breastfeeding and sudden infant death syndrome: What biological anthropology has discovered about normal infant sleep and pediatric sleep medicine. American Journal of Physical Anthropology, 134(S45), 133-161.
- Buckley, S. J. (2015). Hormonal physiology of childbearing: Evidence and implications for women, babies, and maternity care. Retrieved from: http://www.nationalpartnership.org/research-library/maternal-health/hormonal-physiology-of-childbearing.pdf
- Balogun, O.O., O'Sullivan, E.J., McFadden, A., Ota, E., Gavine, A., Garner, C.D., Renfrew, M.J., & MacGillivray, S. (2016). Interventions for promoting the initiation of breastfeeding. Cochrane Database of Systematic Reviews, Issue 11. Art. No.: CD001688. DOI: 10.1002/14651858.CD001688.pub3.
- National Institute for Health and Care Excellence. (2006). Postnatal care up to 8 weeks after birth. Retrieved from: https://www.nice.org.uk/guidance/cg37/resources/postnatal-care-up-to-8-weeks-after-birth-pdf-975391596997

Safe Sleep

Standard: The expert panel affirms the position of the Canadian Paediatric Society (CPS) and other provincial and national bodies regarding safe sleep practices.[19,20] The safest position for the baby to sleep is on his or her back in a crib, cradle, or bassinet that meets Canadian regulations and in a room shared with a parent or caregiver. Breastfeeding should be encouraged and exposure to tobacco smoke should be prevented.

Rationale

There is a broad consensus that a safe sleep environment significantly reduces the risk of Sudden Infant Death Syndrome (SIDS), suffocation and injury in infants in the first six months of life.[21] Despite the highly successful "Back to Sleep" campaign,[22] a large number of parents or caregivers continue to bed-share with their infants.[23] Additionally, despite many caregivers having the intention of placing their babies on their backs to sleep, a high proportion of caregivers do not do so in actual practice.[24] It is thus important that health care providers discuss and provide written information regarding safe sleep practices with all parents or caregivers to reduce the risk of SIDS and injury or suffocation during sleep.[25, 26] These practices include, placing babies on their backs to sleep for every sleep; preventing exposure to tobacco smoke before and after birth; placing babies to sleep in a crib, bassinet, or cradle that meets current Canadian regulations; sharing a room with a parent or caregiver; and breastfeeding if there are no contraindications.[27]

In addition, the following safe sleep practices should also be discussed:

- Socioeconomic and cultural factors that may contribute to parental decisions
- Preterm, small for gestational age, and medically compromised babies who are at greatest risk
- Potential of more than one sleep environment or caregiver for the baby in the first six months and the need to have a safe sleep plan for all potential circumstances

[19] Public Health Agency of Canada and the Canadian Paediatric Society, Canadian Foundation for the Study of Infant Deaths, Canadian Institute of Child Health, and Health Canada. (2011). Joint statement on safe sleep: Preventing sudden infant deaths in Canada. Retrieved from: http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/jsss-ecss-eng.php.
[20] Canadian Paediatric Society. (2016). Safe sleep for babies. Retrieved from: http://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies.
[21] Public Health Agency of Canada and the Canadian Paediatric Society, Canadian Foundation for the Study of Infant Deaths, Canadian Institute of Child Health, and Health Canada. (2011). Joint statement on safe sleep: Preventing sudden infant deaths in Canada. Retrieved from: http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/jsss-ecss-eng.php; Canadian Paediatric Society. (2016). Safe sleep for babies. Retrieved from: http://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies; Perinatal Services BC. (2011). Sleep environment guidelines for infants 0 to 12 months. Retrieved from: http://www.perinatalservicesbc.ca/NR/rdonlyres/D799441C-3E00-49EE-BDF7-2A3196B971F0/0/HPGuidelinesSafeSleep1.pdf.
[22] Centers for Disease Control and Prevention. (No date). Compressed mortality file: Underlying cause-of-death. Mortality for 1979–1998 with ICD 9 codes and Mortality for 1999–2001 with ICD 10 codes. Retrieved from: http://wonder.cdc.gov/mortSQL.html. (Accessed February 17, 2017).
[23] Mitchell, E. A., Cowan, S. & Tipene-Leach, D. (2016). The recent fall in postperinatal mortality in New Zealand and the Safe Sleep programme. Acta Paediatr, 105(*11),* 1312-1320.
[24] Colson, E.R., Geller, N.L., Heeren, T. & Corwin, M.J. (2017). Factors Associated With Choice of Infant Sleep Position. Pediatrics. 2017 Aug 21. pii: e20170596. doi: 10.1542/peds.2017-0596. [Epub ahead of print]
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[26] Perinatal Services BC. (2011). Sleep environment guidelines for infants 0 to 12 months. Retrieved from: http://www.perinatalservicesbc.ca/NR/rdonlyres/D799441C-3E00-49EE-BDF7-2A3196B971F0/0/HPGuidelinesSafeSleep1.pdf.
[27] Public Health Agency of Canada and the Canadian Paediatric Society, Canadian Foundation for the Study of Infant Deaths, Canadian Institute of Child Health, and Health Canada. (2011). Joint statement on safe sleep: Preventing sudden infant deaths in Canada. Retrieved from: http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/jsss-ecss-eng.php

Despite receiving information on risks associated with bed sharing, evidence demonstrates that a majority of parents or caregivers either choose to, or inadvertently, bed share with their baby at some point in the first six months.[28] Bed sharing may be a cultural preference or it may happen unintentionally during breastfeeding or while trying to calm a fussy baby. By employing a risk reduction strategy, health care providers can help parents and caregivers provide the safest sleep environment for their babies.

Given these realities, the expert panel recommends that in addition to discussing current safe sleep practices with parents and caregivers, high-risk activities should also be highlighted and discouraged. These include: sleeping with an infant on a soft surface such as a sofa or in a chair, bed-sharing with a premature or low birth weight infant, and overheating the infant.[29] For those families who choose to bed share despite current guidelines, information should be provided that may mitigate risk. This includes ensuring that the child sleeps on a firm surface on their back with the face clear of pillows, covers, and other impediments.

Resources

Parent Education

- Canadian Paediatric Society. (2016). Safe sleep for babies. Retrieved from: http://www.caringforkids.cps.ca/handouts/safe_sleep_for_babieshttp://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies
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- Best Start Resource Centre. (2014). Sleep well, sleep safe: A booklet for parents of infants from 0-12 months and for all who care for infants. Retrieved from: http://www.beststart.org/resources/hlthy_chld_dev/pdf/BSRC_Sleep_Well_resource_FNL_LR.pdf
- First Nations Health Authority. (2013). Honouring our babies: Safe sleep cards. Retrieved from: http://www.fnha.ca/about/news-and-events/news/new-safe-infant-sleep-toolkit-honouring-our-babies-safe-sleep-cards-and-guide
- La Leche League. (2014). Safe sleep 7: Smart steps to safer bed-sharing. Retrieved from: http://www.llli.org/sweetsleepbook/infographic

Other

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- Public Health Agency of Canada. (2016). Information note to Canadian prenatal nutrition program (CPNP) and community action program for children (CAPC) sites: Baby boxes. Retrieved from: https://gallery.mailchimp.com/0cf6f2962d293fc1b5356938e/files/a6629002-11fc-41e6-b851-6c7fa7fc35e2/Letter_Baby_Boxes_PHAC.pdf
- Gettler, L.T. & McKenna, J.J. (2010). Never sleep with baby? Or keep me close but keep me safe: Eliminating inappropriate "Safe Infant Sleep" rhetoric in the United States. Current Pediatric Reviews, 6, 71-77. Retrieved from: http://cosleeping.nd.edu/assets/32371/gettler_cpr.pdf
- International Childbirth Education Association Position Paper. (2016). Safe infant sleep. Retrieved from: http://icea.org/wp-content/uploads/2015/12/Safe-Infant-Sleep-PP-FINAL.pdf
- Mileva-Seitz, V.R., Bakermans-Kranenburg, M.J., Battaini, C. & Luijk, M. (2016). Parent-child bed-sharing: The good, the bad, and the burden of evidence. Sleep Medicine Reviews, 32, 4-27.

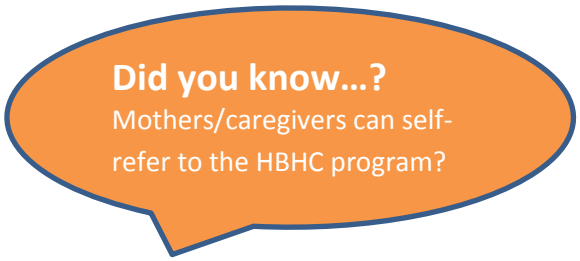
Healthy Babies Healthy Children Screen

Standard: The Healthy Babies Healthy Children (HBHC) screen should be offered to all mothers.[30] For those who are identified as at risk, follow-up contact is made with the mother within 48 hours of discharge from hospital or birth (for home births) and a home visit by a Public Health Nurse is offered.[31] Mothers are referred to the Aboriginal HBHC program as appropriate.

Implementation Considerations

HBHC screen responsibility chart

	Setting standard or guidelines	Offer the HBHC screen to mothers	Follow-up for those identified as high-risk
Responsibility	HBHC Program offered by local Public Health Unit (Ministry of Children and Youth Services)	Nurse, midwife, or public health staff	Public health staff



Inform mothers and caregivers that they are able to self-refer to the HBHC program at any point during pregnancy or up until the child is 6 years of age. Ensure they have written information about the HBHC program to take home with them.

The HBHC Screen can be completed at multiple time points; the prenatal period, postnatal period and up until the child is 6 years old. The screen is offered to all mothers or caregivers within the first week post-partum by public health staff (e.g. Public Health Nurses, Family Home Visitors or Lay Home Visitors, Midwives, or other professionals with the permission from the Ministry). The HBHC program is a free, voluntary program and parental consent is required.

Resources

Patient Education

- The HBHC patient information pamphlet is available in 18 languages: http://www.children.gov.on.ca/htdocs/English/earlychildhood/health/hbhc.aspx
- Locate a Public Health Unit near you: http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx or http://www.mcss.gov.on.ca/en/mcss/programs/community/programsforaboriginalpeople.aspx

Other

[30] Ministry of Children and Youth Services. (2012). Healthy Babies Healthy Children Protocol. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hbhc.pdf
[31] Ministry of Children and Youth Services. (2012). Healthy Babies Healthy Children Guidance Document. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/hbhc_gd.pdf

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- Ministry of Children and Youth Services. (2012). Healthy Babies Healthy Children Protocol 2012. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/hbhc.pdf
- Ministry of Children and Youth Services. (2012). Healthy Babies Healthy Children Guidance Document. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/hbhc_gd.pdf
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- Public Health Ontario. (2014). Healthy Babies Healthy Children Process Implementation Evaluation: Highlights of Provincial Results. Retrieved from: https://www.publichealthontario.ca/en/eRepository/HBHC_Results_Highlights_2014.pdf
- Ministry of Community and Social Services. (2012). Aboriginal Healthy Babies Healthy Children Program. Retrieved from: http://www.mcss.gov.on.ca/en/mcss/programs/community/ahws/individuals/healthy_babies.aspx

Maternal Physical Assessment

Standard: The expert panel recommends that a thorough postnatal maternal physical assessment* be completed for all mothers prior to discharge or within the immediate postnatal period for home births. An early follow-up assessment should be arranged in the community for mothers with pre-existing health conditions or for those who have been identified as high-risk for developing complications.

*Related to the mother's labour and delivery, breastfeeding, and maternal mental health.

Evidence

Timing

Timing of when the maternal postnatal assessment should occur varied among sources and typically ranged from 0 hours to six weeks postpartum;[32,33,34,35,36] whereas, the National Institute for Health and Care Excellence (NICE) guideline stated that an assessment should be conducted at each postnatal visit.[37] The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends that mothers be assessed for their physical, psychological, and social wellbeing prior to hospital discharge and notes that primiparous, young, single women are most likely to return to emergency departments with their neonates.[38] However, once mothers are discharged from the hospital, a comprehensive postnatal maternal assessment should occur around six-weeks postpartum, unless specific health indications necessitate an earlier visit.

Problem-Oriented Visit

For mothers requiring an early postnatal visit due to pre-existing health conditions or those deemed as high-risk for developing complications, an early problem-oriented visit is recommended to evaluate specific risk factors or health conditions. The timing of when such a visit can occur may be within the first postnatal week or may extend past this period. For example, mothers with hypertensive disorders of pregnancy should have an early follow-up visit to evaluate their blood pressure,[39] and mothers at high-risk of complications, such as perinatal mental health disorders/ concerns, caesarean or perineal wound infection, lactation difficulties, or chronic conditions such as seizure disorders, should also be considered for an early follow-up visit.[40]

[32] The American Congress of Obstetricians and Gynecologists. (2016). Optimizing postpartum care. Retrieved from: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care
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[39] The American Congress of Obstetricians and Gynecologists. (2016). Optimizing postpartum care. Retrieved from: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care
[40] The American Congress of Obstetricians and Gynecologists. (2016). Optimizing postpartum care. Retrieved from: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care

Implementation Considerations

Maternal physical assessment responsibility chart

	Assessment prior to discharge	Communicating to mothers that they require an early follow-up appointment with their health care provider	Assessment during the early postnatal period
Responsibility	Nurse, midwife, physician (including obstetrician or family physician), or other trained health care provider	Nurse, midwife, physician (including obstetrician or family physician), or other trained health care provider	Nurse, midwife, physician (including obstetrician or family physician), or other trained health care provider

Resources

Parent Education

- BORN Ontario. (2015). Postpartum. Retrieved from: http://www.omama.com/en/postpartum.asp
- Best Start – Health Nexus. (2016). Prenatal Education: Key Messages for Ontario – Recovery after Birth. Retrieved from: http://www.ontarioprenataleducation.ca/recovery-after-birth/

Other

- Please refer to the Maternal Mental Health Standard in this report for information on how maternal mental health should be assessed during the birth to one week postnatal period

Maternal Mental Health

Standard: The expert panel recommends that the Healthy Babies Healthy Children (HBHC) Screen be used as an initial screening tool for identifying maternal mental health concerns in the immediate postnatal period. If a more comprehensive follow-up assessment is required, the Edinburgh Postnatal Depression Scale (EPDS) should be used.

Implementation Considerations

Maternal mental health responsibility chart

	Offer the HBHC screen to mothers	Follow-up from HBHC for those identified as high-risk	Self-refer to the HBHC program
Responsibility	Nurse, midwife, or public health staff	Public health staff	Mothers, caregivers, or family members

Implementation Tips

- Pregnant women should have their mental health concerns documented on their Ontario Perinatal Record (OPR) to facilitate communication with women's postnatal health care providers. The information found in the OPR can be used to determine what follow-up care needs to be arranged during the immediate postnatal period, for example, psychiatry consultation or appropriate coordination of follow-up care (e.g. return to hospital for follow-up).
- Mothers should be asked about their emotional well-being at every visit/ interaction and encouraged to tell their health care provider of any mood changes outside of their normal pattern.[41]
- Health care provider should remind mothers, caregivers, and families that they can self-refer to the HBHC program at any point during the prenatal or postnatal period to receive support.
- Seamless coordination of care and close communication between health care provider is recommended.

Resources

General

- Best Start – Health Nexus. (2016). Prenatal Education: Key Messages for Ontario – Mental Health. Retrieved from: http://www.ontarioprenataleducation.ca/wp-content/uploads/2016/02/Mental-Health.pdf
- BC Reproductive Mental Health Program and Perinatal Services BC. (2014). Best Practice Guidelines for Mental Health Disorders in Perinatal Period. Retrieved from: http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/MentalHealthDisordersGuideline.pdf
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[41] National Institute for Health and Care Excellence. (2015). Postnatal care up to 8 weeks after birth. Retrieved from: https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#maternal-health

- Beyond Blue. (2011). Clinical Practice Guidelines: Depression and Related Disorders – Anxiety, Bipolar Disorder and Puerperal Psychosis – in the Perinatal Period. Retrieved from: https://www.beyondblue.org.au/health-professionals/clinical-practice-guidelines

Appendix

Appendix A:
Integrated 10 Steps Practice Outcome Indicators for Hospitals and Community Health Services

Step 1: Have a written infant feeding policy that is routinely communicated to all staff, health care providers and volunteers.

Step 2: Ensure all staff, health care providers and volunteers have the knowledge and skills necessary to implement the infant feeding policy.

Step 3: Inform pregnant women and their families about the importance and process of breastfeeding.

Step 4: Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes. Encourage mothers to recognize when their babies are ready to feed, offering help as needed.

Step 5: Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

Step 6: Support mothers to exclusively breastfeed for the first six months, unless supplements are *medically* indicated.

Step 7: Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants remain together.

Step 8: Encourage responsive, cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

Step 9: Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

Step 10: Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.

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