

Home-based postnatal care following early hospital discharge: A descriptive study of the health care service midwife home

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ARTICLE INFO

Keywords:

Early discharge
Length of stay
Home-based postnatal care
Midwifery care
Postnatal care
Readmission

ABSTRACT

Objective: At St. Olav's University Hospital in Trondheim, Norway, "Midwife Home" (MH) is an integrated home-based postnatal service for mothers who want early discharge (i.e. 6–24 h) after giving birth. The purpose of our study was to evaluate MH by (1) describing the characteristics of mother–newborn pairs followed up by MH to investigate whether the service has an appropriate target group; (2) describing the number and causes of possible readmissions for safety; (3) investigating whether MH follows the criteria set for the service; and (4) exploring whether the service facilitates continuity of care.

Methods: Following a cross-sectional design, we collected data from medical records at St. Olav's University Hospital.

Results: In the 212 mother–newborn pairs investigated, most mothers had a high level of education, were multiparous, had vaginal delivery, did not experience postpartum haemorrhage exceeding 500 mL, experienced first-degree or no perineal tear and started breastfeeding before discharge from hospital. Most newborns had a birthweight of 3000–4000 g and an APGAR score exceeding 7 after 5 min. Within the first six weeks postpartum, 1.4 % of the mothers and 2.3 % of the newborns were readmitted.

Conclusion: Mothers who choose follow-up by MH represent a homogeneous group of healthy, highly educated multiparous mothers with uncomplicated births and healthy newborns. The low number of readmissions imply that MH is a safe service, and that the target group is appropriate.

Introduction

The increased understanding of childbirth as a natural physiological process, along with reprioritisations in health services, may have contributed to the significant drop in the length of hospital stay following normal vaginal birth seen in the last decades [1–3]. In Norwegian hospitals, the average length of stay has decreased from 4.0 days in 2001 to 2.6 days in 2021, and early discharge (6–24 h) is not unusual for both healthy mothers and newborns [4,5]. The Norwegian government's guidance regarding routine postnatal care aims to distinguish healthy mothers and newborns from their counterparts who require hospital care and thus suggests that postnatal care should meet the individual needs of mothers and their newborns [1]. In line with these guidelines, St. Olav's University Hospital (SOUH) in Trondheim

established the midwife-led, home-based service "Jordmor hjem" in 2018, known in English as "Midwife Home" (MH). Intended for healthy mothers with healthy newborns seeking discharge within 6–24 h following birth.

Previous studies have shown that mothers have had positive experiences with home-based postnatal care following discharge within 24 h postpartum [6–8]. Families appreciate that such care allows them to be at home in familiar surroundings and describe the home visits as reassuring, relaxing and personal. Moreover, offering mothers home visits from midwives following birth may have a health-promoting impact on mothers' mental health and ability to cope with their new lives [9]. This care model might also reduce overcrowding in hospitals and increase cost-effectiveness [7,9,10]. Nevertheless, the safety of early discharge with home-based postnatal care for women and their newborns has

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<https://doi.org/10.1016/j.srhc.2024.100967>

Received 30 April 2023; Received in revised form 20 March 2024; Accepted 22 March 2024

Available online 23 March 2024

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seldom been examined. A study on the health risks of early discharge revealed a slight increase in the number of readmissions amongst newborns; however, the time of discharge and follow-up given after returning home varied widely [3]. Even so, a randomized controlled trial comparing early discharge (i.e. within 24 h postpartum), in combination with home-based postnatal care, with ordinary maternity follow-up (i.e. discharge later than 48 h) showed no increased risk of readmission or complication for postnatal women and newborns who chose home-based follow-up [3]. Those results are consistent with the findings of a study on the use of health care services by mothers and newborns receiving various types of maternity care based on the number of readmissions and outpatient visits. The study revealed no significant increase in readmissions amongst postnatal mother–newborn pairs discharged early following birth (i.e. within 24 h) compared with pairs who received traditional follow-up [11].

As postnatal care in Norway typically consists of a hospital stay of 2–3 days followed by a home visit by a public health nurse within the next 7–14 days, MH was implemented to ensure sufficient postnatal care for healthy mother–newborn pairs seeking early hospital discharge (6–24 h) after birth [12]. This alternative is however limited to healthy mothers with uncomplicated pregnancies and newborns with normal birthweights and APGAR scores (see Appendix 1 for the full criteria). Both midwives in prenatal care near the hospital and midwives working in the labour- and maternity ward are involved in informing potentially eligible women about the service. Led and organised by the maternity ward at SOUH, MH offers one to three home visits from a midwife. The families usually receive a home visit once a day, where the first visit is within 24 h after hospital discharge. These visits are in addition to the home visit the Norwegian Directorate of Health [4] recommends given all women in the early postnatal period, which many municipalities in the country already offer. Since mothers' individual needs are considered, MH does not state a clear-cut time of eligibility. Mothers may contact the midwives at MH by phone and/or SMS between visits for any inquiries. The service is available during normal work hours all days of the week, including weekends and holidays. Outside the working hours of MH, the maternity hotel and/or the outpatient clinic are also available within the first two weeks after birth, as similar practice for women following ordinary maternity care [12].

The purpose of our study was to evaluate MH by (1) describing the characteristics of mother–newborn pairs followed up by MH to investigate whether the service has an appropriate target group; (2) describing the number and causes of possible readmissions for safety; (3) investigating whether MH follows the criteria set for the service; and (4) exploring whether the service facilitates continuity of care.

Methods

Design

To be eligible for our cross-sectional study, mothers and newborns had to have received postnatal follow-up from MH. Using consecutive sampling, we invited all mothers who received service from MH from 19 April 2019 to 15 June 2021 to participate. Prospective participants received oral and written information prospectively about the study upon discharge from the hospital, and were invited to participate by a midwife from MH during the first home visit. We included all participants signing the informed consent in our cross-sectional study.

Data collection

We collected data from medical records at SOUH. The variables used in this study are independent and consist of categorical variables categorised as nominal and ordinal data, and continuous variables categorised as ratio data. Background data on demographics, current and previous birth(s), as well as information on the newborn, were collected to describe the characteristics of mother–newborn pairs followed up by

MH. Data on outpatient contact with the hospital within two weeks after discharge were also obtained, in line with local guidelines on open contact following all births, whereas the time limit for data on readmission was set to six weeks to cover the postnatal period. To describe organisational features, we gathered logistical data concerning the time of hospital discharge, the time of the paediatrician's examination of the newborn (i.e. offered to all parents on the first day of the postnatal period), along with data on when home visits were received from HM, how many, and who conducted the visits. To get the time of discharge as accurate as possible, we used the time writing of the discharge form that every mother receives shortly before hospital discharge. After registering the data on the forms, we manually transferred the data to the electronic case report file, WebCRF3. To ensure the quality of data, the authors examined the data of the first 20 participants together. Before the data file was converted for use in statistical software, we performed routine internal data collection checks, while an obstetrician from SOUH performed routine external checks.

Ethical statement

The work in this article was conducted in accordance with the Code of Ethics of the World Medical Association (i.e. Declaration of Helsinki) and the research ethics guidelines for the Norwegian University of Science and Technology. The research protocol was approved by the institutional review board at SOUH, by the Regional Research Ethics Committee (Ref. No. 2018/1209), and by the Norwegian Centre for Research Data. Participation was voluntary and confirmed by written informed consent, and we anonymised and kept the data confidential per the Health Research Act and Research Ethics Act [13,14].

Data analysis

We analysed the data using mainly univariate descriptive statistics in IBM's Statistical Package for the Social Sciences (SPSS) version 27.0 (2020). When converting the data from WebCRF format to SPSS format, we automatically encoded categorical variables into numerical values. To detect missing data, if any, we created frequency tables of the categorical variables, and a systematic review of the tables revealed four missing data that we subsequently corrected. We also used the frequency tables to gain a better understanding of the distribution of the observations based on the options for each variable. We next examined the categorical variables in terms of frequency and percentage and the continuous variables in terms of average measurements [15]. To look at any possible associations between the number of readmissions and the time of hospital discharge following birth, we used a cross-tabulation. Since there were more readmissions amongst the newborns discharged before 24 h after birth, we used Fisher's exact test to identify any non-random associations (Table 3). The tables and figures in this article have been graphically processed and finalised in Microsoft Office 365 Excel and Word.

Results

Of 351 mothers with newborns followed up by MH from mid-April 2019 to mid-June 2021, 212 mother–newborn pairs were included in the study (Fig. 1).

Characteristics of the participants

Most mothers in the sample were born between 1985 and 1990 (50.5 %). As shown in Table 1, most were also multiparous (91.0 %) and had a high level of education (78.3 %). Only four newborns were born with a vacuum or forceps, and none of each mother's current newborn had been born via caesarean section. Nearly 90.0 % of the mothers did not experience postpartum haemorrhage exceeding 500 mL, and only one had postpartum haemorrhage exceeding 1000 mL. However, the

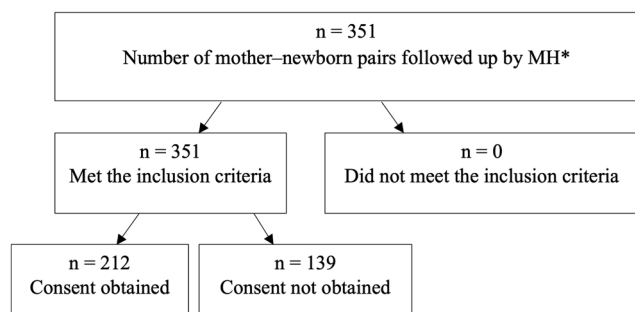


Fig. 1. Flow chart of recruitment process. *Mid-April 2019 to mid-June 2021. The total number of mother–newborn pairs was calculated based on the hospital’s monthly statistics of MH users, including half of April 2019 and half of June 2021 to ensure the most accurate number of users.

Table 1
Background variables.

| Demographic variables | | Number (n = 212) | Percentage % |
|---|-----------------------------|------------------|--------------|
| Marital status | Married | 69 | 32.5 |
| | Cohabiting | 142 | 67.0 |
| | Single | 1 | 0.5 |
| Highest level of education completed | Primary school | 3 | 1.4 |
| | High school | 43 | 20.3 |
| | College or university | 166 | 78.3 |
| Number of previous births | 0 | 19 | 9.0 |
| | 1 | 148 | 69.8 |
| | 2 | 38 | 17.9 |
| | ≥3 | 7 | 3.3 |
| <i>Previous births*</i> | | | |
| Vacuum or/forceps | Yes | 19 | 9.0 |
| | No | 193 | 91.0 |
| C-section | Yes | 15 | 7.1 |
| | No | 197 | 92.9 |
| Unknown | Yes | 1 | 0.5 |
| | No | 211 | 99.5 |
| <i>Current birth</i> | | | |
| Vaginal birth | Yes | 212 | 100.0 |
| | No | 0 | 0.0 |
| Vacuum/forceps | Yes | 4 | 1.9 |
| | No | 208 | 98.1 |
| C-section | Yes | 0 | 0.0 |
| | No | 212 | 100.0 |
| Postpartum haemorrhage | 0–499 mL | 190 | 89.6 |
| | 500–1000 mL | 21 | 9.9 |
| | >1000 mL | 1 | 0.5 |
| Perineal tear | None or first degree | 175 | 82.5 |
| | Second degree or episiotomy | 37 | 17.5 |
| | Third or fourth degree | 0 | 0.0 |
| | | | |
| <i>Newborn</i> | | | |
| Birthweight | <2500 g | 0 | 0.0 |
| | 2500–2999 g | 9 | 4.2 |
| | 3000–4000 g | 164 | 77.4 |
| | 4001–4500 g | 39 | 18.4 |
| | >4500 g | 0 | 0.0 |
| APGAR score after 5 min | ≤7 | 0 | 0.0 |
| | >7 | 212 | 100.0 |
| Breastfeeding before hospital discharge | Yes | 210 | 99.1 |
| | No | 2 | 0.9 |

*Seven multiparous mothers had more than one method of birth in the past.

prevalence of perineal tears was low; 82.5 % of the mothers had experienced first-degree tear or none at all. At birth, most of the newborns weighed 3000–4000 g (77.4 %) and had an APGAR score exceeding 7 (100.0 %) after 5 min. Nearly all of the mothers (99.1 %) had started breastfeeding before discharge from hospital (Table 1).

Hospital readmissions

The proportion of families contacting the hospital was 22.2 % (Table 2). Five newborns (2.3 %) had been readmitted once, and one newborn (0.5 %) had been readmitted twice. Three of the six readmitted newborns were readmitted due to neonatal jaundice. The time of readmission was three days after birth for all six newborns. Three mothers (1.4 %) had been readmitted once within the first six weeks after discharge: two for mastitis and one for hypertension (Table 2). The number of readmissions and hours of discharge after birth are shown in Table 3.

The organisation of MH

In 53.3 % of the sample, the time of hospital discharge had been 6–24 h postpartum, while 45.8 % had been discharged after 24 h (Table 4). The main reason of discharge later than 24 h postpartum were mandatory pediatric examination of the newborn more than 24 h after birth, without any documented cause (58.8 %). Mothers asking to be followed-up by MH later than 24 h postpartum was the second most common cause (18.6 %). Most mothers (73.1 %) had received their first home visit within 24 h after hospital discharge. The most frequent number of home visits per mother was two (51.9 %), and amongst those who had received multiple visits, most had been visited by two different midwives (54.4 %), as shown in Fig. 2.

Discussion

The purpose of our study was to evaluate MH by (1) describing the characteristics of mother–newborn pairs followed up by MH to investigate whether the service has an appropriate target group; (2) describing the number and causes of possible readmissions for safety; (3) investigating whether MH follows the criteria set for the service; and (4) exploring whether the service facilitates continuity of care. Amongst the most important findings, mothers who choose follow-up by MH represent a homogeneous group of healthy, highly educated multiparous mothers with uncomplicated births and healthy newborns. The number of readmissions was low for both mothers and newborns, and a large proportion of mother–newborn pairs received follow-up from MH even though their time of discharge from the hospital exceeded 24 h after birth.

Characteristics of participants

Our results suggest that a high level of education, multiparity, vaginal birth, no or first-degree tear, postpartum haemorrhage less than 500 mL, and breastfeeding before discharge from hospital are the most frequent characteristics of mothers who choose follow-up from MH, as well as that normal birthweight and a high APGAR score best characterise their newborns (Table 1). Those results correspond with findings from a study conducted in Denmark on maternal and newborn predictors of early discharge from hospital [16].

The low number of first-time mothers (9.0 %) means that most participants had previous experience with the postnatal period. Other studies have similarly shown that multiparous mothers choose early returns home (i.e. within 24 h postpartum) more often than first-time mothers [9,16]. Regarding why, the motivation to return home to one or more children, the availability of support from midwives and family, the feeling of security and previous experience have all been highlighted as possible reasons [8,9]. Regardless of the reason, the trend may

Table 2
Readmissions and outpatient contact.

| Readmissions* | | Number (n = 212) | Percentage % |
|--|-------------------|------------------|--------------|
| Mothers | | | |
| Number of readmissions | 0 | 209 | 98.6 |
| | 1 | 3 | 1.4 |
| | ≥2 | 0 | 0.0 |
| Cause for readmission | Mastitis | 2 | 0.9 |
| | Hypertension | 1 | 0.5 |
| | | | |
| Day of readmission following birth | Day 1 | 0 | 0.0 |
| | Day 2 | 0 | 0.0 |
| | Day 3 | 1 | 33.3 |
| | Day 4 | 0 | 0.0 |
| | ≥ Day 5 | 2 | 66.7 |
| | | | |
| Newborns** | | | |
| Number of readmissions | 0 | 206 | 97.2 |
| | 1 | 5 | 2.3 |
| | 2 | 1 | 0.5 |
| Cause for readmission | Neonatal jaundice | 3 | 1.4 |
| | Weight loss | 1 | 0.5 |
| | Other reasons | 2 | 0.9 |
| | | | |
| Day of readmission following birth | Day 1 | 0 | 0.0 |
| | Day 2 | 0 | 0.0 |
| | Day 3 | 0 | 0.0 |
| | Day 4 | 3 | 50.0 |
| | ≥ Day 5 | 3 | 50.0 |
| | | | |
| Outpatient contact*** | | | |
| Outpatient contact with breastfeeding clinic, maternity clinic, or maternity hotel | 0 | 165 | 77.8 |
| | 1 | 34 | 16.1 |
| | 2 | 7 | 3.3 |
| | 3 | 3 | 1.4 |
| | 4 | 2 | 0.9 |
| | ≥5 | 1 | 0.5 |

*Within six weeks following discharge from hospital.

**One newborn had been readmitted twice for the same cause and was therefore registered with only one cause and the first time of readmission.

*** Within two weeks following discharge from hospital.

Table 3
Number of readmissions by discharge time (n = 212).

| Number of readmissions | 0 | | 1–2 | |
|------------------------|--------------|-------------|-----------|-----------|
| | ≤24 h | >24 h | ≤24 h | >24 h |
| Mother | 114 (99.1 %) | 95 (97.9 %) | 1 (0.9 %) | 2 (2.1 %) |
| Newborn | 110 (94.8 %) | 96 (99.0 %) | 5 (5.1 %) | 1 (1.0 %) |

Note. Although there were more readmissions amongst the newborns discharged before 24 h postpartum, the differences were not statistically significant based on Fisher’s exact test (p = 0.22).

Table 4
Length of stay in hospital after birth and reason for prolonged stay (after 24 h).

| Hours between birth and discharge | Number (n = 212) | Percentage % |
|--|------------------|--------------|
| <6h | 2 | 0.9 |
| 6–12 h | 23 | 10.8 |
| 13–24 h | 90 | 42.5 |
| 25–48 h | 97 | 45.8 |
| >48 h | 0 | 0.0 |
| Reason for discharge after 24 h postpartum (n = 97) | | |
| Examined by a paediatrician after 24 h postpartum | 57 | 58.8 |
| Wanted follow-up by Midwife Home after 24 h postpartum | 18 | 18.6 |
| Unknown | 14 | 14.4 |
| Awaiting additional examination by paediatrician | 6 | 6.2 |
| Awaiting paediatric examination | 2 | 2.1 |
| Waiting to avoid leaving at night | 0 | 0.0 |

explain why MH appeals more to multiparous mothers than first-time mothers, who often feel relatively insecure and concerned about their newborns in the initial days after birth. Even so, if offered a home visit from a midwife, first-time mothers may return home earlier from the hospital more often than ones not offered the service [9]. Although most participating mothers in our study were multiparous, a midwife’s visit can indeed offer good postnatal follow-up for first-time mothers. Johansson et al. [6] found that low-risk first-time mothers and their families were very satisfied with home-based postnatal follow-up after

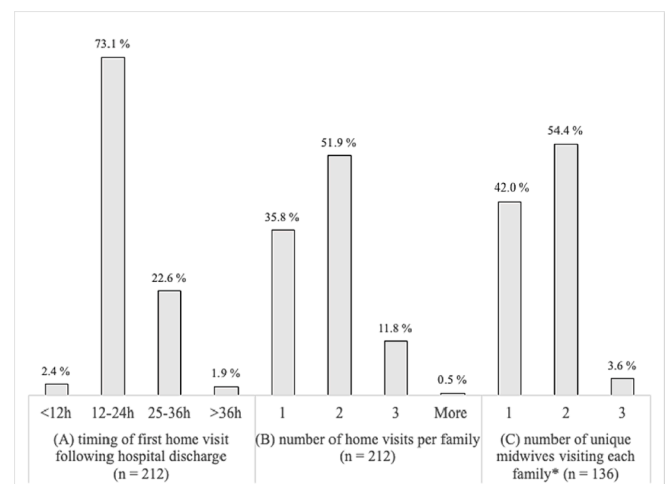


Fig. 2. Logistical data regarding home visits.*When multiple visits had been received.

early discharge (i.e. within 24 h postpartum); all had received information about postnatal care during pregnancy, and several had decided in advance that they wanted it. Mothers' choice to receive postnatal follow-up is affected by the information that they receive during pregnancy and the availability of support from both family and friends [8,17]. Thus, emphasizing adequate information about MH well in advance might lead more first-time mothers to choose the service. However, it is also conceivable that fewer primiparous mothers choosing MH consented to participate in our study than multiparous mothers.

Although MH is available to mothers with an uncomplicated caesarean section, none of the mothers in our study had undergone this surgical delivery method during their present birth (Table 1). According to Kruse et al. [18], early discharge (i.e. within 28 h postpartum) after a planned caesarean section followed by home visits from a midwife does not compromise parents' postnatal sense of security. Although the reasons for the absence of such mothers in our sample remain unclear, factors such as insecurity, fear of pain or complications, or a lack of desire for home-based follow-up in general may contribute. Furthermore, varying levels of awareness amongst midwives regarding inclusion criteria following caesarean section may also have impacted our results.

Hospital readmissions and patient safety

As expected, the number of readmissions in our study was low, because MH targets healthy mothers and healthy newborns (Table 2). Previous large, well-designed studies have shown that hospital readmission rates of mothers followed up at home after early discharge (i.e. within 24 h postpartum) were 2.8 % within 28 days and 1.9 % within six weeks, while the rates for newborns were 1.4 % and 4.5 % in the first 28 days after returning home [10,11]. Those findings correspond with our results. Bueno et al. [10], did not find any significant difference in rates of readmission between newborns in their study's early discharge group and the standard postnatal care group. As in other studies [10,11], our study shows that the most common cause of readmission for mothers was infection and for newborns was neonatal jaundice (Table 2). It is known that several complications, including neonatal jaundice, weight loss, and breastfeeding problems, often become visible 2–4 days after birth and cannot necessarily be avoided [19–21]. Overall, the readmission rate was low (Table 2), which may also indicate that the service has an appropriate target group.

Questions regarding the safety of patients using MH were raised before the service was even implemented. Studies have shown an increased risk of readmission for newborns after early discharge; however, the research behind those studies cannot be used to reflect MH, because it did not consider the mothers' or newborns' health when discharged from hospital or whether the families had received follow-up at home [3,22]. Inadequate planning and follow-up are risk factors for readmission, and it is essential to follow strict discharge guidelines [23]. Early discharge appears to be safe for carefully selected families who receive postnatal follow-up at home [10,11,24,25]. As in traditional postnatal follow-up, all mothers in MH can make outpatient contact with the hospital if needed within the first two weeks after giving birth. A relatively large proportion of participants (22.2 %) took advantage of that offering, which may indicate that the opportunity to seek professional advice is an important part of postnatal care (Table 2). Considering the strict set of criteria set by MH, the close follow-up, the opportunity to seek professional advice and low readmission rates, MH can be regarded as a safe health service that ensures patient safety.

The organisation of midwife home

As the mothers in our study demonstrate, MH follows criteria set for service recipients based on the health condition of the mothers and their newborns. Although the service is primarily intended for mothers seeking to return home within 6–24 h after giving birth, nearly half of

our sample (45.8 %) was discharged within 25–48 h (Table 4). Beyond that, the entire study population was discharged within 48 h, which is less than the average length of stay for mothers with vaginal birth at the postnatal ward at SOUH, which was 57.6 h in 2020 [5]. The reason why 45.8 % of mothers received MH despite being discharged from the hospital after 24 h remains unknown. Because the service was quite new during data collection, it might have had less strict criteria on discharge time to ensure an acceptable number of users in the start-up phase. Our results show that 18.6 % of the mothers were discharged later than 24 h because they wanted MH after 24 h had passed (Table 4). Although we lack information about when the mothers were introduced to MH, according to the National Institute for Health and Clinical Excellence's guidelines for postnatal care, mothers should receive information about the postnatal period, as well as an individually tailored plan, ideally during pregnancy [26]. If information about the service had been provided at an earlier stage or more thorough, either in pregnancy or during birth, it might have been easier to maintain the guidelines for discharge time.

The fact that 98.0 % of the mother–newborn pairs received their first home visit from MH within 36 h after hospital discharge demonstrates that MH observes sound routines for ensuring early home visits (Fig. 2). The service's guidelines state that mothers choose the number of home visits needed together with the midwife and that one visit must occur on the day following hospital discharge. However, the guidelines have not been met regarding the timing of the first home visit for all women, as our results show that 1.9 % of the mother–newborn pairs were visited later than 36 h from the time of discharge (Fig. 2). Although the underlying reason for those exceptions remains unknown; a possible explanation is that the mother–newborn pairs were discharged from the hospital when MH was temporarily closed due to periods of illness amongst the midwives. Regardless, MH generally upholds the government's recommendation for early home visits after childbirth for mothers who choose home-based postnatal care [4].

In midwifery care, continuity is often described as being achieved if the families experience the healthcare as coherent, connected, and consistent with their needs and personal context [27]. Of the participants in our study who received multiple home visits, 42.0 % were visited by the same midwife across multiple visits (Fig. 2). Furthermore, mothers followed up by MH may influence the timing of their discharge and how much follow-up they need, and may consult with health professionals as needed. Thus, even if MH's care model does not ensure care over a long period of time, the above-mentioned factors may contribute to mothers' experience of continuity of care [27,28].

Strengths and limitations

There are inherent challenges regarding data quality when retrospectively analysing data from medical records. Specifically, the exact time of discharge had rarely been documented and reasons for hospital discharge later than 24 h were not specified. Furthermore, one cannot be certain that all inquiries to the hospital were registered. Because data was collected from SOUH only, any readmissions to other hospitals would not have been registered. However, as SOUH was the nearest hospital for all participants and the sole hospital in the city of Trondheim, it seems unlikely that many such readmissions were missed. Despite those limitations, the journal system afforded a great deal of relevant information for our study. Such systems are well-known for being used for documentation amongst midwives, and the hospital has procedures for the use of the systems. Of course, the Norwegian regulations on patients' records need to be followed when journaling [29]. Regarding the selection process, consecutive sampling allowed us to invite all mothers who had used MH from April 2019 to June 2021 to participate in the study, thereby reducing the potential impact of seasonal variations. The sample size is limited as only 60.4 % of these mothers ultimately participated, which also implies potential for bias. Against that risk, all eligible mothers who did or did not participate met

all of MH's criteria, meaning that they were all healthy mothers with uncomplicated pregnancies lasting more than 37 gestational weeks with a healthy newborn [15].

Conclusion

A high level of education, multiparity, vaginal birth with no or first-degree tear, and haemorrhage (i.e. <500 mL) seemed to be the strongest characteristics of the mothers followed up by MH, while normal birth-weight and a high APGAR score seemed to best characterise their newborns. The number of readmissions was low, and the causes of readmission were conditions that cannot necessarily be avoided but were nevertheless discovered in time to allow appropriate care to proceed. Those trends may indicate satisfactory patient safety and that the service has an appropriate target group. Although all participating mothers and their newborns met the criteria set for MH, a relatively large proportion of the sample was discharged later than 24 h postpartum, meaning that the criteria had not been fully met. Last, MH was shown to facilitate an experience of continuity of care. Further studies are needed regarding how a midwifery model of home-based follow-up after early discharge influences the health of mothers, their partners, and their newborns.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

CRediT authorship contribution statement

Benedikte Kjetland Skarsgaard: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing. **Therese Harvold Henriksen:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Visualization, Writing – original draft. **Unn Dahlberg:** Project administration, Conceptualization. **Tone Sletelig Løvvik:** Supervision, Writing – review & editing. **Ingvild Aune:** Supervision, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors would like to thank the mothers who participated in the study.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.srhc.2024.100967>.

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