

**Date:** April 15, 2013

**Title:** Postpartum Mother Accompaniment during Neonatal Transport

**Clinical Question:**

P (*Population/Problem*) Among postpartum mothers whose neonates require transport  
I (*Intervention*) does accompaniment by the postpartum mother during ground or air medical transport  
C (*Comparison*) compared to non-accompaniment  
O (*Outcome*) have an effect on the mother's overall health (e.g. physical, mental) and safety?

[Definitions for terms marked with \\* may be found in the Discussion/Synthesis of Evidence section.](#)

**Target Population for the Recommendation:**

Mothers who have given birth in the last four weeks whose neonates require ground or air medical transport from one hospital to another.

**Recommendation:**

There is insufficient evidence and a lack of consensus to make a recommendation on whether or not accompaniment by the postpartum mother during ground or air medical transport has an effect on maternal physical or mental health and safety.

**Discussion/Synthesis of Evidence related to the recommendation:**

After a comprehensive search only four descriptive studies were found related to parent and transport team feedback surrounding urgent pediatric transport, however none of the identified studies were specific to neonatal transport or address the health and safety of the parent (Davis, Tibby & Murdoch, 2005 [4a]; Macnab, Richards & Green, 1999 [4b]; Woodard & Fleeger, 2000 [4a]; Woodard & Fleeger, 2001 [4a]). While most of the parents expressed they preferred to accompany the child on transport, transport personnel articulated concerns related to parent accompaniment such as interference in the care of the child, gaining the child's cooperation in the parent's presence, and parental apprehension when observing care interventions (Davis, Tibby & Murdoch, 2005 [4a]; Macnab, Richards & Green, 1999 [4b]; Woodard & Fleeger, 2000 [4a]; Woodard & Fleeger, 2001 [4a]).

**Reference List:**

- Davis, J., Tibby, S. M., & Murdoch, I. A. (2005). Should parents accompany critically ill children during the inter-hospital transport. *Archives of Diseases in Childhood, 90*, 1270-1273. oi:10.1136/adc.2005.074195. [4a]
- Macnab, A. J., Richards, J. & Green, G. (1999). Family oriented care during pediatric inter hospital transport. *Patient Education and Counseling, 36*, 247-257. Retrieved from Patient Education and Counseling: [http://www.pec-journal.com/article/S0738-3991\(98\)00090-1/abstract](http://www.pec-journal.com/article/S0738-3991(98)00090-1/abstract) [4b]
- Woodward, G. A. & Fleegler, E. W. (2001). Should parents accompany pediatric intrafacility ambulance transport results of a national survey of pediatric transport team managers. *Pediatric Emergency Care, 17*, 1, 22-27. Retrieved from Pediatric Emergency Care: <http://journals.lww.com/pec-online/> [4a]
- Woodward, G. A. & Fleegler, E. W. (2000). Should parents accompany interfacility ground ambulance transports? A parents perspective. *Pediatric Emergency Care, 16*(6), 383-390. Retrieved from Pediatric Emergency Care: <http://journals.lww.com/pec-online/> [4a]

## IMPLEMENTATION

**Applicability Issues:**

Since there is no recommendation, the plan to address the question is to conduct a research survey of Neonatal/Pediatric Transport Teams nationally in order to determine current beliefs and practice. Survey questions will include whether or not site transport personnel: feel that parents should be allowed to accompany the child on transport, vary their practice in relation to the age of the child, foresee any parent related problems on accompaniment, have experienced safety situations during parent accompaniment, routinely discourage parent accompaniment during either ground or air transport, and have defined standards regarding accompaniment. Survey results will be taken to the CCHMC Transport Team for discussion. The current guideline will be revised once local consensus is achieved for use within CCHMC Transport Team Services.

**Relevant CCHMC Tools for Implementation:**

The current Transport Services guideline G.200-5, "[Transporting Parents](#)," found in the CCHMC Transport Team Policy Manual Compliance 360, states that the decision to allow the patient's parent or guardian to ride on the transport will be determined by the transporting crew members, dependent on space availability and the team's assessment of the patient and family. The parent/guardian will be informed of proper safety precautions.

**Outcome or Process Measures:**

Should a practice change be implemented from the research survey, process measures would relate to provider adherence to any policies, procedures, or guidelines related to parent accompaniment of ground or air transport. Outcome measures related to parent accompaniment could include near misses or adverse events during parent accompaniment and parent, patient, and staff satisfaction.

## SUPPORTING INFORMATION

**Background/Purpose of BES Development:**

Currently transport team members are not using consistent criteria to determine appropriateness for postpartum mother transport accompaniment. There is no standardized process to evaluate the physical and mental capabilities of the mother and context for safe postpartum accompaniment. It was noted through informal dialogue with other pediatric transport providers across the country that they also allowed transport team members to decide the appropriateness of each postpartum accompaniment. Individual decision making may be biased by personal opinion or convenience, resulting in unnecessary variation, rather than solely evaluated on the mothers physical and mental status.

**Search Strategy**

*Databases:* CINAHL, Cochrane, PubMed, and Google Scholar

*Search Terms:* Post-partum early discharge and complications, family/parent on transport, parental support, safety on transport, neonatal transport, pediatric transport, safe travel and postpartum safety maternal distress with the ill newborn, parental grief with newborn transport and neonatal ICU

*Limits, Filters, Search Dates:* English, human, no date specifications

*Date Last Searched:* August, 2012

**Relevant CCHMC Evidence-Based Documents:**

None were found

**Group/Team Members:**

Team Leader/Author: Linda Waechter RN, BSN Transport Nurse

Team Members/Co-Authors: Greg Schano RN, MSN, MBA Manager of Transport Services

Support/Consultant: Patti Besuner RN, MN Evidence-based Practice Mentor

Ad Hoc/Content Reviewers: Paul Beckman, Staff Chaplain, Pastoral Care

**Conflicts of Interest were declared for each team member:**

- No financial or intellectual conflicts of interest were found.
- No external funding was received for development of this BES.
- The following conflicts of interest were disclosed:

**Note:** Full tables of the [LEGEND evidence evaluation system](#) are available in separate documents:

- [Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality](#) (abbreviated table below)
- [Grading a Body of Evidence to Answer a Clinical Question](#)
- [Judging the Strength of a Recommendation](#) (dimensions table below)

**Table of Evidence Levels** (see note above):

Quality level	Definition
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

**Table of Language and Definitions for Recommendation Strength** (see note above):

Language for Strength	Definition
It is strongly recommended that... It is strongly recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. <i>(or visa-versa for negative recommendations)</i>
It is recommended that... It is recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation...	
<i>Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group. (Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)</i>	
<b>Rationale for judgment and selection of each dimension:</b>	
<b>1. Grade of the Body of Evidence</b>	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low
<i>Rationale:</i>	
<b>2. Safety/Harm (Side Effects and Risks)</b>	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Serious
<i>Rationale:</i>	
<b>3. Health benefit to patient</b>	<input type="checkbox"/> Significant <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal
<i>Rationale:</i>	
<b>4. Burden on patient to adhere to recommendation</b>	<input type="checkbox"/> Low <input type="checkbox"/> Unable to determine <input type="checkbox"/> High
<i>Rationale:</i>	
<b>5. Cost-effectiveness to healthcare system</b>	<input type="checkbox"/> Cost-effective <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not cost-effective
<i>Rationale:</i>	
<b>6. Directness of the evidence for this target population</b>	<input type="checkbox"/> Directly relates <input type="checkbox"/> Some concern of directness <input type="checkbox"/> Indirectly relates
<i>Rationale:</i>	
<b>7. Impact on morbidity/mortality or quality of life</b>	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
<i>Rationale:</i>	

Copies of this Best Evidence Statement (BEST) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.

Website address: <http://www.cincinnatichildrens.org/service/i/anderson-center/evidence-based-care/bests/>

Examples of approved uses of the BEST include the following:

- Copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- Hyperlinks to the CCHMC website may be placed on the organization's website;
- The BEST may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- Copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at [EBDMinfo@cchmc.org](mailto:EBDMinfo@cchmc.org) for any BEST adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

Please cite as: Waechter, L., Cincinnati Children's Hospital Medical Center: Best Evidence Statement Postpartum Mother Accompaniment during Neonatal Transport, <http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm>, BEST 153, pages 1-4, 3/15/13.

This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BEST has been in place for five years, the development team reconvenes to explore the continued validity of the guideline. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff performs a quarterly search for new evidence in an horizon scanning process. If new evidence arises related to this BEST, authors are contacted to evaluate and revise, if necessary.

*For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at [EBDMinfo@cchmc.org](mailto:EBDMinfo@cchmc.org).*

**Note:**

**This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.**