

The committee has identified this emerging issue for providers, healthcare facilities and organizations from the first quarter of Maternal Mortality Reviews:

- Hospitals should ensure providers and families are provided bereavement support resources after every maternal death.
- Facilities should be aware that respiratory/contact isolation may be a factor that causes providers to limit contact with patients. The criteria for close surveillance and monitoring should be supported in such patients who are critically ill or unstable throughout pregnancy so that their increased need for assessment and/or intervention can be met without unnecessary delay.
- Facilities should provide perinatal mental health training to all staff (i.e. nurses, physicians, case management, and social workers) to decrease bias and stigma when caring for perinatal patients with mental health and substance use diagnosis.
- The Department of Safety should develop evidenced based educational materials, specific to the importance of seatbelt use and dangers of impaired or distracted driving for drivers of all ages, for healthcare providers to post in their offices and facilities throughout the year.