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Research paper

Early discharge from maternity ward in response to the COVID-19 pandemic: Impact on emergency attendance

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\section*{ABSTRACT}

Background: In response to the coronavirus disease 2019 (COVID-19) epidemic, our maternity department had to rapidly implement a protocol for early postpartum discharge. We evaluated the benefits and risks of early postpartum discharge.

Methods: We performed an observational, single-center case–control study over a 3 month-period during the COVID-19 outbreak (from June 1 to August 31, 2020), following implementation of the early discharge policy. Newborns were classified into an early discharge group (within 48–72 h of a vaginal delivery and within 72–96 h of a cesarean delivery) or a standard discharge group (more than 72 h after a vaginal delivery and more than 96 h after a cesarean delivery). The primary outcome measure was inappropriate pediatric emergency department visits within 28 days of delivery.

Results: A total of 546 newborns were included. A total of 22 (8.9%) of the 246 newborns in the early discharge group attended the pediatric emergency department vs. 30 (10.0%) of the 300 newborns in the standard discharge group (\(p = 0.65\)). Nine visits (40.9%) were considered inappropriate in the early discharge group vs. 13 (43.3%) in the standard discharge group (\(p = 0.83\)). Likewise, the intergroup difference in the hospital readmission rate was not statistically significant.

Discussion: The implementation of early discharge and early follow-up did not result in a significantly greater need (vs. standard discharge) for inappropriate emergency visit or hospital readmission during the first 28 days postpartum, regardless of the parity and breastfeeding status.

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\section*{1. Introduction}

In 1992, the American Academy of Pediatrics/American College of Obstetricians and Gynecologists gave the first definition of early postpartum discharge from the maternity ward: discharge less than 48 h after a vaginal delivery or less than 96 h after a cesarean delivery [1].

In 2017, the median length of stay in a maternity ward was 3.9 days in France, 1.4 days in the United Kingdom, 1.5 days in Canada, 2 days in the United States, and 2.3 days in Sweden [2]. Worldwide, the length of stay in a maternity unit has tended to decrease over the past 10 years [3]. In 2014, the guidelines issued by French National Authority for Health (\textit{Haute Autorité de Santé}, HAS) defined early postpartum discharge as a hospital stay of between 48 and 72 h after a vaginal delivery and between 72 and 96 h after a cesarean delivery [4].

The ongoing pandemic of coronavirus disease 2019 (COVID-19) has led to many organizational changes in healthcare systems, including the establishment of temporary intensive care units [5,6], the closure of operating rooms, the postponement of surgical operations [7], remote learning for medical students [8], video/phone consultation (recommended by the HAS and reimbursed by France’s national social security system for patients with symptoms of COVID-19, pregnant women being followed up by a midwife, and women due to undergo a medical termination of pregnancy) [9], and early postpartum discharge [10], due to the fear of disease transmission and in order to slow the spread of the virus [11]. In response to the first wave of the COVID-19 epidemic in France (from March to May 2020), our maternity hospital (part of Amiens University Medical Center, Amiens, France) rapidly implemented an early discharge plan for all eligible women (as defined by the HAS guidelines). However, some experts have suggested that early discharge is associated with a greater likelihood of subsequent emergency department visits [12], a higher hospital readmission rate for the newborn [3], and a risk of severe jaundice [13]. Furthermore, a lack of follow-up after hospital discharge can be associated with breastfeeding difficulties [14] and consequently early cessation of exclusive breastfeeding [14] or more frequent emergency department visits [15].
DeAngelis and al. developed criteria to define medically appropriate visits in the emergency department, such as cardiac arrest or cyanotic episode; respiratory illness; fever ≥ 38 °C in infants younger than 8 weeks; or any diagnosis resulting in hospitalization [16].

Thus, the goal of the present study was to evaluate the risks and benefits associated with promoting early discharge, as notably measured by inappropriate visits to our pediatric emergency department and hospital readmissions within the first 28 days of life.

2. Material and methods

We performed a retrospective, observational, single-center case–control study in the maternity hospital at Amiens University Medical Center, France. The study took place during the implementation of an early discharge policy in response to the COVID-19 outbreak. The primary outcome of our study was defined as an inappropriate visit to our pediatric emergency department according to the DeAngelis criteria [16], during the first 28 days postpartum. The secondary objectives were to measure (a) the proportion of hospital readmissions after a pediatric emergency department visit, (b) the influence of parity (primiparity vs. multiparity) on pediatric emergency department visits, (c) the relationship between exclusive breastfeeding (vs. nonexclusive breastfeeding or bottle feeding) upon discharge and pediatric emergency department visits, and (d) consultations for jaundice.

The main inclusion criterion was discharge home of a newborn from the maternity ward. The main exclusion criterion was transfer to the neonatology department or other hospital department prior to discharge.

The study was designed to compare early postpartum discharge with standard discharge over a 3-month period (June 1 to August 31, 2020), corresponding to implementation of the new procedure. Early postpartum discharge was defined in accordance with the HAS guidelines, i.e., discharge home between 48 and 72 h after a vaginal delivery and between 72 and 96 h after cesarean delivery [4]. Accordingly, standard discharge was defined as discharge home more than 72 h after a vaginal delivery and more than 96 h after a cesarean delivery [4]. To be eligible for an early discharge, the following criteria had to be met: term at delivery >38 weeks, birth weight >3rd percentile; an Apgar score >7 at 5 min, normal blood gas levels, no transfer to another hospital ward after delivery, a change in birthweight < 8%, the establishment of oral feeding, spontaneous emission of urine and stools; transcutaneous bilirubin <40th percentile [17]; no need for clinical surveillance for infectious diseases; administration of vitamin K1; completion of neonatal blood screening; completion of a hearing test; a scheduled consultation with a midwife within 24 h of discharge; and a scheduled appointment with a pediatrician or family physician 10 days postpartum.

Intergroup differences were analyzed using a chi-squared test or Fisher’s test (for categorical variables) and Student’s test (for continuous variables). The data are reported as mean ± standard deviation (SD) or frequency (percentage). The threshold for statistical significance was set to p<0.05. All statistical analyses were performed with R software [18]. The parents received an information note by mail. Following the French research guidelines, a 1-month period was allocated within which any refusal to participate could be received. After this period, if no opposition was expressed, data were extracted from the electronic medical files. This trial was undertaken in accordance with the Declaration of Helsinki and Good Clinical Practice guidelines. The protocol was approved by local research committee (no. PI2021_843_006, April 1, 2021).

3. Results

During the study period, there were 634 live births in the maternity hospital at Amiens University Medical Center. Of these, 546 were included in the study: 246 (45.1%) newborns in the early discharge group and 300 (54.9%) in the standard discharge group (Fig. 1). As expected, contraindications to early discharge were more prevalent in the standard discharge group. Likewise, we noted a higher proportion of multiparous women in the early discharge group. The two groups did not differ significantly with regard to other factors, such as the socioeconomic level (defined according to the French National Institute for Statistics and Economic Studies’ classification), breastfeeding status upon discharge, and the mother’s age (Table 1).

A total of 52 (9.5%) newborns attended the pediatric emergency department during the first 28 days postpartum: 22 (8.9%) from the early discharge group and 30 (10.0%) from the standard discharge group (p = 0.68) (Table 2).

From these 52 visits, 25 met the DeAngelis criteria (11 from the early discharge group, 14 from the standard discharge group); 22 did not meet the criteria and were considered inappropriate (nine from the early discharge group, 13 from the standard discharge group); and five (two from the early discharge group and three from the standard discharge group) did not meet the criteria but corresponded to newborns referred to the emergency department by their general practitioner (we chose the exclude these newborns from the statistical analysis; p = 0.83) (Table 2) [16].

Furthermore, 19 (3.5%) newborns were readmitted to hospital: 10 (4.1%) from the early discharge group vs. nine (3.0%) from the standard discharge group (p = 0.48) (Table 2). Hence, 45.5% and 30% of the newborns from the early and standard discharge groups, respectively, having attended the pediatric emergency department were readmitted to hospital (p = 0.73).

When considering infants born to multiparous women, the incidence of pediatric emergency department attendance was 7.8% (n = 13) from the early discharge group vs. 11.0% (n = 16) from the standard discharge group (p = 0.33). When considering infants born to primiparous women, the incidence of pediatric emergency department attendance was 11.3% (n = 9) from the early discharge group vs. 9.0% (n = 14) from the standard discharge group (p = 0.59) (Table 3).

Regarding breastfeeding status, the incidence of pediatric emergency department attendance by breastfed infants was 7.2% (n = 8) from the early discharge group vs. 7.3% (n = 11) from the standard discharge group (p = 0.98). The incidence of pediatric emergency department attendance by non-exclusively-breastfed infants was 10.3% (n = 14) from the early discharge group vs. 12.8% (n = 19) from the standard discharge group (p = 0.52) (Table 3). When considering breastfed infants born to primiparous women and who attended our pediatric emergency department, there were three (8.6%) from the early discharge group vs. nine (10.5%) from the standard discharge group (p = 1.00). The incidence of visits in the emergency department for infants with exclusive breastfeeding (n = 19; 7.2%) was not different from non-exclusively-breastfed infants (n = 33; 11.7%), regardless of the type of discharge (p = 0.09).

Seven newborns attended the emergency department for jaundice: three (13.6% of the total number of pediatric emergency department visits) from the early discharge group and four (13.3%) from the standard discharge group (p = 1.00) (Fig. 1).

4. Discussion

Our evaluation of the impact of implementing an early postpartum discharge policy in response to the COVID-19 outbreak did not find any difference between early and standard discharge groups in the frequency of pediatric emergency department attendance for inappropriate reason during the first 28 days of life (p = 0.83).

In the 1990s, the frequency of early discharge started to increase in the United States. Sachetti et al. found that the reduction in the length of stay in a maternity ward between 1989 and 1995 was associated with a greater incidence of pediatric emergency department visits in the first 10 days postpartum [12]. By contrast, other
researchers have concluded that early postpartum discharge had no impact on emergency department attendance [19] or was even associated with less frequent emergency department attendance [20]. Taken as a whole, these results indicate that early postpartum discharge does not increase the risk of emergency department visits.

In our center, a newborn eligible for early postpartum discharge is assessed during two successive scheduled consultations. This ensures that (a) the newborn has been fully assessed, (b) any questions that the parents might have can be answered, and (iii) the mother can be provided with support (especially for breastfeeding). Our results with regard to breastfeeding were in line with the literature data showing that early discharge was not associated with an increased risk of pediatric emergency department attendance for breastfed newborns. Indeed, a lack of follow-up after discharge has been associated with an increased risk of early cessation of breastfeeding [14] and, therefore, a higher risk of emergency attendance [15].

With a clear follow-up schedule and the provision of clear information for the parents, the HAS guidelines enable safe, well-supervised early discharge [4].

We did not find evidence of a higher incidence of hospital readmission among newborns in the early discharge group. In an observational cohort study performed in Belgium, Plusquin et al. compared the incidences of hospital readmission within 4 weeks of delivery during two periods: before and after the introduction of legislation reducing the length of stay in maternity wards in June 2015 [3]. The researchers observed a higher incidence of neonatal readmissions after the introduction of legislation, although the two periods differed markedly in length [3]. Conversely, the results of many randomized controlled trials after the introduction of legislation, although the two periods differed markedly in length [3]. Conversely, the results of many randomized controlled trials of early postpartum discharge in the United States, Hellman et al. did not find a significant difference in readmission after 3 weeks of

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Fig. 1. Study flowchart *Digestive signs and symptoms: gastroesophageal reflux, diarrhea, and constipation **Neurologic signs and symptoms: seizures and an increase in cranial circumference ***Respiratory symptoms: rhinorrhea and dyspnea.
life between newborns discharged within 72 h of delivery and those discharged more than 5 days after birth [21]. In Spain, Sainz Bueno et al. in their study in 2003 found no difference in 28-day readmission rates between those discharged less than 24 h after birth and those discharged more than 48 h after birth [22]. Similar data have been observed in randomized controlled trials performed in Sweden and Canada, in which the readmission rates (at 8 and 6 weeks, respectively) in newborns discharged early (less than 48 h after birth and less than 60 h after birth, respectively) were not higher than usual [23,24].

Table 2
Emergency attendance meeting the DeAngelis criteria* [16] and hospital readmission within the first 28 days of life after early vs. standard postpartum discharge.

|                     | Total n = 546 | Early postpartum discharge n = 246 | Standard postpartum discharge n = 300 | p       |
|---------------------|---------------|-----------------------------------|--------------------------------------|---------|
| Emergency unit attendance | 52 (9.5%)     | 22 (8.9%)                         | 30 (10.0%)                          | 0.68    |
| Not meeting criteria* | 22 (42.3%)    | 9 (40.9%)                         | 13 (43.3%)                          | 0.83    |
| Meeting criteria*    | 25 (48.1%)    | 11 (50.0%)                        | 14 (46.7%)                          |         |
| Addressed by GP      | 5 (9.6%)      | 2 (9.1%)                          | 3 (10.0%)                           |         |
| Hospital readmission | 19 (3.5%)     | 10 (4.1%)                         | 9 (3.0%)                            | 0.48    |

* DeAngelis criteria [16]: Diagnoses: Major medical event: cardiac arrest; respiratory arrest; cyanotic episode; seizure; sickle cell crisis; shock; congestive heart failure; diabetic ketoacidosis; meningeitis/encephalitis; coma Ingestion: foreign body; overdose Trauma: fracture; laceration; bite; burn Affection: a joint more than 5% of body; abuse; infected wound; foreign body Major surgical event: acute abdomen; incarcerated hernia; threatened abortion; testicular torsion Acute allergic reaction Respiratory illness: acute asthma attack; croup; pneumonia; bronchiolitis; peritonsillar/retropharyngeal abscess; otitis media accompanied by fever, pain, drainage Any diagnosis resulting in hospitalization Symptoms and complaints: Fever: ≥ 38 °C in child younger than 8 weeks or sickle cell patient; ≥ 39 °C in any age Gastrointestinal illness: ≥ 2 episodes of vomiting in 24 h in child younger than 8 weeks; ≥ 2 episodes of diarrhea in child younger than 8 weeks; vomiting or diarrhea associated with dehydration; hematochezia; hematremesis Pain: any severe pain; localized and accompanied by fever ≥ 38 °C Trauma: head; eye; blunt abdominal; blunt chest; gynecologic; genitourinary Parental concerns: History of: pronounced irritability; lethargy; earache; vomiting > 5 times in 24 h, > 5 stools in 24 h Sudden onset of limpness Stiff neck Fever > 39 °C GP: general practitioner.
As in the literature, there were various indications for the visits to our pediatric emergency department (Fig. 1) [20,25]. Jaundice is potentially one of the most dangerous adverse events associated with poor follow-up after discharge; however, there was no difference between our two groups with regard to the frequency of consultation for this condition \((p = 1.00)\). Several researchers have stated that early discharge might increase the incidence of severe jaundice. However, these studies had small populations and lacked a suitable control group, which prevented the investigators from affirming the presence of a causal relationship between early postpartum discharge and jaundice [28]. Appropriate follow-up after discharge should make it possible to avoid severe cases of jaundice [4,27]. In response to the COVID-19 pandemic, some centers have initiated home bilirubin-monitoring programs with online follow-up [28].

The proportion of inappropriate visits in the emergency department was 42% in the present study. These results are consistent with previous reports: 28%–41% of children visited the emergency department during their first year of life [29–32]. Furthermore, 32%–60% visited the emergency department for nonurgent reasons [16,32,33]. These data underline the need for parental education and clear criteria required to visit the emergency department [16,32,33].

Our study had several limitations, such as the retrospective, single-center design. However, this approach quickly provided reassuring results during the COVID-19 outbreak, when new procedures had to be rapidly implemented. Secondly, only visits to the pediatric emergency department at Amiens University Medical Center were included. Even though some parents could have consulted at other hospitals, Amiens University Medical Center is the only university medical center in the area and is likely to cover most of the consultations and (if required) hospital readmissions. Furthermore, the COVID-19 epidemic prompted a decrease in the number of patients attending emergency departments [34]. Thus, parents who would probably have consulted for minor clinical signs might have been scared to attend during the study period because of fear of disease transmission. To compensate for this potential bias, we choose to include more than 500 consecutive newborns thus ensuring the creation of a large sample over a short inclusion period.

Our groups were similar in terms of the mothers’ characteristics and the breastfeeding status. Although birth weight and term of birth were significantly higher in the standard discharge group, these variables are among the eligibility criteria for early discharge. Likewise, the proportion of cesarean sections and thus the Apgar score were lower in the early discharge group (Table 1). We noted that the proportion of primiparous mothers was higher in the standard discharge group; this might be explained by the fact that early postpartum discharge is left to the parent’s discretion, and because primiparous women are probably initially less confident about managing at home [35]. Nevertheless, parity or breastfeeding were not significantly associated with an elevated risk of emergency department attendance. Further prospective studies assessing the factors influencing the mother self-confidence for early postpartum discharge are required.

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