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REVIEW ARTICLE

Criteria and guidelines for the safe discharge of healthy newborns admitted to rooming-in unit - a narrative review of the literature

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Patient discharge, Infant, newborn, Rooming-in care.

Abstract

Hospital discharge is a moment of great importance for the newborn (NB) and their family and deserves special attention from the healthcare team. The objective is to present discharge criteria and guidelines for healthy full-term (FWT) or late preterm (LPTN) NBs admitted to a rooming-in unit (HCU), which will enable them to have a safe discharge. A search was carried out in health databases and institutional websites between August and December 2022. The following descriptors were used: "Patient Discharge", "Infant", "Newborn", "Rooming-in Care" and filters were applied for age and date of publication. 1,252 articles were found in the databases and 1,230 in the other sources. At the end of the search, 26 documents were selected. Hospital discharge planning for the mother-child binomial is a dynamics process that should begin during prenatal care. The criteria and guidelines for discharge include factors related to the NB, the puerperal woman, the family and the entire context in which they will be inserted. The following should be considered: physiological stability of the NB and the mother, breastfeeding assessment, neonatal screening tests and completion of the children health book; skin and umbilical stump care, safe transport and sleep, and parents training so that they can recognize signs and symptoms that require a return to the health service. There are differences of opinion regarding various aspects of discharge, especially the length of hospital stay; more studies are needed to establish unanimity on this criterion, especially in developing countries.

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INTRODUCTION

Hospital discharge is an important part of the care for newborns and postpartum women. It must be planned carefully and completed safely for both mother and child. Ideally, preparation for discharge should begin during prenatal care and be reinforced throughout the perinatal period.[1]

There is no consensus in the literature regarding the length of hospital stay after birth. However, various authors recommend that this duration be individualized according to the needs and circumstances of each mother and newborn.[2,3]

Health professionals should collaborate throughout the discharge planning process. Everyone must be involved in understanding the individual, family, and social variables at play and developing an individualized discharge plan for each newborn. To this end, the team's communication skills must be executed effectively.[3]

A collaborative approach must be adopted in the obstetric and neonatal care unit, including obstetricians, pediatricians, nurses, nursing technicians, social workers, and other multidisciplinary care team members. Establishing effective communication between healthcare workers and individuals receiving care can be challenging. Clear, precise, and complete communication reduces errors and improves safety for both mother and child, while also contributing to health promotion.[3]

Hospital discharge planning is crucial for the transition to home and is particularly relevant in neonatal care. Well-defined criteria and guidelines must be defined so newborns and their families are safely discharged.

Preparation enables newborns to grow and develop healthily outside the hospital while empowering families to care for their new members. This review presents a list of evidence-based criteria and guidelines drawn from published literature regarding the organization of safe hospital discharges for healthy newborns, whether born full-term or preterm, in a rooming-in setting.

METHODS

Searches for articles were conducted in PubMed, SciELO, and LILACS, as well as on the institutional websites of the World Health Organization (WHO), Pan American Health Organization (PAHO), American Academy of Pediatrics (AAP), Ministry of Health (MS), and Brazilian Society of Pediatrics (SBP) between August 2022 and February 2023. The following descriptors were used: "Patient Discharge," "Infant," "Newborn," "Rooming-in Care," along with filters related to age (birth to one month) and date of publication (last 10 years). A total of 1,252 articles were found, which included various types of studies. The titles of 97 articles matched the study objectives, and their abstracts were read. Twenty-six were further selected for full reading, and finally, eight of these were included in the review. On the institutional websites, a search was performed for "discharge criteria for newborns." One thousand two hundred thirty documents, including Manuals, Guidelines, and Technical Standards, were listed. Fifty-one of these were directly related to the proposed theme, and 16 were included in the review. The patient age range and publication date criteria remained unchanged (Figure 1). Studies that addressed the subject in moderately or extremely premature newborns, newborns admitted to a Neonatal Intensive Care Unit (NICU), Conventional Neonatal Intermediate Care Unit (NiCUCo), or Kangaroo Neonatal Intermediate Care Unit (KiCUCa) were excluded.

RESULTS AND DISCUSSION

There seems to be no consensus on how long mothers and newborns should remain in a hospital after birth. Similarly, the definition of early discharge varies significantly between countries.[2,4]

A systematic review published in 2021 assessed the impacts of early hospital discharge on mothers and children. It included 17 studies: 13 in high-income countries (Canada, the United States, Australia, the United Kingdom, Denmark, Spain, Sweden, and Switzerland) and three in middle-income countries (Bangladesh, Egypt, and Malaysia). We were unable to find studies conducted in low-income countries. Three studies defined early discharge as a hospital stay of less than or equal to 24 hours; one study defined it as less than or equal to 28 hours; and another defined it as less than or equal to 36 hours. Five additional studies defined early discharge within a time range that varied from 6 to 48 hours.[2]

In the same review, one study differentiated early discharge based on the type of delivery, specifying 24 to 48 hours for vaginal delivery and 72 to 84 hours for cesarean delivery. Additionally, five other studies defined early discharge as 48 hours postpartum, regardless of the type of delivery.[2]

The review concluded that early discharge did not increase maternal or neonatal mortality rates; however, it did lead to an increase in the number of newborns readmitted within 28 days. The risk of readmission was 69 per 1,000 newborns, compared to 43 per 1,000 newborns in the group that did not receive early discharge.[2]

A Spanish study defined early discharge as occurring between 24 and 48 hours, and very early if it occurs within 24 hours after delivery. According to the American Academy of Pediatrics (AAP), a shorter hospital stay (less than 48 hours postpartum) for healthy newborns can be performed. However, it is not appropriate for all mothers and newborns, reinforcing the importance of an individualized discharge plan.[5,6]

The Brazilian Ministry of Health, in agreement with the World Health Organization (WHO), recommends a minimum stay of 24 hours in rooming-in and emphasizes that, after this time, mothers and newborns meeting the criteria for discharge can be allowed to go home.[7,8] However, the Brazilian Society of Pediatrics (SBP) warns about the potential risks of discharge less than 48 hours postpartum, highlighting one of

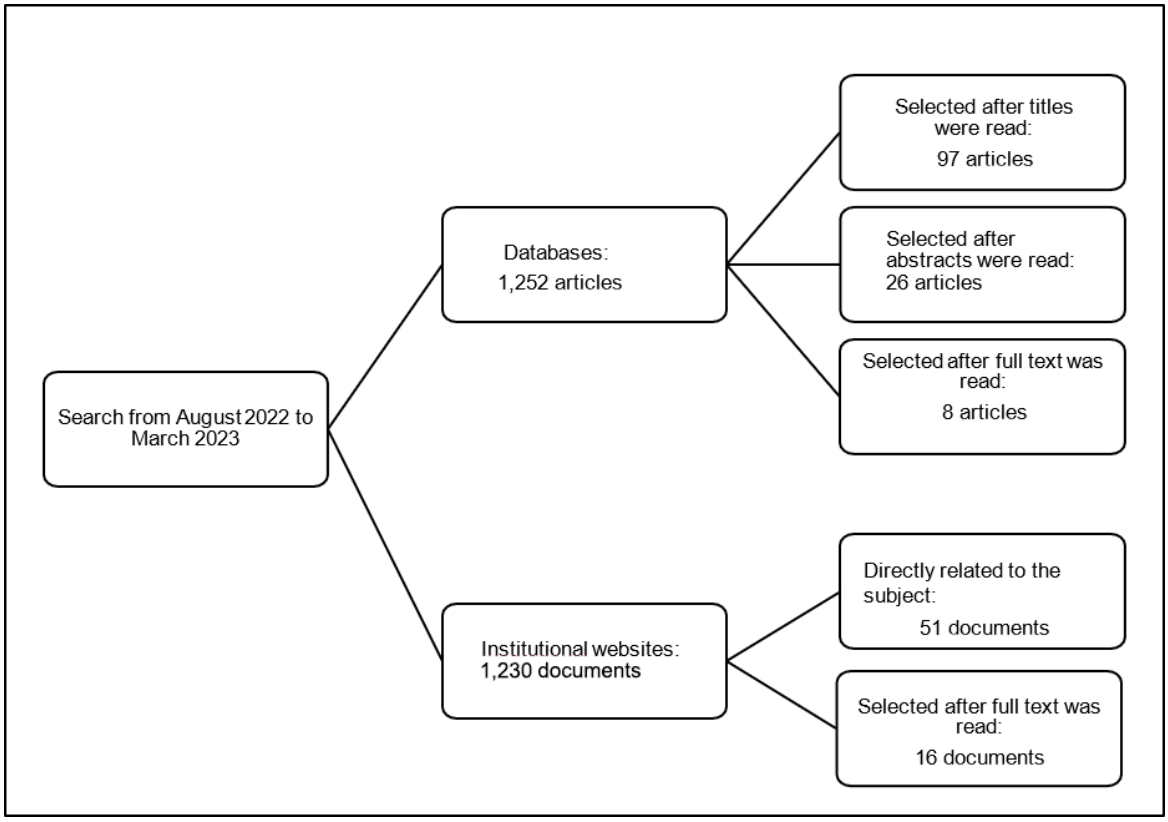


Figure 1. Brief description of the study's method.

the main difficulties as the short time to guide parents and identify clinical events that usually do not manifest within 24 hours of birth.[4]

A study showed that early discharge, followed by an individualized post-discharge follow-up plan, was safe for the newborn. [9] On the other hand, some authors demonstrated that readmission rates, mainly due to jaundice, were higher in newborns who were discharged early. [10,11] In this study, individualized follow-up plans were developed during hospitalization and implemented through telephone and/or in-person calls after discharge. The plan proved effective since, as the authors demonstrated, there were no records of readmissions for reasons directly related to early discharge.[9] Given such controversies, it is worth highlighting that knowing how to identify the criteria necessary for hospital discharge and doing so individually is more relevant than standardizing the length of hospital stay. This time, as an opportunity to prepare the newborn and the mother to live well outside the hospital, it should be sufficient to identify problems and ensure the family is ready to care for the new member. [6,10] In the context of maternal infection by the new coronavirus (Sars-CoV-2), postponing discharge is not recommended, as long as the mother and child are clinically well. There is also no recommendation for testing asymptomatic newborns.[12] Breastfeeding should be maintained, and the family should be advised of the warning signs of illness.[4,12]

Regarding preterm newborns, specifically those with a gestational age between 34 and 36 incomplete weeks, the SBP suggests caution. Generally, preterm newborns with a birth weight greater than 2,500 g can remain in rooming-in, sometimes being treated as preterm newborns. However, from a physiological perspective, they continue to be more susceptible to complications resulting from prematurity, which may lead to difficulties in lactation, body temperature control, maintenance of adequate blood glucose levels, and breathing.[11]

The risk of readmission is also higher in preterm newborns. The primary causes in the first month of life are jaundice (in approximately one-third of cases) and feeding problems (26%). Other causes include infection, apnea, respiratory issues, and hypothermia.[11]

The decision to refer a preterm newborn to rooming-in should be weighed by a pediatrician, considering, above all, the newborn's vitality and respiratory condition immediately after birth. Once rooming-in is chosen, it is essential to monitor the newborn's body temperature and blood glucose levels, as hypothermia and hypoglycemia are common during the first hour of life for preterm babies.[11]

Discharge should be carefully assessed and planned, given the physiological immaturity of preterm infants and their heightened susceptibility to readmissions. Post-discharge monitoring and the frequency of follow-up consultations

should also be organized considering the particularities of preterm newborns.[11]

Several authors describe criteria and guidelines for the hospital discharge of newborns and mothers that should be followed by care teams to ensure a safe discharge.[4-7,12] When assessing the reality of each mother and newborn duo and interpreting the suitability of discharge criteria, healthcare workers should consider sociodemographic, prenatal, perinatal, and postpartum factors.[10]

The criteria and guidelines for discharge include factors related to the newborn, the mother, the family, and the entire context to which they belong. Each criterion should be carefully assessed during hospitalization, and if all are met, the pair can be considered suitable for hospital discharge. The mother's opinion and her level of confidence regarding the care of the newborn must be taken into account throughout the process, and every effort must be made to ensure that the two are discharged simultaneously.[6,13]

CRITERIA AND GUIDELINES FOR THE SAFE DISCHARGE OF HEALTHY NEWBORNS, FULL-TERM BABIES, AND PRETERM INFANTS IN ROOMING-IN

I- Length of hospital stay: a minimum of 24 hours in the hospital, according to the guidelines of the Ministry of Health. The SBP advises against hospital discharge before 48 hours of life.[4,7]

II- Present diuresis and elimination of meconium: Diuresis follows a regular pattern, with at least one spontaneous evacuation documented by the care team.[1,2,5,7]

III- Conduct neonatal screening by using pulse oximetry testing, performing an ocular red reflex examination, carrying out hearing screening, and evaluating the lingual frenulum.[1,2,5,7]

Perform tests to determine blood type, Rh factor, and the Coombs test as part of the risk assessment for hyperbilirubinemia.[2,4,7]

V- Perform the recommended prophylactic care for newborns (vitamin K; eye drops to prevent ophthalmia neonatorum) and immunize the newborn with the Hepatitis B and BCG vaccines (for those weighing 2,000g or more). If the BCG vaccine is unavailable at the maternity hospital, advise the family to seek a Basic Health Unit immediately after discharge.[7]

VI- Observe at least two successful feedings during which the newborn shows adequate coordination of sucking, swallowing, and breathing, along with signs of satiety understandable to the mother. Assess whether the mother is confident and willing to breastfeed.[1,2,5,7,14]

VII- Observe for stable vital signs between feedings and during the 12 hours before discharge: axillary temperature between 36.5ºC and 37.4ºC, measured accurately and with appropriate clothing; heart rate between 100 and 160 bpm while awake; respiratory rate below 60 bpm, without signs of respiratory distress.[5,6]

VIII- Weight loss and hydration status: losses greater than 10% of birth weight increase the risk of hyperbilirubinemia and hypernatremia. Therefore, when this occurs, the adequacy of nutrition should be reassessed before discharge.[1,2,5,7]

IX- Assess risk for perinatal diseases: the newborn should not show signs or symptoms suggestive of neonatal infection, such as lethargy, irritability, decreased diuresis, dehydration, tachycardia, tachypnea, respiratory effort, fever, hypothermia, or significant jaundice; if any of these are present, screening and diagnostic tests should be performed before discharge to determine the necessity for hospital treatment.[1,2,5,7]

X- Physical examination: absence of alterations indicative of need for continued hospitalization, such as jaundice requiring phototherapy, signs of sepsis, among others.[6]

XI- The mother has no contraindications for discharge and possesses a current vaccination card as well as prenatal serologies for HIV, syphilis, toxoplasmosis, and hepatitis B that have been checked.[1,5,7]

XII- Assess the family context: identify social risks and vulnerabilities such as the use of legal and illegal drugs, alcoholism, a history of neglect or mistreatment of previous children, domestic violence, communicable diseases, mental health issues, and socioeconomic status. When necessary, arrange for monitoring by Social Services.[1,2,5,7]

XIV- Guidelines regarding vaccination in the postpartum period: the vaccines against influenza, COVID, and DTaP are formally recommended in the Brazilian Immunization Program for all postpartum women who have not been immunized during pregnancy. The triple viral and varicella vaccines, which are contraindicated during pregnancy, should be administered postpartum to update the vaccination card when necessary. In addition to being contraindicated for pregnant women, the yellow fever vaccine is also contraindicated for lactating women up to the sixth month of breastfeeding; if it is still needed, breastfeeding should be suspended for ten days after vaccination.[15,16]

XIV- Guidelines on preventing vertical transmission of HIV during lactation: Women who tested negative for HIV during prenatal care and childbirth should be advised to continue using male or female condoms throughout the lactation period. Advise the mother not to breastfeed other newborns and not to allow other mothers to breastfeed her child (cross-nursing), and provide guidance on strategies for early diagnosis.[17,18]

XV- Guidelines on transporting newborns in private vehicles: The AAP recommends transporting newborns in a rear-facing safety seat until they reach the maximum weight permitted by the seat's manufacturer. Resolution No. 277 of 2008 of the Brazilian Transit Authority recommends that children up to one year of age be transported in a "baby seat" or convertible seat in the vehicle's back seat, with the baby seat facing backwards.[19,20]

XVI- Guidelines on care for the umbilical cord stump: The WHO advises against the routine use of topical solutions on the umbilical cord stump if the birth occurred in a hospital environment with low neonatal mortality. The Ministry of Health points out that the use of 70% alcohol accelerates mummification but does not interfere with colonization, while chlorhexidine has the opposite effect. In agreement, both emphasize that keeping the stump clean and dry is the most important measure, which contradicts the recommendation by the SBP, instructing the pediatrician to individualize the recommendations for each case.[17-19]

XVII- Guidelines for preventing diaper rash include frequent diaper changes, gentle cleaning, exposure to air, and the use of barrier creams. Cleaning should preferably be done with cotton and water. Wet wipes can be used, provided they contain pH buffers and are free of potentially irritating substances such as alcohol, oils, fragrances, soap, and detergent. Barrier creams based on zinc oxide or petrolatum are most recommended; they should be applied at each change and do not need to be completely removed at subsequent changes, as long as the area is free of fecal residue.[21]

XVIII- Guidelines for bathing newborns: The first bath should be given after the newborn has reached thermal stability, preferably after 24 hours of life (except for newborns born to mothers with positive serology for HIV or Hepatitis B, in which case the recommendation is to bathe as early as possible). Immersion baths are recommended, with water up to the waist, at a temperature between 37ºC and 37.5ºC, for no longer than 10 minutes. Baths can be performed daily or 2 to 3 times a week, provided that the folds, umbilical stump, and diaper area are kept clean. Use mild soaps specifically designed for baby's skin, preferably in liquid form and fragrance-free.[22,23]

XIX- Guidelines on sun exposure: the SBP advises that children under six months of age should not be intentionally exposed to the sun to treat jaundice or increase the absorption of vitamin D. Mechanical protectors, such as hats and umbrellas, should always be used to shield the skin, and after six months of age, sunscreen can be applied in sun-exposed environments.[21]

XX- Guidelines on preventing sudden infant death syndrome: place the newborn to sleep in the supine position, in a crib free of accessories, with a firm surface, without pillows. Do not sleep in a shared bed or crib. Avoid overheating and do not cover the newborn's head with blankets. Maintain exclusive breastfeeding until six months of age. Keep the environment smoke-free and ensure vaccines are up to date according to the age group.[2,17,24]

XXI- Guidelines for recognizing risk situations: train parents and caregivers to identify early changes that indicate a danger to the newborn, such as cyanosis, respiratory distress, fever or hypothermia, weak sucking, lethargy, signs of dehydration, signs of umbilical cord stump infection, and recognition of cardiopulmonary arrest (CPA) so they can seek medical care quickly.[1,2,7,17]

XXII- Filling out the child's journal: record all information related to the birth, including gestational age, weight, head circumference, results of neonatal screening, and vaccines administered.[5,7]

XXIII- Guidelines on post-discharge follow-up: refer the family to a basic healthcare unit for continued care, where the newborn should receive the first consultation within 72 hours after discharge. Guide the application of the first vaccines and the performance of biological screening (heel prick test) between the 3rd and 5th day of life.[1,5-7]

Special attention should be given to breastfeeding. All postpartum women should be informed about the benefits of breastfeeding and the appropriate technique. During their stay in the hospital, the technique should be reviewed and corrected as necessary. They should also be educated on how to prevent and treat complications related to lactation, such as fissures, engorgement, and mastitis.[10,14]

The Brazilian Ministry of Health recommends that during the rooming-in period, health professionals should routinely provide guidance to the mother and family members on various aspects of newborn care. It is also important to ensure that parents and caregivers do not misinterpret information due to language barriers.[5,7,17]

CONCLUSION

Hospital discharge marks a moment of great importance for the entire family. The process should be organized by considering, in addition to technical and scientific aspects, a holistic view of the mother-child duo and their families. Although the literature provides well-established criteria, planning for hospital discharge goes beyond that. It requires time and training from the healthcare team to deliver not only guidance but also individualized support tailored to each situation. The healthcare team must ensure that the transition from hospital to home is carried out as safely as possible.

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