Hospital Stay for Healthy Term Newborns

Committee on Fetus and Newborn

The timing of discharge of the mother and infant after birth was, until recently, a mutual decision between the physician and the mother. Discharge soon after birth began as a consumer-initiated movement and as an alternative to home delivery in the 1980s. Today, financial rather than family or medical considerations frequently drive the decision. Increasingly, insurers are refusing payment for a hospital stay that extends beyond 24 hours after an uncomplicated vaginal delivery, which has placed increasing pressure on physicians to discharge infants shortly after birth.

Few scientific data support the insurer’s mandate. Several clinical studies have examined the effects of short hospital stay on infant outcomes. Unfortunately, these studies have methodologic flaws that make it difficult to draw definite conclusions including their 1) retrospective nature, 2) lack of comparison groups, 3) insufficient sample sizes, and 4) study design.

The pediatrician’s primary role is to ensure the health and well-being of the baby in the context of the family. It is within this context that this statement addresses the short hospital stay (<48 hours of age) for healthy term newborns.

The hospital stay of the mother-infant dyad should be long enough to allow identification of early problems and to ensure that the family is able and prepared to care for the baby at home. Many cardiopulmonary problems related to the transition from an intrauterine to an extraterine environment usually become apparent during the first 12 hours after birth. However, other problems, such as jaundice, ductal-dependent cardiac lesions, and gastrointestional obstruction, may require a longer period of observation by skilled and experienced personnel. Furthermore, the length of stay should be based on the unique characteristics of each mother-infant dyad, including the health of the mother, the health and stability of the baby, the ability and confidence of the mother to care for her baby, the adequacy of support systems at home, and access to appropriate follow-up care. All efforts should be made to keep mothers and infants together to ensure simultaneous discharge.

It is recommended that the following minimum criteria are met before newborn discharge. It is unlikely that fulfillment of these criteria and conditions can be accomplished in less than 48 hours. Furthermore, the timing of discharge of the newborn from the hospital should be the decision of the physician caring for the baby, not by arbitrary policy established by third-party payors.

- The antepartum, intrapartum, and postpartum courses for both mother and baby are uncomplicated.
- Delivery is vaginal.
- The baby is a single birth at 38 to 42 weeks’ gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.
- The baby’s vital signs are documented as being normal and stable for the 12 hours preceding discharge, including a respiratory rate below 60/min, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1°C to 37°C in an open crib with appropriate clothing.
- The baby has urinated and passed at least one stool.
- The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.
- Physical examination reveals no abnormalities that require continued hospitalization.
- There is no evidence of excessive bleeding at the circumcision site for at least 2 hours.
- There is no evidence of significant jaundice in the first 24 hours of life.
- The mother’s knowledge, ability, and confidence to provide adequate care for her baby are documented by the fact that they have received training sessions regarding:
  - Breastfeeding or bottle-feeding. The breastfeeding infant- infant dyad should be assessed by trained staff regarding nursing position, latch-on, adequacy of swallowing, and mother’s knowledge of urine and stool frequency.
  - Cord, skin, and infant genital care.
  - Ability to recognize signs of illness and common infant problems, particularly jaundice.
  - Proper infant safety (eg, proper use of a car seat and positioning for sleeping).
- Family members or other support person(s), including health care providers, such as the family pediatrician or his/her designees, familiar with newborn care and knowledgeable about lacta-

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* Use of noninvasive means of detecting jaundice may be useful.
Initial hepatitis B vaccine is administered or a screening test is performed in accordance with state regulations. Laboratory data are available and reviewed, and a physician-directed source of continuing medical care for both the mother and the baby is identified. A discharge should be delayed until a plan to safeguard the infant is in place.

- Maternal syphilis and hepatitis B surface antigen status. Cord or infant blood type and direct Coombs' test result as clinically indicated.
- Screening tests are performed in accordance with state regulations. If the test is performed before 24 hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.
- Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made within the first week of life.
- A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged in less than 48 hours after delivery, a definitive appointment has been made for the baby to be examined within 48 hours of discharge. The follow-up visit can take place in a home or clinic setting, as long as the personnel examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician, or his designee, on the day of the visit.
- Family, environmental, and social risk factors should be assessed. These risk factors may include but are not limited to 1) untreated parental substance abuse/positive urine toxicology results in the mother or newborn; 2) history of child abuse or neglect; 3) mental illness in a parent who is in the home; 4) lack of social support, particularly for single, first-time mothers; 5) no fixed home; 6) history of untreated domestic violence, particularly during this pregnancy; or 7) teen mother, particularly if other conditions above apply. When these or other risk factors are present, the discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.

It is essential that all infants having a short hospital stay be examined by experienced health care providers within 48 hours of discharge. If this cannot be assured, then discharge should be deferred until a mechanism for follow-up evaluation is identified.

- Assess the infant's general health, hydration, and degree of jaundice; identify any new problems; review feeding pattern and technique, including observation of breastfeeding for adequacy of position, latch-on, and swallowing; and historical evidence of adequate stool and urine patterns.
- Assess quality of maternal-infant interaction and details of infant behavior.
- Reinforce maternal or family education in infant care, particularly regarding infant feeding.
- Review the outstanding results of laboratory tests performed before discharge.
- Perform screening tests in accordance with state regulations and other tests that are clinically indicated.
- Identify a plan for health care maintenance, including a method for obtaining emergency services, preventive care and immunizations, periodic evaluations and physical examinations, and necessary screening.

The follow-up visit should be considered an independent service to be reimbursed as a separate package and not as part of a global fee for maternity-newborn labor and delivery services.

In summary, the fact that a short hospital stay (<48 hours of age) for term healthy infants can be accomplished does not mean that it is appropriate for every mother and infant. Each mother-infant dyad should be evaluated individually to determine the optimal time of discharge. The timing of the discharge should be the decision of the physician caring for the infant and not by arbitrary policy established by third-party payors. Local institution of these guidelines is best accomplished through the collaborative efforts of all parties concerned. Institutions should develop guidelines through their professional staff in collaboration with appropriate community agencies, including third-party payors, to establish hospital stay programs for healthy term infants that implement these recommendations. State and local public health agencies should also be involved in the oversight of existing hospital stay programs for quality assurance and monitoring. Further research to evaluate the various issues of short-stay programs is strongly encouraged.
5. Britton HL, Britton JR. Efficacy of early newborn discharge in a middle-class population. AJDC. 1984;138:1041–1046
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