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Early vs. Routine Hospital Discharge After Uncomplicated Cesarean Section at UPTH: A Randomized Clinical Trial on Maternal Satisfaction and Economic Cost

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Abstract

Background: Early hospital discharge after caesarean section in selected patients has shown both clinical and health system benefits. This study aimed to compare maternal satisfaction and costs of healthcare between routine discharge and early hospital discharge after planned, uncomplicated caesarean section.

Method: The study was a randomized controlled trial conducted among low-risk patients scheduled for elective caesarean section at the University of Port Harcourt Teaching Hospital. Selected patients were randomized into an early discharge group (Day 2) and a control group (routine day 4) by computer-generated random numbers. Both groups were subjected to standardized surgical protocols. The patients in the test group received some additional perioperative interventions. Frequencies and percentages were used to summarize categorical variables. Chi-square test was used to test for association between categorical variables. The confidence interval was 95% and level of significance was set at $p < 0.05$.

Results: 50% of participants in the early discharge group had good satisfaction scores (>70), as compared to 26.5% in the routine discharge group. Based on discharge timing, 64.3% in the early discharge group were satisfied, as compared to 46.1% in the other group. Based on overall care received, 64.3% were strongly satisfied, as against 43.1% in the routine group. The cost range in the early discharge group was ₦66,500 – 300,000 as compared to the ₦71,000 – 478,000 in the routine group

Conclusion: Early discharge on the second day after an uncomplicated caesarean section is associated with significant patient satisfaction, and reduced economic cost.

Keywords: Randomized trial; early discharge; routine discharge; Caesarean section; Maternal satisfaction; economic cost

Introduction

Caesarean section is the delivery of the fetus through a surgical incision in the abdominal and uterine wall after 28 weeks of pregnancy [1]. It is a major surgery in obstetrics and its complications are a major source of concern to the obstetrician, the patient and indeed, the healthcare system. International analysis shows that the caesarean section rates steadily increased over the past few decades [2]. This huge volume of caesarean deliveries and increasing caesarean section rates translates to an increased burden on healthcare systems in terms of higher bed occupancy as well as financial pressure on the patients and health facilities [3].

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Postpartum length of stay varies in different obstetric units worldwide. In recent times, there has been a worldwide tendency to reduce the length of postpartum hospital stay. This has been shown to improve patient satisfaction, quality of care, and decrease costs [4]. The National Institute for Health and Care Excellence (NICE) released a guideline stating that if a woman who had an uncomplicated caesarean section is recovering well, she can be discharged from the hospital after 24 hours of surgery and taken care of at home [5]. The American College of Obstetricians and Gynecologists (ACOG) also has guidelines on Enhanced Recovery After Surgery (ERAS) for caesarean section. It recommends early oral intake, early mobilization, thromboembolism prophylaxis, early catheter removal, discharge counselling and reduced hospital stay [6]. The aim is to improve outcomes in surgical patients, especially as it relates to early recovery, reduction of hospital stay, complication rate and economic burdens, without compromising the quality of care [7].

An important way to evaluate healthcare delivery, particularly as it relates to care of the mother-new born pair in obstetrics is the assessment of patient satisfaction. Patient-centered care is built on key principles such as respect for their preferences, information and education, physical comfort, emotional support as well as access to care. However, not many studies have been conducted in our environment to examine patient satisfaction while comparing outcomes of early and routine hospital discharge following planned caesarean section.

The current practice in the University of Port Harcourt Teaching Hospital (UPTH) is to discharge obstetric patients on the 4th day following caesarean section, except they have comorbidities or complications requiring longer hospital stay. With the rising rate of caesarean delivery and the strain it exerts on healthcare resources, early discharge after elective caesarean section has been shown to improve patient satisfaction and reduce healthcare cost from both human and material perspectives. In low- and middle-income countries where the twin problems of dearth of human and material resources continue to impart negatively on healthcare outcomes, the benefits of early discharge can be profound. Therefore, in this study we aimed to compare maternal satisfaction and costs of healthcare between routine discharge and early hospital discharge after planned, uncomplicated caesarean section in our healthcare facility.

Methods

Study Design and Setting

This study was a prospective randomized single-blinded controlled clinical trial, enrolling pregnant women with uncomplicated pregnancies having planned caesarean section in University of Port Harcourt Teaching Hospital (UPTH). This was an 11 months study that took place from April, 2023 to February, 2024. The University of Port Harcourt Teaching Hospital is a tertiary facility which serves as a referral center for primary and secondary health centers and other tertiary facilities within the South-South and South-East states.

Study Participants

The criteria for participants are given below:

Inclusion Criteria

I. Pregnant women between the ages of 20-35 years

II. Body Mass Index (BMI) <30

III. Booked patients

IV. iv. Gestational age at least 37 weeks of gestation

V. Scheduled for elective caesarean section

VI. singleton pregnancies

Exclusion Criteria

I. Unbooked patients

II. multiple gestation

III. cardiac disease

IV. iv. diabetes

V. Anemia

VI. major degree placenta previa

VII. pulmonary disorders

VIII. fetal anomaly

Study Instruments

Consent

A consent form was signed by eligible participants who indicated interest to be involved in the study. They were educated on the study and allowed to ask questions prior to appending their signatures.

Study Proforma

A study pro-forma was used to collect information from participants after being recruited from the antenatal clinic. It consisted of sociodemographic characteristics- age, marital status; number of pregnancies, previous caesarean section(s), gestational age and information about present pregnancy. This was done concurrently with education of the patients on early hospital discharge and administration of information pamphlets, by the principal investigator or trained research assistants. The pro-forma was also used to enter information about intraoperative events and vital signs on discharge.

Study Outcome variables

Patients' overall satisfaction was assessed using a

questionnaire which was an adaptation of the Long-Form Patient Satisfaction Questionnaire and the Leiden Perioperative Care Satisfaction Questionnaire [8]. The questionnaire contained satisfaction variables and a 4-Point Likert scale. The variables were grouped into quality and cost of healthcare received, doctor-patient communication, professionalism, attitude of health workers and nature of the hospital environment.

Study Protocol

Patient Recruitment and Randomization

Women at 37 weeks' gestation or beyond, scheduled for elective caesarean section and without comorbidities, were recruited from the antenatal clinic of the University of Port Harcourt Teaching Hospital after receiving study information and providing written informed consent. Gestational age was determined using the last normal menstrual period or an early ultrasound where necessary. Participants were randomly assigned in a 1:1 ratio to either early discharge (2 days) or routine discharge (4 days) using computer-generated randomization and sequentially numbered, opaque, sealed envelopes to ensure allocation concealment. Participants were blinded to their allocation until the envelopes were opened after surgery. A contact number was provided for communication with the principal investigator, and participants were followed up from recruitment until their six-week postnatal clinic visit.

Blinding

The participants were blinded to the allocation, up till the immediate post-operative period.

Preoperative Interventions

Patients received counselling on preoperative preparation, intraoperative and postoperative expectations, and early discharge, supported by educational pamphlets. Written informed consent was obtained after confirming their understanding of the study. They were admitted two days before surgery, underwent detailed history-taking and physical examination, and had their investigations reviewed, including packed cell volume (minimum 30%), serology, urinalysis, blood grouping and crossmatching of two units of blood, and obstetric ultrasound. All patients were assessed by the anesthetic team, and the neonatology team was notified to attend surgery for neonatal resuscitation. The surgical team remained blinded to group allocation.

Intraoperative Interventions-caesarean section protocol

All caesarean sections in both groups were performed by senior residents in their second year or above, under spinal anesthesia, using a standardized surgical protocol. Patients received prophylactic intravenous ceftriaxone (1 g) before incision, and a transverse suprapubic incision was used to access the uterus. Following delivery of the baby, intravenous oxytocin (10 IU) was administered, the placenta was delivered by controlled cord traction, and the uterus was closed in two layers using Vicryl sutures, with additional hemostatic sutures where necessary. The abdominal cavity and pelvic organs were inspected, and swab and instrument counts were completed before layered abdominal closure and sterile wound dressing. Postoperatively, 800 micrograms of rectal misoprostol and 200 mg of rectal diclofenac were administered.

Post-Operative Interventions

Test Group (Early discharge)

In the early discharge group, oral intake and mobilization commenced 6 hours postoperatively, with nursing supervision, and the urinary catheter was removed after 12 hours. Multimodal analgesia and intravenous ceftriaxone and metronidazole were administered according to the departmental protocol. Discharge counselling covered maternal and neonatal danger signs, nutrition, breastfeeding, wound and umbilical cord care, and temperature monitoring; participants received digital thermometers and access to a 24-hour contact line. Discharge criteria included stable vital signs, independent ambulation, adequate urination, bowel function, normal diet tolerance, satisfactory wound healing, and an acceptable hemoglobin level (9g/dL in our environment). Before discharge, pain and maternal satisfaction were assessed using a numeric pain rating scale and a four-point Likert-scale questionnaire, respectively. Participants received wound reviews on postoperative day 7 and follow-up visits at two and six weeks postpartum, with telephone monitoring continuing for two weeks.

Control Group (Routine discharge)

The control group received routine postoperative care according to the Department of Obstetrics and Gynecology, University of Port Harcourt Teaching Hospital. Mobilization commenced after 12 hours, graded oral intake after 24 hours, and urinary catheter removal after 24 hours. Postoperative analgesia and intravenous antibiotics were administered at the same doses and duration as in the early discharge group, with oral antibiotics given subsequently. Packed cell volume was checked on the second postoperative day. Patients received counselling on maternal and neonatal danger signs, had telephone access to the principal investigator, and were discharged on the fourth postoperative day.

Definition of Outcome Measures

I. Patient satisfaction – this was assessed using a questionnaire which was an adaptation of the Long-form patient satisfaction Questionnaire and the Leiden

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Perioperative care satisfaction questionnaire that has been validated by several studies. [8]

II. Cost of hospital stay- included cost of investigations, anesthesia, surgery, medications and nursing care.

Follow Up and Data Collection

Data was collected using structured pro-forma which was administered to the study subjects after being recruited for the research work. Patients were followed up daily from admission till discharge according to standard obstetric practice. The neonates were examined prior to discharge, to ensure weight gain, proper cord care and absence of symptoms and signs of disease such as fever, jaundice, lethargy or poor suck. Subsequently, patients were communicated with through a telephone conversation by the investigating resident. Most of the patients were seen at one and two weeks postpartum and followed up for at least six weeks following surgery. At the end of this period, patients were informed of the termination of their involvement in the study.

Data Analysis

The data analyzed using Statistical Package for Social Sciences (SPSS) version 22. Categorical data such as socio-demographic characteristics were presented in frequencies and percentages.

Continuous data such as age and Body Mass Index were presented in means and Standard Deviations. Pearson's Chi-square (X2) test analysis was performed to test for association in proportions between the explanatory variables and the outcome variables and their proportions (%), and to determine the level of statistical significance between the variables associated.

Fischer's exact test was used when an expected cell value was less than 5; for example, statistically significant differences in patient satisfaction between participants discharged after 48 hours and those discharged after 4-5 days. Student t-test was used to test for differences in means for continuous variables. All Odds Ratios were reported with their 95% confidence intervals and corresponding p values. An observation was deemed statistically significant if p value was <0.05 at a 95% Confidence Interval

Clinical Trial Registry

The study has been registered with the Pan African Clinical Trial Registry. The identification number for the registry is PACTR202404768066197.

Ethics, Confidentiality and the Protection of Human Subjects

Approval was given by the University of Port Harcourt Teaching Hospital Research Ethics Committee (REC) to carry out this study, with the reference number UPTH/ADM/90/S. II/VOL.XI/1328.

Results

Over the course of the study, 206 patients met the inclusion criteria and were randomized into two groups. Two of these patients declined further participation, three delivered in other facilities, one was lost to follow-up, and 200 patients were analyzed.

Figure 1 is the CONSORT flow diagram showing the numbers of patients enrolled and analyzed. The two patients who declined further participation were in the early discharge group, as well as the three who delivered elsewhere; hence 98 patients were analyzed. In the routine discharge group, one patient was lost to follow-up.

Baseline characteristics are shown in table 1. The baseline age, educational level and marital status were similar in both groups. The mean age of the study population was 30.5 ± 3.63 years showing that the patients were well-selected. There was a statistically significant difference in the employment status between the two study groups, while the percentage of unemployed women in the early discharge group was 16.3%, and 27.5% in the routine discharge group.

Figure 2 shows the maternal satisfaction scores of both groups. 50% of participants in the early discharge group had good scores (70-100). In the routine discharge group, 26.5% of participants had good satisfaction scores.

Table 2 shows the indications for caesarean section. These were similar in both groups as patients scheduled for uncomplicated caesarean section were enrolled.

Table 3 compares maternal satisfaction in both groups in relation to discharge timing. The majority of patients discharged on the second post-operative day were satisfied with their discharge timing. Most of them agreed to opt for the same discharge timing in the future, and recommend it to friends, compared to the day-4 discharge group.

As regards satisfaction with the overall care received, 64.3% of patients in the early discharge group strongly agreed that they were satisfied, as against 46.1% in the routine discharge group (Table 4).

There was a statistically significant difference in maternal satisfaction scores in favor of the early discharge group (table 5). In the early discharge group, 50% of patients had a satisfaction score of 70 or more, as against 26.5% of patients in the day 4 discharge group ($p = 0.0001$).

Table 6 compares costs of healthcare between both study groups. The range of costs in the early hospital discharge group was reduced compared to the routine group. However, there was no statistically significant difference in cost between both groups ($p = 0.850$).

Discussion

Early hospital discharge after uncomplicated caesarean section has been advocated by The National Institute for Health and Care Excellence (NICE) [5]. The guideline recommends early discharge and monitoring at home. This is in order to create a conducive atmosphere for the patient's recovery. Reduced hospital stay has been shown to correlate positively with patient satisfaction. Studies have also shown no increased risk of complications.

At the core of modern healthcare delivery is patients' satisfaction with the quality of care offered. This is defined as the individual's positive evaluation of a distinct dimension of care. It is positive when the perception of the care given meets the patient's level of expectation [9]. In this study, we have established a positive link between reduced duration of hospital stay and patient satisfaction. The degree of maternal satisfaction was higher in the early hospital discharge group. These patients recovered well at home and there was no higher incidence of complications than in patients who stayed for 4 days after caesarean section.

This study showed that there was increased maternal satisfaction among parturients that were discharged on the second post-operative day compared to routine discharge. Patients in the day 2 group had a higher degree of satisfaction with discharge timing and overall care received. This finding is in keeping with that of a similar study by Oyeyemi et al in a randomized trial of short stay versus traditional protocol in southwest Nigeria [10]. The higher degree of maternal satisfaction recorded in the early discharge group might have been due to the fact that they were made to ambulate early, hence they recovered from surgery faster and looked forward to re-uniting with their families. It may also be related to the fact that these patients were excited about the prospects of going home earlier than normal. The average Nigerian woman has an aversion for caesarean section for several reasons, one of which may be the prolonged hospital stay following delivery. The findings in this study as regards maternal satisfaction were in keeping with those of Onu et al, who also reported higher maternal satisfaction following day 2 discharge in a similar study [11]. Contrary to the finding in this study, Ghaffari et al did not note any statistically significant difference in maternal satisfaction following early discharge [12]. They however went ahead to recommend that the time of discharge can be reduced to 24 hours after surgery if the patient is in a stable clinical state. Their recommendation was based on the fact that there was no significant difference in post-operative complications between early and routine discharge groups ($p > 0.05$).

Our study showed that there was no statistically significant difference in the average cost of hospital stay between both groups ($p=0.850$). This finding may be attributed to the enrolment of some of our patients with the National Health Insurance Authority (NHIA). The median hospital bill in our study for the early discharge group was ₦180,000 with a range of ₦66,500-300,000. For the routine discharge group, the median cost was the same, with a range of ₦71,000- 478,000. Oyeyemi et al found a statistically significant difference in the median hospital bills between both groups [10]. The median for short stay group was ₦83,300, and for the traditional group was ₦90,300 ($p=0.0001$). The relative similarity in average costs of hospital stay between both groups may be due to the fact that the study population comprised patients with similar demographic characteristics, no co-morbidities, and minimal complications.

Conclusion

From this study, the discharge of a patient on the second day after an uncomplicated caesarean section is associated with significant patient satisfaction, and also lowered economic cost for hospital stay.

Limitations

A limitation of this study however is in the study population. It involved young, healthy women between the ages of 20 and 35 years, and uncomplicated caesarean sections. The findings in this study may not be applicable to women who have co-morbidities, or intra-operative complications.

Declarations

Ethics approval and consent to participate

Approved by the UPTH Research and Ethics Committee. Written informed consent was obtained from all participants or their legal representatives.

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Competing interests

The authors declare no competing interests.

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Authors' contributions

ESA conceptualized the study, designed the study, supervised data collection, performed statistical analysis, and drafted the original manuscript.

TKN and POF designed the study, contributed to data collection, reviewed the original manuscript.

ESA, TKN, POF all approved the final submission.

Data availability

De-identified data are available from the corresponding author upon reasonable request.

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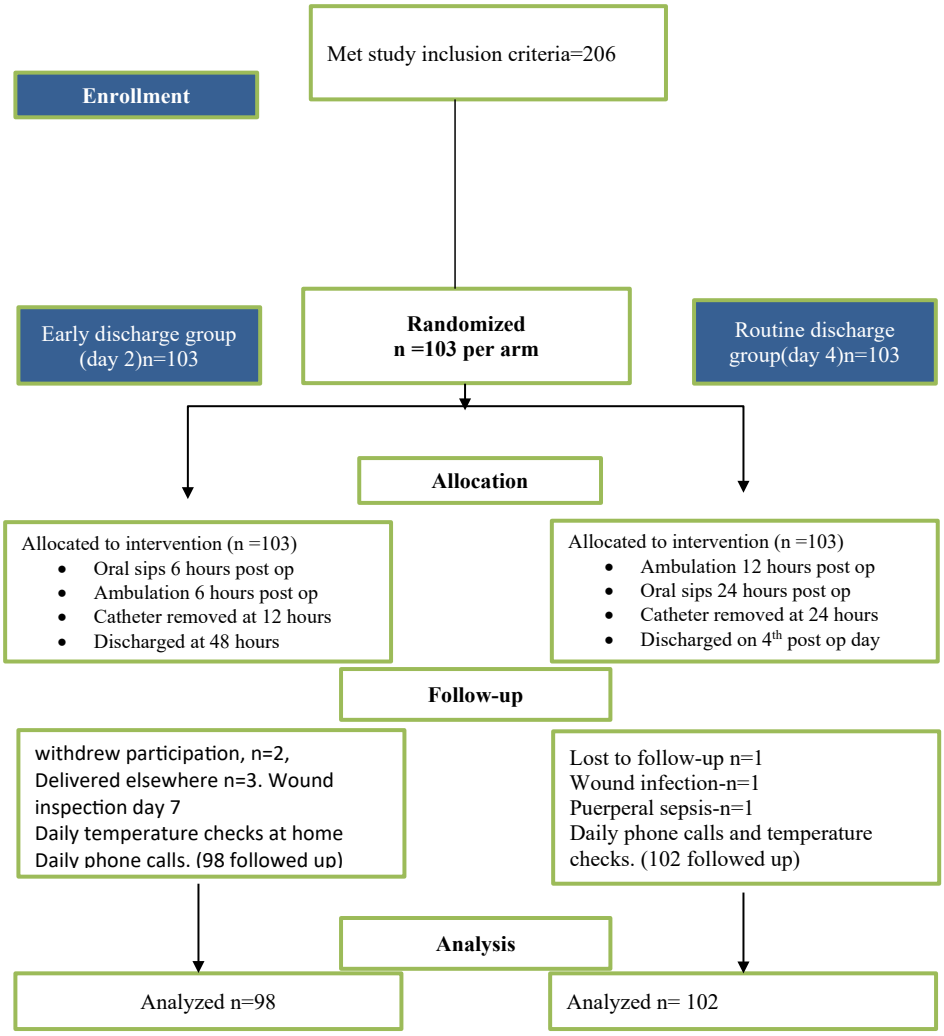


Figure 1: CONSORT (Consolidated Standards of Reporting Trials) flow diagram

Table 1: Sociodemographic characteristics of study population

	Group		
	Early	Routine	Total n (%)
Variables	**Discharge n (%)**	**Discharge n (%)**	
Age category			
≤ 24years	7 (7.1)	9 (8.8)	16 (8.0)
25 – 29years	37 (37.8)	23 (22.5)	60 (30.0)
30 – 34years	41 (41.8)	53 (52.0)	94 (47.0)
35years	13 (13.3)	17 (16.7)	30 (15.0)
	Chi-square = 5.504; p-value = 0.138		
Marital Status			
Married	93 (94.9)	101 (99.0)	194 (97.0)
Single	5 (5.1)	1 (1.0)	6 (3.0)
	Fisher's Exact p-value = 0.113		
Level of education			
None	2 (2.0)	2 (2.0)	4 (2.0)
Secondary	46 (46.9)	26 (25.5)	72 (100.0)

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Tertiary	50 (51.0)	74 (72.5)	124 (62.0)
	Fisher's Exact = 10.240; p-value = 0.003		
Employment Status			
Salary Recipient	16 (16.3)	31 (30.4)	47 (23.5)
Self Employed	66 (67.3)	43 (42.2)	109 (54.5)
Unemployed	16 (16.3)	28 (27.5)	44 (22.0)
	Chi Square = 12.838; p-value = 0.002		
Religion			
Christianity	92 (93.9)	99 (97.1)	191 (95.5)
Islam	4 (4.1)	0 (0.0)	4 (2.0)
Others	2 (2.0)	3 (2.9)	5 (2.5)
Median Parity	*3* *Mann-Whitney U=4401.000*		
Body Mass Index			
18.5 – 24.9 (Normal)	9 (9.2).	25 (24.5)	34 (17.0)
25.0 – 29.9 (Overweight)	89 (90.8)	77 (75.5)	166 (83.0)

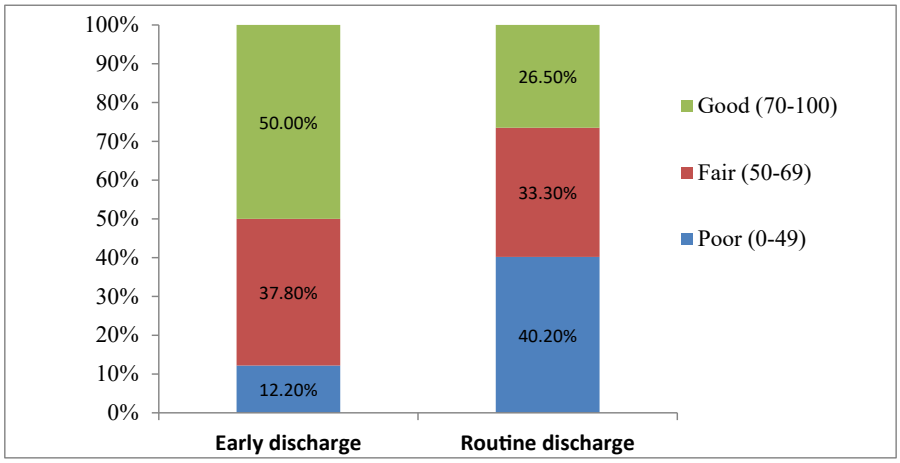


Figure 2: Maternal Satisfaction Scores

Table 2: Indications for Caesarean section

Group			
Variable	**Early Discharge n (%)**	**Routine Discharge n (%)**	**Total n (%)**
One Previous Caesarean section	31 (31.6)	31 (30.4)	62 (31.0)
Maternal request	4 (4.1)	12 (11.8)	16 (8.0)
Primigravida breech	14 (14.3)	16 (15.7)	30 (15.0)
Abnormal lies	13 (13.3)	11 (10.8)	24 (12.0)
Antenatal Cephalopelvic disproportion (CPD)	10 (10.2)	14 (13.7)	24 (12.0)
Short interpregnancy interval	6 (6.1)	4 (3.9)	10 (5.0)
Genital warts	2 (2.0)	0 (0.0)	2 (1.0)
Previous Vesicovaginal Fistula (VVF) repair	2 (2.0)	1 (1.0)	3 (1.5)
Pelvic deformity	2 (2.0)	3 (2.9)	5 (2.5)
Fetal macrosomia	9 (9.2)	4 (3.9)	13 (6.5)
Prevention of Mother-To- Child Transmission (PMTCT) of HIV	2 (2.0)	2 (2.0)	4 (2.0)
Others	3 (3.1)	4 (3.9)	7 (3.5)
Total	**98 (100.0)**	**102 (100.0)**	**200 (100.0)**

Fisher's Exact = 9.763; p-value = 0.562

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Table 3: Patient satisfaction based on discharge timing

Group			
Variable	**Early Discharge n (%)**	**Routine Discharge n (%)**	**Total n (%)**
I am very satisfied with the discharge timing I had			
Strongly Agree	63 (64.3)	47 (46.1)	110 (55.0)
Agree	33 (33.7)	43 (42.2)	76 (38.0)
Disagree	2 (2.0)	12 (11.8)	14 (7.0)
	Chi Square = 10.710; p = 0.005		
I will choose the same discharge timing over again			
Strongly Agree	51 (52.0)	42 (41.2)	93 (46.5)
Agree	37 (37.8)	45 (44.1)	82 (41.0)
Disagree	10 (10.2)	15 (14.7)	25 (12.5)
	Chi Square = 2.572; p = 0.276		
I will recommend this discharge timing to friends and family.			
Strongly Agree	51 (52.0)	37 (36.3)	88 (44.0)
Agree	37 (37.8)	52 (51.0)	89 (44.5)
Disagree	6 (6.1)	13 (12.7)	19 (9.5)
Strongly Disagree	4 (4.1)	0 (0.0)	4 (2.0)
	Fisher's Exact = 10.887; p = 0.008		
The timing of my discharge was cost effective			
Strongly Agree	36 (36.7)	19 (18.6)	55 (27.5)
Agree	41 (41.8)	47 (46.1)	88 (44.0)
Disagree	19 (19.4)	32 (31.4)	51 (25.5)
Strongly Disagree	2 (2.0)	4 (3.9)	6 (3.0)
	Fisher's Exact = 9.534; p = 0.020*		

Statistically Significant

Table 4: Patient satisfaction based on the quality of healthcare received

Group			
Variable	**Early Discharge n (%)**	**Routine Discharge n (%)**	**Total n (%)**
I am very satisfied with the overall medical care I received			
Strongly Agree	63 (64.3)	44 (43.1)	107 (53.5)
Agree	33 (33.7)	54 (52.9)	87 (43.5)
Disagree	2 (2.0)	4 (3.9)	6 (3.0)
	Fisher's Exact = 9.007; p-value =0.008		
I think the wards have everything needed to provide complete medical care			
Strongly Agree	45 (45.9)	20 (19.6)	65 (32.5)
Agree	34 (34.7)	55 (53.9)	89 (44.5)
Disagree	15 (15.3)	27 (26.5)	42 (21.0)
Strongly Disagree	4 (4.1)	0 (0.0)	4 (2.0)
	Fisher's Exact = 21.699; p-value= 0.0001*		

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I was able to get care anytime I needed it			
Strongly Agree	56 (57.1)	39 (38.2)	95 (47.5)
Agree	27 (27.6)	50 (49.0)	77 (38.5)
Disagree	12 (12.2)	11 (10.8)	23 (11.5)
Strongly Disagree	3 (3.1)	2 (2.0)	5 (2.5)
	Fisher's Exact = 10.169; p-value= 0.013		

Statistically Significant

Table 5: Maternal Satisfaction Scores

		Group		
Satisfaction Score		**Early Discharge n (%)**	**Routine Discharge n (%)**	**Total n (%)**
0 – 49	Poor	12 (12.2)	41 (40.2)	53 (26.5)
50 – 69	Fair	37 (37.8)	34 (33.3)	71 (35.5)
70 – 100	Good	49 (50.0)	27 (26.5)	76 (38.0)
Total		**98 (100.0)**	**102 (100.0)**	**200 (100.0)**

Chi-square = 22.292; p-value = 0.0001

Table 6: Relationship between total cost of hospital stay (₦) and discharge timing

Variables	Total cost of hospital stays (₦) Median (Range)	Mann-Whitney U test	p-value
Early discharge	180,000 (66,500 – 300,000)	*4920.5*	*0.85*
Routine discharge	180,000 (71,000 – 478,000)		

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