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Readmission following caesarean section: Reasons for readmission and outcomes for women in one large Irish Maternity hospital

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Abstract

Background: Women who birth by caesarean section are more likely to require readmission to hospital following birth compared to women who birth vaginally.

Aim: to examine the reasons, management and outcomes for women readmitted to hospital following birth by caesarean section (CS).

Methods: A retrospective audit of maternity records.

Results: The total number of births for the period of data extraction was 8580 of which 2470 (28.8%) women gave birth by CS. A total of 107 women (4.3% of the total number of women who gave birth by CS) were readmitted to hospital between 1st August 2014 and 31st July 2015, of which 46 women (1.9%) were readmitted following elective and 61 (2.5%) following emergency CS. The average length of hospital stay was 2.64 and 4.61 nights respectively and the average timeline for readmission was 14.6 (following elective CS) and 15.7 (following emergency CS). The most common reason for readmission was wound infection, with the majority of women requiring analgesics (n=29, 63.05% (following elective CS) and n=51, 83.61% (following emergency CS)) and intravenous antibiotics (n=23, 50% (following elective CS) and n=34, 55.74% (following emergency CS)).

Conclusion: Abdominal wound infection is one of the most common reasons for readmission of women to the hospital following birth by CS. These findings will make it easier to understand and identify women at risk of postpartum morbidity following birth by CS.

Key points

- Readmission following birth has implications for the health service, in terms of women's length of stay in hospital and management (investigations and treatment) during the period of readmission. It also leads to cost implications which can be further explored in future audits.
- An audit was conducted using retrospective data from the hospital database of 107 women readmitted to a large Irish maternity hospital following birth by CS to look into the reasons for readmission, management and outcomes for women.
- Abdominal wound infection was one of the most common reasons for readmission of women (n=13, 28.27% (elective) compared with n=26, 42.63% (emergency)).

- The majority of the women required analgesics (n=29, 63.05% (elective) and n=51, 83.61% (emergency)) and intra-venous antibiotics (n=23, 50% (elective) and n=34, 55.74% (emergency)) during their hospital stays.
- The mean length of hospital stay was 2.64 nights (SD=2.24) following elective and 4.61 nights (SD=3.86) following emergency CS.
- The average timeline for readmission of women following CS was 14.6 days (following emergency CS) and 15.7 days (following elective CS).

Background

Clinical audit has been regarded as a valuable asset to examine existing practices with an aim to improve quality of health care in future (Johnston *et al*. 2000). Rising CS rates, with no improvements in maternal and neonatal morbidity, are a global concern (Euro-Peristat 2013), and show considerable between-country variation (Macfarlane *et al*. 2015). Readmission to hospital following birth is considered to be a key indicator of maternal health (Lydon-Rochelle 2000) and has been listed as one of the top ten maternity care core outcome measures in a multinational Delphi survey (Devane *et al.* 2007). Women birthing by CS are more than twice as likely to require readmission to hospital within 30 days of birth, primarily due to wound complications, compared with women birthing vaginally (Lydon-Rochelle 2000, Thompson *et al.* 2002). Readmission to hospital post CS was estimated to increase the cost of health care by 13% compared to readmission following vaginal birth, in a study of 244,088 women, in Massachusetts, US (Declercq *et al.* 2007). Analysis of data from 900,108 births in Canada for the years 1997/1998 and 2000/2001 showed that birthing by CS was associated with a five-fold increase in cardiac arrest (1.9% versus 0.4%), a four-fold increase in wound haematoma (13.0% versus 2.7%), a three-fold increase in infection (6.0% versus 2.1%) and haemorrhage resulting in hysterectomy (0.3% versus 0.1%) and a two-fold increase in anaesthetic complications (5.3% versus 2.1%) (Liu *et al.* 2007) (Canadian Institute for Health Information's Discharge Abstract Database from 1991 to 2005). Increased maternal and neonatal

morbidities are associated with emergency CS as well as when CS is performed without any medical indication (Karlström *et al.* 2013). The total cost of 'excess' CS in 2008, worldwide, was estimated to be approximately 5.4 times the cost of the 'needed' procedures (Gibbons *et al.* 2010).

While CS can potentially have a positive impact for some women and babies (Turnbull *et al.* 1999, Walker *et al.* 2007, Hofmeyr *et al.* 2011, Hofmeyr *et al.* 2015), it must be remembered that, as a major surgical operation, it may have a negative impact on women and babies, influence the overall level of activity of the hospital and incur additional costs. The negative impact on women (in terms of bonding with their new born, their general health, disturbances in settling to a routine life with the new born etc.) can be even further affected by the increased number of readmissions to hospital following birth by CS. The total number of CSs in 2014 according to the national data was 19,545, of which the total number of reported puerperal complications following birth by CS was 3381 (17.3%) (retrieved from Hospital Inpatient Enquiry-HIPE. HPO(2014)) . This audit was conducted to investigate the reasons for readmission of women to one large maternity hospital in Ireland following birth by CS and their outcome in terms of length of hospital stay, investigative procedures and medication management carried out in hospital.

Aim:

To measure and describe the reasons for, and management and outcomes of, women being readmitted to one large maternity hospital following birth by elective and emergency CS

Objectives

1) To ascertain the number of women readmitted to hospital following birth by elective and emergency CS
2) To identify the reasons for readmission to hospital following birth by CS
3) To describe the outcomes of readmission following birth by CS in terms of investigations, medication management and length of hospital stay

Methods

Study design

An audit was conducted in a large Irish maternity hospital to measure and describe the reasons for, and management and outcomes of, women readmitted to the hospital following birth by CS. The audit proposal was reviewed by the hospital's Research Ethics Committee (REC) and, as only anonymised data were used, REC approval was not required. Variables for data collection were agreed and anonymised data were downloaded from the hospital database for a one-year period from 1st August 2014 to 31st July 2015, with help and support from the IT Department.

Setting

The Republic of Ireland has one of the highest birth rates (15%) in Europe (HPO, 2013). Rates for 2013 in three maternity hospitals in Dublin, each with more than 8,000 births per annum, were: 23.1% (O Mahony 2014) for National Maternity Hospital; 28% (Sheehan 2014) for Coombe Women and Infants University Hospital; and 31% (Coulter-Smith 2014) for Rotunda Hospital.

Sample:

The audit was conducted in the month of August 2015, hence it was decided to abstract data for the 12 months preceding this to obtain the most recent information about reasons of readmission and management following birth by CS. The population included all women who gave birth by elective (n=1288) or emergency (n=1182) CS in the study site from 01st August 2014 to 31st July 2015. A total of 6110 women gave birth vaginally during the period of data extraction, of which 155 women were readmitted to the hospital, indicating a readmission rate of 2.5% following vaginal birth compared to a readmission rate of 4.3% following birth by CS. However, the aim of this audit was to focus on readmission of women following birth by CS, hence, women who had vaginal births during the data extraction period were excluded from the audit.

Data collection

Data collected included non-identifying sample characteristics, number of women readmitted to the hospital following elective and emergency CS, the reasons for readmissions, investigations conducted, medication management and clinical outcomes.

Data analysis

Data were analysed using descriptive statistics, with inferential tests used when appropriate. Data abstracted from the hospital data base included information about readmission to hospital and did not include any information about women who attended the hospital emergency department following birth by CS, which limited the findings of the audit to women who were admitted as inpatients only, which may be considered as a bias in this audit.

Results

Sample characteristics

A total of 2470 women birthed by CS (elective (n=1288) and emergency (n=1182)) during the 12-month period of the audit. Forty-six out of a total of 1,288 women who had an elective CS were readmitted (3.6%), compared with 61 out of 1,182 women who had emergency CS (5.6%), a non-significant difference (chi-square=3.37, df=1, p=0.07). The majority (69.57% and 63.93% respectively) self-referred and the remainder were referred by GPs, public health nurses, community midwives or other hospitals (Table 1). Women were admitted at a mean of 14.61 days (SD=14.0) following elective CS and 15.68 days (SD=10.75) following emergency CS.

Reasons for readmission to the hospital

The most common reason for readmission in both groups was infection, including abdominal wound infection, pelvic haematoma, pelvic collection, sepsis and pyrexia of unknown origin (n=13, 28.27%

(elective) compared with n=26, 42.63% (emergency)) (Table 1). The second commonest reason was hypertension following birth by CS (21.74% vs 22.96%). Other reasons for readmission included breast infection, engorgement, abscess, chest infection, suspected pulmonary embolism, endometriosis, endometritis, UTI, renal colic, urinary retention, retained products of conception, postpartum haemorrhage, upper abdominal pain, gastritis, peptic ulcer disease, hepatic collection, headache, dural tap, Bartholin cyst, anxiety, and vomiting (Table 1).

Investigations and procedures performed during readmission to hospital

Almost all women had a full blood count performed (n=42, 91.34% (elective) and n=58, 95.08% (emergency)) and almost all had further blood tests (Table 2). A small number of women did not require any blood tests (n=4, 8.70% (elective) and n=1, 1.64% (emergency)). High vaginal swabs, mid-stream specimens of urine, or wound swabs were taken for culture and sensitivity tests from the majority of women (n=17, 36.96% (elective) and n=37, 60.66% (emergency)), and most had further tests such as chest x-ray or ultrasound scan, Computed Tomography Pulmonary Angiogram (CTPA), ventilation/perfusion lung scan (VQ scan), Electrocardiogram (ECG), etc. (Table 2). This audit is limited to the description of investigations performed and does not involve analysis of the cost implications associated with these procedures.

Medication management during readmission to and discharge from hospital

Three women had no medications administered on readmission to hospital but the majority had analgesics (n=29, 63.05% (elective) and n=51, 83.61% (emergency)) and intra-venous antibiotics (n=23, 50% (elective) and n=34, 55.74% (emergency)) (Table 2) administered. Eleven women had no medications prescribed on discharge, while the majority were prescribed oral antibiotics (n=26, 56.53% (elective) and n=35, 57.38% (emergency)) and oral analgesics (n=13, 28.27 (elective) and n=22, 36.07% (emergency)) (Table 2).

Timeline for readmission to the hospital

The average timeline for readmission of women following CS was 14.6 days (following emergency CS) and 15.7 days (following elective CS).

Length of stay in hospital during readmission

Length of hospital stay was calculated by subtracting the hospital readmission date from the discharge date. The mean length of time women stayed in hospital following readmission was 2.64 nights (SD=2.24) (elective) and 4.61 nights (SD=3.86) (emergency); this difference was statistically significant ($t= 3.0892$, $p<0.01$).

Discussion

The results of this audit show the reasons and outcomes for the 107 women (4.3% of the total number of women who birthed by CS) readmitted to hospital following birth by CS. Analysis indicates that the mean postnatal day at the time of readmission to the hospital was 14.6 days following elective and 15.7 days following emergency CS. A population-based cohort study from Canada using discharge data from 900,108 women reported an increased readmission of women to the hospital following CS (1.8%) compared to spontaneous vaginal births (1.5%) within 60 days after initial discharge (Liu *et al.* 2005), and similar findings were reported by Lydon-Rochelle (2000) in an American cohort, with an increased likelihood of 80% of readmission to hospital within 60 days following birth by CS compared to vaginal births.

The findings of this audit show that the most common reason for readmission of women to the hospital following birth by CS was infection or suspected sepsis (28-43%). Ade-Conde *et al.* (2011) retrospectively reviewed the 236 maternity records of women readmitted within six weeks postpartum during the four-year period from 2005 to 2008, and reported caesarean section wound infection and pelvic collection (47.5%) to be the common reasons for readmission following birth by CS. Lydon-Rochelle (2000), using data from 256,795 women obtained from the Washington State Birth Events Record Database, reported a 30-fold increased risk of readmission to hospital due to

wound infection following CS. Similar findings have been reported by Declercq *et al*. (2007) from analysis of hospital discharge records in Massachusetts from 1998 and 2003. The authors reported a 2.3 times increased risk of readmission to hospital within 30 days following planned primary CS compared to planned vaginal births. The main reasons for readmission following CS were wound complications (6.60 per 1000 births) and major puerperal infections (3.30 per 1000 births). These studies were conducted up to 15 years ago and it is possible that antibiotic regimes in other countries and in earlier times may have been different. The current practice on use of antibiotics in the study site involves intravenous administration of a single dose of Cefuroxime 1.5 mg (from the Cephalosporin group) during planned and emergency CS. More recent research from 14 sites in the UK still found that 9.6% (394/4107) of 4,107 women undergoing CS developed an infection, with 5.8% of them (23/394) readmitted for treatment (Wloch *et al*. 2009).

Some of the other reasons for readmission following CS in Declercq *et al*.'s study (2007) were genitourinary tract infection, inflammatory diseases of the uterus and postpartum haemorrhage. Other authors have also reported wound complications, venous thromboembolism and major puerperal infection the be the most common reasons for readmission to hospital postpartum (Liu *et al.* 2005). The current audit also found readmissions with a diagnosis of breast related infection, gastritis, endometritis, urinary tract infections, pulmonary embolism, etc. A population based prospective cohort study in Netherlands reported an increased risk of postpartum haemorrhage in the second birth for women who had emergency CS compared to those who had planned vaginal birth for their first birth (Kok *et al.* 2014).

In this audit, readmission resulted in an average hospital stay of 2.6-4.6 days, with women following emergency CS requiring a longer stay. As postnatal costs in an Irish maternity unit have recently been estimated at €1,196 per bed-day (Kenny *et al.* 2015), this means that the costs for readmission

for complications post CS are, on average, €4,306 per woman. As almost all women required medications and laboratory investigations, further costs are incurred.

These results demonstrate the rate of readmission of women for complications following CS was 4.3% of the total number of women who birthed by CS. Frequently these issues remain unknown due to lack or limited availability of follow-up data on women's health after childbirth. What is also not known is the impact these health problems have on the women concerned. Kealy *et al.* (2010), in a qualitative study with women within 12 months of giving birth by CS, found that women reported a range of health issues related to physical discomfort, pain, reduced mobility, abdominal wound problems, infection, vaginal bleeding and urinary incontinence. A survey with 971 primiparous women, aimed at determining the association between mode of birth and self-reported postpartum health at 7 weeks postpartum, found lower self-reported general health postpartum in women who had CS and assisted vaginal birth compared to women with unassisted vaginal birth. Some of these self-reported postpartum health indicators were related to physical functioning, mental health, general health perception, bodily pain, social functioning and daily activity (Lydon-Rochelle, 2001).

Conclusion

Investigating and recording readmissions routinely can help identify the occurrence of maternal morbidities at different stages of the postnatal period. Such discussions may help create an awareness of health problems among women and encourage them to seek timely support to mitigate the severity of complications (Borders 2006). This in turn can help healthcare professionals look into better ways of preventing or managing these health problems promptly. This could improve women's overall health and wellbeing, prevent readmission to hospital and separation from their babies and families, and ultimately, reduce costs to the health service.

Recommendations

Further research is needed to explore the occurrence of health problems at different postpartum time points to see if health service provision is adequate in meeting women's postpartum health needs. Ultimately, timely health service provision can, if not prevent, minimise some postpartum health problems. Future audits are needed to examine the cost implications associated with management and care of women readmitted to hospital following birth by CS, and there is a need to compare the outcomes of women following vaginal births with birth by CS. In Ireland, and in many other countries, there is no connectivity between maternity hospital and primary/community care services and caregivers, so there is a need for health professionals to have further discussions about postpartum health with women in the early postpartum days, in order to mitigate complications.

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Variables	Total number of Elective CS (N=1288)	Total number of Emergency CS (N=1182)

Table 1 Referral route and reasons for readmission of women to hospital following birth by CS

Variables	Elective CS- readmission (N=46) 3.57 %		Emergency CS- readmission (N=61) 5.16 %	
	No. of women	Percent (%) of total readmission following Elective CS	No. of women	Percent (%) of total readmission following Emergency CS
	Total number of Elective CS (N=1288)		Total number of Emergency CS (N=1182)	
Referred by				
Self	32	69.57	39	63.93
GP	3	6.53	8	13.11
PHN	2	4.35	8	13.11
Other Hospital	5	10.87	4	6.56
Community midwife	4	8.70	2	3.28
Reason for Readmission				
Abdominal wound infection,pelvic haematoma,pelvic collection,sepsis and/or pyrexia of unknown origin	13	28.27	26	42.63
Hypertension	10	21.74	14	22.96
Breast infection, engorgement, abscess, follicular abscess	5	10.87	7	11.48
Chest infection, suspected pulmonary embolus	5	10.87	5	8.20
Other: headache, dural tap, Bartholin cyst	3	6.53	1	1.64
Endometriosis, endometritis	2	4.35	1	1.64
UTI, renal colic, urinary retention	2	4.35	1	1.64
Retained products of conception	1	2.18	1	1.64
Postpartum haemorrhage	1	2.18	1	1.64
Upper abdominal pain	1	2.18	1	1.64
Anxiety	1	2.18	0	0
Gastritis, peptic ulcer disease, hepatic collection	1	2.18	2	3.28
To stay with baby	1	2.18	0	0
Vomiting	0	0	1	1.64

	Elective CS- readmission (N=46) 3.57 %		Emergency CS- readmission (N=61) 5.16 %	
	No. of women	**Percent (%) of total readmission following Elective CS**	**No. of women**	**Percent (%) of total readmission following Emergency CS**
Blood tests and investigations				
FBC*	42	91.34	58	95.08
CRP*	27	58.70	43	70.49
U&E/LFT/Lactates*	26	56.53	36	59.02
Blood Cultures	8	17.40	14	22.95
Coagulation profile	3	6.53	2	3.28
Blood grouping and/or Cross-match	3	6.53	1	1.64
No tests	4	8.70	1	1.64
Tests and procedures				
HVS/MSU/Wound swab/samples for culture and sensitivity*	17	36.96	37	60.66
Ultrasound	7	15.22	10	16.39
Chest x-ray/ECG*	5	10.87	5	8.20
CTPA/VQ Scan (in general hospital)*	4	8.70	4	6.56
Investigation for hypertension	4	8.70	2	3.28
MRSA Screening*	2	4.35	2	3.28
ERPC*	1	2.18	0	0
Drugs administered on admission				
Analgesic	29	63.05	51	83.61
Intravenous antibiotics	23	50	34	55.74
Antihypertensive	11	19.65	17	27.87
Anticoagulant	7	15.22	7	11.48
Oral/Topical antibiotics	6	13.01	3	4.92
Intravenous fluids	3	6.53	9	14.75
Oxytocic	3	6.53	0	0
Iron supplementation	2	4.35	3	4.92
Antacid (Ranitidine/Losec)/ Antiemetic	1	2.18	3	4.92
None	1	2.18	2	3.28
Drugs prescribed on discharge				
Antibiotic	26	56.53	35	57.38
Analgesic	13	28.27	22	36.07
Antihypertensive	8	17.40	15	24.59
None	7	17.22	4	6.56
Antacid (Ranitidine/Losec)/Iron supplementation/Lexapro/ Eltroxin/Tamiflu/ Hydrocortisone	4	8.70	7	11.48
Anticoagulant	1	2.18	1	1.64

Table 2 Investigations and management of women during readmission following CS

*** Explanations of abbreviations**

FBC: Full Blood Count

CRP: C-Reactive Protein

U&E: Urea and Electrolytes

LFT: Liver Function Test

HVS: High Vaginal Swab

MSU: Mid Stream Urine

ECG: Electrocardiogram

CTPA: Computed Tomography Pulmonary Angiogram

VQ Scan: Ventilation/Perfusion Lung Scan

MRSA: Methicillin Resistant Staphylococcus Aureus

ERPC: Evacuation of Retained Products of Conception