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Early discharge planning : Primiparous women's perceptions of their readiness for going home

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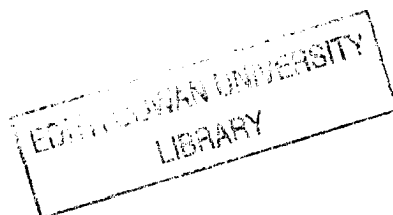
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**EARLY DISCHARGE PLANNING:
PRIMIPAROUS WOMEN'S PERCEPTIONS
OF THEIR READINESS
FOR GOING HOME**

by

Graeme Neil Boardley

A thesis submitted in partial fulfillment of the
requirements for the award of Master of Nursing
at the School of Nursing, Edith Cowan University.



I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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ABSTRACT

Early discharge for women after childbirth was introduced in Australia approximately ten years ago. Early discharge involves going home from hospital within three days of giving birth. Since its introduction, early discharge has been the subject of much debate. Previous research has argued the cost effectiveness and safety of early discharge, but little has been done to examine this phenomenon from the human aspect.

An exploratory study of first time mothers, in an early discharge programme was undertaken to address how these women felt in relation to their readiness for going home. A purposive sample of twenty Caucasian, English speaking women were interviewed in their homes, three weeks after the birth of their baby. Data from personal interviews, telephone follow-up interviews and the researchers observational field notes were analysed using content analysis. Significant statements were extracted from data transcriptions and were clustered into appropriate themes and sub-themes. Validity and reliability was confirmed during data analysis.

The study findings revealed that the 20 participants felt ready to go home from hospital on or before day three. Four key themes emerged from the data: Getting Information and Help for Going Home; Getting Information and Help after Going Home; Caring for Baby; and Own Environment. The conceptual framework developed from the current literature on early discharge was modified to incorporate the themes drawn from the data.

More exploratory-descriptive research on early discharge needs to be undertaken to examine the perceptions of other groups within the community. The experiences of non-English speaking women, single mothers, and adolescents in early discharge programmes need to be explored.

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CHAPTER ONE

Introduction

This was an exploratory descriptive study designed to provide an overview of one of the issues surrounding early discharge of first time mothers. The researcher explored first time mothers' perceptions of their readiness for early discharge from hospital. It was not the purpose of this research to undertake an in depth analysis of the experience of early discharge. It was anticipated that results of this research would identify issues relevant to mothers undergoing early discharge and highlight further questions for future research.

Background

Throughout history, traditions associated with women having babies have undergone constant change. This is particularly so in regards to the length of hospital stay after giving birth. The emphasis has gradually changed from recuperating in hospital to the present situation of finishing the recuperation process at home.

Schmied and Everitt (1996) reported that over the last thirty to forty years in Australia the average hospital stay has decreased from ten days to five to seven days. Brown, Lumley and Small (1995) also confirm that the average length of stay for Australian mothers is currently five to seven days.

Early discharge usually involves discharge within three days after giving birth, but this can vary between two to four days (Brown et al., 1995). Early discharge

was introduced in Australia over the last decade and is a choice for many women who are well and experience uncomplicated pregnancies and postnatal recoveries. The five to seven day average incorporates women with complications, both public and private patients, plus the early discharge women. Therefore, figures for average hospital stays include all women, those who experience caesarean sections and those who leave at three days on an early discharge programme. Women who have a caesarean section can also go home on early discharge, but their length of stay is five days.

The timing of early discharge varies throughout Australia. Brown et al. (1995) in their Victorian study found that one of the difficulties with research on early discharge is that programmes differ in their discharge times. Early discharge programmes vary their discharge time from forty eight hours to as long as four days (Brown et al., 1995). Currently in Perth the standard, early discharge time in all six study hospitals is within seventy two hours or three days after the birth.

Despite the introduction of early discharge, Australia still has traditionally longer hospital stays when compared internationally. Countries such as Canada, America and Great Britain have had discharge times of less than twenty four to forty eight hours since the 1960's (Carty & Bradley, 1991; Lemmer, 1987) and therefore, the community care follow-up in these countries is well established.

It is the timing of the discharge that is of particular importance in the readiness of the mothers for going home from hospital. The researcher had been concerned that discharge within three days does not allow sufficient time to prepare a woman for discharge based on his clinical experience on obstetric wards. This concern is supported by previous literature.

As first time mothers, women are starting a family, which was described as early as 1980 by Knowles as one of the developmental tasks of an adult. Therefore, a readiness to learn is assumed because first time mothers need to learn to be able to cope with this new, real life situation of parenthood (Knowles, 1980). In order to facilitate this learning, the adult learner requires certain conditions such as a suitable learning environment which includes physical comfort (Knowles, 1980). Although Knowles is referring to the actual environment being comfortable, this can also be applied to the physical comfort of the mother recovering from giving birth.

Knowles' (1980) statements regarding the appropriateness of the learning environment highlight a potential concern for first time mothers when Rubin's (1984) two phases of postnatal recovery are considered. In the three days prior to discharge, which Rubin describes as the Taking-in phase, the mother is recovering physically from the birth. During this time she may be disorientated and reliant upon others for help (Rubin, 1984). Rubin (1984) also asserts that the

phase of Taking-hold (4-14 days) is the time when a woman, once physically recovered, is ready to rejoin the adult world and is more likely to be receptive to information.

Given Rubin's assessment of the postnatal recovery period, women in an early discharge programme go home before they are ready to receive information about caring for a new baby. This study set out to explore this aspect, to see how women in an early discharge programme perceived their readiness for going home.

Significance of the study

Postnatal care has had less emphasis placed on it than pregnancy or birth (Schmied & Everitt, 1996). Even women themselves focus on the birth and do not spend enough time preparing for becoming a parent (Schmied & Everitt, 1996).

The birth is only the beginning of the many days, months and years that lay ahead. The first few weeks and months after the birth are often viewed as the most difficult for the new mother. In fact, Percival (1995) has described it as a major life transition or crisis. The many aspects of being a new mother are difficult and Weinberg (1994) describes the overall goal of becoming a new mother as overwhelming. Schmied, Wyllie, Barclay, Everitt and Rogan (1994) also concluded from their research that women do not feel well prepared for their role as mothers when they leave hospital.

Midwives are concerned about whether or not early discharge is appropriate for all women and in particular first time mothers (Lemmer, 1987). The increased responsibility of care, in particular education (both antenatal and postnatal), created by early discharge rests with the hospital midwives (Gillerman & Beckham, 1991). There is less time to prepare the women in readiness for going home on early discharge. This task has been seriously challenged by the shorter hospital stays and increased work loads (Gillerman & Beckham, 1991; Weinberg, 1994). Furthermore, in today's society, customer focus is a high priority and it is essential that midwives are able to meet the needs of the consumers of health care.

The understanding of mothers' perceptions of how ready they were for early discharge has implications for the practice of midwives who are involved in antenatal (formal classes) and postnatal (care on postnatal wards) education. Areas of their preparation for discharge women perceive require attention can be identified for further investigation. It is, therefore, important to gain insight into the women's perceptions of early discharge and of how ready they were for going home, to assess whether the current practice of early discharge is meeting their needs.

Since the inception of early discharge for obstetric patients, praise has been forthcoming for its cost effectiveness and ability to reduce pressure on hospital beds (Keppler, 1995). Patterson (1987)

indicated that the financial benefits of shorter hospital stays was controversial but that it did help to ease overcrowding in hospitals by freeing up beds for other patients. This was evident in the study by Robertson (1996) which revealed a saving of two hundred and ninety three bed days during an eleven month period when compared to the same period in the previous year. This saving was in the first year of the early discharge programme at a major Western Australian regional hospital.

Previous research on early discharge has discussed cost effectiveness, morbidity and mortality, safety and physical recovery. There has been no Australian research published that focuses specifically on women's perceptions of their readiness for discharge. Therefore, the need to explore this human aspect of early discharge has been highlighted.

Purpose of the study

This study set out to explore the human element of early discharge. It examined how ready for going home, first time mothers felt on an early discharge programme, looking back after being at home.

Background of Sample

The women were participants in a larger study entitled 'A comparison of antenatal, birth and postnatal experience of women who gave birth in hospitals (longer stay and early discharge) and birth centres', conducted

at Edith Cowan University by Dr. Patricia Percival. The larger study sample of approximately 600 women was recruited from 12 public and private Western Australian hospitals. The sample for this current research was taken from the larger study but included mothers from only six public hospitals, as private hospitals do not have early discharge programmes.

At the time of being interviewed the women had not completed the hospital postnatal care questionnaire from the larger study. They had been sent one questionnaire on antenatal care and birth, but had received nothing on early discharge planning which might have affected the findings of this research. This study explored in detail the early discharge perceptions of a small group of the 600 women recruited to the larger study.

Research question

How did primiparous women perceive their readiness for early discharge from hospital?

Definition of terms

Antenatal Education - refers to education during pregnancy (formal antenatal classes or personal reading) which has been specifically aimed at preparing the woman for early discharge. Preparation also includes detailed information of the expected discharge, such as day and time.

Attitude - is the woman's individual feelings toward early discharge. One factor which may influence

this is whether or not the discharge arrangements were voluntary or involuntary.

Birth Experience - relates to the woman's perception of her birth experience which involves events such as - length of labour, pain, type of birth, and physical trauma (episiotomy, tears).

Postnatal Education - refers to the education given, in the hospital, to the woman following the birth of her baby in preparation for her discharge.

Primiparous Woman - a woman who has given birth for the first time.

Formal Support - refers to the availability of the professional support of a domiciliary midwifery service, child health nurse, and the woman's own general practitioner.

Informal Support - refers to the mother's non-professional support of family and friends.

Readiness - refers to how prepared the women felt for going home in an emotional, physical and informational sense.

Structure of the Thesis

Chapter one introduced the research topic and discussed the background and significance of the problem. The purpose of the study together with the research question and definition of terms were outlined.

Chapter two contains the review of literature and the conceptual framework which was formulated from the literature. Chapter three describes the research method used, including the design, sample, data collection and analysis. This chapter also includes limitations of the study, ethical considerations and researcher bias.

Chapter four presents the study's findings. Chapter five includes the discussion of these findings in relation to current literature, the conclusion of the study, implications for clinical practice and recommendations for future research.

CHAPTER TWO

Review of Literature

This chapter presents a review of the literature on issues associated with early discharge. The conceptual framework, formulated from this literature review is presented at the end of the chapter. The literature is reviewed and presented in two main sections. The community issues of early discharge are outlined, as are the individual issues of early discharge.

Community issues of early discharge

Several topics relating to the general community as a result of the early discharge of obstetric patients, have emerged from the literature. These topics include economic issues of early discharge, effects of reduced length of stay in hospital, and morbidity related to early discharge.

Economic issues of early discharge

Since its introduction in Australia in the 1980's early discharge has been the subject of some debate. According to Keppler (1995), shortened hospital stays were introduced to reduce health care costs, which is a strategy health professionals have embraced (Hall & Carty, 1993). Norr, Nacion and Abramson (1989) suggested however, that although early discharge is assumed to save money, there has been very little published to substantiate this point.

Two Australian studies evaluated the financial benefits of early discharge. Shorten (1994) conducted a comparative cost analysis between early discharge and traditional hospital stay. The cost advantage of early discharge was \$344.30 per person. However when the costs of servicing the community (cost of a car for the domiciliary follow-up, running the car, goods and services) were considered the saving was reduced to \$37.75 per person. Although a limitation of this study was unequal sample sizes, with 177 early discharge women and 363 traditional stay women, the savings calculated per person are relevant.

Similarly, Scott (1994) performed a cost analysis comparison between early discharge with domiciliary visits and standard hospital care of low risk women. This study was carried out at three hospitals in New South Wales with women in each group from each hospital. The results revealed that the ability of early discharge to generate savings was limited due to the domiciliary visits.

Whether early discharge saves money or not is only one issue of concern and will remain a subject of debate requiring more research. A more important aspect of early discharge is the human cost. The human cost is particularly relevant when the decreasing length of hospital stay is taken into account.

Effects of reduced length of stay

Over the last decade, obstetric patients have been discharged from hospital progressively earlier. In a study evaluating an early discharge programme in a large regional centre in country Western Australia, Robertson (1996) initially reviewed the average length of stay for obstetric patients in four Perth metropolitan hospitals. The average length of stay had fallen from 5.37 days in 1989 to 2.82 days in 1995. In a study hospital, chosen for the second phase of the research, the average length of stay after just eleven months also fell from 4.15 days to 3.59 days (Robertson, 1996). This trend towards shorter postnatal stays is supported by Day, Lancaster and Huang (1997) who found, in an Australia wide statistical survey in 1994, that 31.9% of mothers were discharged before day 4 compared to only 20.2% in 1991.

These figures provide evidence that in Australia the average length of hospital stay has decreased significantly in recent years. With the average length of stay becoming progressively shorter each year, concern increases for the well being of the patients who are going home earlier. It is, therefore, necessary to review the morbidity associated with early discharge.

Morbidity associated with early discharge

Despite the women and their infants having less time in hospital with early discharge, there has not been an increase in maternal or perinatal morbidity. Three Australian studies conducted have revealed that

women in early discharge programmes suffer no more physiological or psychological harm than women who have longer hospital stays.

James et al. (1987) in a quasi-experimental study of parallel groups comparing early discharge women and traditional 5-7 day stay women, found no increase in morbidity in the early discharge group. The women in this study, conducted in Sydney, were allocated to each group by their choice with the early discharge group reporting a more favourable postnatal adjustment than the traditional stay women. This result must be accepted with caution because there was potential bias due to the women choosing which group they would be in, but this was thought necessary by the researchers for the purpose of the research.

Small, Lumley and Brown (1992) performed a postal survey of 773 women in Victoria, Australia. One of the conclusions made was that there was no increase in post partum depression of early discharge women. This study was repeated by Brown et al. (1995) with a larger sample of approximately 1400 women with similar results.

Several international studies have investigated the morbidity associated with early discharge. Norr and Nacion (1987) conducted a review of early discharge programme outcomes in America and found that there was no increase in maternal or infant morbidity. Lemmer (1987), in a quantitative comparison of 21 early discharge women to 21 longer hospital stay women in America, agreed with the finding that there was no

significant difference in medical problems between groups. This study is significant to the current research as all women were primiparous women. However, the sample groups were small ($n = 21$) for a quantitative study making generalisations difficult.

Beck, Reynolds and Rutowski (1992) carried out a correlational study in a midwestern American hospital. The study compared the relationship between maternity blues and post partum depression in early discharge women and traditional hospital stay women. All women were privately insured and primiparous. Thirty six traditional stay women and 13 early discharge women were studied. The findings revealed no significant difference between the groups and it was, therefore, concluded that early discharge women were psychologically safe. However, the discrepancy between sample numbers and the small number in each group casts doubt over the generalisability of this study.

In the review by Norr and Nacion (1987) all American early discharge programmes had some form of follow-up. This follow-up was assumed by the researchers to have helped prevent problems once the women were discharged and therefore reduced the morbidity.

In terms of the community issues early discharge appears to be successful. Cost effectiveness, reduced length of hospital stay, and no increase in morbidity associated with early discharge have been credited as being advantages of early discharge. There still remains the human aspect to be explored. Literature which

examines the individual issues of early discharge was also reviewed.

Individual issues associated with early discharge

The human aspect of first time mothers' perceptions of their readiness for going home from hospital is the subject of the current research. Previous literature associated with human aspects of early discharge has revealed several individual issues which will now be discussed.

Mothers as adult learners

As early as 1980, becoming a mother was identified as one of the development tasks of an adult (Knowles, 1980). Learning for the adult involves immediate application in response to a new or current life situation. Adults view education or learning as a way of improving their ability to cope with a problem.

A readiness to learn is, therefore, assumed because first time mothers need to learn to be able to cope with a new, real life situation (Knowles, 1980). In order to facilitate this learning the adult learner requires a number of conditions, as listed by Knowles (1980).

1. Learners feel a need to learn.
2. Learning environment is characterised by physical comfort, trust and respect, helpfulness, freedom of expression and acceptance of differences.
3. Learners accept a share of responsibility for planning the learning experience.
4. Learners participate in the learning process.

One of the conditions required for the adult learner is a suitable learning environment which includes physical comfort (Knowles, 1980; Knowles, 1989; Merriam & Caffarella, 1991). Although Knowles and Merriam and Caffarella are referring to the actual environment being comfortable, this can also be applied to the physical comfort of the mother who is recovering from giving birth.

Adults do not need to be taught. Adults need to be directed to learn for themselves, what they want or need to learn. It is not as important to teach adults everything as it is to provide a means for them to access the information when they require it (Knowles, 1980; Knowles, 1989). Richness and accessibility of resources, both material and human, are crucial to effective learning (Knowles, 1989).

One of the tasks of entering into adulthood is becoming a parent (Knowles 1980). This new family life role is one of the reasons why adults seek greater learning (Merriam & Caffarella, 1991). Therefore, it is essential that adult learning literature is considered when discussing the education needs for women on an early discharge programme.

Education needs for early discharge

There is cause for concern with first time mothers, when Rubin's (1984) two phases of postnatal recovery are taken into consideration together with Knowles' (1980) conditions for learning. During the three days prior to

discharge the mother is recovering physically from the birth (Rubin, 1984). This phase which Rubin calls Taking-in, is where the mother may feel disorientated and be reliant upon others for help (Rubin, 1984). The phase of Taking-hold (4-14 days) is the time when a woman, once physically recovered, is ready to rejoin the adult world and is more likely to be receptive to information (Rubin, 1984).

Rubin's (1984) assessment of postnatal recovery, suggests that in an early discharge programme, women go home before they are ready to receive information about caring for their baby. Regan and Lydon-Rochelle (1995) described Rubin's Taking-hold phase as the period for learning, which in the case of an early discharge mother is after she has been discharged from hospital.

Regan and Lydon-Rochelle's (1995) American study was a quantitative comparison of the postnatal education of early discharge mothers and longer hospital stay mothers. Regan and Lydon-Rochelle (1995) identified problems with low reliability of their study's instrument, but still raised some valuable discussion points. One conclusion of particular importance was that trying to teach the new mother all she needs to know in the shorter postnatal period is not possible. Keppler (1995) in a review of follow-up care in a hospital-based clinic in America, agreed that mothers are leaving hospital just as they are beginning to learn about parenting.

McGregor (1994) who wrote a commentary on how one American hospital dealt with the changes brought about by early discharge, says that education of a new mother must begin before she gives birth. This view is supported by Lemmer (1987) who suggested that easing the transition into the parenting role needs to start antenatally, because the shorter hospital stay does not allow sufficient time to educate the women. During this shorter stay, the new mothers are bombarded with information and they find it difficult to absorb it all (McGregor, 1994; Weinberg, 1994).

A descriptive approach was used by Ruchala and Halstead (1994) to investigate the postnatal experiences of low risk women after discharge in America. The findings of this research suggested that the problems women experienced were attributed to the small amount of time they were given to recuperate in hospital. Primiparous women in particular had difficulty and gave negative responses in a number of areas associated with lack of knowledge and lack of experience in infant care. Ruchala and Halstead (1994) concluded that health care in the area of educating mothers needed improvement.

Weinberg (1994) describes the overall goal of becoming a new mother as overwhelming and believes the many aspects of being a new mother are difficult to grasp. In a review of post partum visits, Weinberg (1994) described these aspects as baby care, mastering breast feeding and understanding bodily changes as being important for new mothers. Garcia, Renfrew & Marchant

(1994) concluded from a postal survey of all the 189 midwifery directors in the English Health Service, that providing more health education and information about mother and baby care including feeding, baby bathing and perineal care was required.

Gillerman and Beckham (1991) applied a case management process to early discharge at an American hospital, and claimed that accountability has changed. With the administrative control of length of hospital stay, midwives have a much shorter period of time in which to prepare the women for discharge. This task has been seriously challenged by shorter hospital stays and increased work loads (Gillerman & Beckham, 1991; Weinberg, 1994).

Literature has shown that mothers are being discharged from hospital earlier which places greater pressure on hospital midwives to try and educate them before they go home. This is particularly a cause for concern when, as Rubin (1984) points out, the mothers are still recovering from giving birth.

Recovering physically on early discharge

Several studies have looked at the issue of recovering from the birth and how this is affected by early discharge. Keppler (1995) suggested in her review that many women leave hospital before they are ready to go, and do so whilst they are still recovering physically from the birth.

In a prospective, quasi-experimental study of fatigue and functional ability, Smith-Hanrahan and Deblois (1995), found no significant differences between three study groups up to six weeks post partum. The women in these study groups all gave birth in a Canadian tertiary hospital. However, some subjects were transferred between groups during the study, posing potential concerns with generalising these findings.

Waldenstrom (1989) conducted a quantitative comparison of voluntary versus involuntary early discharge in Sweden. She found that the women discharged involuntarily had more problems such as fatigue than the voluntarily discharged women. Lemmer (1987) in an American study of primiparous women reported that mothers who opted to stay in hospital rather than for early discharge, did so because of concerns for their health and recovery. The need for rest was also listed as a reason for not going on an early discharge programme.

Ruchala and Halstead (1994) revealed from their qualitative descriptive study that the overwhelming majority of American women in their sample group blamed their fatigue and physical discomfort on the small amount of time they had to recuperate in hospital. On the other hand Campbell (1992) in a quantitative predictive study in a Canadian urban hospital, found that women on early discharge preferred to recuperate in the relaxed environment of home.

Literature is divided on whether recuperation in hospital or at home is better. However, the majority of research reveals that women feel that going home early from hospital contributes to an increase in fatigue and discomfort. It is important, therefore, that mothers have adequate support at home when they are discharged from hospital.

Support for early discharge mothers

Early discharge is believed to work very well if there is adequate support (emotional, physical and informational) for the woman when she gets home (Brown et al., 1995). The knowledge that support is available enhances the confidence of women and enables them to take control (Hall & Carty, 1993). The need for adequate domiciliary support was expressed by Lemmer (1987). In her American study Lemmer (1987) commented that among other issues, a home visiting service that provided assistance with feeding and parenting skills needed to be developed.

Most, if not all, early discharge programmes in Australia now have domiciliary support and Brown et al. (1995) found that having this support made a difference to how women felt when they left hospital. Domiciliary care, or care at home from a qualified midwife, means the women have the midwives' undivided attention during their daily visit (Kenny, King, Cameron & Shiell, 1993). Regan and Lydon-Rochelle (1995) state however, that the midwife must use the time wisely as competing with

telephones, visitors, the need for sleep and television for a new mother's attention is often difficult.

The issue of support was the subject of an exploratory study of first time English mothers, in an early discharge programme, in the three months after birth. This study focused on the support of family and friends. Rubin's phases of motherhood were used as the basis for the study, which concluded that some new mothers found that visitors in their efforts to help, often overstayed their welcome and aggravated their feelings of tiredness (Herbert, 1994). The sample size for this study was small ($n = 24$) but it raised the interesting point of visitors being a hindrance and the women needing to control the visits.

Hall and Carty (1993) using a grounded theory approach, discovered that early discharge women liked to be able to take control over their post partum recovery. The eight Canadian women, including primiparous and multiparous women, reported that the knowledge of support being available enabled them to take control. Once the women knew that they were going home early they arranged for their family and friends to be available to help when they came home. This preparation resulted in confidence that their home environment would be ready for their return and enhanced their control.

In a phenomenological study of self-reported family health and well-being of 12 mothers after early discharge from a maternity hospital in Finland, Paavilainen and Astedt-Kurki (1997), found that women

could achieve control of their post partum recovery once they were at home. This study also revealed that the mothers felt safer at home and that home provided a protection, peace and freedom which was not available in the hospital.

Support is important to all mothers going home on an early discharge programme. However, it is important that the women are able to maintain control of the available support in order to achieve a satisfactory transition into motherhood (Hall & Carty, 1993).

Satisfaction with early discharge

Several studies, both Australian and international, have looked at client satisfaction with postnatal care with the result that most women in early discharge programmes have a greater level of satisfaction. Kenny et al. (1993) performed a quantitative comparison of client satisfaction with postnatal care in three hospitals in Sydney, Australia. The two groups compared were early discharge with domiciliary follow-up and hospital care until discharge. The domiciliary visits for the early discharge group continued for seven days. The women were grouped according to their choice. Women choosing early discharge rated their satisfaction with postnatal care higher than those with hospital care. A significant finding for the primiparous women was that they reported a very high level of satisfaction in comparison to the multiparous women.

Small et al. (1992) in another Australian study found that women in early discharge programmes felt their stay was about the right length and were more likely to feel confident about looking after their baby. Brown et al. (1995) agreed with these findings when they repeated this study with a larger sample size.

Internationally, the level of satisfaction for women in early discharge has been reported to be the same as in Australia. Patterson (1987) conducted a comparative study of low risk American women in both early discharge and traditional discharge. The traditional stay group was made up of women who were all eligible for early discharge but chose to stay longer and included significantly more primiparous women. Patient satisfaction with their care rated highly for both groups, however, the longer stay group listed rest, sleep and a quiet atmosphere as a reason why they chose to stay in hospital. This finding is contrary to other studies, where the women have chosen to go home for better rest and sleep.

Norr et al. (1989) in another quantitative study of low income mothers in America, performed a three group comparison for early discharge. The groups studied were early discharge of mother and baby, early discharge of mother with baby staying in hospital, and traditional discharge. The mothers in the early discharge group who went home with their baby had the greatest level of satisfaction.

In a review of early discharge patients' records over three years, from an American Air Force Academy hospital, Rhodes (1994) found there was improved patient satisfaction. This greater level of satisfaction was also supported in a Canadian comparative study between early discharge and traditional stay. Carty and Bradley (1991) conducted a group comparison and found similar findings in that the early discharge women were more satisfied with their care than the traditional stay women.

However, satisfaction with early discharge depends upon whether or not it is voluntary or involuntary. Women who go home on early discharge voluntarily are more satisfied than those who are discharged involuntarily with some hospitals discharging women routinely on early discharge (McGregor, 1994; Schmied & Everitt, 1996; Waldenstrom, 1989). Baafi (1995) conducted a quantitative prospective study examining reasons for participation or non-participation in an early discharge programme. The study was conducted in one hospital in Woollongong over a 50 day period with all mothers giving birth being recruited. One of the main reasons some women did not participate was that they were primiparous.

Literature has shown that satisfaction with going home from hospital was higher for women on early discharge programmes than those who have a longer hospital stay (Carty & Bradley, 1991; Kenny et al., 1993; Small et al., 1992). Also revealed was that

primiparous women were more satisfied with going home early than multiparous women (Kenny et al, 1993).

Summary & Conclusion

The literature has revealed several issues associated with early discharge. Both advantages and disadvantages of going home early were reported.

Early discharge has many advantages which have been reported throughout the literature. The individual aspects that are advantageous are: privacy (Kenny et al., 1993; Paavilainen & Astedt-Kurki, 1997), the father and siblings getting to know the baby (Campbell, 1992; Patterson, 1987), a more natural setting (Waldenstrom, 1989), the opportunity to establish a routine (Baafi, 1995; Kenny et al., 1993) and the women having greater confidence in providing infant care (Carty & Bradley, 1991). Community advantages reported are cost effectiveness (Hall & Carty, 1993; Keppler, 1995; Shorten, 1994) and a reduction in the average length of hospital stay (Day et al., 1997; Robertson, 1996). There has also been no increase in morbidity associated with early discharge (Brown et al., 1995; Small et al., 1992).

Disadvantages of early discharge are also reported. One issue was the reduced amount of time in which midwives have to prepare mothers for discharge (Gillerman & Beckham, 1991; McGregor, 1994; Weinberg, 1994). The second issue was the reduced amount of time

in which the women can recuperate before going home (Lemmer, 1987; Ruchala & Halstead, 1994).

In conclusion most of the studies have been of a quantitative nature, with some combining both quantitative and qualitative methods. The qualitative studies reviewed varied in their approach to the human elements of early discharge. None of the literature focused on the women's perceptions of their readiness for going home on an early discharge programme.

Hall and Carty (1993) explored the perceptions of the women's experiences of being at home after early discharge but not how ready they felt to go home. There has been no exploratory Australian research published that examines the perceptions of mothers' readiness for home when involved in an early discharge programme.

Therefore, there is a need to explore how ready to go home women felt on early discharge. Primiparous women in particular have been choosing longer hospital stays (Baafi, 1995; Lemmer, 1987; Patterson, 1987) and have been specifically chosen as the group to be studied for this research. Primiparous women are also the group with the greatest need for information and support.

Conceptual Framework

The central focus of this research study was the individual perceptions of primiparous women with regard to readiness for early discharge. A conceptual framework was therefore developed around potential influences that were identified from the review of literature. These potential influences (as defined in the definition of terms) will now be discussed. This discussion is followed by Figure 1, the conceptual framework.

Education

Knowles (1980) identified becoming a mother as one of the development tasks of an adult. A readiness to learn is therefore assumed so that the new mother can cope with the new situation. The readiness to learn means there is a need to be informed and this education takes place in two phases - antenatally and postnatally.

Antenatal education

Lemmer (1987) suggests that easing the transition into the parenting role needs to start antenatally. This is supported by McGregor (1994) who believes that the education of a new mother begins before she gives birth.

Education in the antenatal period is made all the more necessary given the shorter hospital stays as a result of early discharge. The shorter stay in hospital makes it difficult for midwives to teach the new mother

all she needs to know (McGregor, 1994; Regan & Lydon-Rochelle, 1995; Weinberg, 1994).

Postnatal education

Postnatal education is given at a time when the woman is recovering physically from the birth which according to Rubin (1984) is a time when she may be disorientated. Rubin (1984) asserts that the woman is ready to receive information four days after giving birth. This is now after the woman has been discharged and Keppler (1995) states that they are just beginning to learn about parenting when they go home.

Birth experience

Literature reveals that the women focus on the birth as the climax and very little preparation is done in terms of going home (Percival, 1990; Schmied & Everitt, 1996). The recovery from the birth and resultant physical discomfort can greatly affect the new mothers ability to learn (Keppler, 1995; Knowles, 1980; Rubin, 1984). Women are also leaving hospital with sore perineums or incisions (Hampson, 1989; Williams & Cooper, 1993).

Support

Early discharge is believed to work very well if there is adequate support for women at home (Brown et al., 1995). Knowing that they have family and friends as well as professional agencies to help them greatly

enhances the women's confidence and enables them to take control (Brown et al., 1995; Hall & Carty, 1993; Kenny et al., 1993; Lemmer, 1987). Support has been separated into two categories - formal support and informal support.

Attitude to early discharge

The attitude of the woman to early discharge can depend on whether she is going home voluntarily or involuntarily. Women who go home on early discharge voluntarily are more satisfied than those women who are discharged involuntarily (Baafi, 1995; McGregor, 1994; Schmied & Everitt, 1996; Waldenstrom, 1989).

Consideration was also given to the influence of an unsettled baby compared to a settled baby and the effect that would have on the mothers' perceptions. This factor was not mentioned in the literature relating to early discharge planning and has therefore not been included in the conceptual framework.

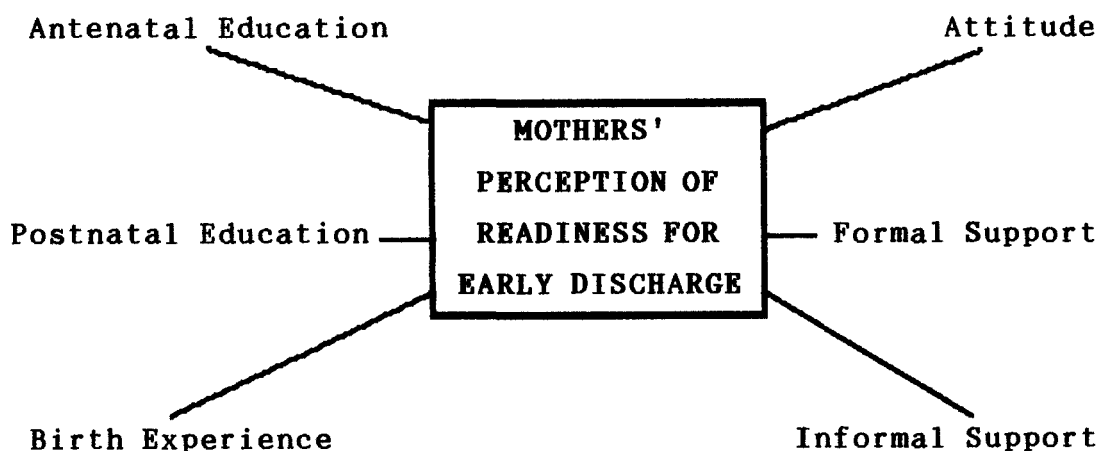


Figure 1 - Conceptual framework.

Chapter three discusses the research methodology, and ethical considerations used to guide this study.

CHAPTER THREE

Methods

This chapter will: outline the research design used; present the criteria used to select the participants; discuss the development of the semi-structured interview guide; and describe the data collection procedure, data analysis and issues of rigour. Ethical considerations and a discussion of researcher bias are also outlined.

An exploratory descriptive research methodology was chosen for this study as the researcher was seeking to describe and analyse first time mothers' perceptions of their readiness for early discharge. It was the intention of this research to add to the body of nursing literature examining the human experience of early discharge from hospital. Qualitative research provides insight into the 'how' and the 'why' of human behaviour (Swanson & Chapman, 1994), which helps to make sense of people's experiences and lives (Boyd, 1993). Human behaviour cannot be evaluated by using true/false or Likert scale responses to a questionnaire (Swanson & Chapman, 1994). Qualitative research in nursing is interested in subjective meanings and not just facts alone (Boyd, 1993), and gives promise to the health of the population served by nurses (Swanson & Chapman, 1994).

There are no published studies that explore the perceptions of women of their readiness for going home

in early discharge programmes. Therefore, as this area has not previously been addressed in the literature, an exploratory design was chosen for this research.

Design

A descriptive exploratory research design was used for this study. By its very nature qualitative research is applicable to nursing practice (Swanson & Chenitz, 1982). Bunckers, Petardi, Pilkington and Walls (1996) believe that qualitative research can be implemented to consistently expand nursing knowledge.

Qualitative methods allow the researcher to explore selected issues in depth and detail (Patton, 1990). Patton (1990) further asserts that studies conducted without the constraints of predetermined analytic categories add to the depth, openness and detail that is qualitative research. Qualitative researchers value the deep understanding permitted by information rich cases (Sandelowski, 1995).

Artinian (1988) states that the descriptive mode of qualitative inquiry allows for understanding of a life situation. Too (1996) believes that qualitative research is relevant to any study that aims to discover and recognise the richness of human experiences.

Content analysis was used for the data analysis because of its suitability to human communication and the ability to reveal interesting and useful information without losing original data (Downe-Wamboldt, 1992). The major themes and categories that emerge through content

analysis of the raw data are the fruit of qualitative inquiry (Patton, 1990).

This design was most appropriate for this research because of the exploratory nature required in this unresearched area. There is a great deal of research about early discharge, but not in relation to mothers' perceptions of how ready they were for going home following early discharge.

Sample

According to Robley (1995), persons who are selected as research participants should be those who serve the research purpose. Selection should involve the inclusion of those whose voices need to be heard (Robley, 1995). Primiparous women were chosen for this study because it was felt that they would be the group most in need of assistance, having had no previous experience at being a mother.

A purposive sample of twenty women, who met the following criteria, were interviewed by the researcher:

- * Primiparous;
- * Singleton birth;
- * Baby greater than 37 weeks gestation;
- * Baby's birthweight greater than 2,500 grams;
- * English speaking;
- * Participant in an early discharge programme; and
- * Discharged within seventy two hours of the birth.

The participants were recruited from six public hospitals with early discharge programmes in and around the Perth metropolitan area. The women were from the larger study being conducted at 12 public and private hospitals. Private hospitals do not have early discharge programmes. Early discharge in the study hospitals involved a post partum stay of greater than four to six hours up to a maximum stay of seventy two hours.

Only women with uncomplicated pregnancies who lived in the hospitals' intake areas were accepted by the hospitals. Therefore, women who gave birth at these hospitals were offered the opportunity to be included in the early discharge programmes. Each hospital services an area within thirty minutes travelling time from the hospital, or within certain suburban boundaries. There were no other criteria by which suitability for inclusion into the early discharge programmes in the study hospitals was made.

Instrument

A semi-structured interview guide (Appendix A) was utilised with each study participant. The instrument was developed by the researcher from a review of the literature on early discharge, in consultation with two other midwife/researchers. A list was developed of twelve open ended questions, designed to explore early discharge from the mothers' perspective. The interview guide was based on the concepts of the conceptual framework to ensure that information obtained from the

respondents enabled exploration of the issues that illustrate the topic (Patton, 1990). The mothers were also given the opportunity to raise other issues that were important to them. The list of questions was reviewed on two occasions by the researcher and the two midwife- researchers resulting in overlapping questions being reworded and combined. The final eight questions were then discussed again and presented at a seminar to fellow students and staff for further feedback.

A pilot study of three women was conducted to assist in further development of the researcher's interview skills. The relevance of issues covered by the interview guide for this study was verified by three midwives. No adjustments were necessary to the interview guide as the pilot study data confirmed that the interview guide was relevant to the intent of the research.

Procedure

Potential participants were identified from a larger study entitled 'A comparison of antenatal, birth and postnatal experience of women who gave birth in hospital (longer stay and early discharge) and birth centres', conducted at Edith Cowan University by Dr. Patricia Percival.

During the recruitment period in the larger research some of the study hospitals were initially experiencing a quiet period and had encouraged their patients to stay in hospital longer if they didn't feel

ready to go home. This then meant that several women no longer met the study criteria. The researcher was provided with women's names from the larger study, a few days after they had given birth, who were participants in early discharge programmes. Forty six women's names were eventually given to the researcher. All women were contacted approximately ten days after the birth to ascertain whether or not they met the study criteria. Twenty eight of the 46 women met the study criteria. Six women were excluded from the study because they stayed in hospital beyond their expected early discharge date. Twelve women were excluded because they were not primiparous. Seven of the mothers contacted refused to participate in the study and one woman, who did not have a phone, did not reply to the letter sent to her.

For the willing participants, interviews were arranged at a time convenient to each participant. Further contact was made by telephone to each participant on the day of the arranged interview to ensure that they were still willing to be interviewed. Informed written consent (Appendix B) was obtained prior to the commencement of each interview. Participants were given a copy of the consent form/information sheet which also contained contact names and telephone numbers of the researcher and one of his supervisors.

Saturation of data occurred after 17 interviews but three more interviews were conducted to ensure full and rich data were obtained. The final three interviews served to confirm that saturation of data had occurred.

More women were available to be recruited from the larger study if this had been required to clarify any issues that had arisen during the initial interviews.

Individual interviews were arranged and conducted at about three weeks post partum. Only one interview took place later, that being three months, because the participant, though keen to be involved, cancelled the arranged time on several occasions. Face to face interviews help to reduce ambiguity in questions because the interviewer was able to clarify any issues and to further prompt the interviewee to elaborate if required (Appleton, 1995).

The mothers were interviewed as soon as possible after waiting at least two weeks after discharge, so that the initial period of going home was recent in their minds. This time factor is important as it allows for minimal distortion of memory but enables the mother and baby to have settled into their own home (Too, 1996).

Time was taken to establish rapport with each participant, especially in view of the fact that the researcher was male. The women were informed on the initial phone contact that the researcher was a midwife. This was again confirmed on the consent form/information sheet (Appendix B).

Each interview took approximately thirty minutes to complete and was conducted in the participants' homes because home interviews remove the influence of the hospital environment and encourage greater disclosure of

information (Too, 1996). The home environment also helps to put the participant at ease.

The interviews were audiotaped. Appleton (1995) believes that reliability is increased by the use of a tape recorder to record interviews. The audiotaped data was transcribed verbatim (Appendix C) into written form for ease of data analysis. Brief field notes (Appendix D) were made immediately after each interview (in the car to decrease recall bias) on the mother/child interaction and non verbal behaviours of the women. These notes served to assist in the formation of categories for the eventual data analysis. Field notes are descriptive, contain what the observer/researcher has observed and enable the researcher to return to that situation during data analysis (Patton, 1990). Eight follow up telephone interviews were conducted to clarify and expand on some of the issues raised in the initial interviews.

It should be noted that the researcher is not affiliated with any of the six study hospitals and the participants were informed of this. There was no contact between the participants and the researcher during any of the hospitalisations.

Data analysis

A content analysis of the information collected from the interviews was undertaken. Content analysis is well suited to this research because of its focus on human communication (Downe-Wamboldt, 1992). Downe-

Wamboldt (1992) further asserts that content analysis has the ability to reveal interesting and theoretically useful information without loss of original data.

Content analysis is a process of systematic and objective analysis of written, verbal or visual data so that tabulation, classification, summary and comparison of the contents can be performed. The data is coded or clustered into categories, which are homogeneous, inclusive, mutually exclusive, exhaustive and useful (Downe-Wamboldt, 1992; Patton, 1990).

The data were analysed by grouping the responses from each question from the interview guide (Appendix A), coding and forming categories of common themes. These categories were then compared with other responses and once again common or similar categories were linked to form distinct themes. These categories together with the field notes made immediately after each interview and the notes made on each of the transcriptions (see Appendix C) were compiled to form the final themes.

It is important that the developed category system is true to the analysed data, and that each category should come from the transcriptions and offer a true summary of the interview data (Burnard, 1994). Two methods of checking the validity of the categories are: returning to some of the study participants, showing them the findings and discussing the interpretations; and by asking a colleague or another researcher to develop their own categorisations and compare them to

those developed by the researcher (Burnard, 1994). This study was validated by both of these methods.

Rigour

Rigour in qualitative enquiry is achieved when the research exhibits credibility, fittingness, auditability and confirmability (Sandelowski, 1986). Beck (1993) asserts that scientific merit of a research study is able to be appreciated once these criteria are met.

The analysis of data was validated by three midwifery colleagues and fellow researchers who analysed some of the transcriptions. From this validity process similar themes to those described by the researcher emerged. This exercise demonstrated that the study's findings were auditable (Beck, 1993; Sandelowski, 1986). Auditability is achieved when another researcher is able to follow the audit trail (see Appendix E) of the study's investigator (Sandelowski, 1986).

The transcriptions of three interviews and the summary of themes were taken back to the respective participants for discussion. Each of the three participants confirmed that the transcriptions were a true record of what they had said and that the themes and analysis of their own interviews gave a true reflection of their experience. This member checking served to demonstrate credibility of the analysis of the data. Qualitative research reaches credibility when the human experience being described by the researcher is recognised by the people having that experience as their

own (Beck, 1993; Sandelowski, 1986). Beck (1993) further states that the criterion of fittingness is also reached when the participants in a study view the findings as meaningful and applicable to their experience. This credibility, auditability and fittingness are demonstrated during the analytic process. As a result, confirmability of the research findings was achieved (Sandelowski, 1986).

Limitations of the study

It is possible that some of the sparser interviews may have been due to the researcher being male and the women not wishing to share too much of their experience. However, this did not appear to be a hindrance and the mothers were aware of this prior to making the interview arrangements. The purposive nature of the sample and the small sample size ($n = 20$) prevents generalisability of the findings, however the results are potentially transferable to groups of women with similar characteristics.

Ethical considerations

Ethical approval for this study was obtained from the Ethics Committee of Edith Cowan University. Approval from the Ethics Committees of the six hospitals was granted as part of the larger study approval. At the time of the initial recruitment to the larger study all women were informed that they may be approached with a request to be interviewed. They were also informed that

they were not obliged to take part in this interview as it was not part of the larger study.

Participants in this research did so on a voluntary basis and were informed that they could have withdrawn at any time. When being recruited to the larger study participants gave permission for their names to be forwarded to the researcher. A brief explanation of the study was given to each participant by the researcher on the initial telephone contact. A full explanation of the study was given and written consent (Appendix B) was obtained at the participants' home prior to commencement of the interview.

Participant information was coded and this list was kept separate from the coded audiotapes and transcribed data. The transcribing was performed by a qualified typist and she was made aware of the need for confidentiality. The tapes were coded and no names were used prior to forwarding the tapes to the transcriber. All discs, tapes and transcripts were returned and remain in the sole possession of the researcher. The tapes and transcriptions will be kept in separate locked cupboards and stored for five years. The tapes will then be erased and the transcripts incinerated.

Should any participants have identified a problem during the course of the interviews, they would have been referred to one of the following agencies: Ngala; Nursing Mothers' Association of Australia; a Child Health Clinic; or their General Practitioner. However,

no such problems were identified during the course of the interviews.

Researcher bias

As a midwife who has worked on obstetric wards and the delivery suite in a major obstetric teaching hospital, the researcher has been directly involved in the preparation of new mothers for discharge on an early discharge programme. The increased work load and decreased amount of time to prepare women for discharge, which has been created by early discharge, places extra responsibility on the midwives in postnatal wards.

The concern of this researcher was that women, particularly primiparous women, were being discharged without adequate preparation for going home. The interview process commenced with this negative frame of mind, with the researcher expecting to find that the women would not be ready for going home. After the first three interviews, a change of attitude was required as the women were, unexpectedly, expressing positive feedback about going home early.

To counter balance this bias when conducting further interviews the researcher maintained an open mind, expecting neither positive nor negative responses, but instead listening to what the women were expressing. Personal notes were made immediately following each interview in the form of a reflective journal (Appendix F). Researchers are best helped when they are able to

reflect upon what is happening to them, on a personal level, during the research process (Scott, 1997).

Each tape was listened to on several occasions and each transcript was reviewed for evidence of bias in interviewing. Two of the early interviews revealed possible bias, with the issues being clarified by follow up telephone interviews. Data were analysed by the researcher but also reviewed by colleagues as discussed to assess that no discernable bias existed. The themes identified in the findings chapter were as a result of this process.

The findings revealed from this research will now be outlined in chapter four.

CHAPTER FOUR

Findings

The purpose of this exploratory study was to explore the perceptions of primiparous women regarding their readiness for going home from hospital following involvement in an early discharge programme.

The Sample

The sample consisted of 20 participants who were first time mothers who gave birth in one of six public hospitals. Seventeen of the women were in long term relationships of greater than one year with no differentiation made between married or de facto relationships. The other three women had no partner, two were living with their parents and the third woman was living alone. All participants were Caucasian.

The mothers ranged in age from 18 to 33 years. Income range (including combined income for couples) was \$10,000 to greater than \$50,000 per year, with the average being approximately \$36,000. Occupations varied, one woman was unemployed, others were students, clerks, receptionists, a hairdresser, registered nurses, sales assistants, a secretary, a child care worker, a food van driver, and home duties.

The education level also varied. No mothers had tertiary qualifications. Seven women had post secondary qualifications including four with trade certificates and three with diplomas. Two mothers left school prior to completing Year 10, eight had their achievement

certificate, and six had their T.E.E. or leaving certificate.

Nineteen of the women gave birth vaginally, either spontaneously, by vacuum extraction (ventouse) or by forceps delivery. One woman who had been booked for an elective caesarean section due to a breech presentation, had a non-elective caesarean section two days early because she began to labour.

There were two readmissions to hospital. The first woman who had a caesarean section was readmitted three days after being discharged due to recurrent pain and discomfort. The length of this second hospital stay was seven days. The second woman was readmitted to hospital two days after her initial discharge. This readmission, for a period of five days, was because her baby developed a urinary tract infection. Both women, however, provided valuable information to the overall study on early discharge.

Emerging Themes

Four main themes emerged from the data. These main themes were: Getting Information and Help for Going Home; Getting Information and Help after Going Home; Caring for Baby; and Own Environment. Several sub-themes emerged within each main theme (Figure 2).

1. Getting Information and Help for Going Home

Aids to getting information and help
Obstacles to getting information and help
Self education

2. Getting Information and Help after Going Home

Information and help from health professionals
Information and help from family and friends

3. Caring for Baby

Developing confidence with feeding
Developing confidence with handling

4. Own Environment

Routine
Comfort and rest
Recovering physically
Control

Figure 2: Common themes from mothers' perceptions of their readiness for going home.

The four themes and their sub-themes will now be described and supported by statements made by the women from the verbatim transcripts of the interviews. These themes will then be discussed and related to the conceptual framework in the discussion chapter. Each statement is coded by placing a pseudonym in parenthesis next to the statement. Each pseudonym is representative of the interview from which the statement was taken and have been used to maintain confidentiality.

Getting Information and Help for Going Home

The focus of this study was on the women's perceptions of their readiness for discharge from hospital. One aspect of their readiness is how well prepared they were. Being prepared for discharge was

achieved by the women getting information and help on infant care.

The theme of Getting Information and Help for Going Home consists of three sub-themes: Aids to getting information and help; Obstacles to getting information and help; and Self education. This main theme describes how the women obtained the information and help needed to assist them at home after they had been discharged from hospital. An important aspect of this information was gaining knowledge of what early discharge meant, to enable the women to prepare for going home.

Two participants did not initially understand about early discharge. These women had not attended any or all of their antenatal education classes and had, therefore, missed information about the concept and the programme. They did however agree to be included in an early discharge programme. The information and help provided by the hospitals was perceived by the mothers as being vital and encompassed information and help on care of the baby, and the early discharge programme itself.

Aids to getting information and help.

The first sub-theme, Aids to getting information and help, represents the things that facilitated the women receiving information and help in preparation for going home from hospital. The mothers received information and help both antenatally and postnatally. The information gained in the antenatal period, from the antenatal clinic, antenatal classes, or from their

booking visit to the hospital, was perceived as being informative and helpful in preparing them to get ready for home. The women who attended most or all of the classes, particularly those on parenting issues such as feeding and settling, thought they were useful.

"The parenthood classes, they were trying to distinguish between the different cries and things like that, and they were really really good and it showed what is out there, what's available and safety and things to help prevent SIDS and things like that" (Catherine).

"We had, like, she had us for four weeks for preparing for parenthood, which was very good, we learnt lots of things there that as a first time parent you don't know" (Jane).

"I went to the antenatal classes . . . There were parenting ones, and antenatal and birth and all that . . . they really helped as well" (Sandra).

The women said they were told what early discharge was, what follow up they would receive, and exactly when they would be going home after they had their baby. The mothers felt this information enabled them to plan for their discharge and as a result greatly improved their readiness for discharge.

The participants who attended antenatal classes felt they were well informed about early discharge and were expecting to go home on the third day. Some of the women were made aware of the early discharge programme when they booked into the hospital during the antenatal period. Eighteen women reported that the concept of early discharge had been explained to them either during a hospital visit, whilst attending the antenatal clinic, or during their classes.

" . . . before we decided to go to the hospital, we went down there just to have a look and we met one of the midwives . . . she explained everything to me then and we just decided that it was OK and she just ran through it all with me and I was quite happy to do that" (Joyce).

"You can go home early and a midwife from the hospital will come out and see you . . . well I know at the hospital you can go home after four hours and before three days and they'll come out and see you and make sure everything's going alright" (Claire).

"It was quite well explained. I just had the one visit when I was up at the antenatal clinic with the sister who advised me on the discharge programme . . ." (Michaela).

The information the mothers received from the midwives during the postnatal period in hospital was, for the majority of women, perceived as being appropriate and adequate. The adequacy of the information varied, depending upon the perceived amount of time the midwives had to spend with the mothers. The women who felt they had sufficient time with the midwives felt happy about the information that they received.

" . . . the midwife that was in the hospital, she was fantastic . . . like showed me everything because I had no idea, on anything . . . She spent a lot of time with her (the baby) . . . I probably spent four hours with her a day and she was showing me all the different things" (Sarah).

" . . . as soon as a question came in to my head I wrote it down so whenever I saw one I'd ask them and they weren't in too much of a rush . . . they'd sit there and explain in detail" (Mary).

"They were really good. They were better in the actual maternity ward than they was on the delivery ward. . . . on the ward they had time and they were really good" (Elizabeth).

The majority of the mothers perceived the information and help they received as adequate in assisting their preparation for going home from hospital. There were some women however, who felt they could have received more assistance in getting ready to go home but for various reasons this did not occur.

Obstacles to getting information and help

The second sub-theme, Obstacles to getting information and help, identifies some barriers that the women perceived may have prevented them receiving all the necessary information and help they required. This sub-theme also encompasses the antenatal and postnatal periods.

Two participants did not know about the early discharge programme or that they would be discharged from hospital early until after they had their babies. These women, however, had attended very few or no classes and had therefore not received the relevant information. Both women were told of their discharge date on the actual day of discharge. They were initially surprised but accepted this and within a very short space of time were able to adjust to going home that day.

"I had absolutely no idea sort of how long I was going to be in there for, I hadn't been told anything about what the early discharge was and how long I could stay. Nothing was said to me until that morning when the sister came in . . . In the morning I really didn't want to come home, but by the end of that afternoon I felt OK"
(Roxanne).

Roxanne, however, is a child care worker and said she felt confident in her ability to look after her baby. Her confidence in caring for children due to her job may have been one factor which helped her to come to terms with this unexpected early discharge.

The second woman, Josephine, who knew nothing about early discharge accepted her discharge because she wanted to get out of the hospital.

"I didn't even know I was on an early discharge . . . Nobody came in and actually sat down and explained to me that I was on early discharge and things like that" (Josephine).

Josephine had said that she received conflicting advice during the three days she was in hospital. By accepting the early discharge on that day she was able to get away from the conflict. Josephine added that the only thing she knew about going home was that a midwife would be coming out to her home to do a heel prick test on the fifth day.

Even women who thought the midwives were rushed or busy felt the information they received was helpful. Some women chose specific areas of the information to acknowledge, whereas others were more general in their responses. The women who thought the midwives were busy felt it was their right to ask for assistance if they were unsure. They felt they received help and advice on those topics which were most important to them such as infant feeding.

"The midwives were really busy but they tried to help as much as they could. You just ask if you don't know. They didn't really have time to sit down with you, only one midwife on night shift and she went through things about bottle feeding with me" (Yvonne).

". . . they were a bit rushed sometimes but they did sit down and talk about, like, breast feeding and things like that which helped. . ."
(Rachel).

". . . they were flat out too, at the time when she was born . . . that was OK . . . I'm the sort of person that would ask questions"
(Susan).

However, two women were unhappy with the postnatal information and care they received. Maxine perceived that the midwives appeared not to care about her, whilst Josephine said that they didn't offer advice and didn't help her.

"None of them even bothered to help me try and change her . . . Most of them didn't care, they were too worried about every other baby"
(Maxine).

". . . they don't tell you anything really. I looked after her, they didn't change a nappy or anything . . . They wouldn't advise you, they wanted you to do it like that . . . it was pretty weird" (Josephine).

When asked what would have helped them to be better prepared for coming home, only four women felt changes were necessary. These included the midwives taking more time helping the mothers, informing the mothers of the options for caring for baby, receiving care from the same midwives during the postnatal stay, and informing the mothers of potential problems with infant care.

Maxine, who had a caesarean section, believed that the midwives didn't care about her and as a result she wasn't shown anything.

"If the midwives had shown me how to bath her, and took more time with me . . . when I couldn't do anything and helped me change a nappy . . . but they just didn't care" (Maxine).

Maxine also added that some of the midwives had indicated to her that if she had attended antenatal classes she would have found caring for her baby a bit easier. Maxine agreed with the midwives but said that she had been unable to attend the classes because she didn't have any transportation.

Josephine would have preferred the midwives to have been more flexible in their approach to giving advice. She said that if the midwives had given her options on the various aspects of caring for her baby such as feeding, bathing, changing and settling, it would have helped her more. She felt instead, that she was being told that she had to do these tasks in a particular way.

". . . advise instead of telling you what to do I'd say. If they'd give you advice and you just take what you want from it, that would be a lot better" (Josephine).

Joyce thought that continuity of fewer carers who knew her better and could give more personalised care would have prepared her better for going home.

"I think a little more individual care, . . . there were just too many people trying to help" (Joyce).

Sarah, who was one of the three women with a baby who had colic, believed that there should be information provided during the antenatal classes that indicates what problems could arise with caring for a baby.

"I think maybe if they made you more aware of the things that you might have problems with, not that everything's just a bed of roses" (Sarah).

The information received by the mothers from the hospitals during the antenatal and postnatal periods was perceived as being helpful. Most mothers felt that the information was appropriate to their needs and that it had helped them to prepare for going home.

Self education.

The third sub-theme Self education depicts the information and help that the women sought for themselves either in the form of reading, from health professionals or their family and friends.

Self education was an important aspect of the women's preparation for discharge. The participants read books, magazines and pamphlets associated with childbirth, child development and care of the newborn infant. Some of the material was provided by the hospitals and distributed through the antenatal classes. Most of the literature that they read was sought out by the women themselves during their pregnancy. The information was obtained from several sources throughout their local communities.

For those women who didn't attend any classes or very few, the reading proved vital in their preparation for going home. For those women who did attend formal classes, the reading served to enhance their understanding and increased their knowledge.

"I read a lot. We bought all the magazines and bought a few good books, got a few from the library so yeah, we did a lot of reading"
(Ruth).

" . . . I did a lot of reading, pamphlets and things at the doctor's surgery and pharmacy and that sort of thing" (Amber).

"I read quite a lot. I got some books from the hospital when I went for my three month check up and they gave me a whole lot of books and I read them " (Maxine).

Several of the women also indicated that they returned to this literature after they had gone home. If they were unsure about something they "looked it up" and this helped to reinforce what they had learnt antenatally and in hospital.

Postnatally, the women felt that if they needed more information all they had to do was ask the midwives. Josephine thought that two particular midwives gave her the information that was right for her, so she waited until they came on duty and asked them for advice.

" . . . two of the midwives were brilliant, so I just waited for them and asked them for advice" (Josephine).

Even Maxine who felt that the midwives didn't care for her, was prepared to ask questions. She said that she was unable to get the advice when she wanted it. Maxine thought that only one midwife on night duty cared, so she also waited for her to come to work and then sought information.

Claire, on the other hand, felt that the responsibility for preparation for discharge belonged to the mother. She believed that it was up to the individual to make sure they were prepared properly.

"I think it's up to you to prepare yourself, you know, sort it out before you go home instead of getting home and saying I wish they'd they'd told me this. I just asked a lot" (Claire).

All the mothers took an active role in seeking the information and help that would be likely to assist them in getting ready to go home. The next theme to be outlined is Getting Information and Help after Going Home.

Getting Information and Help after Going Home

Getting Information and Help after Going Home was the second main theme to emerge. It has been divided into two sub-themes: Information and help from health professionals; and Information and help from family and friends.

Knowing where to get information and help and being able to access it, once they had gone home, was a crucial issue for the mothers in their perception of being ready for early discharge.

Information and help from health professionals for the women in this study came from the following sources: the domiciliary midwives (a home visiting follow-up service provided by each hospital); the child health nurse; the women's own doctor; and other agencies such as Nursing Mothers' Association of Australia and Ngala Family Resource Centre which employs midwives and child health nurses to provide assistance with parenting problems.

Help was also provided by the partners of each of the 17 women in relationships, by immediate family including parents and siblings, and friends.

Information and help from health professionals.

The first sub-theme of this second main theme, Information and help from health professionals, reflects an awareness on the part of the mothers of what professional help was available to assist them once they had gone home. They indicated that they were referred to three main professional agencies - the domiciliary midwives, their own doctor, and the child health nurse - for their follow-up care. The women in this study felt they had a good knowledge of the professional help available to them and were able to utilise this to assist them at home.

"The midwife came out for three days, she was lots of help, she answered lots of questions too, when I could think of questions to ask her. The child health nurse . . . and my GP around the corner" (Yvonne).

"There's the child health centre . . . There's oh there's lots of people out there who can help you. The midwife came for two days . . . That was enough for me, just a bit of reassurance that there was someone there the next day if anything else happened" (Rachel).

There's the midwives at the hospital . . . I had one come out on Tuesday and she just checked to make sure everything was going fine . . . my local GP, child health nurse, I went there today" (Jane).

The most important thing about coming home for the women was the knowledge that extra people were available to help if required. This was particularly so for the breast feeding mothers, of whom there were 17 in this study. Apart from the domiciliary midwives and the child health nurse, the women were aware of the Nursing Mothers Association of Australia and other agencies available to help with any problems.

" . . . you've got Nursing Mothers that you can ring up . . . they (the hospital) give you a lot of phone numbers for all sorts of things which I thought was really good" (Sophie).

"We got pamphlets on Nursing Mothers at the antenatal classes. I know that if anything does go wrong with her, that there's plenty of people I can ask to help me out" (Amber).

"Nursing Mothers, I haven't actually contacted them . . . but I know they're there. There's a shop in the shopping centre, I think it's run by Family and Children's Services . . . oh and Ngala, I've heard of them" (Susan).

However, not all of the women were happy with the professional support they received. Martha, whose partner works away, was not happy with the domiciliary follow-up. She said that she was given incorrect information. Martha had understood that the follow-up would be up until the tenth day and she only received two visits.

" . . . if you go on early release we'll send a health nurse around to visit for up to ten days. . . . she only came twice" (Martha).

Martha said that she still coped with early discharge without the extra visits from the midwife because her mother unexpectedly came to stay with her. Her mother was able to provide the help that Martha needed. Martha revealed that with her mother helping her and the advice she got from her friends, she was able to overcome the perceived gap in her support left by the midwife not visiting after day five. Martha also made sure that she went to the child health clinic in the first week.

Knowing that the domiciliary midwife would be visiting their home and being able to use the other

agencies or at least having access to them, helped the women in their readiness for going home.

Information and help from family and friends.

The second sub-theme of this second main theme, Information and help from family and friends, incorporates the assistance that the mothers received from their partners, their family and their friends. The help provided by family and friends was also a significant factor in the network that helped the women once they had been discharged. The 17 women with partners all reported that the opportunity to have their partner involved in caring for their baby helped them to manage after they got home.

"My husband's been really good, I couldn't have done it without him around I don't think" (Joyce).

"I've got my husband, so he helps me in everything, he's really good" (Elizabeth).

"My husband's very good with him (baby), he's surprised me, he's quite confident handling him" (Michaela).

Several of the women's partners took holidays to be at home to help their partner and baby once they were discharged from hospital.

"I knew my husband had the week off work to help me . . . so I didn't have a problem" (Sandra).

"My husband was home. He was here for a week . . . so that was great you know getting everything done that needed to be done" (Susan).

None of the fathers who took holidays did so because of early discharge. They still would have taken time off had the mother stayed longer in hospital.

"My husband would still have taken holidays anyway, no matter how long I stayed in hospital" (Claire).

The only couple to have changed their original plans was Michaela and her husband. Originally he was not going to take time off. However when Michaela was readmitted due to the infant's urinary tract infection they changed their plans. John took a week off when Michaela and the baby were discharged for the second time.

". . . he wasn't originally going to take any holidays off, but because we were readmitted, when I was discharged again . . . my husband actually took a week off and spent it at home with us" (Michaela).

Ruth's mother took a week off work to help her because her husband was unable to arrange holidays. Ruth revealed however that this would have occurred regardless of how long she stayed in hospital.

"My mother had a week off work because my husband had to keep working . . . It wouldn't have mattered how long I'd stayed in hospital, mum would have taken the week off anyway" (Ruth).

The three women without partners, two of whom were living with their parents, all revealed that their mother helped them to care for their baby when they got home.

"I've got Mum, she helps me a lot. Baths her, feeds her, puts her to sleep and everything" (Maxine).

". . . knowing that my Mum was here when I got home helped . . . otherwise I don't think I would have come home so early" (Sophie).

Kate, who was the only woman in the study living alone, knew she would have help from her mother which she revealed helped her to cope with coming home early. Kate also said that she would have been scared on her own and would not have coped with early discharge.

"I wouldn't like to do things on my own when I got home, but I had Mum with me to help . . . I knew my mum would be staying for a week" (Kate).

Kate also revealed an interesting anecdote, comparing the help she received to that of women with partners. Kate felt that she had received more help from her family and friends because she was a single parent. Kate believed that people tended to stay away when the woman had a partner to allow them time to manage together, but that the partner did not always help the mother care for the baby.

". . . people know I'm single, it's easier because I get that extra support. Whereas my girlfriend who has a husband has less support from outside because they think she's got a husband . . . he does nothing, . . . he's not really helping her. I think that if I had a partner I'd get a lot less family support for some reason" (Kate).

The other two single mothers did not consider this to be the situation for them. Both Sophie and Maxine felt that their family and friends would have provided the same support even if they had a partner.

All 20 women reported having help from other family members and their friends. Each woman either had a relative or friend who had previously had a baby and could therefore help them care for their baby. Knowing

this help was available when required, though not specifically organised, helped the women in their readiness for going home.

"I've got lots of friends with babies. . . The youngest one was born two weeks after her (the baby), so I ask her a lot of things as well" (Martha).

". . . all the women that I work with have got kids . . . so I've got a lot of friends to help if I want to" (Claire).

"A lot of our friends have got young children as well so it's sort of helpful to have them to talk to as well" (Sandra).

Only one woman said that she had made specific preparations for coming home. This did not relate to arranging support but instead to her cooking meals. Sandra cooked extra meals in the last weeks of pregnancy and froze them so that she wouldn't have to cook when she came home early. Sandra indicated that it had been an advantage for her to have known about early discharge in advance for this reason.

"The only thing I did because I knew I was coming home on early discharge was I cooked double amounts of food in the last two weeks of pregnancy and put them in the freezer, so when I came home I didn't have to cook" (Sandra).

Getting information and help or knowing how to get it after they left hospital was important for all the women in helping them to manage at home. The next theme to be outlined is Caring for baby.

Caring for Baby

Caring for Baby was the third main theme to emerge from the data and is outlined in two sub-themes: Developing confidence with feeding; and Developing confidence with handling which includes bathing, changing and settling. Caring for baby is defined as the mothers' perceived confidence in providing for their baby's needs. By the time the interviews were conducted, all the women felt confident about caring for their baby. Three expressed some initial problems but they were able to solve these and at the time of the interview were confident in their ability to care for their baby.

Developing confidence with feeding.

The first sub-theme of this third main theme, Developing confidence with feeding, was the mothers' perceived confidence in their ability to feed their baby. Eighteen of the women expressed confidence with feeding their baby. Of the 20 women in the study, 17 were breast feeding and three artificially feeding. The mothers stated their confidence level was high regardless of the feeding method.

"Breast feeding has been fine, she took to it straight away, so I haven't had any problems . . ." (Sandra).

"I felt pretty confident . . . breast feeding, I didn't find it hard at all" (Claire).

One of the mothers who was bottle feeding her baby revealed that initially some of the midwives did not

support her in her choice. Yvonne did not feel comfortable with the idea of breast feeding and after a lot of thought throughout her pregnancy decided to bottle feed her daughter. Despite these problems Yvonne still felt confident with feeding by the time she was discharged. The other two mothers who were bottle feeding didn't experience any problems and felt confident straight away.

"I'm bottle feeding, they showed me how to do the formulas . . . really confident straight away, I surprised myself" (Elizabeth).

Joyce and Susan, who were both breast feeding, revealed initial problems. Both had some difficulty with attaching the baby to the breast and as a result did not feel confident. However, once the engorgement had subsided, the feeding improved and they became confident.

". . . just the breast feeding that was a bit difficult but when the engorgement settled down I could get her on . . . I felt confident after that" (Susan).

"It just felt awkward, I didn't feel comfortable in any position they tried to show me . . . when I got home it was alright, I felt more confident" (Joyce).

The mothers expressed feelings of increasing confidence with feeding each time they fed their baby. They also revealed that being aware of the support that was available to help them with feeding once they had gone home greatly enhanced their confidence. This knowledge of support also flowed on to the other aspects of caring for their baby and enhanced their confidence with handling their baby.

Developing confidence with handling.

The second sub-theme of this third main theme, Developing confidence with handling, represents the mothers' perceptions of their ability to handle their baby competently when providing day to day care. Bathing, settling and changing the baby have been grouped together to form this sub-theme. Nineteen of the women stated that they felt confident in their ability to provide these needs for their baby when they were discharged.

" . . . after you've done it a few times you feel pretty confident . . . bathing and changing and that was good" (Yvonne).

Amber revealed that she had found caring for her baby harder in hospital because there were too many things going on. At home she felt she could focus more on what she was doing and this improved her confidence.

"I was fine . . . really comfortable with bathing, settling her and changing nappies. I was a bit unsure at first . . . but when I got home it was a lot easier to deal with" (Amber).

Maxine revealed that because she didn't get any help from the midwives, during the first couple of days at home she was a bit unsure about handling her baby. She felt much more at ease with her mother helping her and soon became confident with changing and settling her baby.

" . . . I didn't know how I was going to handle holding her and doing all that but I got used to it after a couple of days" (Maxine).

Maxine added that it took her longer to gain her confidence with bathing however, and she stated that her mother bathed the baby for her. After being discharged the second time (readmitted due to recurring pain due to caesarean section) Maxine was confident with bathing. By the time she was interviewed three and a half weeks after the birth of her baby, Maxine said that she was "now doing it fine".

Kate was the only mother to express that she had been nervous about handling her baby. She was particularly nervous about bathing her daughter. As Kate's experience increased, her nervousness decreased and after the first week at home she felt confident in her ability to handle her baby. Kate's mother stayed with her for the first week and provided the help and advice Kate needed to give her the confidence to care for her baby herself. Kate also revealed that she felt more confident after her visit to the Child Health Nurse at the end of the first week. The Child Health Nurse was able to reassure Kate that her daughter was progressing well.

" . . . a bit nervous about bathing even though it's really fun and she (baby) loves it. I felt comfortable for short periods of time . . . but after the first week it got a lot easier" (Kate).

Kate was one of the single mothers in the sample. During her interview she was feeding her baby and was very obviously comfortable and competent in handling her at that time (See Appendix D - Field Note).

Martha provided an interesting analogy when she compared caring for a new baby to driving a new car. She said that until you get used to the gears and the way the car drives you're not really sure what you are doing. Martha felt that caring for her baby was similar. She had to work out what her baby needed and how best to provide it.

" . . . it's like anything new, it's like a car isn't it. When you first get a new car it takes you a while to get used to the gears and listening to the noises that your car makes so that you know and I think it's the same thing for a baby" (Martha).

Developing confidence in providing care for their baby was important for the women in their perceived readiness for coming home from hospital. They all considered being able to care for their babies was an essential element of coming home.

Own Environment

The fourth main theme that emerged from the data, Own Environment, represents the mothers' homes, where they were in familiar surroundings and had their own things around them. Home was where they felt comfortable, relaxed, in control, and able to set their own routine. Being in their own environment proved a very common motive for coming home on early discharge. This theme is expressed by Elizabeth who said:

" . . . you're not gettin' your proper sleep like you would at home in your own environment and havin' your own things around you makes you feel more at ease, . . . " (Elizabeth).

Own environment will be described in four sub-themes which were indentified by the women: Routine; Comfort and rest; Recovering physically; and Control. The women looked forward to returning to their own environment for these four reasons.

Routine.

The first sub-theme of this fourth main theme, Routine, involved being able to get home and establish their own routine. A high priority for all the women was being able to get into a routine with such things as sleeping, eating and caring for their baby. Doing what they wanted to, when they wanted to helped them to be more relaxed.

" . . . I thought that maybe he'd (baby) think, oh where are we now you know, but I felt fine as soon as he was awake it was all normal, back to the routine" (Mary).

"Just to get into your own routine instead of being in theirs and them always telling you what to do . . ." (Rachel).

"I think it's better to come home early and sort things out at home and start getting into a routine here instead of sitting in hospital all the time" (Sandra).

Two of the women found it easier at home to set their own routine because they had received conflicting advice whilst in hospital. They said that each midwife was telling them a different way of doing things for the baby.

" . . . I felt that I should come home and do it myself. I was getting too many different ideas and conflictions. . . . I just felt that while one was telling me one thing, another was telling me another so that's why I decided to come home and get into my own routine" (Joyce).

"One would tell you one thing and the other one would tell you another. . . . I felt a lot better when I got home, 'cause I relaxed a lot more. I was in my own surroundings . . . she (baby) just fitted into our routine" (Josephine).

Josephine stated that she felt it depended on where the midwives received their education as to how they taught new mothers to do something. When Josephine questioned a midwife about bathing the baby because the day before she had been shown something different, the midwife said "they were all trained at different places". Josephine found this to be an unacceptable answer and was confused by the advice she was receiving. She decided to do what felt right for her.

Michaela who was readmitted because her baby had a urinary tract infection was upset at having to return to hospital because it upset her routine.

"I was happy to come home, I was getting in to a little routine and to have that disrupted was hard" (Michaela).

Regardless of the postnatal experience the women had in hospital they all looked forward to getting home and being able to establish their own routine in their own surroundings. The mothers revealed that being in their own routine made them feel more relaxed and comfortable.

Comfort and rest.

The second sub-theme of this fourth main theme, Comfort and rest, was the mothers greater feelings of physical and emotional comfort created by being in their own environment. Nearly all the women expressed that

they felt more comfortable at home than in hospital for a variety of reasons. One of the most common reasons was the simple comfort of their own bed or lack of comfort in the hospital beds.

" . . . because of the way the beds are, they're quite hard and they're not very comfortable so coming home was probably the best thing that I did 'cause I could lay down a lot more comfortable . . ." (Amber).

"I was looking forward to coming home from hospital, they are the most uncomfortable beds in there that I've ever had. I just wanted to get back to my own bed" (Martha).

Not just the beds but sleep also was a common concern with complaints of sleep deprivation whilst in hospital due to crying babies. It was reported to be difficult to rest and sleep with all the crying babies around.

"Like we had a baby across from us that had colic so he was up like three or four times and every time he woke up, he (own baby) woke up, so it's like he couldn't get a sleep without other babies waking him up" (Mary).

"You can't rest, too many babies screaming and because like, you're all in the same room, just like they all cry at different times, you can't rest I don't reckon" (Rachel).

"I didn't feel comfortable in the hospital, all the rest of the babies crying. She (baby) was sort of restless and I couldn't get her to sleep . . . I just couldn't relax, . . . She settled down as soon as, the first night I was home so it was good" (Amber).

Some women just simply did not feel comfortable in hospital. They were far more comfortable being in their own home.

"I felt more comfortable here in my own home than in hospital . . . I knew that once I was home I felt more comfortable" (Roxanne).

"Even though they were good I just didn't feel comfortable and it was better that I actually had the midwives come to the house" (Sarah).

Three women felt more comfortable at home because they didn't like hospitals or found it boring being in hospital. They couldn't see any point in staying in there, sitting around all day.

"It was too boring in hospital. I was just bored and sitting around all day, so it was quite good to get out" (Yvonne).

"I was really happy to come home, because I was getting bored and thought well, there's no point staying any longer" (Claire).

Comfort to this group of new mothers meant being able to sleep better, feeling more relaxed in familiar surroundings and being able to do their own thing. They felt that this comfort also enhanced their physical recovery.

Recovering physically.

The third sub-theme of this fourth main theme, Recovering physically, describes how the mothers perceived their recovery from the labour and birth. All of the women mentioned feeling tired. Five had sore perineums due to either an episiotomy or a tear. Although they were still recovering physically they were all still happy to go home on or before day three. Coming home early and the subsequently perceived increase in rest assisted the mothers to overcome their tiredness and helped them to recover.

"I felt physically ready to come home . . . I think it's better to come home early and recover at home" (Sandra).

"I was offered to stay longer if I wanted but I was ready to go. I was still recovering physically but I was alright . . . I was so tired, I couldn't believe I could feel so tired . . . but being home, my husband has helped, I couldn't have done it without him around" (Joyce).

"I had a sore episiotomy . . . coming home was probably the best thing that I did 'cause . . . I had to climb up into the bed in hospital and sort of roll out, it made me feel uncomfortable" (Amber).

Elizabeth would have gone home earlier had she felt physically able to but decided to stay until the third day.

". . . if I could have come home after two days then I would have done. It was only for the fact that I was so sore and I couldn't keep gettin' out of bed every two minutes that I stayed" (Elizabeth).

Elizabeth also added that she was tired when she got home but because of the support she had was able to catch up on her sleep in the afternoons.

"My Auntie lives next door . . . when I've felt tired in the afternoon, she's took her around there . . . so I can have a sleep" (Elizabeth).

Michaela had decided that she would sleep in the morning while her baby was sleeping to help her overcome her tiredness and do the household work in the afternoon.

"I was very tired but I decided I'd rest when he (baby) rests. I tend to get back in the mornings for a sleep and the afternoons are spent catching up with things around the house" (Michaela).

Recovering physically, from both tiredness and discomfort, was an issue for all the mothers. They all felt that being at home enabled them to recover quicker

because they had greater control over what they were doing.

Control.

The fourth sub-theme of the fourth main theme Own Environment was control. This is representative of the mothers having control over what they could or could not do. The women liked to be able to do what they wanted to do, when and how they wanted to do it. This control was for things such as caring for their baby, eating, sleeping and having visitors.

One of the issues of control was the regimented way in which the mothers had to eat their meals in hospital. If their baby was feeding or needing attention when in hospital and their meal was being served, then they left it to get cold. At home they were able to eat when it suited them and eat the food that they wanted.

"I felt better at home because I could eat what I want when I want, the meals that I wanted and sleep when I felt like it, as long as he (baby) was asleep . . . " (Mary).

As mentioned by Mary, being able to control when she could sleep was also important. Simply sleeping was not the only issue though. Being able to relax was also a positive reason for being at home. The mothers were able to relax more because they could control their visitors better at home. Many of them revealed that in hospital there were visitors there all the time.

". . . you feel like you can relax more at home . . . in hospital there's always visitors" (Sophie).

The mothers also felt that they had more control over caring for their baby in their own environment. Coming home was considered by some of the mothers as necessary to enhance their ability to care for their baby.

"I think I just needed to do it (care for baby) on my own . . . I felt that I should come home and do it by myself" (Joyce).

Being in their own environment, establishing their own routine, feeling comfortable and being in control were positive motivators for the women to come home from hospital on or before the third day.

The four themes that have been outlined were the common themes taken from the women's own words. Getting Information and Help for Going Home, Getting Information and Help after Going Home, Caring for Baby, and Own Environment were all important issues for the women in terms of going home. In chapter five these themes will be discussed in relation to the literature and the conceptual framework.

CHAPTER FIVE

Discussion, Conclusion, Implications for future research, Implications for clinical practice

The purpose of this study was to explore the human element of early discharge by examining the perceived readiness of first time mothers for going home from hospital. Twenty first time mothers were interviewed and asked questions relating to their perceptions of going home from hospital.

Although the results of this study cannot be generalised to all first time mothers they are potentially transferable to groups of women with similar characteristics (Paavilainen & Astedt-Kurki, 1997). This chapter discusses the issues raised by the findings and relates them to previous literature and the study's conceptual framework.

Discussion

Some of the interviews revealed sparse data and required follow-up interviews to clarify and validate issues raised by the mothers. This was perhaps due to the fact that the majority of the women were positive in their opinions of early discharge and their resultant perceptions of their readiness to go home. The mothers who gave the most information and spoke more openly about their experiences were the few women who had some negative comments.

The results of the larger study revealed similar findings, with the majority of other mothers in early discharge programmes also being positive in their opinions and the care they received.

Getting Information and Help for Going Home

The most important aspect of the early discharge experience for this group of mothers was their preparation for going home. This preparation came in two parts. The information and help provided by the hospital midwives, and the information and help they were able to get for themselves. The self education was perceived as being adequate by all the mothers and is only briefly discussed in this chapter. The hospital preparation spanned both the antenatal and postnatal periods but has been discussed in each individual category for purposes of clarity with some issues that arose during each phase of the preparation.

Aids to getting information and help.

Classes provided by the hospital in the antenatal period encompassed changes in pregnancy, preparation for labour and birth, physiotherapy exercises and parenting issues for infant care. Eighteen of the women attended the classes with the majority finding them relevant and beneficial to their needs.

The antenatal period is important in an early discharge programme for the commencement of the mothers' preparation for going home. The women in this study who

had the greatest postnatal education needs were those women who attended only a few antenatal classes. This supported the views of Lemmer (1987) and McGregor, (1994) who believe it is essential that the education of new mothers begins before they have given birth. Maxine who didn't attend any classes had the greatest need and felt that the midwives didn't care about her. Maxine's situation is further discussed in the following postnatal section.

The only criticism of the antenatal classes attended by the mothers in this study was that there could have been more information given on the potential problems that may arise with infant care. One mother who had a baby with colic was unaware of this potential problem and felt that had she been made aware of it she may have recognised it earlier and would have been better prepared to have coped with it. However, as previously stated women tend to focus on the birth as the climax of the pregnancy (Schmied & Everitt, 1996). Therefore, they may not take in information provided on other issues during their antenatal classes because at the time they do not consider it important.

An important aspect of the antenatal education process for the mothers was being informed about early discharge itself. The knowledge of when they would be going home, on or before day three, and the follow-up they would receive was vital in the planning process for the women. Being admitted to hospital with an awareness

of when they could be expected to go home, if everything progressed normally, was a great advantage. This was evident from the two women who were unaware of what early discharge meant and the shock they experienced when they found out they would be going home on the day of discharge.

It has been well documented that women who are aware of the length of hospital stay on an early discharge programme have a more positive attitude toward going home early. As a result of this voluntary discharge, they usually cope better than those women who were unaware of their expected discharge time (McGregor, 1994; Schmied & Everitt, 1996; Waldenstrom, 1989).

This study supports the body of literature which states that mothers need to be informed about early discharge. The two women in this study who were unaware of their early discharge days had not attended all of the antenatal classes and had missed out on being informed of what an early discharge programme entailed. It is important that all women are made aware of the early discharge programme. If for any reason they have not been informed during the antenatal period, then they must be told when they are first admitted to the hospital postnatally. It should not be left until the day of discharge as was the case for these two participants. It does not allow the mothers any time to plan or get used to the idea of going home early with a new baby.

However, just informing the women of when they will be going home is not sufficient. The women must also be made aware of the domiciliary follow-up they will receive. In the study hospitals, the mothers can receive follow-up visits from a midwife daily up to and including day five. Any further visits beyond this time are at the discretion of the visiting midwife, up until day ten. This visiting procedure must be fully explained to all women in an early discharge programme to avoid confusion and disappointment, which happened to one mother in this study. Martha had interpreted the follow-up as visits up until day ten and felt disappointed when she only received visits on days four and five. It is essential that in order for an early discharge programme to be successful for the mothers involved, all aspects must be explained clearly.

The conceptual framework for this study contained a category called attitude which related to the mothers' attitude to early discharge. The study's findings reveal that this title does not seem appropriate for this group of women and should instead be titled awareness of early discharge. None of the women revealed a positive or negative attitude toward early discharge. They varied only in their level of awareness of what was involved in an early discharge programme. This adjustment has therefore been made in the revised conceptual framework (Figure 3).

Postnatally, the information and help given by the midwives in the hospital ideally reinforces what has been taught antenatally. The new mothers should have an understanding of the issues involved in infant care and be able to put this knowledge into practise with the guidance of the midwives.

Literature abounds with criticism of the short amount of time in which midwives have to prepare women for discharge postnatally on an early discharge programme. It is believed that the added pressure of the shorter hospital stays and subsequent increased work load make the midwives task of preparing the women for going home more difficult (Gillerman & Beckham, 1991; Keppler, 1995; McGregor, 1994; Ruchala & Halstead, 1994; Weinberg, 1994). Schmied and Everitt (1996) suggested that the postnatal care (information on caring for their baby) women received in hospital was limited in its ability to prepare them for the early weeks of parenting at home. This view was not supported by this current study, as the majority of participants believed they were adequately prepared for going home.

Obstacles to getting information and help.

Most of the women in this study felt that the postnatal care they received was sufficient and appropriate. However, two women criticised the care they received. One new mother felt that the midwives did not care about her and spent more time with other mothers. Another felt that the midwives did not give her any

information or demonstrate anything to her. Neither of these mothers felt comfortable in the hospital environment. A comfortable environment is one of the conditions required to assist the adult in their learning (Knowles, 1980; Merriam & Caffarella, 1991). The perception of a lack of caring from the midwives, would have increased the discomfort felt by this participant further decreasing her ability to learn. It is interesting to note that these two women had different antenatal preparations compared to the other 18 women. Josephine attended one antenatal class which was on labour and birth and revealed that it put her off attending any more. Maxine did not attend any classes. Both women said that they did not really know what they expected having a baby would be like. However, they had both done some reading during the antenatal period.

The interview data revealed the mothers' perceptions that most of the hospitals had been busy during their period of hospitalisation and that the midwives had been "a bit rushed" with their care. The busy nature of the hospitals may have been the reason for some of the criticisms from the mothers but cannot be used as an excuse for the perceived lack of caring. However the number of criticisms were minimal when compared to the favourable comments about how helpful the information and help received was. Even though the hospitals appeared to be busy, the majority of mothers still revealed that the midwives were effective in providing helpful information and support.

The mother who felt that the midwives did not care about her was the woman who had a caesarean section. She had also not attended any antenatal classes. Due to these two factors, Maxine's postnatal needs were much higher than some of the other mothers. Her decreased mobility because of the caesarean section and her lack of knowledge due to limited antenatal preparation were complicating factors. The midwives needed to be aware that Maxine required more information and help to ensure that she was adequately prepared for going home. It must be noted however, that Maxine was not expected to go home until day five, but chose to go home on day two.

Maxine's case however does raise an interesting point in relation to postnatal care for all women. It is important that midwives treat each new mother as an individual and their care should be based on each woman's unique needs (Lemmer, 1987). With Maxine not being able to attend antenatal classes, the midwives needed to allow for the fact that she may have needed some more assistance postnatally. Not having transport was a barrier to Maxine being able to receive all the antenatal preparation available to her. It is important, therefore, that midwives are not judgemental when providing care.

A few women in this study indicated that they had received conflicting advice during their period of hospitalisation postnatally. Conflicting advice in the postnatal hospital stay has been previously reported and

continues to be a problem (Brown et al., 1995; Moss, Bolland, Foxman & Owen, 1987; Percival, 1990). Whilst this was a greater problem for some than for others, it remains significant. Two women found coming home was the best way of avoiding the conflicting advice while others simply ignored it. As all mothers were primiparous women, the information they were given was more important than it might have been for multiparous women. With no previous experience with an infant, the women were reliant upon the midwives for advice. Some women revealed that they listened to all that they were told and just used the information that they felt was right for them. Others ignored the information they did not like.

There are obviously different ways to do certain aspects of infant care. The midwives' role, as with all adult educators, is to inform the new mother of the alternatives and then assist the woman in finding out what is right for her. Knowles, (1980) supports this role of the adult educator. It is vital that the information received by each new mother is consistent from all midwives so that a second or third person is confirming what the woman has been previously told and not conflicting with it (See Appendix F). This is particularly important with mothers going home on an early discharge programme as their time in hospital is short and should be a time of quality midwifery care.

Most hospitals have protocols relating to all facets of midwifery care. It is the collective

responsibility of midwives to be aware of these protocols and to pass this information on to the new mothers accurately and consistently. Midwives need to assist women in their decision making and then support each woman with the choice she has made, not confuse her.

Self education.

Schmied and Everitt (1996) believe that women put most of their energy into preparing for the birth and very little into preparing for early parenthood. The mothers in this study, however, did help to prepare themselves for going home from hospital.

As previously mentioned, the women in this study had done some form of reading during the antenatal period to help prepare themselves for having to care for a new baby. They all felt that the preparation they had done was adequate. Some mothers felt that the responsibility for preparation was theirs and made sure that they asked questions relevant to their needs. By doing this, they ensured that they were receiving as much information and help from the midwives as possible. Other mothers indicated that they returned to the literature they had accumulated during the antenatal period, if they were unsure of something postnatally.

It is essential that all new mothers are able to identify the areas they feel they require information and help in. Once they have identified a need they can then ask the appropriate questions of the midwives to

meet that need. The idea of self education is congruent with the adult learner observations of Knowles (1980) and Merriam and Caffarella (1991) who believe that once a need to learn is recognised the adult is only interested in the information relevant to their needs.

The initial conceptual framework for this study had two separate categories of antenatal education and postnatal education. The interviews have revealed that these two aspects of preparation were intertwined and of equal importance to the mothers. Therefore, instead of two categories, antenatal education and postnatal education, a new category has been formed entitled information and help for going home in the revised conceptual framework (Figure 3). This category encompasses the three areas of preparation for discharge (antenatal, postnatal and self education).

Getting Information and Help after Going Home

The issue of support at home for women on early discharge programmes has been the subject of several studies both in Australia and internationally. All studies have revealed that women who leave hospital early manage very well at home providing there is adequate formal and informal support (Brown et al., 1995; Hall & Carty, 1993; Kenny et al., 1993; Lemmer, 1987; Small et al., 1992; McLean, 1997). Support for the mothers in this study came from two main groups, health professionals and family and friends. The support was

supplied by information provided and help given from both groups.

Information and help from health professionals.

The information and help given by health professionals was considered by all the mothers to be vital to their perception of their readiness for going home. The domiciliary midwife visits proved to be of great benefit and helped to reinforce the information that had been supplied previously. This finding is supported by Brown et al. (1995) who reported that early discharge works well if there is adequate domiciliary follow-up for the mothers.

The most important aspect of support for this group of mothers was the knowledge that there was support available to them. Domiciliary visits provide the mothers with reassurance and the opportunity to ask questions (Jansson, 1988). As stated by Knowles (1980), adults will access information when they feel a need to learn. The new mothers in this study felt reassured by the support provided by the health professionals. Not all the women used the agencies available, however, but they were all aware of the agencies and knew how to access them.

Knowles (1980) states that it is not as important to teach adults everything as it is to provide a means for them to access the information when they require it. This observation is relevant, given the concerns with shorter hospital stays and the subsequent pressure on

the midwives to impart knowledge on the new mothers (Gillerman & Beckham, 1991; Keppler, 1995; McGregor, 1994; Ruchala & Halstead, 1994; Weinberg, 1994).

Rubin's (1984) phases of motherhood, Taking-in (day 0-3, a period of disorientation and physical recovery) and Taking-hold (day 4-14, a time when the mother is ready to rejoin the adult world and receive information) indicate that the new mother is going home from hospital before she is ready to receive information about baby care. Rubin's (1984) thoughts may well be true, but Knowles (1980) believes that when the woman/adult is ready to receive information she will access it for herself, given she knows how and where to.

It would appear, therefore, that it is not necessary for the midwives to teach the women everything before they are discharged. It seems that instead, before they are discharged from hospital, midwives must ensure all new mothers have access to knowledge of where they can acquire the information they may need. This supports the view of Lemmer (1987) who stated that written information on community resources and phone numbers of care providers should be given to the mothers. Referral to agencies in the community to assist them with caring for their baby as well as the domiciliary midwifery services from each hospital, ensures that the mothers have access to the information and help they need.

This situation was reflected in this study by most of the new mothers who did not place as much emphasis on

knowing everything immediately, but rather on being able to find out something when and if they required it. The knowledge that they had access to information and help once they had been discharged from hospital was vital to all the new mothers.

Information and help from family and friends.

The support provided by family and friends was invaluable to all the mothers in this study. Seventeen of the women had partners and the three single mothers felt that they had adequate family support. All women said that they had received advice and help from a variety of family members and this advice had enhanced their confidence in caring for their baby. Knowing that family and friends are there to help greatly enhances confidence and enables mothers to come home early (Brown et al., 1995; Hall & Carty, 1993; Kenny et al., 1993; Lemmer, 1987). The findings of this research support the results of these previous studies.

The initial conceptual framework described two categories of support: informal support (family and friends) and formal support (health professionals). Throughout the interviews and subsequent analysis it became obvious that the mothers relied jointly on both groups for information and help. Therefore the information and help provided by health professionals, and family and friends have been grouped together as one

category entitled information and help after going home in the revised conceptual framework (Figure 3).

Caring for Baby

Confidence in caring for their baby was perceived by the mothers as being high. The majority of women felt confident in their ability to care for their baby when they were discharged from hospital. The three women who had initial concerns when they went home were able to overcome these concerns shortly after discharge and were able to develop their confidence. The perceptions of these mothers confirms the findings of previous research.

Carty and Bradley (1991) have reported that early discharge women had confidence in their ability to provide infant care. This view was supported by Shiell, Cameron, Kenny and King (1993) who found that first time mothers on an early discharge programme were very confident in caring for their baby, more so than longer hospital stay mothers although this was not statistically significant.

Confidence in caring for baby has been added to the revised conceptual framework because it was considered by mothers to be a factor which influenced their perceived readiness for discharge. This confidence was discussed by all women and was therefore included in the revised conceptual framework (Figure 3).

Own Environment

All of the women in the study preferred their own environment to that of the hospital. The reasons for this preference varied but could be summarised under four main headings. As presented in the findings the four aspects that made home a more attractive environment for the mothers were: being able to establish their own routine; for comfort and rest; to assist their physical recovery; and having control over what they were doing.

Routine.

Being able to establish a routine for sleeping, eating and caring for their baby was a strong motivating factor for going home for the mothers. The opportunity to establish a routine has been previously reported (Baafi, 1995; Kenny et al., 1993) and provided the women with the opportunity to do things how and when they liked. In the cases of the women who received conflicting advice it was a chance to get away from the conflict and establish a routine of care that worked for them.

Comfort and rest.

The relaxed environment of home, where the mothers felt comfortable and more able to rest was also a positive motivator for going home from hospital early. The women listed uncomfortable hospital beds, a noisy environment including other crying babies, boredom and a

lack of feeling comfortable in hospital surroundings as reasons for being more relaxed at home. This supports Hall and Carty (1993) who described women's home environments as supportive and relaxing.

Some previous research has found that women have chosen to stay in hospital longer for the quieter environment and the opportunity to rest and sleep (Lemmer, 1987; Patterson, 1987). Both studies included significant numbers of first time mothers who opted to stay in hospital for this reason. This did not apply, however, to the new mothers in this current research. Like the mothers reported by Brown et al. (1995) and Campbell (1992), mothers in this study preferred the relaxed environment of home where they felt more comfortable and could rest more easily.

Recovering physically.

Brown et al. (1995) questioned the assumption that longer hospital stay women had greater opportunity to rest and recover. This view was supported by the mothers in this current study. The mothers revealed that the increased comfort and rest provided by their home environment assisted them in recovering physically from the birth. The actual physical discomfort of sore perineums was reported by some women to have been improved by going home. The ability to get more rest and sleep due to having a partner or family member take the baby for a few hours enhanced the mothers ability to cope with tiredness and fatigue.

Ruchala and Halstead (1994) reported that women blamed fatigue and physical discomfort on too little time to recuperate in hospital. The new mothers in this current study disagreed with this point and felt that they had greater opportunity to recuperate at home because they had more control over what they were doing. Rubin (1984) states that women are not physically recovered by day three, which is the day most mothers are going home on early discharge. However, this group of mothers said that they preferred to recover at home. It should be remembered however, that the recognised length of physical recovery after giving birth is six weeks, the length of the puerperium (Ball, 1989). Even longer hospital stay mothers are still recovering when they leave hospital.

Control.

Being in control of what they were doing and what was happening to them was another motivating factor for the women to go home early from hospital. Controlling the number of visitors, also reported by Herbert (1994), caring for their baby, sleeping in their own beds and eating when and what they wanted were important to all the mothers.

Going home from hospital on early discharge enables women to take control of their postpartum recovery and infant care. Being in their home environment with the knowledge that support is available enhances their

ability to take control (Hall & Carty, 1993; Paavilainen & Astedt-Kurki, 1997).

The category of own environment has been added to the revised conceptual framework (Figure 3) as this was a strong influencing factor in the mothers' perceptions of their readiness to go home. Physical recovery has been included as a separate category, but remains linked to own environment, in the revised conceptual framework to replace birth experience. The women in this study did not reveal that their birth experience, despite variations in their labours and deliveries, impacted on their readiness for going home from hospital on or before day three. Even the caesarean section mother perceived she was ready to go home. The actual birth experience was not a major focus for this group of women. Therefore, birth experience was not considered to be an influencing factor and has been replaced with physical recovery in the revised conceptual framework (Figure 3).

Revised Conceptual Framework

As a result of the findings gained from this study it has been necessary to create a revised conceptual framework (Figure 3). Some categories have been merged to form revised ones and new influences have been added.

Birth experience has been replaced by physical recovery, antenatal education and postnatal education have been combined with self education to form information and help before going home, and attitude has

been replaced by awareness of early discharge. Informal support and formal support have been merged to form one category entitled information and help after going home instead of being split into two sections. Two new categories have been added to the framework. These new groups are confidence in caring for baby, and own environment as both categories were mentioned by all women who were interviewed. Physical recovery has been linked to own environment because the mothers revealed that being in their own environment enhanced their physical recovery.

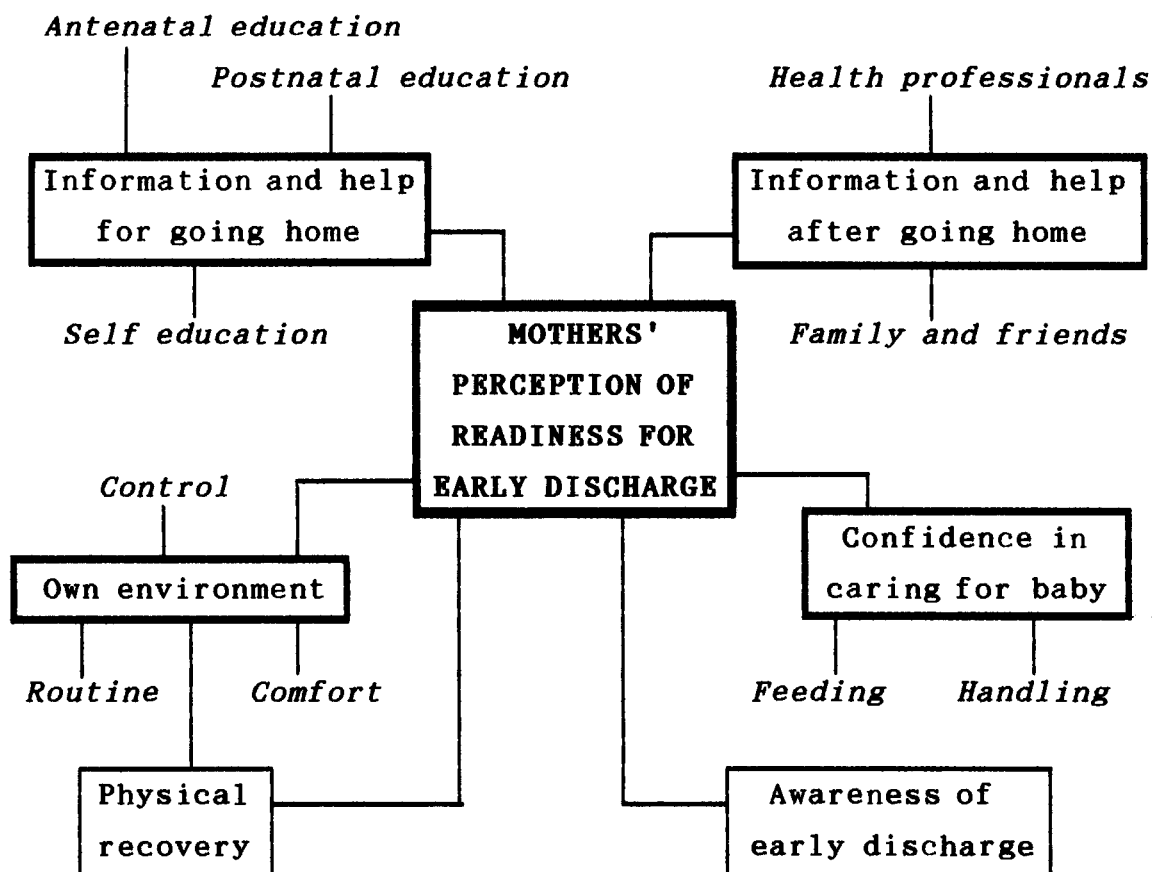


Figure 3: Revised conceptual framework

The influence of a settled baby compared to an unsettled baby as mentioned previously, in relation to the initial conceptual framework, did not emerge from the study findings. Three mothers had unsettled babies with colic but this did not affect their perception of their readiness for going home. The influence of the baby has therefore not been included in the revised conceptual framework.

Conclusion

The perception of the first time mothers in this study was that they were ready to go home from hospital within three days of having their babies. This readiness was in a physical, emotional and informational sense.

The majority of mothers felt their preparation, by the hospital and themselves, was appropriate and adequate. They felt more comfortable at home in their own environment where they were able to rest more, establish a routine and were in control of what they were doing. The mothers were confident in their ability to care for their babies.

The information and help provided before going home from hospital was perceived as being helpful by the majority of the mothers. This information and help came from the midwives in the antenatal and postnatal periods and from the self education the women undertook.

A major part of the perceived readiness for going home was the support that was available to the mothers. Help provided by health professionals and family and

friends enabled the mothers to go home knowing that they were not being left alone to care for their baby. The domiciliary follow-up home visits were very helpful to the mothers and appear to be the only difference in the support network for early discharge women when compared to longer hospital stay mothers.

This was not a comparative study between early discharge and longer stay women, but several mothers indicated that the help they received at home, from their family and friends, would have been the same regardless of the amount of time they spent in hospital. If they had stayed longer they would not have received home visits from the domiciliary midwives. All other professional agencies are still available to support longer hospital stay women.

Developing confidence in caring for their baby was another essential aspect for these new mothers. Being confident with feeding and handling their baby was perceived by all mothers as essential for them being ready to go home from hospital.

Being in their own environment was another important feature of going home for this group of mothers. The familiar surroundings, the comfort of their own beds, the chance to establish a routine, the ability to control their day to day activities, and a perceived opportunity to recover physically were positive motivators to going home.

As a midwife, who has been recently involved in the preparation of women for going home on early discharge, I have found the findings of this study very refreshing and reassuring. At the commencement of this study I was concerned that women, particularly first time mothers, were being discharged from hospital before they were ready to go and as such may not have been coping at home. This has not been the case for this group of mothers and the findings have shown me that early discharge for this group of primiparous women was suitable.

Implications for future research

More exploratory-descriptive research of early discharge programmes needs to be undertaken. This study has explored the perceptions of only one group of women. There are many more who have a voice that needs to be heard. Future research of this nature should examine non-English speaking women, single mothers as a separate entity to gain a broader picture of their perceptions of their readiness for going home, and adolescent mothers. These three groups possibly represent 'at risk' women in our community and their experiences must be explored. Similar studies could be conducted across a broad spectrum of women on early discharge programmes and provide valuable information for the future of discharge planning.

Domiciliary midwives could also be surveyed to ascertain the issues or concerns they perceive that

early discharge mothers may have. Other research could examine the self education of women on early discharge programmes compared to that of women who stay in hospital longer. Continuity of care provider in relation to the amount of conflicting advice could also be explored.

Implications for clinical practice

The findings of this study reveal a group of first time mothers that were predominantly happy to go home from hospital within three days of giving birth. Collectively their perceptions of their readiness for going home reflects well on the discharge planning of the study hospitals. There remains however some gaps in the clinical practice of some midwives (See Appendix F).

It is apparent that conflicting advice needs to be addressed. Midwives need to be more flexible in their approach to giving new mothers advice. Midwives should be providing new mothers with options of care which may decrease the perceptions of conflicting advice. Staff need to be aware of protocols for teaching and follow them. New mothers, particularly first time mothers need to be given appropriate, consistent advice to help them to develop the confidence to care for their own babies.

Nursing administrators must consider the patients' needs when rostering staff to cover ward areas. Staff should whenever possible be rostered to the same ward area to assist in the provision of continuity of care by the same midwives. If there is an improvement in the

continuity of carer, there may be a resultant decrease in conflicting advice with a subsequent increase in confidence for the mothers.

Midwives need to be aware that as adults, mothers need to have the ability to access information and help when required. A list of resources and contact numbers should therefore be given to all new mothers to facilitate their access to support agencies.

Busy hospital wards are stressful work environments but all midwives must still display a caring attitude toward their patients. It is essential that all midwives are not judgemental of their patients and provide a high standard of care to enable all women to succeed in their new role as a mother.

With the apparent success of this group of mothers in an early discharge programme, the main issue associated with readiness for discharge was awareness. It is vital that midwives ensure that all women are aware of the expected date of their discharge and what follow-up care they will receive. This should be done antenatally so that the mothers have sufficient time to get used to the idea of going home within three days of giving birth. Awareness of early discharge allows the women to start their own individual preparation for early discharge which begins in the antenatal period.

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Appendix A

SEMI-STRUCTURED INTERVIEW GUIDE:

1. How did you feel about coming home from hospital?
2. How well do you think you were prepared for coming home?
3. How confident did you feel in your ability to look after your baby? (Bathing/feeding/changing/settling).
4. What would have helped you to be better prepared for coming home?
5. What support do you have, or are you aware of, to help you care for your baby? (Formal and Informal).
6. What did you understand about early discharge before you had your baby?
7. Was it your choice to have early discharge from hospital?
8. How does being a mother differ from how you thought it would be?

Appendix B

PARTICIPANT INFORMATION AND CONSENT FORM

Dear Participant,

My name is Graeme Boardley. I am a midwife and student in the Master of Nursing course at Edith Cowan University. I have undertaken this research study because I am interested in finding out how first time mothers, who are discharged on early discharge programmes, feel. The information gained from this study will be used to assist in future discharge planning.

You have already agreed to take part in a larger study being conducted by Edith Cowan University, and have been chosen for my study because you are a first time mother in an early discharge programme. Participation in this study is voluntary and will involve one only interview (of approximately one hour) to be conducted in your home at your convenience, two to three weeks after the birth of your baby. You may withdraw from this study at any time and do not have to answer any questions that make you feel uncomfortable.

The interview will be tape recorded and information gained will be coded to ensure your confidentiality and will not in any way identify you.

Any questions relating to this study can be directed to me, Graeme Boardley, Master's student on

I, the undersigned have read the above information and agree to participate in the study. I understand that I may withdraw from the study at any time and give permission for the information gained to be used for publication providing I cannot be identified in any way.

Participant's Signature.....

Researcher's Signature.....

Date.....

Appendix C

EXCERPT FROM TRANSCRIBED INTERVIEW

Interview 14 - Sarah

How did you feel about coming home from hospital?

Actually, I rather, I went on the
early discharge programme which was
better because I don't like being in *DOESN'T LIKE*
hospital. Even though they were good I just *HOSPITAL*
didn't feel comfortable and it was better *DIDN'T FEEL*
that I actually had the midwives come to the *COMFORTABLE*
house and I suppose because I could do my *DO OWN THING*
own thing in my own home and I found it easier,
just a lot easier, yeah. I was looking *OWN HOME*
forward to it, I was actually asking them
when can I go home. *Physically, how did you feel?*

Physically, I wasn't too bad actually, the *PHYSICALLY*
only thing that was worrying me a little bit *RECOVERING*
was my stitches, but they were getting *SORE*
checked regularly and I was OK after a few *DOMICILIARY*
days. It was pretty good when I first came *FOLLOW-UP*
home.

*What support do you have, or are you aware of, to help
you care for your baby?*

A lot of support. Both our families
are European so um, Mum and my mother-in- *FAMILY*
law. My mum's a very calm person, she's *SUPPORT*
fantastic if I'm worried about something,

well she'll just say oh nothing's a problem,
 I'll come round and have a look and take
 her off your hands for five minutes or
 something like that. My husband's good,
 he's really really good. Obviously he's at
 work all day, so the time he spends after
 he's had a shower and um he's home, so I
 can cook tea or do something, so he spends
 time with her which is good.

PARTNER

SUPPORT

The clinic sister, actually I heard a
 lot of horrible stories about clinic sisters
 but she's really, really, really good. My
 GP's fantastic, he was actually going to
 deliver her but didn't have time, so,
 because she came too quickly. I had a
 midwife come every day for three days
 and then had one alternative days for four
 days, like every second day they came. I
 got the blurb on a few other different
 places. That was the first thing actually
 that, was give me all, if you need after
 hours advice or parenting information,
 these are the places to contact so that
 was good, yeah.

CHILD HEALTH

NURSE

OWN DOCTOR

DOMICILIARY

MIDWIFE

OTHER

AGENCIES

AVAILABLE

TO HELP

OR GIVE

ADVICE

Appendix D

FIELD NOTE - INTERVIEW 16 (KATE)

Kate is a single mother who appears to be very happy and capable in caring for her baby. Sitting outside in the garden, under a large hibiscus tree, Kate was very relaxed and willing to share her experience.

Throughout the interview Kate was breast feeding her daughter Grace. She appeared comfortable feeding with me interviewing her. Kate handled Grace very competently and carefully. At times when Grace detached herself from the breast Kate very quietly and confidently reattached her.

Kate spent several long periods gazing at Grace whilst answering questions and was obviously happy and comfortable in her role as a mother.

Appendix E
AUDIT TRAIL

<u>Quote:</u>	<u>Common response:</u>	<u>Sub- theme:</u>	<u>Main theme:</u>
"Just to get into your own routine instead of being in theirs . . .".	<i>Routine</i>	R O U T I N E	
"I think it's better to come home early . . . and start getting into a routine".	<i>Routine</i>		
"Because of the way the beds are, they're quite hard and they're not very comfortable . . .".	<i>Uncomfortable Beds</i>	C O M F O R T	O W N
"They are the most uncomfortable beds in there that I've ever had".	<i>Uncomfortable Beds</i>		E N V I R O N M E N T
"I think it's better to come home early and recover at home".	<i>Recovering physically</i>	R P E H C Y O S V I E C R A I L N L G Y	
"I was still recovering physically but I was alright. I was so tired, I couldn't believe it. . . but being home, my husband has helped . . .".	<i>Recovering physically</i>		
"I felt better at home . . . I could eat what I want when I want . . .".	<i>Eating when suits</i>	C O N T R O L	
"You feel like you can relax more at home . . . in hospital there's always visitors".	<i>Control over visitors</i>		

Appendix F

EXCERPT FROM REFLECTIVE JOURNAL

Three women I have interviewed so far have mentioned receiving conflicting advice. I remember being made aware of the potential impact of conflicting advice several years ago during my midwifery education.

One of the patients I was caring for was experiencing problems with engorged breasts, so I sought advice from some midwives on how to best relieve the symptoms my patient was suffering. Two midwives gave me different pieces of advice that were so far apart it was impossible to know which was the correct advice to give to the patient. One midwife wanted the woman to express a small amount to relieve the engorgement, the other wanted to apply a binder.

This conflicting advice served only to confuse me, let alone what it would have done to a first time mother. The end result after discussion with both midwives together, was that one of them had been away from the hospital for a few years and was unaware that the protocol for treatment had changed.

This experience taught me very early in my midwifery career, the importance of being aware of treatment protocols and giving correct, consistent advice to patients.