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MATERNAL CONCERNS AFTER DISCHARGE FROM THE HOSPITAL

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ABSTRACT

The maternity period, as well as the postpartum after the hospital discharge, are regarded as the perfect timing to provide information and training in nursery care to the puerperal, increasing her competence and making her the main agent in her well-being. It is in this period of physical and psychological recovery that the woman experiences many transformations, and emerges the need for health professionals to provide technical support to the mothers in the new reality.

Objective: Understand the main concerns felt by the puerperal at the time of hospital discharge.

Method: Descriptive and exploratory study of quantitative nature. The maternal concerns questionnaire (QPM) was used to obtain maternal concerns and thus to adapt information/training to the needs/interests of women.

Results: Concerns regarding to puerperal, new born, partner, family and community were identified. The postpartum period of hospitalization proves to be insufficient regarding to the acquisition of basic maternal skills.

Conclusion: It is necessary to be aware of maternal concerns and find strategies to solve the doubts/preoccupations and help the puerperal to live the adaptation to maternity in a conscious and healthy way.

Descriptors: Postpartum period; maternal concerns; knowledges; patient discharge; nurse midwives.

INTRODUCTION

According to the history of human civilization, women are responsible for the promotion of care in order to continue life, the woman should be responsible not only for self-care but also for family care, which, regarding the mothers, are essentially the newborn and the mate[1]. Hence it was assumed that all women would be able to take care of themselves and their own, even in the postpartum period. In Portugal, the organization of health services, namely with the emergence of the National Health Service (NHS) in 1979, contributed to the evolution of care provided to puerperal women. Despite several information and teaching strategies being available to pregnant women, these are not sufficient to improve their knowledge and develop their skills. Puerperas continue to face many difficulties in understanding the needs of their babies and are afraid of not being able to take good care of them[2-3].

The transition to motherhood is made in three phases, these occur during the first weeks of postpartum and are characterized by: 1) dependent behaviors or absorption phase, 2) dependent-independent behavior or empowerment phase and 3) independent behavior or relaxation phase[4]. According to the research by Martin et al.[3], these phases should occur between three to five days, however, owing to today's early discharge women are forced to speed up these phases. Becoming a mother implies much more than assuming a role, it means learning new skills and increasing self-confidence as new care challenges arise[5].

One moment that can be considered as unique and particular in a woman's life cycle is the postpartum period, characterized by multiple changes and adaptations, being also considered a transitional period[6]. The countless transformations and adaptations that began in pregnancy continue to happen, whether at a physical, psychological or social level. All these adaptations are part of a natural process and occur in order that the woman's body and mind may equal the woman's personal characteristics before pregnancy[7].

By becoming a mother, the woman will have to perform numerous roles, in other words, by being a mother the woman will assume different identities and the adaptations take place at a very quick and frightening pace for those who, due to the social, physical and psychological changes, face a fragile period characteristic of postpartum women. Reinforcing this idea Raynor[8] considers postpartum a phase in which, in addition to the physiological changes that women experience as a result of the puerperium, they also undergo very striking psychosocial changes as the transition to motherhood occurs.

Women experiencing the puerperium are more vulnerable and take increased risk of physical, psychological and social problems, which can also affect other family members and the newborn[9-10], such as: early termination of breastfeeding, cognitive delays of the child and the impairment of the mother-infant relationship.

After the birth of a child, a myriad of questions arises, certainties and uncertainties that can be overcome with the support of the Specialist Nurse in Maternal and Obstetric Health. Maternal concerns experienced intensely and obsessively in the postpartum period can become distressing and may make decision-making and problem solving[11] impossible. Also postpartum stressors can lead to anxiety, tiredness and decreased self-care, often associated to the increased risk of physical disorders[12].

However, despite the woman's assumption that there is a natural capacity for adaptation in this new phase and reality, this entails many formal and informal learning. Becoming a mother entails more than taking on a role, it includes learning new skills and increasing confidence in yourself. Thus, the knowledge of maternal needs/concerns becomes es-

sential for clinical nursing practice, namely the type and amount of information provided and the adoption of strategies that strengthen maternal skills, for the transition to a healthy parenting role[9]. The objective of this study was to identify the main concerns felt by the puerperal women at the time of hospital discharge.

MATERIAL AND METHODS

A descriptive-exploratory study of quantitative nature was performed. For the application of the questionnaires in a maternity hospital in southern Portugal, appropriate authorization requests were made to the board of directors, which were authorized. The Opinion of Ethics Committee No. 17014 was favorable. The puerperas were invited to participate by completing a self-questionnaire. All procedures were explained and informed, clear and free consent was given by the women. All ethical duties were followed, respecting and ensuring the principles of the Helsinki Declaration.

A non-probabilistic sample was obtained, since the population elements do not have an equal probability of being chosen to constitute the sample[13]. For convenience, mothers who experienced childbirth from April 2 to June 15, 2018 were selected. Patients who did not speak Portuguese and whose newborn was not full-term or had neonatal complications were excluded. The sample consisted of 127 puerperas.

The puerperal questionnaire consists of two parts: in the first, in order to obtain a complete characterization of the sample, it comprises 16 answer items, being the first seven for socio-demographic characterization, and the other nine for obstetric characterization. The second part refers to the Maternal Concerns Questionnaire (MCQ), by Sheil et al., (1995)[14], Portuguese pilot version of Mendes, Rodrigues, Santos and Pedrosa (2010)[15].

The variable is measured using a four-point Likert scale ranging from 1 to 4, where 1 corresponds to "no concern"; 2 the "little concern"; 3 the "moderate concern", and finally; 4 to "high concern". The higher the score the higher the level of concern.

In MCQ five dimensions are considered where each introduces several associated items. In the first dimension, "Concerns About You", in the second dimension "Concerns About Your Newborn", in the third dimension "Concerns About Your Mate", in the fourth dimension "Concerns About Your Family" and finally in the fifth dimension the "Concerns about the Community" are evaluated.

When a questionnaire is applied, the researcher should always verify whether the data collection instrument is reliable and valid[13]. To estimate reliability, the Cronbach's Alpha was applied, which in this questionnaire obtained the value of 0.95, which reveals a very good consistency, that is, a high reliability because the closer the value to 1 the higher is its reliability[16]. It was assumed as significance value p <0.05 and the data were analyzed in the version 22 of the IBM SPSS Statistics software.

RESULTS

The data from the questionnaires were treated statistically and are presented through tables in order that the presentation, the discussion and the confrontation with the authors consulted could be more expressive. Regarding the sociodemographic characterization, the puerperal women are between 15 and 41 years old, with an average of 32.1 years (sd= 4.3). The Mode (Mo) is 28 years old with 9.4% of cases. In general 121 puerperas have Portuguese nationality (95.2%); 118 are Catholic (92.9%); 88 are married or in de facto union representing 69.3% and 109 (85.8%) live with their husband/partner. 51 postpartum women have secondary level qualifications representing 40.1% of the analyzed cases (Table1).

Table 1 – Sociodemographic Characterization.

Variable	Puerperal women (N= 127)	N	%
Nationality	• Portuguese Nationality;	121	**95,2**
	• Spanish Nationality;	1	0,8
	• Romanian Nationality;	3	2,4
	• Brazilian Nationality.	2	1,6
Religion	• Catholic religion;	118	**92,9**
	• Agnostic/atheist/without religion;	9	7,1
Marital Status	• Single;	30	23,6
	• Divorced;	9	7,1
	• Married/de facto union.	88	**69,3**
Who you live with	• Alone;	2	1,6
	• With husband/partner;	109	**85,8**
	• With parents/in-laws;	14	11,0
	• Other.	2	1,6
Academic qualifications	• 1st cycle (1st to 4th grade);	3	2,4
	• 2nd cycle (5th and 6th grade);	5	3,9
	• 3rd cycle (7th to 9th grade);	33	26,0
	• Secondary (10th to 12th grade);	51	**40,1**
	• Higher Education.	35	27,6

Regarding the obstetric characterization of the sample, we can verify that most of them (53.5%, n= 68) are primiparous. Regarding the 59 multiparous (46.5%), most had 3 children or 64 , 4%. However, 7 (11.8%) gave birth to their second child; 8 to the fourth child (13.6%); 5 to the fifth child (8.5%) and one to the sixth child (1.7%). Overall (61.4%, n= 78) reported that it was a planned pregnancy and 92.9% of the sample (118) added that it was a desired one.

Regarding the type of delivery, the question was left open so that it could be classified only in eutocic or dystocic delivery. Thus, according to the current sample 107, ie 84.3%, experienced eutocic delivery and 20 (15.7%) dystocic delivery by caesarean; there were no situations of forceps or suction cups.

Pregnancy surveillance is highly important and there should be at least 6 appointments during pregnancy[17] to be considered a monitored pregnancy regardless of where they occur, whether in the health center, public hospital or private practice. Thus in the present sample we found that 3 mothers (2.4%) reported not having surveilled their pregnancy; 36 (28.3%) followed surveillance at the hospital, 48 puerperal women (37.8%) we-

re surveilled at the Health Center and 40 postpartum women (31.5%) were survellled in private practice.

Considering the values obtained, most mothers (88.2%, n= 112) stated that they had experienced contact with newborns prior to the current delivery. The most frequent care provided was holding them on the lap, corresponding to 112 (100%) of the cases (Table 2).

Table 2 – Providing care to other newborns before current delivery.

Care provided to RN	N	%
Bath	61	54,5%
Food	71	64,4%
Holding on lap	112	100%
Walking	73	65,1%
Diaper changing	68	60,7%
Put to sleep	66	58,9%
Calming when crying	65	58,0%

In the second part of the questionnaire related to the QPM Scale it was possible to identify the main concerns of the puerperas felt at the time of hospital discharge in the five dimensions.

In the dimension "Concerns about You", the ones that stand out as the most worrying for the mothers were: item 10 "breast care" ($\bar{x}$= 2.76; sd = 0.88); Item 9 "breast pain" ($\bar{x}$= 2.65; sd= 1.04); item 6 "discomfort caused by episiorrhaphy points" ($\bar{x}$ = 2.57; sd= 0.90); item 12 "emotional tension" ($\bar{x}$= 2.48; sd= 1.03); item 11 "exhaustion" ($\bar{x}$= 2.44; sd= 0.91); item 3 "return to body shape before pregnancy ($\bar{x}$= 2.38; sd= 0.99). On the other hand, the least felt concerns in which the averages are between 2.36 and 1.86 were: item 17 "having time to personal care" ($\bar{x}$= 2.36; sd= 0.92), item 1 " nourishment" ($\bar{x}$= 2.22; sd= 0.87); item 14 "labor experience" ($\bar{x}$= 2.19; sd= 0.96); item 16 "depression" ($\bar{x}$= 2.04; sd= 0.77); item 13 "inability to concentrate" ($\bar{x}$= 1.98; sd= 1.03); item 2 "physical exercise habits" ($\bar{x}$= 1.97; sd= 0.87); item 7 "constipation" ($\bar{x}$= 1.96; sd= 0.90); item 5 "vaginal discharge" ($\bar{x}$= 1.96; sd= 0.98) and item 4 "return of menstruation" ($\bar{x}$= 1.93; sd= 0.78); item 15 "home alone feeling" ($\bar{x}$= 1.89; sd= 0.74); item 8 "hemorrhoids" ($\bar{x}$= 1.86; sd= 1.44).

In the "Newborn concerns" dimension (Table 3) the average value goes up and the answers are mostly of value 4, ie "a lot of concern". Noteworthy here, with average values between 2.63 and 3.05, are the following concerns: "being a good mother" (item 18, $\bar{x}$= 3.05; sd= 0.87), "Safety, accident prevention" (item 28, $\bar{x}$= 3.04; sd= 0.973), "Newborn feeding" (item 21, $\bar{x}$= 3.00; sd= 0.86), "identifying illness signs" (item 26, $\bar{x}$= 2.96 sd= 0.86), "normal growth and development" (item 20, $\bar{x}$= 2.94; sd= 0.93), "Newborn behavior interpretation" (item 24, $\bar{x}$= 2.70; sd= 0.87), "feeling comfortable when dealing with the Newborn" (item 23, $\bar{x}$= 2.69; sd = 1.54), "how to dress the Newborn" (item 29, $\bar{x}$= 2.66; sd= 1.066), "physical care" (item 22, $\bar{x}$= 2.63; sd= 0.99). On the other hand, items that show less concern are between 2.25 and 2.45 (Table 3).

Table 3 – Dimension Concerns About Your Newborn.

Item	$\bar{x}$	sd
27. Travelling with the Newborn	2,25	1,082
19. Physical appearance of Newborn	2,42	1,033
25. Not waking up with Newborn's cry	2,45	0,899
22. Physical Care	2,63	0,997
29. How to dress the Newborn (clothes too hot/cold	2,66	1,066
23. Feeling comfortable handling the Newborn	2,69	1,544
24. Interpretation of Newborn behavior	2,70	0,875
20. Normal growth and development	2,94	0,933
26. Identify illness signs	2,96	0,865
21. Feeding the Newborn	3,00	0,865
28. Safety (accident prevention)	3,04	0,973
18. Being a good mother	3,05	0,876

Regarding the concerns with the partner (Table 4), these present lower values of concern indicating that the average ranges from 1.62 to 1.94, in this dimension we will find values in which the greatest concern is felt regarding the item "having time to be alone" (item 33, $\bar{x}$= 1.94; sd= 0.94).

Table 4 – Dimension Concerns About Your Partner.

Item	$\bar{x}$	sd
34. Sexual relations	1,62	0,977
31. The partner being a good father	1,63	1,043
35. Family planning	1,70	1,045
32. Have time for fun	1,74	0,875
30. Relationship with the Newborn's father	1,87	0,887
33. Having time to be alone	1,94	0,942

Regarding family concerns, the average is between 2.04 and 2.29. Responses generally focused on "moderate concern". It is the "change in family lifestyle" (item 37, $\bar{x}$= 2.29; sd= 0.89), which concerns the postpartum woman more significantly. The items "Economic Resources" (Item 39) and "Household Management (item 36) have an average of 2.23, sd= 0.89 and 2.28 sd= 0.86) respectively, but the item" setting limits of visits "is where the puerperas mostly showed no concern (item 38, $\bar{x}$= 2.04; sd= 0.93).

The items that involve "community-related concerns" (Table 5), they present an average ranging from 1.57 to 2.30, where the most relevant concern is related to work/employment (item 47, $\bar{x}$= 2.30; sd= 1.01).

Table 5 – Dimension Community Concerns.

Item	$\bar{x}$	sd
40. Change in relationships with single friends	1,57	0,733
42. Change in relations with friendly couples	1,57	0,678
48. Participation in community activities (community celebrations)	1,62	0,855
41. Change in relations with relatives/family	1,70	0,887
43. Advice from family or friends	185	0,734
46. Ease of access to purchases	1,94	0,773
44. Access to health care: health center, hospital/ maternity hospital	2,04	0772
45. Availability of Community resources	2,13	1,072
47. Work/employment	2,30	1,015

DISCUSSION

Considering the 5 dimensions mentioned above, it was possible to highlight the needs/concerns felt by the puerperal women at the time of hospital discharge. Among others, the following are considered basic needs: being able to live in society, good living conditions, easy access to health services and autonomy capacity[10]. There are several discomforts in the postpartum period and in the dimension "Concerns about the self", the painful complaints that lead to fatigue and decreased predisposition to self-care are visible[2,18]. The postpartum women's needs are also intertwined with their idiosyncrasies as a person, based on their life background, social class, as well as their way of thinking and acting, in this period of life, their vulnerability is at its height[10]. The concern "emotional tension" was also mentioned by the mothers because it is closely linked to the maternal experience lived during hospitalization.

In addition to those previously mentioned, this study emphasizes the need to promote well-being and safety for the child, to reconcile daily tasks and rhythms and to recover previous practices and conditions of life; affective-social and affective-marital needs; needs to regain autonomy and freedom and the need for family and social support, which confirms other authors[10,19]. The needs identified by the mothers are related to: having time for themselves, rest, breastfeeding; have guidance. safety, listening and comprehension relating to the needs felt and experienced in this period. Caetano and collaborators while performing the integrative review have also identified six dimensions that reflect the maternal concerns felt in the postpartum period: caring for the newborn; functional recovery; transition to parenting; marital relationship; family/social support, and lastly support from postpartum health professionals[9].

Most women value newborn and family care more than self-care, considering that their experience with the puerperium may be related to multiple factors, such as sociocultural, obstetric, and help/intervention of health professionals. Other postpartum concerns are highlighted by mothers who corroborate those of other authors, such as: hygiene knowledge related to perineal care; blood loss in postpartum; contraception and restart of sexual activity; recovery exercises and especially newborn care[19].

Postpartum needs are a concern for women but their knowledge of this phase is generally quite scarce[20]. Needs in the postpartum period cannot be restricted to the immediate postpartum period experienced in the hospital, but throughout the postpartum period. When it's time to come home many doubts and fears arise and the contact with the health professional becomes more difficult. The mothers often search for information

among their friends, relatives, internet, being most of the information contradictory and unreliable, which raises more doubts[21]. Empowering women for homecoming is the responsibility of the maternal health specialist nurses who ideally should train women for discharge during hospitalization. Some doubts and difficulties arise progressively throughout the period of hospitalization, others at a later stage, already at home. Preparation during the prepartum period can bring benefits to the postpartum phase and help overcome these difficulties[3,21].

There are several studies that demonstrate the importance of keeping mothers informed and cared after discharge, even calling them "obstetric psychoprophylaxis", and under this medical monitoring women would better adapt to their new stage of life and consequently it would reduce health expenses, since unnecessary appointments and even visits to the emergency services would be avoided[19].

CONCLUSION

With the help of this study and the application of the MCQ scale it was possible to identify the main concerns felt by the puerperas at the time of hospital discharge, emphasizing that the concerns are about themselves, the Newborn, the partner, the family and the community. Through the results obtained, it is possible, in the future, to address these concerns in the appointments of pregnant women, in the Preparation for childbirth and postpartum courses in order to respond to the needs of Pregnant and Puerpera Women. According to the opinion of the Nursing Council of the Order of Nurses (OE, opinion no. 12/2011) the puerperal and the NB have to be monitored according to the needs identified by the Specialist Nurse. Also opinion no. 4/2016 of the board of the specialty college determines that the Specialist Nurse in Maternal and Obstetric Health is the health professional with the necessary skills for the creation and implementation of such courses, ensuring that they transmit knowledge and that the puerperas are able to take care of themselves and also take care of the newborn.

Regardless of whether it is a primiparous or multiparous, the postpartum phase is characterized by great needs for care and protection for both the mother and the Newborn. Everything that involves self-care, newborn care, and access to health services may raise doubts, so these are questions that must be answered in order that the postpartum path can be made peacefully[1].

In the present research it was found that the highest levels of concern are centered on the newborn, then the concerns about themselves, followed by those with the partner and family experience and finally with the community. Also through the research conducted it can be concluded that the follow-up done in the postpartum period is extremely relevant, during this period the woman is very vulnerable due to all the transformations she undergoes. Understanding the needs of the postpartum woman by the health professional can avoid the emergence of problems and help the woman/family live a healthy motherhood in all its dimensions.

The firm belief is that postpartum is still a little debated area in specialized care and needs strong intervention by the Specialist Nurse in Maternal and Obstetric Health and that scientific research in this area is necessary and extremely important in order to ratify the actions and strategies developed.

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