EARLY POSTPARTUM DISCHARGE:
FACTORS AFFECTING A WOMAN’S DECISION NOT TO PARTICIPATE

by

JILL MAHY

BSN, The University of British Columbia, 1987

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES
(School of Nursing)

We accept this thesis as conforming to the required standard

Signature(s) removed to protect privacy

THE UNIVERSITY OF BRITISH COLUMBIA
August, 1994

© Nancy Jill Mahy, 1994
In presenting this thesis in partial fulfillment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

(Signature)

Department of Nursing
The University of British Columbia
Vancouver, Canada
Date August 31, 1994
ABSTRACT

This study was designed to investigate factors influencing a woman’s decision not to participate in an early postpartum discharge program. A factor-searching exploratory survey study was chosen for this study. The conceptual framework directing the study was Pender’s (1987) Health Promotion Model. The sample was composed of 55 postpartum women who gave birth at a tertiary care maternity hospital during a two month period. The study participants and their newborns had met the hospital’s early discharge program criteria but the women had made the decision not to participate. All the women in the study were interviewed by the investigator on their second or third postpartum day prior to hospital discharge.

The reasons expressed by the women for not participating in the hospital’s early discharge program were grouped into two major categories: need for physical and emotional restoration, and need for care. External and internal influences on their decision were also identified.

The need for physical and emotional restoration included the following: need for sleep, rest and relaxation, need for comfort, and need for time alone. The need for care included: need for help, need for support, and need for protection. External and internal influences and barriers affecting a woman’s decision to stay in the hospital included: children at home, no help at home, lack of awareness of the program and influences of physician and family.
Recommendations from this study include the need for further research to examine the perceptions and benefits of early discharge in regards to consumers, varying cultural groups, and health-care professionals. Education with respect to the concept of early discharge is also needed. Postpartum preparation and planning for women and their families in the prenatal period through strong collaboration and networking between hospitals and community health units, and the establishment of family, community support systems, and resources is crucial. Development of a regional wide perinatal home care program, standardized perinatal healthcare and follow-up for childbearing women and their families is also strongly recommended.
TABLE OF CONTENTS

Abstract .......................................................................................................................... ii
Table of Contents ........................................................................................................... iv
List of Tables ................................................................................................................ vi
List of Figures ................................................................................................................. vii
Acknowledgements ...................................................................................................... viii

CHAPTER ONE: INTRODUCTION

Background to the Problem ......................................................................................... 1
Problem Statement ......................................................................................................... 2
Purpose ............................................................................................................................ 3
Conceptual Framework ................................................................................................. 4
Significance of the Study ............................................................................................... 6
Definition of Terms ........................................................................................................ 6
Assumptions of the Study .............................................................................................. 8
Limitations of the Study ............................................................................................... 8
Summary ......................................................................................................................... 9

CHAPTER TWO: REVIEW OF SELECTED LITERATURE

Introduction .................................................................................................................... 10
Early Postpartum Discharge ......................................................................................... 10
Maternal Tasks ............................................................................................................... 19

CHAPTER THREE: METHOD

Introduction .................................................................................................................... 27
Research Design ............................................................................................................. 27
Sample ........................................................................................................................... 27
Data Collection Procedures ....................................................................................... 28
Data Analysis ................................................................................................................ 29
Ethical and Human Rights .......................................................................................... 30
Summary ......................................................................................................................... 30

CHAPTER FOUR: PRESENTATION OF FINDINGS AND DISCUSSION

Introduction .................................................................................................................... 31
Characteristics of the Sample ...................................................................................... 31
CHAPTER FIVE: SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction ................................................. 59
Summary ...................................................... 59
Conclusions ................................................. 61
Implications for Nursing Practice ....................... 61
Implications for Nursing Education ..................... 65
Recommendations for Nursing Research ................ 66

REFERENCES ................................................ 68

APPENDICES
  Appendix A: Program Criteria ............................... 73
  Appendix B: Information Letter ............................. 75
  Appendix C: Informed Consent Form ....................... 77
  Appendix D: Physician’s Letter ............................. 79
  Appendix E: Demographic Information Sheet ............... 81
LIST OF TABLES

Table 1: Age Distribution of the Sample ........................................ 32
Table 2: Educational Level of the Sample ................................. 32
Table 3: Employment Status of the Sample .............................. 32
Table 4: Ethnic Origin of the Sample ........................................ 33
Table 5: Need for Physical and Emotional Restoration ............... 35
Table 6: Need for Care .......................................................... 44
Table 7: External and Internal Influences and Barriers ............. 52
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Health Promotion Model (Pender, 1987)</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>Interview Questions (Pender, 1987)</td>
<td>7</td>
</tr>
</tbody>
</table>
Acknowledgments

I would like to thank the chairperson of my thesis, Professor Elaine Carty and committee members Chris Bradley and Wendy Hall who generously shared with me their time, knowledge and expertise of the research topic and research process. Appreciation is also extended to the nurses working in the British Columbia's Women's Hospital/The Vancouver Community Health Maternity Care at Home Program, for their diligent recruitment of the women for this study.

I would also like to thank the women in the study who gave their time and who openly expressed their individual thoughts and experiences thus contributing to nursing research.

My thanks also extends to my husband, Robert, my dear friend Sue, and loving family and friends for their support and encouragement.

This thesis is dedicated to my mother, Joyce Mahy and my beautiful son Patrick, an early discharge baby.
CHAPTER ONE

Introduction

Background Information to the Problem

The changing needs of the childbearing family and the economics of our health care system have resulted in new practices in perinatal care. On the one hand, a desire by families for increased participation around birth and on the other, the necessity for hospitals to cut costs have led to the development of early postpartum discharge programs.

Early postpartum discharge has been defined as the discharge from hospital of low risk postpartum mothers and their infants within 6 to 48 hours following birth and with follow-up home care (Bradley, Carty & Hall, 1989; Hellman, Kohl, & Palmer, 1962). An early postpartum discharge program (EPDP) is designed to function as an organized system of support, education and follow up for mothers and infants as they leave hospital after birth.

In Canada there has been limited research conducted in the area of postpartum early discharge. Studies that have been done, primarily in the U.S., have shown that the benefits of early discharge are numerous for both the family and the health-care system. Early discharge appears healthy and safe for normal low-risk mothers and newborns (Lemmer, 1987; Norr & Nacion, 1987). Going home soon after birth can also result in increased involvement of fathers with their newborns, less separation of the family after birth, and maternity care that is wellness-oriented and less fragmented (Bradley et al., 1989; Patterson, 1987; Stern, 1991; Yanover, Jones, & Miller, 1976). Although economic health benefits have been hard to measure, it has been documented that early postpartum
discharge is an efficient use of hospital and community health services (Bradley et al., 1989; Drummond, 1984; Patterson, 1987).

At the time of the study, British Columbia’s Women’s Hospital, (formerly Grace Hospital) the largest maternity hospital in Canada, and the Vancouver Health Department were piloting an early discharge program called the "Maternity Care at Home Program". This program, although evaluated positively by the families participating in it, was providing service at only one half of its capability. Half of the mothers eligible to go home at 6-48 hours did not wish to do so. Data from other early discharge programs and research studies have also demonstrated that when early discharge is optional, participation is lower than anticipated (Bradley, et al., 1989; Stern, 1991; Waldenstrom, 1989). It appears that some women believe it is better to be at home shortly after birth while others are either unaware of the benefits of the program or choose to recover in the hospital. The belief system underlying refusal to consider early discharge needs to be understood as fewer hospitals offer the option of a traditional stay and most expect all women who have had a normal birth to go home in the first 24-48 hours after birth.

Problem Statement

Early postpartum discharge is rapidly becoming a common practice in North American hospitals. Even though research has demonstrated that women who do participate in such programs are satisfied, many families, when given the option, choose not to participate in this alternative health care service. Little is known about what influences how women decide to participate in an early discharge program.
**Purpose**

The purpose of this study was to identify the factors influencing a woman’s decision not to participate in an early postpartum discharge program. The study was designed to answer the following research question: What factors influence a woman’s decision not to participate in an early postpartum discharge program?

**Conceptual Framework**

The decision to participate or not in the British Columbia’s Women’s Hospital’s early postpartum discharge program is a health care decision faced by 50 families a week. To assist in understanding a woman’s decision not to participate in an early discharge program, a health promotion model based on decision-making around health behaviours was used (Figure 1). Pender’s (1987) Health Promotion Model guided the design of the topic questions for the study interviews and analysis of the data (Figure 2). This health promotion model was effective in examining the actual decision making process in a logical and systematic manner.

According to Pender (1987), determinants of health-promoting behaviours in individuals are categorized into cognitive-perceptual factors, modifying factors and variables affecting the likelihood of action. Pender (1987) emphasized the cyclical process by which individuals move back and forth between the decision-making and action phases. The different factors can be more or less influential in a person’s decision to act.

Factors that facilitate health-promoting decisions and behaviours include: the importance, and definition of health to the individual, the control and self-efficacy the
individual has in relation to her health and health decisions, the individual’s perception of her health status and the perceived benefits and barriers to the health decisions she has made or will make (Pender, 1987). Pender hypothesized that each of these individual perceptions or personal factors have motivational significance, that is; they influence individual readiness to engage in health-promoting decisions and behaviours (Pender, 1987).

Modifying factors that affect an individual’s disposition to engage in health-promoting behaviours are demographic, biologic, interpersonal, situational, and behavioral. Demographic factors include characteristics such as age, sex, race, ethnicity, education, and income. Biologic characteristics encompass one’s physical abilities or physical state that may enhance or disrupt abilities to initiate health actions. Interpersonal variables encompass expectations of others, family health patterns and behaviours, and interactions with health professionals. Situational factors include the health-promoting and care options available and prior experiences with health-promoting actions. Behavioural factors involve having the cognitive and psychomotor skills to carry out behaviours and actions (Pender, 1987).

The two salient variables affecting the likelihood of action are: perceived barriers to action, imagined or real, and internal or external cues that trigger activity. Barriers include individual perceptions regarding unavailability and/or inconvenience of a particular health promoting option.
Figure 1: Health Promotion Model
Pender (1987, p. 58)
The components of Pender’s (1987) model; cognitive-perceptual and modifying factors guided the development of the questions used in the study interviews (Figure 2). These factors in the model appeared relevant in assessing a woman’s health-care decision whether to participate or not in the early postpartum discharge program.

**Significance of the Study**

The findings from this study provide insight into the factors that influence a woman’s decision not to participate in an early postpartum discharge program. Knowledge of the relationships among factors influencing the health-care choices of a woman and her family provide information that can be utilized by health care professionals in both planning and implementing educational and supportive programs to meet their needs. This knowledge is also important for the further development of prenatal preparation for families and for early discharge programs. A greater understanding of the effects of personal and interpersonal influences on women will assist families to plan for a healthy and safe transition from hospital to home. Awareness of the decision-making processes of women surrounding early discharge will enable identification of nursing interventions that are appropriate to women and their families who are discharged early.

**Definition of Terms**

**Early postpartum discharge**: hospital discharge within 6-48 hours of low-risk women and their newborns who meet the established early discharge program criteria (Appendix A).
<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did you decide not to participate in the early postpartum discharge program?</td>
<td>Perceived benefits and barriers to health-promoting behaviour.</td>
</tr>
<tr>
<td>Did you feel you had enough information to make a decision about participating?</td>
<td>Perceived control of health and self-efficacy.</td>
</tr>
<tr>
<td>Did your ability/ confidence to care yourself and your newborn influence your decision to stay in the hospital?</td>
<td>Perceived health status and self-efficacy. Behavioural factors.</td>
</tr>
<tr>
<td>Did you feel that the decision you made was the right one for you and your family?</td>
<td>Perceived benefits and barriers. Demographic characteristics</td>
</tr>
<tr>
<td>What were the benefits for you staying in the hospital?</td>
<td>Perceived benefits and barriers to health-promoting behaviour.</td>
</tr>
<tr>
<td>What were the barriers?</td>
<td>Interpersonal influences. Perceived control over health.</td>
</tr>
<tr>
<td>Who and what influenced you when you were making your decision?</td>
<td>Situational factors. Perceived self-efficacy.</td>
</tr>
<tr>
<td>What role did your home/hospital environment play in your decision?</td>
<td>Situational factors.</td>
</tr>
<tr>
<td>When did you first hear about the early discharge program?</td>
<td>Situational factors.</td>
</tr>
<tr>
<td>Would you choose to stay in hospital the same length of time for another baby?</td>
<td>Situational factors. Perceived health status and control over health.</td>
</tr>
<tr>
<td>Did you feel this was an important health decision?</td>
<td>Importance of health.</td>
</tr>
</tbody>
</table>

Figure 2: Interview questions and their relationship to categories of the Pender’s (1987) Health Promotion Model.

Maternity Care at Home: an established early postpartum discharge program of the British Columbia’s Women’s Hospital in collaboration with the Vancouver Community Health Department, offering postnatal care and follow up at home for mothers and newborns for the first ten days postpartum.

Standard hospital stay: The hospital stay of 3-4 days for postpartum women who experience a vaginal birth and 5-6 days for those who experience a caesarean birth.

Multipara: A woman who has given birth to two or more viable infants.

Primipara: A woman who has given birth to one viable infant.

Assumptions of the Study

1. During the postpartum period, women are the most legitimate source of information regarding their decision not to participate in an early discharge program.

2. The birth of a child is a significant event in the life of a woman and her family.

Limitations of the Study

Interviews took place during the participants’ hospitalization on the postpartum units of B.C. Women’s Hospital. The participants may have been hesitant to verbalize openly due to fear of jeopardizing their care, or feeling like they had to justify their decision to reject early discharge. It was felt that the advantage of interviewing women when the experience was close at hand outweighed the disadvantages.

Limitations also existed regarding the ability to generalize the study findings. The participants were selected from one hospital during a specific period of time. The data that emerged from the experiences of these women were relevant as they represented a
slice of life from the real world (Sandelowski, 1986).

Summary

This chapter has presented the background for understanding the research problem. The study's purpose was discussed, the conceptual framework used to guide the study was outlined, the significance, relevance and key terms used to delineate the research problem were defined. Finally, the underlying assumptions of the study were clarified.
CHAPTER TWO

Review of Selected Literature

Introduction

The purpose of this section is to present an analysis of selected research in the early postpartum discharge and maternal postpartum adjustments. There has been limited literature on the perceptions of postpartum women who choose not to participate in an early discharge program and no research has been done on the factors which influence a woman to stay in the hospital the traditional length of stay. Therefore the literature review that follows will focus on the concept of early postpartum discharge and related maternal-task theory. Literature on maternal tasks of the postpartum period might shed some light on why women feel they need to spend the early days after birth in hospital. This literature review will attempt to integrate these two areas.

Early Postpartum Discharge

Studies from Britain, Europe and North America relating to various aspects of early postpartum discharge have been cited in the literature since the late 1940’s. The concept of early postpartum discharge was first discussed in the medical literature in 1943 when the standard postpartum hospitalization for mothers and newborns was ten days in North America (Guerriero, 1943). Early postpartum discharge was implemented in hospitals across the U.S. to assist with overcrowded maternity units (Callander et al., 1966). It was thought that early discharge would jeopardize the health of the mother and newborn but reports from investigators conducting the first studies indicated it was safe when follow-up home-care was provided. In Canada, early postpartum discharge
programs were not in existence until the late 1980's at which time pilot research projects began to be implemented in areas across Canada.

Most of the research literature either describes the evaluation of established early postpartum discharge programs or, retrospectively, examines patient satisfaction. The research that has been done has been limited by both the size of the samples and the areas of study. For example, only three of the published studies reviewed used experimental design with random assignment utilizing a control group (Carty & Bradley, 1990; Waldenstrom, 1989; Yanover et al., 1976).

Specific criteria for participation in an early postpartum discharge program were developed by Yanover et al., (1976). Their study was the first in which the sample group of 88 participants was randomly assigned into two groups, traditional hospital stay or early discharge. The researchers concluded that early discharge was safe as well as satisfying for the patients and their families (Yanover et al., 1976). Patient satisfaction was due to fewer disturbances in rest and sleep at home and the increased possibilities for father involvement found at home. The participants in the study also felt that the main benefit of being in the hospital after the first postpartum day was to learn to care for the infant and therefore they questioned the need for the traditional hospitalization stay to learn those tasks (Yanover et al., 1976).

Drummond et al., (1984) continued to evaluate discharge criteria relating to patient safety outcomes of mothers and newborns in a community-based early discharge program. One of their conclusions was that admission into an early discharge program should be an optional decision made by the physician and patient. The criteria examined in the above
study have remained standard for many subsequent programs, including the program which is the focus of this study (Bradley et al., 1992; Waldenstrom, 1989).

The effects of early hospital discharge on maternal and infant outcomes were studied by Lemmer (1987) who interviewed 21 primiparas choosing early discharge and 21 primiparas with hospital stays longer than 24 hours. The early discharge sample was chosen from women who chose to go home early and met the study criteria. A comparison group was chosen from women who delivered in the same time period but chose to stay in the hospital longer than 24 hours. Study questionnaires consisted of a demographic form, a maternal concerns questionnaire and an infant and maternal physical assessment completed during a home visit after the women were home one week.

Lemmer (1987), concluded that maternal and infant complications were not linked to time of discharge. No significant differences occurred in intensity of concerns at one week postpartum between the two groups. The most intense concerns of primiparas regardless of length of stay focused on body image, infant care, behaviour and recognition of signs of illness in the new baby. According to Lemmer (1987) primiparous women require nursing care regardless of when they are discharged from the hospital. Women choosing early discharge had more social support at home following discharge (Lemmer, 1987). The limitation of this study was that the sample size was small.

Norr, Nacion, and Abramson (1989) examined the health impact of three different discharge conditions with a sample of low-income mothers and infants. The three discharge conditions were as follows: 1) early discharge of mother at 24 to 48 hours and infant after 48 hours 2) early discharge of both mother and infant together and,
3) conventional discharge of both mother and infant. There were no significant
differences among the three discharged groups in the frequency of maternal or infant
physical health problems. Significant group differences were found for maternal concerns
and maternal attachment. Mothers and infants discharged together early had higher
maternal attachment scores and lower maternal concerns than the conventional discharge
group (Norr et al., 1989). This study was of particular importance because it was the first
to study high-risk women.

Thurston and Dundas (1985) evaluated patient satisfaction and safety of an early
discharge program implemented by two general hospitals and the community health
department in Calgary, Alberta. The study enrolled two hundred and sixty-seven women
and their infants. Participation in the study was voluntary for families who met the early
discharge program criteria. Eligible mothers and infants were discharged from hospital
within 48 hours postdelivery and received three consecutive daily home nursing visits.
Retrospective chart reviews were used to gather data on all participants and questionnaires
were sent out to the women in the study. It was noted by the investigators that there was
no increase in postpartum complications or readmission rates that could be attributed to
early discharge (Thurston & Dundas, 1985).

Through the use of patient questionnaires it was found that patients were very
satisfied with the length of hospital stay and with the home visits. The patients found
they were more relaxed, bonding was improved, and a home support system was available
to them. Over 90% said they would participate again and recommend the program to
friends (Thurston & Dundas, 1985). Five percent of the women in the pilot program said
they would not participate again as they required more rest, help at home, and had not wanted to be discharged home early. The program evaluation concluded that the program was satisfactory and acceptable (Thurston & Dundas, 1985). One limitation noted in this study was that study participants in the study were self-selected. Another area of weakness was the measures used in this study were not well outlined or described.

A Canadian nursing research study examining aspects of early postpartum discharge was conducted at a large westcoast maternity hospital (Bradley, Carty & Hall, 1989). This study examined the effect of the time of discharge on maternal and infant safety, psychological function of the mother, patient satisfaction, and program cost. Using an experimental design, with a sample group of 176 participants, both primiparas and multiparas, the authors found that maternal and infant morbidity was low regardless of discharge time, and women in the early discharge group were less anxious and depressed and more confident than the longer hospital-stay women (Carty & Bradley, 1990).

The quantitative findings of this study were also triangulated with a qualitative study of the early discharge group women. This qualitative study focused on the experience of eight women who were discharged between 12-24 hours postpartum. The investigators revealed the early discharge experience as representing a process of the women taking control of their own and their infant’s care (Hall & Carty, 1993). This is the only grounded theory study found in the literature and is useful because it describes how women prepared for successful early discharge and identifies features of the postpartum nursing care which enhanced women’s feelings of confidence.

Bradley et al. (1989) noted that the nurses in the study providing care at home to
the women believed in early postpartum care as a safe and satisfying option for many women and believed in reinforcement and positive feedback as a way of helping develop maternal self confidence and self esteem. It was concluded by these investigators that early postpartum discharge with follow-up should be made available to women in British Columbia (Bradley, et al., 1989).

One of the major limitations of this study was a smaller than anticipated sample size due to recruitment that took a year longer than expected. Only 10% of the 300 physicians who initially agreed to participate referred patients into the study. This was an experimental design and therefore, it depended on women to volunteer to be randomly assigned to any of the three groups. According to the investigators, this made it difficult for women who wanted to go home early and for those who wanted to stay in hospital longer to participate because in a randomized study the women might be assigned a group in which they did not feel comfortable (Bradley, et al., 1989).

A more recent study was completed by Bradley, Carty and Winslow (1992) examining further the effects and outcomes of early discharge on the postpartum family. This study used a comparative, non-experimental design involving a convenience sample of 117 women. It examined the difference between women who chose a standard hospital stay of four days and those who chose to be discharged within 48 hours of birth.

The significant findings from this study indicated that women who went home early were of lower socio-economic status, preferred to go home early so the father could be more involved with the newborn, and were less anxious at one month postpartum with regards to their baby (Bradley, et al., 1992). The women who stayed in the hospital for
four days required more support, advice, and reassurance than women discharged early and appeared to believe that the hospital was a safer place to spend the immediate postpartum period (Bradley, et al., 1992).

One limitation of this study identified by the investigators was that the sample was smaller than anticipated due to slow recruitment of participants into the early discharge group. This limited recruitment was due to hesitation and ambivalence about early postpartum discharge on the part of women in the community and their health-care providers.

Patient satisfaction, a reflection of consumer attitudes and a key element in determining the acceptability of early postpartum discharge, was investigated by Avery, Fournier, Jones, and Sipovic (1982). Satisfaction and safety in going home early was assessed in women participating in an early postpartum discharge program. A retrospective review was done on all the early discharge patients over a two year period. The review found few newborn and maternal complications (Avery et al., 1982). A questionnaire which asked women about their experience with early postpartum discharge, was sent out to all 154 women for completion. Responses revealed that 80 out of 86 women felt comfortable going home early from the hospital. No control group was used (Avery et al., 1982).

Patterson (1987) conducted one of the first studies which compared the attitudes and beliefs of women who were suitable and wished to be discharged home early following birth with those who wished to remain in the hospital for the standard stay. She studied 226 low-risk women whose post delivery hospital stay was 40 hours or less or
whose traditional hospital stay was two to three days. A ninety-one item questionnaire which had been pre-tested in a pilot study with 52 subjects quantified their discharge choice, early discharge program awareness, subject characteristics, criteria for postpartum care choice, postpartum care beliefs, and satisfaction with postpartum care. Patterson (1987) had a response rate of 84%. She found that the late discharge group of women included more primiparas than multiparas. The mothers in the early group believed that home was the best place to be for recovery and the hospital group thought the nurses were more helpful than family members (Patterson, 1987).

Mothers in the late-stay group indicated that their decision to stay in the hospital was more often influenced by others compared to the early discharge group who checked off "self" as the one making the decision to go home early. Nearly all the women knew about the program prior to delivery. When asked their postpartum care choices and beliefs, the late group stated they valued rest and sleep, quiet atmosphere, attention from others, a knowledgable person nearby and rated the hospital the best place to be following birth. The women in the late group believed the hospital was the best place to rest and that nurses were more helpful than were family for giving confidence and support to new mothers (Patterson, 1987). The early group felt going home early would result in a more comfortable surrounding and a partner that was more involved with the newborn. They also stated their home was the best place to be following birth (Patterson, 1987). This is the only study which looked at attitudes and beliefs as factors influencing a woman’s decision.

Attempts to capture women’s perceptions of early postpartum discharge were the
goals of Rush and Valaitis (1992). Two surveys were conducted in the Hamilton area to ascertain which hospital services were valued by women in postpartum recovery, why some women did not choose the early discharge program, and what services they would need if they were to go home within 48 hours (Rush & Valaitis, 1992).

The first survey involved 65 women. They were given a questionnaire on the second postpartum day asking what hospital services they would miss if they were discharged on the second postpartum day. The second questionnaire, sent to a convenience sample of 200 postpartum women at 6 months, asked them to rate the importance of hospital services and whether they would agree to participate in a randomized study in which they would have been discharged within 48 hours or have remained in hospital for the traditional length of stay. The response rate for the first survey was 89% and, the second survey was 70%. According to these surveys, women ranked the 24 hour access to nursing care and advice as being the most important service. If they were to be discharged home on the second postpartum day they would require a 24 hour telephone line, nursing visits, and homeworker help (Rush & Valaitis, 1992). Only 17% of women stated that they would have agreed to participate in the randomized study as they feared they would be discharged early and they stated they did not have support at home.

The reasons for the development of early postpartum discharge programs have been consistent among the studies. These reasons included: effective utilization of resources and services, increased involvement of fathers and families, the recognition of pregnancy as a health state rather than an ill state, an alternative to home delivery and the
mother's desire to go home earlier (Britton & Britton, 1984; Jansson, 1985; Waldenstrom, 1989). In-depth research is still required to further investigate the above variables and particular outcomes such as safety, cost-effectiveness and patient satisfaction as they relate to early postpartum discharge.

The few studies that have examined why women do not want to be discharged early from hospital suggest that women worry about getting enough rest at home and are concerned that they would miss the information the nurses can provide. No studies have specifically asked the question asked in this study or examined the factors that influence a woman's decision not to participate in an early discharge program. As more hospitals mandate early discharge the answer to this question is critical.

**Maternal Tasks**

To examine early postpartum discharge and the health care decision-making process of postpartum women an understanding of the context of the physical and psychosocial changes that take place following birth is required. The literature on maternal tasks of the postpartum period, including concerns and educational needs expressed by both primiparous and multiparous women will facilitate this understanding. Reviewing the research and literature on the overwhelming adjustments that postpartum women experience will assist in understanding their decision not to participate in an early discharge program.

Many studies have indicated that women encounter a series of maternal tasks in the early postnatal period. These tasks have been defined by studying the expressed concerns of women in the postnatal period (Gruis, 1977; Hiser, 1987; Bull, 1981; Harrison
Postpartum maternal adaptation can be summarized in relationship to six major maternal tasks: 1) physical restoration, 2) learning to meet the needs of the dependent infant, 3) establishment of a relationship with the newborn, 4) altering lifestyle and relationships to accommodate a new family member (Bull, 1981; Gruis, 1977; Mercer, 1986; Rubin, 1984) and, 5) replenishing psychic energy (Ziegel & Cranley, 1984), 6) reviewing the events of childbirth experience and integrating the actual experience with the expected experience (Mercer, 1981). The following section will review the research that examines and supports maternal task theory.

Rubin (1961) described two phases of maternal tasks in the postpartum period, "taking-in and taking-hold". The "taking-in" phase is a time of passive and dependent maternal behaviour taking place on the second to third postpartum day while the "taking hold" phase is a time of independent and autonomous maternal behaviour occurring on the third to tenth postpartum day. The "taking-in" phase allows the mother time for rest, food, care and to adjust to her new role. The "taking-on" phase finds the mother becoming more involved with her baby (Rubin, 1961). The development of the maternal role as described by Rubin (1984), is affected in a progressive series of cognitive operations and the accomplishment of maternal tasks.

Physical restoration is one of the primary maternal tasks of the postpartum period, along with replenishing psychic energy (Ziegel & Cranley, 1984). Rubin (1984) observed that when the new mother's need for sleep has been satisfied she awakens with "a well-spring of trust and faith". The mother's attempts to recover from the birth process and the emotional tension created by the immediate postpartum adjustments are hampered by
unanticipated fatigue and, if recovering in the hospital, the unfamiliar hospital
environment (Grossman, Eichler, & Winickoff, 1980; Shereshefsky & Yarrow, 1973). A
primary complaint among childbearing women is fatigue and lack of energy (Harrison &
Hicks, 1983).

Self-reports by postpartum women confirm that sleep disturbance is a source of
distress (Campbell, 1986; Harrison & Hicks, 1983; Mercer, 1986). When asked to
identify physical complaints in the postpartum period women consistently have noted
fatigue among their foremost concerns (Moss, 1981; Tulman, Fawcett, Groblewski, &
Silverman, 1990). Women report their physical discomforts contribute to the emotional
distress of the postpartum period by decreasing their stamina to cope with the demands of
motherhood (Tulman et al., 1990). Sleep deprivation and insufficient rest are likely to
remain a problem once women get home and throughout the postpartum period (Carty,

It has been suggested that new mothers, even if they didn’t have to care for their
infants, are likely to have sleep problems due to excitement, mood variation and the
strange environment in the hospital (Niven, 1992). Karacan et al (1969) found the
number of night time awakenings were associated with the need to urinate and episiotomy
pain. Schweiger (1972) found causes of disturbed sleep to be due to physical discomforts,
urinary frequency, and the presence of babies. In Campbell’s (1986) study of sleep
patterns of mother infant dyads, frequent interruptions in maternal sleep were related to
the unpredicted sleep-wake patterns of the newborn. Other influences included the
woman’s emotional state, endocrine changes, prenatal sleeping patterns, over tiredness,
and medication usage (Campbell, 1986).

An exploratory study, conducted with 34 women during the first 48 hours postpartum, revealed that women had no opportunity for uninterrupted sleep, due mainly to the newborn feeding and presence of hospital personnel (Lentz & Killien, 1991). This study did find that the disruptive nature of the hospital environment interfered with a new mother's "restorative sleep" (Lentz & Killien, 1991). Keefe (1988) also found that new mothers reported averaging less than six hours of sleep per night. The mothers whose infants were placed in the hospital nursery reported a shorter duration and decreased quality of sleep, than those mothers that kept their infants in their rooms with them (Keefe, 1988). In a descriptive study of 42 early discharged women and 64 traditional hospital stay mothers very little difference was noted between early discharge mothers and the hospital stay group in their self-reported feelings of tiredness (Carty, Bradley & Winslow, 1994).

Although it is often assumed that the period of hospitalization following delivery is a time of recovery and rest for the new mother, research findings would suggest otherwise (Carty et al., 1994; Lentz & Killien, 1991; Moss, Bolland, Foxman & Owen, 1987). From the results of these studies it can be suggested that new mothers experience interrupted sleep in the early days postpartum which interferes with physical restoration.

Studies have found that multiparous women find meeting the needs of everyone at home a frequent and overwhelming postpartum task (Hiser, 1987; Grubb, 1980; Moss, 1981). Allocation of time to meet the needs of the new infant and of other family members and manage a household has been found to be an overwhelming task for
Multiparous women (Grubb, 1980). Multiparous women in a study by Moss (1981) voiced concerns and about the pressures that a new child places on the rest of the family and the new complex structure of the family system.

Moss (1981) examined 56 multiparous women on the third postpartum day and found mothers were more frequently concerned with family relationships, especially other children’s reactions to the baby than with themselves or their baby. This study also concluded that both primiparous and multiparous women were concerned with body alterations and physical restoration in the postpartum period (Moss, 1981). This was also supported by a later study by Strang and Sullivan (1985).

Waltz and Rich (1983) examined maternal postpartum tasks related to the birth of a second child. Data were collected by interview and observation of 14 mothers during the two to three days of hospitalization after childbirth. Written recordings of observations and interviews were made within 24 hours after the observations or interviews occurred. Six behavioural codes were used to analyze the recordings: promoting acceptance of the second child by the first child, planning for the new family life; reformulating the relationship with the first, child, identifying the second child, and assessing self as capable of mothering two children. Findings from this study revealed that mothers focused intensively on their relationship with their other children (Waltz & Rich, 1983).

Postpartum concerns and educational needs of new mothers are described in several studies. The studies following address several of the maternal tasks. Gruis (1977) studied concerns of postpartum women in a study using a questionnaire given to 17
primiparas and 23 multiparas at one month postpartum. It was found that both groups were concerned about regulating family demand, and emotional tension. Primiparas were more concerned about infant behaviour and feeding and multiparas were more concerned about fatigue and time for self.

Pridham, Hansen, Bradley, & Heighway (1982) studied the concerns of new mothers at one week postpartum. The study comprised 38 primiparas and 24 multiparas. The three most frequent daily issues for these postpartum women were infant care, infant development, and signs and symptoms of infant illness. The two groups had similar concerns but multiparas had more parenting concerns than primiparas.

In another study by Pridham (1987) 48 primiparas and 35 multiparas were surveyed using observations and questionnaires at seven days, one month, and three months postpartum. The leading concerns at each time period were changes in present life style and infant care tasks (Pridham, 1987).

Harrison and Hicks (1983) sent 158 multipara and primipara women a questionnaire asking them to identify their concerns and their sources of help at four weeks postpartum. The investigators found the primiparas expressed more minor concerns and multiparas had the same number of concerns but they labelled the concerns as major. These concerns included: regulating demands of husband, fatigue, emotional tension, diet and finding time for personal interests. This study also revealed that the husbands were the most frequent source of help used for support with changing roles and responsibilities for the women in the study (Harrison & Hicks, 1983).

Hiser (1987) examined 20 low risk multiparas and their postpartum concerns at 10
to 14 days postpartum. It was found that mothers were concerned whether they were meeting the needs of everyone at home, finding time for themselves, being a good mother and their physical weight. These woman in the study had more family concerns than mother or baby concerns (Hiser, 1987).

Educational requests of women in the postpartum period emphasize the desire and need to know how to care for their infants and themselves as outlined in the following studies. There is evidence that primiparous women benefit from structured teaching and supportive counselling interventions that address their concerns, attitudes, perceptions, and role-related knowledge (Hall, 1980).

Bull and Lawrence (1985) studied seventy-eight women of mixed parity and their use of knowledge during the first week at home with a new baby. Seventy percent of women reported information on self-care and infant physical care and feeding was helpful and information on infant behaviour would have been useful.

Davis, Brucker, and MacMullen (1988) examined the teaching priorities of new mothers. One hundred and seventeen low risk mothers of various parity and age groups were given a questionnaire on postpartum day 13 to assess their learning needs. Mothers wanted to know how to care for themselves especially with regards to episiotomy care and how to care for and feed their infant.

Women experience several developmental tasks following the birth process, requiring understanding and support from family and health care professionals for them to master them effectively (Gruis, 1977; Rubin, 1984; Mercer, 1985; Ziegel & Cranley, 1984). This knowledge is based on a variety of research studies and theoretical writing on
the emotional and physical concerns and adaptations of women in the postpartum period using interviewing, observing and self-reports of women's experiences prenatally, intrapartum and postnatally.

Although much research has been completed on maternal tasks, and concerns that are linked sometimes to these tasks, no studies have specifically focused on potential early discharge populations and determined what factors prevent them from pursuing early discharge. It is possible that necessary structures and supports for dealing with concerns and maternal tasks have been intrinsically identified with hospital nursing care. However, the needs and concerns of women during the postnatal period must be met whether the new mother and newborn are recovering in hospital or at home.
CHAPTER THREE

Method

Introduction

This section describes the research design of this study, sample selection, data collection procedure, instruments for data collection, data analysis procedures and procedures for the protection of human rights.

Research Design

An exploratory, factor-searching design was used in this study. A factor-searching survey is used to describe or name a given situation. The type of theory produced in a factor-searching study "names theory" either in the form of narrative description, formal concepts or categories (Diers, 1979). This design enabled the investigator to study women’s perceptions of the factors that influenced their decision not to participate in an early postpartum discharge program.

Sample

The sample consisted of 55 postpartum women. All women who met the selection criteria and were still in hospital (n=67) were approached to participate in the study. Eight women declined participation due to their discomfort with the English language and four women stated they did not have time to do the interview.

Women selected for inclusion in the study met the following criteria:

1) The Maternity Care at Home Program (M.C.A.H.) criteria were met (Appendix A);
2) The services of the early discharge program had been offered;
3) They had decided not to participate.
Data Collection Procedures

Participants for this study were recruited from the postpartum units of British Columbia’s Women’s Hospital. The M.C.A.H. nursing staff identified women who had met the early discharge criteria (Appendix A) but who decided not to go home early. An introductory information letter describing the study (Appendix B) was given to the women. If the woman indicated that she was willing to participate by checking the appropriate box on the introductory letter and returned it to the nursing station, the investigator met with the woman and explained the study in more detail. Participants signed a consent form (Appendix C) prior to the interview. The patient’s physician was informed of her participation in this study by a letter (Appendix D).

Interviews took place in each participant’s hospital room. Interview times were flexible and averaged 30 minutes in length. The interviews were audiotaped and field notes were kept by the investigator. Five women declined audiotaping due to difficulties with the English language so these interviews were recorded by hand.

Although each question on the interview guide was asked, each woman wanted to talk about her own personal situation and how it affected her decision not to participate in the early discharge program. Consequently, questions with respect to some aspects of Pender’s model, for example, importance and definition of health, were not clearly addressed by most participants.

Instruments for Data Collection

Two instruments for data collection were utilized in this study. A demographic and health-related information sheet was used to collect background information on each
participant (Appendix E). An interview guide, with questions developed from the concepts of Pender’s (1987) health promotion model was used as the basis of a semi-structured interview (Figure 2). The questions to be used were reviewed by the investigator’s advisory committee.

**Data Analysis**

Each audio tape was reviewed and data were recorded by hand. Because the women did not directly answer all the questions on the interview guide, it was not possible to establish categories based on Pender’s model for analysis purposes. Therefore a decision was made to analyze the data using an inductive approach, "deriving the categories from the data themselves" (Waltz, Strickland, & Lentz, 1991, p.304). The major categories that emerged from the data were the need for physical and emotional restoration, and the need for care. These needs were identified as the main reasons why women chose not to go home early. The women in the study also identified external and internal influences and barriers, such as the views of their family and their physician, which had an impact on their decision. Wherever possible the categories and factors within the categories were related to the concepts of Pender’s (1987) health promotion model.

To ensure reliability of the category descriptions, five experienced postpartum nurses were given the data from ten study interviews and the list of major categories and were asked to identify the categories into which the data would fit. There was a 90% agreement between the nurses and the researcher with respect to the categories in which the factors were placed.
Ethical and Human Rights

Procedures for the protection of human rights were followed. Prior to conducting the study, permission was obtained from the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Permission was also obtained from British Columbia’s Women’s Hospital Research Coordinating Committee, for the utilization of hospital resources for research purposes and for the solicitation of subjects for the study.

The purpose of the study was explained to the participants verbally and in writing (Appendix B). Use of an informed consent and protection of confidentiality addressed the rights of the subjects (Appendix C).

Confidentiality of results was maintained by coding the participant’s names so their identity was known only to the researcher. Access to the data was limited to the researcher and her advisory committee. Participants were not identified by either their responses to the study, or on the demographic health-related sheet, consent forms or interview tapes.

Summary

A factor-searching survey research design was used to collect data for this study. Fifty-five participants were interviewed about their decision not to participate in an early postpartum discharge. The taped interviews were reviewed, summarized and analyzed through the process of inductive content analysis. The categories that emerged from the content analysis are presented in Chapter 4 with a discussion of the findings.
CHAPTER FOUR

Presentation and Discussion of Findings

Introduction

This chapter presents the findings and incorporates a discussion of those findings. Initially, characteristics of the sample are summarized and discussed. Then, the selected categories are presented and discussed in relation to the literature and the study’s conceptual framework. Finally, ancillary findings of the study are presented and discussed.

Characteristics of the Sample

The demographic characteristics of the study sample included; the participants ages, educational background, employment status, ethnic origin, parity, method of birth and postpartum support person. Many of these characteristics represent the demographic modifying factors found in Pender’s (1987) model.

Age of the participants ranged from 19 to 42 years of age (Table 1). Seventy-six percent of the women in the study were married; twelve percent were living in a common-law relationship; seven percent were single and three percent of the women were separated. The women were well educated (Table 2), with approximately sixty percent working outside the home on a full or part-time basis (Table 3). Ethnic origin of the sample is described in Table 4.
Table 1

Age Distribution of the Sample

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20-29</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
<td>30-39</td>
<td>29</td>
<td>52</td>
</tr>
<tr>
<td>40+</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 2

Educational Level of the Sample

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to Grade 12</td>
<td>3</td>
<td>5.4</td>
</tr>
<tr>
<td>Completed High School</td>
<td>20</td>
<td>36.3</td>
</tr>
<tr>
<td>Completed College</td>
<td>15</td>
<td>27.2</td>
</tr>
<tr>
<td>Completed University</td>
<td>17</td>
<td>30.9</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 3

Employment Status of the Sample

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>23</td>
<td>41.8</td>
</tr>
<tr>
<td>Part-time</td>
<td>13</td>
<td>23.6</td>
</tr>
<tr>
<td>Homemaker</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4

Ethnic Origin of the Sample

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>European-Canadian</td>
<td>26</td>
<td>47.2</td>
</tr>
<tr>
<td>Asian-Canadian</td>
<td>14</td>
<td>25.5</td>
</tr>
<tr>
<td>Indo-Canadian</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Hispanic-Canadian</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Filipino-Canadian</td>
<td>4</td>
<td>7.3</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Forty-nine percent (n=27) of the study participants had experienced the birth of their first child and fifty-one percent (n=28) were mothers who had their second to fifth child. Sixty-six percent of women, (n=36) had experienced vaginal births, over half of the study participants and, 34% (n=19) of the women had experienced caesarean births.

Sixty percent (n=33) of women in this study reported that their husbands or partners were the main support person for them in the postpartum period; twelve women (21.8%) reported that their mothers were the main support. Six (11%) reported their sister or aunt were their main support, and four women (7.2%) reported their friends to be their major support. The main support person for these women were their husbands/partners, which has been found in other studies (Bradley, et al., 1989; Lemmer, 1986; Patterson, 1987).

The majority of the women in this study were well educated, with the mean age of 27.7 years with a standard deviation of 4.60. The youngest participant was 19 years and the oldest 42 years of age. In comparing the primiparas and multiparas ages, the primiparas were slightly younger than the multiparas. Most of the women were employed
either in full-time and/or part-time work outside the home. There was almost equal
distribution and representation of women in the study who were primiparas and multiparas
as well as of women who had experienced vaginal and caesarean births. There was a
variety of ethnic representation in the study.

Researchers have noted that demographic characteristics such as multiparity, low
income, and young age have a negative impact on maternal adjustment, suggesting that
these women may be particularly vulnerable in an early postpartum discharge program
(Lederman, 1986; Mercer, 1986; Patterson, 1987). The sample in this study did not
appear to have demographic characteristics that would jeopardize maternal adjustments,
although many of the women expressed having other children at home as a factor for not
participating in the early discharge program.

**Category Concepts**

Content analysis of the interview data resulted in the development of two major
categories: the need for physical and emotional restoration and the need for care. Several
external and internal influences and barriers were also found to be influential in a
woman’s decision to stay in the hospital. The two major categories, and the external and
internal influences and barriers matched the major concepts of Pender’s (1987) health-
promotion model.

The need for physical and emotional restoration included the following factors:
need for sleep and rest, comfort, and time alone. This category was reflective of the
womens’ perceived health status, one of the cognitive-perceptual factors found in Pender’s
(1987) model. The need for care included the following factors; need for help, support,
and protection. This category reflected a woman’s perception of her self-efficacy, another of the cognitive-perceptual factors found in Pender’s (1987) model. The women also identified several internal and external influences and barriers which influenced their decision to stay in the hospital longer and, according to Pender (1987) are classified as modifying factors. The postpartum tasks and concerns of women during the postpartum period enhanced one’s understanding of the categories (Bull, 1981; Mercer, 1981; Gruis, 1977; Rubin, 1984).

Need for Physical and Emotional Restoration

The women described several physical and emotional needs which influenced their decision not to participate in an early postpartum discharge program. The women identified their needs, then indicated that these needs could not be met through the early discharge program. They believed that the home environment was not conducive to having their needs met. Women presented a variety of reasons that ranged from the need for sleep to needing time alone. The relevant factors are summarized in Table 5. The factors are then described with quotations from selected interview responses.

Table 5

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for rest and sleep</td>
<td>38</td>
<td>69</td>
</tr>
<tr>
<td>Need for comfort</td>
<td>15</td>
<td>27.3</td>
</tr>
<tr>
<td>Need to have time alone</td>
<td>12</td>
<td>22</td>
</tr>
</tbody>
</table>

Need for rest and sleep. Women expressed the need for extra rest, time for relaxation and the desire to have more sleep. This response was articulated by a large
majority of the women as an influential factor in their decision to stay in the hospital. The need for more rest was described by the women in the study as a response to feelings of being tired, fatigued, energy-drained, exhausted, and weak. One woman described it as her "battery was totally drained". Another felt as if she had been "hit by a truck", and a third stated that she could "sleep for days".

Women identified biologic characteristics and situational factors such as fatigue from the physical strain of pregnancy, birth process, disrupted sleep patterns and the physical and emotional changes of the immediate postpartum period as the reasons why they were so tired. Situational factors identified by these women included the work they had done prenatally at home, and on the job, and the work that was waiting for them once they got home. Women were tired from working during the prenatal period and anticipated more of the same ahead when they got home.

Women stated that if they stayed in the hospital they could get the rest and sleep they needed by "napping" anytime of the day or night, sleeping in between feedings, having the baby looked after in the nursery, and relaxing anytime to "recharge the battery". Multiparous women commented that it was great having the nursery open so you could have the nurses care for the baby during the night or when visitors and the other children came in. The participants stated clearly that they felt they would be unable to get the needed rest and sleep at home due to other children and household responsibilities. These were seen as perceived barriers to going home early. It was perceived that there would be no one to help with the baby through the night and it would be difficult to relax and rest at home. The women believed the nurses were available to
relieve them of caregiving activities so they could get the rest and sleep they needed.

The multiparous women in this study rated the need for rest and sleep more highly than primiparous women. Eighty-eight percent of multiparous women (n=24) compared to fifty-one percent of primiparous women (n=14), expressed the feeling that the need for rest and sleep was a factor for not participating in an early postpartum discharge program. The multiparous women expressed concerns about the needs of their other children if they went home early to recover. They would find it hard to rest or sleep when the new baby was napping as they would feel obligated to meet the demands of the other children as well as the household tasks. One woman stated, "they expect you to do it all, look after the children and the house as well as a new baby. It is much easier to just stay in the hospital away from all the mess and confusion." There was a sense from the women in the study that family demands were not negotiable.

Fatigue has been documented in the literature as an area of concern affecting the developmental tasks of the postpartum period for both primiparas and multiparas (Campbell, 1986; Gruis, 1977; Moss, 1987; Tulman et al., 1990). Perceived competence in feeding was related to the amount of rest for breastfeeding women (Pridham, 1987). Rubin (1984) believed that a deep refreshing sleep that lasted for several hours after delivery was necessary for the maternal task of physical restoration to be completed.

Studies assessing differences between multiparous and primiparous women and their need for rest and sleep have not presented any conclusive findings. Tobert (1986) and Smith (1989) indicated multiparas score fatigue higher as a postpartum concern than primiparas. This might be due to multiparous women anticipating extra demands of other
children, workload at home, less time for themselves, and less paternal involvement (Lederman, 1984; Patterson, 1987). The integration of a newborn into the existing family structure is one of the major maternal tasks of all postpartum women (Gruis, 1977). Primiparas might find it difficult to sleep due to the new changes in their body, surroundings, and in being awake at night with an infant. Women in this study were interviewed either on their second or third postpartum day, a time when fatigue is great (Bradley et al., 1986; Tobert, 1986).

The findings from Patterson's (1987) study parallels the results of this study. The need for rest and sleep and a quiet atmosphere were highly rated by women discharged late and as the reason the hospital was chosen as the best place to rest. Early discharge women, on the other hand, preferred the comfortable surroundings of their home as the best place to rest after childbirth (Patterson, 1987). It was also found by other investigators that women who participated in early discharge liked being in their own home as they felt more relaxed and they found their home environment comforting (Bradley, et al., 1989; Lemmer, 1987).

Both groups of women, those who chose to stay in the hospital and those who participated in early discharge, regarded rest and sleep as crucial to their recovery. Both choices of environment, home and hospital, should be able to provide the rest postpartum women need. However, even though some women feel that the hospital is more conducive to rest, some studies have found that women report that they are not getting the rest and sleep they need while in the hospital due to noise and repeated interruptions from hospital staff and routines (Lentz & Killien, 1991; Moss, 1987).
In summary, the women in the study believed the hospital was the best place for them to rest and sleep following birth. The flexibility of the hospital environment to rest anytime and the ability to be away from the family and the daily household demands influenced the women’s decision. It seemed these women did not believe they could control these areas of their life and therefore they could not improve their health status on their own.

Need for comfort. Need for comfort was the second highest factor which was found to influence the women’s decision to stay in the hospital. By staying in the hospital the study participants felt they would receive interventions that would help relieve their pain and discomfort. The women stated they were feeling pain and discomfort from the birth process as well as pain from perineal stitches and bruising, and caesarean birth incisions. These physical discomforts are biologic characteristics as identified under the modifying factors of the model (Pender, 1987). The study participants also felt their home environment could not offer the same "comfort measures" they felt they needed for their postpartum recovery.

There were a greater number of women who expressed the need for comfort after a caesarean birth (n=6) and/or forcep assisted birth (n=5) than women who gave birth spontaneously (n=4). Other forms of discomfort described by women in the study were uterine cramping, breast and nipple discomfort, and headaches. These biologic characteristics influenced the women’s perception of their health status. They felt they required a longer hospitalization to restore themselves to a healthy state.

The women also described the health care professionals understanding as being
"emotionally comforting". Measures of comfort offered by the nurses were described as: access to help 24 hours a day, access to analgesics, hot packs and sitz baths, and the ability to rest and sleep anytime. One woman stated that it was "nice to have your meals prepared, your room cleaned and someone around to care for you when you are feeling uncomfortable".

More primiparas (n=7) in this study expressed breast soreness than multiparas (n=4). This was also noted by Smith (1989) in her study of women's postpartum concerns. Breast pain and discomfort has been noted as a major concern of postpartum women who are breastfeeding (Smith, 1989; Ellis & Hewat, 1984). Other researchers have implied that coping with breast discomfort is part of the physical restoration, that is required to adapt to motherhood and care for an infant (Gruis, 1977).

Both situational influences and interpersonal factors were instrumental in the women's decision to stay in the hospital. Two women commented that they felt depressed about going home and therefore staying in the hospital was best for them. Other women stated they felt fearful and anxious about going home, particularly primiparous women. These feelings resulted from the equating home with "facing reality" and, in the case of first-time mothers, the fear of the unknown. The women felt that they would be "isolated and lonely" at home and would have no one to talk "things" over with, as there would be no one available to them. The women perceived the need to have someone to talk to who understood their health status. Women described being in the hospital as helping them "feel better". The women seemed to enjoy being in an environment that provided them with services, such as a clean room and meal services as well as people who were there to
care for them. Several women stated that the "people in the hospital know and understand what you have been through".

The literature supports the fact that coping with physical discomfort, compounded by fatigue in the postpartum period is part of the maternal task of physical restoration (Gruis, 1977; Rubin, 1984). Physical restoration includes healing and recovery of the physical trauma of birth (Gruis, 1977; Mercer, 1986; Rubin, 1984). However, little research has been done on postpartum pain and effective comfort measures.

Bradley, Carty and Winslow (1992) found women who remained in the hospital the traditional length of stay rated their physical condition as an important concern and rated it significantly higher than women in the early discharge group. Patterson's (1987) late discharge mothers reported that attention from others was a significant factor for staying in the hospital. By staying in the hospital the women were able to receive comfort measures they felt they could only receive in the hospital.

The participants in this study emphasized their need for comfort. The women equated their need for postpartum comfort measures with what the hospital environment could offer. These perceptions are supported by research studies that have examined aspects of early discharge (Bradley et al., 1993; Patterson, 1987).

Need for time alone. Needing time alone was another factor that influenced the women's decision to stay in the hospital, as they knew some solitude would improve their health status. Some of the women in the study felt they needed to be away from their families so that the time spend by themselves and with the new baby could be maximized. The women believed that the presence of the other children at home was an interpersonal
influence that interfered with their ability to know their newborn. One woman stated, "It is the only time you have with this baby so you need to make the most of it." "You need time alone with this baby so you can get to know this baby as an individual, as you will never have this chance once you get home," expressed one multiparous woman. Similar comments were made by others. Many women commented that you can never go back on this time or make up for it once it is gone. Another woman stated the she needed to "re-group" and another described this time in the hospital as the chance to "bridge the transition from one stage to another, from the birth to now".

The need to be alone was found to be more relevant for multiparas (n=8) than primiparas (n=4). Multiparous women described many responsibilities involving other family members and no time left over for themselves and the new baby to be alone together. The two primiparous women that expressed this need were from large extended families and feared for alone with their babies. They did not want to have to share them with anyone else.

Women also stated that they needed personal time and the ability to pamper themselves in the hospital. One woman expressed herself by stating, "If you don't get this time now you can crash very easily from the emotional strain of it all." Two women in the study commented that it was a luxury to stay in the hospital. A few women expressed feeling selfish and somewhat guilty staying in the hospital. One woman made the following comment, "I enjoy having the freedom to read, sleep and just do anything, anytime of the day and night." Similar comments were expressed by several other women in the study. Some women did not believe they were capable of going home and taking
control of their lives and recovery, an indication of decreased feelings of self-efficacy. The women in the study felt they needed an artificial environment to set time aside to meet their own needs because they felt they had no control over their health.

The literature supports the need for women to be alone with the new infant. Integration of the infant into the family and adjusting one’s lifestyle is an important postpartum maternal task (Gruis, 1977; Rubin, 1984). Rubin (1961) theorized that the "taking-in" phase of maternal adjustment requires rest, food, care, and time occurring within the first two to three days postpartum prior to "taking-hold" of the woman’s new role. Replenishing psychic energy is part of the postpartum recovery period and women in this study felt that the time in the hospital, away from family and other distractions is a time for regrouping and gathering psychic energy (Ziegel & Cranley, 1984).

Early discharge research has found that many women enjoy being home and sharing time with their families and state that this is one of the main benefits of going home early (Bradley et al., 1989; Patterson, 1987; Lemmer, 1987). Drummond’s (1984) findings also indicated that women were motivated to go home early to avoid any delay in integrating a new infant into the family unit.

Many of the factors in this category are similar to study findings involving women who stay in the traditional hospital postpartum stay and those who participate in early discharge (Bradley et al., 1992; Patterson, 1987). Both groups of women appear to be striving to fulfil the same maternal tasks of postpartum. Some women find it is better to achieve these tasks in the hospital. For others, it is easier at home. The question that needs to be addressed is whether or not they could have time alone at home rather than
having to use hospital resources.

The need for physical and emotional restoration reflects the women's need for rest and sleep as expressed by the study participants for their reason for staying in the hospital. Women also felt the hospital provided them with comfort measures, both physical and emotional in nature, that they felt their home environment could not provide. The women in the study needed the services that the hospital provided them in order to change their health status to be more congruent with their definition of health, which was to be more rested, relaxed, comfortable and recharged.

Need for Care

The women identified a need for care and this care included: help in caring for self and baby, support on a 24 hour basis, and physical and emotional protection from the "outside world". These factors are summarized in Table 6.

Table 6

<table>
<thead>
<tr>
<th>Need for Care</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for help</td>
<td>26</td>
<td>47</td>
</tr>
<tr>
<td>Need for support</td>
<td>19</td>
<td>34.5</td>
</tr>
<tr>
<td>Need for protection</td>
<td>8</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Need for help. Women stated that they needed to be in hospital to receive the help services that only hospital could provide. This included help to care for themselves and the baby, assistance with breastfeeding, meal and accommodation services, educational information, and advice from health professionals. These situational and behavioural factors assisted women to increase their perceptions of self-efficacy and to change their
perceived health status to fit more closely with their definition of health.

The women, mainly first-time mothers, expressed that they particularly needed help in caring for and understanding the needs of a newborn. One woman stated, "I don’t know anything about babies; the nurses know everything and are so confident in handling them." This lack of confidence or perceived low self-efficacy made them fearful and scared to go home early. The women believed they had little control over their health and that they could not independently access information that they required outside of the hospital setting.

The primiparous women defined nurses as providers of information and advice, as teachers and experts. Sixty-eight percent (n=19) of primiparous women stated they needed the educational information they could access in the hospital. One first-time mother stated, "They tell you in prenatal classes about these things but nothing sinks in." Many of the women expressed they would not know what to do if they did not have the nurses to ask or help them. "You are supposed to know all this stuff but you forget everything you read," commented one woman. These women believed resources did not exist outside the hospital for them.

Teaching from the nurses decreased the women’s anxieties and increased their self-efficacy in caring for their baby once they go home. "It is nice to be around the nurses when a problem comes up as it helps for the next time," stated one study participant. One first-time mother said, "If I went home I don’t know who would help me with the baby and answer my questions." Another comment was made by one of the women that "the nurses guide and teach you as you are going through things".
Past postpartum experiences were stated by some women to have influenced their decision to stay in the hospital. Two women had experiences with their last babies becoming jaundiced and requiring re-hospitalization for phototherapy. Both of these women stated they did not want to go through the same experience again. Another woman had her last baby prematurely and had not planned to go home early because she was afraid that might happen again. Because of these negatives experiences these women felt it was best to stay in the hospital for the health of themselves and their babies.

Another factor identified by the women which influenced their decision not to participate in the early discharge program was the need to have breast-feeding established before going home. The women in the study did not perceive they would receive the same help with breastfeeding at home. This lack of knowledge about community was a barrier for the women, therefore they decided not to participate in the early discharge program.

Two women who had breastfed previous children stated that they wanted their milk supply established and breastfeeding "off to a good start" before leaving the hospital. Two other women who had failed to breastfeed with their other children equated support and information on breastfeeding before leaving the hospital with ensuring success at breastfeeding. First-time mothers were anxious for the help they were receiving from the nurses on breastfeeding. One woman stated, "I know absolutely nothing about this whole thing so I need all the help I can get." Another woman stated "it was a lot harder than I had expected and wanted to feel good about breastfeeding before I went home."

The physical strain and difficulty experienced with breastfeeding were expressed
by some women as factors affecting their decision. Sore nipples, difficulty with the baby latching on to the breast, and scheduling feedings were some of the specific problems identified that needed nursing support. The women stated that being in the hospital allowed them to spend time breastfeeding in a supportive and helpful atmosphere. One woman stated, "If you get the feeding off to a good start it will help once you are home."

First-time mothers expressed much more apprehension than multiparas and appeared nervous regarding newborn feeding. They stated that they lacked the knowledge to breastfeed successfully. By staying in the hospital they felt they would gain the skills and information required to be successful. One woman commented that she found it was "great to have the nurse around the first few times that you fed the baby; it helps boost your confidence". The help they received from the nurses was equated with increased feelings of self-efficacy about breastfeeding.

A few of the multiparous women in the study had negative past experiences with breastfeeding which led them to want more help from the nurses. "Milk coming in" was seen as an indicator of success. One woman stated that "once the milk is in, all will go well". Several of the women thought it was best to stay in the hospital until the breastmilk was in.

Establishment of breastfeeding was an important consideration for many of the women in this study as eighty-eight percent (n=48) of the women were breastfeeding at the time of the study interviews. It is well documented that infant feeding is a paramount concern and priority for women in the early postpartum period (Smith, 1989; Tobert, 1986). The women in this study supported the theory that successful breastfeeding was
intrinsic to healthy maternal adaptation. The nurses working in the M.C.A.H. program
cited one of the major concerns of women in the immediate postpartum as breastfeeding.
This was also demonstrated in the study by Bradley et al. (1989). Chapman (1985)
studied women’s postpartum concerns with breastfeeding and they included in the order of
priority: milk supply, sore nipples, frequency of feeds, and breast milk storage. This
study also found that breastfeeding was a priority for women and they felt that staying in
the hospital would lead to success in this process. Ironically, a qualitative study by Ellis
& Hewat (1984) found that women who stay in the hospital longer are less successful
with breastfeeding than women who go home early.

In Patterson’s (1987) study the main concern and the reason for staying in the hospital
longer for primiparous women was their need to improve their ability to care for their
baby correctly and having knowledgable people to help. Lemmer (1987) found that
primary concerns for first-time mothers who stayed longer in the hospital were learning
about their infants and becoming acquainted with them. Women in the traditional hospital
stay group in the Bradley et al., (1992) study rated learning about baby care significantly
higher as a factor of importance in their decision-making, than women in the early
discharge group.

It is apparent from the study’s findings that establishing breastfeeding is a major
component of the need for help for both primiparous and multiparous women. The
women’s lack of self-efficacy around feeding was a factor which influenced their decision
to stay in the hospital. Women approached breastfeeding as a learning process and
believed that by staying in the hospital longer they would learn the knowledge and skills
to establish a milk supply required for successful breastfeeding before being discharged home.

The repeated findings in a number of research studies suggest there is a group of women who are not confident in their ability to care for themselves and a new baby. It would seem these women feel that they do not have the control over their health to the degree that they can independently address their health care needs. The women in this study chose to stay in the hospital to reduce their concerns and to increase their self-efficacy.

Need for support. The women included being supported as part of their definition of health. They felt supported in hospital but they did not believe they would be adequately supported at home. The women defined support broadly. They believed health-care professionals understood what they were going through and consequently their presence was an interpersonal influence that would assist them to feel supported. Support also included helping with the baby at night, providing support for breastfeeding, helping meet their physical needs, and providing interventions in the event of an unexpected crisis for themselves or their infants. The women believed the support would decrease their anxiety and increase their self-efficacy. To address their need for support they wanted access to nursing and medical care and support 24 hours a day. Women described support as having access to nurses and doctors who could check them and the baby anytime.

Nursing and medical support helped build their confidence in caring for their baby and in caring for themselves. One woman commented that she would not trust what her husband said if she asked a question about the baby, but she trusts the nurses’ expert
advice. Another woman said that she wanted to take the night nurse home with her. One woman stated that she was "scared to death" to go home with her baby on the first postpartum day. "I don't know anything about babies. I would probably have killed him," stated the woman.

This need for support, in part, was related to interpersonal influences. These women believed that family members lacked the skills or would not be available to answer questions or help them with baby care at home. Many of these women stated they had no support available to them if they went home early from the hospital.

The literature also describes a woman's need to feel supported and understood in the postpartum period (Mercer, 1981). Patterson (1987) found that the women in the late discharge group highly rated attention from others as a reason for staying in hospital; they also wanted to be in the hospital to ensure nurses would be close by. This same group in Patterson's (1987) study found the nurses more helpful than family members in helping them gain confidence.

**Need for protection.** Women stated that because of their current health status, they needed protection. Protection from the outside world was articulated by responses such as, "I want to stay in a cocoon with just myself and my baby; I don't want anyone to bother us". One woman stated, "The nurses protect you from the external world". Other comments regarding protection were: "You don't have to worry about anything while you are in the hospital; everyone is here to help you. It is so easy in here. I feel depressed when I go home after having a baby. The hospital feels so safe and everyone is so nice. When you go home reality sinks in and there is no one to fuss over you."
When some women talked about being protected from the reality they were describing being away from the work and tasks at home. The hospital acted as "a barrier against the outside world". Many of the women expressing this need wanted to be protected against outside influences such as visitors, other children and loneliness or isolation. The women saw the care they received from the health-care professionals and hospital environment with offering an artificial, protective environment. These situational factors would be absent at home.

The need for protection was one of the most unexpected factors found in this category. More primiparas than multiparas indicated a need for protection, which was defined as both emotional as well as physical. The primiparous women may have been particularly worried about incorporating the new infant into their lives, and taking on the care-taking role that they wanted as little interference as possible.

The women in this study perceived the hospital as a supportive environment in contrast to Lemmer’s (1987) study and Hall & Carty’s (1993) study. Both studies noted that women who chose early discharge felt that it was just as safe at home as in the hospital. They felt a sense of comfort in the home environment and they received support from their husbands and family (Hall & Carty, 1993; Lemmer, 1987).

Other research on postpartum women’s hospital experience contrasts with the results of this study. Moss (1987) found that many women discontinued breastfeeding because of dissatisfaction with the help and assistance from the hospital staff. In an earlier study, Moss (1981) also found that women hospitalized with their first baby found the nursing staff demanding and they would have preferred more help than they received.
Studies have found that women find the advice in hospital which is given by many different people inconsistent, confusing, and anxiety provoking (Moss, 1987).

This category indicates these postpartum women had a need for care, and defined that care as only available in the hospital. The situational factors in hospital as opposed to interpersonal influences at home defined their needs for education, modelling, advice, support and protection. First-time mothers emphasized their need for information and the importance of access to advice, support, and protection from the hospital resources. Questions arise as to whether these needs could be met in the home environment.

External and Internal Influences and Barriers

This section describes modifying factors evolving from the content analysis that influenced a woman’s decision to stay in the hospital. These included situational and behavioral factors, and interpersonal influences such as home environment, influential people and lack of awareness of the early discharge program. These factors affected the feelings of control over their health and consequently their decision about early postpartum discharge. The specific factors are outlined in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children at home</td>
<td>25</td>
<td>45.5</td>
</tr>
<tr>
<td>No help at home</td>
<td>24</td>
<td>43.5</td>
</tr>
<tr>
<td>Physician influences</td>
<td>13</td>
<td>23.5</td>
</tr>
<tr>
<td>Partner, family and friends influences</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Did not know about the program</td>
<td>11</td>
<td>20</td>
</tr>
</tbody>
</table>
Having other children at home was major factor influencing women's decision to stay in the hospital. The women with children at home felt that they needed to stay in the hospital so they could rest and recover without the other children around and so they could spend time alone with the new baby. Three women distinctively stated, "No one else can take your place at home so it is better not to be around at all." One woman added that "you will just get caught up in doing it all". The children, according to the women in the study, expected the mothers to play with them or do things for them that only the mother could do. Many of the women who expressed this concern missed their children but felt it was better to stay in the hospital for them and their families. Concern for the other children at home was one of the highest rated concerns for multiparous women in many studies (Gruis, 1977; Harrison & Hicks, 1983; Patterson, 1987; Smith, 1989). Research reflects the concerns of multiparous women for their children in the postpartum period and for the integration of the new member into the family.

Another factor cited frequently which influenced many women to stay in the hospital longer was lack of help at home. Women described needing help with the children and the household tasks such as cleaning and cooking. Nearly half (44%, n=24) of the women in the study, both primiparas and multiparas, stated they had little or no help at home. The women felt that they would receive better help in the hospital than what they would receive at home from their family. This finding is similar to that of Patterson's (1987), that women who refuse early discharge prefer to stay in the hospital for the help they can receive.

The women stated that their husbands and family members wanted them to rest
and get healthy and stronger before coming home. One woman stated, "My husband wants me to stay in so I can learn as much as I can about taking care of the baby." Many women stated that their husbands and family were scared to take them home so soon and it was up to the doctor to make the decision. Some women commented that their husbands were too busy to have them home and it was better for them to stay in the hospital so they could be looked after by the nurses.

The study participants commented that friends and family influenced their decision by telling them to rest while they could. This was especially true for mothers with other children. One woman said that her friends with children were very adamant that "if you go home early you will never catch up on this time and you will wear yourself out".

The people that women said influenced their decision the greatest were their physicians, although partners and/or husbands, family and friends were also influential in these women's decision to stay in the hospital. Many women expressed that it was up to the doctor to discharge them and their babies. One woman stated, "My doctor said it was better for me to stay in the hospital." Another said that her doctor told her there was no rush for her to go home. Of the thirteen women that stated it was up to their physician to make the decision, all were Asian-Canadian. These women felt it was best to stay in the hospital and wait for the doctor to discharge them. They also expressed that if their doctor felt it was better to stay in then they would do what he or she said was right to do. Over half of these women did not know about the early discharge program and did not know they could ask their doctors about going home. The physicians attending these women were not active users of the hospital's early discharge program.
Women in Patterson’s (1987) study, when asked who was influential in their decision to choose early discharge, said that it was their own decision and for late discharge women it was partners, family, friends, physicians and hospital nurses.

A large percentage of women were unfamiliar with the early discharge program and therefore did not plan to participate. Some women heard about the program prenatally but were unclear on how it worked and operated. Half the women stated that if they had known about the program they might have gone home early. They felt because they didn’t know about the program they were not organized to go home. Other women were adamantly against the concept of going home early. A small group of women when asked whether they would go home early with their next baby said they would have to wait and see how things worked out. Gruis’ (1977) findings suggest that women require antenatal preparation to help cope in the postpartum period.

The factors such as other children and no help at home were prominent and overwhelming issues affecting the study participants’ decision to stay in the hospital longer. There was a sense from the women in this study that the hospital was not necessarily providing them with medical care but a replacement for services and resources that they were lacking in their own homes and community. It could be surmised that it was just easier for the women and their families to stay in the hospital. The women seemed to enjoy being in an environment that provided them with services such as a clean room and meal services as well as people who were there to care for them. The women also appeared to appreciate having things done for them.

The other two areas that were extremely revealing in this section were the
influence others had on the women in this study and the lack of information they had about the early discharge program. It appeared that the women influenced by their physicians and family felt vulnerable and helpless in making the decision to either go home early or stay in longer due to lack of experience and knowledge in making informed health-care choices. Cultural-health practices could play a large role in how influential certain people are and how health-related information is relayed and processed. Lack of family preparation and involvement also appear to be influential in these women’s decision to stay in the hospital longer. The majority of factors listed in this section could be addressed by better education of physicians and families, and increased community services.

These findings contrast with the research that has been done on women who participate in early discharge as they define themselves as risk takers who rely heavily on their own decision making (Hall & Carty, 1993). In Patterson’s (1987) study the majority of women participating in early discharge knew about the program in advance through either prenatal classes or information pamphlets. This assumption is reinforced by the fact that women who chose the traditional hospital stay feel that the hospital is the best place for recovery following birth and have no knowledge of alternatives (Bradley, et al., 1989; Lemmer, 1986; Patterson, 1987).

Ancillary Findings

The investigator had some apprehensions that the women would be reluctant to speak openly about their decision while they were still in the hospital. The study participants on the contrary, were very responsive in discussing their experiences and
decision with the investigator. The majority of the women articulated their reasons for not participating in early postpartum discharge in a well-framed and organized manner.

In addition to the answering the interview questions, the majority of the women in the study were very eager to discuss their labour and birth and immediate postpartum experience. This finding reflects the need to review the events of the childbirth experience and integrate the actual experience with the expected experience. This is one of the tasks of the postpartum period as noted by Mercer (1981).

In conclusion, the information gathered through the interviews was used to develop the categories. The categories were then examined in relation to the health promotion framework. The women in the study did not believe that they had control over their health. They perceived themselves to be tired and uncomfortable. Demographic characteristics, interpersonal influences, situational factors, and behavioural factors acted to influence the women’s perceived health status so they ended up seeing the home environment as a barrier to health-promoting behaviours. In particular, perceived health status, perceived control of health, self-efficacy and perceived benefits and barriers were addressed through the women’s expressed views on their decision to stay in the hospital.

The study participants chose to stay in the hospital because they believed it was the best for their health and for their babies. The women felt this was an important health decision and was important for their postpartum recovery. They based this decision on their health status at the time of the decision and past health experiences with the postpartum period.
Summary

The findings presented in this chapter consist of a summary of relevant demographics of the participants, description of responses obtained from the study interviews, and discussion of the findings. The women who participated in the study were able to describe the factors that influenced their decision to not participate in an early postpartum discharge program. Through a process of content analysis, the responses were categorized according to their primary focus in order to relate them to influential factors affecting a woman’s decision. Two main categories were identified; the need for physical and emotional restoration and the need for care. The individual perceptions that make up the cognitive-perceptual factors of Pender’s (1987) Health Promotion Model were reflected in the findings of the study.
CHAPTER FIVE

Summary, Conclusions, Implications, Recommendations

Introduction

This study was designed to identify the factors influencing a woman’s decision not to participate in an early postpartum discharge program. An overview of the study is presented in this chapter followed by conclusions, implications for nursing practice, education, and recommendations for future research.

Summary

This study was exploratory in nature, and was carried out using a factor searching design and, content analysis was used to examine the data of the interview questions, based on the Health Promotion Model by Pender (1987). Fifty-five study participants consisting of 28 primiparas and 29 multiparas, were interviewed on their second or third postpartum day during their hospital stay. The sample was recruited from a large tertiary care maternity hospital in Vancouver, British Columbia. All women interviewed had met the criteria of the hospital’s early discharge program but had decided to stay in the hospital rather than go home early.

The study identified the factors influencing the study participants’ decision to stay in the hospital. The two major categories factors emerged: 1) need for physical and emotional restoration and 2) need for care. External and internal influences and barriers affecting the participants’ decision to stay in the hospital were also identified.

When examining the findings in light of Pender’s (1987) health promotion model, two of the cognitive-perceptual factors stand out. The women felt they were not healthy
enough to go home (health status) and that they were not confident enough to go home (self-efficacy). The modifying factors found in Pender’s (1987) model were also relevant in looking at the factors. These included: biologic characteristics such as fatigue, situational factors such as having other children at home, and behavioural factors and interpersonal influences such as the ability to carry out the required skills to care themselves and their baby, and the influences of their physician and family.

By staying in the hospital the women were able to increase their self-efficacy and enhance their perception of their health status prior to being discharged home. The women perceived the hospital as the best place for them to access the health-care they felt they needed for recovery and maternal adaptation. The women perceived many barriers to going home and many benefits in staying in the hospital.

Participants demographic profiles revealed no apparent relationship between age and method of birth. Multiparous women reported that the primary reason for not participating in an early discharge program was because they had other children at home and no help. Primiparous women expressed the need for the availability of education and support in caring for themselves and their new baby 24 hours a day. The need for rest and sleep was expressed by more multiparous women than primiparous women as the factor affecting their decision to stay in the hospital. A high percentage of the women in the study did not feel prepared to go home because they did not know about the early discharge program prior to their hospitalization. The participant’s physicians were found to be the most influential figures in the women’s decision to stay in the hospital longer.
Conclusions

Women stay in hospital because they feel their needs for physical and emotional restoration and care can best be met in the hospital environment. Situational factors such as other children at home, lack of support at home, and the views of significant others influence the decision women make about participating in an early postpartum discharge program.

Implications

This section presents the implications for nursing practice, theory, education and research. Changes that can be made within the present perinatal health-care system and those that would be ideal for the future will be discussed.

Nursing Practice

Modifications in nursing practice and in the delivery of consumer education is one of the first steps toward addressing the findings of this study. In the near future it will be expected that all women without complications will go home within 24-48 hours of birth. The focus then needs to be on assisting women to re-frame their perceptions and expectations of the postnatal period. This will increase their self-efficacy and put them in a more effective control of their health status and related health-care decisions.

Nurses and others who care for women in the postnatal period must develop and implement education programs and practice measures that are relevant to the overwhelming needs and maternal definition of health, in the context of the birth of a new infant. Supportive care and education that is able to assist women with unique concerns and maternal tasks of the postpartum period is critical, whether women are recovering in
hospital or at home.

The need for rest and sleep was demonstrated in this study's findings and has been documented in the literature on early postpartum discharge and maternal tasks as being an overwhelming need for all postpartum women (Bradley, et al., 1992; Mercer, 1986; Rubin, 1984). The other area of great need for women was the aspect of education and help in the postnatal period. Both of these areas require care and attention and must be addressed if the goal is to provide optimal postpartum recovery and adaptation for all childbearing families within and outside the hospital environment.

Helping families to plan for early discharge is critical so that women are able to obtain as much rest and sleep as possible. Family members can be involved in screening visitors, planning rest periods, cooking meals and taking on housekeeping tasks. If family members are not available community services need to be put in place.

Expanding and improving postnatal education into existing prenatal classes, and incorporating infant care classes in community centres and on local cable networks would enhance the accessibility of postnatal preparation for women and families.

The care and teaching that individual families receive when in the hospital must be carried through to the community. This can occur by implementing a comprehensive and efficient method of communication between hospitals and community health units, which would allow information to be shared in a timely way. Early contact and home visits following hospital discharge would result, ensuring effective teaching and support extending from hospital to community. Prenatal and postpartum home visits from the community health nurse, utilizing a detailed referral system from community to hospital,
and hospital to community would enhance the utilization of resources and services closer to home.

Childbearing women, their families and health care professionals require accurate information on a variety of perinatal healthcare issues and options. Resources must be accessible and available to assist in bridging the information gap. The belief that the hospital is the only place to obtain support, assistance, and recover postnatally, or that early discharge is also best for all women, needs to be explored and challenged by all parties involved in perinatal healthcare. With education and knowledge, women might increase their self-efficacy and may find health-promoting decisions easier to make.

Familiarizing and educating women and their families as to the choices available to them involves effective marketing of community health resources, services and network system. Communities and their health-care provider’s must be targeted as they may require information and education programs to meet their different needs. These marketing strategies must also be evaluated for their effectiveness in reaching this population of women.

Many of families, such as the Indo-Canadians and Asian Canadians, have culturally-based rituals surrounding the birth of a new family member. For example, these new mothers often have large extended families. Recovery at home, with close family members for comfort and support and with health care professionals visiting in the home rather than the unfamiliar environment of the hospital, would seem to be an excellent choice for these women. Culturally-sensitive programs that encourage interaction and involvement of the family would enhance learning and relieve anxieties for many
childbearing women and their families.

Programs that incorporate support for physical and emotional restoration and provide information to new parents are essential. A regional program would involve close collaboration between the community and hospital, utilizing specialized perinatal nurses, homemakers, and a variety of support services that would follow families through their pregnancy and postnatal period. The program would offer families planned home visits by a nurse, and 24 hour phone contact immediately after hospital discharge for the first two to six weeks postpartum. The visits would be based on need and/or request from the families and would utilize specialized nurses in the area of maternal-family nursing. Homemaker and child care services would be provided on a sliding fee scale to families who need assistance with light housework and child care.

All of the early discharge programs in the regional area would encompass a system in which planning was done with each family. The programs would also include teaching sessions for expectant parents during the last trimester focusing on postpartum discharge instructions for mothers and babies. The program would incorporate and expand the scope of existing perinatal services in the community health units and hospitals, such as prenatal classes and postnatal drop-ins and speciality clinics designed for perinatal families.

Women would be registered into a perinatal program during their pregnancy or postnatal period. Referrals would be made by community/hospital health professionals, primary care givers, and/or the women themselves. By registering the women during their pregnancy, program planning and patient preparation would be facilitated creating less
anxiety for both the families and caregivers. Referrals between professionals could occur at anytime throughout the perinatal continuum. Evaluation would be a standard component of the programs, ensuring ongoing quality and satisfaction for all users of the service. With education and access to appropriate resources new families could view early postpartum discharge of mothers and newborns as a normal and healthy part of the life cycle.

**Nursing Education**

Nurses are closely involved in the provision of care for postpartum women and their families and are often the primary health-care contact for many families within the community and hospital. For this reason there is continued need for updated nursing curriculum. The curriculum needs to incorporate the following: the critical needs and concerns of postpartum women with respect to parity, cultural and socio-economic differences, influential factors affecting health-care decision-making, and the benefits and barriers of associated with early postpartum discharge and traditional postnatal care. Postpartum maternal-task theory and Pender’s (1987) Health Promotion Model are valuable tools and their use should be encouraged in the education of nurses caring for women in the postpartum period.

Pender’s (1987) framework would be helpful for nurses in assessing, assisting, and educating women in other related health-care decisions. Both the cognitive-perceptual and modifying factors were helpful in understanding the decision the women made. The framework can be a model for nurses to use when planning educational programs and in understanding women’s health-care decisions.
Recommendations for Nursing Research

Examination of issues affecting women in the postpartum period such as rest and sleep, physical and emotional comfort needs, and need for care, requires further exploration and research. These issues need to be examined in relation to the hospital versus home environment, and how women's needs can best be met in the early postnatal period. Research on breastfeeding success and the effects of early discharge must be explored further.

Studying women’s expectations about rest and sleep, both prenatally and postnatally, would be extremely useful for women, as well as health-care providers to know and understand. Qualitative research would enhance and contribute to basic constructs in this area. Demographic and comparative studies would be helpful to identify commonalities between groups, and the factors and variables affecting rest and sleep in the postnatal period.

Many studies have been done on the general needs and concerns of women but very few have examined the specific areas in detail and of different sample groups and cultures. By isolating specific groups and populations such as multiparous women and cultural groups, sampling would provide information surrounding the barriers and situational influences affecting women’s postpartum recovery. These issues can then be targeted for appropriate nursing intervention and changes in the delivery and practice of perinatal health-care, especially in relationship to early postpartum discharge.

Examining how women frame their beliefs and expectations surrounding the childbearing period would be enlightening. How do they identify such areas as lost
periods with newborns that can never be regained? Can health professionals be justified in trying to intervene and change these beliefs and expectations?

Examining the perceptions of women’s partners and their experience with early discharge would be very relevant, as husbands and/or partners were found to be the main support person for most women in this study. It would also be interesting to examine the perceptions of other family members in relationship to early postpartum discharge and the affects on the family from a qualitative perspective. Experimental research needs to be continued as well, to assist in unravelling the fears and misconceptions that plague a large group of childbearing women, their families, health-care providers and society in general surrounding the concept of early postpartum discharge.

Investigating in more detail women’s attitudes and beliefs surrounding the perinatal period and how these influence their feelings of self-efficacy and control over their health would be enlightening.

In conclusion, it is this investigators’s hope that research will continue to be conducted to expand the body of nursing knowledge in the general area of postnatal care of women and their families. An area of particular interest is the delivery of present day perinatal healthcare and the everchanging and eclectic needs of today’s childbearing women.
References


Appendix A

M.C.A.H. Criteria
STANDARDS AND CRITERIA FOR POSTPARTUM MATERNAL AND NEWBORN DISCHARGE FROM GRACE HOSPITAL

Standard 1: Healthy mothers and newborns will be discharged and referred to the Maternity Care at Home Program earlier than norm.

CRITERIA

1.1 A mother will be eligible for discharge from Grace Hospital if:
- vaginal birth - discharged 6-48 hours postpartum;
- Caesarean Section - discharged 3-4 days postpartum;
  : Blood Pressure < 140/90;
  : Temperature < 38° C p.o at discharge;
  : No significant vaginal bleeding {excludes any client with transfusion};
  : No uterine atony {exclude IV oxytocins > 12 hrs};
  : Normal appearance of incision/episiotomy;
  : No significant ongoing urinary difficulties;
  : No clinical evidence of deep venous thrombosis;
  : Blood loss < 1000 CC at delivery;
  : HgB > 95 intrapartum
  : Postpartum HgB >= 90 - if not available at time of discharge, then the postpartum
  : HgB must be obtained with a copy of the report to be sent to the attending physician
  : and to the MCAH Program;
  : No surgical or medical problems for which a patient requires continued hospitalization.
  : Breastfeeding Mothers:
    : Mother demonstrates ability to put the baby to breast;
    : Baby able to latch on to the breast and suckle effectively.

1.2 Newborns will be eligible for discharge from Grace Hospital if:
  : Completed Normal Newborn Discharge Examination;
  : Birth weight >= 2500 grams and appropriate weight for gestational age;
  : Gestational age between 37 and 42 weeks;
  : No evidence of asphyxia at birth (Apgar 7 or greater at 5 minutes);
  : Vital signs on discharge: Temperature 36.1° C - 37.2° C
    : Respiration rate 30-60 per minute
    : Heart Rate 100-160 per minute;
  : Normal cord blood results (no blood group incompatibility);
  : No abnormal voiding or stool patterns;
  : No abnormal feeding patterns;
  : No evidence of significant clinical jaundice;
  : Normal muscle tone, cry, infantile reflexes and behaviour;
  : Newborn screening:
    : Hip check - [if not done at hospital, screening will be done by physician]
    : PKU and thyroxine screening test - [if not done at hospital, a form is given to be
      done by physician or laboratory]
  : Appointment to see attending physician within one week of discharge.
Appendix B

Information Letter
Dear

My name is Jill Mahy. I am a registered nurse and I am currently a student in the Master of Science in Nursing Program at the University of British Columbia. As my thesis topic, I am interested in studying the influences affecting a woman's decision not to participate in an early postpartum discharge program.

I believe that it is important to explore human experiences by asking the people who live them to teach me about them. Gaining knowledge about a woman's decision not to participate in an early postpartum discharge will assist in improving the quality of nursing care and services for postpartum families.

Please consider participating in this study by agreeing to be interviewed about your decision. The interview will be scheduled to take place in your hospital room prior to discharge. Your privacy will be protected at all times. Any information that you share will be held in strictest confidence and you will never be identified in any published or unpublished materials. You have the right to withhold or remove any information that you desire. You may withdraw from the project at any time without jeopardy or prejudice to your health care.

Data collected from the interview will be audio tape recorded and handwritten notes will be taken by the interviewer. No names will appear on the recordings, and the only other persons to read them will be two faculty members who are my thesis faculty members. All tapes and transcripts will be destroyed upon completion of the study.

If you are interested in participating in this study, please place a tick in the appropriate spot (yes or no) below and return this letter to the nursing station or to your nurse.

Yes, I am willing to participate in the study.

No, I would prefer not to participate in the study.

Thank you for considering this request.

Yours sincerely,

Jill Mahy, R.N., B.S.N.
875-6956

Elaine Carty,
Associate Professor,
Thesis Supervisor
822-7444
Appendix C

Informed Consent Form
I agree to participate in the nursing research study to be conducted by Jill Mahy, R.N., B.S.N. who is a graduate student in the Masters program of the School of Nursing of the University of British Columbia.

The study and my role in it has been explained to me. I understand that my participation is voluntary and that I may withdraw at any time without consequence to my health care. I understand that my participation includes a 45 minute interview with the researcher in my hospital room at Grace Hospital. I understand that all information will be held in the strictest confidence and that I will never be personally identified in published or unpublished materials. I have received the names and telephone numbers of the thesis advisors at the University of British Columbia. I have had the opportunity to ask questions and concerns about the study.

My signature on this form verify my intention to participate in this study. I have received a copy of this consent form for my records.

SIGNATURE __________________________ DATE _______________________
Participant

SIGNATURE __________________________
Investigator

Jill Mahy, R.N., B.S.N.
875-2899

Elaine Carty, 
Associate Professor 
Thesis Supervisor 
822-7444
Appendix D

Physician Letter
Dear Dr.______________________,

My name is Jill Mahy. I am a registered nurse and I am currently a student in the Master of Science in Nursing Program at the University of British Columbia. I am doing a research study on a woman's decision not to participate in an early postpartum discharge program.

This letter is to inform you that your patient, Mrs./Ms._________________________ has agreed to participate in this study by consenting to one interview during her hospital stay.

If you have any questions or concerns about the study, or your patient's participation, please feel free to contact me at 875-6956.

Thank-you.

Sincerely,

Jill Mahy, RN, BSN
Appendix E

Demographic Information Sheet
Demographic Information Sheet

Age of participant: __________ years

Marital Status of participant: single: __________ common law: __________
married: __________ divorced: __________

Ethnic background of participant __________________________________________

Highest level of education of participant ____________________________________

Occupation of participant ________________________________________________

Occupation of spouse _____________________________________________________

Total income level of household: __________________________________________

Number of persons currently living in participants household: _________________

Number of children/ages of participant: _____________________________________

Number of pregnancies: ________

Brief history of participants present and past birth and postpartum experiences:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Brief description of the support and help that is available to the participant:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________