

**The best of both worlds:
Women's experiences of early postnatal discharge when
supported by a domiciliary midwife.**

by

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for the degree of
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Declaration

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any tertiary institution. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person, except where due reference is made in the text.

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Abstract

Early postnatal discharge programmes form an alternative mode of midwifery care in Australia. The purpose of this descriptive study was to report women's experiences of returning home early after childbirth when visited by a domiciliary midwife. The research topic was recommended in the literature and was in response to concerns voiced by community members at a public meeting about local maternity services.

The design involved the development of an interview schedule of variables that would assist the participants to recount their experiences during a semi-structured interview. A trial of interview schedule was conducted to refine the tool. Forty-nine women, who chose to return home early, were interviewed and the responses were audio taped. A coding sheet was devised to record and assist analysis of the women's responses.

The results of the study were presented using descriptive statistics, which were supported and enhanced by qualitative statements made by the women. Early postnatal discharge experiences were considered favourable overall but three issues--informed choice, readiness to learn and rigid selection criteria--were identified for discussion. The community fears were not founded within this group.

The women's responses and the identified issues can inform midwifery education and practice. Further research topics were identified.

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Introduction

The past is well known; the present must safeguard the future, and midwives must continue to strive to be guardians of standards of care and choice in childbirth (Roch, 1990, p. 110).

Background to the Study

The length of stay in Australian acute care health care agencies has fallen over the last two decades. The average hospital stay declined by 33% between the years 1970 and 1987 (Scott, Shiell & Farnsworth, 1993, p. 81). Scott et al. (1993) assessed the value of three early discharge schemes in New South Wales. The researchers concluded that such schemes were complex to evaluate and whilst the schemes were not cost effective their value was demonstrated as the options available to users were increased. One of the three schemes was an early postnatal discharge programme for well women and babies for whom postnatal midwifery care continued at home until the seventh postpartum day. As a midwife with experience in community midwifery the phenomenon of early postnatal discharge from hospital aroused this researcher's interest, particularly concerning women's experiences following an early discharge.

The reasons for the trend of reduced postpartum length of hospital stay are multifaceted. Issues discussed in the literature included consumer pressure for alternative birthing services, increased involvement of partner and family members, the acknowledgment of pregnancy as a health state rather than an illness state, maternal desire to return home quickly (Thurston & Dundas, 1985, p. 384), staff shortages (Waldenstrom, 1989, p. 190), bed shortages (Rush & Valaitis, 1992, p. 29), alternatives to home delivery (Scupholme, 1981, p. 19) and government initiatives to improve efficiency of the public health system by implementing alternative forms of acute care (Scott et al., 1993, p. 82). Early

postnatal discharge has been practised since the 1960's in the United Kingdom and North America. It has been of more recent interest in Australia where Head (1987, p. 7) stated Australian practice and research findings of issues surrounding early postnatal discharge have not been widely reported.

In this chapter the context of early postnatal discharge into present day health care in Australia will be outlined. The formulation of the research statement will be traced through historical and local events and recommendations for further research studies from the literature. The relevance of the research to midwifery education, practice and research will be stated.

The Re-emergence of Postnatal Care in the Home

During the last 300 years many changes have occurred within midwifery practice in western society. Initially, it was the norm for women to deliver a baby and be cared for postnatally at home. There followed a gradual transfer of maternity services into hospital. The latter years of the twentieth century have heard calls for changes in midwifery care. One such change was for postnatal care, after a hospital delivery, to be given by a midwife in a home environment.

Willis (1989, pp. 92-124), whilst tracing the dominance of the medical profession in maternity care, briefly described a change in venue of the birthing experience. From time immemorial until the seventeenth century midwifery was an art practised by women in the home environment. Male doctors, known as man midwives, began attending births during the seventeenth century. They went on to establish lying-in hospitals where lower class women delivered their babies. Later, middle and upper class women voluntarily received midwifery care in hospital on a fee paying basis. The transfer of childbirth practice from home to hospital occurred in an environment of medical interest, medicalisation,

technicalisation and restriction of midwifery practice until the twentieth century (Willis, 1989, pp 92-122). The effect of this transfer from home to hospital had been to change long-standing social and family patterns of support to childbearing women (Ball, 1987, p. 27).

In the second half of the twentieth century women, health care professionals, politicians and health care agencies have striven to restore a balance between medical and social elements of maternity care. Oakley (1992, p. 9) wrote that the 1970's and 1980's stood out as a time of consumer movement in maternity care, with consumer groups requesting a woman-centred approach, whilst medicine was accused of dominating childbirth. Kenny, Cameron, King, Scott & Shiell (1992, p. 3) explained that women, who had uncomplicated pregnancies and deliveries, wished to be seen as people experiencing a normal life process. The women wanted to decrease medical intervention and the time spent in hospital and increase the involvement of partners and family in the birthing process (Kenny et al., 1992, p. 3 and Thurston & Dundas, 1985, p. 384). Dissatisfaction was also voiced about care that lacked individuality, continuity and self responsibility (Bryar, 1991, p. 48). Filshie, Williams, Osbourn, Senior, Symonds & Backett's (1981, p. 89) rationale for dissatisfaction was that maternity wards were administered using an ill patient model.

Furthermore, social and cultural changes have influenced the services required by families and the ways in which these services are delivered (Postans, 1993, pp. 1, 10). The heterogeneity of families has highlighted the need to constantly review the types of health services available and their modus operandi. Families are now smaller and more mobile, are often isolated from the extended family, are more diverse through culture and religion and are better informed.

James, Hudson, Gebski, Browne, Andrews, Crisp, Palmer & Beresford (1987, p. 434) propounded that the shift in public attitudes led to significant changes in professional attitudes. Two different ways of viewing childbirth were described. One view is that childbirth is a normal physiological process not requiring medical mediation unless abnormalities occur. The other view is that the birth process and first week of life are statistically the most hazardous of times even in the developed world. James et al. (1987) wrote that maternity care had erred on the side of caution, had overemphasised the safety aspects and thus had "blunted the sharp edge of progress in the 'humanisation' of reproduction" (p. 434).

In response to the expressed needs of women, midwives in the United Kingdom, and later in Australia, expanded their roles during the 1980's (Robinson & Thomson, 1991, p. 1). Concepts such as community-based independent midwifery and hospital-based Know Your Midwife (KYM) schemes became realities. Independent midwifery saw interested midwives caring for women during pregnancy, assisting them to deliver at home or in birth centres, then caring for them at home postnatally. This resulted in a rapport between midwives and women, and in continuity of care. These concepts were also central issues for the Know Your Midwife scheme (Flint, 1993, pp. 73-78). The KYM scheme catered for women who wished to have their babies in hospital but not be cared for by many strangers. Women were cared for throughout the childbearing process by a small number of hospital-based midwives. These models of care led to renewed relationships between women and midwives during pregnancy, labour and the postpartum period.

Political pressure to raise the status of women in society also contributed to the expansion of options available to childbearing women. Following consultation with Australian women at the close of the United Nations Decade for Women in

1985 the Federal Government, under the leadership of Bob Hawke, accepted the challenge to formulate policies that addressed the inequality of women in our society (Department of the Prime Minister and Cabinet: Office of the Status of Women, 1988, p. 1). Health Goals and Targets for Australian Women (Australian Health Ministers' Advisory Council Subcommittee on Women and Health, 1993, p. 8) stated health care systems may wish to address the seven identified priority health issues. Goal 1.2 was to improve the range of options for maternity services. Health care agencies were encouraged to increase the range of services to women through special programmes in public hospitals including midwifery services. Agencies were urged to plan and implement quality care that addressed the diverse and ever changing physical, emotional, social and cultural needs of all women.

One response to this challenge was the transition of some postpartum midwifery care from the hospital to the home (Williams & Cooper, 1993, p. 25). James et al. (1987) stated that early postpartum discharge, accompanied by care from domiciliary midwives, was considered a suitable option "to meet the public demand for domesticity in reproduction whilst preserving optimal safety at delivery" (p. 434).

In 1988, the same year that the publication Health Goals and Targets for Australian Women was released, the Medicare Incentive Package was introduced. The package was to provide more funding to State health departments for the establishment of schemes that would increase the efficiency of the public hospital system (Scott et al., 1993, p. 90). The schemes were to provide cost-effective, alternative forms of postacute hospital care. Early postnatal discharge was considered one such scheme. The cost effectiveness of early postnatal discharge in Australia has not been established but Scott et al. (1993, p. 90) stated returning home earlier than the traditional length of stay

improved the welfare of participants and had a value beyond the impact on expenditure.

The researcher's interest in the concept of early postnatal discharge was intensified by events that occurred in the Northern Tasmanian city in which she lived. Maternity services were to be transferred from a separate hospital building to a unit in the general hospital. Within this proposed change the maternity beds were to be reduced from 44 to 32. It was reported in the Tamar Times ("Officials under fire", 1994) after a public meeting held in May 1994 that "more than 200 angry health professionals, mothers and family members questioned the feasibility of the proposed transfer" with hospital and state administrators (p. 4). The reduction of bed numbers led to a discussion of early discharge of mothers and babies. Two questions were asked. Would women be forced to return home against their will, and would they give up breastfeeding because of lack of professional help? Those members of the community who were present at the meeting were assured that early discharge would be of the women's choosing and that women, who chose to return home early, would have access to the domiciliary midwifery service whereby midwives would provide help and support with all aspects of postnatal care. Women referred to the domiciliary midwifery service would be visited once or twice daily until the baby was 7 days old. The service could be extended beyond 7 days if the need arose.

The community's concerns about early postnatal discharge created the catalyst for this study. The impetus was heightened by the belief of McBride (1993, p. 322), Norr & Nacion, (1987, p. 140) and Rush & Valaitis (1992, p. 29) that major life events of women should be studied especially their perceptions of the experience of early postnatal discharge. The need for knowledge about how women experienced early postnatal discharge was not only a local concern but

the concern was well documented in the literature. This study sought to ask women who returned home early to describe their early postnatal discharge experiences. Early postnatal discharge, for the purpose of this study, was discharge on day three or earlier following a non-surgical delivery and day five or earlier after a caesarean section. This definition corresponded to that of the discharging hospital.

The Problem

The introduction of an early postnatal discharge programme was perceived by community members as limiting women's choices regarding their postnatal care and curtailing access to professional support during the early postnatal period. There is, therefore a need to investigate the experiences of women who participate in early postnatal discharge to provide the community with the appropriate information.

The Purpose

The purpose of the study was to encourage women to describe their experiences of early postnatal discharge when supported by a domiciliary midwife. On completion of the study the findings would address two issues. The first issue was identified within the literature. McBride (1993, p. 322), Norr & Nacion (1987, p. 140) and Rush & Valaitis (1992, p. 29) expressed a need for more research into the major life events of women especially their experiences of early postnatal discharge. The second issue was the concern of local community members, present at a public forum, about the welfare of women who would be discharged early from hospital postnatally.

Significance of the Study

The study had significance for women, community members and midwives. The women in the study were given an opportunity to speak and be heard. An attempt was made to validate their experiences and value their responses.

It is anticipated the information from the women will be reported back to the community members. The fears they expressed will be addressed from the viewpoints of the women who chose early discharge.

The study has the potential to fill a small gap in research literature. It can increase midwifery knowledge by highlighting the women's perspective of this alternative mode of care. Midwifery practice, within the local early discharge programme, could change in response to the findings described in this study. This notion is supported by Robinson & Thomson (1991) who stated that findings, from studies about women's views and experiences of maternity care, "identified...and indicated ways in which midwifery practice could more appropriately meet the needs of women" (p. 2). The women's experiences of early postnatal discharge could also have significance for midwifery education.

This study has been written for the women who consented to take part and interested community members as well as midwives. As some of the terminology may be unfamiliar to non-midwives, it has been defined in Appendix 1.

Summary

Chapter One introduced the notion of early discharge from hospital especially early postnatal discharge. The issues surrounding early discharge were

highlighted. A brief history of the transfer of maternity care from home to hospital, and women's participation in alternative modes of postnatal care was undertaken. The rationale for the study came from the literature, from the local community's concerns and the researcher's interest in community midwifery. The research method chosen was a descriptive study to obtain a detailed account of the characteristics of early discharge. Face-to-face, semi-structured interviews were conducted with 49 women who formed the study sample. Descriptive statistics were used to summarise the data. In addition, the women's own words were used to illustrate and enrich the statistical data. The significance of the study to women, midwives, the discharging hospital and the community was discussed.

The second chapter presents issues surrounding early postnatal discharge, that have been studied and documented in the literature by authors from Australia, Europe and North America. Relevant articles from the Australian popular press are also included.

In Chapter Three and Chapter Four the research methodology, data collection and data analysis will be discussed.

Chapter Five is a discussion of the findings of this study. The implications of these findings for midwifery practice, education and further research and strengths and weaknesses of the study are presented in Chapter Six.

Early Discharge in Context in the Literature and the Media

Research on women's attitudes to birth often also discusses them merely as patients whose lives have no context or meaning other than as patients...we learn little about them as women, their hopes and fears, their relationships and the values that are significant in their lives (Kitzinger, 1992, p. 64).

The literature and media reports, published at the time of the introduction of the early postnatal discharge programme, are reviewed in this chapter. Feminist authors offered explanations for the dearth of written works about women's experiences of childbirth. The lack of consistency about the definitions of early postnatal discharge and the lack of clarity about whether women received postnatal domiciliary care are identified in the literature and media releases. The importance of informed choice for postnatal women and the factors that influenced the choice of early discharge are discussed. Research studies that described the characteristics of women who returned home early are reviewed. The experiences of women, who returned home early, are demonstrated by presenting research findings that addressed women's confidence levels, the support they received from family and friends, the gains they hoped to achieve, their readiness to learn mothering skills, their perceptions of their own and their baby's health and their willingness to partake in an early postnatal discharge programme again.

The Silent Female Voice

Thomson (1990, p. 2) claimed that in the western world, in the twentieth century, medicine has mostly dictated the provision of maternity care. An

important factor in medical dominance over midwifery was the gender of the players (Willis, 1989, p. 92). The medical profession was, and still is, a predominantly male occupation. The consumers of maternity care are all women and the midwives, who care for them, are mostly female.

Feminist writers have analysed the gender issue from the viewpoints of woman the consumer and woman the midwife. Allen & Hall (1988, p. 28) criticised the narrow focus of medical model of care. Quality of life was not contemplated, only factors that could be understood through the scientific process were considered of concern. How women experienced the care they received was not considered to be important. Barclay (1986, p. 26) may have provided a reason for this attitude when she wrote of the knowledge base of medicine. It was the knowledge man gleaned from his own experiences and reflected his perspectives and his priorities. Kitzinger (1992) expanded on these notions when she wrote that to comprehend the behaviour of women and their carers at birth and postnatally, there must be an "understanding of the dissonance that exists between the woman's experience and the culture of the medical system that defines the meaning of childbirth" (p. 64). Men and women held differing views of childbirth and it was men within the medical profession who dictated the care.

The knowledge and practice of midwives became subordinate to medicine as it dominated maternity care (Willis, 1989, pp. 92-124). Within an environment of masculine power in the health care system Ashley (1980) wrote that "nurses negate the validity of their own experiences, thereby losing the power they might have by identifying with the needs and concerns of women" (p. 20). Midwives have not validated the experiences of the women for whom they cared.

The last two decades of the twentieth century have seen many changes away from the medicalisation of childbirth. Murphy-Lawless (1988) wrote that whilst the roles of male and female carers within maternity practice are still being defined "the problem of reconstructing and uncovering the silent female voice in childbirth remains" (p. 295). Midwives and childbearing women would appear to have been a silent majority. The study seeks in a small way to end that silence.

Definitions of Early Postnatal Discharge

The literature revealed a lack of clarity about the definition of early postnatal discharge. Two main issues were identified. One was the interpretation of the word 'early' and the second was whether women and their babies were supported by community midwives following discharge.

Scott et al. (1993, p. 90) wrote that the evaluation of early postnatal discharge was complex. The complexity began with the interpretation and definition of the word 'early'. Regan (1984, p. 32) described a programme in which women and babies could be discharged home as early as six hours postpartum. The programmes detailed by Avery, Fournier, Jones & Sipovic (1982, p. 233) and Williams & Cooper (1993, p. 26) identified the time limit of 24-hours or less. The institutions, where the studies of Cleland, Cameron, Kenny, King, Scott & Shiell (1992, p. 1), Evans (1991, p. 113), Jansson (1985, p. 547), Norr, Nacion & Abramson (1989, p. 134) and Rush & Valaitis (1992, p. 29) were conducted, had limits of 24 to 48 hours postpartum for discharge. The Canadian programme evaluated by Thurston & Dundas (1985, p. 385) used specifications of discharge from 48 to 60 hours whereas the broader limit of less than 72 hours was reported in the postnatal schemes studied by Campbell (1992, p. 132) and Kenny, King, Cameron & Shiell (1993, p. 147). To add to the confusion

Small, Lumley & Brown (1992, p. 171) spoke of early discharge occurring before the fifth postpartum day. The guidelines of the discharging hospital were used in this study: discharge on or before the third day postpartum following a normal delivery or a forceps delivery, and on or before the fifth day postpartum following a caesarean section was described as 'early'.

Research studies as well as media reports have not always stated clearly whether women return home earlier than the traditional length of stay in hospital with or without domiciliary visits from a midwife. Therefore, it is difficult to draw conclusions that may contribute to a meaningful comparison with other research findings. Lemmer (1987, p. 230) noted late in her article that none of the women, in her study of the outcomes of primiparae and their babies after early discharge, reported that home visits by midwives had taken place. Lukacs (1991, p. 35) reported that routine postnatal visits to women were not made unless requested. Where the presence of or lack of professional support is not clearly stated in media reports distorted messages are given to the public. A story by Davies (1994, pp. 1,4) in the popular press aimed to inform readers of the increase in problems for Victorian women and babies who were discharged from hospital in the early postnatal period. Only in the final paragraph did Davies (1994) state that if a baby who had to be readmitted to hospital because of high jaundice levels following early postnatal discharge "had been given some postnatal care in the community this would have been picked up sooner" (p. 1).

Early postnatal discharge supported by midwives has been demonstrated, in the literature, to be preferable to unsupported discharge. Norr & Nacion (1987, p. 139) stated that there was no demonstrable increase in maternal or neonatal morbidity in the North American early discharge programme reports they reviewed. All women in the programmes had domiciliary midwifery care. The

essence of their results is supported by Australian researchers, James et al. (1987, p. 438), who concluded that an early return home presented few problems for healthy mothers but could carry risk for the babies. They wrote that whilst the most common complication in neonates was jaundice the risks could practically be eliminated when domiciliary postnatal care by a midwife was given.

Messages from the Media

Whilst the Northern Tasmanian early discharge programme was introduced quietly in 1994 the local community was receiving information about maternity care in Victoria in press reports. Davies (1994, p. 4), in the Sunday Age, related that funding cuts to public hospitals through casemix, a shortage of hospital beds and a reduction in the numbers of employed midwives had resulted in reduced services to postnatal women and their babies. Davis (1994) related "many women ... felt pressured to leave hospital before they were ready, ... had problems breast feeding [and] ... had been told by hospital staff they had to go home because the hospital could not afford to keep them any longer" (p. 4). One woman stated that she felt guilty for having a baby and because she did not know how to breastfeed 'gave up' after she developed mastitis (Davis, 1994, p. 4). A study by the Maternal and Child Health Consumer Group demonstrated that breast feeding rates in Victoria were falling (Davies, 1994, p. 4).

Hincks (1994, p. 3) discussed points from the Sunday Age feature in the Examiner, a local Northern Tasmanian newspaper. She reported that the Tasmanian Health Minister had announced earlier that the present domiciliary midwifery service would be expanded to enable women who wished to return home early to do so. The Tamar Times ("Officials under fire", 1994, p. 4)

reported that the issues of breast feeding problems and choice of early discharge were raised at a local public forum, which was called to discuss the transfer of maternity services in the North of the state from their present location as a separate health agency to a specialist unit in a general hospital. The complexities surrounding early discharge had filtered down to the local community members resulting in anxieties about the welfare of women and babies who returned home early. The major concerns for community members at the local meeting were whether women would be allowed to make a choice about their time of discharge and whether there would be support for women with breastfeeding problems.

Informed Choice for Women Regarding Early Postnatal Discharge

Thomson (1990, p. 2) claimed that the autonomy of women was not valued within the medical model that dominated midwifery care for most of the twentieth century. However, during the last decade changes have occurred. In 1982 the British authors, Burnell, McCarthy, Chamberlain, Hawkins & Elbourne, stated that when a woman was over 18 years of age and both she and her baby were well the "patient's preferences should be given priority" and early discharge should be an option (p. 46). They believed that rigid selection criteria, defined by the discharging hospital to establish suitability for early discharge, were probably invalid. Their belief was supported by Australian researchers James et al. (1987, p. 438), who stated that a pre-discharge home assessment had little value except to establish a relationship with the family as women with the worst home conditions often insisted on going home early and had the greatest need for domiciliary care.

The National Health and Medical Research Council (NH&MRC) (1991), outlining the Principles of Operation for postnatal domiciliary care programmes

in Australia, wrote that participation in early discharge programmes must be voluntary and consent based upon full cognisance of all aspects of the scheme. In spite of the NH&MRC's recommendation for voluntary involvement the reality of encouraging choice may be different. Davies (1994) quoted a Victorian doctor who stated "the reality is that hospitals cannot afford to give women a choice if they want to be financially successful in the current climate" (p. 4). Community members at the local public forum questioned the state and hospital health personnel on their commitment to women's autonomy when there was a restrictive health budget.

Time to contemplate the appropriateness of early discharge was also considered an important issue. The Community Development Committee of Victoria (1995, p. 88) wrote that discharge planning that began in the antenatal period proved to be most successful as women were aware of the community services available to provide assistance postnatally. Small et al. (1992, p. 176) supported the notion that information about early discharge should be given during pregnancy because of their belief that women will not choose early discharge if they are not given time to think about this alternative mode of postpartum care. Prenatal discussions about early discharge and care of the newborn may increase women's confidence in their own abilities.

In the past opposition to childbearing women's autonomy came from women as well as hospital administrators and midwives. Burnell et al. (1982, p. 46) reported that administrators and midwives, in a North West London hospital, actively discouraged primiparae from going home early. Campbell (1992, p. 140) found that some childbearing women believed that early discharge should not be an option for first time mothers as they needed 24 hour care, parenting education and assistance with breast feeding. The debate about informed choice for women contemplating an early postnatal discharge remains open.

Choice is advocated for childbearing women but returning home early without domiciliary midwifery support is not recommended. Australian publications by Head (1987, p. ii), James et al. (1987, p. 438) and Postans (1993, p. 3) promoted early discharge when postnatal care was continued at home. Head (1987, p. ii), in her summary of literature on early postnatal discharge, wrote that if a woman returned home early without adequate support the burden of care was placed on her at a vulnerable time in her life. James et al. (1987) stated that unsupported discharge "achieves the worst of both worlds" (438). Parenting education and assistance with such problems as breastfeeding are not available to unsupported women. Postans' (1993, p. 3) study looked at the changing social support needs of young families. She advocated postpartum midwifery care because the traditional support from extended families had largely disappeared. The "Postnatal domiciliary care programs: Principles of Operation" by the NH&MRC (1991) stated "unsupported return to the home environment should be actively discouraged". An early return home for newly delivered women without visits from domiciliary midwives was not considered a viable option by the NH&MRC.

The literature suggested various social, emotional and attitudinal factors which influenced women to choose an early discharge. Norr & Nacion (1987, p. 137) believed that women who chose early discharge, had not only a favourable attitude towards the notion but also had social support to make the transition smooth, yet only Lemmer (1987, p. 234) cited social support as an important consideration by the women in her study.

Factors quoted by women in the studies of Burnell et al. (1982, p. 46), Campbell (1992, p. 141), Thurston & Dundas (1985, p. 387) and Waldenstrom (1989, p. 192) were a desire to return home to the family to promote family togetherness and involve partners and other children in the care of the newborn.

Three studies by Campbell (1992, p. 141), Lemmer (1987, p. 234) and Waldenstrom (1989, p. 192) showed that many women who were healthy, and had healthy babies, considered that their home environments were safer and better than the hospital environment. The relaxed home atmosphere and the comforts of the home were considered to be more congenial to rest, recuperation and learning (Burnell et al., 1982, p. 46, Campbell, 1992, p. 141 and Harrison, 1990, p. 39). Some women just disliked being in hospital (Small et al., 1992, p. 176, Thurston & Dundas, 1985, p. 387, and Waldenstrom, 1989, p. 192). Thus, emotional, social and physical factors were considerations for women when deciding whether to return home early postnatally or not.

Demographic Data

Two Australian studies, from research centres in New South Wales and Victoria, gave detailed demographic data of the participants in domiciliary, midwifery supported programmes (Kenny et al., 1992 and Small et al., 1992). Small et al. (1992, p. 172) stated that the characteristics of women, who returned early, were as follows: they were multiparous, less than 25 years of age, had no private health insurance, were cared for antenatally in a hospital antenatal clinic and had spontaneous vaginal deliveries. Kenny et al. (1992, pp. 11-13) found also that most of the women who returned home early were multiparous. The mean age was 27.9 years, only 28% of the women attended a private doctor and 44 % of women attended antenatal classes.

Returning Home Early - the Aftermath

Factors that relate to the phenomenon of early postnatal discharge, are discussed in the literature. Such topics included the confidence levels of the women, the amount of support they received from family, friends and

professionals, the reality of their expected gains following early postnatal discharge, support with mothering skills, perceptions of well-being of mother and baby and success of the chosen feeding method. The findings from relevant European, American and Australian studies are presented below.

Confidence Levels

Three Australian studies (Kenny et al., 1992, Scott et al., 1993, and Small et al., 1992) suggested that women, who returned home early, had high confidence levels. Scott et al. (1993, p. 84) stated that the women who selected early discharge demonstrated higher confidence in their ability to care for their newborns than women who had chosen to stay in hospital for the traditional time following the birth of their babies. Small et al. (1992, p. 173) found that multiparous women were more confident than primiparous in caring for their babies, but it was also established that a longer hospital stay did not enhance a woman's confidence. Further research was recommended to identify the reasons for this occurrence. High confidence levels were reflected in the women's stated perceptions of their ability to cope with the home, the family and the newborn in Kenny et al.'s (1992, p. 22) study. Only 16% of the women reported they found their new workload presented some difficulty.

Support from Family and Friends

Confidence levels may have been influenced by the amount of support the women knew they had on discharge. Traditionally guidance and support came from the females in the extended family but changes in social and financial factors mean these resources are possibly no longer available to the modern childbearing family (Evans, 1991, p.114, Laryea, 1989, p. 176 and Postans, 1993, p. 3). Evans (1991, p. 114) and Gruis (1977, p. 186) wrote that partners, while supporting the women, may have to deal with their own concerns surrounding the new babies. Professional help from the midwife, and the help

from the extended family and the partner were in accordance with Weiss' (1976, p. 226) belief. He found that during a period of transition such as childbirth a woman required three types of support; expert, veteran and fellow participant help. Rodd (1992, p. 24) suggested that women needed support for themselves as people before they could benefit from assistance with the parenting role. Kenny et al. (1992, p. 12) reported that whilst a high level of help was given to women who return home early more help was afforded to primiparous than to multiparous women.

Gains

Personal confidence and high levels of support may have helped women to define and achieve the gains they expected when returning home early. Literature reviewed described the gains that women achieved for themselves, their families and the babies. The home environment improved rest and recuperation (Kenny et al., 1992, p. 19 and Thomson, 1990, p. 1), emotional relaxation (Thomson, 1990, p. 1, Thurston & Dundas, 1985, p. 387 and Waldenstrom, 1989, p. 193) and sleep (Thomson, 1990, p. 1 and Waldenstrom, 1989, p. 193). Early integration of the newborn into the family increased bonding and allowed partners and siblings to care for and interact with the baby (Lukacs, 1991, p. 35, Thurston & Dundas, 1985, p. 387 and Waldenstrom, 1989, p. 193). Kenny et al. (1992, p. 19) found that many women in their study were able to achieve the goals of establishing routines, focusing more on the babies and gaining practical experience when they had sole care of their newborns at home. For some women in Waldenstrom's (1989, p.193) study, early discharge meant that they could get on with their lives following a normal life event.

Readiness to Learn

Readiness to learn mothering skills was reported to increase when women were emotionally relaxed at home and had sole responsibility for their new babies (Evans, 1991, p. 114, Harrison, 1990, p. 39 and Lukacs, 1991, p. 39). Evans (1991, p. 117) and Lukacs (1991, p. 39) found that hospital midwives prioritized teaching in postnatal teaching programmes to include maternal and neonatal aspects of care required in the immediate postnatal period. The domiciliary midwife provided continuity of care and education according to the woman's individual needs (Community Development Committee, 1995, p. 89, Evans, 1991, p. 48, Harrison, 1990, p. 39, Lemmer, 1987, p. 230, Martell, Imle, Horwitz & Wheeler, 1989, p. 323 and Regan, 1984, p. 35). To assist in the learning process women showed preferences for having information available in written form for later reference and for telephone hotlines to maternity hospital wards so that they had 24-hour access to advice, if required (Avery et al., 1982, p. 235, Bull & Lawrence, 1985, p. 315 and Lemmer, 1987, p. 230).

Infant Feeding

Infant feeding is a topic about which women often seek information and advice as problems can occur especially with breastfeeding, particularly in the early postnatal period. The literature, which reported the breastfeeding patterns of women following early discharge, was contradictory. Kenny et al. (1992, pp. 12-18) and Burnell et al. (1982, p. 45) reported that equal numbers of women from the short and long hospital stay samples were still breastfeeding at the time of the studies, approximately 7 days after delivery, whilst Small et al. (1992, p. 175) found that women, who chose early discharge, were more likely to breastfeed but Waldenstrom (1989, p. 193) reported more women (who were discharged against their desire) were still breastfeeding at two weeks than those who chose early discharge. Kenny et al. (1992, pp. 12-18) found that 77% of the women, who were discharged early, were still breastfeeding at the time of

the study, approximately 6 days after delivery. Eighty-two per cent were primiparous women whilst 72% were multiparous. Waldenstrom (1989, p. 193) suggested that the continuation of breastfeeding was not related to the time of discharge but to the characteristics of the women. Research findings about the relationship of early discharge and breastfeeding are therefore inconclusive.

Perceptions of Well-being

Personal confidence, support and success with infant care and feeding could influence the women's perceptions of their physical and emotional health. In Kenny et al.'s (1992, pp. 17-19) Australian study women who chose an early discharge stated they felt both physically and emotionally well. Over 90% said they felt better than expected. Two studies, Burnell et al. (1982, p. 45) and Small et al. (1992, p. 175), reported that women who chose a voluntary discharge demonstrated high confidence levels. Early discharge participants also considered their babies to be healthy (Burnell et al., 1982, p. 45 and Kenny et al., 1992, p. 27).

Subsequent Pregnancies - Repeating the Experience

Although the timing of early postnatal discharge and whether its nature is voluntary or involuntary differs from research study to research study, in the majority of studies the experiences were viewed favourably by women. Three of the studies reviewed found that an overwhelming majority of the women would again choose early postnatal discharge following a subsequent pregnancy (Regan, 1984, p. 34, Thurston & Dundas, 1985, p. 387 and Waldenstrom, 1989, p. 195).

Conclusion

Literature reviewed on early postnatal discharge focussed principally on the medical aspects of care and there was little evidence of the re-emerging role of the domiciliary midwife and her renewed relationship with the family. The disharmony between medicine's and women's meanings of childbirth was addressed largely in the feminist literature. Thoughts, opinions and practices are shaped by historical events. Changes emerge but vestiges of old thoughts and opinions remain and continue to influence the acceptance and method of new modes of maternity care.

Scott et al. (1993) wrote that early discharge schemes were complex to evaluate. It is understandable that community members at the public forum had concerns about the recently introduced early postnatal discharge programme when most of the information came from the media. Their concerns were that women would have the choice of early discharge and that the women who chose early postnatal discharge would be given assistance with breastfeeding problems. Literature and media reports demonstrated a lack of clarity in these areas. Reports did not always state whether early discharge was followed by domiciliary midwifery care. Voluntary participation in early discharge programmes was recommended but then challenged by rigid discharge selection criteria the women must meet and media reports that choice was not an option if hospitals were to remain financially viable. Media reports and research findings about breast feeding patterns following early postnatal discharge were inconclusive.

Asking women to discuss their experiences of early postnatal discharge was an acknowledgement of the concerns of the community members present at the public forum. The responses of the women in the study would give feedback about those concerns.

Summary

Midwifery literature and local media reports were reviewed for this study. Rationales were identified for the lack of knowledge about the experiences of childbearing women. The complex issues surrounding early postnatal discharge were discussed. Characteristics of Australian women who had returned home early were traced in the findings of research studies. Recent midwifery publications discussed variables that demonstrated experiences of women who had returned home early with their newborn babies. The results of the variables were collated.

Research Design and Data Collection

Introduction

In this chapter the use of the descriptive research method that guides the data collection and the development of the data collection tool is discussed. Ethical considerations, including informed consent, are detailed. The selection of participants, details of the discharging hospital and descriptions of the processes of data collection and data analysis are also included.

Research Design

Justification of Research Method

The literature review carried out at the time of the research proposal demonstrated that early discharge from hospital following childbirth was a complex phenomenon, influenced by many variables. The definitions of early postnatal discharge differed from study to study and in some instances the reports did not indicate whether the women were able to choose the option of early discharge or stay in hospital for a longer time or whether the women were visited following discharge by a domiciliary midwife. The contradictory findings of the studies and the local community's concern about the impending loss of maternity beds, which was thought would result in early postnatal discharge for most women, indicated that a descriptive study of the women's experiences of early postnatal discharge was timely and appropriate.

Descriptive research is a non-experimental research method, which is used when the researcher wishes to describe a phenomenon or event as it occurs naturally, without manipulation of the variables. The variables may be facts, opinions or attitudes and the detailed information obtained describes the current scene (Lo Biondo-Wood & Haber 1994, p. 233). Waltz & Bausell (cited in Burns &

Grove, 1987, p. 243) noted that a descriptive research study may be carried out to justify as well as identify problems with current practice. The proposed study sought to determine the experiences of women who chose an early postnatal discharge and who were supported at home by a midwife in the early postnatal period. The findings would provide feedback from the women in the study to the community members of the public forum about their concerns and would inform midwives and midwifery practice how one early postnatal discharge programme was experienced by the women involved.

The design of a descriptive research study varies according to its level of complexity but the most commonly used design is that which examines the characteristics of variables of a single sample. The variables are identified and described and these descriptions provide knowledge that can be used as a base to further research in the area (Burns & Grove, 1987, p. 243). In this study the variables of early postnatal discharge, e.g. choice, factors that influenced returning home early, confidence levels, support from family and friends, expected and actual gains, infant feeding, perceptions of maternal physical and emotional health and baby's well-being, sources of other professional help since returning home will be described in detail. Descriptive studies generally utilise a questionnaire or an interview as the method of data collection. Semi-structured interviews were used to collect the data in this study.

Data Collection

An interview is a process of verbal communication between the researcher and the participant whereby the participant gives information in response to the researcher's questions. Interviews can range from being totally unstructured to highly structured (Burns & Grove, 1987, p. 306).

Burns & Grove (1987, p. 306) wrote that structured interviews are controlled by the researcher and questions must be asked in a particular order and only posed in the way designed. A semi-structured interview is more flexible, more like an informal chat, thus allowing the participant more ownership within the process. The interviewer follows a topic guide to ensure that all questions are asked (Polit & Hungler, 1993, p. 201) but does not ask questions in a precise format (Oyster, Hanten & Llorens, 1987, p. 91). The interviewer becomes conversant with the material to be collected and then is permitted to decide the order and wording of the questions. Face-to-face interviews, rather than questionnaires, are more likely to encourage dialogue between the researcher and participant (Polit & Hungler, 1993, p. 201).

Oyster et al. (1987, p. 91) stated that an interview allowed the researcher to directly interact with the participant and develop a rapport. Burns & Grove (1987, p. 309) wrote of two advantages of an interview over a questionnaire; the more intimate nature of the interview leads to a higher response rate thus ensuring a more representative sample and a skilled, face-to-face interviewer can elicit more information from the participant.

A disadvantage of interviews is that they are more time-consuming than questionnaires. Time is spent contacting participants, arranging appointments and travelling to appointments (Oyster, et al., 1987, p.91). Once the interviews are complete there are demands on the researcher's time when organising, analysing and interpreting information (Polit & Hungler, 1993, p. 201). The time factor could lead to limited sampling (Burns & Grove, 1987, p. 309). The meeting of researcher and participants may lead to subject bias (Burns & Grove, 1987, p. 309).

The data collection process was governed by a personal conviction to work *with* women and an ethical obligation to maintain each woman's integrity. A face-to-face interview format was chosen for several reasons. From a personal point of view the researcher was able to build some rapport with each participant. An interview was recognised as a method of gaining more in-depth information. The possibility of misunderstanding the questions was minimised as participants had an opportunity to ask for rephrasing. All the interviews were audio-taped so that at the time of the interview the researcher gave the participant women her full attention.

Development of the Interview Schedule

The types and format of questions were informed by the literature on early postnatal discharge, the objectives of the domiciliary midwifery service of the participating hospital and the issues identified at the public forum. One Australian publication by Kenny et al. (1992) was particularly influential. The authors' permission was granted to use questions from their questionnaire (Appendix 2). The publication described part of a large research project, which evaluated obstetric early discharge programmes in three Sydney hospitals. The whole study examined the early discharge programmes from the aspects of participant client satisfaction, reasons for non-participation and economic value. Other questions were developed using specific objectives of the Domiciliary Midwifery Service of the hospital in which the research was carried out (see Appendix 3)

The issues identified from the public forum were that women would be forced to return home early and that support would not be available to breastfeeding women who faced problems with their chosen method of infant feeding. This resulted in the inclusion of questions relating to notions of informed choice and preferred method of infant feeding.

The researcher concluded that the variables, associated with early discharge, would assist women to describe their experiences. Other variables were adapted from the study by Kenny et al. (1992) and are marked with asterisks in the interview schedule (Appendix 4). These included some demographic data, factors which influenced participation in such a programme, satisfaction with the length of hospital stay, confidence levels when caring for the newborn, support in the home, expectations and gains of returning home early, infant feeding, health status and perceived ability to cope once home. Further variables such as professional support through education, knowledge and utilisation of other supporting agencies and recommendation of early discharge as an alternative mode of postnatal care were identified from the works of the Community Development Committee (1995), Evans (1991), Harrison (1990), Lemmer (1987), Lukacs (1991), Martell et al. (1989), Regan (1984), Small et al. (1992), Thurston & Dundas (1985) and Waldenstrom (1989). During the development of the questions the researcher consulted with academic colleagues with research skills and midwifery colleagues with practical experience of early postnatal discharge programmes. Their opinions were sought about the suitability of the questions to assist the participants to describe the experiences, the appropriateness of the questions and the need for other questions. Some modifications were made as a result of the feedback.

During the interview a variety of both quantitative and qualitative data were sought requiring the use of both open and closed-ended questions. Closed-ended questions offer participants "a set of mutually exclusive and jointly exhaustive replies" (Polit & Hungler, 1993, p. 432). "Was early discharge your choice?", "Was your hospital stay just right, too long or too short?" were examples of closed-ended questions that were used during the interview. Open-ended questions do "not restrict the respondents' answers to pre-established alternatives" (Polit & Hungler, 1993, p. 442), e.g. "What factors influenced you

to take an early discharge?", "What did you expect to gain by returning home early?" Qualitative data were obtained to strengthen, illustrate and complement the quantitative data by allowing women to describe their experiences in their own words. Questions ensured that all women were given the same opportunity to respond to the same issues surrounding early discharge experiences. The interview schedule is presented as Appendix 4.

The validity and reliability of any research instrument should be assessed in order to ensure that the instrument accurately measures the concepts under test. The validity of an instrument refers to whether the instrument accurately reflects the concepts of the research study rather than related concepts. There are three major types of validity. These are content validity, criterion related validity and construct validity.

Content validity related to "whether the measurement tool and the items it contains are representative of the content domain the researcher intends to measure" (Lo Biondo-Wood & Haber, 1994, p. 250). A subtype of content validity is known as face validity. This is a rudimentary method of ascertaining that the instrument appears to measure the concepts. Colleagues and/or participants in the study are asked to peruse the instrument and assess whether it measures the concepts it is supposed to measure. This process also helps to determine readability and content clarity. In this research study face validity was ascertained by asking midwives and participants to comment on the research schedule (Lo Biondo-Wood & Haber, 1994, p. 251). The suggested changes were made.

Criterion related validity is the relationship between the participant's performance during measurement and her actual behaviour. Construct validity considers the extent to which the instrument measures a theoretical construct

and trait (Lo Biondo-Wood & Haber, 1994, p. 252) Criterion related validity and the construct validity of the interview schedule used in this study were not estimated.

The reliability of an instrument is "the extent to which the instrument yields the same test results on repeated measures' (Lo Biondo-Wood & Haber, 1994, p. 253). Reliability is thus concerned with the instruments ability to produce the same results when it is used again on the same individual ie its accuracy/inaccuracy. In this study the reliability of the research schedule was not estimated.

Development of Data Analysis Sheet

An instrument for recording responses was devised (Burns & Grove, 1987, p. 422). Each woman's responses were noted on a separate response sheet (Appendix 5). The mutually exclusive descriptors of the variables for the demographic data were predetermined. Each descriptor was given a number to enable the data to be transferred from the coding sheet to a computerised spreadsheet.

The women were asked to describe their early discharge experiences using their own words. Their responses to questions became the descriptors of the variables allowing the qualitative data to be quantified and displayed in tables. For example, the responses to the question, "What factors influenced you to return home early?" became the descriptors. This information was later transferred to the computerised spreadsheet. Additional comments that illustrated the quantitative data were also recorded on the response sheets so that they could be woven into the analysis to assist clarification of the concept of early postnatal discharge.

The coded data were analysed and displayed using descriptive statistics with some variables qualified by verbatim excerpts from the women's accounts. The qualifying data that best illustrated the variables were chosen for inclusion. In response to the question, "How did you first learn about the early postnatal discharge scheme?" one woman, who had asked a midwife prenatally if an early discharge scheme was available as she had participated in such a programme interstate, added the qualifying response, "There is a need to advertise the service, then women can plan their own discharge rather than they tell you that you can go home".

Participants

The participants of this study were women, 17 years and over, who were healthy and had delivered healthy babies at the designated hospital during the months of October and November 1994 and who were referred to the early postnatal discharge programme. The minimum age of 17 years was chosen for this study as it is the age of consent in Tasmania (Criminal Code Act 1924, 1980, section 124). The characteristics of the participant women were those stipulated by the discharging hospital for referral to the early postnatal discharge programme (Appendix 6) and those stipulated by the researcher regarding the time of discharge (Appendix 1). All but two of the women were visited initially in hospital. These two women chose early discharge after the researcher's daily visit to the hospital. The domiciliary midwife mentioned the study to these women and they were agreeable for their telephone numbers to be given to the researcher.

At the initial visit the researcher introduced herself, the proposed study and its purpose. The women were invited to participate and letters of approval from the ethics committee of the hospital (Appendix 7) and the Director of Obstetrics and Paediatrics (Appendix 8) were shown to them. The women, who agreed to

participate, were given an information sheet each (Appendix 9). The information was explained to them and time was allowed for any questions to be asked. All participating women were asked to sign consent forms (Appendix 10) at this time. Participants were informed that if they wished to see a completed copy of the study one would be made available to them. Three women stated an interest in viewing the final report and the researcher kept a note of their requests.

Three hundred and thirteen women delivered babies in the months of October and November 1994 (A. Lubke, personal communication, January 29, 1997). Sixty-three (20%) women, who elected to take an early discharge during these months, were the potential sample for the study. Eight women declined to participate in the study when first approached by the researcher. It was agreed between hospital staff and researcher that one other woman, who had little command of the English language, would not be able to give informed consent and therefore was not asked to participate. Fifty-four women gave consent to be interviewed but five withdrew. No reason was sought for non-participation; the refusal was accepted. The 49 (16% of total births and 78% of early discharges) women participants were a convenience sample in relation to the two months chosen for the data collection. Time restraints were such that two months were made available for data collection. The researcher had ascertained that 53 (16%) of the averaged 294 delivered women had chosen early discharge, within the definition of this study, in August and September (S. Morris, personal communication, October 1, 1994). A similar figure over the next two months would provide an adequate sample. Permission to conduct the research was granted by the authorities in September 1994, therefore the following two months were chosen as the data collection period.

The Discharging Hospital

The women, who participated in this study, all gave birth to their babies in a northern Tasmanian maternity hospital. The hospital had 44 beds and registered 1810 deliveries in 1994 (A. Lubke, personal communication, January 29, 1997) with an average length of stay of 3.7 days (Department of Community Health Services, Tasmania, 1994, p. 395). The hospital is one of the maternity sections of a university medical school and caters for both private and public clients. It offers a comprehensive range of maternity services. Antepartum care is available in both doctor and midwife conducted clinics. Intrapartum and postpartum care are afforded to in-patients. Other services include antenatal classes, an extended, domiciliary midwifery scheme, postnatal clinic, postnatal physiotherapy classes, a fertility clinic and a menopause clinic. An independent birthing centre is situated within the same building. There is a close liaison between the hospital and Family and Child Health Services.

The mission statement of the hospital states its endeavour to provide an efficient and effective service for the women of the region. The Obstetric and Paediatric Services Philosophy (1994) included the statement that, "Women and their families have the fundamental rights: to be treated with respect, to be accorded privacy, to retain their individuality [and] to participate in an informed manner in decisions about their health and that of their families."

Ethical Considerations

Before commencement of the research a research proposal was submitted to the university's ethics committee. This was redirected to the ethics committee of the discharging hospital. Approval for the study was granted (see Appendix 7). Permission was then sought and approved by the Director of Obstetrics and Paediatrics at the hospital (Appendix 8). Verbal approval was obtained from the Director of Nursing and the domiciliary midwives.

In seeking consent from the participants ethical considerations were outlined both verbally and in written form on an information sheet (Appendix 9). The information sheet gave data about the researcher, the purpose and details of the study and why each woman was considered as a potential participant. Confidentiality and anonymity were assured. Raw data would be seen only by the researcher. Audio tapes and response sheets would be identified by a code number only. The master sheet linking names and code numbers would be kept separately and available only to the researcher. The sheet would be destroyed on completion of the study. The women approached were given an opportunity to ask questions before signing a consent form (Appendix 10). There was perceived to be no potential harm or risks to women who chose to participate.

Consent was obtained from participants, who were aware that they may withdraw at any time. An assurance was given that all data would be kept in a locked filing cabinet at the researcher's home and all identifiable data would be destroyed once the research process was complete. The participants also gave consent for the interview to be audio taped.

Trial of Interview Schedule

A trial of the interview schedule was implemented by interviewing three women who were not part of the study sample but who elected to take early postnatal discharge. The findings of the three interviews were not included in the final study. The trial was to test the comprehensibility of the questions and their ability to elicit answers on the stated topics. It allowed the researcher to gain experience in interviewing participants in a collaborative manner and with using a tape recorder unobtrusively. An average time for interviews was estimated at 30 minutes to 1 hour following the trial.

Following the interviews minor word changes were made to questions for ease of clarity. The three women were asked if the questions assisted them to describe their experience and if other questions should be included. The questions were thought to assist and no additional questions were suggested.

The Interview

All the data for this study were collected by the researcher. One data collector ensured that the study tool was used in a similar manner at each interview. The women were interviewed once in their own home except one woman who chose to be interviewed at her mother's home. All the interviews took place 10-14 days after the birth of the baby. The women chose the day for the interview and the time of day it would take place. Each interview lasted approximately 30 minutes to 1 hour depending on the amount of information the women wished to give.

At the beginning of the interview the researcher restated the details of, and reasons for, the study. Informal talk was engaged during the preparatory stage of the interview before the questions from the interview schedule were asked. All questions were memorised by the researcher but the order of the questions was not necessarily as presented in Appendix 5. Burns & Grove (1987) believed that "the interviewer is free to employ expertise in determining the order and the wording of questions to enhance the respondent's co-operation and comprehension" (p. 360). The women were asked initially to describe their early postnatal discharge experiences then more specific questions followed to elicit detail. At the end of the interview the women were asked if there were further issues they wished to disclose about their experiences before they were thanked for their time.

The interviews went smoothly and the tape recorder seemed to be forgotten after a short time as the information flowed easily. Two women showed particular interest in the study and stated they were happy to have been given an opportunity to talk about their experiences. The encounters with all the women were personally satisfying for the researcher as the women allowed her to share some of their recent childbirth experiences. The interviews demonstrated the diversity of the women as well as their similarities but most of all they illustrated that if one is prepared to listen the sharing of experiences can be enlightening.

Summary

This chapter described the research design and method of data collection. Reasons for the choice of methodology and a semi-structured interview as the mode of data collection were explained. The mode of participant selection was identified and a brief description of the discharging hospital was provided. The issues of obtaining permission for the study, participant consent, confidentiality, anonymity and storage of data were explained. Details of the interview schedules and response sheets for the coding of data were outlined. The interview process was also described.

Results

In this chapter the data collected during the interviews with the participant women (n = 49) are presented. The data were responses to questions that were devised to assist women describe their experiences of early postnatal discharge. Following their discharge from hospital, all the women in the study were supported by daily visits from a domiciliary midwife until the baby was 7 days old. Demographic data and the women's experiences have been documented using descriptive statistics and selected comments made by the women.

Demographic Data

Demographic data was collected to give background information on the participant women. The information included maternal age at discharge, other children in the family, major prenatal care giver, attendance at antenatal classes, type of delivery and age, in days, of baby at discharge.

Table 1 Maternal age (n = 49)

<i>Maternal age in years</i>	<i>No. of Women</i>	<i>%</i>
17 - 20	3	6
21 - 25	13	27
26 - 30	26	53
31 - 35	7	14
Total	49	100

The ages of the participating women varied between 17 and 35 years. Sixteen (32.5%) were 25 years or less. Approximately two thirds (67.5%) of the women were 26 to 35 years old.

Table 2 Other children in the family (n = 49)

<i>Other children in family</i>	<i>No. of women</i>	<i>%</i>
0	8	16
1	27	55
2	13	27
3	1	2
Total	49	100

Forty-one (84%) of the women interviewed had delivered a baby before. Twenty-seven (55%) had one child and 13 (27%) had two children. Only 8 women (16%) were first time mothers.

Table 3 Major professional prenatal care giver (n = 49)

<i>Major prenatal care giver</i>	<i>No. of women</i>	<i>%</i>
Clinic doctor	20	41
Obstetrician	15	31
Shared GP/Clinic Doctor	8	16
Shared Ob/GP	3	6
GP	3	6
Total	49	100

Twenty (41%) of the women received prenatal care at the hospital antenatal clinic. The second largest group of women, 15 (31%), consulted a private obstetrician throughout their pregnancies. Of the remaining 14 (28%), 11 (22%) chose shared care, either obstetrician and general practitioner or general practitioner and hospital doctor. Three (6%) visited their general practitioner only.

Table 4 Attendance at antenatal classes (AN classes) (n = 49)

<i>Attended AN classes</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Hospital this pregnancy	6	2	8	16
Did not attend any pregnancy	2	13	15	31
Attended previous pregnancy	0	26	26	53
Total	8	41	49	100

Attendance at antenatal classes was a hospital criterion for admission to the early discharge programme yet approximately one third (31%) of the women had not attended in any pregnancy. Six of the 8 (16%) women, who did attend, were experiencing their first pregnancy. Four of the attending women did not complete the course. One went to only three classes because of the distance she and her partner had to travel and another "dropped out because they were a bit condescending." One participant found that the classes did not satisfy her needs. She believed that women should go into labour not knowing what is going to happen as the "midwives talk you through it." Another woman and her partner did not agree with much that was said about the use of pain relief in labour. Only one woman said that the early postnatal scheme had been mentioned in the classes.

The following three statements from the audio-tapes were from women who had chosen not to attend prenatal classes in any pregnancy.

"All births are different. You would have expectations and possibly be disappointed."

"I saw videos and did lots of reading. I educated myself being older."

"I'd rather not know what is going to happen. You hear such horror stories."

Table 5 Type of delivery (n = 49)

<i>Type of delivery</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Normal	5	34	39	80
Forceps	1	2	3	6
Caesarean section	2	5	7	14
Total	8	41	49	100

All the participating women had experienced one of three types of delivery; normal, forceps or caesarean section. The majority, 39 (79.5), of the women delivered their babies normally without intervention. Three (6%), who

experienced a forceps delivery, and 7 (14.3%), who delivered by caesarean section, also chose early postnatal discharge.

Table 6 Age of baby at discharge (n = 49)

<i>Age, in days, of baby at discharge</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
0.16	0	1	1	2
1	0	6	6	12
2	1	13	14	29
3	5	16	21	43
4	1	2	3	6
5	1	3	4	8
Total	8	41	49	100

Mean = 2.63 days SD = 1.09

Twenty-one (43%) of the mother/baby dyads returned home from the hospital when the baby was 3 days old. One discharge was from the delivery suite 4 hours after birth. Seven (14%) women and their babies were discharged on the 4th and 5th day after delivery following caesarean sections.

The women had lived at their place of residence for varying numbers of years. The shortest time was 2 months and the longest 25 years. The average time of residency was 4 years. Fifty per cent of the women had lived in the area for less than 2 years.

The women lived in suburbs within a 25 km radius of the centre of a Northern Tasmanian city. The suburbs represented a cross section of the socio-economic areas of the region.

Women's Experience of Early Postnatal Discharge

All the women were asked the same questions but they were not discouraged from adding further comments. Some of the comments follow the descriptive data further illustrating the women's experiences of early postnatal discharge.

Women's Informants of the Early Discharge Scheme

Question - How did you first learn about the early discharge scheme?

The sources, both prenatally and postnatally, of the women's knowledge about the early discharge scheme are presented in Table 7.

Table 7 Women's informants of the early discharge scheme

<i>Source</i>	<i>Prenatally</i>	<i>Postnatally</i>	<i>Total</i>	<i>%</i>
Midwife	3	27	30	61.2
Friend/Family	6	0	6	12.2
Poster	5	0	5	10.2
Doctor	4	0	4	8.1
Researcher	0	2	2	4.1
Other mother	0	1	1	2.1
AN educator	1	0	1	2.1
Total	19	30	49	100

Thirty (61.2%) of the women said they were unaware of the early postnatal discharge scheme before the delivery of their babies. One woman had taken a supported early discharge from an interstate hospital following a previous delivery. She had enquired antenatally from a midwife if a programme was available at the participating hospital.

Twenty-seven (54%) of the women who learned of the scheme postnatally did so from a midwife. The service was explained to them either when they asked

"When can I go home?" or after the doctor had told them they could go home. One participant said she first heard that she could be supported by a midwife at home from another new mother. Two were unaware that they were to receive care from a domiciliary midwife until approached by the researcher for their consent to participate in the study.

Eight (16%) of the women found out about the scheme from hospital midwives or posters in the antenatal clinic. Four (8%) women were informed by their doctors and one (2%) woman was informed by the antenatal educator. The following are statements from the audio-tapes on the information given by friends:

"A girl friend vaguely mentioned it."

"A friend mentioned it but I didn't really take it in."

"By word of mouth in the clinic."

The following comments were made in response to the stated question.

"I'd been told they didn't keep you long in hospital."

"My mother-in-law said they kick you out early."

"My sister had a Birth Centre birth and went home early. I thought she was nuts."

"A friend had gone home early but I didn't realise it was structured."

"The doctor didn't seem interested in me, just asked when I would like to go home. I may have seen the statement differently if I had known about the scheme."

"On the first day I was asked twice by sisters 'When do you want to go home?'. The next day the doctor asked the same question. I felt that they wanted to get rid of me, that they may want the bed. If I had known about the scheme it would have been different."

Five (10%) of the women volunteered the information that they would have returned home early even if the extended midwifery service had not been

available. The response from one woman, who knew about the scheme, was simply, "It was what I planned to do."

Retrospective Opinions of Length of Stay in Hospital

Question - Was your hospital stay just right, too long or too short?

Table 8 Opinion of length of hospital stay (n = 49)

<i>Type</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Just right	8	36	44	90
Too short	0	4	4	8
Too long	0	1	1	2
Total	8	41	49	100

Forty-four (90%) of the women believed that their length of hospital stay was 'just right'. All the primiparous women were included in this group. Three (6%) women were happy with their length of stay but under different circumstances would have returned home earlier. The following comments were made by the three women:

"It was OK. I had a manual removal (of placenta) and a blood transfusion."

"It was too long really but it was in my best interests to stay until the fifth day."

"I would have come home on the second day if an episiotomy hadn't been done. I stayed in for nursing care."

The 4 (8%) women who wished they had remained in hospital longer made the following comments.

"I would have liked an extra day then my milk would have come in."

"When I got home I wouldn't have minded an extra day but I was pretty right. She [baby] started bleeding from the vagina. I had not had a girl before. If I'd have stayed an extra day we would have been in hospital when it happened."

"I should have stayed in a couple of days but I had to cut the grass, cook and clean."

"Looking back I would have stayed in longer, it put too much on my husband. I felt guilty and I'm not as well as I could be."

Choice About Discharge

Question - Was early discharge your choice?

All women responded that their early discharge was by choice. Even though one criterion of the discharging hospital was that the early discharge should be the choice of the woman and her family, it was considered necessary to hear the response from the woman herself. One woman did feel pressured to go home but she had no prior knowledge of the domiciliary midwifery service. A woman, who had taken an early discharge before from an interstate hospital, suggested, "There is a need to advertise the service, then women can plan their own discharge rather than they tell you that you can go home."

Influencing Factors

Question - What factors influenced you to take an early discharge?

Participants were asked to specify all reasons, therefore multiple answers were obtained.

Table 9 Factors that influenced the choice of early discharge

<i>Factor</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>
Mother and baby were well	4	24	28
Has other children at home	0	16	16
Able to relax/sleep better at home	4	11	15
Dislikes hospitals	2	9	11
Easier to establish a routine at home	2	6	8
Has help at home	1	6	7
Negative aspects of hospital environment	2	4	6
Partner/children to know baby	1	4	5
Difficult for family/friends to visit	1	3	4
Family's needs	0	3	3
More confident at home	0	2	2
Life progressing normally	0	2	2

The influencing factor stated by 28 of the participants was that both they and their babies were well. Two other reasons ranked highly. Sixteen of the women said they had other children and wished to be home with them. Fifteen felt that they could relax at home and be comfortable sitting in their own chairs and sleeping in their own beds.

Three women felt the needs of the family took precedence over their own. The partner and elder daughter of one woman were ill and she felt obliged to go home and care for them. Important family celebrations were an incentive to return home for another. "It was my daughter's birthday and our own wedding anniversary." The husband of another woman had work commitments he had to honour but she also stated, "I feel in control at home."

Two women stated their confidence levels were higher in their own homes than in hospital. One stated, "I feel more comfortable and confident at home, I feel as though I'm doing everything right." For two women being home brought a normality to life. This notion was highlighted by the comment, "I wanted to

come home. There is only so much one can relearn and I just wanted to get on with it."

Six responses told of negative aspects of the hospital environment. Three felt that their personal needs were not satisfied and three had complaints about the ward environment. Comments, from the 3 women whose needs were not met, have been cited below.

"I don't like to have to conform. I'm not used to air conditioning and I felt hot all the time. My back hurt, probably because of the hospital bed. I didn't get the attention that the caesarean section women were getting. My needs were not met."

One woman, who had had a caesarean section, made the following comment:

"No one said the baby could be taken away at night. I was not comfortable. I was confused by the different advice and not getting any rest with the flashlight in your (sic) face. I was not getting the support I needed."

A third found that maternity care had changed so much since she had her first child twelve years ago. Mothers, now, are encouraged to room-in with their babies and perform as much infant care as possible. She stated, "I had to do everything for myself in hospital, I thought I may as well go home."

Three women found two aspects of the ward environment presented problems for them. Noise was an issue for 2 women, the number of visitors was an issue for another. One felt the ward was "Too noisy, it wakes up the baby." Another said, "You have your own noises at home, in hospital there are snoring mothers and crying babies." The third, who shared a room with three others, was overwhelmed by the many visitors, "People felt obliged to visit, there were people there all the time."

Confidence Levels

- Questions**
- *How confident did you feel about caring for your baby when you first came home?*
 - *How confident do you feel now?*

Table 10 **Confidence levels** (n = 49)

When first arrived home - numbers not in parentheses

At interview - numbers in parentheses

<i>Level</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Very confident	1 (3)	16 (37)	17 (40)	35 (82)
Quite confident	4 (5)	21 (4)	25 (9)	51 (18)
Occ. apprehensive	3 (0)	2 (0)	5 (0)	10 (0)
Very apprehensive	0 (0)	2 (0)	2 (0)	4 (0)
Total	8 (8)	41 (41)	49 (49)	100 (100)

The participating women were asked twice to relate how confident they felt about caring for their babies. The first occasion was when they arrived home and had total responsibility for their babies and the second at the time of the visit by the researcher, 10 - 14 days after delivery. Initially all but 7 (14.3%) of the women said that they felt very confident or quite confident when they first returned home with their babies. Of the 7 women, 3 primiparae and 2 multiparae felt sometimes apprehensive, and 2 multiparae said they were very apprehensive.

At the time of interview all but 9 (18.4%) women said they felt very confident about their ability to care for their babies. Five of the 9 women, who felt quite confident, were primiparae.

The following comments were made in response to the question regarding the women's confidence levels when they arrived home.

"I did as the staff suggested but when they left the room I did what I wanted."

"I was quite anxious in hospital. Some comments made by the nurses made me on edge. I was less anxious after half an hour at home."

"Once I left hospital I thought she is all mine and I felt confident from the ground floor to the top of the elevator."

"I had a few doubts because it's all new again but it soon comes back."

"I come from a large extended family where there have always been babies."

Three women, who each had one other child, volunteered the following comments.

"How will I cope with two? Will the other child be jealous?"

"Very apprehensive. I didn't know what the new baby would be like and how my ten and a half month old would be with the baby. They would be eating and sleeping at different times."

"I knew mum was here. I was relaxed. I tensed up on Saturday when I was here on my own. I got there."

Two women, who felt some initial apprehension, stated they had problems that undermined their confidence.

*"I had after birth pains that made it more difficult to breast feed."

*"I cried because I had to do everything. My partner and other child were ill."

Help in the Home

Questions - Who usually helps you with housework, cooking, child care?
- Who has helped you since you returned home from hospital?

Multiple answers were given by the women.

Table 11 Help in the home

Usual help - no parentheses.

Help since returning home - in parentheses.

<i>Source of help</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>
Husband/partner	7 (7)	39 (40)	46 (47)
Mother/mother-in-law	1 (7)	2 (30)	3 (37)
Friend	1 (3)	0 (15)	1 (18)
Other family member	0 (2)	0 (15)	0 (17)
Children	0 (0)	7 (7)	7 (7)
Father/father-in-law	0 (1)	0 (2)	0 (3)
Paid help - Nanny	0 (0)	0 (1)	0 (1)
No help	0 (0)	2 (0)	2 (0)

Before the early discharge all but 3 of the women had help from partners with housework, cooking and child care, if other children were present. Only 2 women said they had no help at all. One said her partner worked two jobs and helped if she was sick. Seven women had help from their children, 3 mothers or mothers-in-law and one friend had given assistance but no woman had paid help.

After discharge from hospital the help received from partners and children remained constant but help from other sources rose dramatically. No woman stated she had had no help at all since returning home. Most of the additional assistance was received from family members, particularly parents, and friends.

One woman employed a nanny when she first returned home to assist with the other children.

Table 12 Help from extended family

<i>Source of help</i>	<i>Women</i>	<i>%</i>
Some family member	41	84
Parents/parents-in-law	37	76
Family member other than parents	17	35
Partner only adult help	5	10

Eight (16%) women had no help from a family member and 12 (24%) women had no assistance from parents or parent-in-law. Seven of the women added that they liked to be independent but were happy to know that family members would make themselves available if necessary. The following comment clearly expressed this sentiment.

"My mother is there if needed but does not impose. She is doing the right thing by me."

For one woman the help of her mother was essential.

"If mum was not here I wouldn't cope. She [the other child] gets up to things when I feed. She wakes up the baby."

Expectations of Gains and Actual Gains

*Questions - What did you expect to gain by returning home early?
- Did you gain those things?*

Table 13 Expected gains and actual gains

<i>Gains</i>	<i>Expected</i>	<i>Achieved</i>
Establish a routine	23	20
Rest and recuperation	21	20
Be with other children	19	20
Children/partner involved with baby	18	17
Comfort - physical and emotional	9	9
Do things one's own way	8	7
Privacy	7	7
Be a family	6	6
Personal freedom	4	4
Easier for family	3	3
Continuity of care	1	1

Multiple answers were given in response to these questions. All the women expected to gain something by returning home early but only one woman said she gained nothing. With few exceptions the gains were achieved. The four highest ranked gains, both expected and achieved, were to establish a routine, gain rest and recuperation, be with other children and to allow the partner and/or other children to become more involved with the baby. One woman's search for rest at home did not eventuate. She made the following comment.

"I expected to be able to rest and recover but visitors were here all the weekend. They brought presents so I didn't like to ask them to leave. They made tea and coffee and left a mess."

Nine women expected to gain and did gain comfort by returning home early. Physical comfort was gained from sleeping in one's own bed, sitting in one's own chair to breastfeed and eating home-cooked meals. Psychological comfort was obtained from familiar surroundings.

The women who wished to have a return of privacy all had shared accommodation in hospital. Two of the women who wished to "be a family again" had felt very lonely in hospital. The extended families of the women were either living interstate or overseas. Neither had lived in the area for long.

The hospital routines and environment were too restrictive for 4 women. The importance of personal freedom was stated as follows:

"This is a natural event and life goes on. I need a life of my own and my own space."

"I needed more space. I got too dependent on the nurses."

"I felt as though I was being looked at by the midwives in hospital - that they were the experts."

"Peace of mind, not disturbing others at night."

Information Given During Hospital Stay

Question - Were you given enough information to meet your needs when you first arrived home?

Table 14 Information given in hospital was adequate to meet initial needs

<i>Response</i>	<i>No. of women</i>	<i>%</i>
Yes	38	78
Not given much	7	14
Felt confident with knowledge	4	8
Total	49	100

Thirty-eight (78%) of the women stated they were given enough information in hospital to enable them to care for themselves and their babies before the first visit of the domiciliary midwife. Seven (14%) women said they were given little information and 4 (8%) women felt confident with their knowledge as they had given birth to babies before. Two of the 7 women, who were given little information, gave additional comments.

"I was only given information by the physiotherapist about exercises."

"I was given photocopies but I would have liked more personal contact."

Two of the women, who were given an adequate amount of information, commented on women's ability to listen to and retain the information.

"You wouldn't retain the information if it wasn't happening to you."

"Women will listen if they want to. Most will ask questions."

Another statement showed that whilst women may ask questions they do not necessarily ask them of the midwife.

"You usually ask someone you feel confident with. I ask my mother if I want to know anything. I feel the midwife is an expert and that I should know the answer."

The ensuing comments were made about the timing of information given in hospital.

"You are given a lot of information immediately after birth and you remember snippets of it only."

"On the first day nothing sank in, on the second I was on a high and on the third weariness set in and the world stood still."

"Sometimes they give information too early."

One woman, who stated she had all the information she needed added the following comment.

"I wouldn't have got all the information if I had come home earlier."

Question - What information had been particularly helpful?

In response to this open-ended question items that had proved to be particularly beneficial were identified. One woman was pleased to learn about, and become familiar with, new feeding equipment for her child with a cleft palate. Another

woman, who had had a caesarean section, was pleased to hear which activities were and were not recommended in the postpartum period. Other helpful hints were how to make up formula feeds, different positions for holding a baby to empty the breasts when the nipples were sore, bringing up baby's wind, dealing with blocked milk and dealing with babies who wished to feed frequently.

Question - What else would you have liked to have been told?

The 7 women, who would have liked more information, identified such topics as contraception, circumcision, colic, vaginal bleeding in newborn females, feeding babies and a baby's "soft spot". Two women would have liked explanations of procedures. One wished to know about the importance of the postnatal check at six weeks. She did not attend this visit after her first baby as she was unaware of the necessity. The other woman wanted to know why she had an episiotomy. One multiparous woman would have liked to have had her practical mothering skills acknowledged. She stated that she would have liked to have been told "to do things my own familiar way not the hospital's way."

Question - Would it have been helpful to have had the information in the form of a booklet?

Table 15 Helpfulness of an information booklet

<i>Response</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Yes	4	30	34	69
No	4	11	15	31
Total	8	41	49	100

The majority of women, 34 (69%), thought a booklet about baby care would be a useful tool to take home so that they could read it at their leisure in a comfortable environment and use it as reference material, if necessary. Fifteen (31%) were not interested in the idea of a booklet. Differing reasons were

given for the decisions. Five women thought a booklet would be useful for first-time mothers. The following is one of the five comments:

"If it is a first baby, a woman needs technical advice and needs confirmation that what she is doing is correct."

Five women stated they had been given photocopied information sheets. The usefulness of the photocopied sheets is presented.

"They could be put in the baby book. Single sheets would be put in a drawer and I would forget where I put them."

"I had many leaflets and I read them since coming home."

"I got photocopied sheets and read them."

"So much paperwork and heaps of pages that were just put in the top drawer."

"I had several sheets and they are waiting to be read."

Five of the women, who said a booklet would not be helpful, stated they had already read books on baby care. Representative comments are given below.

"I read and swapped stories with other mothers."

"I do a lot of reading especially when it concerns me and my baby."

"There are so many good magazines around now. There would be very few people who did not know common sense things."

"I read a lot during pregnancy and the reminders in hospital were enough."

Other reasons for not requiring a booklet were as follows:

"I wouldn't read it."

"I'm not into reading."

"I have had two other babies."

"I had a leaflet on artificial feeding and that was all I wanted."

"It would be good for others. I didn't really need it as I have my mother here."

Infant Feeding

Questions - What method of infant feeding are you using?

- Is that what you planned to do?

- How is feeding progressing?

Table 16 Method of infant feeding (n=49)

Method at time of interview - no parentheses

Planned method - in parentheses

<i>Method of feeding</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Breast	6 (6)	28 (34)	34 (40)	69 (80)
Bottle	2 (2)	13 (7)	15 (9)	31 (20)
Total	8 (8)	41 (41)	49 (49)	100 (100)

At the time of interview, 10 - 14 days after the birth, 34 (69.4%) of the women were breastfeeding and 15 (30.6%) were bottle feeding. Of the 15 bottle feeding women 6 stated that breast feeding had been their first choice. Three women had had severely bleeding nipples, 1 mastitis and 2 had tried but changed to bottle feeding when problems arose. All 6 women were multiparae. Thirty-four (85%) women who planned to breastfeed were still breastfeeding 10-14 days after delivery and 43 (88%) women were practising their preferred method.

The following reasons were offered in support of decisions to artificially feed their baby.

"It is easier for me. I can have a break."

"My last child breast fed for three years. He wouldn't drink from a bottle or a cup. I hated it. I'm not doing it again."

"The young midwives push breastfeeding. Artificial feeding is looked down upon. I didn't want to breast feed. Three tense females in the family would be too much."

"When the nipple shield filled with blood I put her on the bottle."

All appeared happy with their mode of infant feeding at the time of the interview. The 6 (12%) women who changed to bottle feeding made no complaints about feeling unsupported when breastfeeding difficulties arose. One woman was unsure about how she would feed her baby because she had previously given birth to a child with a palate abnormality. As the new baby also had the same problem she decided to use specially designed teats for bottles to assist the baby's sucking. One of the multiparous women, who changed to formula feeding, stated that she was having some difficulty with feeding at the time of interview.

Three women, who were successfully breastfeeding at the time of interview, had had problems that they had been able to overcome. They made the following comments.

"My nipples are better now and I've a good milk supply. The first time I had cracked nipples and it was six days before I was attaching the baby myself. The bad routine continued for 11 months."

"He wouldn't attach when I had mastitis. He was restless when I was on antibiotics."

"You do better when you go home. You're more relaxed; there is no one looking over your shoulder."

Table 17 Progress of infant feeding (n = 49)

<i>Progress</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Very well	4	29	33	67
Satisfactory	3	9	12	25
Some difficulty	1	3	4	8
Total	8	41	49	100

The 4 (8%) women, who stated they had some difficulty with feeding made these comments.

"The baby resisted the breast for a day and a half. He wanted it but wouldn't take it."

"He feeds for long periods and does not settle for long. I think he has colic."

"She feeds well and settles at night but she snacks during the day and falls asleep."

"He only drinks small amounts of the formula and wakes frequently."

Women's Perceptions of Their Physical and Emotional Health

*Questions - How would you describe you physical health?
- How did you think you would feel?*

Table 18a Women's perceptions and expectations of physical health

(n = 49)

Perception of health status - no parentheses

Expected status - in parentheses

<i>Status</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Really good	0 (0)	4 (1)	4 (1)	8 (2)
Good	5 (2)	25 (19)	30 (21)	61 (43)
All right	3 (6)	2 (21)	15 (27)	31 (55)
Not good	0 (0)	0 (0)	0 (0)	0 (0)
Total	8 (8)	41 (41)	49 (49)	100 (100)

The women used different words to describe how they felt. The term "really good" was chosen to represent "excellent", "terrific", "wonderful" and "very well"; "good" represents "well"; "all right" represents "OK" and "not good" represents "not well".

Table 18b Women's conclusions of physical health (n = 49)

<i>Conclusion</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
As well as expected	1	18	19	39
Better than expected	5	18	23	47
Worse than expected	2	5	7	14
Total	8	41	49	100

The women defined the meaning of health for themselves. They used their own criteria for measurement as no guidelines were given. Seven (14%) women, 2 primiparae and 5 multiparae, thought they would have felt better physically than they did. Twenty-three (47%) women, 5 primiparae and 18 multiparae, felt better than expected and 19 (39%), one primipara and 18 multiparae, felt as well as expected.

Many problems were identified and mentioned but only 7 (14%) women thought they would have felt better physically than they did. The most common problem was tiredness. Two women, who had had caesarean sections, complained of discomfort around the abdominal scar but both related it to doing housework.

"I probably overdid the housework."

"I hung out the washing and I drove the car my first day home.

I'm not as well as last time."

Positive comments were made by 4 women about the status of their health.

One believed good health may have been related to returning home early.

"I have never looked better figure wise. I've grown up a lot within the last few days."

"Good to get my figure back. I had two quick pregnancies. I've been pregnant for the last eighteen months."

"I feel better, nicer baby."

"I thought I would be more tired. Maybe, I'm better because I came home early."

Questions - How would you describe you emotional health?
- How did you think you would feel?

Table 19a Women's perceptions and expectations of emotional health
(n = 49)

Perceptions - No parentheses

Expected status - in parentheses.

<i>Level</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Really good	1 (1)	4 (1)	5 (2)	10 (4)
Good	2 (2)	25 (19)	27 (21)	55 (43)
All right	5 (4)	12 (21)	17 (25)	35 (51)
Not good	0 (1)	0 (0)	0 (1)	0 (2)
Total	8 (8)	41 (41)	49 (49)	100 (100)

Table 19b Women's conclusions of emotional health (n = 49)

<i>Conclusion</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
As well as expected	3	22	25	51
Better than expected	3	15	18	37
Worse than expected	2	4	6	12
Total	8	41	49	100

There were only 6 (12%) women who perceived their emotional health to be worse than expected. Two were primiparas and 4 were multiparae. Uncharacteristic behaviours mentioned were sudden tearfulness, "cranky" moods, making large issues out of small incidences and having "the blues". Three women thought these behaviours could be attributed to hormonal changes. Eighteen women (37%), three primiparas and 15 multiparae, believed they were emotionally better than expected. Twenty-five women (51%), three primiparas and 22 multiparae were as well as expected.

Three (6%) of the multiparous women compared their present state of emotional health with that experienced in their last puerperium.

*"I'm so happy I couldn't be happier. I expected to feel so well.

It is a pleasure to look after my daughter."

*"I feel wonderful. I didn't smile for 6 weeks last time."

*"Better because it's the second time. Been there, done that."

Ability to Cope with Home and Family

Question - How do you feel you are coping with the new baby, your home and your family?

Table 20 Perceptions of ability to cope with home and family (n = 49)

<i>Level</i>	<i>Primipara</i>	<i>Multipara</i>	<i>Total</i>	<i>%</i>
Easy	0	14	14	29
Fairly easy	6	21	27	55
Some difficulty	2	6	8	16
Total	8	41	49	100

The women's perceptions of their ability to cope with both home and family mirrored their perceptions of their physical and emotional health. Only 8 (16%) women found they were experiencing some difficulty with coping. No one thought life was very difficult at the time of interview. Some of the comments are presented.

"The children have to fit in with our lives. We don't intend to change, just carry on as before."

"I'm coping unbelievably much better than expected."

"I surprised myself how well I'm coping. I was paranoid about the 'baby blues'. I didn't think a baby would be so time-consuming."

"I'm coping because mum's here. I thought everything would be fine but I was wrong."

"I don't get much work done. I wash up once a day and the bathroom gets cleaned in the afternoon."

Well-being of Babies

Question - How is baby progressing?

Table 21 Women's perceptions of babies' progress

<i>Status</i>	<i>Number</i>	<i>%</i>
Content	29	59
Mostly content	18	37
Unsettled	2	4
Total	49	100

Twenty-nine (59%) women considered their babies to be contented. Only two of the women thought their babies were unsettled to some degree. The two mothers, who reported an unsettled baby, made the following comments.

"He sleeps for short periods only."

"She wakes every two hours. She was a little jaundiced."

Colic, wind, wakefulness and constipation were reasons given for stating babies were mostly content.

"He's going through a colicky stage."

"He's awake a couple of hours during the day. He has wind occasionally."

"She was constipated so I changed the formula."

Source of Help Sought Since Returning Home

Question - *Have you sought help from or been referred to other people or agencies?*
 - *From whom did you seek help?*

Table 22 **Requests for help from other professionals (n=49)**

<i>Response</i>	<i>Women</i>	<i>%</i>
Yes	21	43
No	28	57
Total	49	100

Twenty-eight (57%) of the women had not sought help from, or been referred to, any person or agency. All the assistance they required was given by the visiting midwife. "I would have sought help if the midwife had not called" was a typical response. Twenty-four instances of assistance had been obtained by the remaining 21 women.

Table 23 **Sources of professional help (other than visiting midwife) (n=24)**

<i>Source</i>	<i>No. of instances of help</i>
Doctors	12
Family and child health nurse	4
Hospital midwives	4
Nursing Mothers Association	1
Chemist	1
Physiotherapist	1
Nurse neighbour	1
Total	24

In most instances, 12, help was obtained from doctors for such problems as mastitis, uterine infection, abdominal pain, painful perineum, a lump in the axilla and passing a large clot vaginally. Baby consultations were for a sticky eye, and a female child who passed a small amount of blood vaginally.

There were two readmissions to hospital. One woman required a dilation and curettage and 1 baby had high serum bilirubin levels. The child received a course of phototherapy.

Four women, 2 primiparae and 2 multiparae, rang the midwives at the maternity hospital to discuss such issues as bleeding following a circumcision, a rash on the baby's buttocks and painful breasts. Four visits to the family and child health nurse were made to talk about feeding problems, constipation, snuffly nose and have the baby's weight recorded. One multiparous woman rang the Nursing Mothers' Association for breastfeeding advice. The local chemist was consulted for the treatment of haemorrhoids, the doctor at the Accident and Emergency Department for mastitis, a physiotherapist for back pain, and a nurse neighbour was sought out for reassurance.

On discharge from the hospital all women were given the telephone number of the maternity ward should they need to ring for advice. The majority, 45 women, were given the number before discharge whilst 4 women received it on the midwife's first visit.

Recommendation of Early Postnatal Discharge

Question - Would you recommend early postnatal discharge to other women?

All women said they would recommend early discharge but it was not necessarily suitable for all women. The two comments below are typical examples of responses.

"If mum and baby are well. It depends what you have to come home to and if you have family to come home to."

"If both are well."

Thirteen (26%) multiparae would not recommend first time mothers go home early. No primiparous woman shared this notion. Twenty of the multiparae said it was up to the woman herself to decide what was right for her. The need for women to decide the time of discharge was stressed. The following comments are representative of the women's beliefs about choice.

"The service is exactly what I needed. It's good if you are not pressured and are aware of the programme."

"If it is the woman's choice."

Repetition of Early Postnatal Discharge

Question - Would you again return home early if you had another baby?

Only four (8%) of the participating women, all multiparous, said if they were to have another baby they would remain in hospital longer. One was unsure but thought she would return home early again. Three of the comments are quoted.

"I would stay in and enjoy the food. Hopefully, I would not be so lonely."

"I would think pretty hard about it as I would have two children to come home to."

"No. I wouldn't take an early discharge. I would stay in four days."

Summary

The data were presented using descriptive statistics interspersed with qualitative comments made by the women. Demographic data showed the characteristics of the participants. The associated characteristics demonstrated women were aged 26 years or older, had lived for 4 years in their present home, had at least

one other child at home, had attended the hospital antenatal clinic for prenatal care, had attended antenatal classes in a previous pregnancy and had delivered her baby normally.

Thirty of the women learned of the early postnatal discharge scheme from a midwife and 30 women heard of the scheme after the births of their babies. All but 5 women believed their length of hospital stay to have been correct for them. The predominating factor, which influenced the early return home, was the good health of the women and their babies. Most of the gains women expected to achieve by returning home early were achieved. Confidence levels about caring for the newborn babies were overall higher at the time of interview than at the time of discharge. All women had the support of family or friends once home. Additional help from professionals was sought in 24 instances. Most women were happy with the amount and depth of information given to them in hospital before discharge. A minority felt they were not ready to learn in the very early postnatal days and questioned the amount of information given at that time. All but 6 women were feeding their babies by their planned feeding method. The 6 multiparae, who changed to bottle feeding, were happy with the change. The majority of women reported their physical and emotional health to be as good as or better than expected. Only 8 women were having some difficulty coping with their family responsibilities and home. Whilst women would recommend early discharge they believed it should be the woman's choice and she and her baby should be well. All but 4 women would return home early again after the birth of another baby.

Discussion of Research Findings

This chapter will present a discussion of the research findings. The demographic data of this study group will be compared and contrasted with the findings of other research studies. The notion of informed choice by the participants, the support from family and friends and the quality and quantity of information received before discharge will be examined and solutions will be offered to improve the effects of some of these variables on early postnatal discharge. Comparisons will be made with the findings of other studies about the factors which influenced women to return home early, expected and actual gains of early discharge, confidence levels, infant feeding, perceptions of health and coping abilities and future plans to repeat the early discharge experience.

Demographic Data

Some of the demographic features of this participant group were consistent with those quoted in Small et al.'s (1992, p. 172) study. The associated characteristics of women were multiparity, cared for prenatally in the hospital antenatal clinic and a vaginal delivery. In spite of women, in both the literature (Campbell, 1992, p. 140) and this study, saying early discharge was not suitable for first time mothers, the eight primiparous women interviewed did not find their parity posed problems for them. No primiparous women reported that they were actively discouraged from returning home early as those in the study by Burnell et al. (1982, p. 46). Telephone calls to the discharging hospital immediately after returning home were equally divided between the primiparous and multiparous women in contrast to the findings of Sumner & Fritsch (1977, p. 31), who found that most calls were made by first time mothers.

Only 15 (31%) of the women in this study consulted private obstetricians for antenatal care. An Australian study by Kenny et al. (1992, p. 11) found that few (28%) of the participating women attended a private obstetrician. Brown et al. (1995, p. 64) further established that women who sought antenatal care at a hospital clinic or had shared care from a general practitioner and clinic doctor were more likely to go home early. Postans (1993, pp. 1, 10) suggested that demographic, social and cultural changes have influenced the services required by families and the ways in which these services are delivered. Participants, in this study, were not asked whether they had private health coverage but there is a nationwide trend away from private health insurance.

Two-thirds of the women were over 25 years of age and half were between the ages of 26 and 30 years. The literature was divided about the ages of women who took an early discharge. The findings of this study were in line with the reports of Waldenstrom (1989, p. 189) and Kenny et al., (1992, pp. 11-13), who quoted average ages of 28 and 29 years. Brown et al. (1995, p. 64) stated women under the age of 25 years were more likely to return home early. Young women were more likely to be uninsured and using public hospital facilities. In their study these factors were associated with returning home early.

The women of this study belonged to a more mobile population than those in the report of Postans (1993, p. 3). Ninety per cent, as opposed to 66 per cent of the women in Postans' (1993) study, had lived in their present location for less than 10 years.

Less than one third (31%) of the women interviewed said that they had not attended any antenatal education classes, even though attendance was a criterion for inclusion in the domiciliary scheme by the discharging hospital

(Appendix 6). As the experiences for the women were favourable overall, participation in antenatal classes was not demonstrated to be an important factor for this study group. Publications by Burnell et al. (1982, p. 46) and James et al. (1987, p. 438) stated that rigid selection criteria for inclusion in a domiciliary midwifery programme were probably invalid. Burnell et al. (1982, p. 46) said the wishes of women should be given priority. The discharging hospital may wish, therefore, to reassess the validity of the criterion.

Choice and Informed Choice

All the participants said they chose to return home early, supported by daily visits from a community midwife, but informed choice is questionable especially for the 30 (60%) women who had not heard of the early postnatal discharge programme until going home was mentioned by the professionals during the postnatal period. The lack of information occurred in spite of the Mission Statement of the discharging hospital asserting that "women and their families have the fundamental right to participate in an informed manner in decisions about their health and that of their families" (Obstetric and Paediatric Philosophy, 1994). Twenty-eight (57%) women attended the antenatal clinic at the discharging hospital for prenatal care but only 5 stated they had seen a notice introducing the early discharge programme and 7 reported that they had heard of the programme from a doctor or a midwife during the prenatal period. These results suggest that the notice was not prominently displayed or eye catching enough and that the early postnatal discharge programme was not discussed with all women. Although 6 women said they heard about the early postnatal discharge scheme from friends, comments suggested there had been a lack of understanding and detail, e.g. "A friend mentioned it but I didn't take it in" and "A friend had gone home early but I didn't realise it was structured."

Norr & Nacion (1987, p. 138) stated that if women chose to return home early there could be an expectation that they would find the experience favourable is also debatable. It could be argued that those women who chose to return home early without prior knowledge of the programme made the decisions impulsively without full assimilation and processing of the information given or time to plan necessary support once they were home. When early discharge was discussed two women felt that they were not valued as individuals: "The doctor didn't seem interested in me, just asked me when I wanted to go home", and "I felt they wanted to get rid of me, that they may want the bed." Misunderstanding could have been prevented if they had prior knowledge of the early postnatal discharge scheme.

The literature suggested solutions to the issue of informed choice. The NH&MRC (1991), in its guidelines for early postnatal discharge programmes, stated, "Participation in the programme must be voluntary and based on full information on all aspects of the scheme." The Australian Development Committee (1995, p. 88) and Small et al. (1992, p. 176) suggested that discharge planning should begin in the antenatal period to give women time to think about the programme and plan the amount and type of community-based care they may require. A similar sentiment was echoed by one of the participant women.

"They need to advertise the service, then women can plan their own discharge rather than they tell you when you can go home"

One woman, when asked at the interview about her opinion of the length of her hospital stay, gave an answer that suggested she still did not understand fully the meaning of early discharge supported by visits from a midwife. She said, "I would have come home on the second day if an episiotomy had not been done. I stayed in for nursing care". Experienced midwifery care was available to the

women both in hospital and at home. In spite of the lack of clarity about early discharge more women (89%) in this study found their length of hospital stay to be correct for them than the 66% in the study of Burnell et al. (1982, p. 45) although in the study of Thurston & Dundas (1985, p. 387) 86% found the length of hospital stay to be correct.

Despite the recall of the experiences of early discharge demonstrating that the women's perceptions of choice varied from pre-planning for an early return home to feeling pressured to make the decision to choose early discharge, all the women in the study clearly stated that they chose early discharge from hospital postnatally. The findings of this study should reduce the concern of the community members, present at the public forum, that early postnatal discharge will limit women's choices.

Influencing Factors, Expected and Actual Gains

Four predominating factors influenced the participants to choose early discharge. They were that mother and baby were well, they wished to return home to their other children, they were able to sleep and relax better at home and they disliked hospitals. The good health of mother and baby and a need to avoid unnecessary separation from other children were factors that also ranked highly in the studies of Burnell et al. (1982, p. 46), Campbell (1992, p. 141), Thurston & Dundas (1985, p. 387) and Waldenstrom (1989, p. 192). Burnell et al. (1982, p. 46), Campbell (1992, p. 141) and Harrison (1990, p. 39) found that the women in their studies believed that they could rest and recuperate better in a familiar, comfortable home environment too. Furthermore a dislike of hospitals was quoted by women as an influencing factor in the research findings of Small et al. (1992, p. 176), Thurston & Dundas (1985, p. 387) and Waldenstrom (1989, p. 192). Brown et al. (1995, p. 67) stated women found the

noise levels, interruptions, rushed care givers and conflicting advice to be problems whilst in hospital.

Some influencing factors highlighted the individuality of women. Two women went home for company whilst 7 wished to have time for themselves in the quiet of their own homes, 3 felt the hospital failed to meet their needs whilst 3 others returned home in response to family needs, 2 were bored by their hospital stay and 2 had a positive outlook wishing to get on with the new phase in their lives. Factors that guided women's decisions to return home early were more than physical manifestations of their health.

The expected and actual gains most often cited by the women were in line with the findings of the studies by Kenny et al. (1992), Lukacs (1991), Thomson (1990), and Thurston & Dundas (1985). The women said they wished to establish a routine, rest and recover from the birth, be with the other children and have their partners and children become involved with the new baby. No study was found where a woman reported she had gained nothing from the experience of early discharge.

The responses given demonstrated the diversity of women's needs. The heterogeneity of women and their needs complements the notion by Burnell et al. (1982, p. 46) and James et al. (1987, p. 438) that well women and their healthy babies should be given an option to return home early without rigid selection criteria determining their eligibility.

Confidence in Ability to Care for Newborn

Small et al. (1992 p. 173) stated that 96% of women in their study felt confident when initially assuming full responsibility for their babies at home. The figure

was slightly lower in this study, 42 (85%) women, but Small et al. (1992) defined early discharge as discharge on or before the 5th day postpartum not the 3rd day as in this study. The increased experience gained in 2 days may account for the increased confidence levels. The higher percentage of apprehension in primiparous women was demonstrated in both the findings of this study and that of Small et al. (1992). Whilst Small et al. (1992, p. 174) found that apprehensive women were significantly more likely to state that their hospital stay had been too short, only one woman, a multipara in this study, reported feeling very apprehensive and stated that her stay in hospital was too short.

A variation existed between the findings of this study and the study of Kenny et al. (1992, p. 22) where Kenny found confidence levels were reflected in the women's perception of their ability to cope. In this study all women, at the time of interview, felt very or quite confident in their mothering abilities yet 8 women (2 primiparae and 6 multiparae) felt they were having some difficulty coping with their homes and families.

High confidence levels may reflect the success of the one-to-one relationship between each woman and the domiciliary midwife where care and support are individualised and autonomy of the women encouraged.

Support from Family, Friends and other Professionals

All women identified at least one support person who assisted them when they went home. The discharging hospital agreed with the notion that women, who returned home early, should have someone to assume some responsibility for household chores and other children as recommended by Avery et al. (1982, p. 233), Carr & Walton (1992, p. 29) and Kenny et al. (1992, p. 12). Criterion 6

of the discharge guidelines stated the necessity for "...a support person to assume household responsibilities and care for other siblings..." (Appendix 6).

The literature had suggested that the support structure for newly delivered mothers was now different because of societal changes. Traditionally help from the females of the extended family had been the norm (Evans, 1991, p. 114, Laryea, 1989, p. 176 and Postans, 1993, p. 3). In this study help from this source was high (37 women had help from parents and 17 from other family members) but 47 (96%) of the 49 women reported their partners as chief sources of assistance. Evans (1991, p. 114) and Gruis (1977, p. 186) wrote of the increasing involvement of partners during the early postnatal period. Postans (1993, p. 9) envisages a further change whereby new age families can receive client-focussed support from domiciliary midwives. The midwives would see families throughout the childbirth process and provide or seek home support as necessary to optimise outcomes.

Weiss (1976, p. 222) wrote of the importance of three types of support, expert, veteran and participant, in the postnatal period. All women had expert support from the domiciliary midwife, veteran support was provided to 44 (90%) by parents, other family and friends and 47 women had participant support from their partners. The 8 women who perceived they were having some difficulty coping reported having the three types of support. There was no evidence in this study of primiparous women receiving more support than multiparous women as stated in the findings of Kenny et al. (1992, p. 12).

The support by a midwife, family and friends met the needs of 28 (57%) of the women. They did not need to seek outside help. The 21 (43%) women who did seek outside help did not attribute the need to returning home early. Two

major problems (a woman and a baby who required medical attention) were identified and referred by the midwife to the appropriate agencies.

All women were given the telephone numbers of the hospital for 24-hour access to information and reassurance as discussed by Avery et al. (1982, p. 235), Bull & Lawrence (1985, p. 315) and Lemmer (1987, p. 230). No woman stated she had the telephone numbers of other local community services that may be contacted in an emergency. The knowledge deficit supported the statement by the Community Development Committee of Victoria (1995, p. 88) that unless adequate planning was commenced during pregnancy women lacked information about community services that were available to provide assistance postnatally.

Information

Whilst most women were happy with the quantity and quality of information given before leaving hospital, a few made comments that upheld findings in other studies. Five women talked about readiness to listen, learn and retain advice in the early postpartum period. They agreed with Evans (1991, p. 114), Harrison (1990, p. 39), Lukacs (1991, p. 39) and Norr & Nacion (1987, p. 141) that information was more likely to be taken in once they were home with sole responsibility for their babies, when the relationship was one-to-one and questions could be asked of a familiar person. One woman clearly described her experience of the early postnatal days.

"On the first day nothing sank in, on the second I was on a high and on the third weariness set in and the world stood still."

This statement implied that the woman's personal feelings would have been barriers to receiving messages about personal and infant care during the three

days. The implication of this statement was supported by another comment, "You are given a lot of information immediately after birth. You remember snippets of it only". A solution to this issue was written about by Evans (1991, p. 114) and Lukacs (1991, p. 39). They described how hospital postpartum nurses in their studies prioritised teaching to include information essential to meet the immediate needs of the women. Further teaching by the domiciliary midwife was on a one-to-one basis according to the individual needs of each woman.

Written information was considered useful by 34 (69%) of the participants. The reference material would be available at all times. These findings were upheld by Avery et al. (1982, p. 235), Bull & Lawrence (1985, p. 315) and Lemmer (1987, p. 230).

Infant Feeding

Eighty-five per cent of the women in this study were still breastfeeding at the time of interview in contrast to the 77% of early discharge women in the study by Kenny et al. (1992, pp. 12-18). There was little difference between the numbers of women, in the two studies, practising their preferred method. The primiparous women in both studies demonstrated higher breastfeeding rates than multiparous women. Whilst women did experience breast feeding problems no woman stated she had felt unsupported at those times. Five instances of help was sought from professionals other than the domiciliary midwife. The women sought help at the time they perceived the need not because they felt unsupported by the domiciliary midwife. The experiences of the 49 participating women can provide valuable information to the community members who had a concern that women who were discharged early would not receive adequate professional help for breastfeeding problems.

Health and Coping

In spite of identifying physical and emotional problems 42 (86%) women perceived their physical health to be as good as or better than expected and 43 (88%) perceived their emotional health to be better than or as well as expected. Those who had anticipated the 'baby blues' were happy to report they had not eventuated. The findings of this study reflected those of a major Australian research project by Kenny et al. (1992, pp. 17-19) whereby 90% of the women reported feeling as good as or better than expected. The high levels of emotional health and confidence on the day of interview were consistent with the research results of Small et al. (1992, p. 175).

Forty-seven (96%) of women were happy to announce the well-being of their babies. The high level of satisfaction about babies' health amongst these women, who returned home early, supported the results of three studies (Burnell et al., 1982, p. 45, Kenny et al., 1992, p. 17 and Norr & Nacion, 1987, p. 138). The mothers of the babies, who were not content, reported that they had difficulty coping within the home.

Future Plans

For the women of this study early postnatal discharge had been acceptable and was demonstrated to be a viable option and a desired alternative to longer hospital stay. Whilst 92% of the women would repeat the experience compared to the 80% in Waldenstrom's (1989, p. 195) study, they agreed with Kenny et al. (1993, p. 151), Scott et al. (1993, p. 87) and Waldenstrom (1989, p. 195) who stated that early discharge should remain the choice of women.

Conclusion

The study has documented the experiences of 49 women who chose early postnatal discharge supported by a domiciliary midwife. The experiences discussed included the issues of women choosing early postnatal discharge and support for women experiencing breastfeeding problems. The two issues were concerns for community members at a public forum about the transfer of maternity services from a separate hospital to a unit within a general hospital. It is hoped that the findings and the women's comments can eliminate the concerns. The way the women experienced early postnatal discharge has added another dimension to midwifery research into early postnatal discharge.

Summary

This chapter discussed the findings of the study. The demographic data obtained were very similar to findings in other studies from within Australia. Differences were noted with the ages of the participants and the time they had resided in their homes. Identified issues surrounding parity were examined. One criterion for referral to the domiciliary midwifery service was challenged as women returned home without attending antenatal classes in any pregnancy. However the validity of rigid selection criteria was questioned in the literature.

The notion of informed choice to return home early by the participant women was discussed. Solutions to this dilemma were identified in the literature. The factors which influenced women to return home early, the expected and actual gains of being home, the amount and type of support received by the women at home, the patterns of infant feeding and the women's perceptions of their own and their babies' health were consistent with findings in other studies. Whilst the high confidence levels of the women, especially the multiparae, were

comparable to findings in other studies a discrepancy was noted in the relationship between confidence and ability to cope within the home. An issue of readiness to learn in the early postnatal period before discharge was discussed and a solution from the literature identified.

Review of the Study and its Implications for the Community, Midwifery Practice, Education and Research.

In this final chapter, the implications of the study for midwifery practice, research and education will be discussed. The strengths and limitation of the research will be examined and a summary of the study will be presented.

Implications of the Study

The Community

Midwives are advocates for childbearing women through their membership of their profession and the community. Quality midwifery care is demanded by standards within the profession and expectations of the community. Changes occurred in midwifery care that were causing concern for community members. Their apprehensions, that early postnatal discharge would curtail choices for women and that adequate professional support would not be available to women experiencing breastfeeding problems, provided the impetus for this advocacy study. The purpose of the study was to respond to these concerns by addressing a call, identified in the literature, for research to be conducted into the experiences of women who chose early postnatal discharge. The study will give the community a background knowledge of early postnatal discharge through the documentation of the history of the re-emergence of domiciliary midwifery care and the findings of other studies. The experiences of the 49 women of the community will be able to give valuable information that will allay the expressed concerns.

Midwifery Education

The delivery of optimum care to each childbearing woman requires midwifery education to be informed by research to ensure midwives give quality care in

their every day practice world. Frequent evaluation will be required because the needs of childbearing women will change as society's needs change.

As domiciliary midwifery is now established in Australia, midwifery education programmes need to adequately prepare students to meet this challenging new role. At present, some Australian midwifery programmes are still hospital based and prepare midwives for caring for women in hospital only. All midwives of the future will be prepared in tertiary institutions to be not only technically proficient but also advocates for women and their families within the community (Barclay, 1993, p. 6). Cutts (1993, p. 7) hopes that with the change in learning environment there will be a change in focus of maternity care. The physical focus of the medical model of care will be balanced by a humanistic perspective that values subjective experiences and psychosocial influences on health. A humanistic perspective suggests midwifery curricula and staff development programmes need to address communication and counselling skills as well as midwifery knowledge and clinical competence to ensure a midwife can fully assist the childbearing woman and her family with the transition to parenthood (Cutts, 1993, p. 8).

During pregnancy and the early postnatal period the woman requires information to help her make choices. The midwife, as educator and facilitator, can inform the woman and create an environment in which the woman can achieve empowerment to make her own decisions and control her own resources (Gould, Sullivan & van der Klei, 1993, pp. 2-3). Gould et al. (1993, p. 6) stated that to be a facilitator of empowerment the midwife should be empowered. They continued that empowerment for the midwife is a lifetime process achieved through education, acceptance of the importance of change and the value of colleague support, reflection on practice and self respect. The domiciliary midwife is able to facilitate the woman's empowerment through the

development of a rapport, the sharing of information and the provision of continuous individualised care away from the rigid rules of the hospital. Two comments made by women suggested they felt empowered once home.

"I feel in control at home."

"I feel more comfortable and confident at home, I feel as though I'm doing everything right."

Midwifery Practice

Maternity care that is woman and family focussed can be practised as a partnership between the woman, her family and the midwife. The preferred locus for this partnership may be in the woman's own home. A partnership built on mutual respect during the antenatal period would allow information to be shared with ease. The midwife would be able to learn of the expertise, strengths and needs of the woman and her family. In turn, he or she could increase the strengths by providing the required support, whether physical, emotional or educational, to assist the woman to meet her needs.

The sharing of information will enable each woman to make informed choices including the type of postnatal care she may wish to receive. Timely, individualised support would ensure that educational needs are met when the woman is ready to learn. Information sharing should lead to a better informed childbearing community whose fears could be allayed and misunderstandings reduced.

The eligibility criteria for referral to the domiciliary midwifery service may need to be evaluated by practitioners and administrators. Criteria that are not adhered to are superfluous and rigid criteria may be invalid. If, as stated in *The Obstetric and Paediatric Services Philosophy* (1994), women and their families are to be afforded the right "to participate in an informed manner in decisions

about their health and that of their families" are eligibility criteria for inclusion in an early discharge programme necessary?

Midwifery practice must be ever forward looking, anticipatory and inquiring because change is inevitable. Will the length of postnatal hospital stay continue to fall? What could this mean for women and service providers? Some answers may be gained through further midwifery research into current practice.

Midwifery Research

This descriptive research study has answered some questions about the women's experiences of early postnatal discharge but has highlighted other issues for further research. Will fiscal restraint take precedence over the humanisation of maternity care? If so, early postnatal discharge may be compulsory for all women not only those who meet strict selection criteria. Is there a relationship between the day of discharge and favourable outcomes, e.g. the continuation of breastfeeding? Are early postnatal discharge schemes flexible enough to meet the needs of all women? Do all women require domiciliary visits by midwives? If so, how often should midwives visit? If not, what support mechanisms are available to women in their area? Brown et al.'s (1995, p. 67) research, conducted and published after this study, also identified such gaps in knowledge of midwifery practice concerning early discharge. A major disappointment for them is that policies to promote early postnatal discharge were implemented in Victoria before such questions had been asked.

It is not too late to ask these questions in Tasmania and knowledge gleaned from such studies could further inform midwifery education and practice. Through midwifery practice, education and research, the rights and needs of childbearing women can be demonstrated and protected in these times of economic restraint in health.

Strengths and Weaknesses of the Study

Strengths

The prime strength of this study is that it responded to a community need. At a time of relocation of the local maternity hospital community members raised the issues of forced early discharge and women with breastfeeding problems obtaining inadequate support. This research study showed that the women were not forced to leave hospital early and had professional support with breastfeeding problems.

Eighty per cent of the women, who took an early discharge and were referred to the domiciliary midwifery service in the months of October and November, agreed to participate in the study. The high response rate was attributed to the personal contact made by the researcher during the two visits to each woman, once in hospital and once at home.

All the interviews were conducted by the same person. This ensured that all data was collected in the manner planned.

Weaknesses

The results of the study are limited because participants were drawn from one discharging hospital, which was the only maternity hospital in the region. Findings and conclusions from a descriptive study are not generalisable but pertain only to the participants of the study.

The reliability and validity of the interview schedule are limited. The interview schedule's reliability was not assessed and only face validity was determined.

The women had taken an early postnatal discharge by choice, a criterion of the discharging hospital. Findings and conclusions may have differed if early discharge had been forced upon the women.

All the women who were discharged in the months of October and November 1994 could have been participants in the study. The months of October and November were chosen merely for convenience. In the two months of the study the women who formed the convenience sample may have been atypical of the population with regard to their experiences of early postnatal discharge.

Review of the Study

Early postnatal discharge, with visits from a domiciliary midwife, is a re-socialisation of childbirth practices. It offers women an alternative mode of postnatal care and heralds a renewed relationship between women, their families and midwives. The new baby is integrated earlier into the home and the family and the woman is able to rest and recover in familiar surroundings. For the majority of women, for whom childbirth is a normal physiological process, early discharge provides an opportunity to accept a desired level of medical and technical intervention during a hospital delivery but also to recapture childbirth as a cultural and social event.

The opening chapter introduced the notion of early postnatal discharge and traced the re-emergence of domiciliary postnatal care. The recent humanitarian, social, attitudinal, political and economic influences that brought about the alternative mode of care were discussed. Following a public forum about the transfer of maternity services a community need for a research study was identified and the topic was clarified after a literature search. A descriptive study was chosen in order to describe the experiences of women who chose to

take an early discharge from hospital and received visits from a domiciliary midwife. The findings will be able to inform midwifery education, practice and research.

Midwifery literature and media reports, published at the time of the introduction of the early discharge programme, were reviewed for the second chapter. The feminist literature offered explanations for the dearth of written reports about women's experiences of childbirth. Two complexities, the many definitions of 'early' and whether discharged women were supported by domiciliary midwives, were explored. The importance of informed choice was discussed and the factors that influenced the choice of early postnatal discharge were traced. The demographic data of women in other Australian early discharge programmes were presented. Other aspects of the experiences of women who were visited by domiciliary midwives during the early postnatal period were identified and discussed. These included confidence levels, support received from family and friends with housework, expected and actual gains of returning home early, information given in hospital, infant feeding, other professional help sought since returning home and women's perceptions of the length of hospital stay, their own physical and emotional health, their ability to cope and their babies' health.

In the third chapter the rationale for the choice of the descriptive research method was presented. The processes of data collection and data analysis were outlined. Details of the tools that were developed to assist data collection and analysis were provided. The selection of participants and the ways taken to protect the participant women's rights were described.

In Chapter 4 the results of the study were presented using descriptive statistics. These statistics were supported and enhanced by qualitative statements made by

the participating women. Demographic data presented characteristics of the participating women. The effects of selected variables on the phenomenon of early discharge were identified by quantifying the women's responses to questions. Responses were obtained regarding the informants of the early discharge scheme, factors that influenced the choice of early discharge, expected and actual gains of returning home early, confidence levels, support received from family, friends and other professionals, infant feeding and the women's perceptions of their own and their babies' health. The women disclosed whether they would recommend early postnatal discharge to others and whether they would repeat the experience.

The findings of this study were discussed in Chapter 5 and compared to and contrasted with findings of other research reports. Whilst all women stated they chose to return home early, the informed choice of most women was challenged as 30 women were unaware of the early discharge programme until going home was mentioned. The support by family and friends was compared with recommendations found in the literature. Solutions to problems identified about the amount and timing of information given before discharge were offered. The women's experiences were compared to those found in other research reports and were found to be similar.

The final chapter examined the study's significance to midwifery education, practice and research. The strengths and limitations of the study were stated.

Conclusion

The final chapter has explored the implications of this study for midwifery education, practice and research, considered the study's strengths and weaknesses and reviewed the study. If the hospital stay following childbirth

continues to decrease midwives in the future must be prepared for roles in both the hospital and the community. Domiciliary midwifery represents an extended role and a renewed relationship with childbearing women where flexibility and the sharing of information are important issues. Further change in practice is inevitable as the health system and society change. Constant inquiry by practitioners and researchers can inform practice and education.

The main strengths of the study are its response to a community need and the high participation rate. Weaknesses are that results are not generalisable, the women chose to return home early and participants were a convenience sample over a two month period.

This study was an attempt to work with women by giving them an opportunity to talk about their early return home after having a baby in hospital, respond to a call for more research into women's experiences of a major life event as well as provide information to the community about early postnatal discharge. The findings of this study will inform local community members about the participant women's perceptions of choosing to return home early and support for breastfeeding problems, broaden midwives' knowledge of the women for whom they care and provide a baseline data for further research. If, as James et al. (1987, p. 438) state, early postnatal discharge without professional support "achieves the worst of both worlds" surely postnatal domiciliary midwifery schemes achieve the best of both worlds for childbearing women, who choose an early discharge from hospital.

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APPENDIX 1

Definition of Terms

Definition of Terms

Community

A number of people having common ties or interests and living in the same place (Barnhart, 1975, p. 426).

Early postnatal discharge

For the purpose of this study two time lines for early postnatal discharge are used. Following a caesarean section or surgical delivery early discharge occurs on day 5 or before. For a non surgical delivery early discharge occurs on day 3 or before.

Intra partum

Pertains to the period of labour and delivery (Glanze, 1990, p. 640).

Multipara

A woman who has delivered more than one viable infant (Glanze, 1990, p.775).

Post partum and postnatal

These words are used interchangeably. They mean after childbirth (Glanze, 1990, p.947).

Prenatal

Before birth and is used interchangeably with antenatal (Glanze, 1990, p. 957).

Primipara

A woman who has given birth to one viable infant (Glanze, 1990, p. 946).

Puerperium

The six weeks following childbirth when the anatomic and physiologic changes brought about by pregnancy resolve and the women adjusts to the expanded responsibilities of motherhood (Glanze, 1990, p. 986).

Supported early discharge

When a woman returns home within the defined times stated above and is cared for by a midwife at home. The woman will be visited once or twice daily until the baby is 7 days old. The time can be extended should the need arise.

Viable infant

An infant who at birth weighs at least 1000g or is 28 weeks or more of gestational age (Glanze, 1990, p. 1234).

Abbreviations

G.P.

General Practitioner

Ob.

Obstetrician

APPENDIX 2

Letter from CHERE

CHERE

Centre for Health Economics Research and Evaluation

University of Sydney

Division of Community Medicine, Westmead Hospital

Westmead, NSW 2145 Australia

Phone: (02) 633 6869 Facsimile: (02) 689 1049

Director: Dr. Jane Hall

1st June 1994

Dear Joyce,

Thanks for your letter of 30th May. Its always great to hear our discussion papers are of interest and use beyond the immediate project they considered!

The research team here is quite happy for you to use some of the questions from our questionnaire, but I should point out that it has not been formally tested for reliability or validity. However, if it had been validated, utilising only some of the questions instead of the whole questionnaire would I think invalidate them anyway.

We would be grateful to be acknowledged within the research and on your questionnaire. I would be particularly interested in a copy of your questionnaire because as the Survey Manager here I collect them.

Best wishes for your dissertation. Its a great topic!

Yours sincerely,



**Sue Cameron
on behalf of the team**

APPENDIX 3

Objectives of Domiciliary Midwifery Service

Objectives of the Domiciliary Midwifery Service

1. To provide quality comprehensive postnatal care within the home environment for clients meeting the stated criteria.
- *2. To minimise family separation and facilitate parent/child bonding.
- *3. To provide up to date information and support with parent craft skills on an individual basis.
4. To provide follow-up on postnatal procedures required at home.
- *5. To assist families to identify common problems in the early postnatal period and provide referral to appropriate services where necessary.
- *6. To assist families adapt to parenthood through the provision of advice, information and support.
7. To offer care, support and information to families returning home following stillbirth or neonatal death.
- *8. To increase choice by providing a mother with the option of giving birth in safe environment followed by an early return to her home and family.
9. To reduce pressure on obstetric beds by reducing the period of postnatal hospitalisation.
- *10. To promote pregnancy and childbirth as states of wellness rather than states of illness (QV Home Support Service, 1993, p. 1).

APPENDIX 4

Interview Schedule

Interview Schedule

Demographic Data

What is your age? *
Do you have other children? *
What are the ages?
From whom did you receive prenatal care? *
Where did you attend prenatal classes? *
Was the early postnatal discharge scheme mentioned?
What type of delivery did you have?
How old was your baby at discharge?
What is your residential suburb? *
How long have you lived here?

Choice

How did you first learn about the early postnatal discharge scheme? *
Was early discharge your choice?

Length of Stay in Hospital

Was your hospital stay just right, too long or too short? *

Influencing Factors

What factors influenced you to take an early discharge? *

Confidence

How confident did you feel about caring for your baby when you first came home? *
How confident do you feel now? *

Support within the home from family and friends

Who usually helps you with housework, cooking, child care? *
Who has helped you since you returned home from hospital? *

Expected and Actual Gains of Returning Home Early

What did you expect to gain by returning home early? *
Did you gain those things? *

Information Given

Were you given enough information to meet your needs when you first arrived home?
What information had been particularly helpful?
What else would you like to have been told?
Would it have been helpful to have had the information in the form of a booklet?

Infant Feeding

What method of infant feeding are you using? *

Is this what you planned to do? *

How is feeding progressing? *

Perception of physical and emotional health

How would you describe your physical health? *

How did you think you would feel? *

How would you describe your emotional health? *

How did you think you would feel? *

Ability to Cope

How do you feel you are coping with the new baby, your home and your family? *

Baby's Wellbeing

How is baby progressing? *

Source of Other Help Since Returning Home

Do you have telephone numbers of other people or agencies who may help you?

Have you sought help from or been referred to other people or agencies?

From whom did you seek help?

Recommend and Repeat

Would you recommend early Postnatal discharge to other women?

Would you again return home early if you had another baby?

Is there anything else you would like to say about your experience of returning home early after having your baby?

APPENDIX 5

Coding Sheet

Coding Sheet

The design for the coding sheet follows the guidelines outlined for the codebook in Burns & Grove (1987, p. 422). The responses of each participant were transferred to a coding sheet from the audio tape. The data from the coding sheets were entered on a computerised spreadsheet. The coding sheet denotes the column location of the data on the spreadsheet. The values of the descriptors of the variables are entered in rows after the identification number of each participant.

Data File Column	Variable Descriptors
1	Respondent identification number
Demographics	
2	Maternal age in years
	1. 17 - 20
	2. 21 - 25
	3. 26 - 30
	4. 31 - 35
3	Other children in family
	1. 0
	2. 1
	3. 2
	4. 3
4	Ages of children
5	Major professional prenatal care giver
	1. Clinic doctor
	2. Obstetrician
	3. Shared GP/Clinic Dr
	4. Shared Ob/GP
	5. GP
6	Attendance at antenatal classes
	1. Hospital this pregnancy
	2. Attended previous pregnancy
	3. Did not attend any pregnancy
7	Was the early postnatal scheme mentioned?
	1. Yes
	2. No
8	Type of Delivery
	1. Normal
	2. Forceps
	3. Caesarean Section
9	Age of baby at discharge
	1. 0.16
	2. 1
	3. 2
	4. 3
	5. 4
10	Residential suburb

Experiences

- 12-13 **Women's informants of the early discharge scheme**
1. Antenatally
 2. Postnatally
- 14-16 **Opinion of length of hospital stay**
1. Just right
 2. Too long
 3. Too short
- 17-18 **Early discharge by choice**
1. Yes
 2. No
- 19-20 **Factors that influenced the choice of early discharge**
1. Primipara
 2. Multipara
- 21-24 **Confidence levels**
1. Initially - Primipara
 2. Initially - Multipara
 3. At interview - Primipara
 4. At interview - Multipara
- 25-28 **Help in the home**
1. Usual help - Primipara
 2. Usual help - Multipara
 3. Since returning home - Primipara
 4. Since returning home - Multipara
- 29-32 **Help from extended family**
1. Some family member
 2. Parents/parents-in-law
 3. Family member other than parents
 4. Partner only adult help
- 33-34 **Expected gains and actual gains**
1. Expected
 2. Actual
- 35-36 **Information given in hospital was adequate to meet initial needs**
1. Yes
 2. No

37	What information had been particularly helpful?
38	What else would you like to have been told?
39-40	Helpfulness of an information booklet
	1. Primipara
	2. Multipara
41-44	Method of infant feeding
	1. Breast - Primipara
	2. Breast - Multipara
	3. Bottle - Primipara
	4. Bottle - Multipara
45-48	Planned method of infant feeding
	1. Breast - Primipara
	2. Breast - Multipara
	3. Bottle - Primipara
	4. Bottle - Multipara
49-50	Progress of infant feeding
	1. Primipara
	2. Multipara
51-54	Women's perceptions and expectations of physical health
	1. Perception - Primipara
	2. Perception - Multipara
	3. Expectation - Primipara
	4. Expectation - Multipara
55-56	Women's conclusions of physical health
	1. Primipara
	2. Multipara
57-60	Women's perceptions and expectations of emotional health
	1. Perception - Primipara
	2. Perception - Multipara
	3. Expectation - Primipara
	4. Expectation - Multipara
61-62	Women's conclusions of emotional health
	1. Primipara
	2. Multipara

- 63-64 **Perceptions of ability to cope with home and family**
1. Primipara
2. Multipara
- 65 **Women's perceptions of babies' progress**
- 66-67 **Requests for help from other professionals**
1. Yes
2. No
- 68 **Sources of professional help (other than midwife)**
- 69-70 **Recommend early postnatal discharge**
1. Yes
2. No
- 71-72 **Repeat early postnatal discharge**
1. Yes
2. No

APPENDIX 6

Criteria for Referral

**Maternity Hospital's Criteria for Referral to Early
Discharge Programme**

1. A desire by the woman and her family to participate in the program. The option to withdraw at any time prior to discharge will be made clear.
2. Geographic inclusion. Living within 20 (later 25) km radius of the hospital.
3. A healthy infant.
4. A low risk client with no antenatal or intrapartum problems that would impact on postpartum recovery.
5. Medical approval for both the mother and baby to be discharged to the service.
6. Support within a suitable home environment. This includes a support person to assume household responsibilities and care for other siblings, connection to a telephone and appropriate communication ability of mother or support person.
7. Completion of an antenatal education program.
8. Mothers are required to have a GP.
9. Breast feeding mothers must have initiated breastfeeding.
10. Artificial feeders must be able to make up formulae and feed baby in the correct manner (QV. Home Support Service, 1994).

APPENDIX 7

Ethics Committee Approval Letter

9400 file

**LAUNCESTON GENERAL HOSPITAL**

File Reference:

Direct telephone:

22 September, 1994

Ms Chris Hooper,
Secretary,
University Ethics Committee (Human Experimentation),
University of Tasmania,
GPO Box 252C,
HOBART 7001

Dear Ms Hooper,

**re: WOMEN'S EXPERIENCE OF EARLY POSTNATAL
DISCHARGE FOLLOWING A HOSPITAL DELIVERY.**

I acknowledge receipt of your letter of the 15th July, 1994 in relation to the above application. This research project was considered by the Launceston General Hospital Medical Research Ethics Committee at its telephone conference held on the 21st September, 1994. I am pleased to advise that the committee approved this study for performance at the Launceston General Hospital.

Yours sincerely,

(Dr.) P.J. Renshaw,
REGIONAL PRINCIPAL MEDICAL OFFICER

PJR/dlw

OFFICE FOR RESEARCH

23 SEP 1994

APPENDIX 8

Approval Letter from Director of Obstetrics and Paediatrics



QUEEN VICTORIA HOSPITAL
7 High Street,
Launceston

Private Bag No. 5 Launceston
Tasmania Australia 7250
Telephone: (003) 32 7111

File No:
Contact:
Enquiries:
Fax: (003)

15th September 1994

Mrs Joyce Forrester
Tasmanian School of Nursing
University of Tasmania
PO Box 1214
LAUNCESTON TAS 7250

Dear Mrs Forrester,

**RE: Project: 'Women's Experience of Early Postnatal Discharge Following a
Hospital Delivery'**

This matter has been considered by the Executive of the Obstetric & Paediatric
Program.

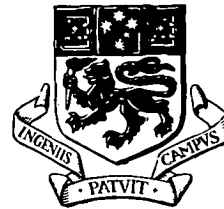
We are happy to confirm approval of this project.

Yours faithfully,

J.R. GROVE
DIRECTOR OF OBSTETRICS & PAEDIATRICS

APPENDIX 9

Information Sheet for Participants



UNIVERSITY OF TASMANIA

*Tasmanian School of Nursing
PO Box 1214
Launceston
Tasmania 7250
Australia*

Title:- Women's experience of early postnatal discharge following a hospital delivery.

The members of the research team

Chief investigator:-	Mrs Louise Venter	Tasmanian School of Nursing
Researcher:-	Mrs. Joyce Forrester	Tasmanian School of Nursing

Purpose of the study

The purpose of the study is to collect information from healthy postnatal women, who have delivered a healthy baby and taken an early discharge, with follow up by a midwife, from the Queen Victoria Hospital, Launceston. The information is to identify what women's experiences of early discharge were.

Participants in the study

The women, who will be asked to participate in the study, will be healthy, have delivered a healthy baby at the Queen Victoria Hospital in the months of September to November 1994, have taken an early discharge and been visited by a midwife of the Home Support Team. All participants will be a minimum of 17 years of age.

Study details

If you consent to participate in the study you will be asked questions such as:- what were the advantages for you of early discharge, what did you expect to gain, what did you actually gain, are you confident about your chosen method of feeding your baby, who helped you within the home, how are you feeling now, how confident do you feel about caring for your baby, how is your baby? The interview will take approximately one hour and with your permission would ordinarily be conducted in your place of residence. If you agree the researcher will audio tape the interview, so that you receive the interviewer's full attention, as well as record your responses on a questionnaire.

Are risks or discomforts anticipated?

The members of the research team cannot foresee any risks or discomforts for participants. Any communication with the participants will be undertaken in a manner to maintain dignity and self esteem.

Protection of confidentiality

All information from the interview will be held in confidence and not be traceable to you as an individual. All data will be kept in a locked filing cabinet and identifiable data will be destroyed when the research process is complete. Should the research study be published participants are not named.

Participation choices

You are entirely free to participate or to refuse to participate in the study and to withdraw at any time without effecting your present or future relationship with the Queen Victoria Hospital. Participants, who choose to withdraw, will be offered an opportunity to discuss their feelings.

Ethics Committee approval

This research project has been approved by the Ethics Committee of the Launceston General Hospital. Also, it has the approval of Dr. J. Grove, Director of Obstetrics and Paediatrics.

Results of research

As a participant, if you wish to see the results of the research, a copy will be made available to you.

Information sheet and consent form

All participants will be given copies of the information sheet and statement of consent for their personal files.

Contact people for further information

Mrs. Louise Venter Tasmanian School of Nursing, University of Tasmania, Launceston campus.
Tel. No. (003) 243318

Mrs. Joyce Forrester Tasmanian School of Nursing, University of Tasmania, Launceston campus.
Tel. No. (003) 243318

People who may be contacted if there are any concerns of an ethical nature, or if there are any complaints about the manner in which this research project is being conducted.

Dr. Margaret Otlowski Acting Chair, University of Tasmania Ethics Committee, Department of Law, University of Tasmania Sandy Bay Campus. Tel. No. (002) 231 987

Ms. Chris Hooper Secretary, University of Tasmania Ethics Committee, Office of Research, University of Tasmania Sandy Bay Campus. Tel. No. (002) 202 763

APPENDIX 10

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH INTERVIEW

Study title:- Women's experience of early postnatal discharge following a hospital delivery.

You have been asked to speak with a researcher about your experiences of early postnatal discharge from the Queen Victoria Hospital. You will be asked questions about your experiences and also be given an opportunity to elaborate on your responses. In order that you receive full attention during the interview we ask your permission to audio tape the conversation.

You are free to choose not to participate in this study or to withdraw your consent at any time. Your consent, dissent and any information that you give will not effect the present or any future relationship you may have with the Queen Victoria Hospital.

Identifiable information will be known only to the two people whose names appear at the bottom of the form. Information from the interview will be used in the results and discussion of the research but we will ensure that it is not possible to trace your individual contribution.

If having read the above statement you agree to be interviewed please sign the following declaration:-

I have read and understood the information sheet and the above details and any questions I have asked have been answered to my satisfaction.

I agree - to the interview being audio taped,
- that the information gathered for this study may be published providing my name is not used.
- to participate in the interview realising that I may withdraw at any time

Name of participant

Signature of participant

Date

I have explained the study to the participant and I believe the consent to be informed.

Name of researcher

Signature of researcher

Date

Should you have any queries about this research please feel free to contact:-

Mrs. Louise Venter

Tasmanian School of Nursing
Tel. No. (003) 243318

Mrs. Joyce Forrester

Tasmanian School of Nursing
Tel. No. (003) 243318

10.2.97

Dear Isobel,

Here is the final copy of my Thesis. To go for hard

binding in the schools colours.

In addition to the ones for the School, the Uni library & me

wonder if it would be possible to have a copy done for

the local library at the Royal Hobart Hospital. Don't worry

this is not possible, within the budget. I'll get something

sorted out

Regards

Catherine