Impact of Educational Program for Mothers' Knowledge Regarding Care of Pre-term Infants in General Hospitals in Port Said

Hoda EL-Gawly; Mohamed EL-Kalioby; Soheir Dabash;, Amal Khalil , Azza fathy Atyia.

The Department of Pharmacology, Faculty of Medicine Suez Canal University; the Department of Pediatric Medicine, Faculty of Medicine Suez Canal University; the Department of Pediatric Nursing, Faculty of Nursing Cairo University; the Department of Pediatric Nursing, Faculty of Nursing; Port Said University; the Department of Pediatric Nursing, Faculty of Nursing, Port said University

_____

Abstract

Background: Having a premature infant is one of the most stressful experiences a parent can have. Most parents find it very difficult to go through the experience of having their baby in a Neonatal Intensive Care Unit (NICU) without needing emotional support. Nurses play a vital role in helping parents by developing therapeutic relationships, providing emotional support, providing parents with accurate, clear information, involving parents in providing care for their premature infants and encourage parents to ask questions and get the information they need.

Aim: The aim of this study was to study the impact of home care program on mother's knowledge regarding care of pre-term infant.

Materials and Methods: A quasi-experimental study was carried out at the neonatal intensive care units at El Naser, general Port Fouad hospitals and maternal and child health (MCH) centers representing at Port-Said city. The sample comprised 100 mothers' study and control groups.

Results: The results indicated that the implementation of a well designed applied educational program proved to be successful in improving mothers' knowledge.

Conclusion: An educational program for mothers having preterm infant showed significant impact on their knowledge regarding care of pre-term infant.

Recommendation: The study recommends implementation of the present study intervention in the study setting and in similar settings to confirm its beneficial effects and to further improve its content and process

Key words: Nursing care of pre-term infant, emotional support, -needs of pre-term infant

Introduction

THE birth of a preterm infant and hospitalization in the Neonatal Intensive Care Unit (NICU) disrupts the expected development of interactive skills for both the parent and the infant. The preterm infant's extensive period of hospitalization in the neonatal intensive care unit (NICU) impairs the establishment of maternal bonding and attachment. This separation favors mothers' feelings of insecurity toward taking care of her preterm infant. Moreover, most preterm infants are born ill and the mothers, in this context, experience several feelings, like fear, uncertainty, and anguish. (Talmi & Harmon, 2003).

Having a preterm infant is one of the most stressful experiences a parent can have. Most parents find it very difficult to go through the experience of having their preterm infant in a NICU without needing emotional support. It is normal for parents to feel overwhelmed by stress and confused by their feelings. There are also ongoing pressures and worries because pre-term infant are biologically younger and less developed than full-term infants, as they need emotional support from caregivers (Torpy et al., 2009).

Parents need guidance in their relationships with their infants and assistance in their efforts to meet their infant's physical and developmental needs. The nursing staff must help parents understand that their preterm infant offers few behavioral rewards and show them how to accept small rewards from their infant. The significance of early parent infant interaction and infants stimulation has been recommended by reliable researchesand nurses' awareness of these infant's family needs must incorporate activities that facilitate family interaction into the nursing care plan. Therefore, parents need guidance throughout the infant's hospitalization to help prepare them for this new experience. (NANN, 2005 and Schulte et al., 2001).

The significance of early parent-child interaction and the infant stimulation has been documented by reliable research. Parents need help to understand the infant's condition and what is expected to occur throughout the hospital stay. They find themselves simultaneously coping with their own needs, namely the needs of their infant and the needs of their families. They are faced with multiple crises and over whelming feelings of responsibility, expenses and frustration. The nurse being aware of their infant and family needs, must incorporate activities

that facilitate family interaction into the nursing care plan (Miles et al., 1996 and Henderson & Brownstein, 1994)

The discharge planning for the preterm infants should begin early in the hospital course. The goal of the discharge plan is to identify home care provided by the mother and/or those responsible for care of the premature infants, describe care given to the premature infants at home and describe aspects that interfere with the premature infants care process to ensure successful transition to home care. Home care needs of the infants' parents are assessed and steps are taken to eliminate any knowledge deficits. Parent education include having them give return demonstrations of their infants care skills to show whether they are becoming increasingly independent in the provision of this care (Perry, 2006 and Rollant et al., 2001).

Therefore, parents need guidance throughout the preterm infants' hospitalization to help prepare them for this new experience. They may be disheartened by the unattractive appearance of the preterm infant**.** The goal of the nurse will be to prepare for discharge and home care**.** The nurse must know the family members, their social circumstances, accepting all and every variations. Meeting their needs are all the nurse's responsibilities. So the nurse should be prepared to assist mothers in this transition process, and provide instructions in term of her responsibility and dedication in view of the preterm infant's health condition (Vaskelyte & Butkeviciene, 2010 and Ashwill & Droske, 2002).

The parents must be educated in the proper care of their infant, to ensure proper infant safety and they need to be confident in routine infant care, as well as any special care the infant requires, and hygiene care, e.g., cord care, sponge bath, feeding, etc (Litteton & Engebretson, 2002). Additionally, instructions in preventing infection should be a priority-teaching goal. Follow up visits are scheduled and any home health care needs identified and met. The nurse should stress the importance of well preterm infant examination and immunization for this preterm infant (Schulte et al., 2001).

Significance of the Study:

Because the preterm infants need for better care have drawn the increasing concern and effort of all those working with them particularly the mother. Therefore, this study involves the implementation of educational program for mothers having preterm infant for developing mother's competencies for proving safe care to their premature infants.

Aim of the study:

The aim of this study was to assess pre-mature infants' mothers' knowledge about care of their pre-mature infant, plan and implement an educational program about care for these mothers, and evaluate the impact of the program on mother's knowledge

Materials and Methods

Study Design: A quasi-experimental controlled study design was used to assess pre-mature infants' mothers' knowledge about care of their pre-mature infant, and evaluate the impact of the program on mother's knowledge.

Setting: The study was carried out at the general hospitals in Port Said at El Nasr and, Port Fouad General Hospital, and maternal and child health (MCH) centers for follow-up.

Sample: It involved mothers with their preterm neonate (26 to 37 weeks) hospitalized in the NICU. Mothers were divided into a study group (50) to whom the homecare study intervention was applied, and a control group of same size (50) who received the standard hospital care.

Data collection tools:

Two tools were developed and used by the researcher for data collection.

Tool I: Structured Interviewing questionnaire for the mothers:

(A) Interview Questionnaires Sheet*:*

This was designed and constructed by the researcher after reviewing the related literature and getting experts' opinion to assess mothers' knowledge about home care of the pre-term infant, the questionnaire was composed of two parts:

Part (I): Socio demographic data and maternity history of the mothers. It include: mothers' age, level of education, job status , maternity history as gravidity, parity, number of live birth, mode of previous delivery, and history of previous preterm delivery.

Part (2): Mother's Knowledge related to preterm infant and home care. It covered the area of prematurity (definitions, care of the pre-term including sleep, warming skin care, prevention of infection, breast-feeding and kangaroo care, management of some premature problems, helping respiration and dangerous signs). This part was applied before the beginning of the program (pre-test), immediately at the end of program implementation (post-test 1) and two months later during follow up (post-test 2).

Scoring:

For the knowledge items, a correct response was scored 1 and the incorrect response zero. For each area of knowledge, the scores of the items were summed-up and the total divided by the number of the items, giving a mean score for the part. These scores were converted into a percent scored and means and standard deviations were computed. Knowledge was considered satisfactory if the percent score was 50% or more and unsatisfactory if less than 50%.

(B) Neonatal Initial Assessment Sheet:

This tool was developed in order to record the physical assessment findings of the preterm infant in hospital *it consisted of two parts:*

Part (1):   Neonate's characteristics as name, gender, gestational age, date of admission, diagnosis on admission (causes of admission), weight on admission, and current diagnosis.

Part (2):   Assessment of the preterm infant in incubator (during hospitalization) by the researcher. This was carried out three times: the first when the neonate was admitted, the second when the neonates' feeding pattern change from IV to oral and the third upon discharge.

Assessment included:

▪   Vital signs: body temperature, epical pulse rate, and respiration rate.

▪   Anthropometric measurement: weight, length and head and chest circumference.

▪   Skin condition: color, dryness and rash.

▪   Nutritional status: assessment of related reflexes (Sucking, rooting, swallowing), and route of feeding (oral, nasogastric, or intravenous).

▪   Level of activity: poor, weak, good, or strong.

Results

Table (1) represent to the demographic characteristics and obstetric history of mothers in the study and control groups. It is clear from the table that mothers had an almost equal mean age of about 27years (27.2±5.2-27.8±5.5) respectively. More than half of mothers in both the study and control groups had Basic/intermediate level of education (54.0% and 66.0%) respectively, and the majority of them were housewives, (86.0% and 84.0%) respectively. More than half of the mothers in the study and control groups were multigravida (56.0% and 70.0%), had two or more living children (50.0% and 58.0%) and had history of preterm delivery (52.0% and 56.6%) respectively. It also noticed that more than three fifths of the mothers of the study and control groups (62.0% & 72.0% respectively) had history of cesarean section delivery

Concerning Characteristics of preterm neonates and current diagnosis in the study and control groups and their period of hospital stay, the table shows that more than half of neonates (52.0%) were males in study groups, while 42.0% in control. Most of neonates in the study and control groups (82.0% - 84.0%) were of gestational age ranged between 32-36 weeks, with an almost equal mean of about 33 weeks. As for the duration of hospital stay, the mean of hospital stay at the study group was. 17.8±6.0 while in control group were 19.2±5.8 days. The same table indicated that, the majority of both the study and control group had respiratory distress currently (90.0% and 84.0%, respectively). While, the minority in both groups had jaundice (10.0%, 16.0%,respectively) (Table 2).
.

Table (3) represent to the comparison between the study and control groups regarding their knowledge about home care of preterm infants pre/post and follow up the implementation of the program. Shows the mothers' knowledge about prematurity definition, needs of preterm infant, feeding (advantage of breast feeding and practice of breast feeding), prevention infection, practice of kangaroo care management of some problem of prematurity, helping respiration, and identify the dangerous signs among mothers in study and control groups proved to be very deficient at the pre intervention phase, with no statistically significant differences. Immediately after implementation of the program, all mothers in the study group had satisfactory knowledge in almost all areas, this improvement continued through the follow-up phase. On the other hand, the control group mothers' knowledge in the control group continued to be unsatisfactory, and the differences between the study and control groups were all statistically significant at both the post and follow-up phases (p<0.001).

Table (4) represent to the comparison between the total mean score of Knowledge about prematurity among mothers in the study and control groups throughout pre/post and follow up the implementation of the program Demonstrates a statistically significant improvement in the knowledge mean scores of mothers in the study group and control group throughout the program phases. However, the score mean in the study group increased from a pre-program level of 21.94% to 91.7% at the post, and slightly dropped to 88.41% at the follow-up phases. Meanwhile, the mean score of the control group slightly increased from 20.73% at the pre-test to only 27.75% at the follow-up phase.

Table (5) represent to the best fitting multiple linear regression model for the score of knowledge among mothers Represents the best fitting multiple linear regression models for the score of knowledge among mothers. It was shown that the study group and mother's working status are the statistically significant independent positive predictors of knowledge score. The model explains 47% of the variation in this score. Other factors as mother age, education, parity, number of living children, and history of preterm delivery have no significant influence on knowledge score.

Discussion

The present study demonstrated that mothers in both the study and control groups had major deficiencies in their knowledge about prematurity before the intervention. where, none of the mothers in either group had satisfactory knowledge. The only area with some satisfactory knowledge was that of skin care, which could be due to their observation of the nurses while providing this service. This knowledge deficiency among mothers could have a negative impact on their preterm infants as this may negatively influence their practices. In congruence with this, Lima De Souzal (2010); Dragovich et al. (2008) emphasized that, limited knowledge, or incorrect knowledge of temperature control, umbilical cord care and danger signs could increase morbidity and mortality in neonates.

Results similar to these current study findings were also reported in a study in Singapore by Gale et al. (2004); Lian et al. (2008). These authors demonstrated a significant gap in parents' knowledge about prematurity. They clarified that given the high impact of a premature infant upon the family, both emotionally and financially, this gap needs to be remedied urgently. Public forums and talk could be held by relevant professional at hospitals and public venues to raise awareness.

The lack of mothers' knowledge about prematurity and preterm infants' care revealed in the present study as well as in previous studies may have a number of explanations. The effect of mothers' educational and cultural backgrounds may play a role in this deficiency, although Boykova (2008) confirmed the idea that parental concerns are similar between cultures and not influenced by culture or geographical settings.

Other factors may underlie this lack of knowledge such as the general belief that premature infants are more fragile and less capable than full-term infants, and mothers' concerns about their infants' vulnerability to illness, injury, and delayed development, and this may influence their interaction with their infants (Stern et al., 2000). Moreover, these mothers may be intimidated by the NICU environment, which may result in delayed maternal attachment (Heermann et al., 2005; Shin & White-Traut, 2007).

The implementation of the present study educational program led to significant improvements in mothers' knowledge in the study group. This was shown immediately after the program (posttest), and continued through the follow-up phase. The improvement was demonstrated in all areas and in the total knowledge. This indicates that the intervention program achieved its first objective of improving mothers' knowledge about prematurity.

A similar success was reported by Weiner et al., (2011) who emphasized that simple, easy-to-understand and easy-to-teach intervention have been shown to reduce neonatal morbidity and mortality. On the same line, package of health education provided by health workers to pregnant women to identify premature and LBW infants resulted in an approximately 60% reduction in neonatal mortality (Moss et al., 2002).

Furthermore, Browne & Talmi (2005) documented that implementing family-based interventions for parents whose infant is in the NICU will enhance parental knowledge and sensitivity and decrease stress, which promotes effective parenting roles. On the same line, Broedsgaard & Wagner (2005); Dokken & Ahmann, (2006) demonstrated that the implementation of educational intervention that increased parental support, met parental needs, increased parental feelings of well being, and increased parents' ability to provide care for their infant. Therefore, Stringer et al. (2004) recommended that nurses help mothers to manage their stress by listening to them, by providing ongoing information, and by involving parents in decision-making.

The positive effect of the present study intervention program on mothers' knowledge was further confirmed by multivariate analysis, which demonstrated that intervention was a statistically significant independent positive predictor of the knowledge score. This success of the program may be attributed to the fact that it was custom-tailored to mothers' needs, in addition to its simplicity and practicability. The response to mothers' needs of information is essential in such programs as indicated in previous studies that showed that parents of the infant's in the NICU were struggling to understand information and that they depended mainly on nurses who gave them booklets related to prematurity (Wocial, 2000; McHaffie et al., 2001; Kowalski et al., 2006).

Conclusion:

Based on the results of the present study, it can be concluded that:

The implementation of well designed applied intervention educational program for mothers about care of premature infants proved to be successful in improving their knowledge.

Recommendations:

The study recommends the implementation of the educational program for mothers` knowledge regarding care of pre-term infant intervention in NICU to confirm its beneficial effects and to further improve its content and process. Training sessions and educational classes should be planned in the hospital for mothers, with educational materials

References

Ashwill JW. and Droske SC. (2002). Nursing Care of Children: Principles and Practice. London: W.B. Saunders Company; P.p. 72-74.

Boykova M. (2008). Follow-up care of premature babies in Russia: evaluating parental experiences and associated services. Infant; 4(4): 126-30.

Broedsgaard A. and Wagner L. (2005). How to facilitate parents and their premature infant for the transition home. International Nursing Review; 52(3): 196–203.

Browne V. and Talmi A. (2005). Family-based intervention to enhance infant-parent relationships in the neonatal intensive care unit. Journal of Pediatric Psychology.; 30(8): 667–677.

Dokken D. and Ahmann E. (2006). The many roles of family-centered care. Pediatric Nursing; 32(6): 562–565.

Dragovich D., Tamburlini G., Alisjahbana A. and Kambarami R. (2008).Thermal control of the newborn: knowledge and practice of health professionals in seven countries Article first published online: 21 JAN DOI: 10.1111/j.1651-2227. Issue Acta Paediatrica; Volume 86, Issue 6; P.p. 645–650.

Gale G., Franck SL., Kools S. and Lynch M. (2004). Parents' perceptions of their infant's pain experience in the NICU. International Journal of Nursing Studies; 41(1): 51–58.

Heermann JA., Wilson ME. and Wilhelm PA. (2005). Mothers in the NICU: Outsider to partner. Pediatric Nursing; P.p. 31:176-181, 200.

Henderson P. and Brownstein (1994). Pediatric Emergency Nursing Manual. U.S.A.: Spring Publishing Company; P.p. 1-65.

Kowalski W., Leef K., Mackley A., Spear M. and Paul D. (2006). Communicating with parents of premature infants: who is the informant? Journal of Perinatology; 26(1): 44–48.

Lian C., Ying K., Peng C. and Yann T. (2008). Early Discharge Study for Premature Infants: Singapore General Hospital Perm J Fall; 12(4): 15–18.

Lima de Souza1 N., Ana C., Pinheiro F., Clara-C., Bertha E., Jovanka C. and Lourdes M. (2010). Domestic maternal experience with preterm newborn children; J of public health; Volume 12 (3): 356-367.

Littleton L. and Engebretson J. (2002): Maternal, neonatal, and women' health nursing. United Kingdom: Delmar; P.p. 1121-1165.

McHaffie H., Laing I., Parker M. and McMillan J. (2001). Deciding for imperiled newborns: Medical authority or parental autonomy? Journal of Medical Ethics.; 27: 104–109.

Milles M., Garlson J. and Funks G. (1996). Sources of Support Reported by Mothers and Fathers of Infants Hospitalized in Neonatal of Intensive Care Unit. Maternal Child Nursing Network.; 15(3): 45-51.

Moss W., Darmstadt G., Marsh D., Black R. and Santosham M. (2002). Research priorities for the reduction of perinatal and neonatal morbidity and mortality in developing country communities.; J Perinatology; 22: 484-95

National Association of Neonatal Nurses (NANN) (2005). Parent needs developmentally supportive care. Pediatrics J; 21(1): 1 – 7.

Perry S. (2006). Maternal child nursing care 3rd ed., United States. Mosby Elsevier; P.p. 795-825.

Rollant PD., Hamlin JJ. and Piotrowskii KA.(2001). Mosby's Rapid review Series Maternal Child Nursing. 2nd ed., London: C.V. Mosby, A. Harcourt Health Sciences Company; P.p. 315-3330.

Schulte E., Price D. and Gwin J. (2001). Thompson's pediatric Nursing: An Introductory text. United States of America: W.B. Saunders Company; P.p. 67-77.

Shin H. and White-Traut R. (2007). The conceptual structure of transition to motherhood in the neonatal intensive care unit. Journal of Advanced Nursing; 58(1): 90–98.

Stern M., Karraker K., Meldrum A. and Norman S. (2000). The prematurity stereotype revisited: impact on mother's interactions with premature and full-term infants. Infant Mental Health Journal; P.p. 21: 495–509.

Stringer M., Miesnik S., Brown L., Martz AH. and Macones G. (2004). Nursing care of the patient with preterm premature rupture of membranes. American Journal of Maternal Child Nursing; 29(3): 144–150.

Talmi A. and Harmon R. (2003).Relationships between preterm infants and their parents: Disruption and Development, 24(2): 13–20.

Torpy J., Lynrn C. and Glass R. (2009). Premature infants. JAMA, 301(21): 290.

Vaskelyte A. and Butkeviciene R. (2010). Needs of parents with premature newborns in the Neonatal Intensive Care Unit: parents' and nurses' perceptions. Medicina (Kaunas). 46 Suppl 1: 43-53.

Weiner E., Billamay S., Partridge J. and Martinez A. (2011). Antenatal Education for Expectant Mothers Improves Knowledge: Nature Publishing Group National Center for Biotechnology Information, U.S. National Library of Medicine Discussion Medscape Nurses; 31(2): 92-97 .

Wocial LD. (2000). Life support decisions involving imperiled infants. Journal of Perinatal & Neonatal Nursing; 14(2): 73–86.

Table (1): Distribution of the study and control groups according to their characteristics

Characteristics	Group Study (n=50)		Control (n=50)		χ^2 test	p-value
	No.	%	No.	%		
Age (years):						
<25	18	36.0	15	30.0		
25-	16	32.0	15	30.0	0.75	0.69
30+	16	32.0	20	40.0		
Range	19.0-40.0		18.0-40.0			
Mean± SD	27.2±5.2		27.8±5.5		t=0.38	0.54
Educational level:						
Illiterate	8	16.0	3	6.0		
Basic/intermediate	27	54.0	33	66.0	2.91	0.23
High	15	30.0	14	28.0		
Job status:						
Housewife	43	86.0	42	84.0		
Working	7	14.0	8	16.0	0.08	0.78
Gravidity:						
Primigravida	22	44.0	15	30.0		
Multigravida	28	56.0	35	70.0	2.10	0.15
Living children:						
1	25	50.0	21	42.0		
2+	25	50.0	29	58.0	0.64	0.42
Mode of delivery:						
Vaginal delivery	19	38.0	14	28.0		
Cesarean	31	62.0	36	72.0	1.13	0.29
History or pre-term delivery:						
No	24	48.0	22	44.0		
Yes	26	52.0	28	56.6	Fisher	1.00

Table (2): Characteristics of preterm neonates and current diagnosis in the study and control groups and their period of hospital stay

Characteristics of preterm neonates	Study (n=50)		Control (n=50)		χ^2 test	p-value
	No.	%	No.	%		
Gender:						
Male	26	52.0	21	42.0		
Female	24	48.0	29	58.0	1.00	0.32
Gestational age(weeks):						
<32	9	18.0	8	16.0		
32-36	41	82.0	42	84.0	0.07	0.79
Range	28.0-36.0		28.0-36.0			
Mean± SD	33.0±2.4		33.3±2.5		t=0.64	0.42
Hospital stay (days):						
<=10	8	16.0	9	18.0		
11-	21	42.0	10	20.0	5.89	0.053
20+	21	42.0	31	62.0		
Range	7.0-28.0		10.0-30.0			
Mean± SD	17.8±6.0		19.2±5.8		t=1.69	0.19
Current diagnosis:						
Respiratory distress	45	90	42	84.0	1.52	0.217
Jaundice	5	10	8	16.0	Fisher	0.591

Table (3): Comparison between the study and control groups regarding their knowledge about home care of preterm infants pre/post and follow up the implementation of the program

Satisfactory knowledge about (50%+)	Time (%)								
	Pre			Post			FU		
	Study N=50	Control N=50	χ^2test (p-value)	Study N=50	Control N=50	χ^2test (p-value)	Study N=50	Control N=50	χ^2test (p-value)
1. Definition of Prematurity	12.0	4.0	Fisher (0.27)	100.0	4.0	92.31 (<0.001)*	100.0	2.0	96.08 <0.001*
2.Needs of the premature									
Sleep	6.0	2.0	Fisher (0.62)	98.0	2.0	92.16 <0.001*	100.0	0.0	100.00 <0.001*
Warming	2.0	0.0	Fisher (1,00)	98.0	0.0	56.08 <0.001*	100.0	0.0	100.00 <0.001*
Feeding Advantages of breastfeeding	12.0	10.0	10.70 (0. 21)	100.0	2.0	96.08 <0.001*	100.0	0.0	100.00 <0.001*
Practice of breastfeeding	10.0	6.0	4.33 (0.14)	100.0	6.0	88.68 <0.001*	100.0	6.0	88.68 <0.001*
Skin care	20.0	18.0	0.06 (0.80)	100.0	18.0	69.49 <0.001*	100.0	38.0	44.93 <0.001*
Prevention of infection	4.0	2.0	Fisher (1.00)	100.0	2.0	96.08 <0.001*	100.0	2.0	96.08 <0.001*
Advantages of kangaroo care	10.0	6.0	0.06 (0.80)	100.0	6.0	69.49 <0.001*	100.0	38.0	44.93 <0.001*
Practice of kangaroo care	0.0	0.0	0.00 (1.00)	100.0	0.0	100.00 <0.001*	100.0	0.0	100.00 <0.001*
3.Management of some premature problems	0.0	0.0	0.00 (1.00)	100.0	0.0	100.00 <0.001*	100.0	0.0	100.00 <0.001*
4.Helping respiration	0.0	0.0	0.00 (1.00)	100.0	0.0	100.0 <0.001*	100.0	0.0	100.00 <0.001*
5.Identyfy dangerous signs	0.0	0.0	0.00 (1.00)	100.0	0.0	100.00 <0.001*	100.0	0.0	100.00 <0.001*

(*) Statistically significant at p<0.05

Table (4): Comparison between total Mean Score of Mothers' Knowledge about prematurity among mothers in the study and control groups throughout pre/post and follow

Total knowledge score	Time						Kruskal Wallis test	p-value
	Pre test		Post test		Follow up test			
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*		
Study group	21.94	8.86	91.07	4.13	88.41	2.77	107.53	<0.001*
Control group	20.73	7.50	20.73	7.50	27.75	4.55	32.90	<0.001*

(*) Statistically significant at p<0.05

Table (5): Best fitting multiple linear regression model for the score of knowledge among mothers.

	Unstandardized Coefficients		Standardized Coefficients	t-test	p-value
	B	Std. Error			
Constant	110.367	4.324		25.522	<0.001*
Job: (reference: none)	7.039	3.810	.078	1.848	0.066
Group: (reference: control)	44.214	2.721	.685	16.251	<0.001*

r-square=0.47

Model ANOVA: F=89.12, p<0.001

Variables excluded by model: age, education, parity, living children, history of pre-term delivery

تأثير برنامج تعليمي علي معلومات الامهات عن الرعاية لأطفالهن المبتسرين بالمستشفيات العامة ببورسعيد

د / هــدى الـجـاولــى ـ د/ مـحـمد القـليوبي ـ د/ سهير ضبش ـ.د/ أمـل خـليل- م.م / عـزة فتحي

أستاذ الأدوية كلية الطب جامعة قناة السويس ـ أستاذ طب الأطفال كلية الطب جامعة قناة السويس ـ أستاذ مساعد تمريض الأطفال كلية التمريض جامعة القاهرة ـ أستاذ تمريض الأطفال كلية التمريض جامعة بورسعيد- مدرس مساعد تمريض الأطفال كلية التمريض- جامعة بورسعيد

الـخـلاصــة

ولادة طفل مبتسر ودخوله وحدة العناية المركزة للأطفال حديثي الولادة امر صعب جدا عند كثير من الاباء ومـن اكثر التجـارب المرهقـة لـهم دون الاحتيـاج الـي دعـم عـاطفي حيـث يشـعرون بالإجهـاد والاضطراب في المشاعر لذلك فان الاباء يحتاجون الي التوجيه والمساعدة لبذل جهودهم نحو مقابلة الاحتياجات الطبيعية والتطورية لأطفالهم المبتسرين .ان دور الممرضة هو الحفاظ علي اطلاع الآبـاء بالمعلومات اللازمة عن حالة الطفل وتقدمه.

الدراسـة الحاليـة دراسـة شبة تجريبيـة هدفها تقييم تـأثير برنـامج تعليمـي صـحي للأمهـات عن الرعاية لأطفالهن المبتسرين. نفذت هذه الدراسة بالمستشفيات العامة ببورسعيد في وحدات العناية المركزة للأطفال حديثي الولادة و مراكز رعاية الامومة والطفولة ١٠٠ أم وأطفالهم المبتسرين مقسمين الى ٥٠ ام فى مجموعة الدراسة و ٥٠ ام فى مجموعة المقارنة(الضابطة). وقد تم استخدام ادوات لتحقيق هدف الدراسة وهما استمارة استبيان لقياس معلومات الامهات المتعلقة بعناية الطفل المبتسر داخل المنزل و استمارة استبيان وتقييم عن الطفل داخل المستشفي وعند خروجه و وقد وجد ان معلومـات الامهـات لكل من العينة التجريبية والعينة الضابطة غير مرضي قبل البرنامج ،بينما البرنامج التدخلي ادي الي تحسين معرفة الامهات وهذا التحسن احتفظ علي مدار الاربع شهور متابعة ، وكانت الفروق ذات دلالة احصائية .اوصت الدراسة بتطبيق هذا البرنامج في اماكن الدراسة و اماكن مماثلة لتأكيد اثاره المفيدة ولتحسين مضمونه .

الكلمات الدالة : العناية التمريضية للطفل المبتسر احتياجات الطفل المبتسر –الرضاعة الطبيعية–الدعم العاطفي .