

# Perceptions and Practices of Parents in Caring for their Hospitalized Preterm Infants

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**Abstract:** Hospitalized preterm infants are separated from parents in many countries, including Thailand, neonatal care has promoted parental involvement in caring for their infants to support breastfeeding and parent-infant bonding. This descriptive qualitative approach aimed to gain a better understanding of Thai parental involvement in caring for hospitalized preterm infants. Purposive sampling was used to select 22 parents, two grandmothers, and three nurses at a sick newborn unit of a regional hospital in Eastern Thailand. Data were collected through in-depth interviews, participant observation and clinical document reviews, from September 2014 to October 2015. The data were analyzed by using a thematic analysis.

The findings revealed parents' perceptions and caregiving practices regarding their involvement in caring for hospitalized preterm infants that could be categorized into five categories, 1) uncertainty about their child's condition, 2) desire to be close to their preterm babies, 3) lack of confidence in providing care for their preterm babies, 4) overcoming difficulties in breastfeeding, and 5) socio-cultural factors influencing parental involvement. Parental involvement in caring for hospitalized preterm infants is crucial to the quality of infant care. The findings of this study could assist in evidence for developing a nursing intervention program to enhance and support parental involvement in caring for preterm infants.

*Pacific Rim Int J Nurs Res* 2017; 21(3) 220-233

**Keywords:** Descriptive qualitative study, Hospitalized preterm infant, Parents, Parental involvement, Premature infants, Thailand

## Introduction

The World Health Organization (WHO) estimates that approximately 15 million babies are born premature every year.<sup>1</sup> In Thailand, about 80,000 babies are born preterm annually, accounting for around 8-10% of all live births.<sup>2</sup> Preterm infants are considered a high risk group due to their physiological immaturity and instability, and the prolonged intensive care required for their survival.<sup>3</sup> Preterm birth and

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subsequent hospitalization may have deleterious effects such as parent–infant separation<sup>3</sup>, impaired infant brain development,<sup>4</sup> negative physiologic responses,<sup>5</sup> infant stress,<sup>6</sup> parental distress and negative feelings.<sup>7-9</sup> Evidence suggests that parent–infant closeness and parental involvement in caring for hospitalized preterm infants can improve both parent and infant outcomes.<sup>10-12</sup>

In the West studies have explored the perceptions and experiences of parents providing care for their premature infant.<sup>12-15</sup> Numerous studies have tested interventions designed to strengthen parental knowledge and skills,<sup>16,21,22</sup> improve parental psychological well-being,<sup>17,18</sup> infant outcomes,<sup>17,19-22</sup> and promote positive parent–infant relationship.<sup>18</sup> Thai studies have focused on the level of parental participation<sup>23-25</sup> and factors related to parental participation.<sup>23-26,33</sup> Most interventional studies have adopted Western concepts such as Bandura’s self-efficacy, Hull’s systematic behavior and Mercer’s maternal role attainment as a conceptual framework to enhance parental knowledge and skills,<sup>27-29</sup> improve parental psychological well-being<sup>28,30</sup> infant outcomes<sup>27,29,30</sup> and promote parent–infant attachment and bonding.<sup>30,31</sup> Two Thai qualitative studies found that maternal participation was a continuous process that included initial participation and engagement as best for their infant,<sup>32</sup> and that mothers participated in their infant’s care by following nursing guidelines and performing child care activities arbitrarily.<sup>33</sup> However, little is known about perceptions and caregiving practices of parents in caring for hospitalized preterm infants. This knowledge is crucial for developing intervention program that is in accordance with Thai parents’ needs. Therefore, this topic needed further exploration.

## **Review of Literature**

A preterm infant is one born before 37 completed weeks of gestation.<sup>1</sup> Major health problems stem from immaturity of body systems and the degree of this immaturity is related to gestational age.<sup>3</sup> While hospitalization is required to support infants’

physiological immaturity, hospitalization itself confers important risks for both the preterm infants and their parents. Preterm infants are exposed to a variety of stimuli, potentially leading to impaired brain development,<sup>4</sup> negative physiologic responses including apnea, fluctuation of heart rate, and increased blood pressure,<sup>5</sup> stress, and disrupted sleep and wake states.<sup>6</sup> Parents frequently experience sleep disturbance and fatigue,<sup>8</sup> emotional distress,<sup>7-9</sup> negative moods such as sadness, guilt, anger, fear, and uncertainty.<sup>7,9</sup> Preterm infants are separated from their parents which may delay parent–infant bonding and attachment.<sup>3</sup> Efforts have been made to decrease the negative effects of hospitalization, especially by avoiding parent–infant separation through supporting parental involvement in the care of their preterm infants.<sup>10</sup> Parental involvement in care is accepted as beneficial for both parents and infants including increasing parental satisfaction,<sup>11,12</sup> promoting parental confidence<sup>12</sup> and parent–infant closeness,<sup>10,12</sup> and decreasing infants’ readmission rates and hospital stays.<sup>11</sup>

Parental involvement is exemplified by parents staying near their child, providing physical care, and actively participating in decision–making processes related to that care.<sup>34</sup> Parental involvement is affected by many factors including the infant’s size and physical appearance, the clinical condition,<sup>6,35</sup> parental health, parental knowledge and skills, support from family,<sup>35</sup> support from healthcare professionals,<sup>9,12,35</sup> environmental conditions,<sup>9,35</sup> and visiting policies.<sup>35</sup> In Thailand, prior studies found that parent participation was related to parental preparation,<sup>23</sup> parental opinion about participation,<sup>24</sup> parents’ beliefs about the quality of nursing care,<sup>25</sup> support from nurses,<sup>26</sup> and support from spouses.<sup>33</sup>

Previous intervention studies tested general education programs<sup>16-18</sup> and the Newborn Individualized Developmental Care and Assessment Program (NIDCAP)<sup>21,22</sup> for strengthening parental knowledge and skills, promoting parent–infant interaction, and improving parental psychological well-being.

Intervention studies have examined the effectiveness of kangaroo care on breastfeeding rates,<sup>19,20</sup> physical growth,<sup>19</sup> and length of hospital stay.<sup>20</sup> In Thailand, prior intervention studies have focused on enhancing parental knowledge and basic care skills, infant development, as well as improving parental psychological well-being and infant outcomes by promoting perceived self-efficacy,<sup>27,28</sup> maternal role,<sup>30</sup> and oral stimulation programs.<sup>29</sup> Other interventions investigated the effectiveness of a maternal role promoting program<sup>30</sup> and kangaroo care<sup>31</sup> on parent-infant attachment and bonding.

Nevertheless, there is limited information to understand how Thai parents involved in caring for hospitalized preterm infants. To ensure optimal uptake of interventions that are in concordance with the needs of Thai parents, it is essential to explore the perceptions of parents, their caregiving practices and the socio-cultural factors influencing their involvement in caring for hospitalized preterm infants by employing a descriptive qualitative approach.

#### **Study Aim**

To explore perceptions and caregiving practices of parents regarding involvement in caring for their hospitalized preterm infants and the socio-cultural influences involved in this.

## **Methods**

#### **Design:**

A descriptive qualitative approach was used, since this design focuses on studying the phenomenon of interest in its natural state.<sup>36</sup> This approach helps the researcher to understand parental involvement in caring for their preterm infants at a sick newborn unit (SNB).

#### **Sample and Setting:**

This study was conducted at the SNB of a regional hospital in eastern Thailand. This site was selected based on its capacity to care for preterm infants at various gestational ages and its encouragement of parents to get involved with caring.

After gaining study approval the primary investigator (PI) contact the head of pediatric unit and head nurse of the SNB to obtain study permission. Purposive sampling was used to select the informants from the SNB based on characteristics of parents and their infants such as age, educational level, occupation, type of family, number of child, gestational age at birth, and infant birth weight and diagnosis. Additionally, family members and/or relatives who were involved with the family, and nursing staff, were recruited.

#### **Ethical Considerations:**

Study approval was obtained from the Institutional Review Board of the Faculty of Nursing, Chiang Mai University, and the Research Ethics Committee of the hospital. Informants were informed verbally and in writing about the purpose, methods, potential risks and benefits of participation, and duration of the study. Informants were informed that their participation was voluntary and they could refuse or withdraw from the study at any time without any impact on them or their infant's care and treatment. Written consent was obtained after the informants agreed to participate in the study. Informants' confidentiality and anonymity were protected throughout the research and presentation of findings.

#### **Data Collection:**

Data were collected through in-depth interviews, participant observation, field notes and clinical document reviews, from September 2014 to October 2015.

In-depth interviews were conducted after establishing trust and rapport. Each informant was interviewed in Thai 1 to 4 times with each interview ranging from 20–90 minutes. Interviews were arranged in various locations to maximize informants' convenience and to protect their rights and confidentiality such as the private room, breastfeeding corner, a mother's bedside, and the balcony seating area. Each interview began with general questions, "What do you think is the reason for hospitalizing your baby in the SNB?", then specific/probing questions, "While your baby is hospitalized in the SNB, what activities you do for

your baby”, “how do you feel?” and “why?” Parents were asked to describe their feelings or perceptions, caregiving practices, and factors influencing their involvement. Grandmothers and nurses were interviewed about their perspective toward parental involvement and factors related to parental involvement in caring for preterm infants. Grandmothers were interviewed via phone because of time constraints while visiting the baby. The interviews guidelines with open-ended questions were used. All interviews were digitally audio-recorded with the informants’ permission and transcribed verbatim for data analysis. Moreover, the PI observed parental caregiving practices, parent–infant interactions and parents–nurse interactions. Observations were made at different times of day to ensure that all parental caregiving practices were observed. Field notes were jotted down during or immediately after an observation or interviews. The clinical documents such as medical charts, shift reports, admission criteria, policy documents, and pamphlets in the SNB were reviewed. Data collection continued until no new data emerged, that is the data were saturated.

#### **Data Analysis:**

Data were analyzed using Braun and Clarke’s thematic analysis method.<sup>37</sup> The process of data analysis consisted of six phases: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. To become familiar with the data, the interviews were transcribed *verbatim* in Thai as soon as possible, read and re-read line-by-line several times, and ideas were marked for coding. To generate initial codes, the PI coded the transcripts, collated data for each code, and then organized the initial codes into sub-categories and categories. To review categories all data within candidate categories were reviewed for several times by looking at coherence, and the ability to make clear and identifiable distinctions between categories. After reviewing each category, the PI defined and refined the categories by identifying the essence of each in relation to the whole. All steps

of data analysis were made under the supervision of the researcher’s advisory committee.

All data collection, analysis and consultation with the advisory committee was conducted in Thai. After final analytic codes were generated, the PI translated codes and selected quotations into English by consulting an expert editor who was Thai and fluent in English.

#### **Rigor and Trustworthiness:**

The researchers used four criteria of Lincoln and Guba to establish the trustworthiness of the study.<sup>38</sup> The credibility was established by using triangulation, peer debriefing, and member checking with six informants, while the transferability was achieved through thick description. To achieve the dependability, field notes were made throughout the study and the dissertation advisory committee provided their expertise as auditors. Confirmability of the analysis was established by using an analysis audit trail and method triangulation that included participant observation, in-depth interviews and clinical data documents.

## **Findings**

There were 27 informants in this study, comprising 22 parents (19 mothers and 3 fathers), 2 grandmothers and 3 nurses. All were Thai and Buddhist. Parents ages ranged from 20–42 years old. Over half of the parents had a bachelor degree (n=12), while one completed primary education. Twelve parents worked in a factory. Most parents came from other provinces and lived in a nuclear family (n=17). Most of them had a first child (n=15). The gestational age (GA) at birth of their preterm infants ranged from 27–34 weeks. Twelve infants were late and moderate preterm infants (GA at 32–36 weeks), while two were extremely preterm infants (GA<28 weeks). Birth weight ranged from 1,010 to 2,555 grams. Most preterm infants were diagnosed with respiratory distress syndrome (n=17).

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The two grandmothers ranged from 52–53 years of age, and they had primary school education. One grandmother had her own business and another worked freelance. Nurse informants were a head nurse of the SNB and two staff nurse. They were aged between 24–55 years and single. Two nurses had a bachelor degree, while one had a master degree. Two of the nurses had work experience of >10 years while

the other had work experience of <3 years.

Findings are presented into five categories: uncertainty about their child’s condition, desire to be close to their preterm babies, lack of confidence in providing care for their preterm babies, overcoming difficulties in breastfeeding, and socio-cultural factors influencing parental involvement (Table 1).

**Table 1** Categories and sub-categories regarding parental involvement in caring for hospitalized preterm infants

Categories	Sub-categories
Uncertainty about their child’s condition	-Worrying about the child’s condition -Praying to the holy idols for their child’s well-being
Desire to be close to their preterm babies	-Longing for performing a maternal role -Seeking opportunity to be involved in caring for their babies
Lack of confidence in providing care for their preterm babies	-Being afraid of their babies being at risk -Performing care for their babies with insufficient skills -Following the nurses’ advice
Overcoming difficulties in breastfeeding	-Believing in the benefits of breast milk -Attempting to produce enough milk supply -Bonding with their babies through breastfeeding -Confronting problems of breastfeeding
Socio-cultural factors influencing parental involvement	-Parental involvement policy -Lack of parental involvement guidelines -Passive recipients of health care -Employee leave policy -Family support

**Category: Uncertainty about their child’s condition**

Preterm infants are at risk due to prematurity of body organs. Most parents felt uncertain about their babies’ conditions such as baby’s tiny body, breathing with retraction, having many medical devices, and having complications. Due to these conditions, most parents were worried about their baby’s clinical conditions. Some parents prayed to the holy idols for their babies to be healthy and to get better.

**Sub-category: Worrying about the child’s condition.** Some parents who were separated from

their babies were anxious because they did not know their babies’ status. Some were fearful of losing their child (*กลัวลูกจะไม่รอด- Glua- Look-Ja-Mai-Rod*), particularly, in the first few days of birth during which time their babies had unstable conditions or complications, for example two mothers stated:

*I was worried about my baby...they allowed me to visit my baby during the visiting time. I didn’t stay with my baby all the time and what concerned me was whether he was okay or he would develop any symptoms. (ID, M7)*

*...in the first few days, his condition was very terrible. It seemed like he was going to die...he was so tired, and breathed so strongly...I was so worried that my child won't survive...I cried all night. (ID, M9)*

**Sub-category: Praying to the holy idols for their child's well-being.** All parents in this study were Buddhists, they paid respect to Buddha and the shrines as their spiritual anchor. Some told their parents or close relatives to make a vow to the shrines in their hometown on the belief that their babies would be protected from any sickness and would be safe and healthy. As one father and one mother stated:

*... When my baby was at the hospital. I prayed to a Buddha statue. That was the only thing that I have since I was born because I'm a Buddhist. I prayed to Buddha along with my wife...to wish our baby to be healthy and get well. (ID, F2)*

*My baby slept without any clothes on (in an incubator). He was breathing but I wondered if he would survive. When anybody called me, either my relatives, father or sister, I asked all of them to make a vow to the holy idols for me...In my hometown, we have San Klang Ban (ศาลากลางบ้าน –the shrine of the village) that I pay much respect... When I did that, I felt very relieved. (ID, M18)*

**Category: Desire to be close to their preterm babies**

Parents were separated from their babies because they could only gain access into the unit during visiting time. Most mothers wanted to perform their maternal role and sought more opportunity to nurture their babies.

**Sub-category: Longing to perform a maternal role.** Mothers cared for their babies by changing diapers, spoon feeding, breastfeeding, taking their baby's temperature and providing kangaroo care. Most mothers said that they wanted to do as much as

possible for their baby because as mothers their duty is to raise and take care of their child.

*...I could do everything for my baby...because she is my child...I'm her mother...so I have to raise and look after her. (ID, M14)*

**Sub-category: Seeking opportunity to be involved in caring for their babies.** Parents often sat in front of the SNB, awaiting visiting hours. When visiting time arrived, they rushed to touch, talk to and care for their babies. Some parents asked the nurses for permission to stay and look after their babies.

*I came here and went back home for two days because my baby's intake of milk was only 1 cc. to 3 cc...When she got 15 cc. of milk I asked nurse's permission to stay here. I felt that if I took care of my baby by myself, my baby would get encouragement. (ID, M1)*

**Category: Lack of confidence in providing care for their preterm babies**

Most parents lacked confidence providing care for their babies because they were afraid that they would put their babies at risk. Some parents cared for their babies with insufficient skills, especially during the first few times. Some did not dare care for their babies on their own; they only provided care when specifically directed by a nurse.

**Sub-category: Being afraid of their babies being at risk.** Parents were afraid to provide care for their babies because their babies were very small and fragile. They worried that they might break their baby's bones.

*I didn't want to do much because my baby was so small. I didn't dare turn his body to one side. He's very tiny and his bones may not be very strong...I was scared, particularly for the neck, as I heard that a newborn baby's bones are still weak. (ID, M16)*

Some parents were afraid of infecting their immuno-compromised babies or interfering with the operation of medical devices, for example:

*...After delivering my breast milk, I just stood and looked at my baby...because she was in the incubator...I didn't dare touch her. I was afraid she might be infected. I was not brave enough to do anything. (ID, M19)*

**Sub-category: Performing care for their babies with insufficient skills.** No parents had prior experience providing care for premature baby. Parents expressed that initially, they were not confident doing activities such as giving a bath/a shampoo, giving a mouth care, changing a baby's diaper and holding baby.

*I never changed a baby's diaper. I was quite bad at it...When I changed a diaper for her, I didn't know if she'll get hurt...I have to try it anyway. As she doesn't stay still...Now I'm better at changing my baby's diaper. (ID, M19)*

**Sub-category: Following the nurses' advice.** Parents only provided care for their babies when the nurses told them to do activities such as pumping breast milk, feeding, and changing their baby's diaper. Parents' rationale for passively following the nurses' advice was that they were afraid that actively initiating other activities might put their baby at risk and worsen their condition.

*...When I first entered the SNB, I didn't know what I could or couldn't do. It depended on the nurse's advice. I didn't dare do...because I didn't know that if it is proper or not. When I arrived there, a nurse told me to change my baby's nappy. Okay, I can do this. (ID, M14)*

**Category: Overcoming difficulties in breastfeeding**

Most mothers strongly believed that the breast milk was good for baby's health. As a result, they tried many ways to produce enough milk supply. During breastfeeding, some mothers felt love, happiness and

appreciation for being near with their babies, while others confronted problems with breastfeeding.

**Sub-category: Believing in the benefits of breast milk.** Most mothers believed that breast milk helped their babies become healthy and that it was more readily digested than formula. As two mentioned:

*I want to breastfeed my baby...Breast milk is good, it's better than everything else...It makes my baby healthier as it has more antibodies than formula milk. (ID, M4)*

*My baby must be fed with my own breast milk as people said breast milk is easy to digest, helps to pass stool easily and prevents gassiness. (ID, M11)*

**Sub-category: Attempting to produce enough milk supply.** To maintain sufficient milk supply mothers ate specific foods and stimulants and expressed every 2-3 hours.

*...At first, I drank a lot of instant ginger and warm water, I could produce breast milk but the supply was quite low, so when I took motilium, I could express more breast milk. (ID, M8)*

*I never stopped pumping my breasts even a single time because I'm worried that if my baby starts getting milk, I would have no breast milk for her... So I try to express milk every 2-3 hours to keep my milk...(ID, M17)*

**Sub-category: Bonding with their babies through breastfeeding.** Mothers were delighted when their baby fed from their breasts. They said that breastfeeding enabled them close contact with their babies such as touching baby's body and hands, looking at baby's face, and talking with baby.

*I'm so happy and glad. When looking at my baby's face, I think: "Wow the feeling is like this." I don't know how to explain. When I look at his face, while his eyes are closed, his*

*mouth is sucking milk from my breasts. My baby is so cute...I love him so much. (ID, M3)*

**Sub-category: Confronting problems of breastfeeding.** Mothers encountered problems breastfeeding when their babies were unable to latch, if there were conflicts about forcing their baby to suck or if they were sleep deprived from 24-hour breastfeeding.

*I have to breastfeed my baby...I feel so sleepy. I sometimes close my eyes and fall asleep while breastfeeding my baby. (ID, M7)*

*...I know that my baby must get milk, but I don't want to force him. When my baby gets a little milk...It's like two-sided pressure. A nurse pressured me to force my baby. He doesn't wake up even after I try to wake him. I need to force him, is it right? (ID, M9)*

**Category: Socio-cultural factors influencing parental involvement**

Parental involvement in caring for hospitalized preterm infants was influenced by socio-cultural factors, including the unit policies regarding parental involvement, the lack of parental involvement guidelines, parents' role as passive recipients of health care, Thai employee leave policy, and family support.

**Sub-category: Parental involvement policy.** The SNB implemented the policy of promoting bonding and newborn development through the Family Love Bonding Project (*โครงการสายใยรัก-Sai-Yai-Rak Project*), the Baby-friendly Hospital Project (*โรงพยาบาลสายสัมพันธ์แม่ลูก-Sai-Sam-Phan-Mae-Look Hospital*) and the policy of preparing parental skills for discharge. Some parents and nurses noted that these policies allowed parents to be involved in caring for their babies.

*It's the hospital that has a policy of supporting mothers to take care of babies...The Sai-Yai-Rak Project promotes breastfeeding, allowing a mother to have a close bond with her baby and*

*they pushed me to be here to have a chance to care for my baby. (ID, M1)*

*The hospital implemented the Sai-Yai-Rak Project which promotes breastfeeding as its main activity...Later on, we have a lot of activities that help form the bond between mothers and babies. (ID, N2)*

**Sub-category: Lack of parental involvement guidelines.** The SNB had policies to enable parents to take part in caring for their babies. However, it did not have parental involvement guidelines, consequently information provided by each nurse varied, depending on each nurse's perspective. Some parents received advice about basic infant care needs from nurses, while others did not, especially for the most basic caregiving activities.

*When I was visiting my baby, a nurse told me to check if my baby pees. If she does, I should change a diaper for her. I couldn't do it at the first time, so the nurse taught me. (ID, M7)*

*A nurse didn't teach me how to change a diaper... I didn't know how to do it at the first time, so I observed from an old one that a nurse did. (ID, M16)*

**Sub-category: Passive recipient of health care.** Parents assumed roles as passive recipients of care from physicians/nurses, rather than taking an active role in care. In particular, they were less involved in decision making and left care decision to physicians/nurses. In addition, some parents were reluctant (*เกรงใจ-Kreng-jai*) to ask physicians or nurses about their baby's conditions, medical treatment or methods of taking care of their babies as they saw physicians or nurses busy with other cases, for example:

*(regarding a blood draw) I guess the nurse didn't want me to see my baby crying, so she told me to wait outside. But actually I wanted*



*to be with her...I wanted to lull her, hold her and be close to her. (ID, M10)*

*...Nurses were working...When I asked them, they told me to wait a moment. I visited my baby, I often saw them keeping busy...I felt hesitant (Kreng-jai) and afraid to ask them and I thought if they were available, they would come to me. (ID, M13)*

**Sub-category: Employee leave policy.** Thai female employees are eligible to take maternity leave for 90 days under the national Labour Protection Act. Mothers specifically noted that their maternity leave enabled them to be involved in caring for their hospitalized baby.

*I have 3-month's maternity leave, so I can devote myself to taking care of my baby. This helps a lot. I don't have to worry about anything that could prevent me from visiting my baby conveniently. (ID, M14)*

As one father worked for a logistic company, he was able to visit and help his wife take care of their child. He was eligible for an annual leave of seven days to handle family affairs.

*I submitted my baby's birth certificate as a supporting document to take leave...If it's related to the family, spouse, parents and children, the company allows staff to take seven days leave for special affairs per year. (ID, F2)*

**Sub-category: Family support.** Most mothers were supported primarily by their family members, especially by fathers and grandmothers. This support included doing housework, providing information, and emotional support. This support from family enabled mothers to take care of their babies at the hospital and learn how to take care of their babies. As one mother and grandmother said:

*...My husband wants me to take care of this baby...He would do all the housework and everything at home that was used to be my duty. That relieves me and allows me to take care of this baby. (ID, M6)*

*I just told her (the preterm baby's mother) how to take a bath and what kind of milk to feed a baby...She should pour some water on the face first to prevent a baby from getting cold... Be careful not to wet a baby's umbilical cord stump as it might get infected...(Grandmother)*

## **Discussion**

The informants' perspectives regarding parental involvement in caring for hospitalized preterm infants indicated that most parents felt uncertain about their child's health condition. They were afraid of losing their infants. This might stem from the fact that preterm infants are considered a high risk group because their physical organs are not fully formed which causes various health problems and their condition can change any time. This finding is supported by literature findings that when preterm infants are hospitalized, their parents experience stress, anxiety, guilty, and fear of infants' death.<sup>7,9</sup> Some parents in this study felt relieved when they prayed to Buddha and made a vow to the shrines, believing that their preterm infants would be recovered and safe. Most Thais are Buddhists; they have a strong belief that when they encounter problems and pray to Buddha or sacred objects, believing these holy idols will help and protect them. This is congruent with previous studies in Thailand which found that parents prayed to the holy idols for their child's recovery.<sup>32,33</sup>

Most parents sought any chance to be close to their babies as they longed to perform their maternal role. This strong desire for physical contact and interaction during the care is typically associated with

parent–infant bonding which begins during pregnancy and continues after birth.<sup>39</sup> This finding is similar to a qualitative study with Swedish mothers: mothers felt satisfied when they could have close contact with their infant; they preferred providing kangaroo care and staying together with their infant in hospital rather than returning home.<sup>13</sup> Similar findings were reported from a grounded study which found that Thai parents<sup>7</sup> needed to participate in doing anything for their ill child during hospitalization and were driven by their love, bond, concern and desires to be close to their ill child.<sup>40</sup>

Most parents lacked confidence when providing care for their preterm babies. As some parents were afraid that they would put their preterm babies at risks of sepsis or break their baby's bones. They did not possess the knowledge and skills required to care for a preterm infant who was sick and fragile. For more than half of the parents this was their first child and none had the experience of taking care of preterm infants, making them feel hesitant to look after them. This finding is similar to a qualitative study in Taiwan which found that mothers of very low birth weight (VLBW) preterm infants would not hold their baby until they were assured that their infant's conditions were very stable.<sup>35</sup> As a result, some parents in the present study only provided care by following nurses' advice. This may be because Thai parents place a high level of trust and belief in the capacity of physicians or nurses as they are knowledgeable about baby care. This finding is congruent with a qualitative study, describing that Thai mothers of preterm babies on a respirator performed caregiving activities only by following nurses' advice because they perceived that their babies' lives were in uncertain and dangerous conditions and needed special care.<sup>33</sup>

Mothers in this study faced difficulties with breastfeeding. Most parents strongly believed that breast milk is good for a preterm baby's health. This is probably because the Ministry of Public Health has launched several campaigns encouraging Thai women to breastfeed their babies. Most Thai hospitals have

adopted the Family Love Bonding Project and the Baby Friendly Hospital Project to promote breastfeeding and these projects are very well known in the Thai population. Consequently, most parents tried many ways to produce enough milk supply by expressing milk every 2–3 hours, drinking warm water and eating foods that contained milk supply boosting food such as banana blossom, ginger, Chinese chives and pumpkin. Belief in milk supply boosting foods exists in all cultures, particularly those in the region of Asia such as Thailand, China, Indonesia and India and the kinds of foods relies on what is available in their country.<sup>41</sup> This finding is congruent with a study in Taiwan which found that mothers of VLBW infants tried different ways to boost their milk supply such as expressing breast milk at least every 3 hours or more frequently, eating specific soups (fish soup and chicken soup) and maximizing rest after midnight.<sup>42</sup>

Some mothers strove to bond with their babies through breastfeeding as they could be close and have an interaction with their babies such as touching, seeing and talking. This is supported by Klaus et al.<sup>39</sup> who indicated that mother–infant bonding is developed through touching, smelling, seeing, breastfeeding, and caring for the infant. However, some parents in this study encountered problems with breastfeeding when their preterm babies were unable to latch. This is probably due to the fact that a majority of infants in this study had a gestational age at birth of less than 34 weeks and their ability of sucking a mother's breast was limit.

Findings in the present study showed that five socio–cultural factors influence positively or negatively Thai parental involvement. First, regarding parental involvement policies, some parents and nurses perceived that these policies helped parents to be involved in caring for their babies, especially the Family Love Bonding Project and the Baby–Friendly Hospital in a response to the policy of breastfeeding promotion in Thailand. In the Eleventh National Economic and Social Development Plan (B.E.2555–2559), Ministry

of Public Health, the target was that at least 50% of newborns should be exclusively breast fed for at least 6 months.<sup>43</sup> Second, the lack of parental involvement guidelines in the SNB resulted in each nurse providing information about babies' care that varied in amount and content. This inconsistency may limit parental involvement as some parents did not know that what they were allowed to do for their babies. Third, as passive recipients of health care, parents were less involved in decision-making regarding their babies' care and felt consideration to ask health care providers. They just followed physicians or nurses' instruction. This may have occurred because parents believed in the capability of physicians or nurses as health care professionals with greater expertise regarding their infant's physiologic status and care needs. This finding is supported by existing literature in which Thai parents did not dare to participate in decision-making because the baby's conditions were critical.<sup>33</sup> Fourth, because of the national employee maternity leave policy, some parents were able to be involved in taking care of their newborns. According to Thai labour law, Thai female employees are entitled to take a maternity leave of not exceeding 90 days with full salary.<sup>44</sup> Fifth, family support, most mothers were primarily enabled to care for their babies through support of the father and grandmother. This may be because of fathers and grandmothers had a close relationship with the mothers. In addition, mothers were the primary caregivers in raising a child. This finding is congruent with a Thai qualitative study, finding that the spouses are an important factor that can either encourage or hinder maternal participation in caring for their premature baby on a respirator.<sup>33</sup>

### **Limitations**

Most of informants were mothers and, therefore the study findings may not reflect the unique perceptions of fathers who are involved in care. This homogeneity of informants may reduce the transferability of the

study findings to other Thai parents in caring for hospitalized preterm infants.

## **Conclusions and Implications for Nursing Practice**

This study provides an understanding of how Thai parents involved themselves in caring for their preterm infants and the socio-cultural factors influencing parental involvement which facilitated or limited their involvement. The findings could be used as baseline data for healthcare providers, especially nurses, to develop a program for promoting parental involvement in caring for their preterm infants effectively.

Moreover, the findings revealed a lack of parental involvement guidelines and showed that most parents desired to be involved in care. Therefore, nurse administrators should develop parental involvement guidelines and consider allowing unrestricted visiting hours of 24 hours a day to reduce parent-infant separation and parental uncertainty as well as to support parental involvement. Additionally, nurse administrators should arrange a training course to improve the ability of nurses to enhance parental involvement in care.

### **Acknowledgments**

The authors gratefully acknowledge the assistance of all informants for sharing their valuable information. This study was funded by the Graduate School, Chiang Mai University.

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## การรับรู้และการปฏิบัติของบิดามารดาในการมีส่วนร่วมดูแลทารกเกิดก่อนกำหนดที่เข้ารับการรักษาในโรงพยาบาล

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**บทคัดย่อ:** ทารกเกิดก่อนกำหนดที่เข้ารับการรักษาในโรงพยาบาลต้องแยกจากบิดามารดา ในหลายประเทศรวมทั้งประเทศไทย การดูแลทารกแรกเกิดได้ส่งเสริมให้บิดามารดามีส่วนร่วมในการดูแลทารก เพื่อที่สนับสนุนให้ทารกได้รับน้ำนมมารดาและส่งเสริมความรักความผูกพันระหว่างบิดามารดาและทารก การศึกษาเชิงคุณภาพครั้งนี้ มีวัตถุประสงค์เพื่อเพิ่มความเข้าใจการมีส่วนร่วมของบิดามารดาในการดูแลทารกแรกเกิดก่อนกำหนดที่เข้ารับการรักษาในโรงพยาบาล คัดเลือกกลุ่มตัวอย่างแบบเฉพาะเจาะจง กลุ่มตัวอย่างคือ บิดามารดาของทารกเกิดก่อนกำหนด 22 ราย ยาย 2 ราย และพยาบาล 3 ราย ที่หอทารกแรกเกิดป่วยของโรงพยาบาลศูนย์แห่งหนึ่ง ในภาคตะวันออกเฉียงเหนือของประเทศไทย เก็บข้อมูลโดยการสัมภาษณ์เชิงลึก การสังเกตแบบมีส่วนร่วม และการทบทวนเอกสารทางคลินิก จากเดือนกันยายน 2557 ถึงเดือนตุลาคม 2558 การวิเคราะห์ข้อมูลใช้วิธีการวิเคราะห์แก่นสาระ

ผลการศึกษาพบว่า การรับรู้และการปฏิบัติกิจกรรมการดูแลของบิดามารดาเมื่อมีส่วนร่วมในการดูแลทารกเกิดก่อนกำหนด ประกอบด้วย 1) มีความรู้สึกไม่แน่นอนเกี่ยวกับอาการเจ็บป่วยของทารก 2) ประารถนาที่จะใกล้ชิดกับทารก 3) ขาดความมั่นใจในการดูแลทารก 4) ก้าวข้ามความยากลำบากในการให้นมทารก และ 5) ปัจจัยทางสังคมวัฒนธรรมมีอิทธิพลต่อการมีส่วนร่วมในการดูแลทารกของบิดามารดา การเข้ามามีส่วนร่วมของบิดามารดาในการดูแลทารกเกิดก่อนกำหนดเป็นสิ่งสำคัญต่อคุณภาพการดูแลทารก ผลการศึกษานี้ สามารถเป็นหลักฐานเชิงประจักษ์ในการพัฒนาโปรแกรมการพยาบาล เพื่อส่งเสริมและสนับสนุนการมีส่วนร่วมของบิดามารดาในการดูแลทารกเกิดก่อนกำหนด

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**คำสำคัญ :** การศึกษาเชิงคุณภาพโดยวิธีการพรรณนา ทารกเกิดก่อนกำหนดที่เข้ารับการรักษาในโรงพยาบาล บิดามารดา การมีส่วนร่วมของบิดามารดา ทารกเกิดก่อนกำหนด ประเทศไทย

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