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INTEGRATIVE REVIEW ARTICLE

FAMILY GUIDELINES NEEDED FOR A SAFE HOSPITAL OF THE PREMATURE NEWBORN: INTEGRATIVE REVIEW

ORIENTAÇÕES FAMILIARES NECESSÁRIAS PARA UMA ALTA HOSPITALAR SEGURA DO RECÉM-NASCIDO PREMATURO: REVISÃO INTEGRATIVA

ORIENTACIONES FAMILIARES NECESARIAS PARA UNA ALTA HOSPITALARIA SEGURA DEL RECIÉN NACIDO PREMATURO: REVISIÓN INTEGRATIVA

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ABSTRACT

Objective: to identify the knowledge available in the literature about the care needed to be oriented to the family of the premature newborn in its preparation for discharge. ***Method:*** integrative review about the care needed to be directed to the family of the newborn in preparation for discharge. We used the Cinahl, Lilacs and Medline databases from July 2012 to October 2015. Eight hundred and twenty-four (824) articles were found, however, only nine were considered fit for the analysis because they met the inclusion criteria Of the study. ***Results:*** the findings were divided into two thematic axes << 1. Preparing the family for discharge from prematurity >> and << 2. Continuity of care at home and the importance of family support >>. ***Conclusion:*** this analysis allowed us to know and describe aspects that permeate the process of transition from the premature to the home. ***Descriptors*:** Infant, premature; Child Care; Patient Discharge.

RESUMO

***Objetivo*:** identificar o conhecimento disponível na literatura sobre os cuidados necessários a serem orientados à família do recém-nascido prematuro em sua preparação para a alta hospitalar. ***Método*:** revisão integrativa acerca dos cuidados necessários a serem orientados à família do recém-nascido em sua preparação para a alta hospitalar. Utilizaram-se as bases de dados Cinahl, Lilacs e Medline, de julho de 2012 a outubro de 2015. Oitocentos e vinte e quatro (824) artigos foram encontrados, porém, apenas nove foram considerados aptos para a análise por atenderem aos critérios de inclusão do estudo. ***Resultados*:** os achados evidenciados foram divididos em dois eixos temáticos <<Preparo da família para a alta do prematuro>> e <<Continuidade dos cuidados no domicílio e a importância do apoio da família>>. ***Conclusão*:** tal análise permitiu conhecer e descrever aspectos que permeiam o processo de transição do prematuro para o domicílio. ***Descritores*:** Prematuro; Cuidado do Lactente; Alta do Paciente.

RESUMEN

Objetivo: identificar el conocimiento disponible en la literatura sobre los cuidados requeridos a la orientación de la familia con respecto al recién nacido prematuro en su preparación para la alta hospitalaria. ***Método:*** revisión integral acerca de los cuidados necesarios a la orientación de la familia con respecto al recién en preparación para la alta hospitalaria. Se utilizaron las bases de datos Cinahl, Lilacs y Medline, de julio de 2012 a octubre de 2015. Ochocientos veinte y cuatro 824 (824) artículos fueron encontrados, sin embargo, sólo nueve fueron considerados aptos para el análisis por cumplieren con los criterios de inclusión del estudio. ***Resultados:*** los resultados evidenciados fueron divididos en dos ejes temáticos << 1. Preparo de la familia para la alta del prematuro >> y << 2. Continuidad de los cuidados en el hogar y la importancia del apoyo familiar >>. ***Conclusión:*** este análisis permitió conocer y describir aspectos acerca del proceso de transición del prematuro a su casa. ***Descriptores*:** Pretérmino; El Cuidado del Bebé; Alta Paciente.

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INTRODUCTION

Premature birth is a public health problem. The World Health Organization/WHO classifies prematurity according to gestational age at birth, considering a premature birth when it occurs before 37 weeks. In addition, it is the leading cause of death among children during the first four weeks of life and the second leading cause of death among children younger than five years. It is estimated that every year, around the world, about 15 million babies are born before reaching the end of gestation, that is, more than one in ten births. More than one million of them die each year due to complications in childbirth.[1]

To reduce health problems and the number of lives lost due to premature birth, WHO has teamed up with partners and published, in 2012, a report entitled "Born too soon", which aims to save 16 million lives by 2015, Taking some specific measures, including: guidelines for the care of preterm infants, including the kangaroo mother technique, feeding babies with low birth weight, treatment of infections and respiratory problems, and, in particular, home care and follow-up.[2]

The Brazilian proposal of the Kangaroo Method is a policy of the Ministry of Health that has been shown to be a strategy of safe humanization, promoting breastfeeding and low cost when compared to conventional care.[3] This method has modified neonatal care in Brazil by expanding the care provided to the newborn (NB), adding to them the need for attention focused on the parents, as well as for the entire network of family and social support of the newborn, starting from the understanding that the success of the treatment of a newborn Neonatal ICU is determined not only by their survival and hospital discharge, but also by the construction of bonds that will ensure continuity of care after discharge.[4]

The method is developed in three stages: the first one begins during high-risk prenatal follow-up and remains throughout the period of hospitalization of premature and/or low birth weight in the neonatal ICU. The second one begins when it is stable and can rely on its mother's continuous follow-up in the kangaroo ward. The third stage starts with hospital discharge, but, not with the method. The maintenance of the kangaroo position is oriented and the NB is monitored by the team that assisted it during hospitalization until it reaches the weight of 2,500 g.[4]

The preparation of the mother for the home care of the NB should take place during the entire hospitalization of the preterm, however, in practice, it is observed that the second stage of the Kangaroo method is the most important for the learning and preparation of the family for the discharge of the baby. The family environment of the kangaroo unit, favors the development of skills and the acquisition of specific knowledge that reduces anxiety and increases self-confidence for the home care of the family, and especially, the mother.[5]

However, this method is not yet widely and fully implemented in Brazil. Not all premature infants are able to pass through the Kangaroo Unit, the second stage is then performed in the Neonatal Intensive Care Unit (NICU), or in the medium risk units, where the mother reserves the time of day to perform skin-to-skin contact and stimulate breastfeeding. These moments, however, do not occur in an intense and continuous way as is the Kangaroo Method proposal, which caused harm, mainly, in the acquisition of autonomy and safety of the mother in the care of her baby.[4]

The importance of preparing the extended family, especially, the parents, for the home care of the premature newborn, and the anxiety caused by the lack of systematization and standardization of the guidelines given to the family about the hospital discharge of the premature infant, led to the reflection on which strategies and orientations are reported in the literature on this subject.

In this context, this study presents as objectives:

- Identify the knowledge available in the literature about the care needed to be targeted to the family of the premature newborn in preparation for hospital discharge;
- Check the difficulties shown in this practice.

METHOD

Integrative Review.[6] The databases used were *Cumulative Index to Nursing and Allied Health Literature (Cinahl); Latin American and Caribbean Literature in Health Sciences (Lilacs) and Medical Literature and Retrieval System On Line (Medline)*. The descriptors adopted were: premature, infant care and patient discharge. These descriptors were combined, with Boolean AND logic.

The first three databases generated a total of 824 articles. A first reading of the titles and abstracts allowed the selection of 60 articles. Of these, after a second more in-depth reading, only nine were considered for analysis because they met the study selection criteria. The data analysis was guided by an adapted instrument and the levels of evidence

were considered to determine the confidence in the use of its results.

For the construction of RIL, six distinct stages were defined: 1) identification of the theme and selection of the hypothesis or research question; 2) establishment of criteria for inclusion and exclusion of studies; 3) definition of the information to be extracted from the selected studies/categorization of the studies; 4) evaluation of studies included in the integrative review; 5) interpretation of results; 6) presentation of knowledge review/synthesis.[7]

In the first stage, the following question was defined for the research of the articles: "What scientific evidence is available in the literature about the care needed to be directed to the family of the premature newborn during hospitalization and hospital discharge?" For the second stage, the following inclusion criteria were defined: be published in English, Spanish or Portuguese; have been published in the period of July 2012 and October 2015; approach investigated research question. We excluded the published papers that did not contain, in the results, the focus of the present study.

The unselected articles were separated and excluded and the selected ones for the third stage, that was characterized by data analysis based on reiterative readings for the grouping of data and themes. The meticulous reading of these articles was guided by an adapted instrument.[6]

The themes seized from the analysis were: the preparation of the family for the discharge of the premature and the continuity of the care in the home and the importance of the support of the family.

In the fourth stage, a more profound and critical assessment of the selected studies and the suggested themes was carried out with the objective of identifying the regularity of relevant aspects, complementarity and the articulation between the information present in each theme, looking for explanations for the different results or conflicting in the different selected studies.

The fifth stage, corresponded to the comparison of the results with the theoretical and practical knowledge and the identification of conclusions and implications resulting from the review, culminating with the elaboration of a descriptive integrative text, corresponding to the discussion of the results obtained in this review. The sixth stage, is the presentation of this integrative review, in a clear and objective way.

RESULTS

Figure 1 presents a description of the authors of the article, the year of publication, the main objectives, the subjects of the research, the type of study, the main results and the level of scientific evidence.

Authors/Year	Objectives	Subjects	Method	Synthesis of results	Level of evidence
Morais, Quirino, Camargo. (2012)[8].	Identify the social support that mothers of premature infants had to take care of their children at home.	Seven mothers	Qualitative	The mother needs the family to reduce the stress of everyday situations. Inadequate preparation or lack of family involvement will result in lack of attachment and inadequate home care. Difficulty in accessing the service and financial constraint result in ineffective or non-existent follow-up.	VI
Pickler et al. (2012)[15].	Check for changes in feeding abilities from discharge to the early post-discharge period and determine whether pre-discharge feeding skills provide for post-discharge feeding skills.	85 premature infants	Quantitative	Feeding ability of babies continues to change and matures after discharge. Feeding skills at discharge were predictive of post-discharge feeding abilities.	IV
Zamanzadeh	Explore the	16 mothers	Qualitative	Health professionals need	VI

et al. (2013)[9].	experiences of the newly born mothers of the NICU in the cultural context of Iran.			to understand the "nightmares" of mothers related to breastfeeding. Health professionals can facilitate the training of mothers to care for their babies at home. Children and their families need a favorable environment of development and learning.	
Stokowski (2014)[10].	Disclose a communiqué from the Canadian Pediatric Society that advises health professionals on the planning of discharge from the NICU for the home of clinically stable preterm infants born before the gestational age of 34 weeks.	-	Informative	A planned and complete discharge of the PTNB, following discharge readiness criteria, helps to ensure a safe and effective transition to the home. Supporting family involvement, and teaching from admission, improves parental confidence. Evaluate the physical environment and psychosocial aspects of the home is an important part of the discharge process.	VII
Custódio et al. (2013)[15].	To describe the knowledge regarding the family's experience in the high and post-discharge of the PTNB and low weight of the NICU.	16 articles	Integrative Review	Relationships within the NICU are permeated by insecurity and the conception of a lack of capacity for child care. The lack of interaction between NICU, ABS and specialized services professionals is a barrier to the improvement of NBPT care and their family.	V
Frota et al. (2013)[12].	To know the perception of the mother about the hospital discharge and the care of the premature newborn at home after the first week of discharge.	Nine mothers	Qualitative	Some mothers take the baby home without being prepared for this reality. The nursing team must allow the needs felt by the mothers to emerge instead of determining them. Some mothers did not receive guidance from the multi-professional NICU team about the care they should be offered to the baby at home. Social support has proved to be a strong ally in adapting parents to the new reality.	VI
Dos Anjos et al. (2012)[16].	To know maternal perceptions about the birth of the premature child and the care after discharge.	18 mothers	Qualitative	The birth of a preterm infant represents a critical experience for mothers and their families and deserves as much zeal as possible with the maximization of care for the recovery of the baby's health, but also with the appreciation of the care of the weak family. Mothers feel insecure about caring for the premature child. There is a great need for family support and spirituality.	VI
Schmidt et al. (2013)[11].	To identify the strategies used by the nursing team working in the neonatal unit of a school hospital	Nine professionals of the nursing team, between nurses and	Qualitative	As recognized strategies in the teaching process were listed: the early insertion of the family in the care of hygiene and comfort required by the	VI

	during the preparation of the family for the discharge of the premature infant.	technicians		hospitalized newborn, encouraging breastfeeding and other guidelines related to feeding, medication and the need for outpatient and network follow-up of primary care, after discharge from the hospital. Main difficulties: absence of mothers in the continuous follow-up of the hospitalized child, lack of systematization of preparation for discharge, low schooling, drug addiction and teenage motherhood. Potentialities of the service: and the practices that promote the humanization of care.	
Raffray et al. (2014)[13].	Explore the perception of Colombian health care providers about the barriers and facilities to prepare families with premature infants for discharge from the neonatal intensive care unit (NICU).	15 professionals working in NICU	Qualitative	It is important to strengthen parent-infant contact in neonatal settings. Specific challenges in preparation for discharge: adolescent mothers, indigenous families, uneducated parents or those living in poverty, in addition to limited health resources and a fragmented health system. A unified team approach is important, to prepare for discharge, individualized education adapted to the specific needs of parents, the use of systematic tools to guide and evaluate the preparation of parents at hospital discharge and the improvement in the relationships between hospitals and services for families with preterm infants.	VI

Figure 1. Characterization of articles inserted in the integrative review according to authors, year of publication, objective, subjects, method, synthesis of the main results and level of evidence. Fortaleza (CE), Brazil, 2016.

DISCUSSION

The discussion of the results was divided into two thematic axes. Of the analyzed articles (n = 9), seven gave subsidy to the first axis: "Family preparation for the discharge of premature babies." The second axis, "Continuity of care at home and the importance of family support" was based on six of the articles analyzed.

♦ Preparing the family for discharge from prematurity

The preparation of mothers for the hospital discharge of the premature child is of extreme importance for reducing anxiety and increasing self-confidence for home care. This should occur during the entire hospitalization of the premature infant, seeking to develop skills, transmit necessary knowledge, and provide early contact between the baby and the family.[8-11]

The Pediatric Society of Canada has chosen discharge readiness criteria for preterm infants that include: demonstration of functional maturation in the areas of physiological competence of thermoregulation; breathing control; respiratory stability; feeding and weight gain skills, assessment of the physical and psychosocial environment of the high. It also suggested pre-discharge: tests; screening tests; vaccinations, and above all, parental education to care for the baby, as well as the assurance that an adequate follow-up plan.[10]

Two of the analyzed articles cited, in a superficial way, the direct care to be oriented

to the family with the care of the premature newborn in the home environment. One of them brought the following guidelines: care when receiving a visit; stimulate baby sucking; maintaining its temperature; avoiding humid places with clusters of people; cleaning the house with damp cloth; using medications, according to medical prescription; importance of returning to specialist appointments; signs of danger to the baby's health and pausing breastfeeding, if the baby becomes dyspnoic.[12]

The care mentioned in the other article, besides some already mentioned above, included: the use of gavage; need of touch; care in handling the baby; positioning of the child; care in case of choking; supply of milk; monitoring by the BHU in childcare; prevention of rashes and the importance of vaccination.[11]

None of them has brought, in any specific or detailed way this care, how and why to carry them out, or where their scientific evidence comes from, and here is a suggestion for new studies on the subject to be carried out, in order to keep the professionals, so that, with scientific support, they can be passing on these guidelines, with responsibility and safety.

The orientation that was most closely addressed by the surveys and which the professionals evaluate as the main one for the training of the mothers is about the nutrition of the premature baby. They suggest that mothers should be helped with breastfeeding and improved self-confidence as soon as possible so they can better care for their children. In Iran, the guidelines on breastfeeding are practical and formal, right after delivery, whether normal or cesarean, even in the hospital environment, because of its importance in the cultural context of the population.[9]

Investing in early skin-to-skin contact between the binomial and the mother's involvement in caring for her child, still in the hospital, promote attachment with encouragement to maintain breastfeeding after discharge.[13] Hospitals supported by the Friend Hospital Initiative (BFHI) include, in their guidelines, the administration of milk, when breastfeeding is not possible, in the cup, and the use of baby bottles and pacifiers during the hospitalization period is precluded.[11]

Already the separation of the binomial and the lack of resources for milking and storage of milk at home were reported as significant barriers to the initiation and maintenance of lactation, as well as the expectation of the mother for the maturity of her babies to feed directly from the breast. The transition from gavage/feeding in the cup to breastfeeding are complex steps that require support, especially, among mothers who have had little contact with their hospitalized infants.[14]

Stimulating the feeding abilities of preterm infants in the pre-discharge period favors the establishment of effective suckling after discharge.[15] Accordingly, corroborating with the studies cited above, it is suggested that the incentive to breastfeeding occurs even before the premature infant is able to breastfeed, as, this often takes time and the production of breast milk can be inhibited by lack of stimulation.

Mothers should be encouraged to milk their breasts, even if their child needs specialized formula or is undergoing parenteral nutrition. Then, when it is feeding by gavage, not only the mother, but also the father and other members of the family should learn how to manage such care. In the meantime, the mother should receive guidance on the correct handgrip, be clarified as to the difficulties that may arise and what to do to prevent or even treat them, as well as the particularities of breastfeeding to premature babies, demystifying some preconceptions.[9]

And for high adoption guidelines to be received and well understood, foster care is needed because the professionals in the neonatal unit come in contact with their mother, parents and other relatives to provide them with the first health conditions of the child, thus forming a bond that will provide a good relationship of the health team with them. This, coupled with clear and objective guidelines, enables parents to be good caregivers at home.[5-16]

The study shows that the mothers recognize that the guidelines received in the NICU contribute to the care of the child at home, [13] however, the majority of studies selected showed that the guidelines made by the multi-professional team did not happen in a systematic way and were done informally. Little care was reported by the interviewed mothers, which leads us to question the form and timing of these guidelines or even the possibility that factors, such as anxiety and stress, generated in the NICU interfere with the mothers' learning.[6-9,12- 6]

Most mothers report that the NICU is more stressful than their own homes.[9] In addition, there is often disagreement among practitioners about counseling, which leaves mothers uncertain about which guidance to follow. Also, the amount of guidance received and the maternal difficulty in understanding

the language used by the professionals provide anxiety and insecurity in relation to the care of premature infants.[13]

There are also divergences between the concept of "caring" for mothers and expressing it by professionals. For mothers, care is related to the feeling of affection, while professionals relate care to the execution of technical procedures and to the attendance of the physiological needs of the child.[11]

For the most part, studies show that just guiding how to bathe, feed, among other care is not enough to gain the confidence of parents in their performance in caring for the premature child. This security and sense of competence depend on the quality of the relationships between NICU and family professionals. Dialogue with parents is essential during the hospitalization of the newborn, allowing for sensitive listening, reducing stress and helping to bond with the baby and assume the role of parents in the neonatal unit.[12-4]

It is also important that the guidelines only happen after the clinical stability of the premature infant, because only then will the parents be emotionally available to learn. The information can not only be assimilated by the parents, but understood and incorporated into the home care of the newborn after discharge. The development of skills should be based on the caregivers, through stimulating strategies proposed by the nursing team. Such guidelines should be concise, easy to understand and meet individualized needs.[12]

Some factors have been shown as barriers to health education actions during the process of discharge from prematurity. Among them were: maternal drug addiction; low schooling and/or cognitive deficits that make information difficult to understand; maternity in adolescence; indigenous families and those living in poverty and the absence of parents in the NICU.[6-11]

There are parents who abandon their children because they believe that caring for a premature or sick baby would be a "burden" for their community. Others find significant barriers to visit their children in the NICU, such as: prejudice and judgment of the professionals; difficulty of displacement of the families, because they reside in another municipality; and depend on the transportation offered by the city council, have other small children at home and need care and need to work to feed the family.[11-4]

With a view to the well-being of premature infants and their families, strategies must be proposed and carried out to address these barriers, such as: working professionals on the importance of humanization in a universal way in care, free of prejudice; provide a support house or housing for the mothers of premature babies living in other municipalities; facilitate the stay of the parents in the neonatal units and expand the educational opportunities during the stay of the parents in accompanying the child.[11]

Lack of staff and administrative tasks are also shown as barriers to prepare families for discharge in the NICU.[14] In one of the studies, mothers who were in the NICU for a long time recognized the shortage of nurses and their overload. They noted that nurses do not have enough time to instruct them, 9 however, it is important to note that the guidelines given to families are the responsibility of all members of the health team, including physicians, nursing staff, speech therapists and all those involved in care for the NB.[17] In Iran, mothers experience a variety of sources of education such as nurses, physicians, other mothers, and learning pamphlets.[9]

Therefore, it is important that all NICU professionals consider their responsibility to prepare parents as a form of continuity of hospital care at home. It is also important that they know not only the biological characteristics of the child, but also the living conditions of the families, the health care network, the social network of each family, before the discharge of the child, so that the discharge preparation facilitates the process of transition to the home.[16]

There is, still, the challenge in assessing parental readiness for neonatal discharge. This requires the development of standardized high-level planning tools and assessment methods to help ensure that the premature infant will be well cared for at home.[14]

The organization of work, preparation of a plan of care for hospital discharge, insertion of active methodologies with the parents and the elaboration of an evaluation instrument are considered important tools in the articulation of the hospital discharge process of premature babies. Research also suggests that, at hospital discharge, they should be delivered to booklet families or manuals to assist them in daily care, ensuring continuity of care in the home, with a broader range of healthy choices for premature infants.[12]

Therefore, a thorough and well-planned discharge, including careful assessment of the needs of the newborn and the premature infant, helps ensure a safe and effective transition home, as parents will be more confident in their ability to care for their baby. Premature newborn.[10-11]

Finally, it is also suggested to systematically record routines and record the actions related to the preparation of the family for the discharge, since they are important for proving and valuing the professionals providing such care.

♦ Continuity of care at home and the importance of family support

The arrival at the home is a critical period of adaptation of the newborn and the parents to the new environment, because, from that moment, they will be the one who will take care of the child. Memories of the child's health instability, during hospitalization in the NICU, mark the mothers of premature infants, causing them to fear that something bad happens with the baby, which limits care and brings insecurity day-to-day.[12]

Prematurity generates a natural insecurity in the mothers, because it demands redoubled care and greater attention with food, the risk of aspiration and gastroesophageal reflux. The handling of the premature one, in the first weeks, is more delicate, due to its natural muscular hypotonia. There is also the use of various medications and vitamins. Even the mothers, who received guidance during the hospitalization of the children, feel insecure and difficult in the initial moments.[17]

Soon, the arrival of the premature child modifies the domestic routine, since most women are totally and exclusively dedicated to the care of the child and have it as the center of their life, delaying the care of the house and with themselves. [8-10]

Culturally, the woman is recognized as the custodian and the originator of the care, and she is given the direct care of the child. And this is reinforced by her own, when, although the family wants to get involved, she limits her participation because she feels the only one with enough knowledge to take care of her baby.

This attitude can have repercussions on their emotional state, especially, the feeling of overload due to the absence of a consistent family support network, both by the concept of self-sufficiency of the mother, as well as, by the remoteness of family members due to the difficulties of accessing the baby in the NICU, and by the shake-up of the family structure, due to the conception that one should not establish a bond with a child who could die at any moment.[12-3]

The absence of the family during preterm admission makes it difficult to carry out actions aimed at health education, which, in turn implies a lack of preparation for home care after hospital discharge.[11] However, research shows how necessary this support is, especially, in the case of the birth of a premature infant, because the mother, who is weakened by the "condition" of the child and by the time she was away from home in a stressful situation, which is that of a NICU, needs the family and husband to help her with ancillary actions. The studies show that help with the care of the premature baby mainly comes from people close to the mother, such as the children's spouse and grandparents.[8-12-7]

One way to prevent family separation and to contribute to the physical and emotional health of the mother would be to insert the family into the daily care of the child within the NICU, also aiming at establishing bonding with the baby and strengthening the maternal trust in the family members who care together in the home environment.[11]

In addition, due to being in the puerperium, a period of strong emotional instability, which is very conducive to depression and anxiety, the woman requires more attention from her family and her husband, so that she can go through this complicated moment and overcome the insecurity of taking care of the baby without the help of professionals . Emotional overload is also related to the sum of problems and the lack of empathic and supportive listening.[8-12]

During pregnancy, women construct an imaginary child. This building inspires dreams for the family and the expectation of healthy children. The prematurity and the environment of the NICU frustrate these dreams and limit the mother in her motherhood, causing them to have, negative feelings, at the beginning. Reports of mothers of premature infants show feelings of sadness, disgust, anguish, suffering, and mainly, guilt as the most present before the premature birth and the early termination of gestation.[17]

Lack of family involvement and support may result in maternal stress, family disruption, lack of attachment and inadequate home care, contributing to higher rates of morbidity and mortality, and the main strategy to prepare the family for hospital discharge is the early insertion of the family. In the process of care, including dialogue as a fundamental tool for establishing trust in the relationship between professionals-baby-family.[8-11]

Family support plays a significant role in the mother's adaptation to the changes that have occurred and in the acquisition of self-confidence in caring. The experience passed on by previous generations (parents, grandparents, uncles, etc.) represents strong support and lowers feelings of insecurity. A

healthy and harmonious family environment allows a greater understanding of the difficulties experienced. The contribution of relatives, friends and neighbors also becomes important in everyday situations or even in crisis and reduces the fatigue and stress of daily situations.[8-12]

There is also, for this family, the emotional support of religious beliefs and practices, better lived at home, which is spiritual help in the face of the feelings of insecurity, guilt and sadness experienced, and the almost always unexplained questions about living and dying.[17]

Some barriers to the continuity of assimilated care were found in the texts. Many mothers, at home, reproduce the care assimilated in the NICU, but, over time, given the knowledge promoted by their own care, they ease such care, giving up much of the practices learned in the NICU, and begin to take care of the child in their own way, feeling fullness and success in the maternal role.[16] However, studies have also recognized that, for the most part, they are always attentive and insecure about food and the ability to recognize the functional stability of especially those related to breathing, or to recognize their physiological particularities; live with ambiguous feelings, such as happiness and fear, and sleeping well is rare, mainly because of the concern that they cannot wake up if the child needs their care at night.[12-3]

Breastfeeding is also a major challenge in the home environment and the supply of milk by the bottle is common. Mothers are insecure about the amount of milk ingested and, therefore, the adequacy of feeding for the child. Using the bottle is, for them, the possibility of knowing exactly the volume of milk ingested by the child. Early weaning often occurs because, for many mothers, the prematurity and/or diseases associated with it, justify the fragility of premature infants who should not exert too much effort, in addition to believing that the volume of milk produced by the mother is not enough for its needs.[13]

The planned discharge, together with the family, and home visits are a source of support in reducing anxiety and fear. The provision of information, humanized attention and follow-up of this process, with the implementation of interventions at home, increase the family's adaptability and reduce the risks of stress and the number of frequent readmissions.[12]

Mothers who have been able to exclusively breastfeed their children at home bring that fact to the support and prior support of the professionals, listening to them and understanding their individual demands and offering practical help when needed.[13] However, they do not only need practical support, but also of people who reinforce their qualities and abilities in the care of the child, because when they are recognized as positive, the woman is driven to become more involved with the care of the child and experiences more fullness in their performance. Whereas, in the disapproval, the woman feels incapable of exercising the motherhood well, being able to experience feelings of abnormality of the child.

Studies have also shown that the experience of having a premature and/or underweight child, being able to take him home and provide him with care generates an inexplicable satisfaction, which is conceived as a promoter of maturity and faith, with feelings of reward and triumph, having unfoldings for the way of being, thinking and living of the family. This makes the work of caring for the child smoother and enables the family to architect a future, hoping for stable study, work and social life.[12-3]

CONCLUSION

The preparation of the preterm family for discharge is important for the reduction of neonatal morbidity and mortality. This review was relevant because it allowed us to know and describe aspects that permeate the process of transition from premature to the home, such as the nutrition of the premature infant, which was the most cited and detailed guidance, and because it is about mothers that they have more doubts.

As for the direct care of the child, necessary to be oriented to the family of the premature newborn during his hospitalization and at discharge, only two articles were found that cite, superficially, the direct care to be guided. This fact allows us to suggest that future studies should be carried out in order to describe the necessary guidelines, based on scientific evidence, that can be used with support by the professionals responsible for family preparation.

It is also necessary to ensure the follow-up of prematurity in the post-discharge by the health services, both to ensure a good transition and to reduce the fears and longings experienced by the family.

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