

Parental Readiness for Discharge and Home Care of Premature Infants: A Comparison of Mothers and Fathers

Abstract

Background: Premature infants require specialized care following discharge from the Neonatal Intensive Care Unit (NICU), making adequate parental preparation essential for ensuring safe and effective home care.

Aim: This study aimed to assess and compare the readiness of mothers and fathers of premature infants for discharge and home care and to identify factors associated with parental readiness.

Methods: This cross-sectional study included 39 mothers and 39 fathers of premature infants admitted to the Neonatal Intensive Care Unit of a tertiary maternity and children's training and research hospital (blinded for peer review). Sociodemographic characteristics and readiness for discharge and home care were assessed using validated instruments. Data were analyzed using the chi-square test and the Mann-Whitney U test.

Results: Mothers and fathers demonstrated similarly high levels of readiness for discharge and home care. After adjustment for differences in the maximum possible scores of the assessment scales, no statistically significant difference was observed in overall readiness scores between mothers and fathers. Previous neonatal intensive care experience was reported more frequently by mothers (25.6%) than fathers (7.7%). Fathers who perceived the care of premature infants as similar to that of term infants had significantly higher scores in the nutritional support subdomain.

Conclusion: Both mothers and fathers demonstrated high levels of readiness for discharge and home care. Fathers' perceptions of premature infant care were significantly associated with their readiness, particularly in the domain of nutritional support. These findings highlight the importance of family-centered discharge education and targeted interventions to strengthen fathers' caregiving competencies.

Keywords: Home nursing, infant, intensive care units, neonatal, parents, patient discharge, premature

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Introduction

Premature birth is a leading cause of neonatal morbidity and mortality worldwide, including in Türkiye. According to the Turkish Statistical Institute, approximately 150,000 infants are born prematurely in Türkiye each year, many of whom require intensive medical and psychosocial care during the neonatal period.¹ Parents of premature infants often experience considerable stress, anxiety, and uncertainty throughout their infant's hospitalization in the Neonatal Intensive Care Unit (NICU), with these challenges frequently intensifying during the transition from hospital to home.^{2,3}

Discharge from the NICU is a major milestone for families, bringing hope and relief while also introducing new caregiving responsibilities and concerns. Caring for a premature infant at home requires knowledge and skills in multiple areas, including feeding, medication administration, respiratory care, and infection prevention.⁴ Therefore, ensuring that parents are adequately prepared with the necessary knowledge, practical skills, and psychosocial support before discharge is essential for promoting infant health and family well-being.^{4,5}

Although family-centered care has become increasingly integrated into neonatal services in Türkiye, parents' active involvement in NICU care and preparation for discharge remain suboptimal. Mothers traditionally assume primary caregiving responsibilities, whereas fathers often have fewer opportunities to participate in infant care.^{3,6} However, growing evidence indicates that fathers' active involvement in the care of premature infants promotes infant neurodevelopment and psychosocial well-being, strengthens parent-infant attachment, and enhances family functioning.^{3,4,7} Moreover, involving fathers in caregiving has been associated with reduced maternal stress and anxiety, increased parental self-efficacy, and improved family cohesion.⁷⁻⁹

Most studies examining parental readiness for NICU discharge and home care have focused primarily on mothers, with relatively little attention given to fathers' experiences and educational needs.¹⁰ Comparative evidence regarding mothers' and fathers' readiness for discharge, as well as the sociodemographic and clinical factors associated with readiness, remains limited. Similarly, studies conducted in Türkiye have largely described the challenges experienced by parents of premature infants rather than quantitatively evaluating and comparing discharge readiness between mothers and fathers.^{2,3} This study addresses this gap by comparing the discharge and home care readiness of mothers and fathers of premature infants and examining the sociodemographic and clinical factors associated with parental readiness. This study aims to contribute

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to the advancement of family-centered care by highlighting fathers' roles and support needs during the discharge and home care process. The findings may help inform the development of pre-discharge parental education and tailored support programs that address the specific needs of both mothers and fathers.

Study Questions

1. What are the discharge and home care readiness levels of mothers and fathers of premature infants?
2. Is there a significant difference in discharge and home care readiness between mothers and fathers of premature infants?

Materials and Methods

Study Design

This descriptive, comparative study was conducted to assess the discharge and home care readiness of mothers and fathers of premature infants and to determine whether there was a statistically significant difference between the two groups.

Participants

The study included mothers and fathers of premature infants who had been hospitalized for at least 24 hours in the NICU of Giresun University Women and Children's Training and Research Hospital between April and July 2025 and whose infants were within 24 hours of discharge.

The required sample size was determined using G*Power version 3.1 based on Cohen's (1988) effect size recommendations, assuming a significance level of $\alpha=0.05$ (95% confidence level) and a statistical power of 80% ($1-\beta=0.80$).¹¹ The power analysis assumed a large effect size (Cohen's $d=0.80$), and a minimum sample size of 39 participants per group was targeted. The power analysis indicated that a minimum of 34 participants was required in each group (mothers and fathers) to achieve adequate statistical power. To account for potential data loss, 39 mothers and 39 fathers were recruited. Mothers and fathers were analyzed as separate groups.

Eligible participants were required to be able to speak and understand Turkish, communicate verbally, have no diagnosed psychiatric disorder, and provide written informed consent. Parents who did not meet these criteria or whose infants had major congenital anomalies were excluded.

Data Collection Instruments

Parent-Infant Descriptive Information Form: This researcher-developed questionnaire consisted of 22 items assessing parents' sociodemographic characteristics, pregnancy and birth history, previous NICU experience, and infant health characteristics.

Readiness for Discharge and Home Care Scale for Mothers of Premature Infants in the NICU: This scale, developed by Tiryaki,¹² consists of 22 positively worded items grouped into four subscales: Nutrition, General Condition Assessment, Hygienic Care, and Care Practices. Items are rated on a 7-point Likert scale ranging from 1 (Not ready at all) to 7 (Completely ready). Total scores range from 22 to 154, with higher scores indicating greater readiness for discharge and home care. In the present study, the scale demonstrated excellent internal consistency (Cronbach's $\alpha=0.935$).

Readiness for Discharge and Home Care Scale for Fathers of Premature Infants in the NICU: This scale, also developed by Tiryaki,¹² comprises 20 positively worded items organized into three subscales: Nutritional Support, Hygienic Care, and Care Practices. Items are rated on a 7-point Likert scale ranging from 1 (Not ready at all) to 7 (Completely ready). Total scores range from 20 to 140, with higher scores indicating greater readiness for discharge and home care. In the present study, the scale demonstrated high internal consistency (Cronbach's $\alpha=0.872$).

Data Collection

Data were collected through face-to-face interviews conducted by a trained researcher (in Giresun Women and Child Education and Research Hospital Neonatal Intensive Care Unit between April and July 2025). Parents of premature infants who had been hospitalized in the NICU for at least 24 hours and were within 24 hours of discharge were interviewed using standardized data collection proce-

dures. Clear inclusion and exclusion criteria were applied to minimize selection bias. Mothers and fathers were analyzed as separate groups to allow independent evaluation of maternal and paternal readiness. Owing to the nature of the study, blinding of participants and the researcher was not feasible.

Statistical Analysis

Because the maternal and paternal readiness scales differed in the number of items and maximum possible scores, normalized readiness scores were calculated using the following formula:

$$\text{Normalized score (\%)} = (\text{Observed score} / \text{Maximum possible score}) \times 100$$

Comparisons between mothers and fathers were based on normalized scores rather than raw total scores. Data were analyzed using Number Cruncher Statistical System (NCSS) software (NCSS LLC, Kaysville, UT, USA). Normality was assessed using skewness and kurtosis values. According to Tabachnick and Fidell,¹³ skewness and kurtosis values between -1.5 and $+1.5$ indicate an approximately normal distribution. For variables that met the assumption of normality, data are presented as mean $\pm$ standard deviation, and between-group comparisons were performed using the independent-samples *t* test. Variables that were not normally distributed are presented as median (minimum-maximum) and were compared using the Mann-Whitney *U* test. Categorical variables were compared using the chi-square test. Internal consistency of the scales and their subscales was evaluated using Cronbach's alpha (α) coefficient. Cronbach's alpha values of <0.40 indicate poor reliability, $0.40-0.60$ low reliability, $0.60-0.80$ acceptable reliability, and ≥ 0.80 high reliability.¹⁴ Continuous variables are presented as mean $\pm$ standard deviation or median (minimum-maximum), as appropriate, whereas categorical variables are presented as frequencies and percentages. A *p* value <0.05 was considered statistically significant, and 95% confidence intervals were reported.

Ethical Considerations

Ethical approval was obtained from Giresun Training and Research Hospital Scientific Research Ethics Committee [Approval Number: 16.04.2025/06, Date: 16.04.2025]. Permission to use the study instruments was obtained from the scale developer. Before data collection, all participants received information about the study and provided written informed consent. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Results

Table 1 summarizes the sociodemographic characteristics and health-related variables of the participating mothers and fathers. No statistically significant difference was found in the educational level between mothers and fathers ($p=0.906$). High school graduates constituted the largest educational group among mothers (33.3%) and fathers (38.5%). No statistically significant differences were observed between mothers and fathers in employment status ($p=0.774$), spouse's educational level ($p=0.657$), spouse's employment status ($p=0.170$), or socioeconomic status ($p=0.989$). A statistically significant difference was found in preferred infant gender ($p<0.001$), with mothers more frequently preferring a female infant and fathers more frequently preferring a male infant. Additionally, mothers were significantly more likely than fathers to report having previously had an infant admitted to a neonatal intensive care unit (25.6% vs. 7.7%, $p=0.033$). No significant difference was observed in the history of previous preterm birth ($p=0.498$) (Table 1).

Tables 2 and 3 present the descriptive statistics for the maternal and paternal readiness for discharge and home care scales. Mothers had a mean total readiness score of 138.79 ± 18.02 (range: 95-154), whereas fathers had a mean score of 127.41 ± 12.80 (range: 89-140). Because the maternal and paternal scales differ in the number of items (22 vs. 20), raw total scores were not directly compared. After normalization to the maximum possible score of each scale, the mean total readiness score was 90.1 ± 11.7 for mothers and 91.0 ± 9.1 for fathers. No statistically significant difference was observed in overall discharge and home care readiness between mothers and fathers ($U=845.000$, $p=0.400$) (Table 4). Both scales demonstrated high reliability ($\alpha=0.935$ for the maternal scale and $\alpha=0.872$ for the paternal scale) (Tables 2, 3).

Tables 5 and 6 compare discharge and home care readiness scores according to parents' expectations of experiencing difficulties in caring for or feeding their

Table 1. Comparison of sociodemographic and clinical characteristics of mothers and fathers

	Group				χ^2	p
	Mothers		Fathers			
	n	%	n	%		
Educational level					0.559	0.906
Primary school	6	15.4	5	12.8		
Middle school	8	20.5	6	15.4		
High school/university	13	33.3	15	38.5		
Bachelor's degree or higher	12	30.8	13	33.3		
Employment status					0.083	0.774
Employed	8	20.5	7	17.9		
Unemployed	31	79.5	32	82.1		
Spouse's educational level						0.657
Primary school	9	23.1	12	30.8	2.433	
Middle school	12	30.8	11	28.2		
High school	10	25.6	6	15.4		
University	4	10.3	7	17.9		
Graduate degree	4	10.3	3	7.7		
Spouse's employment status					1.880	0.170
Employed	33	84.6	28	71.8		
Unemployed	6	15.4	11	28.2		
Socioeconomic status					0.021	0.989
Income less than expenses	14	36.8	15	38.5		
Income equal to expenses	20	52.6	20	51.3		
Income greater than expenses	4	10.5	4	10.3		
Planned pregnancy					0.743	0.389
Yes	30	76.9	33	84.6		
No	9	23.1	6	15.4		
Previous pregnancy					0.052	0.820
Yes	22	56.4	21	53.8		
No	17	43.6	18	46.2		
Mode of delivery					0.126	0.723
Vaginal delivery	5	12.8	4	10.3		
Cesarean section	34	87.2	35	89.7		
Infant sex					78.000	<0.001
Female	39	100.0	0	0.0		
Male	0	0.0	39	100.0		
Previous preterm birth					0.459	0.498
Yes	6	15.4	4	10.3		
No	33	84.6	35	89.7		
Previous infant admitted to the NICU					4.523	0.033
Yes	10	25.6	3	7.7		
No	29	74.4	36	92.3		

premature infant after discharge. No statistically significant associations were found between anticipated caregiving difficulties and readiness scores in either mothers or fathers ($p>0.05$). Among mothers, the mean total readiness score was 130.20 ± 24.24 for those who expected difficulties and 140.06 ± 17.03 for those who did not ($U=0.827$, $p=0.409$). Among fathers, the corresponding scores were 123.17 ± 12.38 and 128.18 ± 12.90 , respectively ($U=0.997$, $p=0.319$) [Tables 5, 6].

Table 2. Readiness for discharge and home care scale for mothers of premature infants in the neonatal intensive care unit

	Mean $\pm$ SD	Range	CA (α)	Skewness	Kurtosis
Nutritional support	18.08 $\pm$ 3.77	8–21	0.694	-1.306	0.680
General condition assessment	24.56 $\pm$ 4.44	10–28	0.893	-1.515	2.076
Hygienic care	42.15 $\pm$ 8.51	17–49	0.895	-1.308	1.148
Care practices	54.00 $\pm$ 4.70	37–56	0.944	-2.526	5.653
Total score	138.79 $\pm$ 18.02	95–154	0.935	-1.206	0.421

SD: Standard deviation, CA (α): Cronbach's alpha.

Table 3. Descriptive statistics and reliability of the paternal readiness or discharge and home care scale

	Mean $\pm$ SD	Range	CA (α)	Skewness	Kurtosis
Nutritional support	49.62 $\pm$ 6.64	32–56	0.784	-1.107	0.512
Hygienic care	43.21 $\pm$ 6.89	21–49	0.832	-1.730	2.997
Care practices	34.59 $\pm$ 0.79	32–35	0.660	-1.859	2.578
Total score	127.41 $\pm$ 12.80	89–140	0.872	-1.316	1.378

SD: Standard deviation, CA (α): Cronbach's alpha.

In both groups, parents who did not expect to experience difficulties after discharge had higher readiness scores than those who did. No significant differences were observed in the subscale scores for Nutritional Support, Hygienic Care, or Care Practices in either mothers or fathers. Among mothers, scores for the General Condition Assessment subscale also did not differ according to anticipated caregiving difficulties. These findings suggest that the relationship between parents' perceived readiness for discharge and their expectations of future caregiving difficulties is complex. Similar patterns observed among mothers and fathers indicate that parental readiness may not differ substantially by parent gender in this context.

Table 4 presents the comparison of normalized readiness scores between mothers and fathers. Normalized scores were calculated as [observed score / maximum possible score] $\times$ 100 to account for differences in the number of scale items and maximum possible scores [maternal scale: 22 items, maximum score=154; paternal scale: 20 items, maximum score=140]. After normalization, no statistically significant difference was observed in overall readiness scores between mothers and fathers ($p>0.05$). The General Condition Assessment subscale was not compared because the paternal scale does not include an equivalent subscale [Table 4].

Discussion

This study compared the discharge and home care readiness of mothers and fathers of premature infants and examined factors associated with parental readiness. When interpreted in the context of the current literature, these findings provide important insights into the gender dynamics of parenting roles, the distribution of caregiving responsibilities, and the implementation of family-centered care.

In this study, the sociodemographic characteristics of mothers and fathers were largely comparable. This finding is consistent with the study conducted in Australia by Aydon et al.¹⁰ which reported relatively similar educational and occupational characteristics among parents of premature infants. However, the marked difference in infant gender preference between mothers and fathers is noteworthy. This finding is consistent with the observations of Ireland et al.⁸ regarding fathers' experiences in neonatal care units and suggests that gender roles may shape parental expectations.

Previous studies have also highlighted the impact of the coronavirus disease 2019 [COVID-19] pandemic on parental involvement in neonatal care. Parental perceptions indicate that neonatal unit visitation restrictions implemented during the

Table 4. Maternal readiness for discharge and home care according to expected difficulty in infant care after discharge

	Do you expect to have difficulties caring for and feeding your baby at home after discharge?						U	p
	n	Mean	SD	Median	Minimum	Maximum		
Nutritional support							1.135	0.256
Yes	5	16.60	3.65	15.00	13.00	21.00		
No	34	18.29	3.79	20.00	8.00	21.00		
General condition assessment							0.502	0.616
Yes	5	23.80	4.27	24.00	19.00	28.00		
No	34	24.68	4.51	26.00	10.00	28.00		
Hygienic care							1.045	0.296
Yes	5	36.20	13.39	33.00	17.00	49.00		
No	34	43.03	7.46	46.00	23.00	49.00		
Care practices							0.657	0.511
Yes	5	53.60	4.83	56.00	45.00	56.00		
No	34	54.06	4.75	56.00	37.00	56.00		
Total score							0.827	0.409
Yes	5	130.20	24.24	127.00	96.00	154.00		
No	34	140.06	17.03	147.00	95.00	154.00		

Mann-Whitney U test; p<0.05. SD: Standard deviation.

Table 5. Comparison of normalized readiness scores between mothers and fathers

Subscale	Mothers Mean±SD (%)	Fathers Mean±SD (%)	U	p	r	Significance
Nutritional support	86.1±18.0	88.6±11.9	705.0	0.564	0.065	p>0.05
Hygienic care	86.0±17.4	88.2±14.1	763.0	0.984	0.002	p>0.05
Care practices	96.4±8.4	98.8±2.3	–	–	–	–
Total score	90.1±11.7	91.0±9.1	845.0	0.400	0.095	p>0.05

Comparisons were performed using the Mann-Whitney U test on normalized percentage scores (n=39 per group). SD: Standard deviation.

Table 6. Paternal readiness for discharge and home care according to expected difficulty in infant care after discharge

	Do you expect to have difficulties caring for and feeding your baby at home after discharge?						U	p
	n	Mean	SD	Median	Minimum	Maximum		
Nutritional support							1.259	0.208
Yes	6	46.50	7.56	46.50	38.00	56.00		
No	33	50.18	6.42	51.00	32.00	56.00		
Hygienic care							0.730	0.465
Yes	6	41.67	6.86	42.00	33.00	49.00		
No	33	43.48	6.96	45.00	21.00	49.00		
Care practices							1.525	0.127
Yes	6	35.00	0.00	35.00	35.00	35.00		
No	33	34.52	0.83	35.00	32.00	35.00		
Total score							0.997	0.319
Yes	6	123.17	12.38	122.50	107.00	140.00		
No	33	128.18	12.90	133.00	89.00	140.00		

Mann-Whitney U test; p<0.05. SD: Standard deviation.

COVID-19 pandemic negatively affected parental involvement and discharge preparation.¹⁵ These findings suggest that pandemic-related restrictions may have influenced parental readiness and engagement during the discharge process.

Difference was observed in overall readiness scores between mothers and fathers. This finding suggests that the apparent difference in raw total scores was primarily attributable to differences in the structure of the maternal and paternal

scales rather than to a true difference in readiness. Previous research has emphasized the importance of involving both mothers and fathers in discharge preparation and promoting fathers' active participation in neonatal care. Evidence further suggests that technology-supported and digitally delivered educational interventions can enhance fathers' engagement and preparedness for infant care.⁹ These findings suggest that technology-supported educational programs may represent a promising strategy for enhancing parental preparedness during discharge.⁹ In our study, fathers who perceived the care of premature infants as similar to that of term infants had significantly higher scores on the Nutritional Support subscale. This finding is consistent with previous research on fathers' roles in premature infant care and suggests that fathers' knowledge and confidence regarding infant nutrition may contribute to their overall readiness for caregiving.³ Recent research has further emphasized the importance of fathers' involvement in neonatal care and discharge preparation. Evidence from the COVID-19 pandemic indicates that neonatal unit visitation restrictions reduced opportunities for parental participation in infant care and negatively affected discharge preparation.¹⁵ These findings support the association between fathers' involvement in nutritional care and parental readiness observed in our study and underscore the potential value of targeted educational interventions.¹⁶ Furthermore, the absence of a significant association between parents' expectations of experiencing difficulties after discharge and their readiness levels is consistent with Pohlman's⁶ qualitative study of parenting experiences in the NICU. Together, these findings suggest that parents' perceived readiness for discharge may not necessarily.

Emerging evidence also indicates that parents' perceived readiness before discharge does not always correspond to their actual experiences after returning home. Studies have shown that parents often report higher levels of preparedness than are reflected in the challenges they encounter after discharge, particularly in emergency management, the use of medical technologies, and access to social support services.⁵ These findings suggest that pre-discharge assessments should be comprehensive and should evaluate both parents' perceived readiness and their anticipated support needs.

Compared with the findings of Bora Güneş and Çavuşoğlu² on the post-discharge experiences of mothers of premature infants in Türkiye, our results suggest that although mothers report high levels of discharge readiness, they may still encounter challenges in providing care after discharge. This discrepancy between perceived readiness and actual caregiving experiences underscores the importance of ongoing post-discharge support and follow-up services.

Recent studies conducted in Türkiye also support these findings. A multicenter study reported that parents of preterm infants experienced considerable difficulties during the transition from hospital to home, along with increased anxiety related to infant care and post-discharge stress.¹⁷ These findings highlight the need for Türkiye-specific discharge preparation programs that address cultural and psychosocial factors.

The findings of this study have important implications for family-centered neonatal care. The association between fathers' readiness and nutritional support highlights the need to actively involve fathers in discharge education and infant feeding programs. Additionally, although mothers demonstrated high readiness levels, the similar expectations of post-discharge caregiving difficulties reported by both parents suggest that discharge education should address not only technical caregiving skills but also psychosocial support and problem-solving strategies. Recent evidence supports the effectiveness of innovative approaches in family-centered care. Systematic reviews have shown that technology-enhanced educational interventions, including virtual reality-based applications, improve parental engagement and learning outcomes compared with traditional educational methods. In addition, peer support-based interventions have been shown to enhance perceived social support and reduce parental stress during the transition from hospital to home. These findings suggest that future discharge support programs should integrate technology-enhanced educational strategies with structured social support components.¹⁸

Study Limitations

This study has several limitations that should be acknowledged. First, it was conducted at a single center with a relatively small sample of 39 mothers and 39 fathers, which may limit the generalizability of the findings to other settings and populations. Second, the cross-sectional design precludes causal inferences and

does not allow changes in parental readiness or post-discharge outcomes to be evaluated over time. Third, the marked difference in preferred infant sex between mothers and fathers may reflect sampling characteristics or response bias and warrants further investigation. Fourth, the study relied on self-reported measures, which may have been influenced by social desirability bias. Fifth, cultural and socioeconomic factors specific to the study setting may limit the generalizability of the findings to other populations. Finally, the study did not include post-discharge follow-up to evaluate actual home care experiences and outcomes, limiting the ability to examine the relationship between perceived readiness before discharge and caregiving experiences after discharge.

Conclusion

This study highlights the importance of involving both mothers and fathers in discharge preparation and home care education for premature infants. Discharge education should adopt a family-centered approach that recognizes the caregiving roles and support needs of both parents, with particular attention to fathers' involvement in infant feeding and care. Tailored educational and supportive interventions may help strengthen parents' confidence and preparedness during the transition from hospital to home. Future multicenter and longitudinal studies with larger and more diverse samples are needed to further explore parental readiness and evaluate the effectiveness of family-centered discharge education and support interventions. [ÖE1] The Conclusion has been rewritten to emphasize the main implications of the study findings and practical recommendations without repeating the statistical results.

Ethics Committee Approval: The study was approved by the Giresun Training and Research Hospital Scientific Research Ethics Committee (Approval Number: 16.04.2025/06, Date: 16.04.2025).

Informed Consent: Written informed consent was obtained from all the participants.

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