HEALTH SCENARIO REGARDING CARE FOR NEONATES AFTER HOSPITAL ADMISSION

CENÁRIO DE SAÚDE SOBRE CUIDADOS COM NEONATOS APÓS INTERNAÇÃO HOSPITALAR

ESCENARIO DE SALUD SOBRE LOS CUIDADOS DE NEONATOS DESPUÉS DE LA HOSPITALIZACIÓN

https://doi.org/10.56238/sevened2025.036-146

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ABSTRACT

Considering that the neonatal period represents a phase of high vulnerability to infant health, marked by biological, environmental, and social risks, the continuity of care after hospital discharge is a challenge for families and health services. This study aims to understand the continuity of care and follow-up of newborns after hospitalization. To this end, a descriptive, cross-sectional study with a quantitative approach was conducted in a referral outpatient clinic in the city of Recife/PE, with the participation of 11 caregivers of newborns previously hospitalized for more than 24 hours and under outpatient follow-up. Data collection was carried out using a structured questionnaire, including sociodemographic information, clinical data, and aspects of the post-discharge scenario, with the data analyzed using descriptive statistics. Thus, it was observed that the median age at admission was 17 days, with an average length of stay of 10 days, the main causes of hospitalization being infections and jaundice. It was identified that only 45.5% of families left the consultation with a scheduled follow-up appointment, and that 81.8% required unscheduled care. The difficulties reported involved insecurity in care, emotional overload, and socioeconomic barriers, while the solutions suggested included prior scheduling of

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consultations, clearer guidelines, and systematic use of the Child's Health Record. It is concluded that the continuity of neonatal care after discharge presents clinical and social weaknesses, reinforcing the need for supervised professional follow-up.

Keywords: Neonate. Hospital Discharge. Childcare. Nursing Care Planning.

RESUMO

Considerando que o período neonatal representa uma fase de elevada vulnerabilidade à saúde infantil, marcada por riscos biológicos, ambientais e sociais, a continuidade do cuidado após a alta hospitalar configura-se como um desafio para famílias e serviços de saúde. Objetiva-se conhecer a continuidade do cuidado e o acompanhamento de neonatos após a hospitalização. Para tanto, procede-se a um estudo descritivo, transversal e de abordagem quantitativa, realizado em ambulatório de referência no município de Recife/PE, com a participação de 11 responsáveis por neonatos previamente internados por período superior a 24 horas e em seguimento ambulatorial. A coleta de dados ocorreu por meio de questionário estruturado, contemplando informações sociodemográficos, dados clínicos e aspectos do cenário pós-alta, sendo os dados analisados por estatística descritiva. Desse modo, observou-se que a mediana de idade ao internamento foi de 17 dias, com tempo médio de internação de 10 dias, sendo as principais causas de hospitalização infecções e icterícia. Identificou-se que apenas 45,5% das famílias saíram da consulta com retorno agendado e que 81,8% necessitaram de atendimentos não programados. As dificuldades relatadas envolveram insegurança no cuidado, sobrecarga emocional e barreiras socioeconômicas, enquanto as soluções apontadas incluíram agendamento prévio das consultas, orientações mais claras e utilização sistemática da Caderneta da Criança. Conclui-se que a continuidade do cuidado neonatal pós-alta apresenta fragilidades clínicas e sociais, reforçando a necessidade de acompanhamento profissional supervisionado.

Palavras-chave: Neonato. Alta Hospitalar. Puericultura. Planejamento da Assistência de Enfermagem.

RESUMEN

Considerando que el período neonatal representa una fase de alta vulnerabilidad para la salud infantil, marcada por riesgos biológicos, ambientales y sociales, la continuidad de la atención tras el alta hospitalaria representa un desafío para las familias y los servicios de salud. Este estudio busca comprender la continuidad de la atención y el seguimiento de los recién nacidos tras la hospitalización. Para ello, se realizó un estudio descriptivo, transversal y cuantitativo en una clínica ambulatoria de referencia de la ciudad de Recife/Perú, con la participación de 11 cuidadores de recién nacidos hospitalizados previamente durante más de 24 horas y en seguimiento ambulatorio. La recolección de datos se realizó mediante un cuestionario estructurado que incluyó información sociodemográfica, datos clínicos y aspectos del contexto posterior al alta, y se analizaron mediante estadística descriptiva. Así, se observó que la mediana de edad al ingreso fue de 17 días, con una estancia media de 10 días, siendo las principales causas de hospitalización las infecciones y la ictericia. Se identificó que solo el 45,5% de las familias abandonaron la consulta con una cita de seguimiento programada, y que el 81,8% requirió atención no programada. Las dificultades reportadas incluyeron inseguridad en la atención, sobrecarga emocional y barreras socioeconómicas, mientras que las soluciones sugeridas incluyeron la programación previa de las consultas, directrices más claras y el uso sistemático de la Historia Clínica Infantil. Se concluye que la continuidad de la atención neonatal tras el alta presenta deficiencias clínicas y sociales, lo que refuerza la necesidad de un seguimiento profesional supervisado.

Palabras clave: Neonato. Alta Hospitalaria. Cuidado Infantil. Planificación de la Atención de Enfermería.

1 INTRODUCTION

The neonatal period, which comprises the first 28 days postpartum, is a phase considered to be vulnerable to child health due to biological, environmental, social and cultural risks. This requires adequate care, greater vigilance and monitoring by the health professional, in order to ensure better growth and development of the child. This period is also responsible for 60% to 70% of infant deaths in recent decades, occurring mainly up to the 6th day of life, being the fundamental indicator of the quality of care for the newborn (Pinheiro *et al*., 2016).

Newborn health care is of fundamental importance for reducing infant mortality, which is still high in Brazil, as well as promoting a better quality of life and reducing health inequalities. In the neonatal period, a time of great vulnerability in life, where biological, environmental, socioeconomic and cultural risks are concentrated, with the need for special care, with timely, comprehensive and qualified social and health protection, rights recognized by the Statute of the Child and Adolescent (ECA).

It is in the first week of life, especially in the first day of life (representing 25%), that infant deaths in the country are concentrated. Health promotion, prevention and care actions aimed at pregnant women and newborns are of great importance, as they influence the health condition of individuals, from the neonatal period to adulthood. The determining relationship between intrauterine life, health conditions at birth and in the neonatal period, and chronic-degenerative problems in adult life, such as obesity, diabetes, cardiovascular diseases, and mental health, among others, has been increasingly highlighted (Ministry of Health, 2014).

The literature highlights the importance of guidance for the preparation of the newborn's family members, provided by health professionals, during hospital discharge from an intensive care unit or neonatal unit (Conceição, 2023). Intersectoriality, the technical and scientific knowledge of professionals to care for NICU discharged, public policies, multicenter research, as well as the construction of bonds between health service professionals and families, are important strategies for the construction of care for neonates and their families after hospital discharge (Braga *et al*., 2012).

Studies have revealed that there are already innovative initiatives and practices that have signaled a reconfiguration of neonatal care, among which we mention: the implementation of strategies that enable the participation of the family in the daily care routine, by recognizing that it should be a protagonist in neonatal care and that it should be assured the possibility of establishing a bond and attachment with the newborn; dialogical care practices that enable the expansion of knowledge, recognition of practices and the effective participation of the subjects involved in the daily care routine; care initiatives centered on the demands and needs of newborns and their families, understanding that in addition to the biological recovery of the newborn, there are psychosocial demands that permeate and determine the daily life (Duarte; Sena; Xavier, 2011).

In this context, the present study is justified, since the transition of the newborn from the hospital environment to the home represents a critical moment, in which risks and vulnerabilities that can compromise the continuity of care are concentrated. Despite advances in public policies aimed at neonatal health, there are still gaps related to communication between services, the preparation of families at the time of discharge, and articulation with primary care. Knowing the health scenario of neonates after hospitalization is essential to contribute to more qualified professional practices, strengthen health education and reduce avoidable complications and rehospitalizations. Thus, the guiding question of this study is: "What are the conditions and challenges faced by families in the care of neonates after hospitalization, considering clinical and social aspects?".

From this perspective, the main objective of this study is to know the continuity of care and follow-up of neonates after hospitalization.

2 METHODOLOGY

This is a descriptive cross-sectional study with a quantitative approach that seeks to know the health scenario of neonates after hospital discharge and to analyze its factors. The quantitative-descriptive study is presented through empirical-based research that aims to present and/or interpret occurrences or phenomena, evaluate programs or analyze main parts or variables, with standardized data collection techniques (Marconi; Lakatos, 2011).

The research was conducted in the outpatient sector of reference in child and women's health care of a reference maternity hospital located in the Metropolitan Region of Recife - PE. The target population of the study comprised legal guardians of neonates who had a history of hospitalization for a period of more than 24 hours and who were under outpatient follow-up at the referral service. Those who agreed to participate by signing the Informed Consent Form (ICF) and who were present at the time of the follow-up visit of the newborn were included.

The sample was defined by convenience, depending on the availability of the participants and the practical feasibility of collection in the flow of the service. Although more than 100 families were approached during the collection period, only 11 fully met the inclusion criteria and made up the final sample of the study. This difference occurred due to the specificity of the theme, the required clinical profile (previous neonatal hospitalization) and logistical limitations of the field process.

As an instrument for data collection, a structured questionnaire was used, elaborated based on the objectives of the research and the literature review. The questionnaire was composed of three blocks:

1. Sociodemographic profile of the family (sex/gender of the caregiver, age, income, economic class, marital status, level of education, living at home with the newborn, among others);
2. Clinical data of the newborn (comorbidities, diagnoses and conditions, therapy used, length and age of hospitalization, number of consultations performed);
3. Post-hospital discharge scenario (care recall, guidance received, use of the Child's Handbook, outpatient follow-up, family difficulties and strategies).

The data obtained were organized in an electronic spreadsheet and analyzed by means of descriptive statistics, with absolute and relative frequencies, measures of central tendency and exploratory analysis of correlations between variables. The exploratory nature and the small sample size made it impossible to perform inferential tests, so the results were presented in a descriptive and interpretative way.

3 RESULTS AND DISCUSSIONS

100 families were approached in person during the collection period at the CISAM/UPE outpatient clinic. However, only 11 fully met the inclusion criteria, i.e., neonates who had been previously hospitalized and were under outpatient follow-up at the service, and agreed to answer the questionnaire in a reserved place. This contrast between the families approached and included highlights the difficulties inherent in data collection in such a specific theme and in a scenario of continuous flow care.

The sociodemographic profile of the participants revealed main caregivers living with the neonate, mothers (100.00%), with high daily time (more than 12 hours) dedicated to care. Diversity was observed in relation to education, marital status and family income, and part of the families made use of social benefits. These findings suggest that care burden is a relevant factor, and that the available support network varies according to the context of each family.

Table 1 presents the sociodemographic characterization of the parents or guardians of the neonates monitored in the study, highlighting relevant aspects of the social and economic context of the families. It is observed that most participants (72.7%) reported participation in the Bolsa Família Program, which indicates the significant presence of families in situations of socioeconomic vulnerability. This finding reinforces the influence of social determinants of health on neonatal care, since limited financial conditions can impact access to resources, transportation, and continuity of health follow-up.

Regarding marital status, there was a balanced distribution between married and single guardians, both corresponding to 45.5% of the sample, while stable unions were less frequent (9.1%). This result suggests diversity in family configurations, which may reflect different levels of social support available for the care of the newborn, an aspect that can interfere with the burden of the main caregiver and the organization of home care.

Regarding schooling, most of the parents or guardians (63.6%) had 13 or more years of schooling, while 36.4% had up to 12 years of schooling. The absence of participants with up to four years of schooling indicates a relatively high educational level in the sample. However, even in the face of higher education, difficulties related to the continuity of care persist, which indicates that barriers in post-discharge follow-up are not restricted only to the level of education, but also to the organization of health services and the clarity of the guidance provided by professionals.

Regarding family income, it was observed that 36.4% of the heads of households did not have a fixed income and 27.3% lived on less than one minimum wage, totaling 63.7% of the households in an unfavorable economic condition. Only 36.4% reported income equal to or greater than one minimum wage. These data show a scenario of financial instability, which can increase difficulties in the continuous care of newborns, especially with regard to travel to consultations, acquisition of supplies and maintenance of outpatient follow-up.

Regarding insertion in the labor market, most of the parents or guardians (72.7%) did not have a profession or occupation at the time of data collection, which may be related to their full dedication to the care of the newborn or to the limitations imposed by the socioeconomic context. Although the availability of time can favor direct care, the absence of work activity can intensify dependence on social benefits and increase the financial vulnerability of families.

Table 1

Distribution of synthesized data on the sociodemographic characteristics of the caregivers of the neonates (n = 11)

Variables	n	%
Participation in the Bolsa Família Program		
Yes	8	72,7
No	3	27,3
Marital status of the responsible adult		
Married	5	45,5
Single	5	45,5
Stable union	1	9,1
Number of years of study		
≤ 4 years	0	0,0
5 to 9 years	3	27,3
10 to 12 years	1	9,1
≥ 13 years	7	63,6
Family income		
No fixed income	4	36,4
Less than 1 minimum wage	3	27,3
1 minimum wage	2	18,2
2 or more minimum wages	2	18,2
Has a profession/occupation		
Yes	3	27,3
No	8	72,7

Source: The authors, 2025.

Taken together, the sociodemographic data reveal that those responsible for the newborns live, for the most part, in contexts of social vulnerability, characterized by low income, dependence on social programs and occupational instability, although with relatively high levels of education. This scenario reinforces the need for post-discharge care strategies that consider not only the clinical aspects of the neonate, but also the social conditions of the families, strengthening the articulation between health services and the social support network, in order to promote comprehensive care and reduce the risk of care discontinuity.

Table 2 describes the clinical and care characterization of neonates after hospitalization, showing a profile marked by clinical vulnerability and weaknesses in the organization of health follow-up. It is observed that the highest proportion of neonates were in the age group of 22 to 28 days of life (36.4%), followed by those up to 7 days (27.3%), which indicates that a significant part of the hospitalizations occurred in the late neonatal period, a phase that is equally sensitive for clinical complications and demand for continuous follow-up.

Regarding the causes of hospitalization, a wide diversity of diagnoses was identified, covering both acute clinical conditions and diseases that require specialized follow-up. Diseases of the lower airways and inguinal hernia stood out (both with 18.2%), in addition to other homogeneously distributed causes, such as infections, jaundice, immunization-preventable diseases, gastrointestinal alterations, and malformations. This heterogeneity of causes reinforces the clinical complexity of neonates followed and highlights the need for individualized care strategies after hospital discharge. In addition, the possibility of more than one cause per newborn signals multifactorial disease trajectories, which increase the risk of rehospitalizations and require continuous surveillance.

Regarding the type of birth, most of the neonates were born at term (81.8%), while 18.2% were preterm. Although prematurity is recognized as a risk factor for neonatal morbidity and mortality, the data indicate that even full-term neonates presented clinical conditions that required hospitalization, showing that neonatal vulnerability is not restricted to gestational age, but involves multiple clinical and contextual determinants.

With regard to health follow-up after discharge, there was a high frequency of consultations, and 63.6% of the neonates had already had more than six Child Health consultations. This finding may reflect both the need for intensive monitoring, due to the clinical conditions presented, and possible failures in the problem-solving capacity of consultations, leading to repeated visits. It was also observed that more than half of the neonates (54.5%) did not leave the appointment with the next previously scheduled appointment, which evidences weaknesses in the organization of outpatient follow-up and in the articulation of the care network.

In addition, the high proportion of neonates who required unscheduled care in urgent and emergency services (81.8%) stands out. This result suggests that the absence of structured planning of post-discharge care, associated with the clinical complexity of the cases, may contribute to the recurrent use of more complex services, often for situations that could be followed up in the context of primary or outpatient care.

Table 2

Distribution of synthesized data on the clinical and care characteristics of neonates after hospitalization (n = 11)

Variables	n	%
Age of the neonate		
0–7 days	3	27,3
8–14 days	2	18,2
15–21 days	2	18,2
22–28 days	4	36,4
Cause of hospitalization*		
Immunization-preventable diseases/sensitive conditions	1	9,1
Infectious gastroenteritis and complications	1	9,1
Bacterial pneumonias	1	9,1
Asthma	1	9,1
Lower airway diseases	2	18,2
Functional diversity	1	9,1
Accidents	1	9,1
Inguinal hernia	2	18,2
Urethral stricture	1	9,1
Jaundice	1	9,1
Congenital constipation	1	9,1
Adenoid hypertrophy	1	9,1
Type of birth		
Term	9	81,8

Preterm	2	18,2
Number of Child Health Consultations		
A	1	9,1
Two	1	9,1
Four	1	9,1
Five	1	9,1
More than six	7	63,6
Leaves the appointment with a scheduled return		
Yes	5	45,5
No	6	54,5
Unscheduled emergency care		
Yes	9	81,8
No	2	18,2

*Possibility of more than one cause per neonate.
Source: The authors, 2025.

In summary, the data show that the neonates followed up have a heterogeneous clinical profile and a high demand for health services after hospital discharge. The high frequency of unscheduled appointments, associated with the absence of prior scheduling of appointments, points to weaknesses in the continuity of care, reinforcing the need to strengthen discharge planning, counter-referral and articulation between the different levels of care, in order to reduce avoidable readmissions and promote comprehensive neonatal care.

Table 3 presents the data regarding the guidance provided by health professionals and the use of the Child's Handbook in the post-discharge follow-up of neonates, evidencing advances, but also important gaps in communication and standardization of care. It is observed that, in most of the consultations, the professionals requested the Child's Handbook (81.8%), which indicates recognition of this instrument as a relevant tool for monitoring child growth and development. However, the isolated request does not guarantee its effective use, an aspect that is reflected in the subsequent results.

Regarding the completion of the booklet, a little more than half of the parents or guardians (54.5%) reported that the information is recorded systematically, while 27.3% reported that it is filled out only occasionally and 18.2% stated that there is no record during consultations. These data reveal inconsistency in the use of the instrument, suggesting weaknesses in the continuity of the recording of information and in the standardization of professional practices, which may compromise the longitudinal follow-up of the child.

Regarding guidance on healthy eating and exclusive breastfeeding up to six months, it was found that most of the parents or guardians (72.7%) reported receiving these guidelines continuously, while a smaller portion reported receiving them only occasionally (18.2%) or not receiving them (9.1%). Although this finding indicates progress in the approach to a central axis of neonatal care, the absence or irregularity of these guidelines in part of the care can negatively impact fundamental practices for the health and development of the newborn.

Regarding the guidance on the growth curve, the results point to a more worrying scenario. Almost half of the parents or guardians reported not receiving explanations about the meaning of the child's positioning on the curve (45.5%), as well as about the recognition of risk signs associated with growth (45.5%). Only 45.5% stated that they received these explanations systematically, which evidences an important gap in health education. Considering that the interpretation of the growth curve is an essential instrument for monitoring child development and for the early identification of diseases, the absence of these guidelines can contribute to caregivers' insecurity and delay in seeking adequate care.

With regard to guidance on the vaccination schedule, it was observed that 54.5% of the parents or guardians reported that professionals continuously call attention to the date of the next vaccine, while 27.3% reported that this occurs only occasionally and 18.2% reported the absence of this guidance. Although most receive information about vaccination, the irregularity observed can compromise adherence to the vaccination schedule and expose neonates to avoidable risks.

Table 3

Distribution of synthesized data on the orientations and use of the Child's Handbook in post-discharge follow-up (n = 11)

Variables	n	%
Request for the Child's Handbook		
Yes	9	81,8

No	2	18,2
Filling out the Booklet		
No	2	18,2
yes, sometimes	3	27,3
Yes, always	6	54,5
Guidelines on breastfeeding and healthy eating		
No	1	9,1
yes, sometimes	2	18,2
Yes, always	8	72,7
Explanation of the positioning on the growth curve		
No	5	45,5
yes, sometimes	1	9,1
Yes, always	5	45,5
Risk Signal Recognition Explained		
No	5	45,5
yes, sometimes	1	9,1
Yes, always	5	45,5
Guidance on the date of the next vaccine		
No	2	18,2
yes, sometimes	3	27,3
Yes, always	6	54,5

Source: The authors, 2025.

In general, the data indicate that, despite the recognition of the Child's Handbook as a follow-up instrument, its use still occurs in a heterogeneous and poorly systematized way. The gaps in the guidelines, especially related to the growth curve and risk signs, highlight the need to strengthen educational practices, standardize professional conducts and value the Child's Handbook as a central tool for the promotion of comprehensive and safe care in the post-neonatal discharge period.

The guidance provided by the hospital to families after discharge covered central themes for home neonatal care, such as identification of alarm signs, safe sleep practices, adequate nutrition and compliance with the vaccination schedule. To a lesser extent, guidance emerged on the support network and flows for seeking help in situations of complications. However, the need for unscheduled returns indicates that such guidelines, although pertinent, still lack greater clarity and uniformity.

From the point of view of family experiences, almost half of the caregivers reported difficulties in adapting to the post-discharge period (45.5%). Social support, when present, proved to be a protective resource, but it was described in a heterogeneous way and, in some cases, insufficient. Among the coping strategies reported were the active search for information with the service, the use of the booklet as a guide, family support and early return in the face of doubts.

Although the sample size limits inferences, some descriptive associations were observed. Families who did not leave with the next scheduled appointment had a greater need for unscheduled appointments, suggesting that the previous organization of the segment can reduce emergency visits. Similarly, the presence of social support seemed to soften the difficulties of adaptation, although the data do not allow statistical confirmation.

Among the main difficulties reported, the following stood out: fear of clinical complications due to the baby's fragility, insecurity in the face of poorly understood risk signs, emotional and physical overload of the main caregiver, difficulty in accessing transportation and financial resources to maintain follow-up, as well as barriers in communication with health services, especially in scheduling appointments and in the clarity of the guidance received.

When asked about what could help overcome these challenges, the families suggested the following as the most desired solutions: immediate scheduling of the next appointment at the end of the service, more detailed guidance in accessible language, greater social and psychological support in the post-discharge period, better use of the Child's Handbook as a monitoring tool, and public policies that expand material support (such as transportation, health benefits and resources close to home).

In summary, the results reveal a scenario in which the continuity of care for the newborn after hospital discharge is weakened. The absence of structured scheduling, the variability in the guidance provided, and the frequent need for additional care point to the importance of strategies that promote standardization of conduct, strengthening health education, and valuing the Child's Handbook as a central monitoring instrument.

The results of this study show that, although hospital care for neonates is decisive for their clinical stabilization, the transition to home remains marked by weaknesses, especially with regard to continuity of care and family safety in post-discharge management.

The sample studied showed that less than half of the families left the outpatient appointment with the next scheduled date, and most needed unscheduled care, revealing that the absence of planning and effective counter-referral still compromises the comprehensiveness of care.

This scenario converges with the findings of Vieira and Whitaker (2016), who identified that the perception of children's health care in the post-discharge period is directly associated with the quality of the information received and the clarity of the dialogue established between the team and the family. For the authors, the lack of adequate communication at the time of discharge generates insecurity, increases family overload and increases the risk of avoidable rehospitalizations. In the present study, insecurity in the face of signs of risk and fear of complications were some of the main difficulties reported by the families, confirming the relevance of this aspect.

Silva and Ramos (2011) also highlight that one of the main limits of the hospital discharge process lies precisely in the absence of articulation between the hospital and primary care. According to the authors, when there is no effective counter-referral, the continuity of care is compromised and families tend to resort to urgent and emergency services to solve problems that could have been monitored in the primary care network. This finding dialogues directly with the high proportion of families who, in the present study, sought additional care outside the scheduled appointment.

Another fundamental point refers to the standardization and clarity of the guidelines offered. Although topics such as food, breastfeeding, risk signs and vaccination schedule have been addressed, the reports of the families demonstrate that the way these guidelines are transmitted is not always accessible or uniform. Paranhos, Pina and Mello (2011) point out that strategies such as Integrated Care for Childhood Illnesses (IMCI) were developed precisely to fill these gaps, by integrating the most common conditions of childhood and training both professionals and family members to identify warning signs and adopt appropriate conducts. In this sense, the lack of standardization observed in our study reinforces the need to strengthen tools such as the IMCI and the Child's Handbook.

In addition, the present study revealed social and emotional challenges, such as the overload of the main caregiver, financial difficulties and limited access to transportation, factors that increase the vulnerabilities faced by families. These questions are supported by the literature, which recognizes that post-discharge home care is influenced not only by clinical factors, but also by social determinants of health. For Silva and Ramos (2011), the potential to strengthen the Family Health Strategy lies precisely in welcoming these demands in the territory, promoting continuous and comprehensive support.

It is interesting to note that the solutions pointed out by the families in this study, such as immediate scheduling of the next appointment, clearer guidance in accessible language, greater social and psychological support, and strengthening the use of the Children's Handbook, coincide with the recommendations of the literature analyzed. Vieira and Whitaker (2016) emphasize the need to expand the dialogue between team and caregivers, while Paranhos, Pina and Mello (2011) emphasize the importance of integrated protocols that ensure continuity of care and avoid other hospitalizations.

Thus, the findings of the present study, although based on a small sample, reaffirm that the continuity of care for the post-discharge newborn depends on three central pillars: (1) structured discharge planning, with prior scheduling of appointments; (2) clear, accessible and standardized guidelines that guarantee autonomy to families in home care; and (3) articulation between hospital and primary care, ensuring that caregivers have support in the territory, reducing the unnecessary use of emergency services.

4 CONCLUSION

The present study allowed us to understand that the care of the newborn after hospital discharge is still a challenge, permeated by clinical and social vulnerabilities that require continuous attention from health services. Although advances in neonatal care have contributed to the reduction of infant mortality, the results revealed that gaps persist in the transition process from hospital to home, especially regarding the standardization of orientations, planning of outpatient follow-up and social support for families.

The difficulties reported by those responsible for them, such as insecurity in the face of signs of risk, emotional overload and access barriers, reinforce the need for strategies that expand communication between the health team and the family, promote health education in accessible language and ensure the continuity of care at different levels of care. In this sense, the importance of strengthening primary care, the systematic use of the Children's Handbook as an instrument of registration and guidance, and intersectoral articulation to ensure social support to families is highlighted.

Thus, the findings of this study offer relevant support for managers, health professionals, and public policy makers, pointing out ways to improve neonatal care practices after hospital discharge. Finally, this study fulfills its role by revealing critical points of care for newborns after hospitalization and by proposing reflections that can guide future studies of greater scope. It is reinforced, therefore, that the continuity of neonatal care is not restricted to the hospital environment, but depends on an articulated, welcoming and prepared network to support the family in its role as protagonists in the care of the child.

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