“What’s helpful, what’s problematic, what’s missing” during your stay Fathers’ experiences of supports in NICU: A qualitative study.

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Abstract

**Background:** The birth of a premature or unwell baby results in the need for a neonatal admission and a period of stay within a Neonatal Intensive Care Unit (NICU). This ushers a period of time of uncertainty and stress for parents. Premature birth and hospitalisation are known to interrupt the normal attachment process. The attachment between parents and children is a precursor to the strengthening of parenting skills, the growth and development of the baby and an establishment of a bond between parent and child. (Fegran, Helseath & Fagermoen, 2008). Research to date into the experiences of parents within the NICU has placed an emphasis on mothers or the parents collectively. Very little is known on the experiences of fathers’, how they cope over a longer period of hospitalisation and what supports may assist them as fathers through this journey.

**Aim:** The aim of this qualitative study was to hear first-hand from fathers their experiences of having a baby in the NICU. What they felt helped, was problematic or was missing in the way of supports and resources over a period of time. The purpose of this study aiming to inform NICU services and the professionals working within the NICU environment with further insight into and consideration of dedicated provision of supports and facilities for fathers’.

**Method:** A Qualitative research approach was undertaken to explore and gain insight into the underlying reasons, opinions and experiences of the consented fathers. Semi structured individual interviews were completed with ten consented fathers. The participants were fathers with infants born less than thirty three weeks gestation and cared for in the Christchurch NICU. For this study a long term NICU stay was defined as being for a period of four weeks or more. Interviews were held at least one month post discharge. The participants’ interviews were audiotaped and in addition notes were taken to gather any further contextual material. Qualitative thematic analysis using Sandelowski’s (2000) qualitative descriptive approach to analysis was utilised to identify and explore the valuable information shared by the fathers.

**Findings:** The rich data that emerged from the ten fathers’ stories, were analysed into a number of sub themes that could be categorised into four major themes. These major themes were categorised into; the facilities and the environment of the NICU. Communication and
interaction with others. Through their eyes, the father’s perception of their role in the NICU and finally fathers’ supports experienced or suggested.

**Conclusion:** The insight that was provided by these fathers’ highlights that fathers experiences of a NICU stay is different to that of mothers. That the experiences and supports required can alter over time and that when there is a need for support this should be tailored to and for fathers as discussed within this study. The findings and recommendations would locally offer the opportunity to explore improvements to or the introduction of dedicated supports for fathers. Dissemination at a national level could enable the wider neonatal community to reflect upon the findings and recommendations and consider wider provision of supports and facilities for fathers in the NICU.
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Chapter 1.
Introductory Chapter

This chapter informs the reader of how the study evolved. By introducing the study, providing background information surrounding the importance of why this topic has been chosen, the significance of the study and the purpose and outline of the research approach taken.

As increasing numbers of premature infants are surviving due to advances in technology and neonatal care, more parents are being exposed to and needing to spend time within the NICU (Thiele, Knierim & Mader, 2016). Research has shown that having a baby in a NICU is a stressful experience for parents (Franck, Cox, Allen & Winter, 2005). Becoming the parent of a healthy full term baby is considered to be challenging in western cultures (Francis-Connolly, 2004). Having a premature or unwell baby admitted to the NICU confronts a family with the loss of their expected and desired parenting role (Miles, Holditch-Davis, Schwartz & Scher, 2007).

Mothers may experience loss, grief, powerlessness and changes in their anticipated role as the primary caregiver. Fathers may experience the added stress of trying to manage competing challenges of being a partner, a father and the family wage earner (Pohlman, 2005). An unexpected, unplanned premature birth or unwell new born baby has been shown to place increased stress on parents, further intensified by the unknown journey ahead for their baby in the NICU and the unknown long term developmental outcomes. This increased parental stress has been shown to interfere with the parent-child relationship (Ramchandani et al., 2012). The attachment between parents and children is a precursor to the strengthening of parenting skills, the growth and development of the infant and an establishment of a bond between parent and child (Fegran, Helseath & Fagermoen, 2008). Premature birth and hospitalisation are known to interrupt the normal attachment process and research into neonatal parenthood continues to demonstrate the long lasting feelings and burden that parents experience following a preterm birth and NICU hospitalisation (Goutaudier, Lopez, Sejourne & Denis 2012).
Premature birth is the single most important determinant of adverse outcomes for infants and their parents in terms of infant morbidity and mortality, the impact on the family and costs for the health care service (Arnold, Sawyer, Rabe & Abbott, 2013). The ultimate goal for neonatal care is optimal growth, neurodevelopment and long term health. Infants born preterm and or of extremely low birth weight are at greater risk than infants born at term for mortality and a variety of health and neurodevelopmental problems (Behrman & Stith Butler 2007; Benzies, Magill-Evans, Hayden & Ballantyne, 2013). Research also demonstrates that a baby’s low birth weight and premature birth are contributing factors for the risk of child abuse and neglect. Additionally other risk factors stem from having a long term hospital stay, such as lack of social supports and isolation, poverty and attachment issues (Ben-Natan, Sharon, Barbashov & Minasyan, 2013).

Much of the literature on attachment theory and family centred supports for families within NICU to date, focus’s upon the mother-infant dyad and largely neglects to include the role of fathers. The neonatal environment is already acknowledged as interfering with a mother’s ability to bond with her baby, very little is understood about fathers’ experiences in this journey (Denney, Lohan, Spence & Parkes, 2012). Research to date on parental experiences in NICU have primarily focused upon the mother or parents as a collective. Engaging mothers in providing care for their infants is seen as a priority. Engaging fathers at the cot side is considered less of a priority and more challenging. This is loosely based upon the stereotyping of men as either being emotionally detached, or showing less emotions than the mother’s and therefore less of a priority for healthcare professionals to tackle and support (Hugill, Letherby, Reid & Lavender 2013). Hollywood and Hollywood (2011) indicate that the experiences of fathers of premature babies are diverse and complex, with a baby in NICU instigating a multitude of experiences for fathers, who strive to balance work and family life, whilst attempting to engage in care and get to know their baby.

These feelings may not solely be unique to fathers, grandparents supporting a solo mother or a single sex relationship may also encounter the same feelings but for the purpose of this research study the aim was to explore father’s experiences. The research question aims to provide the neonatal service and the professionals working within the NICU further insight into considering what can be done more to incorporate fathers within the neonatal journey with their infant and foster improved long term outcomes for the infant and the family.
Challenges are evident for nurses to integrate care that supports the infants whilst at the same time facilitates and supports parents (Arockiasamy, Holsti & Albersheim, 2008). The technological intensive care environment of the NICU and the rules in place that influence service delivery and care, are factors that can hinder that parental engagement and involvement.

To facilitate a family centred/integrated approach to care a number of parental support systems can be identified within the literature, many based upon what health professionals perceive parents might need rather than based upon parental input into what these support structures might look like (Miles et al, 2007). Many health care facilities including the Christchurch NICU has a philosophy of care and service charter that details the foundations for staff to perform and provide the families with confidence that their infant is receiving the best possible care. Benzies et al., (2013) describe the importance of sharing the key components of care delivery such as a philosophy of care with parents as a way to reduce parental stress and anxiety, this in turn encourages and establishes a thoughtful receptiveness to the interaction with their infant. Frost, Green, Gance-Cleveland, Kersten and Irby (2010) describe the need for the philosophy not just to be shared with families but to be a collaborative approach to care between the staff and families to be truly meaningful and beneficial.

Even though the primary focus of NICU care is the baby, the NICU environment places the parents as recipients of aspects of care and engagement with NICU staff over a considerable period of time. Clearly research demonstrates that to improve the long term outcomes for vulnerable infants the family need to be key participants in the care. Fathers are increasingly becoming more involved in their children’s care but despite this research suggests that men continue to be viewed as a support for the mother or of less significance (Hugill et al, 2013). The majority of studies to date on fathers experiences of having a baby in the NICU have focused upon their responses to the early period of a stay following admission (Hughill et al, 2013; Deeney et al, 2012). How father’s emotional management evolves beyond this early stage is still relatively unknown. There is an identified need that future research needs to focus on the fathers in the NICU for longer lengths of stay. This would be important in establishing how a father’s emotional experiences and management evolve over time and what factors assist or impact upon their experiences (Hughill, 2014). Hence this study aims to
explore, through narrative, concepts, practicalities, experiences fathers have during a longer neonatal stay.

The study:
The neonatal service
A neonatal intensive care unit (NICU), is a specialised area providing medical treatment and nursing care following birth. Between six to ten percent of babies born in New Zealand are admitted to a NICU. These babies may be low birth weight and or preterm, born between 23-37 weeks gestation. More mature babies with health concerns are also admitted including, surgical conditions and chromosomal abnormalities. The Christchurch NICU where the research was conducted has a cot capacity of forty one spaces and an average annual admission rate of 1000 babies. The average length of stay of a premature baby is eight to twelve weeks.

This qualitative study focused upon father’s personal accounts of their experiences of having a baby within the Christchurch neonatal unit, for a period of four weeks or more. The aim was to hear first-hand father’s personnel accounts of what they felt helped, was problematic or was missing in the way of support and resources over a period of time. A one to one interview provided the opportunity to allow an exploration of the father’s feelings and thoughts which may not have been gleaned through a survey or questionnaire. The overall purpose of this study was to identify gaps in the service offered and explore the introduction of dedicated support systems for fathers locally and throughout New Zealand.

By enabling fathers to share their personal experiences, the information gleaned would assist staff and the service, not only to recognise the complexities associated with the stay and the impact of the NICU environment, but also provide more understanding and insight into what factors and feelings are unique to fathers. By identifying and then addressing common stress situations for fathers it may ultimately enhance the father/infant attachment and improve long term health outcomes for the infant.
Why a father’s focus?

Bringing up a child is one of the most important roles anyone can have, it involves learning new skills, different ways of thinking and changing relationships and juggling life as a new parent. There is noticeably a shift in the relationship dynamics with becoming a parent, even with the birth of a full term healthy baby who does not require hospital care the partner’s attention on the baby will be evident and potentially dad’s left feeling side-lined and slightly unsure about their role. Adding to this change in role and responsibility, with the inclusion of a NICU stay, possibly an unwell partner, sick baby and a unnerving hospital environment an already life changing experience of having a baby as a father can become increasingly complicated (National Childbirth Trust, 2011).

Fathers do make unique contributions to their children’s development and sense of belonging and security (Cabrera, Shannon & Tamis LeMonad, 2007). In the 1970’s, fathers were described as “forgotten contributors” to child development (Lamb, 1975), and research on parent-child relationships had focused almost exclusively on the relationship between a mother and her child and its impact on the child’s social, emotional, behavioural and cognitive development. Fathers are now being included within the research and studies have continued to demonstrate that father’s unique contribution to their child’s development starts during early infancy and long term is associated with better cognitive and psychological infant outcomes (Hall et al., 2014).

Talmi and Harmon (2003) discuss the immense positive effects of having a nurturing involved father. The child who has an involved father tending to do better at school and into adulthood. Children who are securely attached do better academically, they are more sociable and have better language and cognitive skills. Holmberg and Olds (2015) describes a father’s involvement in the lives of children by being physically available, nurturing, caregiving and ensuring the provision of adequate financial resources to meet living costs as being associated with positive child health and development. Whereas, if a father is disengaged, engaged in antisocial behaviour or impaired by psychopathology, increased risks to the child are evident. New Zealand research within Christchurch revealed that 65% of Youth offenders are not living with their father or having a male role model in their lives (For our Children, 2017). Owens (2012) raises the question that if society wants to foster a strong emotional connection between fathers and their children, starting early, when patterns and habits are forming, is
very effective. He states, “If we want a father to be there for his child in the long-run, we need to be mindful that the long run starts at the beginning” (p.4). According to Owen’s (2012) when a father is involved in the daily care of their baby, and responds and engages with their baby the relationship is one of secure attachment and these attachments have positive benefits. Therefore to foster this important relationship when there are potential barriers or feelings of vulnerability as one can with premature or sick infants, the NICU needs to be an environment which is supportive and encouraging as well as being able to be individualised for each and every father or father figure in that infant’s life.

To foster this environment and approach to care the question that needs to be asked is what are the perceived barriers to the active involvement of fathers in the care of their infant in the NICU? Johnson (2008) discusses the perception amongst neonatal staff that fathers appear to focus upon understanding the NICU experience by grasping the technology and questioning the long term plans for discharge rather than the immediate emotional attachment. Johnson also states that the obvious interactive differences between a mother and father suggest that fathers may detect barriers in the NICU that are not apparent to others. Fathers have described themselves as bystanders, and more disconnected than they expected or wanted to be (Deave & Johnson, 2008).

Practitioners caring for families with infants need to recognise the impact of the transition to fatherhood in the same way that it has been long recognised the transition to motherhood (Rubin, 1984; Benzies & Magill-Evans, 2015). Jackson, Ternestedt and Schollin (2003) highlighted within their study in Sweden of seven sets of parents interviewed together, as the mothers needing a sense of responsibility and control in caring for their infant, whilst fathers needed confidence in the health professionals caring for their infant in the NICU. They also commented, that nursing staff found that fathers all but disappeared from the cot side and that the fathers were known to have negative perceptions of help seeking, which placed increased obligation on staff to invite the father’s to be involved. Johnson (2008) goes on to describe disruptive factors that can be identified within a NICU and includes, the birth experience, difficult parental relationships, rigid hospital policies, challenging relationships with the infant’s caregivers and problems with access to resources. These disruptions can affect mothers and fathers in different ways with the mothers seen as looking for resolve with the staff through sharing their story and participating in the care and supports made available, whilst the fathers seeing the disruptions as a barrier to the NICU environment and their
subsequent involvement. This highlights a need for the neonatal service and staff to proactively take steps to remove the barriers to the baby in the NICU for fathers, so that they are actively participating in the care of their baby. To be able to do this there is a need to consider the need for guidance and support that meets the needs of fathers, but what should this look like?

Past studies have identified that nursing supports can reduce parental stress and anxiety during their infants stay within a NICU and foster the parent’s ability to cope (Hedberg Nyqvist & Engvall, 2009). With much of the current research focusing upon what those supports should look like for mothers in the NICU, there is very little on what fathers may need. What is known is that fathers have feelings of loss of control and struggle to gain control and attain paternalistic feelings with their infant in the NICU (Arockiasamy et al, 2008). This loss of control being associated with not being involved in their infant’s care, receiving insufficient information and feeling reluctant to approach staff (Mode, Mard, Nyqvist & Blomqvist, 2014). When fathers receive adequate information and are included in their infant’s care they demonstrate increasing confidence in their paternal role (Lindberg, Axelsson & Ohrling, 2007). What needs to be determined by neonatal staff is what fathers require in the way of supports and how that support is best delivered. Benzies and Magill-Evans (2015) research focused upon the introduction of a father-infant interaction programme in late preterm infants, first time fathers and a shorter hospital stay. However, they concluded that when practitioners were looking at establishing supports for fathers that consideration needed be given to tailored, father-orientated programs that incorporated individualised advice and guidance from a professional with male health care providers being considered in providing this support as beneficial.

Within the Christchurch NICU, the current parental supports provided are predominately based upon staff perception of needs. There is a well-established parent information group which comprises of both nursing, medical and consumer representatives. The group meets on a regular basis to look at opportunities for and the introduction of resources for parents within the unit. This to date has seen the establishment of a mothers’ coffee group and resources made available for parents(such as written lay publications on common neonatal conditions and their treatment, support network and group contacts and the development of a neonatal website with unit information and a virtual tour of the service). To date representation by and a voice for fathers has been missing within this group and currently there are no dedicated
supports for fathers. The unit sees this as a gap in provision of care based on staff feedback and a known gap in the research.
Outline of Thesis

Chapter 1 Introduction

This is an overview of the thesis and outlines the aims and purpose of the research study. It introduces the study, provides background information surrounding the importance of why this topic has been chosen, the significance of the study and the purpose and outline of the research approach taken.

Chapter 2 Literature Review

There is extensive international literature published about the experiences for mothers and parents collectively when they have a baby cared for in a NICU. There is little literature published, however, about how fathers experience the NICU and very little that considers how these experiences change over a period of stay. This chapter will discuss the review of the literature available regarding fathers’ experiences within the NICU. To determine what is already known on how fathers cope with a baby in the NICU, how they can be better supported, and the way the father-infant relationship can be enhanced within the NICU environment?

Chapter 3 Methodology

This chapter discusses the qualitative research approach undertaken to explore and gain insight into the underlying reasons, opinions and experiences of the consented fathers. A qualitative thematic approach was used to explore the father’s personal accounts of their experiences relevant to the research question. This chapter outlines the aim of the study, the research methods and the research process completed and the structure of the analysis. The chapter describes the research setting, the research activities and what data was collected.
Chapter 4 Findings and Analysis

This chapter discusses the findings and analysis from the rich data gained from the fathers’ stories. The results of this research study are presented within this chapter in the form of text and tables. The chapter will provide the context to the findings by referring to the fathers’ stories and quotes. The discussion on the analysis of the data will be outlined following the method utilised to organise the data.

Chapter 5 Discussion

This chapter discusses, what this research study has revealed by hearing first hand from fathers of their experiences within the Christchurch NICU. This chapter will address how the themes extracted from the interviews compare or are rather different to other relevant research. Finally there will be discussion on how the findings from this research study could contribute to a known gap in the research.

Chapter 6 Conclusion

This chapter brings together the significant findings within this study. It provides recommendations for the neonatal unit to consider implementing as either enhancements to the service already provided for fathers or to consider as additional supports both at the cot side and as non-cot side supports. Recommendations are presented for consideration within a wider New Zealand context of neonatal nursing care.
Chapter 2.

The Literature Review

This chapter will discuss the review of the literature published regarding father’s experiences within the NICU. The chapter will discuss the analysis of the scope, quality and understanding obtained from the relevant literature to determine what is already known on how fathers cope with a baby in the NICU, how can they better be supported? And how can the father-infant relationship be enhanced within the NICU environment? The literature discussed will highlight what is already known around this subject, where there is an identified need to undertake further research and subsequently the purpose of this study.

It is already known that becoming a father is a major life changing event that is often associated with a variety of emotions such as delight at being a new father but at the same time anxiety around the responsibilities that go with being a parent (Salzman-Erikson & Erikson, 2013). Having your new-born baby admitted to hospital adds another stressful and worrying dynamic (Lundqvist, Hellstrom-Westas & Hallstrom, 2014). Increased parental stress is a known risk factor and has been shown to interfere with parent-infant relationships during early childhood and consequently increased risk for problematic long term outcomes (Griffin, Wishba & Kavanaugh, 1998). Reduction of parental stress should be a key target of those services and staff caring for infants and children in hospital to further foster parenting (Matricardi, Agostino, Fedeli & Montirocco, 2012). A number of research studies that have explored supportive interventions in the NICU environment have criticised the apparent focus on fostering the mother-infant relationship, but on being silent on the interventions that have been or should be established to foster the father–infant relationship (Hopper, 2000; Ward, 2001). There is some consensus evolving that what men experience has similarities to but yet different from mothers, with some of the differences expressed in terms of gender, around differing stressors and demands such as being the family supporter emotionally and economically, as well as wider cultural and social norms about men’s behaviour (Lundqvist, Hellstrom-Westas & Hallstrom, 2007).

To foster and establish a supportive approach to care neonatal staff need an understanding of the impact and influence a NICU experience can have on parenting and the family, as well as the wider socioeconomic and long term health outcomes that can be influenced through a
neonatal stay. Premature birth disrupts the anticipated course and outcome of pregnancy. Long term neonatal care can disrupt positive interactions between a parent and their baby (Lundqvist et al., 2014; Thiele, Knierim & Mader 2016). The busy environment replaces the intimacy of a family home. These disrupted early interactions in parenting can have a known impact on the attachment and bonding of a parent and child whilst in the NICU and influence the long term relationship beyond the NICU (Keilty & Freund, 2005). Gage, Everett and Bullock (2006) described parenting as the most important public health issue in society. Parenting has the potential to either promote the health and wellbeing of a child, or impede the child’s physical and emotional development leading to significant future health and social problems.

The parental perception of the NICU can be one of unfamiliarity, challenging, influenced by others personal stories and challenged further by external responsibilities as a consequence of a long term hospital stay (Ichijima, Kirk, & Hornblow, 2011). Gonya, Martin, McLead, Nelin & Shepherd (2014) discuss the continued high rates of impaired development that NICU infants experience. That the families often suffer significant disruption and stress, due to separation from their baby, exposure to a complex, technologically intensive physical environment with rules and complexities involving interaction and communication with multiple staff.

**Environmental stressors**

Apparent throughout much of the neonatal literature, is the noticeable impact the noxious over stimulation the environment can place on vulnerable infants (Matacardi et al, 2013). As neonatal care continues to evolve there has been an increased focus into infant brain development and the importance of considering the long term neurodevelopmental effects of the neonatal environment. Brain development in the neonate and early infancy occurs at an unprecedented rate, the vulnerable neuropathways being influenced not only by the infant’s genetic makeup and medical condition but also through the experiences the baby is exposed to (Als et al., 2004). The infant themselves are now known to be an active contributor in their own development and can interact and respond to their surrounding environment (McGrath, Samra & Kenner, 2011). Premature infants are already at increased risk for adverse outcomes including developmental delay as a consequence of their premature birth, immaturity and vulnerability (Teune, Bakhuizen & Bannerman, 2011; Benzies & Maghill-Evans, 2015). Add
to this a known noxious over stimulating environment (McGrath et al, 2011) and the impact of this unfamiliar and intimidating environment on a parent’s stress levels and there is an increased risk of long term poor health outcomes (Nicolaou & Glazebrook, 2008). Neonatal services and staff need to strive to provide and foster an approach to care that minimises the harmful impact of a NICU stay whilst also encouraging and supporting parental attachment. McGrath et al. (2011) point out that although the NICU with all of its technology and expertise save lives, there are long lasting negative effects from the noxious over stimulating environment and families are necessary caregivers in the team who can support their infant to develop as normally as possible within this abnormal environment. Neonatal care has become less uniform and more individualised to meet the needs of the infant and their family, however there is still a lack of understanding by neonatal facilities to understand and tailor the needs of fathers into this family centred approach to care (Griffin, Wishba & Kavanaugh, 1998). Examples of where fathers are generally considered to be as important as the mother in the parent–infant interaction and involvement in the plan of care is within Swedish NICU’s (Lindberg et al, 2007; Lundqvist et al, 2007; Nyqvist & Engvall, 2009). Research studies undertaken in Sweden have explored the most conducive environments that place the parent’s as the infant’s primary caregivers. These research studies have assisted the design of purpose built NICU’s which encourage parents to stay and the development of policies for the parental role (Nyqvist & Engvall 2009). Of importance to note which is unique to the Scandinavian countries such as Sweden is the legislation and the national parental insurance that facilitates and supports and encourages parental presence in the NICU during their baby’s hospitalisation. This social support system for both parents is not available in most other countries including New Zealand where the birth of a premature baby needing a hospital stay can lead to wider situational and social stresses for the parents (Pinelli et al, 2008).

**Situational stressors**

Even within the context of New Zealand a number of alarming statistics place these families at greater long term risks as a consequence of being born too soon. Between six to nine percent of all live births are admitted to a NICU in New Zealand per year, approximately 7% are premature and of those around 27% will have mild to severe cognitive and language delay (ANZNN, 2014). Add to this the impact of a long hospital stay, the potential to constrain or disrupt the parent’s attachment with their baby and social and economic instability. The long term morbidity of these infants is a serious health concern. Studies have consistently found
that a growing concern due to the improved survival chances of premature infants is the long term developmental outcomes and quality of life (Jackson et al, 2003; Doyle, Roberts & Anderson, 2010). Non optimal parenting which can start within a NICU due to a separation or disturbance in parent and infant attachment can be shown to have a direct influence on a neonates long term health outcomes (Tooten et al., 2014).

Child poverty within New Zealand is one of the highest in the developed world with approximately 25,000 children (27%) being found under the poverty line (Child Poverty Action Group, 2014). Many of these children will have their lifelong health and education compromised. Poverty has a deep impact on child health leading to more severe and recurrent illnesses into adulthood. High levels of household stress and insecure or poor living conditions create further difficulties with learning and education, more frequent hospitalisations and abuse. In addition to these alarming statistics Māori children disproportionally experience poorer health outcomes. Recent data demonstrates that there is a significantly higher rate of preventable disease being seen in Māori children such as rheumatic fever and respiratory disease and as a consequence increased hospital stays and long term poor health outcomes (Child Poverty Action Group 2014; Māori Affairs Select Committee, 2013). Premature babies have a higher incidence of chronic respiratory complications as a consequence of their prematurity (Day & Ryan, 2017). Māori mothers are more likely to have still births and preterm babies and Māori children are more likely to be admitted to hospital with assault injuries, neglect or maltreatment (Child Poverty Action Group, 2014). Ben-Natan et al. (2014) identified risk factors for child neglect and abuse stating that the features of those at significant risk included, low birthweight, premature birth and poverty, with men also being more highly represented as committing harm to their child. These statistics and facts place an urgent need to introduce and build on the current approach to care and support within the NICU context.

The attainment of health equity is a moral necessity, the neonatal services need to place an emphasis on introducing care and support strategies in an attempt to minimise such risks. For these approaches and initiatives to be instigated there needs to be an understanding of how parents can be supported both emotionally and physically during their time in the NICU in an attempt to minimise any negative outcomes from having a neonatal stay.
Personal stressors

When an infant is born premature the normal parental journey and the preparation for parenthood has been interrupted and their baby requires specialised care and attention (Als et al., 2004). The infant is dependent upon on the equipment and the specialised knowledge and skills of the medical and nursing staff, the parents need to learn about their baby. The parents have yet to build that attachment and bonding with their child impacted upon by the challenging environment and the vulnerability of their baby.

There are a number of research studies on parenting completed within the paediatric setting however the findings of these are difficult to truly compare to that of the neonatal experience because, when a baby is admitted to a NICU following birth the first real meeting with their parents is in the NICU (Jackson et al, 2003; Lindberg et al, 2007). Parents of any child in hospital are stressed and worry but as parents they have had time to get to know their child, care for and understand their child’s behaviour and personality which does have a direct impact on how they are involved and in control of their child’s needs, through providing advice to the staff on their child’s likes, dislikes, and individual health care needs (Alderson, Hawthorne & Killen, 2006). Becoming a parent to an infant admitted to a NICU tends to happen fast and in most cases is unexpected. Parents of babies in the NICU still have to get to know their baby and so feel inadequate in giving that advice to staff on their baby’s needs, likes and dislikes, they see the neonatal staff as being the experts and the primary caregivers providing them advice on their own baby (Hedberg et al, 2009).

There is a known conscious effort by NICU staff to humanize the environment in the NICU to make parents feel more comfortable about spending time with their baby (Nicolaou & Glazebrook, 2008). This humanized environment and approach to care continues to be researched within the context of a NICU environment. Family-centred/integrated developmental care has been described in a number of research studies as being an essential element of neonatal care and is of significant importance when the infant is vulnerable and at greater risk for poor health outcomes. Complicated by a family who are challenged by the unique needs of their baby and the environment and journey they find themselves embarking upon (Griffin & Abraham, 2006; Kenner & Wright Lott, 2010; McGrath et al, 2011). Family centred/integrated developmental care can be described as a philosophy underpinning neonatal care that is deemed as essential care, which provides an all inclusive individualised
infant and family centred approach to care (McGrath et al, 2011). The approach is based upon the close and continuous involvement of the baby’s family in the care (Lundqvist et al, 2007).

This approach to care within the NICU has already been found to foster brain development in the neonate that supports later learning and behaviour (Fox, Levitt & Nelson, 2010). Family centred care focuses on the individual infant and their needs and attempts to strengthen the relationship between the parents and the healthcare professionals through the sharing of information and collaborative approaches to planning and jointly providing the care (Lundqvist et al 2007; McGrath, Samra & Kenner 2011; Hall, Phillips & Hynan, 2016).

Family centred care has been widely accepted within the paediatric setting as a model of care which recognises the family as the experts in the care of their child, pursuing and maintaining a partnership between the family and the health care professionals (Baird, Davies, Hinds, Baggott & Rehm, 2014). This approach to care has been deemed more challenging within the NICU, Johnson (2008) discussed the challenges a NICU faced from nurses’ perspectives of attempting to integrate care that supports the development of the infant whilst facilitating and supporting parents as collaborators in the infant’s care within a highly technological and medically focused environment. Frost et al. (2009) describe the philosophy of family centred care as the family being the constant in the child’s life. A number of research studies have considered how well this approach to care fits within the neonatal context, where the infant is a new member of that family and the family have to be supported and coached within the unknown neonatal environment, rather than taking a lead in the care undertaken. True family centred care identifies the families as being integral members of the health care team (Bell, 2009). Key is the collaboration between families and the neonatal staff working in partnership, and could this be seen as a challenge for staff to embrace when the technical environment, vulnerability of the infant in their care and the significant learning and support parents need to get to know their baby is what faces them day to day? Fenwick, Barclay and Schmeid (2012) suggests that clinical practice in NICU’s continue to focus on nurse’s directing the care and being in control. The parents feeling like visitors, having a loss of control and being less involved or responsible for day to day care and decision making about their baby. Separation of parents and a baby continues to be common practice in a NICU environment. Family centred developmental care is deemed essential (McGrath et al. 2011). It is an element of care that is of particular importance when the infant is vulnerable and at greater risk of poor outcomes complicated by parents that are easily tested by the unique
needs of their infant. It is a component of care that all neonatal families deserve and it should not be seen as just nice to have, it is a shared responsibility between leadership and staff to firstly educate, remove any existing barriers and work in collaboration with the families on the interventions to be introduced and established.

McGrath et al. (2011) acknowledge that family centred care is now recognised as an essential component of high quality neonatal and family care and is practiced to some extent within most NICU’s. However this care does still need to be tested through research to determine which interventions work for which infants and families, what does not work and what requires refinement. To understand what this may look like there firstly needs to be an acknowledgement of and an understanding of parenting and the different needs for mothers and fathers.

**Fathers**

Becoming a parent necessitates a transition to new roles and responsibilities. Men and women become parents at the same time but individuals make the transition to parenthood in different ways. As research demonstrates the experience of having a baby hospitalised in a NICU produces significant emotional distress including anxiety, dissociation and post-traumatic stress (Hynan, 2005). Hynan goes onto to discuss that within the field of maternal and child health research there has been an apparent lack of focus on fathers and the father’s voice and a lack of understanding by nursing staff into how to communicate and support the father in the NICU. As more fathers than ever before are at the birth of their baby and are increasingly becoming more involved in their children’s care. It is therefore more important than ever to understand how father’s experience maternal and neonatal health services and to understand how they can be effectively accommodated within these environments alongside their partner (Denney et al. 2012). Staff need an understanding of gender differences in experiences and needs to be able to provide an individualised supportive approach to the parents within the NICU (Jackson et al, 2003).

Ten years on from Hynan’s published review of research in 2005, into the differences in communication needs and styles with fathers and mothers in the neonatal nursery during times of stress where he identified a need for future research to focus upon the fathers, there still appears to be a significant gap in the research that places a focus upon understanding the father’s unique needs during the neonatal journey. Hynan within his 2005 review posed
questions such as “As a nurse in the neonatal unit what do you expect from the father? How might your expectations influence what you will say, how will you communicate with them, how you will support them? And compared to consideration for the infant and mother how much time do you spend thinking about the father in the plan of care”? (Hynan, 2005). To this day research still does not appear in any depth to have explored these questions. Gage et al. (2010) in their integrative review of parenting in nursing research, found of the seventeen studies reviewed only one study where fathers were the specific focus of the research. This may not be surprising when traditionally women have assumed the main role in raising children, however in this present day there is a noticeable societal shift with many men now seeking and taking on greater responsibilities in parenting and so a greater need to understand a father’s needs and role. Most studies of parents with a baby in the NICU have failed to present findings by gender. Families are becoming increasingly complex, and parenting roles are seen as more flexible than in the past (Friedman, Bowden & Jones, 2006).

Hall et al. (2014) make the comment that even though the research has traditionally focused upon mothers with extensive research being undertaken looking into the relationship between a mother and her child and its impact on a child’s social, emotional, behavioural and cognitive development. To this day when fathers have been included in studies, the results are often grouped with the mothers or if purely focusing upon fathers and their perceived needs and experiences they are very small sample sizes. This poses limitations for widespread acceptance and credibility (Alderson, Hawthorne & Killen, 2006). The challenge for the neonatal nursing staff is how to help the father to define his own role, develop an understanding and subsequently provide a truly supportive environment with very limited research to base their actions and decisions upon. Hughill (2014) states that, gender and relational psychological differences more than likely influence how fathers react to a preterm birth and while mothers’ and fathers’ experiences after the birth will share some similarities they differ in significant ways. Tooten et al. (2014) concluded from their research study of three hundred and seventy eight NICU parents across the Netherlands that the gender of the parent did strongly influence the attachment with a premature baby in NICU. They found on comparing maternal and paternal attachment, father’s displayed more role disengagement and withdrawal, mothers more role confusion and disorientation. The recommendation of their study being that gender differences between mothers and fathers must be acknowledged by staff and that it might be essential to tailor interventions and supports accordingly. No further insight was provided into what those tailored interventions and supports should encompass.
Neonatal staff working with families need the insight and an understanding of what those gender differences are within the context of parents with a baby being cared for in the NICU to be able to provide the most appropriate support. Lundqvist et al. (2012) investigated the experiences of Swedish fathers with premature babies and they determined that fathers’ prioritised their own needs lower than those of the mother or child. Lindberg et al. (2007) describe fathers as having difficulties in prioritising the role of partner, father, and family wage earner in their study in Sweden of eight fathers who had had premature babies admitted to the NICU. The aim of their study was using narrative story to describe the experiences of the birth of premature infants from the fathers’ perspective. The fathers described their experience as getting into the core of something never previously considered, they were protective over the mother and infant, they wanted to be with them both as much as possible and to be seen as being included however they did feel left out and their own needs were not being met. The length of their NICU stay was not captured within the study and so the impact of a longer stay could not be concluded from the findings.

Fegran, Helseath and Fagermoen (2008) in their small descriptive study compared mothers and fathers experiences of the attachment process in a NICU within Norway. Twelve parents were interviewed separately so that each parent could speak freely and provide a comparison of their views and experiences. The analysis revealed two common themes of being taken by surprise and building a relationship. For mothers, the premature birth created a feeling of powerlessness and following the birth feeling surreal and strange, father’s on the other hand were initially shocked but were ready to be involved straight away. With building that relationship with their baby in the NICU environment, mothers needed to regain the temporarily lost relationship with their baby, whereas the fathers experienced the beginning of a new relationship. What is crucial for staff to consider when working with parents is that increased parental stress is a significant risk, consequently reducing parental stress has to be a key target for neonatal units. With the aim being to minimise the interference of the parent and infant relationship in the long term, have an understanding of how parental stress may present differently between mother’s and father’s and how best to support their individual needs.

To support the staff there is already a wealth of research and literature that has and continues to focus upon the experiences, needs and stress of mothers in the NICU (Aagaard & Hall, 2008; Davis, Edwards, Mohay & Wollin 2003; Glazebrook et al., 2007). Research into understanding
of father’s actual or potential stress in the NICU is still limited. Research does suggest that the attitude of men towards pregnancy, child birth and child caring is different from that of women (Sloan, Rowe & Jones, 2008). It is well established that maternal prenatal and postpartum depression is prevalent and has long term negative personal, family and child development outcomes, add into this a baby that requires neonatal care the incidence of depression and anxiety disorder has been shown to increase significantly in mother’s (Pinelli et al, 2008). What is unexplored in any great detail is whether fathers also experience the same? Very few studies to date have followed parents of NICU infants over time or included father’s responses when considering parental coping and depression. A correlation longitudinal study by Pinelli et al. (2008) studied one hundred and fifty two parents within the NICU in Canada and found that the mothers reported significantly higher depression than fathers. They concluded that the results provided valuable information for neonatal staff regarding the pattern of depression, family function, and the use of resources and coping strategies of mothers and fathers of NICU infants over the first year of life, which should be considered when supporting families through the neonatal journey. They did not however go in to any detail as to what resources or strategies could be introduced and whether they should look different for mothers compared to fathers.

Kong, Cui, Qiu, Han, Yu and Guo (2013) investigated the prevalence of anxiety and depression in parents of hospitalised neonates in The People’s Republic of China. Parents were recruited within the first week of their stay and a total of six hundred parents were interviewed, four hundred of these fathers and two hundred mothers. The methodology included the completion of four questionnaires including demographics, and self-rating anxiety, depression and social support rating scales. Their results found that anxiety and depression were widespread, with 20% of fathers and 24% of mothers meeting the criteria for anxiety and 30.75 % of fathers and 35% of mothers reported possible clinical depression. What is not presented is how many of these parents were already diagnosed with anxiety or depressive illness prior to a neonatal stay. They concluded that, the mental health of parents with hospitalised neonates is far from positive and this should be a cause of concern. The study does have limitations in regards to its ability to be fully compared to New Zealand, because China potentially places different stress demands on parents, there is a known economic burden with medical expenses needing to be met by the family and very strict visiting regulations, with some parents being unable to visit their own baby even if very unwell. This study does however highlight that fathers are a vulnerable group and they recommend that neonatal health care professionals urgently need to address the concerns of parents and support them through the neonatal experience.
Fathers are one of two parents, and are important for their child’s growth and development, emotional health and cognitive development. Bell (2009) found that fathers wanted to be involved with their infants and were eager to learn how to promote their child’s growth and development in the best possible way, however it was a challenge in terms of balancing this wish with all of life’s challenges and demands. The majority of studies focusing upon fathers as parents appeared to focus mainly upon fathers’ experiences and needs with the well newborn baby not the hospitalised unwell vulnerable baby. Fagerskiold (2008) explored first time father’s experiences during early infancy of their children. They interviewed twenty fathers on their attitudes towards pregnancy, child birth and child caring, this did not include any fathers who had had the added experience of a neonatal journey. What they discovered was that the father’s viewed the mother as the main parent, partly because of their alternating between work and home and also because the mother’s breast feed the infants.

Although there are similarities between being a father to a child born at term and to one born preterm, there are specific differences and experiences that father’s will encounter as a consequence of a neonatal stay and the birth of their child prematurely. Negative experiences and feelings could include, the sudden exposure to their vulnerable, fragile baby and uncertainty about their child’s long term health (Deeney et al, 2012). Or positive, as a qualitative study in Sweden by Lindberg et al. (2007) found with the eight fathers studied describing the preterm birth as giving them the chance to get to know their infant as they had spent time at the NICU, and that their feelings and attachment for their infant increased over time with the father’s themselves feeling they had a stronger bond with their child compared with friends who had babies born at term, because they had had longer to get to know their baby.

Hall et al. (2014) in their longitudinal study, followed two hundred and twenty fathers of term and preterm infants in the Netherlands over the first two years following birth to examine whether the quality of early paternal representation is associated with later paternal and infant interactive behaviour. They found that the early attachment resulted in more positive paternal behaviour and interaction which resulted in a positive influence on long term infant behaviour and cognitive development. Most interestingly they found that there was no significant difference between term and premature babies and concluded that the health status of the infant did not influence the father and infant relationship, it was the importance of early and positive...
interaction between a father and his baby that made the difference. They recommended that neonatal staff need to be made aware of the positive impact of quality father and infant relation and not to solely focus on mothers alone.

When looking further into the literature to attempt to determine the impact of a neonatal stay on father’s unique experiences, there were a lack of studies which focused upon father’s attitudes and experiences over a period of time with a baby in the NICU. There were a number of studies focusing upon admission and the first few days, including such studies as those conducted by Denney et al. (2012) who interviewed fathers on their experiences and feelings at the time their baby was admitted to a NICU and O’Brien and Warren (2013) who investigated fathers perceptions of nursing support in the neonatal unit after a stay of forty eight hours. These time frame do provide insight into how fathers are feeling and the emotions they are experiencing which could still be considered as having a long term impact on their experience and ability to cope. Arnold et al. (2013) found within their qualitative study which included interviewing seven fathers within a NICU in England, that the fathers first experiences of seeing and being with their very preterm infant was a highly emotional time, characterised by a rollercoaster of emotions with them feeling excluded and confused about their role. They felt awkward at the delivery, wanting to be supportive and witness the event but also feared getting in the way. Despite them feeling excluded at the birth they tended to be the first to see their baby following birth and also within the NICU environment at admission. The fathers also referred to feeling confused over their role, caring for the mother and visiting their baby. The NICU initially felt overwhelming and their baby for many too fragile to touch. These early experiences can be seen to continue to influence their involvement over the neonatal stay due to the fragility of the baby, the parental relationship and the ups and downs many experience during a NICU stay. They concluded that the study did contribute to understanding fathers experiences in the early days but recommended to offer truly family centred care which also acknowledges the needs of mothers and fathers as individuals, responses over a longer period of stay also needed to be explored and understood to guide and inform practice.

Research into a longer length of stay are limited, a number of neonates stay in hospital anything up to twelve to fourteen weeks. A Canadian study by Arockiasamy et al. (2008) studied fathers of very ill neonates who had been in the NICU for thirty days to try to understand their experiences. They interviewed sixteen fathers who were interviewed by a male neonatologist who may or may not have been involved directly in the care of these infants and this was noted
as a potential limitation. Because he was male and also the potential power imbalance between the fathers being interviewed and the physician of the service where their baby was being cared for. Their findings concluded that, the fathers overwhelmingly felt a lack of control. Their recommendation was that specific activities to help fathers to regain a sense of control and help them to fulfil their various roles of protectors, fathers, partners and breadwinners were required. They focused upon the ways of supporting fathers being fundamentally through information sharing and communication. No further insight was shared into the possible activities that should be considered or recommendations made on the strategies or styles of communication that should be adopted to meet the fathers’ unique needs.

Sloan et al. (2008) explored the stress experienced by fathers of preterm infants during the infant’s first few weeks of hospitalisation within a NICU in Queensland Australia. They found that of the twenty one fathers studied overwhelmingly their partners were the most frequent providers of social and emotional support and nurses and doctors were the most frequent providers of information support. Less than half of the fathers were satisfied with the information support provided. Again they concluded that it is important to understand father’s adjustment in this difficult situation in order to develop effective, supportive interventions in the NICU, but provided no discussion into what shape that support should take.

Gavey (2007) undertook a qualitative study investigating retrospectively the experience of parents whom required a NICU stay of seven days or more within a NICU in the United Kingdom. Findings revealed several themes of parental impressions, care delivery, impact on relationships and parental control issues. Sixteen parents were invited to be interviewed together but of those the mothers outnumbered the fathers almost two to one and there was no opportunity for fathers to be interviewed alone, which could limit either parent speaking freely when interviewed together. The recommendation from this study was that the staff’s understanding of the parental journey is quite different from their experienced reality. Despite an outward appearance of patience and understanding, parents sometimes struggled to understand and keep pace with the events. Most of the parents overriding concern was to gain access and information and that they appreciated honest and frequent updates. Parents had said they wanted to be actively involved in the care of their baby but felt a need for regular, positive reinforcement to gain in confidence, again this study gave no guide as to the supports or specific needs of fathers, just a need for neonatal healthcare professionals to acknowledge the need for supports on this journey and how fragile parents can be.
Possible supports

Griffen et al. (1998) described a number of documented nursing interventions to reduce stress in parents of preterm infants in hospital but again did not clarify or differentiate between mothers and fathers to help guide or confirm a need for different types of support for mothers compared to fathers. They discussed the importance of nurses describing and showing the neonatal environment, providing honest and accurate information, education and support around their baby’s appearance and cues of behaviour, as well as encouraging the parents’ role in infant caretaking. Much of the study focused upon parenting with the mother being the primary caregiver and very little detail on how nurses should work alongside fathers. The father’s voice seemed to be underreported.

For parents, information sharing is demonstrated as an essential aspect of neonatal care. Communication with the neonatal staff is a fundamental principle of family centred care, enhancing parental involvement and facilitating parent-infant attachment and transition to parenthood. The information sought is seen as being dependent upon the individual parent’s coping style and the individual infant’s condition. As discussed by Fisher and Broome (2011) communication not only provides opportunities for information sharing but also helps develop relationships and establish a rapport by the healthcare staff with the parents. What still did not appear clear from the literature was should this communication and information be tailored and delivered in the same way or differently for mothers compared to fathers? Understanding the ways in which fathers wish to obtain information ensures the staff are communicating most effectively with each parent.

Psychological researcher Michael Hynan (2005) within his paper “Supporting fathers during stressful times in the nursery” reviewed eleven research studies that intended to investigate communication approaches needed when communicating with fathers and mothers in the neonatal nursery during times of stress, and how different should this need be. He describes the Mars-Venus hypothesis, that men and women differ in all aspects of their lives with not only men and women communicating differently but that they also think, feel, perceive, react, need and appreciate differently. He goes onto state the need to consider both the mother and father as being similar as “caring parents” and that to truly be able to deliver family centred care, the staff who are educating the parents and providing emotional support need to adapt their own approach, knowing that one communication style does not fit all whether they be a
mother or a father, assumptions should not be made. Assumptions such as are fathers treated differently because they are male and is the NICU geared towards the mother as the primary care giver?

To understand fatherhood within the NICU, Deeney et al. (2012) completed a qualitative longitudinal follow up study within a NICU in Ireland. The first interview period being between two to four weeks following admission and again following discharge which was anything between three to six months later. They found that during the individual interviews a number of the twenty one fathers interviewed described a number of male gender stereotypical narratives. A number of them felt a need to be strong for their partner and baby which they both resented and clung onto. They felt it a natural thing to do to ‘soldier on’ as a coping mechanism and placed their own personal needs for support to one side believing seeking help would weaken their handling of the current situation they found themselves in. These narratives also highlighted a lack of specific opportunities for men to engage in supports. A number of the men also seemed very aware of the perception that fathers embrace technology and some did describe how they did focus upon the technical equipment and how it worked whereas others only spent a lot of time focusing upon this in the first few days as they familiarised themselves with the NICU, many described the technology as a barrier to them being close to their baby. Many felt the need to be the protector and the breadwinner trying to keep it all together but many struggled to uphold this dual role. The research study also found that their socio-economic class appeared to influence the ability to or not to meet this dual role. Those with higher socio-economic status and flexible employment found it far easier to be with their partner and baby. Interestingly, many talked about the need to negotiate equal parenting with their partner, they felt that the NICU environment was geared towards the mother and sidelined the father. They often waited for permission from the staff or their partner to get involved. These often stereotypical narratives could provide some insight into how men may or may not feel and what is needed.

To guide the staff into what may be needed, an understanding of the factors that facilitate or hinder a father’s level of involvement with their hospitalised baby is required. A study by Feeley, Waitzer, Sherrard, Boisvert and Zelkowitz et al. (2012) interviewed eighteen fathers in a Canadian NICU a week into their stay. They identified three major themes which influenced the father’s involvement or not. These were, infant characteristics such as the size and health of the infant, which could make them fear harming their baby if they touched, held or cared for
them. Interpersonal factors, which included their own attitude and beliefs around fatherhood and wanting to be with their baby which could find visiting difficult whilst juggling work, caring for other children, looking after the home and being a support for their partner. Also environmental factors such as the complex physical environment of a NICU with equipment and visiting hours seen as barriers, as well as the social environment observing other parents journey’s, understanding medical jargon, inconsistent information and the nurses being seen as role models and in control. They concluded that there are a range of factors that appear to act as barriers or facilitators to fathers’ involvement with their baby in the NICU, and how nurses are key to providing support and encouraging involvement, through teaching, coaching and role modelling. Again this was very early in the stay so would these identified barriers and facilitators change over a period of time.

Nicolaou and Glazebrook (2008) described in a review, of evidence that explored the psychological impact on families of having an infant in the NICU. As there being a need to provide a varied, flexible and ongoing programme of support options, to promote parental wellbeing, noting the changing needs of parents as the journey progresses. The paper goes on to say that further research should focus on the needs of fathers, as much to date has focused upon the mother-infant dyad and the long term positive effects of this both for the maternal mental health and the infants growth and development. My study aimed to focus upon this identified gap by attempting to understand further the needs of fathers, and the possible change in needs as the length of NICU stay increased.

When reviewing the current literature there was a wish to determine whether specific supports and recommendations had been made in regards to known benefits for supporting fathers through this journey that could be considered within the Christchurch NICU? What could be determined from the literature was that, nursing supports for parents in NICU are known to facilitate parents coping within a stressful environment. Identifying experiences perceived by parents can help the nurse in anticipating parent needs. Furthermore knowing which nursing and wider staff supports are perceived as most helpful for parents can help the staff in formulating supports and interventions. When both parents receive consistent information and guidance they become more knowledgeable and more secure to become involved with their baby’s care. Nurses are in a unique position to be able to support fathers on their journey. As highlighted by O’Brien and Warren 2013, nursing staff need to consider each individual father’s situation and develop an individualised approach and plan, which acknowledges
previous experience, other demands and possible stressors that impacts on their flexibility and readiness to be involved.

The question needs to be asked, how should neonatal nurses approach and develop individualised plans with fathers? Mode et al. (2014) within their qualitative study of interviewing eight fathers in a Swedish NICU found that the fathers used communication with neonatal staff as a coping strategy, but did not actively approach staff for communication and support until they felt more acquainted with the staff and the environment and more in control of their feelings. Consequently, the father’s perception of the quality of the information they had received was dependent upon the content and how it was delivered. Clear, easy to understand information from admission helped to boost the father’s sense of security which assisted them going forward. They also found that an open dialogue between individual fathers and staff was beneficial, with the father appreciating a personal approach to communication and the development of individualised care plans. This study concluded that continued research is required for exploring father’s suggestions and perceptions about individualised support for their paternal role over a longer period of time. They also stated that although knowledge facilitates both the coping and ability to adapt fathers have less access to sources of support than mothers during their transition into parenthood whether that does or does not involve a neonatal experience.

A study by Garten, Nazary, Metze and Buhrer (2013) in Germany, focused purely upon fathers within the NICU and their thoughts on what supports they believed would assist with parenting attitude and confidence. They gained feedback via a self-reported questionnaire from one hundred and eleven fathers. The results found that 54.4% of the respondents reported missing the opportunity for non-cot side interventions. The researchers made a recommendation that cot side support for fathers should be complimented by additional father specific non bedside support such as specific workshops, courses and platforms or chatrooms on the internet.

Several studies (Fletcher, Vimpani, Russell & Keatings, 2008; Salzmann-Erikson & Eriksson 2013) have explored the benefits of supporting fathers through on line forums, these were targeted at fathers of newborn well infants and becoming a father not NICU fathers who are known to have specific needs. Eriksson and Salzmann-Erikson (2012) described the internet as a new way of health care systems providing information and support. The online forum providing the scope for seeking out and establishing contact with others in a similar situation
without needing face to face contact or at a set time as formal healthcare support may give the impression.

Fletcher et al. (2008) within their study in Australia evaluated targeted web based information for expectant fathers and whether this was a beneficial form of support. The information was provided via email or internet and included topics of father-infant bonding, breast feeding, and work-family balance. Of the one hundred and five respondents they concluded that 82% were from professional or skilled occupations and the most accessed topic was that of father-infant bonding, the least breast feeding. They concluded that tailored information delivered in an electronic format maybe a feasible means of support for some new fathers but no recommendations around its appropriate and beneficial use within the NICU context.

Nicolaou and Glazebrook (2008) did discuss some of the possible interventions and programmes that could be considered as helpful in emotionally supporting NICU families. Their suggestions included educational-behavioural programmes, psychological support meetings with the parents, parent support groups and skin to skin. Most of these interventions have been evaluated in controlled studies that have focused upon the mother-infant relationship with very few considering or including fathers. This means that a number of strategies implemented or recommended to provide emotional support to families of sick neonates within the NICU and currently practiced in NICU’s worldwide are often derived from interventions tailored for mothers and may not be as supportive for fathers. Research clearly demonstrates that fathers do have unique needs.

Helth and Jarden (2013) did explore the experience fathers had when offered skin to skin care with their infant. Skin to skin care has been demonstrated through a number of studies to have a stabilising effect on the premature infant, improve a mothers breast feeding abilities and facilitate the early attachment process between mother and infant but very little is known on its potential benefits as a father, Charpark et al.2005 (as cited in Helth & Jarden, 2013). Helth and Jardin’s small study in Denmark of five fathers, described how the fathers expressed a great desire to play an important and caring role in their baby’s life and the skin to skin opportunities had helped them to gain in self-confidence when handling their baby and made them feel a significant person in their infants life through establishing feelings of being able to protect and comfort.
A study by Lee, Wang, Lin and Kao (2012) in Taiwan evaluated the effectiveness of an early intervention programme to increase fathering ability following the admission of their baby to the NICU and reduce paternal stress. Within Taiwan due to the maternal postpartum practice of the mother having a month’s rest at home the father is the main visitor to his baby over this time and is expected to be there for his baby and a support for his partner. The intervention included distributing a booklet entitled “About my premature baby: things a father must know” and a nursing guidance intervention to support the practicing of the contents of the book. The father could choose when he read the book and would inform the nurse when he would visit and she would then be present to encourage the father to practice the contents of the booklet with support, setting individual priorities and goals. The timing of such guidance included on admission, the first, second and third day and then at one week. Not only was this intervention seen to have positive outcomes, the fathers also felt that they received a lot more interaction and support from the nurses in the intervention group. This study recommend further research be undertaken into the long term effect on paternal involvement as they had focused upon the first week in the NICU.

As discussed by Nicolaou and Glazebrook (2008) if researchers are interested in finding ways of providing support for families of infants in the NICU, whether this be mothers, fathers or parents collectively. They must listen to what such families and individuals perceive their needs to be in order to avoid increased anxiety and distress and long term negative outcomes for them as a family.

This research study aimed to do this through asking fathers what helped, what was problematic and what was missing during their stay within the Christchurch NICU for four weeks or more.
Chapter 3. Methods

This chapter discusses the underpinnings of this research study, both from that of a theoretical and process perspective. It outlines the aim of the study, the research methods and the research process completed and the structure of the analysis. The chapter describes the research setting, the research activities and what data was collected.

Method and Methodology.
A qualitative research approach was undertaken to explore and gain insight into the experiences of the consented fathers. Denzin and Lincoln (2005) describe qualitative research as exploratory research. An approach to research that is used to gain an understanding of underlying reasons, opinions and motivations. This approach attempts to make sense of or interpret the meanings people bring, providing insight and helping to develop ideas. Qualitative thematic analysis was utilised to identify and explore the valuable information shared by fathers during one to one interviews. Sandelowski (2000) describes qualitative descriptive studies as having a goal of achieving a comprehensive summary of events in the everyday language of those events. This chapter details the research question asked, the design undertaken to be able to answer the question posed and the process completed to be able to undertake the research study and a description of how the findings were analysed.

This qualitative research study aimed to explore fathers’ experiences of having a baby in the Christchurch NICU and what they felt helped, was problematic or was missing in the way of support and resources over a period of time. Using the analysis from semi-structured interviews with the fathers the ultimate goal was to attain valuable insight into their thoughts and ideas rather than others perceiving what was needed and helpful for them as fathers during a NICU stay for a period of time. Ferketich and Mercer (1995), on studying fathers’ behaviour towards their infants, felt that there was more engagement within an environment where the nurses considered their goals, feelings and included fathers within the care. Even though this research was published over twenty years ago, still to this day there is limited research which focuses upon the fathers experiences within the NICU and this is what has driven the completion of this research study.
The research question

As described by Morse (1995) the use of questioning in research indicates a matter for discussion, it invites a reply, dialogue and a searching out of possibilities and the pursuit for knowledge. This research study explored through one to one discussion and questioning with the consented fathers, what they found helpful, problematic or missing in the way of supports for them as fathers within the Christchurch NICU.

The rationale for this approach to the interview was to meet the objectives discussed by Sandelowski (2000) that assist the researcher in discovering the who, what, where and how experiences through narrative and open ended interviews.

Who
- Fathers who have had a baby cared for in the NICU for a period of four weeks or more.

What
- The perceptions of fathers on what currently worked well in the way of supports for them as fathers in the NICU,
- Current rules or practices that they perceived hindered their involvement,
- What possible gaps could they see in the service currently offered to fathers.

Where
- Christchurch NICU.

How
- Through hearing their personal experiences and ideas.

Why
- To explore the introduction of identified dedicated supports or changes in current practice.
• To share findings of the research project within a wider context at national neonatal service and staff level for consideration.

**Research design**

Given the sensitive nature of this study and for a wish to gain insight and understanding of individual father’s experiences to help identify the value of and the type of dedicated supports needed, a qualitative approach to this research study was chosen. A qualitative research approach would provide insight, enhanced understanding and a meaningful guide to action (Strauss & Corbin, 1998). It is the preferred method of ascertaining the perception of a person or group of people, and assists in re-iterating the understanding of human behaviour and actions from an interpretivist perspective (Festa, 2005).

Sandelowski (2000) describes the qualitative descriptive study approach as being a valuable way of gaining information for practice through a summary of an event or experience in everyday terms. Language being one of the ways the information is communicated. For this research study no one father’s experience was expected to be exactly like any other father found in the same situation, each father is an individual and the neonatal experience and the influence and impact on his family and life will be unique to him. However, it was hoped through the individual interviews and the experiences they shared that there would be a deeper understanding of the impact and influence the neonatal environment, staff and resources have on the neonatal experience for fathers and a number of common themes to inform and/or potentially assist the service, tailor and improve that support going forward.

Using Sandelowski’s (2000) approach enabled exploration of valuable information shared by the participants during their interviews. The experiences shared providing real meaning and worth described by Edwards and Saunders (1990) as an approach to research which enables behaviours to be understood, shaped by and influenced by the context in which they experience them, resulting in more therapeutic care being given.

Qualitative research, as described by Morse (1995) can assist with the empowerment of disenfranchised groups by giving them a voice which in this research study has been identified as the father. It may also be the most effective methodology for identifying concerns and priorities for people who encounter health care systems. A possible criticism to
this approach which the researcher needed to consider was the potential for an uneven interview relationship. The study clearly needed to consider whose best interests were being served as discussed by Hall and Stevens (1991). For this study the researcher has a different status to the participants being a health care professional working within the neonatal service and the potential criticism could be that the researcher is perceived as being in control of the final product, the researcher needed to be both transparent with the participants about her role and mindful of how she approached those interviews. (Webb, 1991). This research focused upon those consented father’s personal experiences within the health care setting of the NICU. The inclusion criteria to be able to meet the aims of the research question included, participants who identified themselves as the father of the infant cared for in the NICU, and who had a neonatal stay of at least four weeks. This was a voluntary recruitment process.

The process

Ethics

Ethical consideration and potential issues arising as a consequence of this research project were considered. This study included human participants as consumers of health and disability support services as caregivers of their baby. Therefore ethical guidelines were developed in consideration of any issues that could potentially arise. This guideline was the deciding factor shaping the research methodology, data collection and analysis (Clare & Hamilton, 2003).

The ethical approval application was submitted and approved by the University of Otago Human Ethics Committee (Appendix 1) and required completion of the Research Ethics (Health) application, a locality assessment (Appendix 2) and Māori consultation to acknowledge the Bi- Cultural partnership within New Zealand and the Treaty of Waitangi (Appendix 3). The Research Ethics application included:

A Brief description of the background to the study;

The inclusion /exclusion criteria which included:
The population from which the sample would be recruited and the inclusion and exclusion criteria. The criteria being any father with a baby admitted to the neonatal service at less than 33 weeks gestation with a stay of at least four weeks and the participants would be able to communicate in English. There was no exclusion criteria based upon the amount of time they were able to visit or to be involved in the infant’s stay in hospital.

Explanation for the study which included:

- Brief summary of the main ethical issues that may arise and an explanation on the approach that would be taken to deal with them. This information was also provided within the participant information sheet included in the application (Appendix 4) and for the researcher within the risk proposal included (Appendix 5). A brief outline of dealing with potential risks which was also reflected within the information sheet under the heading risks (Appendix 4). This information provided clear explanations of the steps the researcher had undertaken to protect the participants and how any potential harm would be minimised which could include psychological harm or a potential conflict of interest. In the event of them becoming distressed about any issues discussed, immediate reassurance would be given, the interview suspended and additionally, participants would be advised how to access a staff member or patient advocate for them to speak to in confidence.
- An outline of the Informed consent process and a copy of the consent form (Appendix 6).
- A copy of the information flyer, invitation to participate sheet (Appendices 7 & 8).
- An outline of how the privacy and confidentiality of health information would be addressed. This information was outlined to potential participants within the participation information sheet (Appendix 4).

Access:

Locality authorisation: The location where the interviews were conducted took into consideration the need for the environment to be private and relaxed to encourage
conversation. A Locality assessment form was completed and submitted to the Director of Nursing within the Canterbury District Health Board where as the student researcher I am employed (Appendix 2). The locality form provided a brief outline of the research project and locality involvement in the study. Locality authorisation is required from the establishment from which the procedures outlined in the protocol are to be conducted. This authorisation confirms that the locality, if outside the University of Otago, has addressed research governance issues that may arise as a result of the study.

**Researcher ethical considerations and potential conflict of interest**

According to Rumbold (2000) ethics is concerned with the basis, on which people individually or collectively decide that certain actions are right or wrong and whether one ought to do something or has a right to do something. A common framework used to guide research is the Belmont reports described by Casey (2004) as having three key guiding principles:

- **Beneficence or doing good:** participants have a right to freedom from exploitation
- **Respect for human dignity:** Participants have the right to self-determination and informed consent and that the research study is fully described and explained to them
- **Justice must prevail:** Participants have a right to fair treatment and privacy.

The ethical dilemma’s posed by my knowledge of the Christchurch NICU environment and my role as the neonatal nurse manager responsible for the leadership and management of the neonatal nursing staff required explanation pertaining to my research position. I am a member of the neonatal team where this research was undertaken with a neonatal nursing and management background. It is important to acknowledge that as a researcher I am part of the neonatal community with insight and experience of NICU culture and practices. All of these experiences shape my role as a researcher and provides me with valuable knowledge and familiarity with the environment and personnel. My current practice within the NICU is as the manager and not at the cot side caring clinically for infants and their families, I do not have direct daily contact with the families. Hauser (1998) states that qualitative research conducted with special populations brings a sharp perspective. Whether researchers can accurately represent and understand, without the experience of “special populations” is a
question presented. Hauser points out that subjectivity and bias become “non-issues when researchers are explicit about their biases and purpose (p.137).

By arranging the interviews away from the NICU, demonstrated thoughtful acknowledgement of a potential power imbalance. However the safety of the researcher also needed to be considered as well, ensuring that the interview location was in area where other staff could be contacted if the need arose and that a member of staff had been made aware that an interview was in progress without compromising confidentiality and anonymity.

As the researcher and a neonatal nurse manager, consideration was needed as to how to manage and respond to any revelations made during the interview that could potentially overlap with professional nursing responsibilities. Many researchers in a dual role have indicated that as a researcher they would intervene in a situation where either the participant or researcher were in danger or that there was a moral or professional judgment on whether to stop the interview (Davies et al, 2000). For this research study, an ethical risk proposal was developed that outlined at what point the researcher would intervene and for what purpose. For example should a negative disclosure arise about the practice of a staff member or a child protection concern the participant would need to be made aware of this or if the conversation lent itself to the father exerting dangerous behavior. A clear risk proposal of how the researcher would manage such a situation and how this would be managed with the participant was submitted as a component of the Ethics application. The proposal detailed:

- The participants right to approach the Health & Disability advocacy service,
- That the researcher may terminate the interview if the participant becomes uncomfortable or distressed with the conversation,
- Of their right to withdraw from the study,
- That if there were a disclosure where the researcher suspected abuse or risk of abuse there would be a need for the researcher to inform the participant about their mandatory reporting obligations before reporting to others.
Māori consultation

As a University of Otago student researcher there is an identified need to comply with the policy for research consultation with Māori. The policy framework sets out the appropriate and mandated consultation process with Māori for research. It ensures an effective mechanism for managing the consultation process whilst acknowledging that all health research in Aotearoa New Zealand benefits the Hauora (health and wellbeing) of tangata whenua.

The consultation included the submission of the research project proposal and a face to face meeting with the University of Otago Māori Research Advisor. To discuss and outline the research project and the specific relevance of the research to Māori and how Māori participants are acknowledged and supported within the same way.

The recruitment of fathers for this study was voluntary and whilst this study did not specifically target Māori fathers, ideally their presence within the recruitment population should be reflective of the Māori population living within the Canterbury region which is approximately twenty eight percent in 2013. To ascertain those that identify as Māori within the NICU relies upon ethnicity data collection in hospital protocols and databases which has been limited to date.

To ensure that Tikanga Māori processes were integrated where and when necessary during this research study the involvement of the Christchurch NICU Māori health worker (Kaitiaki Hauora) was necessary. This provided a culturally safe approach to the study for those that may identify as Māori and would allow for Māori values and realities to be considered and data from interviews interpreted within the correct cultural context.

Research and statistics demonstrate that having a premature or low birth weight baby increases the risk of mortality, morbidity, sudden infant death, child abuse and neglect compounded by the stress on families due to a long hospital stay of a sick baby. The indigenous people of New Zealand are disproportionately over represented in poverty statistics, child abuse, hospitalisation rates, neonatal mortality and morbidity therefore the findings of this study and what is put into place may also provide greater benefit to those who identify as Māori, by reducing stress factors on the whanau and supporting infant attachment.
This study provided an opportunity to consider the supports that could be put in place for fathers and the views of those fathers who identify as Māori would contribute to what these supports should look like, to assist fathers and their whanau through the neonatal journey and ultimately benefit health outcomes for the pepi (infant).

The ethnicity of the father was documented as part of the research and as detailed within the consent form and the information sheet (Appendices 6 & 4) for those fathers who potentially identified as Māori there would be the opportunity to meet with the neonatal Māori health worker for any cultural issues that could arise as a result of participating in the study. Ethical and Māori consultation was approved in August 2015 (Appendices 1& 3).

**Interview schedule**

The interviews were semi-structured with the focus being on encouraging the fathers to share their own experience and neonatal journey. The one to one interview providing the opportunity to allow exploration of the father’s feelings and thoughts in a sensitive way which may not be gleamed through a survey or questionnaire. The researcher also had the benefit of the visual opportunity to note any other expressions and body language that could contribute to those reflections on their neonatal experience (Morse, 1995). One to one interviews were chosen, the rationale being that by conducting individual interviews rather than a focus group, the one to one environment would provide the opportunity for individually focused dialogue and telling of that individual’s story without other’s influence or interruption.

Interviews were arranged and undertaken either within the hospital in the administration area away from the clinical environment and neonatal service or at the Centre for Post Graduate Nursing Studies, University of Otago Christchurch. Care and discretion was taken with the location to ensure that the environment was not going to cause any stress but support an environment that encouraged trust and open dialogue. The researcher had considered the potential power imbalance between the researcher and being the nurse manager of the NICU and the father being interviewed. There was a need for the researcher when preparing for the interview process to be clear on role clarity, to ensure there were no blurring of the boundaries and how potential issues would be managed (Wilkes & White, 1995).
Interview format:

To encourage an interview setting that felt relaxed and unintimidating, opening questions to encourage the conversation included an introduction and several demographic questions which included:

- Baby’s name
- Gestation at birth
- Length of stay in the NICU
- Any siblings
- Any previous neonatal experience.

Semi structured questions were used with the questions aiming to explore the father’s experiences, stressors, routines and suggestions for improvement. The control of the conversation was with the father. The interview however was interactive, with the father being the primary informant the researcher in a secondary role. Morse (1995) describes this process as being essential to ensure that the interviews do not contain irrelevant information and that the data collection process is relatively efficient. With this in mind it was important that the format of the questions were cognisant of the need for non-medical jargon to encourage the father to feel at ease. Open ended questions were chosen to enable respondents an opportunity to express themselves. The answers not being facts or figures, but personal feelings, opinions, or ideas (Sandelowski, 2000).

A prompt sheet (Appendix 9) was available to encourage conversation. This sub set of predetermined questions if needed would support development of the conversation and possible exploration of areas not mentioned by the father. This broader to narrower focus might reveal things to the analysis about participant’s experiences that had not been considered.

Regardless of the questions that the researcher would like to ask participants. Sandleowski (2000) explains that the descriptions shared in qualitative descriptive research must always accurately convey the meanings participants attributed to those events, noting that although human beings can never and probably never want to describe everything what they choose to describe will be something that most observers would agree is in fact “There”. To be able to convey that accurate meaning the researcher needs to be mindful of the necessity to stay
close to their data and to the surface of the words and events so that the meaning given to those words or events are true to those participants and have descriptive validity to others.

The study population: Fathers

The study focused upon interviewing participants who identified as the father and did not include the interview of significant others such as grandparents. The father figure does not always have to be a child’s biological father, this study focused upon those participants who identified as the father of the infant who was being cared for in the NICU and discharged from the service. The researcher acknowledges that there are other family models of care as highlighted earlier within the background to this study, but for the purpose of this study the experiences of fathers’ was the focus, based upon an identified need within the service to review current supports and tailor any further support to specifically meet fathers’ needs.

Whilst physical care and technological support are essential components of neonatal care as equally important is the focus that needs to be placed towards the emotional care of parents. Still to this day much of the research has focused upon the experiences and needs of mothers and less a focus upon fathers’ experiences and needs (Carter, Mulder, Bartram & Darlow, 2005). The ultimate goal for interviewing this defined study population was to obtain rich information first hand from fathers on what they actually would like (Sandelowski, 2000).

The rationale for interviewing fathers who had at least a four week stay was that there is currently a gap in the research and an identified need that future research needs to focus on longer length of stays, to establish how a father’s emotional experiences and management change over time and what factors help or impact upon their experiences (Hughill, 2014). It is known from studies of mother’s that their perspectives on their experiences in the NICU change over time (Gavey, 2007). To meet this criteria participants were fathers with infants born less than 33 weeks gestation. As already noted for this study a long term stay is defined as being a stay of four weeks or more (a baby born prematurely can anticipate a hospital stay up until expected date of delivery of 37 weeks or more).

For this research the decision was made to interview fathers whose baby had been discharged home for at least a period of four weeks. The rationale for interviews being held following discharge was to minimise the potential risk that if very difficult issues arose in real time,
they could potentially interfere with the family’s experience and the data collected research findings.

**Participant recruitment & enrolment**

For this study, a cohort of 8-12 fathers were individually interviewed. The participants being those who met the criteria from the potential population that the researcher wished to interview. This sample size was considered a reasonable representation of views and experiences to ensure justifiable assumptions and recommendations to be made (Field & Morse 1985). The strategy for sampling was to utilise the volunteer method with a reliance on the potential participants volunteering themselves on receiving the initial invite based on meeting the criteria.

Potential participants were identified via the NICU’s admissions data sheet and admission book by the neonatal ward receptionist, the rationale for this approach to recruitment by the neonatal ward receptionist was to minimise any potential bias by the researcher being involved in the selection process. A major criticism of volunteer and purposeful selection as described by Morse (1995) is that by nature there is already a bias because of the self or researcher selection. This method does facilitate a certain type of informant but this is the purpose and intent. The researcher seeking to describe the experiences heard as richly and as accurately as possible.

On receiving a referral the researcher checked the eligibility criteria and those who met the criteria were sent an invitation to participate (Appendix 8) and if they indicated an interest in wishing to be involved they were sent an information sheet (Appendix 4) and consent form (Appendix 6). At this time the researcher’s contact details were also forwarded to be able to answer any questions they had and to arrange a suitable interview date and time. A flyer informing parents about the study was displayed on noticeboards in the parent lounges in the NICU to encourage fathers to consider participating (Appendix 7). Neonatal staff were also made aware of the research study being undertaken so that they were in a position to be able to respond to any questions they may be faced with and have the knowledge of where to direct these questions.
Informed consent for any research within the NICU is considered by some researchers to be burdened with ethical dilemmas; due to the stressful environment, possible vulnerability of the infant and family and the perceived expert /lay knowledge differential and potentially the possibility of a balance in control by the staff (Alderson et al, 2006). A study performed by Ballard, Shook, Desai and Anad (2004) in the United States of America, researched the validity of informed consent obtained by parents whilst their baby was an inpatient in the neonatal unit. Of the sixty four parents interviewed, five (7.8%) had no recollection of the study or of signing a consent for their baby’s enrolment. Of those who had signed only 67.8% understood the purpose of the research study and of those who understood the purpose of the study 95% were able to verbalise the benefits but only 5% understood any potential risks. None of the parents felt coerced to sign. In regards to this research study, when considering the process of consent and interviewing. The sensitivity placed on timing of interviews following discharge, the location of the interview away from the department and the information provided and the time to consider partaking being set by the father’s response themselves, provided an enrolment and consent process that was felt ethically appropriate.

The consent form clearly explained that participation was voluntary and at any time if the line of questioning developed in such a way that the father felt hesitant or uncomfortable they could decline to answer the question or withdraw from the project without disadvantage of any kind (Appendix 6). Both the consent form and the information sheet both provided clear explanations of how any potential harm would be minimised and in the event of them becoming distressed about any issues discussed, immediate reassurance would be given at the time and the interview suspended. Additionally, arrangements would be made for an independent patient advocate, to be made available for them to speak to in confidence. There was also the option for them to have a support person of their choosing present throughout the interview and the availability of culturally appropriate support was also described. These enrolment steps aimed to facilitate a more ethical and sensitive enrolment process.
Response rate/recruiting issues

Recruitment commenced in October 2015, with a total of sixty six initial invites being distributed over the three months leading up to the Christmas holiday period. This did reflect a quiet period of recruitment with only six responses. The holiday period had been considered but was felt that for some fathers it may offer more flexibility around availability due to the taking of leave at this period of time, however this could also be a time when families were on holiday and unavailable, which did appear to be reflected in the response rate. Due to this holiday period the six fathers who wished to be interviewed were unavailable until February 2016 to be interviewed.

In February a further nineteen invites were distributed and a 2nd reminder to those previously invited where no response had been received. A further six responses were received over the next three months from February to April 2016.

In total eighty five fathers who met the criteria between January 2015 and April 2016 were sent invites. A total of twelve fathers responded to the student researcher either by email or telephone wishing to receive further information. All twelve agreed to be interviewed and completed the necessary consent.

Interviews commenced in February and were completed by end of July 2016. This reflects the difficulties fathers had to be available due to life demands. Even with flexible days of the week and times being afforded. The researcher did not need to rearrange any booked interviews.

Unfortunately two of the fathers who initially consented were unable to follow through on the actual interviews. Both fathers commented upon the demands they had on their time with work and being unable to offer time for an interview. Given the option to arrange this for a later date was declined with both commenting that they effectively had put the NICU experience behind them and wished to focus on the future, and did not feel they could contribute after such a length of time.
Privacy and confidentiality of health information

The interviews were audiotaped and all of the fathers interviewed were comfortable with this method of recording. No father requested the presence of a support person. The fathers were advised within the information sheet and at the completion of the interview that copies of the written transcript would be made available to them to read if requested. The completed work would have the names changed to protect confidentiality and the overall findings and recommendations would be made available to them. Pseudonyms were used rather than the father’s or baby’s name to respect that need for confidentiality.

The researcher confirmed both within the consent process and at the interview that any written notes and the audio tapes were confidential and would not be available to anyone except the researcher and the supervisors thus anonymity and confidentiality being maintained. To ensure the confidentiality of the health information during the study the audio tapes and written information was kept in a locked filing cabinet in the researcher’s office. Data transcribed onto the computer was password protected.

The Health Information Privacy Code (1994) requires that health information be retained for a period of ten years. For this study all information would be kept safely for ten years in the centre for Post Graduate Nursing Studies and then destroyed by an administrator.

Transcribing

All interviews were taped recorded and transcribed verbatim. The interviews were listened to and typed by an employed transcriber. The transcriber signed a confidentiality form (Appendix 10). This confidentiality form ensured that the transcriber agreed to ensure all of the materials were securely stored and that no content or aspects of the audiotapes and scripts would be discussed. As the researcher to be thoroughly familiar with the data, the audio tapes were listened to and the transcriptions were read through a number of times.
Analysis

Data was analysed through thematic content analysis a qualitative descriptive approach in which the researcher systematically applies codes to the themes derived but these codes are generated from the data themselves there are no pre-existing set of codes. Sandelowski describes this as a dynamic form of analysis using verbal and visual data to summarise the informational contents of the data (2000). Using Sandalowski’s (2000) approach the analysed findings remain close to the original data, and yet are still “detailed and nuanced” interpretations (Sandelowski, 2010 pg. 78).

Braun & Clarke define the process of analysis as “identifying, analysing and reporting patterns (themes) within data”. The themes captured within the data aiming to represent a level of patterned response or meaning across the data set. A theme needs to capture something important in relation to the questions asked. The analysis for this study relied on both Sandelowski’s (2000) approach and Braun and Clarke’s related processes (2006). Braun and Clarke (2006) identify six phases to conducting thematic analysis

- Becoming familiar with the data,
- Generating initial codes,
- Searching for themes,
- Reviewing those themes,
- Defining and naming these themes,
- Producing a report.

As this is qualitative analysis the proportion of data required to display evidence is not necessarily a quantifiable measure, it requires the researcher to be flexible in refining the analysis into important overall themes and sub themes.

As the researcher collecting the data, on analysis I had prior knowledge of the questions and data, Webb (1991) talks about this professional knowledge and the control this can have of the final product. For the transcript to be rigorous it needed to retain the information in a way that was true to the original nature of the conversation. The codes developed being derived from organising the data into meaningful groups and then sorting these codes into identified
categories and then defining and refining the evolving themes into a final analysis and report which is logical, concise and tells a story (Braun & Clarke, 2006).

To take into account the need for reliability of the transcribing process certain actions were completed. Firstly transcripts were read through and re-read to identify the themes. A selection of anonymous transcripts were read by the supervisor who examined the themes and assisted and challenged the clarification of the themes developing.

To ensure the rigor of the findings and present robust research findings there was a need to ensure that the sample group were representative of the population that wished to be studied so that the insight and knowledge shared allowed for justifiable findings to be concluded. That the data produced was reliable with the themes being coherent, consistent and distinctive and that they had been analysed not just described. As the research aim was to have credibility in the health sector with the potential ability to influence and achieve change in practice necessary requirements were established and appropriate applications made to ethics and cultural committees to ensure the research as ethically sound. The reliability, accuracy, stability, likeness and consistency had been established.

The credibility of the researcher was supported by there being demonstration of a good fit between what as the researcher I had claimed to do and what was shown to have been done. The research study also captures my active role in the research process being transparent of my position as the researcher and my understanding and awareness of the potential impact of this position supported the integrity of the process. To balance the analytical narrative and extracts, sections from the transcripts are captured within the findings and analysis chapter to ground the theory in the participants’ words (Braun & Clarke, 2006).
Chapter 4.
Findings & Analysis

The results of this research study are presented within this chapter in the form of text and tables. The chapter will provide the context to the findings by referring to the fathers’ stories and quotes. The discussion on the analysis of the data will be outlined following the method utilised to organise the data.

The purpose of interviewing fathers was to gain a more in depth understanding into how they found the experience of being the father of a baby who required a stay within the NICU for a period of time. The research question, “What’s helpful, what’s problematic, what’s missing during your stay,” aimed to identify valuable thoughts and ideas unique to fathers through:

- Identifying what currently worked well for fathers,
- Gaps in the services currently offered to fathers,
- Current rules or practices that could be perceived as hindering their involvement.
- To explore the introduction of identified dedicated supports or changes in current practice.

**The participating fathers**

The chart below summarises the demographics of the fathers interviewed. These charts aim to protect their anonymity and where needed pseudonyms have been used. The demographics captured were:

- Ethnicity
- Residential catchment area
- Employment status
Nine of the fathers interviewed identified as New Zealand Pakeha and one father stated his ethnicity as South East Asian. No father’s identified as Māori.

Seven of the fathers resided in Christchurch city boundary, three lived over one hundred kilometres away from the hospital.

All ten fathers were in paid employment.
Table 2 captures four parameters that relate to the neonatal experience which could potentially have an influence on the father’s NICU journey. These were:

- Any previous neonatal experience,
- Whether this was a singleton or multiple birth,
- First baby or other children,
- Duration of this NICU stay.

**Table 2.**

**FATHERS and NEONATAL DEMOGRAPHICS**

<table>
<thead>
<tr>
<th></th>
<th>Jim</th>
<th>Jack</th>
<th>John</th>
<th>Pete</th>
<th>Dave</th>
<th>Ken</th>
<th>Mike</th>
<th>Bob</th>
<th>Bill</th>
<th>Kev</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Neonatal Experience</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Multiple Birth</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Existing Siblings</strong></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Duration of Stay: Days</strong></td>
<td>99</td>
<td>67</td>
<td>110</td>
<td>56</td>
<td>70</td>
<td>54</td>
<td>49</td>
<td>71</td>
<td>110</td>
<td>77</td>
</tr>
</tbody>
</table>

Three fathers had previous experience and involvement in a NICU with both having a baby in the Christchurch NICU. Eight fathers had singleton babies, and two fathers had twin babies. Six fathers were having their first baby and four fathers had other children. Duration of the NICU stay varied from fifty six days to one hundred and ten days.
**The sampling:**

It was necessary for the researcher to make interview times flexible, noting that the fathers were trying to make themselves available for an interview whilst juggling work and home commitments. Seven of the interviews were held of an evening, lunchtime or weekend. Nine interviews were face to face, one interview by skype due to residing over two hours away from Christchurch. Twelve fathers consented to the interview however two fathers were unable to commit to the actual interview due to outside commitments. There was no convenient time for either of them to meet face to face or by skype when provided with that option. The researcher thanked both fathers and offered the opportunity at a later time if they wished to partake. The researcher was mindful of not wishing to place any further pressure on either father.

Of those interviewed three lived out of town (over one hundred kilometres distance) and two of these fathers arranged the interview times to coincide with other commitments they had that day in Christchurch. The interviews were planned to take approximately one hour, there was no time minimum or limit. The researcher noted that the interview needed to be sufficiently long enough for the fathers to feel unrushed and have the time to reflect and share their experiences.

**The analysis**

Thematic analysis was conducted on each of the ten individual interviews completed. Each interview was transcribed and ranged in length of time from forty minutes to ninety minutes. Analysis involved immersion in the data collected and the searching for and identification of themes from within the interview conversations (Braun & Clarke 2006). Following the thematic approach it was apparent that there were a number of recurring topics, as these were identified a context analysis was undertaken to consider the extent of the topics that occurred.

During the ongoing process of analysis, the transcripts were read through a number of times and sections of conversation highlighted. General titles for assisting with the coding were created and numbers were added into the margins of the transcripts next to the highlighted text for easy identification. Interestingly a number of the conversation sections had up to three relevant coding symbols assigned to them.
Themes were emerging that appeared to be pulling together a number of common groupings. As the reading of the transcripts continued key themes were identified, at the same time single issues that were significant for some fathers but did not fit into any of emerging key themes were also documented. To assist with drawing together the main and emerging sub themes, all themes and supporting quotes were displayed on a whiteboard which provided a visual summary. Braun and Clarke (2006), describe this as defining and refining the themes into a final analysis and report which is logical, concise and tells a story and makes an argument and supports the research question. As the researcher working within this speciality the rich data collected and an understanding of the NICU supported the ability to identify and code key themes and extract sub themes within each category, cognisant of the aim of the research question being asked.
Findings:

The major key themes that emerged and subsequent sub themes are represented within the flow diagram below.

**Figure 1.**

**THEMES**

**MAJOR and SUB THEMES**

<table>
<thead>
<tr>
<th>Major themes</th>
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1. The facilities and the environment

The environment

For seven of the fathers interviewed they had never experienced a NICU stay or had been exposed to what a NICU environment encompassed before. Six of the fathers had been able to have a tour of the unit during the antenatal period or when their partner was in early labour, which was appreciated and appeared to reduce some of their anxiety and fear. Ken described the opportunity of having a tour as useful stating,

“It was suggested that we do a tour because more likely than not we were going to be premature, so we ended up being taken through NICU showing us exactly what goes on up there, so that it wasn’t so much of a shock when we got there which was a really good thing. Having that prior knowledge of what the place looked like was really handy”.

Bob described the opportunity to have a tour as

“It was really cool, it helped heaps having a tour, and it is hard not to get freaked out so it definitely made everything a lot easier but yeah it’s still a rollercoaster”.

In comparison, for the other fathers where there had been no time to prepare for a NICU admission, they expressed anxiety and an overwhelming daunting feeling on not only entering the unit for the first time, but until they felt comfortable with the surroundings, staff and less worried about their baby’s own wellbeing. John on entering the NICU for the first time described his feelings,

“I went inside the room, I saw this different area, incubators, machines, sound and I thought what’s happening?”

Dave described how it felt for him after a few days saying,

“It just didn’t even register to me what was happening, I didn’t know NICU existed so two or three days into it the penny dropped and holy hell we are here for two or three
Several fathers talked about how the environment felt for them as time moved along, having become familiar with the surroundings and the staff and the routine. Jack describing the environment as

“You do become immune to it you know after a few weeks, the changes, the people, the conversations, you just tune out I suppose.”

Pete described the NICU as

“People say “how do you do it?” leave your baby there, but you feel comfortable, it gives me comfort to know I can go visit 24 hours a day, the doors always open, you can go back and forth, not intruding”.

Jim talked about the length of stay enabling him more time and opportunity to feel confident with his baby who had complex needs stating,

“The fact that I had to go through the training and like it was daunting, but once I got used to the equipment and I had confidence over time when we went home with so much equipment there was no panic”.

This overarching theme of what the NICU environment felt like provided some general insight into some of the father’s thoughts and experiences of the neonatal environment as a place. A number of them talked more in depth around specific factors about the neonatal environment that had either a positive or negative experience for them. These subsequent sub themes included:
The visiting rules and the rituals of the NICU

Several of the fathers when commenting on these rules and rituals touched upon an understanding of why there needed to be certain rules but also went onto talk about how such rules influenced and impacted upon their neonatal experience for themselves and their partner and wider family.

Visiting times

The Christchurch NICU visiting policy (Appendix 11), has been developed to ensure an optimal safe and secure environment for the babies, by minimising infection risk, protecting family’s individual privacy, and providing an environment that promotes baby’s wellbeing and development. The visiting policy outlines the times of day when visitors which includes siblings can visit and how many visitors can be present at the cot side at any one time. The visiting policy welcomes parents twenty four hours a day seven days a week to be with their baby. On exploring these rules with the fathers and the impact they had on their experience all of them described an aspect of visiting within their interview, the majority understood the rationale for such rules with Bill describing this as

“I like twenty four seven for parents that’s good, I like the visiting rules, I think it’s good it’s limited that you restrict friends and family because there is plenty of time to come.”

Bob describing it as

“A good strategy of visiting times”

He acknowledged that it was appropriate even though it seemed harsh initially but then he got it. With him going on to explain that,

“You think well that’s a bit harsh but once you’re in there you see why, it gets way too crowded and nobody would be able to move otherwise”.

Several fathers talked about how the visiting rules should be disseminated to others and whose responsibility that should be. Pete described this as
“I think it is up to the parents as well to inform their visitors that these are the hours, it’s got to be enforced you know, and at times you may let your visitors down”.

Siblings visiting and trying to manage this in a busy day as well as a wish to be together as a family was something that the fathers who had other children did find difficult and became harder to manage and became an increased stress for them over a longer period of time. Pete stated that,

“Probably one of the hardest things for us is that we have a wee daughter and it did affect me and M and of course my ability to be able to visit. It was quite hard because the three of us couldn’t be at the cot side at the same time”.

Overall the general consensus appeared to be that the fathers understood the rationale for the visiting rules, they did not seem to see it as a significant hindrance to their own visiting as Pete stated,

“ You know it’s quite good in terms of you can just spend time with the wee one and mum, don’t have to worry about visitors coming, that time is quite important”.

But for those fathers with other children they did find it difficult as the length of stay increased, to juggle and needed to seek the support of others to be able to visit themselves. For many they in fact preferred the limited visiting as it allowed them as parents to focus on their baby with Ken describing this as

“We felt that with our visitors that as much as we love our family when you have people there you feel the need to entertain them a wee bit rather than actually concentrating on the job with our baby”

And Bill

“We say it’s more important that baby gets to know us first.”
Quiet time was introduced within the service in 2008 after collaboration with parents. This daily two hour period of time from 13.00 hours - 15.00 hours provides the opportunity for quietness free from interruptions of ward routine and visitors. The NICU staff consciously quieten the nurseries by the dimming of lighting and the reducing of noise. This quiet time was introduced to support a neurodevelopmental approach to care that attempts to minimise the noxious environment for premature infants and encourage parental infant attachment as described earlier within the background to this study. Only parents are permitted during these hours. Five of the fathers interviewed talked about quiet time and all five expressed this as being a special time for them. Jack describing this as

“That 1-3pm period was golden. It was fantastic. It was almost like the curtains were closed, everyone was quiet even the nurses were hardly moving, much more peaceful”.

Bob

“That quiet time the best part, no one constantly walking past and you can actually sit there and relax with your newborn, I think you need it you know, it’s such a busy place all the time so it’s nice just to have that little period that you can just chill out.”

Kev

“Can just spend time with the wee one, don’t have to worry about visitors coming at that time, there is quiet its important it’s parents time with baby.”

John

“We still need to give those babies like a rest, their own time cos even those tiny noises give stress to babies”.

Rituals

The only ritual that any of the fathers commented upon was the unit’s giving of the One Hundred Day Cake to the parents when their baby reached one hundred days of age and was still an inpatient. The neonatal staff see this as an important milestone in a difficult journey
that needs acknowledging and celebrating. However the responses from those fathers that touched on it were mixed. There were positive comments such as that by Bill,

“Yes, Hundred day cake, very nice, actually it did fly by to be honest”.

Others saw it in a more negative way by still being there after that length of time as commented on by Mike,

“No, The cake, a celebration for the staff but not the family we didn’t want to be there”.

Kev stating,

“We were trying to get out before one hundred days.”

**The Facilities**

The facilities provided within the neonatal environment was a talking point for the majority of the fathers interviewed, they were discussed alongside the considerations about the NICU environment itself. General comments included:

“I mean this is a hospital and you give too much, you have free coffee, your chocolate drink and I was even surprised when I saw bread and fruit on the table”.

“It was more than adequate you put on tea and coffee and stuff and you probably don’t have to but you do”.

“Not enough comfy big chairs, the recliner is designed for breast feeding and skin to skin so it’s comfier which is hard for a father as you feel guilty sitting on it”

Further sub themes on the facilities included:

**Written Information**

The NICU service currently provides a number of parent information sheets which cover a broad range of topics. The service decided that rather than overwhelm parents in those first
few days the initial parent pack would contain those early deemed important things to know such as the visiting policy, quiet time, the layout of the unit, facilities available and what to expect in those first few days. As the days progressed the nursing staff would tailor the ongoing dissemination of written information to meet the individual baby’s clinical condition and other information pertinent at that time. This further information would include feeding advice, clinical conditions, upcoming tests and examinations needed. All of the information provided being based upon best evidence in collaboration with wider consumer input and other key stakeholders or experts.

Interestingly the fathers described the written information either by describing the content and terminology described by Jim as being,

“Technical speak but felt well informed”.

Jack describing it as

“The info is really beneficial. That’s my analytical mind and it’s me being able to have some form of control even though you’ve got no control over things, you feel you know what they are talking about and that’s beneficial”.

Others discussed the timing of the giving of information, four fathers found the timing worked for them Bob describing this as

“I pretty much read the whole information pack the first night. I was able to just sit down and that gave me something to do. I actually found I could use the buzz words”.

Pete described his thoughts on the information provided as

“Never fear bombarding the parent, as a parent I wanted to know everything. As long as you have the right to ask six times what things are in the end you will eventually get it.”

Several fathers found it too much in the early days as commented on by Ken,
“Too much information initially it’s too much to comprehend because you’re just not thinking about that because you are so worried”

A number of fathers touched on the visual displays around the unit which capture photographs and stories of other babies and families NICU journeys. These posters have over the years been gifted by parents wanting to share their story with other neonatal families. All of the fathers who discussed these posters found them inspiring such as Dave who recalled,

“I remember looking at all the pictures of the families and thinking its just little stories but we’re fine, we’ll be alright”

John described the stories as being,

“You can see those stories on the board, yeah inspiring I can see a baby which was born at twenty five weeks so tiny and then you think about your current situation. Sometimes you tell yourself I’m so lucky and they are also lucky because these babies on the board look at them now all grown up because of these amazing staff”.

The giving of health Information and advice on infant health and parenting has been demonstrated within the research as being well received by parents, leading to more confident and nurturing parenting through understanding the needs of their infant (Fletcher, Vimpani, Rissell & Keating, 2007). Information can be disseminated through a number of mediums. Paper based information is just one method, technology is another which is advancing rapidly. The Christchurch NICU to date has focused upon developing a parent internet page which provides a virtual tour of the service and provides the current written information electronically. There is the potential for further enhancement of this form of technology for parents.

**The use of technology**

Several of the fathers interviewed commented on the use of technology within the NICU, none of the fathers discussed the use of technology within the context of providing parent information. Instead they talked about its use as a means of possibly enhancing communication.
The ability to use Skype was mentioned by six of the fathers. All of them saw this as beneficial when wanting to connect with family or when working themselves and wanting an update on their baby’s progress that day. Jack described this as,

“Like A had to have a blood transfusion and during those key things it would have been nice to be able to be without a forty five minute trek to get there and then find a park during work time, defiantly Skype would have been a way to do it”.

Mike, when talking about the wider family,

“The reality is when you can’t bring people in and you’ve got multiple sets of grandparents that want to say hello having Skype would be fine”.

The use of cell phones was also raised by several of the fathers, several fathers commented upon feeling perplexed by the rules as Pete stated,

“If I was to have input in terms of determining the cell phone usage it would be a safety thing that both hands on the baby if holding baby, but that otherwise it can be used for accessing the Internet not texting”.

The current rule within the Christchurch NICU is that cell phones must be kept in silent mode within the nurseries and there should be no talking or texting within the clinical areas. The rationale for such a rule being the wish to minimise any potential concerns with privacy and confidentiality for parents and also to keep noise levels to a minimum. The fathers who raised cell phone use, discussed how they found staff when monitoring cell phone use. They felt that for many parents they utilise their cell phones to read articles and for keeping in contact with their friends and family during a difficult period of time and felt that as long as the phone was silent that their use should be supported. As Mike stated

“I think the reality is cell phones are a part of life and most people don’t have their phone beeping all the time, so as long as it’s on silent I don’t really see how it’s a risk to text or read from the phone.”
Pete described cell phones as being,

“Cell phones are the new TV if you sit there and you are just looking at the wall for an hour straight it would be nice if you could put a movie on”.

John’s approach to this rule was,

“I’m inside the unit and there’s a sign saying be quiet you cannot use your phone, of course I have to adhere to it because it’s the rule”.

The final sub theme discussed by a number of the fathers focused around the lack of opportunity to be able to stay overnight within the parent bedrooms as a part of the rooming in process before discharge home with baby. The two fathers that had the opportunity to stay due to the individual needs of their baby, had mixed responses to the experience they had of rooming in with their partner and baby.

**Fathers rooming in**

The current criteria for parents to room in with their baby prior to discharge is only offered to mothers and for a stay of forty eight hours prior to discharge. The aim being to provide time for the mother to care for her baby in the room with overarching nursing support. The service has limited ability to extend the offer of rooming -in to partners due to the limited bedroom space available. The rooms are shared and the option for partners is limited to individual infant needs and or complexity where the partner will be directly involved in certain care for example palliative care or complex home oxygen therapy and nasogastric feeding.

All five fathers who discussed rooming in acknowledged that they realised it was a space issue with all of the rooms needing to be on a shared basis to meet the demand Mike stating,

“I appreciate it is a space issue but if fathers could they should its kind of a good thing to know what to expect from a father’s perspective for when we get home.”

Feedback from three fathers focused upon how unfair they felt this to be and given the opportunity they would have embraced this wholeheartedly. Mike describing this as
“It seems extremely unfair that dad’s cannot room in at that final point. I think to expect mum to cope alone in a strange environment with a new baby without someone else’s support is harsh. At least at home they are going to be tired but at least there are others to help”.

Bob reflecting on how useful it would have been,

“If I had the opportunity I would have taken it hands down. That would have made part of this experience so much easier, because she’s doing it all by herself all night for two nights and she was so tired definitely partners being able to stay should be supported”.

Interestingly for the two fathers that were able to stay due to the complexity of their infants clinical needs they commented upon the lack of support for providing meals for them with it only being the mothers that received delivered meals, with Ken stating that,

“You can’t have a meal and I have to stay here it just seemed a bit tight, if we had no money I don’t know what the hell we would have done”.

**Additional comments on facilities**

One topic that was raised by four of the fathers and was outside of the control of the NICU service was the lack of hospital parking a situation that did appear to have a significant impact on the day to day experience for the fathers and parents in general. The service already had prior knowledge of the parking being a hospital wide challenge for patients and visitors. What became clear from the fathers who commented upon the parking was that the parking was a problem but that they all believed it to be beyond the control of the service but wished to acknowledge as a service that there had been an effort to try and minimise any potential stress this could cause described by Dave as

“The parking is a nightmare, you can’t do anything about that. The social workers are really good gave us a little pass its miles away and if sometimes in and out twice a day it’s a bit of a problem, it’s about the best you can do”.

Jim commented on the provision of the hospital transport service as being beneficial,
“The shuttle is really good, reassuring for getting to and from the car.”

The key and sub themes reflected how the fathers over time found the environment and the facilities having an impact positively or negatively on their own experience and journey and on their partner and wider family from their perspective. The communication and interaction with others was another major theme that evolved.

2. Communication & interaction with others.

The interviews identified two main groups of people other than their own partner that fathers talked about engaging with the most over their stay; staff and other fathers.

Staff

Interviews highlighted both the positives and negatives of the interaction and communication experienced with staff. The staff being discussed predominately fitting either into the category of nursing or medical. Nursing interactions were heavily commented upon almost certainly as a consequence of the increased involvement and engagement with nursing staff caring for their baby one on one twenty four hours a day. Pete described his interaction and thoughts on nursing relationships as being,

“It was a cool thing that the nurses would check up on how work was going, they would get a good picture of us and check in, asking are you being supported, so it was quiet cool to know that they knew you were going through a stressful time”.

Jack described relating to nursing staff thus

“I often came in at half past eight at night and hung around for an hour or two, which was really nice because there were very few people there and the nurses were all generally a bit free and up for a chat”
Medical interaction was described by Mike as helpful,

“I felt like I guess I was part of the team, you feel comfortable enough to make decisions and you can ask the right questions and you know where you stand I guess. Like all my questions were answered at the time and I felt empowered to actually feel confident enough to speak up.”

Bob talked about his and his partner’s positive relationship with the nurses by stating,

“We were grateful that we made friends up there, and did have really good relationships with a few nurses, we were able to joke around a little bit and actually made the experiences a bit more enjoyable”.

On further exploration of the comments around staff, key sub themes emerged and included specific interaction experiences around the support and information shared. Overwhelming were the positive experiences shared which had enabled them as fathers to feel supported, encouraged and included. Dave described his experience as

“You’re scared you are going to break baby and quiet often I felt I’ve stuffed this up and they would come over with a smile and clean it up. So they were fantastic, and you would come in and one would bring over a chair and say here you go daddy and you would sit and feel as though they are running around after you which they shouldn’t do”.

Jim talked about how the staff encouraged his involvement stating how it felt in the early days for him as

“I was naturally pretty worried cos they seemed so small and fragile and I just didn’t even think I could touch them you know, but the nurses were brilliant and all the clinical staff, supportive, they didn’t force me, I did want to but I wasn’t sure what I could or couldn’t do. They were very encouraging, I never felt pressured or never felt I couldn’t do anything”.
John stated that,

“Little by little I ask what this thing what this is all about, and they explained to me those things. Most nurses are very accommodating and if they see you look curious they try to explain it to you very well, some nurses are just quiet”.

In comparison Jack talked about how the support from staff felt for him further into the journey and how he attributed this to the staff needing to gain confidence in his care of his baby,

“You know it got to a point where I think they saw the confidence in me and they were comfortable and at the same time I was comfortable enough too. It certainly took some time”.

Further experiences shared focused upon the relationships and communication with staff with a particular reference to continuity Pete said,

“They will take the time to talk and get to know you and talk about your day to day things, you talk to them about a lot of personal things, it’s quiet nice in terms of you know them and feel comfortable in the environment and even though the shift of nurses would change it was quiet cool cos sometimes you got three nights in a row of the same nurse and that was comforting”.

Due to the length of stay of the baby the parents tend to have increased time and opportunity to build relationships with staff and as they get to know them more there is a wish to know more about them as people. The fathers that made specific mention of this made comments around staff conversations and boundaries. They had all expressed a wish to build those friendships Bob describing this stating,

“In NICU if you can laugh about something it makes the journey so much easier and we were grateful that we made friends and did have really good relationships with some nurses, and we were able to joke around a little bit and this actually made our experience a bit more enjoyable”.
Pete preferred that,

“We wanted to get them to be our friends and build a good rapport with them, get to know them and build some relationship”. He went onto say “I felt like I was part of the team and you feel comfortable enough to make decisions and you can ask the right questions and you know where you stand”.

Within the interviews a further common sub theme that arose within staff communication and interaction concentrated upon the presence of and interaction with male nurses. The Christchurch NICU has been fortunate to employ a number of male nurses within a profession where males are underrepresented. Bob described this commenting that,

“I did not expect to see so many male nurses in this place. I don’t know it was good just being able to sit down and like just have a chat you know. It wasn’t baby related, I just sat there and like talked about work and you know sport and just everything other than NICU”.

Each of the six fathers that talked about their interaction with male nurses saw it as a positive interaction. Each one commented on the ability to talk about male things and how that helped, Jack describing this as

“Male nurses were great, we would chat about rugby, talk about this and that and probably click better with another male”

Ken describing the presence of male nurses as

“While they showed enough compassion towards the mothers there was that mix of testosterone for the boys and that was welcome to be honest”.

Several commented on how good it would be for the NICU to have a few more male nurses. Another way that fathers appeared to have that ability to relate to and talk with other males was in the way of other fathers within the NICU.
Other NICU Fathers

Talking to and interacting with other fathers was raised in a number of the interviews, with a number of fathers discussing this relationship as either being that of a casual acquaintance as described by Bob,

“We were neighbours in the unit so kind of started talking, just struck up conversations cos you’ve obviously got a common theme seeing as its NICU”.

Others described lifelong friendships being developed, Dave described this as

“There were several of us country guys in same situation and we would talk about hunting and fishing and all sorts and you do form a good bond and we made really good friends”.

Most of the communication the fathers described as having with other fathers centred on any focus other than NICU as a way of coping with the experience, Dave describing this as

“You do talk about something that is not NICU related just to keep you sane and keep things ticking over, I think it’s really important just to talk about rugby and diggers and that sort of stuff with the other fathers”.

This insight into how they as fathers related to and with others was explored further as they talked about how they as a male and a father saw their role in the neonatal environment. The main theme captured as;

3. Through their eyes: fathers perceptions of their role in NICU

This theme focused upon how they saw themselves as fathers and the responsibilities, the commitments and involvement that they felt came with that. The main sub themes emerging being categorised as

- The need for juggling of personal commitments and outside responsibilities
- The practical involvement in care
• Skin to skin

**The personal juggling of commitments and outside responsibilities.**

Most of the fathers acknowledged the need to be strong as a male and that it was like the natural thing to do, a characteristic part of male coping described by Ken as

“*Look as a father going through this experience you have to be the homemaker, the counsellor, the provider. You have to be the rock that the mother leans on and some men recognise that quicker than others, we don’t know what we’re doing, we’ve got no idea*."

All of the fathers interviewed were in employment and the need to try to balance work and being with their partner and their baby in the NICU was highlighted by all as a difficult time. Several were self-employed and Ken commented upon the stress and impact of this,

“*It was difficult in fact when you are self-employed if you don’t work you don’t get paid so I was pretty much running at 50% production and really had no idea for how long that was going to be which was very stressful*.”

Others worked part time or appeared to have some flexibility from their employer which really helped with the juggling of commitments and reducing that stress, Bob stating that for him,

“*I have the most amazing flexibility in the world and my boss let me do what the hell I wanted over the ten weeks*.”

Pete also talked about the need for his work to be supportive to be able to juggle the ongoing commitments, the need to spend time with his partner and baby and that this was not just for a few days but weeks on end,

“*Work understood what was going on, I thought it would just be plain sailing, I thought my days would be structured in terms of how I do things but they were not. So as long as your workplace understands what the hell’s going on cos I guess guys are very much like ok they’re very structured so right this is my plan I’m going be here between these times,*"
I will be at work at this time and it doesn’t work, because there is so much going on you have to be with your family at a drop of a hat”.

Interestingly some felt that being at work helped psychologically, by keeping some balance of work, visiting the NICU and home as described by Pete,

“ I guess my work was quiet supportive in what I was doing, so work pretty much said come to work when you want but just for my mental sanity I went to work”.

Five of the fathers interviewed had other children to also care for and all of them commented upon the need to ensure the children were cared for in amongst the juggling of everyday work and responsibilities, Jack describing this time as being,

“Pretty busy and a stressful six months, three other children, full time job and a business, It’s amazing how the human body can cope with the juggling. I know I was only getting about four to five hours sleep a night because by the time I went home from work and sorted the house out, did the washing and took care of the kids and visited the unit it made me look back and go how did I do it? How did I cope”?

Mike commented,

“Sometimes you do feel guilty if you’ve only been there twice a week and some weeks I was. You feel like people are going to judge you for that but given the fact of time at work, looking after the three year old, go do the shopping, cooking, cleaning, keeping the house running. So there is lots of things dads do behind the scenes. It’s kind of nice to see that staff have that understanding of how a family runs”.

Even though staff appeared to have an understanding of how families were coping, the fathers with other children talked about the significant lack of support networks or childcare facilities offered by the hospital and the need to rely upon their immediate family. All five commented upon this as being crucial to the family managing over the time baby was in the NICU, Jack describing this aspect as
“There was no way I could take time off work, it was very much the family all rallying behind us and supporting us”.

The impact of travel on their day was discussed by a number of the fathers, the benefit of working locally to the hospital was a great help for several fathers who commented upon being able to visit during their lunchtime, for others the travelling at least one hour from the hospital was a significant barrier to how often they could be with their partner and baby, compounded also by the financial burden. Dave describing his travel experience as being,

“I was just pretty much every second night visiting, the travelling was getting really tough but it was just the way it was because we are an hour and ten away, I was getting really tired and quiet mentally drained”.

The service is in a position through travel assistance funds to be able to support families who reside over one hundred kilometres away from the hospital with petrol and accommodation allowances. This does relieve some of the financial burden for families over this period of time.

Being able to juggle and manage their responsibilities and commitments was one aspect of their experience which caused challenges and which all of the fathers had made comment upon. A number of them talked about wanting to be in two places at once, torn between work and home commitments and visiting the unit. Bob stating that,

“It becomes your life but you know coming up here is just what you do like every day like I don’t know what all dad’s did but like I didn’t miss a single day”.

The other sub themes emerging talked about the feelings they had when they were with their baby and what they did whilst visiting their baby.

**Practical involvement in the care**

There was a particular emphasis placed on sharing their experiences of hands on care of their baby and helping their partner. A number acknowledged and shared their thoughts on what
they perceived the man’s role to be within the NICU environment from a practical perspective and how that felt for them as fathers, with Bill stating,

“Sometimes you felt like the third wheel especially when she is feeding, I can’t really do anything so you sit there and start looking at your tablet”,

Kev describing this as

“At the end of the day we don’t have boobs we are in there as a support person, you just sit there and go oh what do I do now, you look at the monitor”.

Bill went onto describe how he felt stating,

“I think it’s great you are thinking about fathers too but I mean at the end of the day we’ve got to be second. You can’t come on, I know some father’s may beg to differ but goodness what my wife went through I mean hat’s off to her, I mean this in the most positive way it was better than I was expecting as a parent as a father ”.

Dave went onto to talk about how he felt stating,

“So many things running inside my mind during these times so that’s why I was thinking oh maybe I’ll just let my wife do it, because she is the mum she knows best for the baby. So I gave her every opportunity”.

The fathers who had had a previous neonatal experience shared insight into how this time around they had an understanding of what they could do to help their partner and how they could practically get involved in caring for their baby, they felt more confident with handling their baby and asking questions due to the past experience. The other fathers talked about the need for their partner or nursing staff giving them the encouragement and support to get involved. Several fathers talked about how they focused upon supporting their partner and taking some of their own initiative Dave describing this as

“I was very hands on with getting the expressing going and once she didn’t need me anymore when she got the hang of it I took it upon myself to find the machine, taking the milk to the milk room, washing the stuff”,
Mike commented,

“When C was sick I was expressing for her and was actually happy to help out but as soon as you get beyond that it becomes more of a focus on the mother and the dad’s don’t seem to have a specific role”.

The neonatal service does have a model and approach to care which encourages the inclusion of families in the care of their baby, feeding is a fundamental focus which does place an emphasis upon the mother and infant dyad, however there are many other aspects of care that the father can be involved in from a practical sense such as changing the nappy, taking baby’s temperature and bathing the baby. A number of the fathers interviewed talked about the need for this inclusion to be gradual but once supported and shown they were keen to at any opportunity. Jack described his early experiences as being,

“He was far too small for me, you know I’d touch him and things like that, it was really weird. Changing a nappy took me a while cos that was like phew, my big fat hands and the palm of my hand was the size of his tiny body and um trying to figure out how to do it all with those wires and cables but yeah it was good”.

Kev sharing his feelings as

“For a father the first time actually held him and touched him I was sweating like I’ve never shaken so much I was thinking “I don’t want to play”.

Many of them talked about how pivotal the nurses were in encouraging and supporting them with the handling of their baby until it got to the point that they were comfortable doing the cares and keen to be involved as much as possible, Kev described this support as being,

“I was given jobs, like change the nappies, do the cares, it gave me something else to do which was good. The nursing staff coaxed me into the jobs that were needed”.
Jim explained,

“I was standing in the NICU going what? They’ve got these tiny little things that I don’t know what to do with and within the first couple of days the nurse was like, right we’ll change the nappy and I’m like how the hell do I do that and she calmly guided me though the process”.

Jim went onto talk about how the length of stay helped him to feel more confident,

“The fact that we had to go through the training and like it was daunting, but once we got used to the equipment and we had confidence over time when we went home with so much equipment there was no panic”.

The timing of this encouragement by staff and how it was delivered was expressed by several fathers, Bob describing the timing as

“As soon as the opportunity was given to me and yeah I’m straight in. I think from day three or four really encouraged to start helping out with the cares which I reckon was awesome”.

Whilst Mike commented that,

“I didn’t actually touch him for three days because no one said I could”.

The comments on timing of this involvement appeared to be very much individualised with Jack stating that for him,

“It certainly took some time before I felt confident and comfortable, I’m going to say three weeks into the stay a third of the way through”
Bill described his experience as

“You see the nurses and they just like do rubix cube stuff, they know what they are doing and I’m like I don’t want to break him he needs to be a bit more robust”.

The way the encouragement, support and education was delivered by the nurses was viewed by the fathers as being crucial to their own involvement and confidence, Pete described this as

“Like most nurses wanted to include me as much as possible, it is about the woman but we are part of the team and the nurses were mindful of this”.

A frequently discussed aspect of the hands on care that fathers talked about the most was the opportunity for skin to skin contact.

**Skin to skin or kangaroo care**

Provides the parents with the ability to have close contact with their baby. The baby is placed on the parent’s bare chest. Skin to skin contact has been demonstrated within the research as enhancing parental attachment with their premature baby and also benefitting the baby through better sleep organisation, decreased pain and a longer duration of quiet sleep and establishment of and longer duration of breast feeding, all fundamental to infant growth and development (Baley, 2015). These benefits are not isolated to the mother alone for many of the fathers it was a special and powerful experience. Jack describing his experience as

“Have a little chest cuddling just be chatting away to him, have a nap skin to skin was great”

Ken described how it felt for him as being,

“Skin to skin absolutely encouraged I thought it my little pamper session every day, cos like I don’t know what happens whether its physiological or mental but having that baby up against me just absolutely chilled me out and my worries of the day were lost. I ended up falling asleep most of the time to be honest”.

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Several fathers talked about needing the encouragement of their partner or staff to take up the opportunity for skin to skin. Kev described his anxiety as

“You don’t want to crush him but once did it a few times it was good I did plenty of skin to skin”.

Dave talked about his partner encouraging him,

“I showed up in a polo shirt one day and G said oh where the .... Is your buttons you need to get your chest out for skin to skin, I really enjoyed that, I fell asleep and I know you are not supposed to but I was relaxed and so knackered.”

Mike talked about the staff’s encouragement,

“I mean I think pretty much every time I walked in someone would say do you want to have a cuddle? So that was kind of put out there from the beginning you know”.

Only one father John avoided the skin to skin contact because he was concerned about the nature of his work and the potential risk to his baby,

“I only gave him my hands not skin to skin because I am sometimes exposed to chemicals, I mean I was explaining to my wife the baby will understand why.”

The only possible hindrance identified by several of the fathers which could have been seen to limit their opportunity as a father to embrace skin to skin with their baby was as a result of insufficient comfortable chairs being available, Kev described his thoughts on this stating,

“You know I just wanted to cos you’ve been at work all day to have some hands on with him and you did not want to sit in a hard chair, you have to hunt one down”.
Several fathers commented upon this situation making them feel very awkward Pete stated,

“I guess what is hardest for a father is that you feel guilty sitting on a recliner, because the recliners are designed for breast feeding cos it’s comfier so it’s more as a father I always took the shoddiest one”.

The experiences shared by the fathers reflected how they had felt supported others were keen to share their thoughts on what they thought might be helpful for other dads in the future that the service may wish to consider. This final key theme captured those experiences and suggestions.

4. Father’s supports

Experienced during the stay

Discussion included the supportive relationship several fathers had made with each other through informal opportunities. Many found the nurses just being available to listen and support as being all they needed. Others found the support of their work colleagues was enough to help them through the journey, Pete describing his experience as

“I found talking to my work colleagues about what was going on helped, they were very supportive. As long as you can talk to people about what the hell was going on and they were supportive that’s all that’s needed”.

Several fathers commented upon their partners being a great support and the encouragement they gave them to get involved, Ken talked about supporting his partner in the early days and then being encouraged to do more himself, commenting on this being because they had the opportunity to be there together over a period of time,

“Very much in those early days it was concentrated on B getting her milk production up and I was helping with that and then as time went on she encouraged me to do the naps or do the cares, it gave me something to do which was good”.

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How men generally communicate was a discussion point by a number of the fathers, they wanted to share how they as a man thought and how that did or could influence their involvement, and could be helpful when considering the development of more formal dedicated supports for fathers. Ken describing this as

“*I think getting fathers together for a coffee and chat is going to be impossible, guys are wired a wee bit different more closed in, they don’t tend to talk about how they feel it’s got to be quiet manly*."

Pete made the comment that,

“*If it was an arranged time I would sort of feel a bit awkward about the whole thing I wouldn’t know who I was going to talk too and about what I’d just go okay I don’t want to worry myself going to that I’m going through enough at the moment*”.

**Suggestions**

These conversations tended to focus either upon how interaction between fathers could be promoted and supported on this journey in a more formal way and if dedicated supports were put in place for fathers how they should be promoted and facilitated to be successful. Promoting father to father support ranged from establishing a one to one buddying approach where it was a low key affair, the introduction being organised by the staff but the ongoing conversations and relationship being managed by the two fathers themselves. Jim described it as

“*Buddying might work, say staff introduce two fathers one who has been there for a long time another new. The conversations held could help to reduce that anxiety for the new dad for example, he says they want me to change his nappy and you go that’s really cool I did that day three I bit the bullet*."

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Pete also described this buddying as needing to be a more experienced father connecting with a new father as

“Guys are wired a wee bit different, guys are a bit more closed in so they’ll never talk about how they feel but the experienced ones would like talk to the new dads so felt more comfortable asking those questions”.

Dave felt that the buddying could be with a male nurse rather than another father. This approach providing an opportunity for a father to feel comfortable asking another male but at the same time pitched at a level that the questions were not perceived as silly and in confidence with it being a health care professional,

“To have someone cos you’ve got a million questions but you don’t know what to ask and what you think they’re dumb questions but there probably not maybe being offered a male nurse and he approaches you and says he’s got twenty minutes do you want to have a chat, I’d say yes because he came to me I don’t think I would have gone to him”.

Others suggested a more formalised group approach with Kev describing this as

“Getting the fathers together could be educational and a social thing maybe in the parent lounge. We can be a bit clueless at times it’s a completely alien environment it’s not so much we don’t want to help it’s more an ignorance of what we can do to help having some sort of prompting by gathering guys together could work”.

Ken’s positive thoughts being,

“I think some sort of time out of the way, organised would actually give us a chance to sort of share our experiences, we are all going through similar experiences, shared information is a good thing, let’s call it Father time”.
Others such as Jim went on to describe where and when this type of group could work,

“Let all fathers know that say 7pm to 8pm every Tuesday night we are doing a wee talk, have a range of options it might be that you hear from other dad’s further into their journey”.

Evenings seemed to resonate with the fathers who shared these suggestions Kev describing this time as being,

“Needs to be a night after work, have a chat about what’s going on, just to share experiences has to be after work”.

The location seemed to favour the opportunity to meet somewhere quiet in the NICU, there was mention of the need for a few beers or something to entice the fathers along. Bob commenting

“Yeah I reckon I probably would go to something like a fathers evening but I know how males think and honestly a lot of guys probably wouldn’t go. We are not really the most social creatures, getting together for a few beers is where it works”.

Finally the consensus appeared to be that these group meetings needed both an opportunity to have a short presentation on a topic of relevance as fathers and by a healthcare professional such as a male nurse but also to have the opportunity to share experiences rather than be completely educational to be of most benefit and support to them.

Additional comments of note

The analysis of the data also identified some recurrent discussion by several fathers on the benefit of being prepared for having a baby admitted into the NICU before birth. The benefits of this tour and information helping them to understand a little about the facility, environment and care their baby would receive. This valuable insight was outside of the period of time that this particular research question aimed to focus upon which was after at least a four week stay. These early supports discussed were prior to or over the first few days following admission. There has already been a number of international research studies that have
focused upon this period of time in the neonatal journey for fathers. This research study wished to focus upon a father’s experience over a longer period of stay where there is a gap in the research and understanding. The conversations held with the fathers around this preparation and early days following admission would still be important for the staff of the neonatal service to be made aware of and for there to be a need to consider sharing this insight with other staff responsible for such preparation including midwives, Lead Maternity Carers’s and the fetal maternal medicine service. As what can be demonstrated is that if time permits this pre tour and information sharing can be seen as reducing some of the fathers’ anxieties and fear into the unknown NICU environment which ultimately could have an impact on their ongoing coping and experience over a longer period of stay.
Chapter 5.
Discussion

In this chapter I will discuss, what this research study has revealed by hearing first hand from fathers of their experiences within the Christchurch NICU. This chapter will address how the themes extracted from the interviews compare or are rather different to other relevant research. Finally there will be discussion on how the findings from this research study could contribute to a known gap in the research, when it comes to seeking father’s own experiences and thoughts after a period of stay and the potential implications for practice changes within the Christchurch NICU. Recommendations are presented for consideration within a wider New Zealand context of neonatal nursing care.

So why pose this question?

The literature review established that a significant amount of research to date has focused upon the mother’s experiences of the NICU, however the benefits of involving fathers in the NICU journey has been demonstrated to promote an emotional bond with their baby that later translates to parenting capability and attachment (Johnson, 2008; Fegran et al., 2008). The research to date highlights a gap in understanding the experiences of fathers over this NICU period of time. Feely et al. (2012) in their qualitative study with eighteen fathers argued that studies must explore men’s own accounts of their perspectives on their role in the NICU. This was the motivation for this research study with the purpose being to provide the Christchurch NICU unit and staff with further insight into and understanding of, the unique experiences and needs of fathers who have a baby cared for within the service. The overall objective being to consider what may be identified as barriers for fathers to the NICU and what changes to current practice could be considered to minimise those barriers. There was also a wish to look at the introduction of specific supports for fathers that they would consider helpful. Feeley et al. (2012) went on to recommend that there was a need to identify appropriate supports for fathers in NICU to encourage their involvement and inclusion on the NICU journey. To be able to successfully achieve the overall aims this research study sought fathers’ own stories.
How was the question answered?

A contributing factor to being able to successfully obtain this data was as a result of the approach taken compared to a number of other published research studies. A number of the studies that have explored fathers’ experiences within the NICU have utilised a range of methods to achieve that insight, and have commented upon the limitations of their studies due to the way the fathers’ experiences were reported or collected, tending to be either grouped with the mothers’ comments when interviewing parents together (Jackson et al, 2003; Gavey, 2007. Hall et al, 2014). Or through a questionnaire, which do not uncover the motivations behind the answers (Sloan et al, 2008; Lee et al, 2012; Nyqvist & Engvall 2009). The one to one interview approach undertaken for this study provided an opportunity for the consented fathers to share their individual story, free from interruptions, distractions and the possibility of limiting free flowing conversation and as a result the data presented has provided rich information sharing from the ten fathers interviewed.

The approach taken in this research study in regards to the question being asked and the identified study population aimed to focus on an identified gap in the research about whether those early experiences and need for supports change over time. Much of the research to date on father’s experiences of the NICU has focused upon the early days following admission (Hughill et al, 2013; Deeney et al, 2012). This research study, by interviewing fathers who had at least a minimum of four weeks stay, aimed to reveal insights which to date have not been specifically addressed in any great detail.

How did the findings of this study compare or contrast to other research?

What can be identified from the stories shared within this study is, as the fathers told their stories, a number of the themes discussed unravelled further thoughts, ideas and reflection on how it had been for them as the weeks progressed and what impact that had had over time on them personally and their family. These experiences could be observed within both positive and potentially negative ways and ultimately the decisions lay with them as individuals and as a family as to how to prioritise those ongoing challenges with the support of the staff and service where able at that time. What was key for the researcher was to be able to hear if there were any events shared where the NICU itself had influenced those experiences in
either a positive or negative way for that father or whether there were already supports available that had been helpful at this time. The impact on them as individuals in regards to their own health and wellbeing was shown as that of being compromised, the length of stay seen as influencing the ongoing financial constraints, the need for travelling, trying to manage and juggle a number of commitments resulting in tiredness and fatigue, as described by Dave (see page 71). The juggling of these commitments had resulted in a need over a longer stay for some of the fathers to seek further supports whether that be from within the service and staff, their employer or wider family. A number of the fathers’ shared feelings of overwhelming tiredness but felt a need to just keep going, the juggling of competing demands was just seen as part of the journey that they needed to get on with managing as Bob described (see page 71). These findings of prioritisation and acceptance are similar to those of Pohlman’s study (2005) who found from interviewing nine fathers in the NICU that they gave priority to their work, this was seen as pivotal to being able to provide financial security for their family, a feeling of being able to be in control of one aspect of the NICU experience. Pohlman’s study interviewed fathers after a stay of thirty days, and even though the minimum period of stay stipulated in my study was four weeks, the shortest stay captured from the ten fathers interviewed in my study was forty nine days and up to one hundred and ten days. These lengths of stay provided valuable insight into how a longer length of stay did impact further on their own experiences. What became a discussion point for a number of fathers in my study, was the need to focus upon a commitment to work and the financial implications and worries they had as a result of this period of longer stay as Ken talked about (see page 69). These patterns of behaviour differ to those studies completed in the Scandinavian countries such as that of Lindberg et al. (2007) and Lundqvist et al. (2007) whose studies both found that from interviewing fathers that they played an active part in their infant’s care by prioritising their time in the NICU over other competing demands. This was achieved by the taking of parental leave whilst their infant was in the NICU. These societal differences which can be seen to make a significant difference in a father’s ability to be more or less involved in their baby’s care are discussed further within the discussion on the NICU environment and perceived barriers.

From a positive perspective the length of stay was seen as providing more opportunity for fathers to become acclimatised to the NICU environment through gaining familiarity with the environment itself, the ability to build relationships with staff and more opportunities for direct involvement in the care of their baby even whilst juggling other commitments. The
length of stay positively providing time as described by Jim when caring for and being well prepared for home with his baby with complex needs (see page 74). My findings suggest that within several of the key themes extracted there are added challenges and barriers for fathers as a consequence of the length of NICU stay and in contrast benefits and openings when comparing the findings of this study, in comparison to other research noted later within this chapter. In essence what this study brings to light is that the length of stay can influence those early experiences and changes in the support needed by fathers over time. This study provided further insight into what those supports should and could look like as discussed within this chapter and recommendations. When looking at the major themes and sub themes extracted from this study’s data compared to current literature some of the findings are broadly similar to the existing research others are rather different.

NICU environment.

Disruptive factors have been identified within the NICU that can hinder parental engagement including rigid policies, problems with access to resources and a suggestion that fathers may perceive these as being even more of a barrier to their involvement than mothers (Feeley et al, 2012). Literature would suggest that a number of practices and policies have become more flexible over time (Davis, Mohay & Edwards, 2003). The possible disruptive factors discussed by the fathers within this study focused particularly upon the visiting times, specific rituals embraced by the service and several of the facilities offered. This suggests similar factors to those identified in other studies as being barriers even after a shorter period of stay, my intention was to explore whether over a period of time they were still seen as significant barriers to their involvement or rather seen as an initial hurdle that they were soon able to overcome.

Visiting

Fathers are able to visit the Christchurch NICU twenty fours a day, seven days a week, the opportunity for open visiting in place for parents aligns with published research such of that by Feldman et al. (2002) who recommended that physical proximity is required to develop attachment between a parent and child and the amount of contact needs to be encouraged to maximize these interactions. The open visiting policy for both parents within the Christchurch NICU attempts to minimise any visiting rule that could inhibit their
engagement, avoids the perception that the NICU environment is geared more towards supporting mothers and promotes the opportunities for both partners to be with their baby at the same time. Feeley et al. (2012) described the mothers as affecting paternal involvement by encouraging fathers to engage in caregiving. The findings in my research study suggests similar results with several fathers talking about the encouragement they received from their partners to be involved which gave them the confidence and encouragement such as Dave (see page 76). The flexibility to be able to be with their partner at any time was seen by the fathers as not placing any barrier in the way to their ability to be involved.

What was clearly evident from this research study was that the barriers in place to the father being unable to visit more often were more related to the other day to day commitments they had whether this be work commitments, travelling or other children to care for, rather than as a result of the NICU environment itself. All ten fathers were in employment with a range of full time, part time and self-employment. A significant concern for them seemed to be that as the weeks progressed they were not financially in a position to take more leave, the juggling of other commitments became more challenging, and they relied more heavily on wider family supports if available. These findings are consistent with those highlighted within other studies such as Garten et al. (2011) who undertook a retrospective chart review of one hundred twenty seven infants in a NICU in Ireland, looking at visiting patterns of frequency, and duration by mothers and fathers. The average frequency and duration of visits was consistently lower in fathers than in mothers and they made the suggestion that measures are taken to increase paternal involvement with hospitalised premature infants. They also made the comment that the average frequency of paternal visits during the first twenty eight days declined significantly (P< .05) while the duration of visits remained constant. This may reflect the external demands and commitment’s placed on fathers over time. However they also reported the fathers as stating that the pressures of having a baby in the NICU had a negative impact on their occupation and their own health even after a shorter period of time.

Arockiasamy et al. (2008) concluded from interviewing sixteen fathers after a thirty day stay in the NICU that the fathers experienced a sense of lack of control and needed supports to help them to fulfil their perceived various roles of protector, partner, father and breadwinner. They concluded that the neonatal health care team needs to understand these experiences to help shape what is needed.

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What became evident from both those studies and an objective of this study was for a need to focus more on how fathers can be better supported to be able to spend more time with their baby, from both a local service perspective and from that of a wider societal standpoint. Consideration also needs to be placed upon the longer length of stay changing or increasing those needs. The fathers in this study shared rich conversations about their experiences and also ideas for supports that could be considered some requiring in-service changes and acceptance others requiring wider national and/or societal consideration.

Service perspective

The open visiting rules in place for fathers did not inhibit fathers visiting at any time. The visiting rules in place for others potentially could. The fathers that commented upon the visiting rules in general terms felt that on initially seeing them in black and white as being very rigid and harsh. But over time they felt them to be fair and reasonable and in essence they supported the rationale with a wish to want to protect their infant and partner during this time from others and have space and privacy as described by Pete when discussing his own situation (see page 56). Similar points are highlighted in other studies where fathers strove to put the mother and infant first and want above anything else to protect them (Lindberg et al, 2007).

Sibling visiting restrictions has been highlighted in the past by Christchurch staff as an aspect of the current policy that needs further consideration, staff perceive that it currently limits sibling visiting opportunities and consequently the family increased challenges when trying to juggle their day. However the fathers interviewed in this study who had other children did not find this to be a noticeable barrier to them visiting. The only comment raised around the impact of sibling visiting restrictions was the inability for them to truly be together as a family when there are only two people permitted at the cot side. This aspect of the visiting rule around sibling involvement and supporting the family is a focus that the staff within the Christchurch NICU unit does need to consider to truly be aligned with the service’s philosophy and charter of promoting and supporting family centred care (Appendices 12 &13). What the fathers within this study shared were possible opportunities to consider so that the family could be supported more to spend time together which can be constrained further over a longer hospitalisation and these opportunities are discussed within the recommendations.
The focus raised in this study into visiting and supporting the family, aligns itself to previous literature which advocates that to truly support family centred developmental care there is a need to recognise and support the identified family. Despite widespread acceptance of family centred care within the paediatric setting it is only just gaining momentum within the NICU environment because it is seen as a challenge. Boykova and Kenner (2016) describe the neonatal team as needing to recognise the family as an integral part of the health care team. They go on to claim that while family needs have been central to neonatal care guidelines for decades, there is still along way to go to incorporate the family completely as the philosophy of family centred/integrated care suggests. Baird et al. (2015) describe the challenges to this for the neonatal team as, trying to balance the busy complex intensive care environment with its traditional practices of visiting restrictions, family exclusion from the care planning and ward rounds, the need to have adequate space and hygiene practices, whilst at the same time provide an environment and approach to care which encourages a strong workable relationship with families. Defining the family within this context of care can also be seen as challenging as there is a need to work with the parents to explore the key support people for them, respect their cultural needs whilst at the same time uphold an environment that is safe for the staff to work within, to provide that essential care to the most vulnerable babies. To be able to truly support this family integrated approach to care within the Christchurch NICU unit there is an identified need to look at current policies such as the visiting policy to ensure we are supporting that approach. The review of associated polices requires consumer feedback to reflect parent’s needs, this study contributes to this by sharing the fathers voice. This valuable insight assists the service and staff to look at internal possibilities and highlight to management the areas for improvement and associated resourcing. Other insight provided by the fathers on the environment and facilities requires wider national and societal consideration.

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1 Family centred developmental care is a philosophy underpinning neonatal care that is deemed essential care. It is an essential aspect of providing excellent, clinically sound care to every infant and family who enters the healthcare arena (McGrath, Samra & Kenner, 2011)
Societal perspective

The opportunities that require attention outside of the NICU to reduce some of the external pressures placed on fathers requires wider societal influence and national political support. To be able to support fathers in the workplace so that they can spend time with their baby was found within this study to depend upon the approach and support taken by the individual employer. For there to be a wider consistency to the support provided by employers would require national political and societal focus on employee’s rights and employment conditions. This would require attention to the current employment act and employment conditions. For a number of years within New Zealand there is access to paid parental leave for one parent for a period of sixteen weeks following the baby’s birth, recently this has changed to include extending the paid parental leave entitlement to a parent if the baby is born prematurely from the date baby is born until the end of the thirty sixth week and then the regular 16 week payments. There is currently no provision for both parents to receive this payment although it can be transferred to one or the other (Inland Revenue, 2017). This is very different when compared to the Scandinavian countries where there is paid parental support for fathers as well as mothers, which lends itself to less financial constraints, more flexibility and encourages the availability of both parents to be actively involved in their baby’s care. It is of interest to note that only this week within the New Zealand national press there was reference made to a recent study undertaken in Australia where nine hundred and fifty one new fathers were interviewed and 85% said they would have taken three months off work to take care of their baby if there was no financial penalty (Dufu, 2017). It is encouraging to hear that parental leave conditions still remains on the agenda of some New Zealand political parties with support of a number of lobbying from action groups concerned about parenting such as The Great Fathers Organisation².

Support for travelling costs and alternative accommodation options close by could be seen as a way of supporting fathers to be closer to their partner and baby over the weeks. Currently the provision for travel and accommodation is governed by the Ministry of Health National Travel Assistance criteria (Ministry of Health New Zealand, 2017). For the Christchurch

² Great Fathers organisation is a New Zealand constituted trust that provides resources and information for new and expecting fathers http://www.greatfathers.org.nz
families this is a challenge to access due to the need to be residing over one hundred kilometres away to be approved support. Less than one hundred kilometres away is still not seen by staff and families to be an insignificant distance to travel for a number of families requiring NICU care in Christchurch and places demands on time, availability and finances which have been shown in this study to increase over time. This is an area of support that requires wider management and the District Health Board to review and make recommendations nationally in light of the wealth of research around the need to promote family integrated care for long term health outcomes.

When considering the environment and the length of stay a family has within the healthcare facility of a NICU there is an identified need to make this as inviting as possible. Discussed in several studies is how the NICU physical environment can have a direct impact on father’s involvement. Feeley et al. (2012) describes the physical aspects of the NICU, the controlled environment the stark contrast to home as deterrents for father’s involvement. Johnson (2008) describes the issues associated with noise, light, and equipment as intimidating and overwhelming for parents. This study suggests different perceptions with regards to the physical environment of the Christchurch NICU when discussed with the fathers, and this may well be as a consequence of a number of aesthetics that have already been implemented to make the environment less like a hospital and sterile in appearance. For example the integration of quiet time on a daily basis in an attempt to make the NICU less intimidating for families and more neuro- developmentally appropriate for the babies. The protected daily quiet time was discussed by all ten of the fathers and was overwhelmingly seen as a positive experience, Bob described how beneficial this was personally for him (see page 57).

Secondly the fathers interviewed felt that the facilities provided were adequate for a hospital and they seemed very matter of fact about it being a hospital and as a service there was only so much influence over space and resources that could be achieved by the staff. At no time did the facilities appear to deter fathers from wanting to visit. There was however two common themes discussed within the facilities that for a number of them they felt impacted on how it made them feel as fathers.
Facilities

The lack of opportunity to be able to room in with their partner before discharge was seen as a real issue for several fathers who felt that it was unfair and did not give the father an opportunity to support their partner such as Mike who described this lack of opportunity and how that felt for him and Bob who talked about the importance of offering this opportunity (see page 62 & 63). This lack of opportunity reflected in a negative way for all of the fathers in this study who discussed rooming in, this demonstrates insufficient attention or importance being paid to this avenue of support within the Christchurch NICU. When comparing this support with other research findings there is a lack of discussion on this particular way of supporting fathers however it could align with the comments shared in a number of studies around fathers need and concern for their partner’s wellbeing by needing to be in the role of overseer and protector (Arockiasamy et al, 2008). Our current policy could be seen as compromising for fathers, fathers who have spent a number of weeks included within and overseeing their partner and infant’s wellbeing, being suddenly excluded at the last part of this journey does not align with the Christchurch philosophy of care (Appendix 12) or the literature.

The availability of comfortable chairs for fathers, on the surface may seem of minor importance in the wider scheme of NICU care and resourcing, however it was a common bone of contention for most fathers interviewed. They felt these chairs were a priority for the mothers however there never seemed enough of them, let alone for them as fathers to use. Lack of comfortable seating was seen as detrimental to their ability to have that one on one cuddle or skin to skin time, which they felt, was such a positive interaction. As shared in other research studies having the ability to hold their baby in their arms as soon as possible was of great importance for fathers (Jackson et al, 2003; Lindberg et al, 2007). This practical improvement appears simple to integrate to increase father and infant attachment and improve the overall NICU experience for fathers.

Finally, a ritual embraced within the Christchurch unit which appears to be unique to this department, has been in place for a number of years and is seen by the staff as an acknowledgement too and a celebration with the parents, is the giving of the one hundred day cake. This one hundred day milestone is seen as an achievement in the eyes of staff, however, most interestingly were the mixed responses from the fathers about how they saw this ritual.
When discussing this event some saw it as a positive opportunity to celebrate with staff on how far their baby had come on the NICU journey, whilst for others it was a milestone they did not want to celebrate. In fact they saw one hundred days as a target date to avoid and to be out of the NICU before then, unfortunately as a consequence if they were still inpatients it was then seen as a negative. The inclusion of rituals within the NICU environment when attempting to compare to other studies did not appear to be addressed, however Griffin et al. (1998) made the recommendation that nurses must evaluate how their interventions effect the parents and efforts should be made to promote parental involvement and decision making at an individualised level to reduce stress. This could include parental consultation around such rituals if they are known to cause stress or seen in a negative light by some parents. The staff should not assume that all parents would see this as a celebration; this should be communicated to and discussed within the individualised care plan for the baby and family in advance.

To support the development of individualised care plans in a collaborative way with families’ communication needs to be clear, knowledgeable, informative and inclusive. Communication is a vital component of neonatal clinical care (Reid et al, 2007). Family centred models of care acknowledge the importance of involving parents and other family members (Bell, 2009). To be able to truly involve parents in the planning of, involvement in and decision making for their baby they need to be well informed supported and educated. A gap in the research as identified by Reid et al. (2007) was the relatively little known about the way parents perceive aspects of interpersonal supports such as communication particularly for fathers who are generally underrepresented within the research. The main comments shared in this study by the fathers was focused upon their communication experiences, and concentrated upon information sharing and interaction with others.

**Information**

The sharing and the ability to inform parents of not only their baby’s condition but the NICU environment and facilities available is vital for reducing some parental anxiety through alleviating fears (Hollywood & Hollywood, 2011). However such information needs to be able to be understood, consistent and given in a timely manner. Previous research has shown that staff are concerned around the timing of giving information when parents are new to the unit, overwhelmed with having an unwell baby, exposed to unfamiliar surroundings and
experiencing high levels of stress (Lindberg et al, 2007). Comments raised by fathers in this study found that a number of them on reading the information soon after admission found some of the rules on the surface to appear harsh and rigid but over time they gained more insight into why the rules were in place and could see the purpose. Aligned to the other studies this finding highlights the need for staff, when sharing any information with parents (be this verbal or written) the importance of considering the timing and also the need at the same time for thorough explanations and rationale being provided.

As this study focused upon how things changed over time for fathers, comments shared highlighted that a longer period of time involved within the NICU provided them with a better understanding of the environment and how the service needed to function and why. In an attempt to explore further the timing of giving of information and the content of the information provided this research study suggests that fathers themselves found the information provided sufficient and timely. They appreciated getting this early on and there was never too much information that could be shared. What needs to be considered as reflected in other studies is the importance of repeating information to support parents who might momentarily be unable to process this due to the situation they find themselves within at that moment in time (Lindberg et al, 2007). Similar to Lindberg’s findings this study found fathers expressing a need for information to be repeated and that the staff were always receptive to this and that they never felt they were put in an awkward position by asking, Pete described this communication (see page 59).

The way the information was presented to the fathers in this study setting could be defined as both verbal and written information. The giving of written information was seen by the fathers as beneficial as it could be referred to repeatedly, gave them something to do when visiting and as time progressed, the ability to build upon relevant information as needed for their individual situation and baby’s condition. However some fathers identified the lack of and availability to online resources. The service needs to consider the technology available and permitted within this environment. Research undertaken into information sharing with families has highlighted that parents seek out social support online. They want to access more experience based information not just factual details, as described within Eriksson and Salzmann-Erikson (2012). My study found that a number of fathers were perplexed by the current rules in place around cell phone usage when it came to being unable to use this for any other reason than for taking photographs of their baby within the clinical area. Pete
described his thoughts on cell phone usage (see page 61) and Mike described how cell phones are so common place in day to day interactions for most people (see page 61). The service does not currently provide any alternative to using a cell phone or provide resourcing for accessing online information or networking opportunities. There are a number of possible opportunities to consider and/or build upon as discussed within the recommendations.

When it came to discussing specific information tailored for fathers, none of the fathers specifically talked about what was missing or what would be helpful to them, most of them felt the priority focus needed to be on the current situation understanding the here and now rather than long term fathering. Salzmann-Erikson and Eriksson in their ethnographic study of the online behaviour of new fathers in Sweden identified a need to include information on parenthood and parenting skills as being crucial to support the development of long term parenting skills in fathers of a NICU baby (2013). Fletcher et al. (2008) on interviewing two hundred and fifty three new fathers in Australia found that that information tailored to new fathers through the internet may increase new father’s access to useful knowledge and support, specific health topics being identified as father-infant bonding, work-family balance, and baby play. My study however did not capture the father’s individual thoughts on the actual content or range of topics already provided by the service or deemed missing. This maybe because the participants did not consider this as a point of discussion within the interview. Or they may not have placed importance on this aspect of support as being a priority. Regardless it does highlight an area where the service should be more inclusive of fathers when looking at parental resources as discussed in the recommendations.

**Communication and interaction with others**

A culture exists where NICU’s have been constructed to take care of premature and unwell newborns, with survival and clinical outcomes being the benchmark on which NICU’s are rated on their performance (Saunders, Abraham, Crosby, Thomas & Edwards, 2003). To strive for these outcomes there continues to be increasing technology, participation in clinical trials and as a consequence an environment that can be deemed frightening to parents. Gavey (2007) states from her research findings that investigated the experiences of sixteen parents in a NICU in the United Kingdom, that technology and healthcare professionals were seen as displacing parenthood within the NICU. Research continues to challenge NICU’s to consider
ways to have an approach to care that balances advances in medicine and nursing care whilst recognizing both parents as integral to the infants care and long term wellbeing.

Treyvaud (2014) discusses within his review of parent and family outcomes following very premature birth, that to be able to provide this integrated approach to care there is a need to understand parental experiences from both a mothers and fathers perspective to help guide what approach and interaction and support should be offered by the NICU service and staff. A motivation behind this study.

Research continues to suggest that possible barriers to father’s involvement includes the nurses beliefs about the importance of the fathers role in the NICU (Franck & Spencer 2003; Feely et al, 2012). Staff interaction and communication discussed by fathers within this study refuted this suggestion as can be demonstrated by the number of comments on the encouragement and support the staff provided to the fathers over the duration of their stay, both from the early day’s right up until planning for home. Jim talked about how the staff encouraged his involvement stating how it felt in the early days for him (see page 65). In comparison Jack talked about how the support from staff felt for him further into the journey and how he attributed this to a need for the staff to gain confidence in his care of his baby (see page 66). It should be noted that only one father talked about the medical staff and that their communication and interaction did not appear as inclusive as the nurses, very little can be assumed from this comment as it was one person’s opinion and the interaction, presence of and engagement with nursing staff is more visible when compared to the medical staff, due to nurses being responsible for the care of the baby at all times.

Overwhelmingly the fathers felt supported and included in their baby’s care and wanted to be involved as much as they could. This aligns with previous research that found that fathers with greater overall support from staff were more involved in infant care in the NICU. Such as the findings from a study in Israel by Auslander et al. (2003) where sixty three couples were interviewed together around their expectations of NICU staff and even though the mothers expectations were higher than their partners, the fathers verbalised how supported they felt by staff who encouraged their involvement and met their expectations. Auslander’s study did not differentiate between the disciplines of the staff. Whereas a study completed by Feeley et al. (2012) after interviewing eighteen fathers found that when nurses provided information, encouragement and support to father’s increased involvement was fostered.
Neonatal nurses are in an ideal position to be able to support fathers on the NICU journey and promote an environment that is father friendly by creating and supporting meaningful fathering experiences. Research demonstrates that nurses who care for preterm infants and their families are in a unique role to support parents because of their expertise, understanding of the environment and their continued presence in the infant’s care (Griffin et al, 1998). What this study highlighted was the positive interactions and support fathers felt they received from the nursing staff as described by Pete (see page 67).

These positive interactions and the support provided by staff discussed within this study could be attributed to a number of factors, the communication style and approach to parents by individuals, the overall culture of the NICU and the ability to establish relationships with families over a longer period of time. A number of studies over the years have discussed common experiences felt amongst fathers over a shorter stay such as a sense of lack of control and a struggle to gain control if not involved in their infant’s care (Arockiasamy et al, 2008; Lindberg et al, 2007). The staff approach and interaction with them as fathers being seen as key to helping them cope; have some control and certainty about what is expected from them (Mode et al, 2014). My findings suggest that the majority of interactions that fathers had with the staff had been a positive experience. The fathers talked about wanting to get to know the staff, enjoying that continuity in care and also sharing stories around individual nurses that they felt a connection with which built up over time. These findings are rather different to those discussed in previous research where nurses were identified as being less than encouraging and more in control rather than working in partnership and acknowledging the important role fathers play. A study by Nyquist and Engvall (2009) on parents and nurses perceptions of parental involvement in caregiving activities, found that the nurses saw the parental role in the care of their infant as being limited to providing normal baby care. The nurses generally felt hesitant to encourage parents to perform more aspects of care required within the NICU for their baby with the rationale being, that it could place unnecessary extra stress on parents through undertaking aspects of care that neither parent wanted to carry out but felt pressurised to do. In comparison the parents, however, talked about needing to guess what the nurses expected from them and seldom dare ask permission to take over aspects of the care. Nyquist and Engevall’s study did not differentiate between mothers and fathers responses whilst Hughill’s study (2014), focused specifically on the fathers’ thoughts and experiences. After interviewing and also observing ten fathers in a NICU in the United Kingdom and their interactions and communication with staff Hughill
describes the observing of gatekeeping behaviours by staff and staff being seen as critical towards father’s involvement or presence. Hughill’s findings are from a single study restricted to one NICU in the United Kingdom however the intentions of his study was to prompt deeper and critical reflection by neonatal staff on how fathers are judged within the NICU environment.

These potentially negative behaviours by staff were not made apparent in any of the interviews within my study when conversations were held on staff interaction and communication. The stories shared by the fathers, into their relationships with a particular emphasis on the nursing staff provides insight into how advantageous a longer period of stay can be in providing the time and opportunity to connect and get to know the staff caring for their baby, as Pete and Bob described (see page 66). The benefits of a length of stay has similarities to that discussed further by Hughill (2014) who described fathers and staff moving from backstage to front stage over the NICU stay. Hughill, found in his study that of those staff who were critical of individual fathers getting involved, their opinion shifted over time, he stated this might be in response to getting to know the father better and establishing relationships based upon better shared understanding. This time and relationship building can be seen to support how it makes fathers feel and their contribution and participation. In comparison the fathers in this research study did not verbalise any noticeable shift in how staff’s approach shifted from more critical or judgemental to being seen as more positive over time, they commented upon how supportive and encouraging it was right from the beginning.

Several fathers commented upon the confidence building that happened for them as a consequence of being encouraged to be involved in the care of their baby. They had noticed a perceived shift in the nurses’ approach to them which included even more encouragement to take on increased aspects of care which they considered was as a result of the staff gaining in confidence in their ability. This finding is the only similarity to the findings shared by both Hughill (2014) and Nyquist and Egnell (2009) in my study this need for staff to see confidence building in the fathers was seen as a positive attribute not a negative criticism as described by Jack (see page 65).
Father's own perceptions

Hynan (2005) within his review of research on sex differences in communication, focused upon reviewing summaries of meta-analytic research which focused upon the communicating with mothers and fathers in the NICU during times of stress. He talks about the stereotypical ideals of mothers and fathers and how that may alter the different types of support and communication staff have with each parent, and preconceived ideas on what support they may need if the staff believe in stereotypes of men and women. The stories shared by the fathers in my study did not raise any feelings of being excluded or discriminated because they were males. The fathers felt acknowledged included and encouraged as described by Dave (See page 65).

Family centred/integrated care involves staff not only focusing upon the needs of the baby but also understanding the role they have in educating both the mother and father on important parenting skills and emotional support. Hynan (2005) goes onto say that the first strategy for staff to consider when communicating with NICU parents would be to consider mothers and fathers as similar, as caring parents not as different species. Within my study what was shared rather than the fathers feeling the staff were treating them differently because they were males, was more around their own their perceptions of themselves as males and how they fitted in the NICU environment. Both Bill and Kev talked about how even with the best intentions of the staff and service to include fathers there were certain aspects of NICU and neonatal care that needed to be geared towards the mother-infant dyad (See page 72). The most common aspect of care talked about by the fathers which they felt was outside of their role was that of the supporting of breast feeding for their partner. Sweet and Darbyshire (2009) within their study of seventeen sets of parents in Australia explored fathers’ experiences of breast feeding of their premature baby. They highlighted the role and influence that fathers can have on breastfeeding through their involvement in breast feeding education and the active and positive contribution they can make through supporting their partners.

This is an approach to care that has not gained any specific focus in the Christchurch NICU. There is currently no planned approach to actively including fathers in breast feeding education and supports. Several of the fathers in this study talked about taking on such feeding related tasks proactively such as the cleaning of equipment, the finding of the
expressing pump and for some helping with expressing. What was apparent from the stories shared was that those who talked about being actively involved in feeding had the advantage of a previous NICU experience and took their own initiative to be involved. What was not clear as stated by Sweet and Darbyshire (2009) was whether fathers' struggle in negotiating a parenting role related to baby feeding. This requires further exploration to understand better what is missing and what is needed in the way of supports for fathers’ in regards to infant feeding within the Christchurch unit as discussed within the recommendations. Staff need to pay particular attention and focus on encouraging and supporting the fathers to be involved in the NICU. Research suggests that when fathers feel their own importance in being part of the family and care they become more actively involved (Lundqvist et al, 2007).

One key approach to interaction and involvement in care, which is beneficial for both mothers, fathers and their baby, is the opportunity for skin to skin contact. As described in previous research fathers experienced many benefits from having physical contact with their baby, the feelings of being physically and emotionally close to their baby (Feeley et al, 2012). Skin to skin contact is one way of encouraging and supporting that connection for fathers and was clearly shown within this study as being a very positive experience, how much it was encouraged by the staff and how the benefit of time gave fathers that confidence starting from early on in the stay. Sullivan (1999) found that some fathers lacked physical contact with their infant in the NICU despite the fact of touching, he suggested the sooner fathers held their baby the sooner they fell in love. Within my study it was clear that all ten fathers were encouraged and valued that close contact and as soon as possible, Bob talked about how the staff encouraged him right from the early days (see page 74). My study reinforced the focus the service and staff already place on the importance and value of skin to skin contact, however there is a need for the service to continue to develop the opportunities for promoting skin to skin care in line with the most recent research on its benefits (Helth & Jarden 2013) as detailed within the recommendations.

Hynan (2005), within his review writes about fathers in NICU displaying few emotions and finding it difficult to tell anyone how they may be feeling. My study did reveal that none of the fathers felt hindered or unable to talk to or share their anxieties with staff, although if given the opportunity, they relished the interactions they were able to have with the male nursing staff. The Christchurch unit has been fortunate to employ a number of male nurses which is of great benefit when fathers wish to seek male interaction with a health care
professional caring for their baby. However to be able to consider increasing the visibility of male nurses within the workforce there are challenges beyond recruitment strategies a process which cannot be gender specific. New Zealand nursing workforce statistics state that in the latest period 2014-2015 of a total of 50, 356 nurses practising only 8% are male (n = 4,280), spread throughout New Zealand within different geographical locations and across the full spectrum of nursing specialties. Neonatal nursing is captured within the overall child health statistics, which represents in total 2, 731 nurses or 5.4 %, there is currently no ability to capture how many male nurses are working within child health including neonatology (Nursing Council New Zealand, 2016). Therefore within the wider context the current representation of males in the nursing workforce in New Zealand is significantly underrepresented. Going forward possible recommendations need to be discussed at a national level as highlighted within the recommendations of this study?

Locally however building upon the fact that there is already a number of male nursing and medical staff working within the service, this study has highlighted possible supports fathers would find beneficial by having the ability for structured male interaction in the NICU which they themselves have identified as being helpful during their interviews. The development of a more structured way of providing that male supportive approach is recommended rather than relying upon the potential likelihood of being allocated a male nurse on a shift that coincides with the need for the father to seek support. This structured support is discussed further within the recommendations.

Further to this specific support what this study also provided was the fathers insight into other avenues of potential support that they would find helpful. Nicolaou and Glazebrook (2008), discuss, in their review of studies that focused upon the emotional support for parents of sick neonates, that if researchers are interested in finding ways of providing support for families, then they must listen to what families need. Furthermore appropriate support be it emotional, informational or social will enhance parental coping abilities. They concluded that most interventions evaluated have focused upon supporting the mother. Few have included fathers and, as such many of the strategies implemented to date aiming to provide family support in the NICU have been tailored for mothers. My study provides data from fathers themselves on what supports they have identified as potentially being beneficial during the NICU stay.
My research study highlights that a number of the fathers discussed a need to have the ability to share and communicate with others around their baby and journey. This reflects similar findings within other research studies which identified the need for fathers to have the ability to communicate with others around the concerns for their infant, share the feelings of joy and distress and gaining information from contact with others in a similar situation is one important way of receiving that support (Eriksson & Salzmann-Erikson, 2012).

Of interest within my study was the range of comments and ideas shared by the fathers into what that support should or could look like, down to the practicalities of when it should be available and who should provide that support within the NICU. Others talked about seeking their support from outside of the NICU and many wanted to focus upon anything other than NICU as a way of coping. Highlighted within this study and that found in other research such as Hollywood & Hollywood (2011) is that for a number of fathers their work can be viewed as a double edge sword, having both positive and negative benefits. The constraints of work can impact on the amount of time they can spend visiting their baby in the NICU however on the other hand work and talking to their work colleagues provided normality and familiarity in a part of their life which felt inside of their control, their work place was seen as a means of support. A number of the fathers talked about men not being particularly social and wanting to share their feelings. There was a very mixed response in regards to the type of support needed, which clearly identifies that no one type of support will fit all fathers and that several options need to be considered and offered. As discussed within the recommendations.
Final Chapter 6.
Conclusion

This chapter will highlight the most significant findings within this study. It also highlights some limitations of the study. It provides recommendations for the Christchurch neonatal unit to consider implementing as either enhancements to the service already provided for fathers or to consider as additional supports both at the cot side and as non-cot side supports. This chapter also provides ideas for other neonatal services nationally to consider and comments upon wider societal considerations.

Limitations

It must be noted that this is a small study of ten fathers whose reasons for consenting to the interview and experiences shared may not be similar for all fathers who experience the NICU. However the sample did include a range of circumstances and situations that could enlighten the researcher to the experience for fathers over a period of time which included previous experiences of a NICU, other children, the need for travel and a mix of employment situations. There were no fathers that identified as Māori which was an aim within this study as captured within the Māori consultation (Appendix 3). The lack of ethnic diversity amongst the fathers that volunteered and participated could be seen as a limitation. A recommendation for future research could be to focus upon this study population to better understand the cultural needs of fathers within the NICU. A particular focus should be placed upon those fathers that identify as Māori so that the NICU services both within Christchurch and throughout New Zealand reflects the rights and needs of the indigenous peoples (Robson, 2001).

Recommendations

When considering the findings of this study and the potential opportunities that the Christchurch NICU could consider further, the recommendations can be categorised in line with the major themes and sub themes discussed earlier within this thesis. Several of these recommendations require wider national and societal consideration to be able to progress any changes.
**NICU environment**

The current visiting times provide open access for fathers and at the same time upholds the conducive environment required for vulnerable infants. However to enable immediate family to be able to spend time together as a family during the NICU stay, the Christchurch NICU should consider the development of a planned approach to “family time”. This designated family time with the parents and all the siblings would align with the philosophy of family centred/integrated care which the unit is committed to enhancing. To progress would require scheduled periods of time being organised and the availability of a family room or space that could be pre booked. These opportunities would be dependent upon the clinical appropriateness of the infant at that time to be able to move to the allocated space. The other opportunity for the service to explore would be the introduction of some arranged childcare oversight whether this be by the use of screened volunteers and/or the establishment of a supervised playroom. Both of these possible interventions could enable fathers to be relieved of some of the childcare barriers they discussed and the reliance on wider family support.

The ability for fathers to room in with their partner prior to discharge of their baby was seen by some as not being fully inclusive of fathers within the care of their baby, at this important time for discharge planning and confidence building. The inability to offer rooming in to all fathers remains constrained by insufficient beds and rooms with mothers needing to take a priority. However the unit needs to continue to support the opportunities for a father to be able to stay if there is space available. As a team there needs development of a robust process around how this is managed so that it is fair and transparent to all.

All of the recommendations highlighted to date require resourcing and the availability of space to progress. Many NICU’s are now considering such amenities within their NICU design such as those described within the study by Jones et al. (2016), who explored the influence of neonatal design on interactions in the nursery, with reference to the shift in NICU design to support family centred care. Through moving from multi-patient open spaces as can be found in the Christchurch NICU to single family rooms which provide increased privacy, space and a more individualised appropriate neurodevelopmental environment for the infant. Christchurch is not in the position to design a new unit however there is an opportunity to look at best use of current space and resources and to consider better utilisation of that space with minor adaptions. Within a wider context there is already an
international neonatal focus on best neonatal design (Hogan, Jones & Saul, 2016; Jones, Jones & Feary, 2016).

Wider national and societal recommendations to consider exploring further, are as a consequence of other external commitments that were seen to hinder the fathers’ ability to spend more time with their baby. Financial stress was evident for many and work needing to be the priority, the current funding polices in place in New Zealand around parental leave entitlements needs attention. Paid parental leave entitlements continues to be a focus of New Zealand politics and now is an opportunity for nationally those working with and for families and children to take a more political stance through their respective organisations. For the neonatal profession this could jointly be through the Neonatal Nurses College of Aotearoa (NZNO, 2017) and the New Zealand Neonatal Newborn Network (Ministry of Health, 2017). Travel commitments were also seen as a barrier and the travel assistance criteria and funding is overseen by the Ministry of Health and was last reviewed in 2010. Again there needs to be discussion held with national representation requesting a timely review of the current criteria in consultation with those interested parties.

Facilities

The improvements suggested by the fathers in regards to the current facilities provided did not identify any significant concerns or barriers for them as fathers utilising the facility. The availability of suitable chairs so that fathers could have increased option for that hands on care with their baby was seen as an area of improvement which the service could remedy with financial support.

Ritual

The one hundred day cake provided a mixed response with both positive and negative opinions. Based on these responses going forward this ritual should be seen as a milestone that needs to be individualised for each set of parents. The individualising of this approach to care fits within the service’s focus to build upon the current family centred approach to care. Care planning includes collaboration with and decision making being able to be made by the parents themselves. Of importance will be the need to share with staff not only this study’s findings on this specific ritual but also the planned change so that they understand the context
and rationale for the change of a long standing tradition within the service which staff believe to be an acknowledgement and celebration.

Information

The way information was provided to parents was reflected upon by the fathers and discussed either within the context of verbal communication and explanations or written. Where there appeared to be a gap in resources and support currently was within the area of online information and access to suitable devices. A number of possible strategies to remedy this could include looking at further technological opportunities which would also provide them with extra support as the length of stay increased such as,

- Supporting the use of Skype whether this is on a personal device or service provided devices which would also support a father’s opportunities to connect with their partner and baby whilst at work or a distance away from the hospital as discussed earlier in the findings chapter.

- The revising of the cell phone rule so that the parents’ personal phones could be safely utilised more.

- The addition of a web based camera system as an alternative to Skype which is currently being researched within a European group of NICU’s with a focus upon understanding the perspectives from all involved groups and hospital data protection (European Foundation for the care of newborn infants, 2017).

- The installation of PC’s into the parent lounges for access by parents.

- Building upon the current parent education topics currently screened on the parent televisions, so that there would be a broader range of topics available and ideally identified by the parents themselves as being beneficial.

When considering the information provided whether this be written or online, a limitation of this study could be that further exploration is needed into the content of information provided
and its relevance and usefulness for fathers. To be truly inclusive requires a father’s voice. To be able to promote such an opportunity firstly there needs an established forum where such work is completed which within the Christchurch NICU is the established parent information group. To gain that father’s voice requires local promotion through advertising, networking and consumer engagement. Nationally within the realms of neonatal care there is an ongoing need for consumer engagement and their ongoing commitment for reasons still largely unknown is a challenge, nationally there needs to be further exploration on securing consumer representation within the NICU. The inclusion of and collaboration with parents is fundamental to establishing a family integrated approach to care. Representation of both mothers and fathers needs to be factored into any review of, or development of parent information and guideline development, which aims to foster a family integrated approach to care as highlighted within the findings of this study and truly advocates and supports family as the centre of care (Boykova & Kenner, 2016).

**Communication/interaction with others**

Overall the communication and interaction with staff was seen in an encouraging light by the fathers. They felt supported and encouraged to be involved right from the early days. As time progressed due to the support and their confidence building they were keen to be involved in more hands on care of their baby. The ability for skin to skin was one approach that was a very positive interaction and even though this is already an established practice within the unit that staff encourage, there is an opportunity to develop further resources so that both mothers and fathers feel well informed and comfortable with the care. Such resources could include, information sheets for parents which captures both mothers and fathers in the photography and dialogue, the supply of suitable tops to be worn by either parent, comfy chairs and headphones for that privacy and quiet time. Staff ongoing education is also of importance so that supportive consistent guidance continues to be provided to both mothers and fathers.

The only aspect of care where the fathers themselves felt they had no or a limited role was in supporting breast feeding for their partner and baby. Several talked about in the early days being able to assist with expressing and the equipment however as time progressed there seemed less for them to do even though feeding is a key focus of neonatal care. Consideration needs to be given by the staff as to how over a period of time fathers can feel included within
this aspect of care. This will require further exploration by the nursing staff and infant feeding team to work with parents together and fathers specifically in what other practical and theoretical skills and knowledge would assist them with feeling more included within a structured approach.

**Identified supports**

Nicolaou & Glazebrook (2008) when discussing emotional supports for parents within the NICU highlighted research studies that had produced some encouraging interventions such as parent to parent support and group support as being beneficial. However they stated that due to the needs of parents changing over time these supports should be varied, flexible and sustainable. As discussed within this thesis and the motivation for this study, what has not been explored in any great detail is should this emotional support be tailored differently for mothers compared to fathers? Findings from my study was mixed in the response to the fathers thoughts and ideas around the support they may have found helpful during their time in the NICU. Most shared ideas and thoughts around males in general and what may or may not be seen as helpful. Due to the nature of this mixed response the recommendation would be to consider and pilot several approaches to fathers’ supports.

A more casual structure was seen as being a preferred approach for some, where fathers felt the support needed to be self-directed rather than formalised and the conversations being of a casual nature. Some fathers expressed a need at times for the opportunity to talk about anything other than NICU, many found the casual conversations with other father’s as very beneficial and helped to keep them grounded in an environment that could be so overwhelming. The opportunities arising from having baby’s cared for in the same nursery, catching up over coffee in the parent lounges or just whilst waiting in the corridor provided those opportunities. The service currently supports such opportunities through having space such as the parent lounges and open clinical nurseries rather than single rooms that provides opportunities for relationship building by families over time. As this type of support relies totally upon the fathers instigating there still appears currently to be a gap in provision of more structured supports that the service could consider, knowing from the findings of this study, that a number of fathers would have accessed and found helpful.
Several fathers talked about a structured group setting, of an evening on a regular basis, they talked about it needing to be manly and blokes for blokes to encourage attendance. They also felt that to encourage attendance there needed to be a focus at the start to make fathers feel comfortable a topic for the month was one such suggestion.

Others gravitated towards suggestions of more one to one buddying structured support networks, one father Pete stating,

“I think getting two fathers together would be the way to do it, teaming up one who has been there for a long time and one at the start, bit more comfortable”.

Consistent in all the discussion around supports and what may be beneficial was the inclusion of male nurses, whether this be one on one at the cot side, whether the male nurse organised the buddying programme or facilitated the group meetings. The service needs to consider how the current male staff can take a lead in these potential initiatives by having those discussions and developing a plan. Nationally there needs to be a focus placed on attracting males to a career in nursing which has historically and continues to be seen as a female dominated workforce.

In conclusion this study has highlighted through hearing fathers accounts of the NICU stay what they found helpful, problematic or was missing in the way of supports for them as fathers over a period of time within the Christchurch Neonatal Unit. The insight that was provided highlights that a father’s experiences of a NICU stay is different to that of a mother’s that the experiences alter over time and that the supports that would be helpful need to be tailored to and for fathers.
References


Appendices:

1. Ethics Approval
2. Locality assessment approval
3. Maori Approval
4. Participant information sheet
5. Risk proposal
6. Consent form
7. Information flyer
8. Invitation to participate sheet
9. Questionnaire prompt sheet
10. Transcriber confidentiality form
11. Christchurch NICU visiting policy
12. Christchurch NICU service philosophy
13. Christchurch NICU service Charter
Dr B Burrell  
Centre for Postgraduate Nursing Studies (Chch)  
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21 August 2015  

Dear Dr Burrell,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "What's helpful, what's problematic, what's missing" during your stay, fathers experiences of supports in NICU: a qualitative study".

As a result of that consideration, the current status of your proposal is: Approved.

For your future reference, the Ethics Committee's reference code for this project is: H15/085.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

While approving the application, the Committee would be grateful if you would respond to the following:

Information Sheet (Appendix 3): Please note that the data must be stored at the Centre for Postgraduate Nursing upon completion of the data collection and not on the students computer in Christchurch Women's Hospital. Please amend paragraph 2, on page 3 of Information Sheet accordingly.

Reporting of results: The Committee asks whether you have considered disseminating the results beyond internal reports as indicated in question 6.3.

Principal Investigator experience (question 2.1.4): Please note, for future applications, that this section should include all named investigators relevant qualifications and experiences.

Please provide the Committee with copies of the updated documents, if changes have been necessary.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:
Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

http://www.otago.ac.nz/healthandsafety/index.html

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

gary.witte@otago.ac.nz

jo.farrondediaz@otago.ac.nz

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

[Signature]

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Dr P Seaton  Director, Senior Lecturer  Centre for Postgraduate Nursing Studies (Chch)
Dear Debbie,

Many thanks for your email with revised Information Sheet attached.

Thank you also for your response relating to reporting of results. Just so you know, the Committee did note the response in question 6.3 but thought it worth asking whether you had considered reporting beyond those means as outlined in 6.3. This was not a condition of approval, more a suggestion.

Thanks once again,
Jo

-----Original Message-----
From: Debbie O'Donoghue [mailto:Debbie.ODonoghue@cdhb.health.nz]
Sent: Thursday, 3 September 2015 2:28 p.m.
To: Jo Farron de Diaz
Subject: FW: Human Ethics Application H15/085

Hello Jo

As per the attached letter in regards to project H15/085, please find attached as requested further responses/clarification:

Revised information sheet (appendix 3) with amendment to paragraph 2, page 3 in regards to data storage.

The reporting of results: The original Research ethics application form did capture within its submission under 6.3 page 8 that the reporting and dissemination of results would include internal reports, conference presentations and other publications and I wish to confirm this to be the planned approach, I have not attached a full application as the original had identified this but please do let me know if you need further copies.

Please could you let me know if you require anything else or whether I should also be forwarding this information onto any other committee members.
Kind regards
Debbie O'Donoghue

Debbie O'Donoghue
Neonatal Nurse Manager
Neonatal Service
Christchurch Women's Hospital
Private Bag 4711, Christchurch
Ph: 03 364 4945 / Int 85945 Pager 5004

-----Original Message-----
From: Jane Hinkley
Sent: Monday, 24 August 2015 2:59 p.m.
To: Beverley Burrell <beverley.burrell@otago.ac.nz>
Subject: Human Ethics Application H15/085

Dear Dr Burrell,

Please find attached correspondence relating to your proposal entitled "What's helpful, what's problematic, what's missing" during your stay, fathers experiences of supports in NICU: a qualitative study", Ethics Committee reference number H15/085.

Kind regards,
Jane Hinkley

Academic Committees Administrator
Academic Services
Clocktower Building
University of Otago

Tel: (03) 479 6531
Email: jane.hinkley@otago.ac.nz
Appendix 2

3rd August 2015

Lynne Johnson
Nursing Director
Women's and Children's Health.

Dear Lynne

Research proposal:

Please find enclosed a locality assessment form with respect to this proposed study. The project is due to be assessed by the Otago University Ethics committee in August. I have also included with the form copies of supporting information.

The neonatal service including Nicola Austin are aware of the proposed study and following ethics approval I will be disseminating further information. The study will have minimal impact on the service and will not require any resourcing. The plan to start advertising and interviewing will be from September 2015.

I am happy to answer any questions you may have to clarify things.

For the purpose of my Ethics application I require a letter of support to be forwarded from my Manager

With kind regards

Debbie O'Donoghue
10 August 2015

Dr Beverley Burrell
Primary Researcher
Debbie O’Donoghue
Student Researcher

RE: RESEARCH PROPOSAL

‘Supports in NICU ‘what’s helpful, what’s problematic, what’s missing’ during your stay,
fathers experiences of supports in the NICU: A qualitative study,’

This research proposal has both my full support and that of the Child Health service.
Exploration of the needs and experiences of fathers in the NICU setting will help healthcare
providers better understand “what matters most” to this group and better meet the needs of the
whole family.

[Signature]

Lynne Johnson
Nursing Director
Women’s & Children’s Health

Lynne Johnson, Nursing Director, Women’s and Children’s Health
Canterbury District Health Board, Private Bag 4711, Christchurch
19 October 2015

Dr Beverly Burrell
Centre for Postgraduate Nursing Studies
University of Otago, Christchurch

Mā te rangahau Hauora e tautoko te whakapiki ake te Hauora Māori.
All health research in Aotearoa New Zealand benefits the Hauora (health and wellbeing) of
tangata whenua.

Tēna kōe Beverly,

Thank you for taking the time to meet with me at my office at the University of Otago,
Christchurch on the 16th October 2015, to discuss your research study titled:

“What’s Helpful, What’s Problematic, What’s Missing” During Your Stay? Father’s
Experiences of Supports in NICU: A Qualitative Study

I note that you are the Principal Investigator for this study and that Ms Debbie Donoghue, a
Master's degree student within your department will be involved. This study has received
some financial support from the Canterbury District Health Board Professional Nursing
Development Fund.

Commentary on Proposed Research Project
This study is a small qualitative study. The purpose of this project is to explore fathers
personal accounts and experiences of having a baby in the Christchurch Neonatal Intensive
Care Unit (NICU), Canterbury District Health Board, Christchurch for a period of four weeks
or more.

Participants will be identified as the father of the infant who has been cared for in the NICU
and discharged from the service. Potential participants will be identified via the NICU’s
admissions data sheet and if they meet the study criteria, will be sent an invitation to
participate.

Māori Health Gain
Research and statistics demonstrate that having a premature or low birth weight baby
increases the risk of mortality, morbidity, sudden infant death, child abuse and neglect
compounded by the stress on families due to a long hospital stay of a sick baby. Unfortunately,
Māori are disproportionally over represented in neonatal mortality and morbidity statistics.
Therefore the findings from this study may benefit those who identify as Māori by reducing
stress factors on whānau and supporting child attachment. This study also provides an
opportunity for Māori fathers to identify what supports might look like to assist whānau through
the neonatal journey and ultimately benefit health outcomes for the pāpi (infant).
Ethnicity
It is likely that your study will involve Māori participants, there is a need to acknowledge the issues pertaining to ethnicity and to consider how ethnicity data will be collected for this project. It is recommended that ethnicity data is collected from each participant in accordance with the New Zealand Ministry of Health guidelines, which involves the use of the Census 2013 question. If a participant identifies as Māori, but this is not recorded in their records, this should be rectified. This may be likely to occur given the poor ethnicity data collection in hospital protocols and databases.

Consent
Issues regarding informed consent for Māori participants who are recruited into this study were discussed. With this in mind, you must ensure that Māori participants are aware that consent will be for this study only. Whilst this research does not specifically target Māori fathers you have indicated that it is possible that Māori father’s may have a presence within the recruitment population. Ideally, this presence should be reflective of the Māori population living within the Canterbury region (approximately 8%).

Partnership
With regard to Māori involvement in your study, you have advised that Hauora Māori input will be sought from Kathy Simmons, Kaitiaki Hauora Māori for Christchurch Women's Hospital at the Canterbury District Health Board, Christchurch. As you are aware, Hauora Māori involvement for this study would ensure that Tikanga Māori processes are integrated where/when necessary, particularly during the engagement process with Māori participants. Consideration for how Hauora Māori staff may be supported to participate in the study should not only be discussed with the Hauora Māori staff directly, but also between yourself and the appropriate General or Service Manager. This will help you to identify the availability of Māori capacity for this project and ensure that current patient workload for Māori staff is not compromised. Further, I have suggested that Māori participants be offered the option to be interviewed by a Māori interviewer. This will allow Māori values and realities to be considered and data from interviews interpreted within the correct cultural context.

Potential Further Support Resources
Further resources that you might want to access to strengthen your responsiveness to Māori within your research are: 1. HRC’s Ngā Pōu Rangahau Hauora Kia Whakapikihaka Te Hauora Māori 2004-2008, 2. The Health Research Strategy to Improve Māori Health and Well Being 2004-2008.

The other reference that is available is 3. Hauora Māori Standards of Health IV: A Study of the Years 2000-2005 by Bridget Robson and Ricci Herring, Māori Health Research Unit, Wellington School of Medicine, University of Otago, Wellington. All provide Māori specific information on a range of health issues.


Dissemination of Results
The HRC’s Guidelines for Researchers on Health Research Involving Māori, is important in terms of how your research results may contribute to Māori health gain. This should occur not only in an academic forum, but also within the community from where data is drawn. I note that you are intending to disseminate your findings locally to Ngā Maia (Canterbury Māori Midwives Collective) and be looking to develop a whānau friendly newsletter for whānau
# Information Sheet for Fathers

|-------------|-----------------------------------------------------------------------------------------------------------------------|
| Primary supervisor: | Name: Dr. Beverley Burrell  
Department: Centre for PostGraduate Nursing Studies, University of Otago  
Christchurch  
Position: Deputy Director-Teaching/Senior lecturer |
| Second supervisor: | Name: Gillian Halksworth-Smith  
Department: Centre for PostGraduate Nursing Studies, University of Otago  
Christchurch  
Position: Senior Lecturer |
| Student Researcher: | Name: Debbie O'Donoghue  
Department: Neonatal service, Christchurch Women's Hospital  
Position: Neonatal Nurse Manager |
| Contact phone number: | 03 3643850  
03 364 6865  
03 364 4945 |
Appendix 4

Introduction

Thank you for showing an interest in this research project. Please read this information sheet carefully. Involvement is voluntary and please take time to consider and, if you wish, talk with relatives or friends, before deciding whether or not to participate.

If you decide to participate we thank you. If you decide not to take part in the study, your baby and family’s care will continue to be the best available, there will be no disadvantage to you and we thank you for considering our request.

What is the purpose of this research project?

The research project aims to hear father’s personal accounts of their experiences of having a baby in the Christchurch NICU. Listening to what fathers have to say about their experiences will help the service look at how we currently meet the needs of fathers who have babies in the unit and also to consider the introduction of dedicated supports for fathers within the Christchurch NICU which the fathers themselves may have identified as being helpful.

Who is funding this project?

Funding has been provided by the individual student researcher with the support of the employer the Canterbury District Health Board

Who can participate in this study?

All fathers with babies admitted to the neonatal service at less than 33 weeks gestation and at least 4 weeks into their baby/babies stay. The purpose for this is to gain further insight into the impacts and effects of a longer term hospital stay.

Participants will be able to communicate in English.

12 fathers will be individually interviewed for this study.

If you agree to take part in the project the following will happen.

An individual interview will be organised with the researcher, this will be informal and focus upon your experiences and personal stories about how the experience of NICU has been for you. The interview will be audio-taped and then listened to later by the researcher and written down. You will have the opportunity, if you wish, to review the comments you have made during the interview before their inclusion in the study. The interview will be held in a neutral and agreed venue and will take approximately 60 minutes.

Risks?

It is not anticipated that there will be any risks involved for you in this study. There are no effects on your baby or partner as the project is only concerned with your experiences and what has been written or said about those experiences.
### Appendix 4

<table>
<thead>
<tr>
<th>Name: Gillian Halksworth-Smith</th>
<th>Contact phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Centre for PostGraduate Nursing Studies, University of Otago Christchurch</td>
<td>03 364 6865</td>
</tr>
<tr>
<td>Position: Senior lecturer</td>
<td></td>
</tr>
</tbody>
</table>

This study has been approved by the University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz).

Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix 4

In the event of you becoming distressed about any issues discussed a staff member from the neonatal service or a patient advocate will be available for you to speak to in confidence. All efforts will be made to provide you with access to a culturally appropriate person.

What happens to the interview information?

Audio-tapes and written information will be kept in a locked filing cabinet in the researcher's office at Christchurch Women's Hospital and data transcribed on to the computer will be password protected. All information will be kept safely for ten years and then destroyed.

What about anonymity and confidentiality?

All written notes and audio-tapes are confidential and will not be available to anyone except the researcher and supervisors. Staff in the neonatal service will not have access to any of the information received from you during the interviews. Your information will be recorded using a study number rather than using you or your baby's name. Copies of the written transcripts of your interview will be available for you to read if you would like to do so. The content from the interview intended for use in the finished work will have the names changed to protect confidentiality.

If you agree to participate, can you withdraw later?

Your participation in this project is voluntary and you may withdraw at any time. If you decide not to take part the care of you, your baby and your family will continue to be the best available. If you change your mind at any time you may withdraw from participation in the project.

Any questions?

If you have any questions now or in the future, please feel free to contact either:

<table>
<thead>
<tr>
<th>Name: Debbie O'Donoghue</th>
<th>Contact phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Neonatal service, Christchurch</td>
<td></td>
</tr>
<tr>
<td>Women's Hospital</td>
<td>03 364 4945</td>
</tr>
<tr>
<td>Position: Neonatal Nurse Manager</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: Dr. Beverley Burrell</th>
<th>Contact phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department: Centre for PostGraduate Nursing Studies, University of Otago Christchurch</td>
<td>03 3643850</td>
</tr>
<tr>
<td>Position: Deputy Director-Teaching/Senior lecturer</td>
<td></td>
</tr>
</tbody>
</table>
This plan outlines what will happen if a participant reveals to the researcher abuse or the risk of abuse.

The researcher has worked with vulnerable children and families for a long time and is aware that sometimes babies and children have been abused.

If a participant discloses abusive behaviour or attitudes where the researcher suspects abuse or risk of abuse, the researcher will talk with them about whether they require further support. Sometimes the researchers may be obliged to pursue mandatory reporting. This is when researchers are told about abuse that is still happening and they think children or adults might not be safe. The researcher will tell a participant about their obligations to report before they tell other people about the abuse.

This plan is in response to the CDHB policy on Child Protection and the Ministry of Health's family violence screening mandate to DHB's and obligations on health care professionals.
“What’s helpful, what’s problematic, what’s missing’ during your stay” fathers’ experiences of supports in NICU: A qualitative study.

Principal Researcher: Dr Beverley Burrell (baverley.burrell@otago.ac.nz 03 364 3850)

Student Researcher: Mrs Debbie O’Donoghue (debbie.odonoghue@cdhb.health.nz 03 364 4945)

CONSENT FORM FOR PARTICIPANTS

Following signature and return to the research team this form will be stored in a secure place for ten years.

Name of participant: ............................................................

1. I have read the Information Sheet concerning this study and understand the aims of this research project.

2. I have had sufficient time to talk with other people of my choice about participating in the study.

3. I confirm that I meet the criteria for participation which are explained in the Information Sheet.

4. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.

5. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage.

6. I know that as a participant the interview will explore my experiences of having a baby in the Christchurch neonatal unit and that if the line of questioning develops in such a
way that I feel hesitant or uncomfortable I may decline to answer any particular question(s), and /or may withdraw from the project without disadvantage of any kind.

7. I understand that the interview will be audio-taped. I understand that interview tapes and information will be kept in a locked filing cabinet and on a computer which is password protected. Information will be destroyed after a period of ten years.

8. I know that when the project is completed all personal identifying information will be removed and that all comments made by me during the interview will remain private to the researcher and research supervisors. I understand that my baby and I and my family will be unable to be identified in reports written about this study. I understand that the results of the project may be published and be available in the University of Otago Library, but that any personal identifying information will remain confidential.

9. I know that there is no remuneration offered for this study, and that no commercial use will be made of the data.

10. I would like the opportunity to review my comments prior to inclusion       Yes /NO

11. I would like to receive a summary of the completed study                    Yes/No

Signature of participant: ____________________________  Date: ________________
'What’s helpful, what’s problematic, what’s missing' during your stay, fathers’ experiences of supports in the NICU: A qualitative study.

This research project will be undertaken within the Christchurch NICU between September 2015 and February 2016. The project aims to hear father’s personal accounts of their experiences of having a baby in the Christchurch NICU. Listening to what fathers have to say about their experiences will help the service look into how we currently meet the needs of fathers.

Those fathers eligible to participate will receive a personal and confidential invitation to consider being involved.

Any questions please contact Debbie O'Donoghue, Neonatal service, Christchurch Women’s Hospital 03 363 4695.
“What’s helpful, what’s problematic, what’s missing during your stay”, fathers’ experiences of supports in NICU: A qualitative study.

Invitation to participate

This research project aims to hear father’s personal accounts of their experiences of having a baby in the Christchurch NICU. Listening to what fathers have to say about their experiences will help the service look into how we currently meet the needs of fathers.

Who can participate? Any father with a baby admitted to the NICU at less than 33 weeks gestation and having had at least a 4 week neonatal stay.

The commitment will involve a one to one interview with the researcher for approximately 60 minutes.

Please do not hesitate to contact the researcher if you are keen to be involved or have any questions for the researcher:

Debbie O’Donoghue, Neonatal Service Christchurch Women’s Hospital, 03 364 4945, debbie.odonoghue@cdhb.health.nz

If you indicate interest in participating the Information Sheet and Consent Form will be provided.

[This project has been reviewed and approved by the University of Otago Human Ethics Committee, (Health). Reference: #### The project is study toward a master’s degree.]
"Open-ended questionnaire prompt sheet"

Open ended questions give respondents an opportunity to express themselves. The answers will not be facts, but personal feelings, opinions, or ideas. This prompt sheet will be used to encourage conversation. The control of the conversation being with the father being asked the question. The purpose of the interview is to meet the aim of the research study which is to capture father’s experiences of having a baby in the Christchurch NICU for a period of 4 weeks or more.

First question after introduction will be to encourage open conversation

1. Please could you tell me about your experience on the neonatal unit?
   To develop the conversation or explore areas they have not mentioned there will be the use of sub set questions which will be guided by the responses

   **Sub set questions:**
   What have you found has helped you with the experience?
   Is there anything currently that the service provides/encourages which has felt supportive and beneficial?
   Is there anything the service has in place which has found the experience more stressful/challenging?
   Can you think of anything that as father you would find helpful as a form of support for other fathers?
   Do you have anything else you wish to share?

   **Possible prompts;**
   How did that make you feel?
   What do you think about…. ?.
   Why do you say that?
Transcriber’s Confidentiality Form

"What’s helpful, what’s problematic, what’s missing" during your stay, fathers’ experiences of supports in the NICU: A qualitative study.

I agree to transcribe the audiotapes for the above research and to be bound by the ethical principle of confidentiality.

I agree to ensure all materials in my possession, related to this research, are securely stored until all such items have been handed over to the student researcher Debbie O'Donoghue & primary supervisor Dr. Beverley Burrell

I will not discuss any content or aspects, or make references to these audiotapes and scripts now or in the future.

Any queries or concerns I have will be discussed with the researcher only.

Name: [Signature]

Signed: [Signature]

Date: 21/11/2016

If you require any information please contact:
Debbie O'Donoghue
Neonatal Service, Christchurch Women’s Hospital
Ph. 03 364 4895
Visitor’s Policy

Policy Details

1. Hands must be washed immediately on entering the Unit
2. Footwear must be worn
3. Parents may visit 24 hours of the day. All parents will be informed of the Neonatal Service visiting policy by a staff member as part of the admission / first contact procedure
4. Only two people at the infant’s cot side at any time
5. Brothers and sisters of all ages welcome under supervision, with consideration given to immunisation status and wellness
6. Other children under the age of 12 years are not permitted to visit
7. Other adult visitors are welcome between the hours of 1100 – 1300, and 1500-2000 hours only, but one parent must be present unless prior permission has been given. Quiet time is for parents only between 1300 and 1500.
8. Anyone with a cold, cold sore or infection must discuss whether they are able to visit with a nurse before entering.
9. Visitors must wait outside the Unit to prevent obstructing the corridor, visitors lounge available
10. Visitors are to be asked to respect the other families by focussing only on the baby they are visiting
11. To ensure confidentiality, information is only provided to parents / guardians (including telephone enquiries)
12. Any special visiting needs may be discussed, as changes to the above can be altered to suit individual needs
13. Any breaches of the Visiting Policy – inform Security and the ACNM and complete an Incident / Accident Form
**Canterbury**

**District Health Board**

Te Poari Hauora o Waitaha
Christchurch Women's Hospital

**Neonatal Services**

**Operational Procedures**

**Definition**

**Parent**  Postnatal mother, identified father, selected adoptive or foster parents

**Sibling**  Identified brothers and sisters of baby on the Unit

**Supporting Documentation**

- NZ HDC Code of rights
- CDHB Health and Safety Manual Vol 6 CDHB intranet
- NICU Visiting Information leaflet Ref xxx

**Associated Forms**

- CDHB Incident / Accident Form Ref 1077
- MCP Neonatal Care Plan CXXXXX Ref XXXX

**Procedure**

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<th>Action</th>
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<tr>
<td>2.</td>
<td>Make parents aware of their right re: visiting – provide written and verbal information on admission</td>
</tr>
<tr>
<td>3.</td>
<td>Maintain communication with hospital security between the hours of 2000 – 0800 hours</td>
</tr>
<tr>
<td>4.</td>
<td>Explain to parents the security measures in place at the front entrance after 2000 hours.</td>
</tr>
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**Procedure Owner:** Clinical Director, Neonatal Services
**Definition**

**Parent**  Postnatal mother, identified father, selected adoptive or foster parents  

**Sibling**  Identified brothers and sisters of baby on the Unit

**Supporting Documentation**

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</table>

**Procedure Owner:** Clinical Director, Neonatal Services
Philosophy of the Neonatal Service
Women’s Health Division
Canterbury District Health Board

Our Philosophy as Health Care Providers is to:

- To consistently provide, as a team, quality holistic care with respect for whanau/family, encompassing the concepts of Te Whare Tapa Wha (The four cornerstones of health), Te taha Wairua (Spiritual), Te taha Tinana (Physical), Te taha Whanau (Family), Te taha Hinengaro (Emotional and psychological) in accordance with Te Tiriti O Waitangi (The Treaty of Waitangi) and the Code of Health and Disability Services Consumers Rights (1994).

- Create and maintain an environment, conducive to the provision of developmentally supportive care, which will maximise the peepi/baby’s outcome and potential for a dignified and independent life.

- Promote and foster healthy interpersonal relationships, between Nga Matua/Parents, extended whanau/family and peepi/baby.

- Ensure the multi-disciplinary team advocates for the peepi/baby and their whanau/family in all aspects of care including complaints.

- Encourage open and effective communication between all staff and whanau/family in a supportive caring environment, providing interpretation when required, without discrimination.

- Ensure appropriate preparation for discharge and ongoing needs. These needs will be established in consultation with the whanau/family and multi-disciplinary team members.

- Recognise the necessity, of maintaining high levels of care and skill within the Neonatal Service in accordance with Te Tiriti, and based on evidence based practice, current teaching and research.

References:
Code of Health and Disability Services Consumer Rights, Health and Disability Commissioner 1994
Dictionary of the Maori language, HW Williams, GP Publications, 1997
Doris Tamarapa, Kaiawhina Whaea me nga Peepi, WHD, Canterbury DHB, 2003
Deited by Shery Tuutu, Kaiawhina Whaea me nga Peepi, WHD CDHB 2008
NEONATAL SERVICE CHARTER

OUR VISION  
TA MATOU MATAKITE

The aim of the neonatal service is to provide sound evidence based care, to ensure that infant mortality and morbidity rates are reduced.

To provide an environment conducive to the provision of developmentally supportive care, which maximises baby’s/peepi outcome and potential for a dignified and independent life. This is within the Baby Friendly Hospital Initiative (BFHI) framework and in accordance with the principles of Te Tiriti o Waitangi.

TEAM VALUES  
A MATOU UARA

Open, effective and respectful communication between all staff and caring for family/whanau in a supportive and caring environment.

Support a smoke free work environment and promote smoke free homes for families/whanau

Acknowledge the importance of individual professional development in the pursuit of clinical excellence by the sharing of knowledge and skills.

OUR WAY OF WORKING  
KA HAURI MAHI

Within a family/whanau centred partnership
Use of evidence- based best practice.
Engaging with wider multi-disciplinary and community resources

References:
Philosophy of the Neonatal Service WHD/Ref/532
CDHB Nursing Code of Conduct

Reviewed
August 2011