



# Perceptions of parent–staff communication in Neonatal Intensive Care: The findings from a rating scale

Tilly Reid <sup>a,\*</sup>, Ros Bramwell <sup>b</sup>, Nicola Booth <sup>c</sup>, Michael Weindling <sup>d</sup>

<sup>a</sup> Department of Midwifery Studies, Brook Building, University of Central Lancashire, Preston PR1 2HE, UK

<sup>b</sup> Department of Clinical Psychology, University of Liverpool, UK

<sup>c</sup> Neonatal Medical Unit, St Marys Hospital, Central Manchester Hospitals NHS Trust, UK

<sup>d</sup> Liverpool Womens' Hospital NHS Trust, University of Liverpool, UK

Available online 15 February 2007

## KEYWORDS

NICU;  
Parent–staff  
communication;  
CRIB;  
Transfer;  
Mode of birth;  
Parent gender;  
Clinical role

**Abstract** A rating scale has been developed assessing parental perceptions of the quality of communication received at two time points during the first 2 weeks following birth (see [Reid, T., Bramwell, R., Booth, N., Weindling, M., 2007. Perceptions of parent–staff communication in Neonatal Intensive Care: The development of a rating scale. *Journal of Neonatal Nursing* 13 (1), 24–35]). This paper explores the findings according to various parental and infant characteristics, for example parental gender, infant illness, transfer status and mode of birth.

There were no differences in mothers' and fathers' communication ratings, and infant illness did not appear to influence ratings significantly. Parents who were transferred from their planned place of birth had more negative ratings at the later assessment. Previous negative experiences such as previous preterm birth, poor reproductive history or history of previous poor outcome did not appear to unduly influence communication ratings, though the numbers of such parents were relatively small in this study. Mode of birth appeared to influence communication ratings for mothers at the early assessment, as ratings were more positive for elective caesarian birth compared to those giving birth normally or by emergency caesarian section. Analyses which explored differences in subscale scores according to socioeconomic status, birth order, pregnancy risk, maternal or paternal age, cohabitation status or presence of congenital anomaly revealed no significant influence on communication scores. The study also examined ratings between the earlier

\* Corresponding author. Tel.: +44 01772 893812/29.  
E-mail address: tpadden@uclan.ac.uk (T. Reid).

and later assessments, and results revealed significantly increased negative ratings over time. There were also differences in ratings between nurses, nurse practitioners and medical staff, revealing that parents were able to discriminate differing clinical roles in NICU.

© 2007 Neonatal Nurses Association. Published by Elsevier Ltd. All rights reserved.

## Introduction

Communication in NICU is a vital part of clinical care. Communication needs are complex as parents at various stages of their experience require emotional support and validation, practical help and information, positive attitudes and clarity. In many instances recipients may be unable to accept, comprehend or remember the communication received due to their underlying emotional state or the complexity of the information. The situation may rapidly change and both diagnoses and prognoses typically evolve over prolonged periods. Parents must cope with their own emotional responses whilst at the same adapt to unfolding clinical events. It is essential that any assessment of communication accommodates a changing situation, as the clinical status and parents' understanding and coping abilities will inevitably change over time.

Family-centred models of care acknowledge the importance of involving parents and other family members, however, relatively little is known about the way that parents perceive aspects of interpersonal support, particularly for fathers who are generally under represented. See Reid et al. (2007) for a literature review of communication in newborn intensive care.

This paper explores the findings according to various parental and infant characteristics, and to explore the differences in ratings between the earlier and later assessments, and between nurses, nurse practitioners and medical staff.

Most studies of parental experiences in NICU are either exclusively or predominantly maternal, and relatively little is known about the paternal situation. This study obtained responses from large numbers of fathers, which has enabled gender comparisons to be made. The methods used in conducting this study are outlined in Reid et al. (2007).

## Measures

### Parent and infant characteristics

Maternal age, mode of birth, transfer status, birthweight and gestation are recorded with

admission data, the remaining information was ascertained following recruitment to the study. Infant morbidity was determined by a series of measures including a CRIB score (Clinical Risk Index for Babies) (International Neonatal Network, 1993) and the actual length of stay, including the time spent on return to the referring unit for those infants spending only part of their NICU course at the research site. Basic demographic profiles of respondents and eligible non-respondents are presented in Reid et al. (2007).

The CRIB score is measured at 12 h post-birth, and consists of birthweight and gestation data, maximum and minimum supplemental oxygen need, maximum base and blood pH deficit, and the presence of congenital anomaly. Higher scores reflect greater medical risk. The maximum score for infants weighing less than 700 g is 23, for infants weighing less than 851 g, 20, and for infants weighing over 850 g, 17 (International Neonatal Network, 1993). The CRIB index is regarded as a robust indicator of neonatal morbidity and is predictive of longer term risk.

Pregnancy risk status was defined as 'any clinical condition, or previous or family history of a clinical condition in either the mother, fetus or newborn which warrants current pregnancy surveillance above routine levels'.

Transfer status was categorised as 'inborn' where the unit was the planned place of delivery either because parents were local residents or were using the regional obstetric services for high risk pregnancy, and 'transfer' either antenatally because of preterm labour or pregnancy complications or postnatally due to infant illness following birth.

Socioeconomic status was determined by the occupational grouping of the higher status partner using the OPCS classification (1991).

## Analysis

Distribution of items was explored, and the criterion for deletion was if >20% scored 0 (not applicable). No items at either time 1 or time 2 were deleted. Prior to exploratory factor analysis, scatter plots revealed a likely three factor solution for both time 1 and time 2. The derived factors were

Download English Version:

<https://daneshyari.com/en/article/2631956>

Download Persian Version:

<https://daneshyari.com/article/2631956>

[Daneshyari.com](https://daneshyari.com)