Abstract

Objective: Nursing staff are an important source of support for parents of a hospitalised preterm infant. This study aimed to describe parents’ and nurses’ perceptions of communicating with each other in the context of the Special Care Nursery. Method: A qualitative descriptive design was employed. Thirty two parents with a newborn admitted to one of two special care nurseries in Queensland, Australia participated and 12 nurses participated in semi-structured interviews. Thematic analysis was used to analyse the interviews. Results: Nurses and parents focused on similar topics but their perceptions differed. Provision of information and enabling parenting were central to effective communication, supported by an appropriate interpersonal style by nurses. Parents described difficulties accessing or engaging nurses. Managing enforcement of policies was a specific area of difficulty for both parents and nurses. Conclusion: The findings indicated a tension between providing family-centered care that is individualised and based on family needs and roles, and adhering to systemic nursery policies.

Keywords: Communication; neonatal nursing; preterm birth;
Negotiating care in the special care nursery: Parents’ and nurses’ perceptions of parent-nurse communication

Preterm birth (<37 weeks gestation) accounts for between five to 18% of all births worldwide (Howson, Kinney, & Lawn, 2012) and approximately 7.4% of births in Australia (Li, McNally, Hilder, & Sullivan, 2011). The birth of a preterm infant and admission to the neonatal nursery therefore affects a significant number of families. For parents the experience of giving birth, often very unexpectedly, and the subsequent forced separation from their newborn is a stressful time that is commonly described as an ‘emotional rollercoaster’ (Davis, Edwards, Mohay, & Wollin, 2003; Sheeran, 2013; Whitfield, 2003). The experience can have long-term psychological consequences for women. For example depression and anxiety are higher in this group of vulnerable mothers (Doucette & Pinelli, 2004; Miles, Holditch-Davis, Schwartz, & Scher, 2007). Research suggests that mothers of preterm infants report reduced confidence in their ability to parent (Hess, Teti, & Hussey-Gardner, 2004; McGrath, Boukydis, & Lester, 1993). In addition mood disorders affect maternal responsiveness and are associated with poor child development (Eshel, 2006; Lee, 2007). Less is known about how fathers cope, as they are under-represented in the research (Carter, Mulder, Bartram, & Darlow, 2005; Doucette & Pinelli, 2004). Rowe and Jones (2010) reported however that while fathers experienced less stress than mothers, they were less optimistic, and appraised themselves more harshly, in terms of parenting confidence.

The support parents receive from health care professionals, especially nurses, is critical in parents’ experiences in the nursery environment (Reis, Rempel, Scott, Brady-Fryer, & Van Aerde, 2010). Some time ago Miles (2003) argued that neonatal nurses were best placed to provide support to parents of hospitalised newborns as they are the group mostly likely to come into daily contact with parents. The work of Kowalski, Leef, Mackley, Spear, and Paul (2006) supports this assumption. In their survey study they found that parents
identify nurses as “the best source of information about their baby” and “the person who spent the most time explaining the baby’s condition” (p. 46) with 86% of parents stating they felt less worried after speaking to the nurse. Similarly, Boucher and colleagues (2011) identified that parents valued a neonatal nurse’s ability to provide information, encourage participation in care activities and support breastfeeding. Indeed, these aspects of a nurse’s work have been associated with a reduction in the likelihood that a woman with a baby admitted to the neonatal intensive care unit will suffer perinatal depression (Bicking & Moore, 2012). So it is not surprising that the relationship parents share with neonatal nurses is considered critical in determining a parent’s satisfaction with their experience in the nursery environment (Reis et al., 2010).

How care is negotiated between parents and nurses, during the newborn’s admission to the neonatal nursery, is said to be a reflection of the unit’s philosophy. Over the last twenty years there has been a substantial body of work advocating for the adoption of a family centred care approach (see, for example, Gooding, 2011; Griffin, 2006). Family centred care means putting the family at the centre of care and recognising and valuing the unique contribution parents and/or families make in life of the infant (Bruce & Ritchie, 1997; Griffin, 2006; Newton, 2000). Parents are considered best placed to care for infants, in collaboration with health professionals. There remains evidence however that many neonatal intensive care units struggle to enact these principles (Gooding, 2011; Griffin, 2006).

Pridham (2006) argued that there was still a need to further investigate the communication between parents and professionals in the neonatal care environment, in particular, how the "qualities of interaction" (p. 134) between the parents and nurses influences parental expectations and needs. Subsequently, Jones, Woodhouse and Rowe (2007) found that parents valued 2-way communication that they perceived as informal and was both nurturing and informative. Like the earlier work of Fenwick, Barclay and Schmied
(2001a, 2001b) these authors also found that parents expected nurses to interact in a way that was polite and respectful and treated them as equal partners within the interaction. More recently, Guillaume et al. (2013) confirmed that parents valued communication that was both informative but also delivered in a caring manner. There has, however, been limited research examining nurses’ perceptions of communication with parents. The work of Fenwick et al. (2001a), while primarily focused on women’s experiences of mothering in the nursery, did examine nurses’ perspectives. Juxtaposing their data sets they were able to identify that nurses, like mothers, recognised the importance of using social interaction such as chatting to establish a positive relationship with parents and enhance subsequent communication. However, to date, research has typically focused on the perceptions of parents, with little research from the perspective of nurses, meaning we have a limited understanding of whether nurses and parents have a shared notion of communication, as well as what may or may not be effective. What research does exist suggests that there may be differences in the perceptions of nurses and parents with regard to the roles of each within the nursery environment and the meaning ascribed to various actions and interactions in which nurses and parents engage (Hurst, 2001; Lupton & Fenwick, 2001). The aim of this study was therefore to explore and describe parents’ and nurses’ perceptions of what constitutes effective communication in the nursery environment.

**Method**

A qualitative experiential approach was used in this study, where the focus is on participants’ interpretations of their experiences (Braun & Clark, 2013). Semi-structured interviews were used to elicit detailed descriptions of effective and ineffective communication in the nursery.

**Study settings**
Two hospitals in Queensland participated in the study. The first was a tertiary neonatal unit in a tertiary referral hospital in *metropolitan* Brisbane with 69 beds, admitting approximately 1500 babies per year. The second was a Level 2 unit in a *regional* hospital in Queensland with 20 beds, admitting approximately 550 babies per year.

**Participants**

Participants were parents of preterm infants admitted to the Neonatal Special Care Nursery (SCN) and nurses working in the nursery.

*Parents.* In total 32 parents participated. Fifteen mothers and five fathers were recruited from the tertiary service. Four fathers were partners of the women who also participated. The fifth father’s partner did not participate in the study. The remaining 12 parents were women with preterm infants admitted to the regional unit. Parents were eligible to participate if they were over 18 years of age, had no ongoing health concerns and had a medically stable, preterm infant (less than 37 weeks gestation) hospitalized who had spent at least 48 hours in the SCN. Parents were, however, generally interviewed close to their infant’s discharge.

*Nurses.* Twelve nurses (11 female and 1 male) were recruited from the tertiary hospital. All nurses were midwives or neonatal nurses with a minimum of three years of training. Nurses were eligible to participate if they were full-time or part-time employees working in the Special Care Nursery. No nurses were interviewed from the regional hospital due to staffing issues at the hospital at the time approval was given, which meant that staff had a lack of time available for interviews when the study was being conducted.

**Recruitment and data collection**

Prior to data collection ethical approval was obtained from each hospital’s Human Research Ethics Committees, and Griffith University Human Research Ethics Committee.
In-service session for all staff was conducted in each neonatal nursery. Project material for both parents and nurses, including brochures and information sheets, were left in key areas of each unit including break rooms, nurses stations and family rooms. During the information session nurses were asked to provide parents with brochures about the project. Nurses were recruited individually during shifts where they were provided with an information sheet about the project. After reading the information sheet nurses signed a consent form if they were interested in participating.

All parents who met the inclusion criteria were approached initially by nurses with an information brochure about the project. Members of the research team visited at a later time to determine if the parent was interested in participating. Time was provided for parents to ask questions and seek clarification. Parents subsequently signed a consent form if keen to participate. Recruitment of parents and nurses continued until the interviewers thought saturation had been reached (Braun, 2006).

Parent Interviews. Individual interviews were conducted in close proximity to the nursery (e.g., in the family room or a quiet area in the café) or within the SCN when confidentiality could be maintained (i.e., a room at back of nursery). Six parents (three couples) were interviewed together at their request. Interviews lasted approximately 30 minutes and all but one were audio-recorded. One parent declined to be audio-recorded, so notes were taken during interview with a more detailed summary made at the end of that interview.

The interviews were semi-structured. Two members of the research team conducted all interviews. Parents were asked: ‘Can you tell me about a time here when you talked to a nurse and it went really well?’ Clarifying questions were asked when required to obtain more detail, as well as the impact of the communication on the parent. Parents were then asked, ‘Can you tell me about a time here when you talked to a nurse and it didn’t go so well?’
Parents then shared any additional thoughts about their communication with nurses in the nursery.

*Nurses.* Nurses were interviewed at a time and location convenient (e.g., in meeting room at hospital or in a quiet area in a café). Similar to the parent participants, the audio-recorded interviews lasted approximately 30 minutes with the nurses being asked firstly to describe what they considered to be examples of effective communication, followed by ineffective communication.

**Analysis**

Interviews were professionally transcribed. The accuracy of the transcription was checked by the two interviewers. Thematic analysis was used to generate the key descriptive themes in the participants’ stories, using Braun and Clarke’s (2006) guidelines and checklist. Descriptive themes were generated inductively rather than imposed apriori or deductively. This process commenced with sentence by sentence coding. Like codes or concepts were then clustered together to form tentative themes. Further grouping was undertaken on the basis of effective and ineffective communication. Initially, we kept our analysis of effective and ineffective communication separate to enable us to identify differences. After separate analyses were conducted, combined analyses were also conducted to determine final themes due to minimal identified differences between communication types, as discussed later in this manuscript.

Two of the authors initially coded the interviews to identify the themes, with each interview analyzed in its entirety before moving to the next interview. The first author then coded the interviews to verify the themes identified. Regular discussions took place to ensure consistency with regard to coding procedures, with excerpts of the participant’s transcript recorded to ensure it adequately represented the code recorded.
As part of the analysis, potential differences between mothers and fathers, and the male and female nurses, were also explored. In the three cases where mothers and fathers were interviewed together each parent contributed equally to the interview, and identified some similar and some different characteristics to their partner. There were no instances of the mothers and fathers disagreeing either explicitly or implicitly with the descriptions provided by their partners. Differences between mothers and fathers were rare. There were no differences identified between the parents from the metropolitan hospital compared with the regional hospital nor the sole male nurse and the female nurses.

Results

Participant characteristics

Table 1 contains descriptive information about the participants.

INSERT TABLE 1 ABOUT HERE

Themes

As previously mentioned, minimal differences were noted between responses to questions about effective and ineffective communication, and therefore, we combined these data for the generation of final themes. The only exception was one theme (Nursery rules and regulations), which was only found in the descriptions of ineffective communication. We identified four core themes: The importance of sharing information, Enabling parenting, Being mindful: the importance of a supportive communication style, and Nursery rules and regulations and for each theme there were both similarities and differences between parents and nurses in what they talked about (see Figure 1, which includes both similarities and differences for each theme). Interestingly, both parents and nurses described nurse behavior when describing content that eventually mapped onto the identified themes.

INSERT FIGURE 1 ABOUT HERE
The importance of sharing information. One of the most common and important issues for both parents and nurses was the concept of sharing ‘information’. Parents ‘wanted’ nurses to ‘provide’ information and nurses ‘wanted to provide’ parents with information. Interestingly, fathers had a tendency to mention information first compared to mothers. From the parents’ perspective they wanted to know ‘everything’ from what they considered to be ‘general information’ about for example what ‘creams’ they should use on their baby to how equipment worked and, of course, the condition and progress of their baby. A major focus for parents was seeking information that told them that what was happening was ‘normal’ and that everything was going to be ‘fine’. The ability of nurses to answer parent questions was critical as was their ability to ‘check back’ with the parents. Parents also spoke about the importance of nurses giving ‘unsolicited’ information. The ability of nurses to ‘engage’ parents and thus provide information that parents would not know to ask was important.

*I feel like I’m receiving all the information that I need, so I’m really extremely happy about that even though sometimes we’re not asking questions, they will give us additional information* (Metropolitan mother 24)

Nurses similarly spoke frequently about providing information to parents. Concepts such as explaining what was happening so parents understand and giving information about options were common to the data set. Nurses’ descriptions were, however, more limited and focused on providing information about the infant’s condition and treatment. For example, “*I just chatted through the processes that happen with babies, with her baby’s condition and the sorts of set backs that we expect with regards to breastfeeding against enteral feeding or tube feeding* (Nurse 10). For nurses there was a particular focus on providing information around ‘breastfeeding’. The following comment is reflective of many “*it was her first time and just explaining to her how, the right way to breastfeed and attachment and things like that* (Nurse 9)”. 
Given the importance of information sharing it is perhaps not surprising that a perception of not receiving information was considered problematic. Both parents and nurses alike recognised how a lack of information could negatively affect their interactions. The most difficult and distressing situation for parents was when they perceived nurses were not sharing information about their infant’s status and/or how to physically provide hands on care to their baby.

Yeah, I think the nurse was worried about the whole touching and whatnot ... Like she’s very full on with protocol but she was very abrupt and didn’t explain things. So she upset mum and this upset me a bit too (Metropolitan father 26)

What had the potential to make this worse was when parents received inconsistent information and advice from a range of different nurses. As one mother stated; ‘Everybody had a different point of view but they were opinions, not facts. So that was huge, don’t even get me started on that, that was just a nightmare. (Regional mother 6)’. Parents also spoke about having trouble engaging nurses to get information regarding infant care and their infant’s condition. Implicit in parents’ description was the expectation or desire for nurses to initiate communication.

Although nurses acknowledged to some degree how a lack of information from them might affect parents they also talked about the difficulties of communicating with parents who had not been informed about, or were inadequately prepared for, changes to their infant’s care. While there were a number of examples in the data set perhaps the extract from one nurse’s interview demonstrates this best;

She rang the previous room, and they told her, “Well, your baby’s not here anymore,” so they put her through to my room, I got the phone call, to me and she was like, well, just a bit cranky at the fact her baby had been moved without any prior knowledge to it, and I coped a brunt of it (Nurse 13)

Enabling my/their parenting. Both parents and nurses talked about enabling interactions where the focus was on both developing parental competence and giving authority to parents to parent. However, there was a difference between the two. For parents
enabling was about the nurse’s ability to be able to ‘explain, demonstrate and assist’ them to actively participate and undertake the care of their baby. As one mother said;

‘so just their being there and saying, “Yeah, that’s right and you do this now” or whatever else and I appreciated the demonstration ones that they would do first, before the next time they watch you and help you do it. So they were very patient’.  
(Metropolitan mother 12)

Furthermore, reassurance and encouragement from nurses enabled parenting.  For a small number of parents effective ‘enabling’ also included the nurses’ ability and/or willingness to respect and encourage parent led decisions around the care of their baby.

They’d say “Well at the end of the day go with your feelings of what, if you feel she’s feeding really well when you do a certain thing, then keep doing it and if you do something else it and doesn’t work, then stop doing it.”... “You will know best because you just know how it works with your new baby.”  
(Metropolitan mother 22)

Nurses also verbalised the importance of making parents feel positive about their ability to provide direct care to their infant. There was a genuine desire to assist parents to ‘parent’ and to make sure they were left feeling positive about doing the activity again or ‘tying’ again. Two nurses discussed possible differences between mothers and fathers stating men often ‘required more encouragement’ than mothers to be involved in caring for their baby.

For the most part the examples nurses provided around this concept of enabling parenting related to breastfeeding, similar to their descriptions of giving information focusing on breastfeeding.

We went through from start to finish any questions she had. We ran through a breastfeed, we had all the props out, and just with the use of the props and things it was a bit easier ...It actually worked out really, really well. After that, we got the baby to breastfeed beautifully and it was nice  
(Nurse 14)

Sometimes the feeding hasn’t gone very well, you know, but everybody walks away still at the end of the day feeling good and you can give people positives to hang onto, to come back with the next day to try again  
(Nurse 5)

Nurses, also talked more than parents about ‘enabling’ decision making; ‘So it's just about giving them lots of options and supporting them to make the choice that’s right for them  
(Nurse 6)’. However, a key difference between nurses in their accounts, which could create
difficulties for parents, was that some nurses regarded effective communication to be parents undertaking infant care activities as dictated to them by nurses; ‘she was willing to take all the information and she was – that was a really good conversation ‘cause she agreed with what we’re trying to do (Nurse 7). This conflicted with the approach of other nurses described above where parents were encouraged to participate in and make their own decisions.

When mothers and fathers perceived that nurses were not fully engaged in ‘helping’ them with their parenting role they became disaffected and dissatisfied. Working in a ‘harmonious’ way with nurses was challenging for parents when they perceived nurses to be ‘controlling’ and always ‘dictating’ to them what they could or could not do. For example one parent said “some nurses where they’re suggesting you to do something and you don’t feel comfortable with doing (Metropolitan mother 7 describing breastfeeding)”.

Similarly, ineffective interactions occurred when parents felt ‘unheard’ and ‘dismissed’, perceiving nurses to be unresponsive to their needs. Parents gave examples of not being able to ‘ask for help’ and of struggling to initiate effective communication with nurses.

I asked “Can you come?” ‘Cause they had to check that it’s down the right tube, .... And she didn’t come and do it and I had to go and get her and say, “Can you help me?” ‘Cause I’m not allowed to do it by myself. And then she was talking and it took her 5 minutes to finish her conversation with the other nurse, and it wasn’t a nurse related conversation it was just a casual conversation ...Like I felt a bit (sic) she wasn’t their priority. (Regional mother 4)

These situations could be made worse when nurses were not communicating with each other.

Can you please write on her chart that Nuk teat went really well?” Well she comes along and she just wrote here, “Using Nuk teat.” Okay, so then I added on, “Went really well” but then I come in the next day and there’s a different teat altogether in her thing, and I thought that’s, that’s ... that’s wrong. .... whether or not they get the time to tell each other every little thing or, but I mean, but then if it’s written in the chart (Regional mother 8)
In addition, parents commonly described situations where they felt ‘pressured’ to carry out a care activity in a particular way even though they may have voiced their disagreement. In this situation mothers often used examples related to breastfeeding; *some nurses where they’re suggesting you to do something and you don’t feel comfortable with doing* (Metropolitan mother 7 describing breastfeeding).

For nurses poor or ineffective communication about enabling parenting resulted, for the most part, from situations where they considered parent actions to be unhelpful or in direct opposition to what they considered was in the best interests of the baby. Sometimes nurses subsequently recognised how their interactions had negatively affected the parent but mostly they did not. The episode described was not uncommon in the data set.

*She (the mother) rang on the phone to say was the baby due for a feed. And I said, “Oh as a matter of fact I’ve just fed him and I’ve just put him down and got him to sleep.” She said, “Oh I will be there in about 20 minutes.” And I said, “Well there’s probably not a lot of point because he’s just had a feed and just gone to sleep,” ... She just said, “Yeah good bye.” The next day when I came to work ... this mother had rung up and made a complaint about me ... I just thought, “Oh my gosh” I was just shattered* (Nurse 5)

**Being mindful: the importance of a supportive interpersonal communication style.** Both parents and nurses talked about the importance of nurses using language that demonstrated ‘kindness’ ‘sensitivity’ and ‘genuine respect’ for parents. Nurses who ‘listened’ and were ‘empathic’ were highly valued. Parents also used words such as ‘friendly’ ‘approachable’ and ‘caring’ to describe the communication style of supportive nurses; *I just felt she had a way with words and made me feel really safe* (Regional Mother 4). Nurses who ‘chatted’ and conveyed a sense of partnership and equality were also frequently mentioned as supportive. Parents valued nurses who made an effort to ‘get to know them’, who had the ability to make them feel ‘normal’ and who were able to engage in conversations that recognised that there was ‘life outside’ the nursery; *so you don’t necessarily want to always be asking questions and getting information, so there is general chitchat which is really nice*
and it’s a relief. (Metropolitan Mother 5). Conversely parents used negative examples to demonstrate the positive; You’re not patronised, you’re not made to feel silly (Regional Mother 6).

Like parents, nurses talked about the importance of using a communication style that could demonstrate connection and compassion. Building relationships with parents was paramount; I have been nursing for a while now, the most important thing you would do with any patient; whether it a baby, whether it an adult, you build up a rapport (Nurse 12)

The opposite of the supportive interpersonal communication was one that reflected ‘judgement’ and ‘aggression’ and was always targeted towards the other. At times parents talked about being made to feel ‘stupid’ and ‘incompetent’. One mother provided an example of what she believed was discrimination to demonstrate ineffective communication.

“I was too old to have a child,” “I’m way too old to have a partner as young as xx,” “What business were we doing having a baby together?” All of these things have been said to my face and behind my back but within earshot (Regional mother 4).

Nurses similarly talked about parents who were defensive, aggressive or stressed. They related this to the different ways parents cope.

“I guess it was quite hard to have an easy conversation with them and explain things; they were quite defensive and quite angry and quite stressed….. Some people’s coping method is to be quite aggressive” (Nurse 4)

Nurses also spoke about the challenges of communicating with particular sub-groups of parents, including younger mothers, drug affected mothers and mothers from different cultural or ethnic groups. There was also some evidence of stereotyping in their comments.

I think your very young mothers, very hard to talk to because they’re babies and they don’t understand, they see us more as a authority figure as in someone that could be their friend, and be helpful …..But I think sometimes some of the Aboriginal Community can also be hard to talk to. I think that’s just their environment that they’ve been bought up in (Nurse 3)

Nursery ‘rules’ and ‘regulations’. This theme was developed from participant data that asked for examples of ‘ineffective’ communication. How nursery ‘policies’ and
‘procedures’ were enacted in the nursery environment was mentioned by both parents and nurses. Parents commonly described two distinct situations. One was where nursery ‘rules’ were enforced without due consideration to the context of the situation. The second was the situation where parents perceived the policy to be disregarded without explanation. This created ‘confusion’, ‘frustration’ and at times ‘conflict’. For example, one woman requested that her friend be able to come into the nursery and hold her baby. The woman had no family members in Australia and her friend was the only person providing support. The nurse caring for her baby refused her request on the grounds that the unit had a ‘policy’ that only parents and grandparents could hold the baby. This created distress and conflict. Another woman described a similar situation stating; *I spoke to the nurses and asked permission for that to happen and was told quite sharply by one nurse that that wasn’t the policy and that wouldn’t be happening* (Metropolitan mother 18).

Inconsistency in the enacting of policies and practice was equally unsettling for parents. Most parents could provide examples with one woman saying; *It happens, that happens quite a bit. Yeah, whether some nurses don’t follow up on it or not, I don’t know, or whether you get casual nurses in and they don’t understand the policies and let them* (Metropolitan mother 17)

Nurses also described how their role in ensuring policies and procedures were followed had the potential to contribute to ineffective or poor communication between parents and nurses. They recognised how frustrating it must be for parents when ‘policy directives’ are applied inconsistently. Nurses could appreciate how a parent might get upset but generally they felt parents did not appreciate the importance of the policies; *A lot of them don’t understand, they don’t like having the policy and they don’t want, it frustrates them ... I just say okay do you mind if we do it this way because it's the policy* (Nurse 6).
Overall, both parents and nurses recognised that effective communication could reduce parents’ stress and ineffective communication increased parents’ stress. Where nurses and parents differed, however, was the extent to which nurses’ communication affected parenting. Mothers and fathers emphasized the importance of reassurance from the nurse as a main contributing factor to their confidence in parenting, including normalising the parent’s emotional response, encouraging and praising the parent’s efforts to care for their baby, and emphasising the importance of the parent’s contribution. Nurses’ accounts showed much less recognition of the impact of their communication on parenting.

**Discussion**

This study explored nurses’ and parents’ perceptions of effective and ineffective communication patterns in the special care nursery environment. Overall, the same themes were identified in parents’ and nurses’ descriptions of effective communication: information provision, enabling parenting and the interpersonal style of nurses. At the same time there were subtle differences between parents and nurses in how they described each theme, which could impact negatively on parents. As has been previously demonstrated, parents valued information about all aspects of infant care, their infant’s condition and the functioning of the nursery (Fenwick et al., 2001b; Guillaume et al 2013; Jones et al., 2007). Moreover, parents relied on nurses for ‘sensemaking’ in the nursery, including normalising their situation. Parents also described how nurses enabled them to parent through modelling, support and encouragement. Effective communication promoted their parental engagement in the nursery environment. The findings of this study are consistent with the work of Reis et al.’s (2010) who found that parents identified and valued nurses as teachers, guardians and facilitators. Mothers and fathers were consistent in their perceptions of communication patterns, however, fathers, as others have found, typically focused initially on the importance of information.
being readily exchanged and shared (Arockiasamy, Holst, & Albersheim, 2008; Jones et al., 2007).

Although nurses also described effective communication as involving information provision and enabling parenting, there were subtle differences in their descriptions. Nurses were much more likely to focus on breastfeeding and the infant’s condition. The emphasis by nurses on providing information on breastfeeding likely reflects the prioritisation of breastfeeding at both a local and international level, with the metropolitan hospital accredited as a Baby Friendly Hospital (WHO/UNICEF, 2009). Similarly nurses emphasised the ‘enabling’ of breastfeeding over other aspects of infant care. This primary focus on breastfeeding has the potential to be a source of conflict within the nursery when a mother chooses not to breastfeed or experiences difficulties/is unable to breastfeed, yet support from professionals is regarded as an important aspect of the establishment of breastfeeding (Hauck, Fenwick, Dhaliwal, & Butt, 2011). The focus on breastfeeding may also mean a lack of attention or support by nurses for other aspects of infant care. In combination with our finding that nurses have a low awareness of the effect they can have on parents’ confidence, the focus on breastfeeding may have a significant negative impact on parents. This difference between parents and nurses in the focus of communication has not previously been identified in the literature.

The findings of our study showed both similarities and differences in how parents and nurses considered a partnership should be enacted. Effective interpersonal communication styles were important here. From a parent’s perceptive nurses who were friendly, empathic and able to engage parents in social interactions that reflected ‘equality’ were highly valued. Our findings resonate strongly with the early work of Fenwick et al. (2001a,b), who identified the different facets of both facilitative and inhibitive nursing actions on mothering in the special care nursery. A unique finding of their early work was the importance mothers
placed on a nurse’s ability to be able to use ‘social interaction’ (for example chatting) to engage with mothers. More recently, Guillaume et al. (2013) similarly described parents’ expectations that nurses communicate with an attitude that is caring and humane. In the current study the ability to share life experiences outside the nursery was instrumental in building positive nurse-mother relationships, which in turn facilitated a parent’s ability to develop confidence, competence and a sense of connection with their baby.

Nurses need to be aware of the difficulties that parents have initiating communication with nurses, as well as parents’ desire for communication that is open and respects that the parents are the most important people in the infant’s life. It is vital that parents do not feel “patronised” or “made to feel like an idiot” as was apparent in the current study. The neonatal nursery is an unfamiliar and stressful environment for parents (Franck, Cox, Allen, & Winter, 2005; Miles, 1989) and parents value nurses’ ability to socialise them to the unit including actions and interactions that normalise the situation. The challenge for nurses is that both parents and nurses position nurses as responsible for the development and maintenance of the parent-nurse relationship. Yet at the same time, nurses’ communication needs to facilitate equality, as FCC situates the parent as the most important person in the infant’s life, and thus care team, whereby FCC enables a partnership between parents and nurses (Griffin, 2006). The “power struggle” between nurses and parents has been described by several researchers (see Cleveland, 2008 for a review), yet it was parents, not nurses, in the current study who identified this struggle. The negotiation of power relations is always a difficult task but potentially more so within the emotionally charged context of the neonatal nursery where organisational structures and policies may be counterproductive to providing care that is flexible and tailored to individual parent needs. Indeed, some nurses in Trajkovski, Schmied, Vickers and Jackson’s (2012) study questioned whether a partnership is even possible. It may be a challenge both to increase nurses’ understanding of, and enhance their skills in
negotiating, the complex dynamics of communication between nurses and parents (Watson, Hewett, Gallois, & Jones, 2012). Moreover, such training needs to include recognition that parents are negotiating this complex relationship with multiple nurses.

In this study the policies and procedures of the special care nursery, sometimes interpreted by parents as ‘rules and regulations’, were a frequent area of communication conflict. The potential conflict created between adhering to policies whilst attempting to enact FCC has received insufficient attention. In particular, nurses are required to consider the needs of all babies within the nursery and have previously been found to regard themselves as “protectors of the infant” (Lupton & Fenwick, 2001, p. 1017). This can create tension for nurses as they attempt to enforce policies which protect babies within the nursery (e.g., not visiting when sick, following hand washing and gown procedures) but may negatively impact on the individual parent’s wellbeing. Managing this complex situation requires well developed communication skills by nurses who can be directive but also supportive to parents. On the other hand, parents found particularly challenging managing inconsistent practices by different nurses in terms of both decision-making about infant care and enforcement of policies, exacerbated by inconsistent information. Managing such a situation tests the communication skills of both parents and nurses, particularly given the power difference between parents and nurses. Nursery staff should also periodically review policies involving parents, such as contact with visitors, to determine which policies need to be consistently implemented in the same manner by all staff and which may be implemented in a more flexible manner reflecting FCC principles that acknowledge family differences in needs and roles. It is noteworthy that it was parents, not nurses, questioning the current policies or rules in the nurseries, showing how the culture of a nursery may become embedded and taken for granted (Alvesson, 2011).

Limitations
There are some limitations to this study which provide direction for future research. First, this study did not evaluate how the particular point in the parent’s journey (e.g., soon after admission versus close to discharge) impacted their perception of communication with nurses. Longitudinal research may determine how parent’s perceptions and needs change throughout their journey. Additionally, further research is required to explore potential differences between the perceptions of mothers and fathers, due to the limited number of fathers who participated in this study. Researchers should also explore how parental demographic factors (e.g., having other children) and membership of particular social groups (e.g., cultural background) may impact upon nurse-parent communication. For example, Sheeran, Jones, & Rowe (2013) identified particular difficulties adolescent mothers experience in interacting with nurses in special care nurseries and our own findings suggest nurses experience communication with particular sub-groups of parents as more challenging. However, a strength of this study is the focus on nurses’ perceptions of both their communication and relationship with parents, although a limitation is that we were only able to recruit nurses from the metropolitan hospital. Future work should include this perspective, because nurses and parents did differ in their perceptions of communication between them, in ways that may impact parenting and parental wellbeing. Such research should include nurses from more diverse settings (such as regional hospitals) to identify whether practice setting affects nurses’ perceptions.

Conclusion

The findings of this study provided specific descriptions of parents’ and nurses’ perceptions of nurse-parent communication. Provision of information and enabling parenting were central to effective communication, supported by an appropriate interpersonal style by nurses that facilitated the development of a relationship with parents. Yet parents and nurses differed in their perceptions of what information should be provided, as well as the scope of what
enabling parenting involved. While both parents and nurses situated nurses as more responsible for the development and maintenance of their relationship each was focused on the other’s interpersonal style as creating difficulties rather than their own. More systemic issues around policy implementation were also acknowledged by both as contributing to difficulties in their communication. The findings highlight the differing expectations and foci of parents and nurses that may create sources of tension and dissatisfaction. Overall, the results highlight the important role of nurses in not only caring for the infant but also supporting the psychosocial functioning of parents and their ability to parent.
References


expectations of staff in the early bonding process with their premature babies in the intensive care setting: a qualitative multicenter study with 60 parents. *BMC Pediatrics*, 13(18), 9. doi: http://www.biomedcentral.com/1471-2431/13/18


