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The impact of a father's presence during newborn resuscitation: a qualitative interview study with healthcare professionals

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ABSTRACT

Objective: To explore healthcare professionals' experiences around the time of newborn resuscitation in the delivery room, when the baby's father was present.

Design: A qualitative descriptive, retrospective design using the critical incident approach. Tape-recorded semistructured interviews were undertaken with healthcare professionals involved in newborn resuscitation. Participants recalled resuscitation events when the baby's father was present. They described what happened and how those present, including the father, responded. They also reflected upon the impact of the resuscitation and the father's presence on themselves. Participant responses were analysed using thematic analysis.

Setting: A large teaching hospital in the UK.

Participants: Purposive sampling was utilised. It was anticipated that 35–40 participants would be recruited. Forty-nine potential participants were invited to take part. The final sample consisted of 37 participants including midwives, obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses and paediatricians.

Results: Four themes were identified: 'whose role?' 'saying and doing' 'teamwork' and 'impact on me'. While no-one was delegated to support the father during the resuscitation, midwives and anaesthetists most commonly took on this role. Participants felt the midwife was the most appropriate person to support fathers. All healthcare professional groups said they often did not know what to say to fathers during prolonged resuscitation. Teamwork was felt to be of benefit to all concerned, including the father. Some paediatricians described their discomfort when fathers came to the resuscitaire. None of the participants had received education and training specifically on supporting fathers during newborn resuscitation.

Conclusions: This is the first known study to specifically explore the experiences of healthcare professionals of the father's presence during newborn resuscitation. The findings suggest the need for more focused training about supporting fathers. There is also scope for service providers to consider ways in which fathers can be supported more readily during newborn resuscitation.

ARTICLE SUMMARY

Article focus

- The research question for this study was; 'What are the experiences of healthcare professionals of the father's presence during newborn resuscitation in the delivery room?' To address this question, the objectives of this phase of the study were
  - To conduct interviews utilising the critical incident approach with healthcare professionals (HCPs) who had experience of newborn resuscitation when the baby's father was present.
  - To provide an account of the experiences of HCPs of newborn resuscitation when the baby's father was present.

Key messages

The key messages and significance of the study are

- While the HCPs were aware of the information and support needs of fathers during newborn resuscitation, they acknowledged that these needs were rarely met.
- The HCPs in this study had not received education and training specifically about supporting fathers during newborn resuscitation.
- The HCPs in this study did not utilise strategies to support fathers that are recommended when relatives are present during resuscitation events in other critical care settings.

INTRODUCTION

The birth of their child is often a landmark event for a father and can be an important episode in the on-going process of adaptation to parenthood. Short-term and more longer term benefits of a father's involvement in the life of his child have been described which can impact on the father, his partner, his baby and society more generally.[1–3] As a consequence there has been a drive in the UK over the last 10 years to engage and involve fathers more readily,

ARTICLE SUMMARY

Strengths and limitations of this study

- Although undertaken in one setting, the findings from this independent study provide insight to the experiences and perceptions of HCPs and the context in which the resuscitation events occurred.
- The critical incident approach was generally an appropriate way to explore HCPs' experiences of specific events. This approach enabled many of them to consider the impact of newborn resuscitation on fathers for the first time.
- Some participants found focusing on issues pertaining to the father more difficult and sometimes talked about the mother or the parents collectively. However, subsequent probing questions encouraged them to concentrate on the father.
- Some participants chose to describe events that occurred a while ago. It is therefore difficult to determine the extent to which recall bias influenced their descriptions. However, they appeared to have no difficulty remembering their feelings or what happened. They were often surprised at how clearly they could recall the event.
- Incidents where the baby did not survive were not described. HCPs may have thought the researchers were only interested in events where the baby survived, although this was not stated by the interviewer. Alternatively, they may have deliberately elected not to recall an incident that they thought might be too sensitive or potentially controversial to discuss.
- While the preliminary data analysis was undertaken by the first author, the thematic framework was discussed with the second author as it was developed and the final framework was agreed by both authors.
- Given the qualitative nature of this study, it is inappropriate to generalise the findings to the wider population. However, in accordance with the notion of transferability, the findings of this study have highlighted issues that may be of relevance in other settings.

particularly during the perinatal period and during childbirth specifically.[4–6] However, in order to ensure that fathers are appropriately supported during the perinatal period, it is important that healthcare professionals (HCPs) have insight to fathers' experiences and needs.

While for the majority of men childbirth is straightforward, for others it is not.

When a newborn baby requires resuscitation in the UK settings, the father will usually be present because most fathers attend the birth of their baby and delivery and resuscitation generally take place in the same room.[7–9] While some studies have investigated the impact of parental presence on HCPs during neonatal resuscitation in the neonatal unit (NNU)[10 11]; the father's presence during newborn resuscitation in the delivery room has only been reported in terms of the impact on the father.[12]

The experiences of HCPs in the presence of a relative during the resuscitation of a family member have been investigated in settings such as adult and paediatric intensive care and accident and emergency.[13–15] Early 'witnessed resuscitation' (WR) research identified that many HCPs were not supportive of this approach.[16] They were concerned that relatives would be unduly distressed or would be at risk of physical harm due to the nature of the environment. HCPs also felt WR would impinge on themselves and their practice in a negative way.[14 17 18] However, despite some initial opposition, most HCPs now embrace the concept of WR and it has become an accepted practice in many Western countries over the last two decades. This reflects a generally more open and inclusive approach to healthcare and recognition of the need to deliver family-centred care.[19 20]

The feelings and perceptions of HCPs' experiences and perceptions of the father's presence during newborn resuscitation in the delivery room do not appear to have been previously investigated. The aim of this part of a wider study[12] was to gain a broader understanding of fathers' experiences through HCPs' accounts of episodes of care. Participants also reflected on the ways in which the father's presence impacted on themselves and their practice. This paper focuses on the findings pertaining to the experiences of HCPs of a father's presence during newborn resuscitation.

METHOD

A qualitative descriptive, retrospective design was utilised using the critical incident approach.[21]

Participants

Purposive sampling was utilised to recruit participants from one large teaching hospital in the UK. It was anticipated that 35–40 participants would be required to obtain descriptions of a range of scenarios. Therefore recruitment, data collection and analysis were carried out concurrently until data saturation was achieved. The only inclusion criterion was that the HCP had experience of neonatal resuscitation in the delivery room when the baby's father was present. No exclusion criteria were identified. Participants were recruited using a range of strategies: posters inviting HCPs to take part were displayed in various locations within the maternity unit and NNU; HCP meetings were attended to discuss the study and information leaflets were distributed in the delivery suite and NNU. Some participants also recommended other HCPs. In accordance with the critical incident approach,[21] recruitment continued until a range of HCPs who had encountered a variety of experiences was recruited.[22]

Forty-nine HCPs were approached about or volunteered to take part in the study. Six HCPs subsequently decided not to take part (2 midwives and 4 neonatal nurses). Another six said they would participate but staff shortages and workload issues meant that the interview did not take place (2 midwives, 2 neonatal nurses, 1 paediatrician and 1 obstetrician). The final sample consisted of 37 HCPs including midwives, obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses and paediatricians. The sample included

participants with diverse clinical backgrounds and experience[23] (table 1). The participants were from a range of ethnic backgrounds corresponding to the main groups represented in the study site's local population. Details regarding the participants' ages and ethnicity have not been included to safeguard participant anonymity. Neonatal nurses were recruited because this part of the study also explored HCPs' experiences of the father's first visit to his baby on the NNU (not reported here). All the neonatal nurses who participated in this phase of the study, regularly attended delivery suite to support other staff during newborn resuscitation.

Interviews

Semistructured, qualitative interviews were undertaken using Flanagan's critical incident approach.[21] Participants were asked to select an incident involving newborn resuscitation in the delivery room when they and the baby's father had been present. The intention was to explore the HCP's interpretation of the father's experience. Participants described what happened and how those present, particularly the father, responded.[22 24] Some chose to describe incidents that had occurred within the previous week, while others selected events that had occurred several months ago. The interviewer (MH) used key questions and follow-up questions to facilitate the description of events and to explore HCP perceptions and feelings. The use of the follow-up or probing questions varied according to the participant's initial response. In some instances HCPs began by talking about the mother or the parents collectively. However, subsequent probing questions encouraged them to focus their account on the father. This flexible approach enabled HCPs to describe what happened and their feelings in their own words.[25 26] In order to ensure a range of scenarios were explored, participants were asked to describe two contrasting incidents.[27 28] The interviews ranged between 22 and 78 min (mean 48 min). Participants were interviewed in a private room within the Hospital. Most of the interviews took place on weekday afternoons within the HCP's working day. With participant informed consent, the interviews were tape-recorded to enable verbatim transcription and data analysis. Five HCPs (midwives and neonatal nurses) cried as they recalled the resuscitation and on two occasions, the recording was temporarily stopped. At the end of the interview, all participants were given a debriefing sheet identifying possible sources of support. In accordance with qualitative methods; data collection, transcription and data analysis were carried out concurrently.[26 29] The study was approved by the Solihull Local Research Ethics Committee (05/Q2706/104). University and trust approvals were also obtained. All participants gave informed consent immediately before the interview.

Analysis

The first author transcribed the interviews and undertook preliminary data analysis. The transcriptions were read and reread in order to facilitate understanding. Thematic analysis was then undertaken whereby the first transcript was coded into themes. Subsequent transcripts were then analysed and additional themes or subthemes were generated when the data captured something new. The software package 'NVivo 7' was used to facilitate this process as it enables the researcher to identify relationships between the themes.[30] During this stage, the development of the thematic framework was undertaken in consultation with the second author. Data collection continued until no new themes were identified during data analysis (data saturation).[25 31] The thematic framework was then reviewed and revised by both authors until the final framework was agreed.

RESULTS

Analysis of the data generated four themes, each of which contained subthemes: 'whose role?' 'saying and doing,' 'teamwork' and 'impact on me.' These themes are described and illustrated with a direct quotation that represents the participants' responses. While the focus of the study was the experiences of fathers, a range of quotes have been utilised to demonstrate the extent to which participants also referred to the parents or the mother.

Table 1 Participant biographical details

HCP group	No.	Sex	Time from initial qualification (years)	Length of time in current post
Midwives	12	Female*	1–29	6 months–5 years
Neonatal nurses	10	Female*	2–32	6 months–23 years
Neonatal nurse practitioners	2	Female*	7–19	6 months–7 years
Obstetricians	3	Female	9–22	1–6 years
Anaesthetists	4	2 Female 2 Male	6–16	1–6 years
Paediatrician	6	1 Female 5 male	2–33	2.5 months–18 years

*No males were employed in this role during the period of recruitment.
HCP, healthcare professional.

Whose role?

This theme focuses on whose role it was to support the father during and after the resuscitation. In the events described no-one exclusively took on these roles and no-one was delegated to do so. This was because HCP attention was focused on delivering care to the mother and/or baby (table 2–2.1). While representatives of all HCP groups felt the midwife was the most appropriate person to support and communicate with the father, they acknowledged that she had other responsibilities at the time (table 2–2.2). Verbal communication with the parents during the resuscitation was in most cases directed towards the mother. Participants thought this was appropriate because unlike the father, most mothers could not see what was happening. In addition, HCPs believed that fathers could hear what was being said. Consequently, fathers received limited direct information and support and this was generally only given on an 'ad hoc' basis.

Any information that was given to fathers during the resuscitation was usually provided by an anaesthetist or midwife. This was most commonly general information because they did not feel it was their responsibility to give more detail at this time. On occasions when the resuscitation was prolonged neonatal nurses sometimes described going over to the parents/mother to explain what was happening when the baby's condition had been stabilised (table 2–2.3). Once resuscitation was completed some babies required NNU admission while others remained with their parents. Paediatricians, neonatal nurse practitioners and neonatal nurses described speaking to the parents at this time. However, midwives also recalled advocating for parents by prompting paediatricians to speak to parents before they left the delivery room.

All HCP groups discussed whether they debriefed the fathers after the resuscitation. Most midwives described attempting to speak to the father by himself to explain what had happened and correct misunderstandings. However, in many instances this was not possible because of other demands or lack of opportunity. Anaesthetists and obstetricians did not feel it was part of their role to debrief fathers and although paediatricians, neonatal nurse practitioners and neonatal nurses recalled instances when they had done this, the discussion was usually initiated by the father days or weeks later, when the baby was being cared for in the NNU. Many of the participants were reluctant to get involved in these discussions particularly neonatal nurses who had been present during the resuscitation (table 2–2.4). They felt uncomfortable discussing events particularly if they thought the father would become distressed. They were also concerned about being asked questions they could not answer.

Almost all participants were aware that other specialties have implemented WR strategies to support relatives who are present during the resuscitation of a family member. While participants felt that these strategies would be of benefit to fathers, they felt these were unlikely to be implemented due to staff shortages and a lack of resources (table 2–2.5).

Table 2 Whose role?

2.1	"My main focus is the mother. I think that's, I think it's important to understand that because the mother's my patient, the father's not my patient." (Anaesthetist14)
2.2	"When the baby was born and she needed resuscitating, he ran out the room crying. I felt like I should have ran after him really which I couldn't at the time because I was trying to like stop her ((the mother)) from bleeding. So it was difficult but I did think, oh my God." (Midwife9)
2.3	"I at that time, I could not speak to dad because we, our priority was the baby and baby needed intubating. Once that was done I was able to then go and speak to mum just to give her brief information of what was going on, how the baby was." (NeonatalNurse1)
2.4	"It's not my place, just in case he asked me sensitive questions that I'm not able to answer. It's very difficult in that situation especially if you've got a very sick baby. I would not take part in that at all." (NeonatalNurse5)
2.5	"There's no-one specifically to do that, unless we employed an extra member of staff just to look after the father, but we can't do that." (Anaesthetist13)

Saying and doing

This theme focuses on the HCPs' reflection on factors that influenced what they said to fathers and the ways they supported them during and after the resuscitation. Anaesthetists and midwives acknowledged that they usually only gave fathers general information during the resuscitation because they were uncertain what was happening or how the baby was responding. However, they tried to say something positive such as commenting on the amount or colour of the baby's hair.

When paediatricians, neonatal nurse practitioners and neonatal nurses spoke to parents after the resuscitation the information given varied, ranging from detailed information to a more general summary of events. Needing to get the baby to the NNU as quickly as possible appeared to influence the nature and extent of information given. Consequently, parents whose baby required more extensive resuscitation were often given the least amount of information.

Being able to draw on previous experience and background knowledge was felt to be invaluable. However, most participants had not received any education or training about communicating with fathers, either generally or in specific situations such as newborn resuscitation. HCPs in senior posts also said they did not address these issues when teaching juniors (table 3–3.1). Midwives who had trained more recently had received

Table 3 Saying and doing

3.1	"I don't think it's anything that anybody's spoken about and I suppose I don't really speak to the trainees who come through about it either." (Paediatrician16)
3.2	"I think my practice is probably based on what I've heard husbands and partners tell me and how they felt." (Midwife15)
3.3	"I have a series of horror stories of observing my consultant teachers in days of yore making a complete and utter hash of it. And I use that you know and I just, you just learn by thinking, right, if I live a thousand years, I will never do that." (Paediatrician15)
3.4	"I always say, speak to people how you would want to be spoken to. Treat them the way you want to be treated and just put yourself in their situation. You know, it's your partner, that's your baby and somebody's not even acknowledging that you're there, how would that make you feel?" (Obstetrician61)
3.5	"It was awful. No-one was saying anything and mum was crying. I was just thinking please, please somebody say something." (NeonatalNurse7)

some teaching about supporting fathers in general, but this was minimal. All HCPs felt their way of supporting and communicating with fathers had evolved through experience. Some midwives and anaesthetists felt they had become skilled at observing non-verbal cues portrayed by fathers and this enabled them to support them more effectively. Other HCPs drew on experience in related specialties, taking personal responsibility for their own learning, discussions with fathers and reflection on their practice (table 3–3.2).

In developing their ways of supporting and communicating with fathers, HCPs said they drew on two other elements: observing the practice of others and thinking about how they would like to be treated. They described learning from mentors, senior colleagues, their peers or junior staff, and recalled both positive and negative scenarios (table 3–3.3). Obstetricians often specifically mentioned learning good practice from midwives. Several HCPs used the phrase 'putting yourself in their shoes'. Female HCPs modified this approach to thinking about how they would like their partner to be treated (table 3–3.4). Despite the various strategies developed over time all HCP groups said they often did not know what to say to fathers during prolonged episodes of resuscitation (table 3–3.5).

Teamwork

When thinking about factors that may have impacted on the father's, participants identified the importance of effective teamwork and interprofessional working during the resuscitation. They felt that when the team worked well together, the situation was usually dealt with quickly and smoothly to the benefit of all concerned, including the father. Senior HCPs described having an 'instinctive' way of working with their colleagues such that verbal communication was not required. They described scenarios when those present spontaneously took on different roles and responsibilities assisting and supporting each other (table 4–4.1). Obstetricians and anaesthetists recalled distracting the father so that he could not see what was happening and for reducing the risk of him hindering the resuscitation in any way. This approach enabled their colleagues to focus on the resuscitation and none of the fathers intervened with the resuscitation in the incidents described. Anaesthetists also described assisting with the resuscitation, particularly when a junior paediatrician was having difficulty intubating the baby. Several midwives described responding to a crash call. They often took on the role of 'go-between,' relaying information between the neonatal and obstetric teams and the parents. The importance of senior HCPs supporting junior staff was also identified (table 4–4.2).

Impact on me

While the intention of this study was to explore the HCP's interpretation of the father's experience, the HCPs frequently reflected on the impact of the events they described on themselves. During the resuscitation, HCPs described trying to adopt a calm and self-assured manner regardless of how they were feeling. They hoped this attitude would be transmitted to the father and as a consequence, he would be comforted and reassured. Many midwives however, said it was difficult to adopt this approach and when recounting specific events described them as being 'awful', 'horrendous', 'terrible' and 'shocking'. In a less-extreme way, when they reflected on specific events, several midwives felt they should have done more to support the father (table 5–5.1).

Another issue some paediatricians and the neonatal nurse practitioners talked about was when the father approached the resuscitaire during the resuscitation. The neonatal nurse practitioners and some of the more

Table 4 Teamwork

4.1	"If I'm happy the mother's suturing is done and mum's not bleeding, mum's fine and everybody is working on the baby then I will stay and do whatever I can whether it's fetching for the paediatrician or whether it's staying and supporting mum and dad because the midwife's helping the paediatrician." (Obstetrician10)
4.2	"It's like yesterday the shoulder dystocia, the baby needed to be resuscitated. Me and the Shift Leader talked about it, like you know, you go over it like, oh that was awful and, oh he ((the father)) was crying, oh it was terrible and you just talk about it and then that helps you to kind of deal with what's happened." (Midwife9)

Table 5 Impact on me

5.1	"You try and support the fathers and meet their needs when it happens. I do have days where I go home deflated thinking I really wish I could have done more for him that day." (Midwife12)
5.2	"I don't mind it at all. I'm used to people watching what I do and I think he needs to see anyway." (NeonatalNursePractitioner14)
5.3	"I don't like it. Not because it's a worry to me it's just because I don't happen to like being watched when I'm working." (Paediatrician7)
5.4	"Yes. Even now, after all this time, there are some difficult deliveries and you want to, you share in all of that emotion and it's very easy to kind of get prickly eyes when the baby is ok." (Midwife7)

senior paediatricians were comfortable with this and felt it did not impact their practice in a negative way (table 5–5.2). Others however, felt uneasy being watched so closely and felt it placed additional stress on them in an already pressurised situation (table 5–5.3).

The HCPs rarely said the events they described had a positive impact on them. Their relief and satisfaction when all was well was usually implied rather than stated. This may be because in many cases, the busy nature of the care setting meant that they often quickly became involved in the care of other parents and babies with a limited opportunity to reflect on what had happened. Midwives were the only HCPs who described becoming emotional when the resuscitation was successful (table 5–5.4). This is probably because in most cases they had been directly involved in the couple's care during labour.

DISCUSSION

This is the first known reported study to explore the experiences and perceptions of HCPs involved in neonatal resuscitation in the delivery room when the baby's father was present. The interviews provide strong evidence of HCPs' perspectives of this type of scenario. Although all HCP groups said the fathers needed support and information during the resuscitation, it was acknowledged these needs were almost always unmet. This confirms a finding from an earlier phase of the broader study.[12] HCPs felt this was because their priorities at the time were the health of the baby and/or the mother, a view also shared by fathers in an earlier phase of this study.[12] Although HCPs thought the midwife was probably best placed to support the father, it was acknowledged that she had a duty of providing care to the mother and was often involved in her ongoing care. A key factor in the failure to meet the needs of fathers appeared to be that none of the professional groups involved had direct responsibility to support and communicate with him. It was frequently stated that 'he wasn't my patient' or 'that's not part of my role'.

Most HCPs were aware that in other care settings a designated HCP often supports relatives when they witness resuscitation events.[14 32 33] The role of the chaperone is to explain what is happening and to support, reassure and de-brief the relative. They can also intervene if the relative's behaviour becomes distracting.[20 32] This role is generally undertaken by a senior HCP, usually a nurse, who can provide appropriate information and support.[32] While the HCPs suggested a chaperone would be beneficial for fathers, it was felt staff shortages and lack of resources would prevent this from happening.

The HCPs identified a number of factors that could have added to what would have already been a difficult experience for fathers. These factors included a lack of direct information at key points and situations where fathers were excluded or marginalised. Many HCPs also described the impact of events on them and aspects they found difficult. An issue that frequently occurred was what to say during prolonged resuscitation. Experienced HCPs as well as those who had been working in the specialty for a short time identified this difficulty. The more acute distress displayed by midwives and neonatal nurses during the interviews was most common because they felt the situation was not handled well and they felt culpable to some extent. Obstetricians, anaesthetists and paediatricians were more 'matter-of-fact' about what happened and did not appear to feel responsible when a father's needs were not met. However, paediatricians described their discomfort when fathers came to the resuscitaire. This may indicate a lack of confidence in their ability or their recognition that the presence of the father can cause additional pressure at an already stressful time. This was explored in the earlier literature regarding WR in other care settings such as adult and paediatric intensive care and accident and emergency departments which report that HCPs felt WR would have a negative impact on them.[14 17 18] However, over time HCPs who have been exposed to WR have found ways to accommodate it in their practice.

Guidance about supporting parents in the delivery room is given in the recently updated European and UK newborn life-support training programmes, mainly in relation to communicating with parents before, during and after the event.[34 35] However, no specific guidance is given about ways to communicate with or ways to support the father. This would appear to be an area worthy of development given the lack of confidence that some HCPs expressed about communicating with fathers during resuscitation events, particularly when the resuscitation was prolonged.

Strengths and limitations

The study's strengths and limitations are acknowledged

- The critical incident approach was generally an appropriate way to explore HCPs' experiences of specific events. This approach enabled many of them to consider the impact of newborn resuscitation on fathers for the first time.

- Some participants found focusing on issues pertaining to the father more difficult and sometimes talked about the mother or the parents collectively. However, subsequent probing questions encouraged them to concentrate on the father.
- Some participants chose to describe events that occurred a while ago. It is therefore difficult to determine the extent to which recall bias influenced their descriptions. However, they appeared to have no difficulty remembering their feelings or what happened. They were often surprised at how clearly they could recall the event.
- Incidents where the baby did not survive were not described. HCPs may have thought the researchers were only interested in events where the baby survived, although this was not stated by the interviewer. Alternatively, they may have deliberately elected not to recall an incident that they thought might be too sensitive or potentially controversial to discuss.
- While the preliminary data analysis was undertaken by the first author, the thematic framework was discussed with the second author as it was developed and the final framework was agreed by both authors.

Although undertaken in one setting, the findings from this independent study provide insight to the experiences and perceptions of HCPs and the context in which the resuscitation events occurred.[25] Given the qualitative nature of this study, it is inappropriate to generalise the findings to the wider population. However, in accordance with the notion of transferability, the findings of this study have highlighted issues that may be of relevance in other settings.[23] To gain a broader view of HCPs' experiences and the longer term impact, this study could be replicated with larger groups of HCPs. It would also be valuable to explore the experiences of HCPs where the baby did not survive the resuscitation. Although such a study would present challenges, it would have the potential to provide insight to situations that could have profound and possibly long-lasting effects on HCPs. This in turn could influence the provision of HCP education, training and support in the future.

Implications for practice

To some extent newborn resuscitation is part of the normal working day for many HCPs involved in perinatal care. However, some midwives and neonatal nurses became distressed when discussing events some of which occurred some time ago and yet remained a strong memory. This suggests that there is a need for greater recognition of the impact of resuscitation events on HCPs. The provision of opportunities for formal and informal reflection on practice, debriefing and support could be more extensive.

The HCPs were generally aware of the needs of fathers during and after newborn resuscitation. However, a number of difficulties and challenges affected how they supported and communicated with fathers. While there is increasing evidence pertaining to the needs of fathers, in maternity care, HCPs generally focus on the needs of mothers and babies[36]; duty of care and professional responsibilities determine this. Nevertheless, it would appear that there is scope for much more extensive HCP education and training about supporting and communicating with fathers around the time of newborn resuscitation. The allocation of resources to support the provision of a chaperone for fathers during resuscitation would also be worthy of consideration by service providers.[14 20]

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Contributors MEH developed and designed the research proposal, negotiated access to the study-site, obtained the required approvals, recruited participants, conducted the interviews, undertook the data analysis and wrote the first draft of this paper. Professor HMP supervised MEH throughout the study, reviewed and agreed the coding framework, contributed to and agreed upon the final version of the paper. MEH is the guarantor.

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Competing interests None.

Patient consent Obtained.

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