

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 study¹² 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 experience²³ (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).

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 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)

Table 3 Saying and doing

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| 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

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| 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 babies³⁶; 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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Competing interests None.

Patient consent Obtained.

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REFERENCES

1. World Health Organization. *Fatherhood and health outcomes in Europe*. Copenhagen: World Health Organization, 2007.
2. Klaus MH, Kennell JH. *Parent-infant bonding*. 2nd edn. St. Louis, MO: CV Mosby, 1982.
3. Ramchandani P, Stein A, Evans J, *et al*. Paternal depression in the postnatal period and child development: a prospective population study. *Lancet* 2005;365:2201–5.
4. Department of Health, Department for Education and Skills. *National service framework for children, young people and maternity services—maternity*. London: Department of Health, 2004.
5. Burgess A. *Maternal and infant health in the perinatal period: the father's role*. Abergavenny: The Fatherhood Institute, 2008.
6. Shribman S. *Making it better: for mother and baby*. London: Department of Health, 2007.
7. Kiernan K, Smith K. Unmarried parenthood: new insights from the millennium cohort study. *Popul Trends* 2003;26–33.
8. TNS System Three. *NHS maternity services quantitative research*. Edinburgh: TNS System Three, 2005:44–57.
9. Murthy V, Rao N, Fox GF, *et al*. Survey of UK newborn resuscitation practices. *Arch Dis Child Fetal Neonatal Ed* 2012;97:F154–5.
10. Fulbrook P, Latour JM, Albarra JW. Paediatric critical care nurses' attitudes and experiences of parental presence during cardiorespiratory resuscitation: a European survey. *Int J Nurs Stud* 2007;44:1238–49.
11. Perry SE. Support for parents witnessing resuscitation: nurse perspectives. *Paed Nurs* 2009;21:26–31.
12. Harvey ME, Pattison HM. Being there: a qualitative interview study with fathers present during the resuscitation of their baby at delivery. *Arch Dis Child Fetal Neonatal Ed* 2012;97:F439–43.
13. Sacchetti A, Carraccio C, Leva E, *et al*. Acceptance of family member presence during pediatric resuscitations in the emergency

- department: effects of personal experience. *Pediatr Emerg Care* 2000;16:85–7.
14. Grice AS, Picton P, Deakin CDS. Study examining attitudes of staff, paediatrics and relatives to witnessed resuscitation in adult intensive care units. *Br J Anaesth* 2003;91:820–4.
 15. Fulbrook P, Albarran JW, Latour JM. A European survey of critical care nurses' attitudes and experiences of having family members present during cardiorespiratory resuscitation. *Int J Nurs Stud* 2005;42:557–68.
 16. McGahey PR. Family presence during pediatric resuscitation: focus on staff. *Critic Care Nurs* 2002;22:29–34.
 17. Schilling RJ. Should relatives watch resuscitation?—no room for spectators. *BMJ* 1994;309:406.
 18. MacLean SL, Guzzetta CE, White C, *et al*. Family presence during cardiopulmonary resuscitation and invasive procedures: practices of critical care and emergency nurses. *Am J Crit Care* 2003;12:246–57.
 19. American Academy of Pediatrics. Family-centred care and the pediatricians role. *Pediatrics* 2003;112:691–6.
 20. Baskett PJF, Steen PA, Bossaert L. European Resuscitation Council Guidelines for Resuscitation 2005—Section 8. The ethics of resuscitation and end-of-life decisions. *Resuscitation* 2005;67: S171–80.
 21. Flanagan JC. The critical interview technique. *Psychol Bull* 1954;51:327–58.
 22. Broström A, Strömberg A, Dahlström U, *et al*. Congestive heart failure, spouses' support and the couple's sleep situation: a critical incident technique analysis. *J Clin Nurs* 2003;12: 223–33.
 23. O'Leary Z. *The essential guide to doing research*. London: Sage Publications, 2004.
 24. Sharoff L. Critique of the critical incident technique. *J Res Nurs* 2008;13:301–9.
 25. Pope C, Campbell R. Qualitative research in obstetrics and gynaecology. *Brit J Obstet Gynaec* 2001;108:233–7.
 26. Kvale S, Brinkmann S. *Interviews: learning the craft of qualitative research interviewing*. 2nd edn. Los Angeles: Sage, 2009.
 27. Robson C. *Real world research*. 3rd edn. Oxford: Blackwell Publishing, 2012.
 28. Silvester J. *Work and organizational psychology in willig C, stainton-rogers W. The sage handbook of qualitative research in psychology*. London: Sage Publications, 2008.
 29. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ* 2000;320:114–16.
 30. Lewins A, Silver C. *Using software in qualitative research*. London: Sage Publications, 2007.
 31. Malterud K. Qualitative research: standards, challenges and guidelines. *Lancet* 2001;358:483–8.
 32. Goldstein A, Berry K, Callaghan A. Resuscitation witnessed by relatives has proved acceptable to doctors in paediatric cases. *BMJ* 1997;314:144–5.
 33. Robinson SM, Mackenzie-Ross S, Hewson GL Campbell, *et al*. Psychological effect of witnessed resuscitation on bereaved relatives. *Lancet* 1998;352:614–17.
 34. Nolan JP, Soar J, Zidemanc DA, *et al*. European Resuscitation Council Guidelines for Resuscitation 2010 Section 1. Executive summary. *Resuscitation* 2010;81:1219–76.
 35. Resuscitation Council. *Resuscitation at birth*. 3rd edn. London: Resuscitation Council (UK), 2011.
 36. McVeigh CA, Baafi M, Williamson M. Functional status after fatherhood: an Australian study. *J Obstet Gynecol Neonatal Nurs* 2002;31:165–71.

Interview schedule

Opening statement: **This interview forms part of a larger study that aims to gain an understanding of the experiences and perceptions of fathers who attend the birth of their baby, especially when the baby has required resuscitation at birth and / or admission to a neonatal unit.**

Within this interview I am particularly interested in your experience of situations when a sick / preterm baby is delivered, requires resuscitation at birth and / or admission to a neonatal unit, and the baby's father is present. Before consideration of key issues, can I clarify the following?

Job title / Qualifications / Length of time qualified / Length of time this post

KEY ISSUES TO EXPLORE

There are a variety of situations that you might have experienced:

- **The antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.**
- **Being at the delivery of a sick / preterm baby when the baby's father is also present.**
- **Being at the resuscitation of a newborn baby when the baby's father is also present.**
- **Being present when a baby is admitted to the neonatal unit when the baby's father is also present.**

Which of the above do you have experience of?

When was the last time that you encountered each situation?

(check each individual situation)

So, for the purpose of this interview we'll be talking about you

- *Being involved in the antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.*
- *Being at the delivery of a sick / preterm baby when the baby's father is also present.*
- *Being at the resuscitation of a newborn baby when the baby's father is also present.*
- *Being present when a baby is admitted to the neonatal unit when the baby's father is also present.*

Can you recall an occasion you were involved with relating to

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

Why does this case particularly spring to mind?

Is there anything that you'd like to add, particularly regarding what happened to the father?

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

Do you know if the father wanted to be there?

Thinking back to that occasion, do you think that the situation went well or not as well as it could have done?

Why do you think this was the case?

What about the father in this case? – looking at it from his perspective – did it go well or not as well as it could have done?

Why do you think this was the case?

Can you recall a contrasting situation you were involved with, by that I mean one that didn't / did go well?– can you tell me about that?

Follow up any specific information to clarify description of events.

Clarify details / participant's role in the situation – what did you do / say?

What do you think were the key issues that made this situation different to the previous case?

Why does this case particularly spring to mind?

Is there anything that you'd like to add, particularly regarding what happened to the father?

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

From his perspective do you think that he'd say it went well or not as well as it could have done?

Clarify participant's role in the situation – what did you do / say?

What do you suppose fathers feel that they need in terms of information / support antenatally / prior to the delivery / resuscitation / admission of their baby?

On what basis do you say this?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do think are the issues that a health care professional should consider when supporting a father at this time?

Do you think that different fathers have different needs? – if so – how do you determine individual needs?

Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?

What do you suppose fathers feel that they need in terms of information / support during the delivery / resuscitation / admission of their baby?

On what basis do you say this?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do you think are the issues that a health care professional should consider when supporting a father at this time?

Do you think that different fathers have different needs? – if so – how do you determine individual needs?

How do you determine if the father wants to be there?

Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?

What do you suppose fathers feel that they need in terms of information / support after the delivery / resuscitation / admission of their baby?

On what basis do you say this?

What impact do you think being present at..... has on fathers?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do you think are the issues that a health care professional should consider when supporting a father at this time?

Do you think that different fathers have different needs? – if so – how do you determine individual needs?

Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?

Can you tell me about the nature / extent of any educational preparation you've received regarding the provision of support specifically for fathers during delivery / resuscitation / admission to the neonatal unit?

Clarify details.

Have you participated in 'mock' incidents? For example: labour ward drill?).

Was it father / mother / parent focused?

Has this been adequate?

If no how do you now know what to do / say in these situations? What additional educational preparation do you feel you need?

Apart from more formal educational preparation, how else have you learned what to do / say in these situations?

We've talked quite a lot about the health care professional role when supporting fathers – I'd like now to ask you to think about the impact that carrying out this role has on you – can you tell me about that?

Positive / negative impact – particularly re: helping / supporting fathers.

Short & long-term effects.

Is this always the case or just sometimes?

If sometimes – what key factors trigger this effect on you?

Re: negative effects – how do you deal / cope with this?

In these situations is there anything that fathers could do to help you?

Do you have any suggestions about ways that hospitals / health care professionals could help fathers who experience the situations we've discussed?

Follow-up any specific issues that might have been raised earlier.

Does the hospital have policies / procedures / guidelines re: supporting / care of fathers? – if yes – clarify details – if not – why not? – do you think that there should be policies / procedures / guidelines in place?

What advice would you give to another health care professional who might be about to support a father in one of these situations for the first time?

Are there any other issues that you would like to raise in relation to these issues?

Can I end by asking some more information about yourself?

Age / How would you describe your ethnicity /

Thank-you very much for your help with this part of the study.

Fathers attending the birth and immediate care of their baby

Phase three information leaflet

Introduction

My name is Merryl Harvey; I am a neonatal nurse lecturer and I also have a part-time research nurse post at the National Perinatal Epidemiology Unit in Oxford. This research nurse post is funded by the newborn baby charity BLISS. I am studying for a post-graduate degree at Aston University, which involves me carrying out a research study, and I would be grateful for your help.

You are being invited to take part in a research study. Before you decide, it is important that you understand why the study is being done and what it will involve. Please take time to read this information sheet and to decide if you would like to take part in this study. Please let me know if you would like more information about the study.

What is the study about?

Although it is quite usual nowadays for fathers in this country to attend the delivery of their baby, there is limited published evidence regarding the affect that childbirth has on fathers. This is especially the case when a baby requires resuscitation at birth and is then admitted to a neonatal unit. The aim of this study is to identify the experiences and perceptions of health care professionals supporting fathers around the time of the delivery of a compromised baby.

Why have I been asked to take part?

I am hoping to recruit approximately 40 health care professionals who have experience of supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit. I understand that you are part of this group. This leaflet is being given to you now to give you time to think about taking part in the study.

Do I have to take part?

Involvement in this study is entirely voluntary. It is up to you to decide if you want to take part. If you would like to participate, you will be asked to sign a consent form and you will be given a copy to keep. If you decide to take part you can still withdraw from the study at any time without having to give a reason without being discriminated against in any way.

What will happen if I agree to take part?

I would like to interview you about your experiences supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit. This interview will be tape-recorded and this will enable me to compare what health care professionals have to say. The interview will be as informal as possible; it will take place in a mutually agreeable location and will last approximately 45 minutes. You will not incur any costs or be paid any money to take part in the study. Findings from this part of the study may be used to develop a questionnaire that could be sent to a larger sample of health care professionals.

What are the possible risks of taking part?

It is possible that you might become upset whilst talking about your experiences; therefore you are under no obligation to take part in this study. If you agree to take part in the study and then change your mind, you can withdraw from the study at any time. This includes before, during or after the interview.

Once the interview has been completed I can give you a list of places where you can get support, if you feel that you need it.

What are the possible benefits of taking part?

It is hoped that information gained will provide a better understanding of issues relating to the provision of support to fathers around the time of complicated childbirth. It is anticipated that this new knowledge will enable the provision of care and health care professional education and support to be reviewed and if necessary developed.

Will my involvement in this study be kept confidential?

Your consent will be necessary before you take part in the study and any personal information such as your name will be kept strictly confidential. All documents and tapes from this study will be securely stored; these will not be available to anyone other than my research supervisor, the person transcribing the tapes (neither of whom will not have access to your name) and myself. The tapes and any documentation that identifies participants will be destroyed at the end of the study. None of your personal details will be included in any reports or publications arising from this study.

What if something goes wrong?

If you feel at any time that you have cause for complaint arising from this study, please let me know. In addition, the usual National Health Service staff complaints mechanisms are available to you.

What will happen at the end of the study?

I will be submitting my thesis, a copy of which will be held at Aston University library. The findings of this study will also be published in health care journals and presented at conferences. Your personal details will not be included in any of these.

Who has reviewed this study?

This study has been reviewed and approved by Solihull Local Research Ethics Committee and XX Hospital Research and Development department.

Contact for further information

If after reading this you have any questions or need some further information, please contact me:

harveyme@aston.ac.uk

merryl.harvey@npeu.ox.ac.uk

National Perinatal Epidemiology Unit: 01865 289700

For further information regarding the National Perinatal Epidemiology Unit or BLISS please see:

www.npeu.ox.ac.uk

www.bliss.org.uk

Whatever you decide, thank you taking the time to read this information leaflet.

Merryl E Harvey BLISS Neonatal Nurse Research Fellow

Fathers attending the birth and immediate care of their baby – phase three

Researcher: Meryll E Harvey, BLISS Neonatal Research Fellow
National Perinatal Epidemiology Unit, University of Oxford

Please read and sign each statement in the presence of the researcher.

1. I confirm that I have read and understand the information leaflet (COREC-V1, MEH-V4 13-10-05) for the above named study and I have had the opportunity to discuss the study with the researcher.

2. I understand that my involvement in the study is voluntary and that I can withdraw from the study at any time, without giving any reason and without being discriminated against in any way.

3. I understand that my participation in the study will involve the researcher interviewing me about my experiences supporting fathers of babies requiring resuscitation at birth and / or admission to a neonatal unit, and that the interview will be tape-recorded.

4. I am aware that any personal details that could identify me will only be accessed by the researcher. These details and the tape recordings will be securely stored during the study and they will be destroyed when the study is completed.

5. Having signed all of the above, I agree to take part in the study.

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Name of participant	Date	Signature

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Name of researcher	Date	Signature