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Relational Communications Strategies to Support Family-Centered Neonatal Intensive Care

Karen M. Benzies, PhD, RN

ABSTRACT

The philosophy of family-centered care in neonatal intensive care units is intended to facilitate parental involvement, shared decision-making, and improved outcomes for infants and families. To support family-centered care, there are multiple interventions with different components and associated outcomes that have been described in the research literature. This evidence leaves many unanswered questions about how best to implement and evaluate strategies to enhance family-centered care. This article provides a brief overview of interventions designed to support family-centered care in neonatal intensive care units and offers an evidence-informed staff education strategy to enhance family-centered care. The evidence-informed relational communications strategies of circular pattern diagrams, questioning, and commendations are described, along with specific examples of how nurses can use them in in their day-to-day practice in neonatal intensive care units.

Key Words: infant, neonatal intensive care, nursing, patient-centered, shared decision making

For more than a half a century, family-centered care (FCC) has been recognized as critical for the developmental health of hospitalized children[1,2] and is the recommended practice standard in pediatric care.[3] Family-centered care is a philosophy of care that encourages parental presence, involvement in care, and open communication to promote shared decision making.[4,5] It is important in neonatal intensive care units (NICUs), where the highly technological environment diminishes opportunities for mothers and fathers to establish critical early parent-infant relationships.[6] While institutions espouse the philosophy, and practitioners contend that they practice FCC, inconsistent implementation of FCC with a focus on different components and associated outcomes has left gaps in the evidence about how to implement FCC.[1,7] The *objectives* of this article are to (*a*) briefly describe interventions designed to support the philosophy of FCC in NICUs and (*b*) offer an evidence-based staff education strategy to facilitate relational communications in NICUs.

Researchers have described communication, relationships, partnerships, and individualized care as components of FCC. Parents of infants in NICUs can describe effective and ineffective communication. For example, in an Australian study of mothers ($n = 20$) and fathers ($n = 13$), effective communication strategies included nonhierarchical control of interactions, as well as appropriate reassurances and empathy from nurses.[8] Ineffective communication was more a factor of inconsistent information, or failure of the nurse to validate parental understanding of information or encourage questions.[8] Orzalesi and Aite[9] recommend the following strategies for improving communication with parents in NICUs: introduction of team members, creating a welcoming environment, encouraging parents to interact with their infant, and empathic listening.[9] A positive relationship between parents and providers contributes to increased satisfaction with care and greater willingness by parents to seek further support for the care of their infant.[10] In a Canadian qualitative study

Author Affiliation: Faculty of Nursing and Department of Paediatrics, University of Calgary, Calgary, Alberta, Canada.

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Corresponding Author: Karen M. Benzies, PhD, RN, Faculty of Nursing and Department of Paediatrics, University of Calgary, PF 2222, 2500 University Dr NW, Calgary, AB T2N 1N4, Canada (benzies@ucalgary.ca).

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($N = 10$), a strong relationship between parents and NICU nurses was the most significant factor affecting satisfaction with NICU care.[11] Furthermore, parents described nurse characteristics such as "perceptive engagement, cautious guidance, and subtle presence"[11(p677)] as contributing to a negotiated partnership model. In contrast, in a study conducted in the United Kingdom, Coyne and Crowley[12] reported that partnership models represent an inaccurate depiction of the roles of parents and nurses and nurses preferred the term "involvement." Others have argued that FCC should be individualized to accommodate sequential clinical phases from admission to postdischarge care of the infant.[13] Although individualized developmental care in NICUs supports parents to recognize infant cues, these studies have shown mixed results.[14,15] Parental engagement in NICUs may also be influenced by cultural and socioeconomic differences.[16] Recent publications about parental experiences in NICUs may provide additional guidance about the FCC practices that would best support them.[17,18] While FCC is almost universally espoused as the philosophy of care in NICUs, its conceptualization lacks clarity. This lack of clarity is further evidenced by serious challenges associated with implementation and evaluation of interventions to support the philosophy of FCC.

INTERVENTIONS TO SUPPORT FCC IN THE NICU

Many studies have reported on interventions designed to optimize implementation of specific aspects of FCC. Researchers in Australia used an appreciative inquiry approach to develop[19] and qualitatively evaluate[20] a 1-day workshop for parents and nurses to explore ways to enhance FCC generally. Another qualitative evaluation of a structured educational intervention for a multidisciplinary NICU team in Finland discovered that nurses ($N = 22$) observed beneficial changes related to FCC, including increased interactions with families, and a change in their role from caregiver to facilitator of care.[21] In guided family-centered care, researchers from Denmark evaluated the effects of structured parent-nurse reflection sheets designed to match the typical NICU phases: acute, stable, and preparation for discharge.[22] The qualitative findings ($N = 22$) revealed that the reflection sheets improved parental coping by enabling mothers and fathers to share emotions, communicate more deeply, and achieve mutual understanding.[22] In a study ($N = 9$ parents) to improve communication in an Italian NICU, the combination of (*a*) education for the NICU multidisciplinary team, (*b*) communication guidelines for the most common scenarios, and (*c*) problem case documentation and review demonstrated increased parental satisfaction with communication.[23] Similar increases in parental satisfaction resulted from an educational intervention to improve communications between parents and nurses.[24] In this brief intervention, a 30-minute moderated slide show was used to emphasize the importance of interpreters, frequent communications, and elements of family meetings.[24] In addition to the education module, contact cards with the names and photographs of the NICU staff caring for their infant were given to parents. In another educational intervention, researchers evaluated the effect of didactic sessions, role-play, and reflection as strategies to improve communication between parents and neonatology fellows and nurse practitioners.[25] After the intervention, practitioners ($N = 13$) felt better prepared to engage in challenging communications, and 1 month later were still using their new skills and were more willing to engage with parents to discuss life-threatening neonatal complications.[26] Twelve months after an educational workshop to improve family-focused care in a multidisciplinary NICU team, staff ($N = 61$) reported improvements in their relational and communication skills, as well as increased confidence and decreased anxiety, particularly for those who reported the highest levels of anxiety at baseline.[27] The sum of these multiple small studies with diverse interventions and outcomes provides limited suggestions about key educable components to support FCC. However, the path forward does seem to suggest that interventions should focus on communication skills, including negotiating dynamic role boundaries and shared decision making.

Involving parents in the care of their infant requires changes in traditional hierarchical role structures and continuous renegotiation of mutually equitable roles as parents gain confidence and skill.[28] Parental readiness to be involved in the care of their infant will vary by parent ability, health status of the baby, and time. The need to negotiate role boundaries in hospital settings emerged from tensions between parents of children with a disability and nurses[29,30] and highlights the inconsistencies in the degree to which nurses are willing to negotiate role boundaries and share in decision making.[28] A review of the literature about how nurses negotiate with parents reported that parental involvement in care was limited by lack of communication and limited negotiation because nurses made assumptions about how parents could be involved and did not negotiate care.[28] Nurses want more support and training to communicate with parents, particularly related to difficult conversations.[31] Based on family systems theory,[32] "relational communications" is a useful tool for negotiating role boundaries and shared decision making.

IMPLEMENTING RELATIONAL COMMUNICATIONS TRAINING

Circular pattern diagrams

Relational communications includes approaches to understanding communication patterns, asking questions, and commendations. The art of relational communications is fundamental to nursing practice.[33] Effective relational communications begins with an understanding of the power of circular pattern diagrams.[32] Circular pattern diagrams locate interactional patterns within recursive sequences of interpersonal interactions and include cognition, affect, and behavior. Understanding the components of the interaction determines whether efforts should be focused on reframing cognition, modifying affect, or changing behaviors.[32]

To practice with circular pattern diagrams, ask nurses to draw each component (cognition, affect, and behavior) for the parent and the nurse in a recent dyadic interaction and present to the group. Ask the group to hypothesize about how the interaction could be shifted by altering different components. For example, ask, "If a change in thinking (cognition) occurred, how might that influence feelings (eg, anxiety) and behavior (eg, avoidance)?"

An innovative extension of circular pattern diagrams may have additional benefit in NICUs. Once nurses are comfortable with the components, circular pattern diagrams can be used to understand how to integrate the family into the multidisciplinary team. Ask nurses to rethink the "individuals" on each side of the circular pattern diagram, with the family and nurse as one side of the diagram and the problem (eg, feeding problems, apneas) as the other side of the diagram. This perspective integrates the family into the multidisciplinary team and creates a space for them to work together to achieve common goals.

Questioning

Although linear questions that require a simple "yes" or "no" response are important (eg, "Do you want to feed your baby?"), uncovering the effects of cognition, affect, and behavior in interactions is best accomplished by circular questioning.[34] The use of circular questions assumes that (*a*) parents are best understood in the context of their relationships with others, (*b*) the perceptions of both mothers and fathers are important, (*c*) answers to questions provide new insights for the parents, and (*d*) questions are therapeutic and strengthen the parent-nurse relationship.[34] Circular questions are considered therapeutic.[33] There are 4 types of circular questions. The first type, difference questions, compare the perspectives of individuals or time (eg, "Who best understands what the doctors have explained to you about your baby?" "How is this baby different from your full-term baby?"). Behavioral effect questions connect a parent's behavior with a specific component of the interaction (eg, "What do you do [behavior] when your wife is upset [affect] about the baby's 'spells'?" "What does your baby do when she is being held skin-to-skin?"). For the parent who is hesitant to be involved in the infant's care, a hypothetical question helps elicit alternative actions (eg, "If your baby were going home tomorrow, what would you need to know before you leave the hospital?" "If I [nurse] could be more helpful, what would I do?"). Finally, triadic questions can elicit a response that cannot be obtained by direct questions. For example, the nurse may notice a stoic mother who looks like she has been crying, but when asked says she is fine. A triadic question may elicit a response that enables the nurse to identify support needs for the mother and/or family (eg, "If I asked you husband about how you are doing, what would he say?" or "If I were to ask your husband to make this decision, what would he say?").

Once nurses and other healthcare professionals (eg, respiratory therapists) understand the power of circular questions, typically, they are keen to practice. The questioning exercise starts with the instructor selecting one person to formulate and ask a question of another person in the group, who provides a response.[33] It is useful to have the definitions and exemplar questions available to support participants' efforts. After each question, the group identifies the type of question and how it might be reworded if not a circular question. The instructor points out the difference in the structure of questions and the potential responses that each might elicit. Once each person in the group has had a chance to ask and answer a question, the instructor debriefs the session about exploring how this new approach to questions can be applied in daily practice.

Commendations

Commendations are statements that acknowledge an observation of sustained positive patterns of parental behavior that have occurred over time.[33] Commendations are not compliments, which are related to single occurrences. These statements help parents not only recognize and enhance their strengths but also challenge the nurse to actively seek out strengths, rather than focus on problems.

The structure of the commendation exercise is similar to the questioning exercise where one person is selected to receive commendations from each of the other members in the group. The person receiving the commendations is asked to reflect on reactions to receiving the commendation, "What was it like to hear these words from your colleagues?" Following reflection

on being the recipient of commendations, that individual selects the next person to receive commendations, until everyone in the group has had a turn.

CONCLUSION

The philosophy of FCC in NICUs is intended to facilitate parental involvement, shared decision making, and improved outcomes for infants and families. Based on relational communications theory, circular pattern diagrams, questioning, and commendations are evidence-informed strategies that could be implemented and evaluated to improve FCC in NICUs.

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