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Motivational Interviewing with Patient Education to Promote a Safe Sleep Environment for Lakota Infants

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This is to certify that **Kari Johnson** has successfully defended her Graduate Project entitled **"Motivational Interviewing with Patient Education to Promote a Safe Sleep Environment for Infants"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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Sudden Infant Death Syndrome (SIDS) has preventable risk factors; the sleep environment of the infant is one of those risk factors. SIDS is the leading cause of infant deaths in the Aberdeen Area of Indian Health Service, accounting for more than one fourth of the infant deaths. The project proposed utilizes Madeline Leininger's Culture Care Theory combined with an education model incorporating motivational interviewing with the current patient education used by the Public Health Nursing Department at the Pine Ridge Indian Health Service Hospital promoting a safe sleep environment.

Motivational Interviewing with Patient Education to Promote a Safe Sleep Environment for Lakota Infants

Chapter One

Introduction

Sudden Infant Death Syndrome (SIDS) has several preventable risk factors. Many of these risk factors are in the sleeping environment of the infant and can be altered relatively easily when one is aware of the dangers. As such, SIDS prevention education for mothers needs to be done at their emotional and educational level as well as being sensitive to the culture of the Oglala Sioux Tribe (OST) on the Pine Ridge Indian Reservation, which is the population of interest for this project. This paper presents an educational model combining motivational interviewing with culturally appropriate patient education that is aimed at promoting a safe sleep environment for newborns as a means to preventing SIDS. The model takes into account the culture of the mothers and is designed to be utilized by the Public Health Nursing Department at the Pine Ridge Indian Health Service (IHS) Hospital.

This topic is relevant for several reasons. First, the loss of a new life is overwhelming to anyone who has cared for a family who has lost a new baby. Secondly, the grief and suffering of families that have lost a new baby to SIDS, is heart-breaking. Thirdly, are the frightening statistics within the Aberdeen Area of IHS. The Aberdeen Area is one of twelve regional administrative units of the IHS, serving approximately 94,000 Indians on reservations located in North Dakota, South Dakota, Nebraska, and Iowa (Indian Health Service 2011). It is this Area that has the highest rate of SIDS in the IHS as well as the entire of the United States (Solomon, Randall and Welty, 2002). The Pine Ridge Indian Reservation is in the Aberdeen Area.

Other statistics related to maternal and infant health are also staggeringly high in the Aberdeen Area IHS. Of all the IHS areas, the Aberdeen Area has the highest infant mortality rate of 12.5 infant deaths per 1000 live births, compared to the All races rate of 7.2 infant deaths per 1000 live births among non IHS residents. It is also higher than the overall IHS infant mortality rate of 8.9 infant deaths per 1000 live births. (EagleStaff, Klug, & Burd, 2006, p.141) From 1996 to 1998, the US all races SIDS rate was 10.7 infant deaths per 1000 live births. That same year, the All IHS rate was 18.1 infant deaths per 1000 live births; the Aberdeen Area rate was **27.6** infant deaths per 1000 live births**.** SIDS is the leading cause of infant deaths in the Aberdeen Area, accounting for more than one fourth of the infant deaths (EagleStaff, Klug, & Burd, 2006, p.141). Although there was a 42% decline in the SIDS rates for all IHS regions, from 2.77 per 1000 live births in 1992-1994 to 1.61 per 1000 in 1996-1998, the rate in the Aberdeen Area has remained relatively constant: 3.66, 3.55, and 3.46 per 1000 live births for 1992-1994, 1994-1996, and 1996-1998, respectively (Solomon, Randall, & Welty, 2002, p. 2717). The statistics referenced to illustrate the ongoing crises of infant deaths in the Aberdeen Area of IHS. While there was a decline in the SIDS rate for all IHS regions, the Aberdeen Area has remained relatively the same. IHS has developed the Infant Mortality Review Board to review all the Aberdeen Area infant deaths quarterly. This is done area by area and service unit by service unit in the Aberdeen Area. They compile the findings and come up with recommendations for different areas of focus for patient education to hopefully reduce these staggering numbers. There are also multiple agencies on the reservation funded by the government thru grants to help prevent SIDS deaths as well, such as Healthy Start, the Aberdeen Tribal Chairman's Health Board, and Stanford University (Solomon, Randall, & Welty, 2002).

The project developer's background in nursing has included seventeen years in IHS, caring for Native Americans in North Dakota and South Dakota. The last fourteen years have been spent on the Pine Ridge Indian Reservation working with the Oglala Lakota. The past eight years working specifically in the Public Health Nursing (PHN) department. The focus of the PHN department is health promotion and disease prevention. Working in PHN, the project developer has done many home visits with postpartum mothers and their babies. SIDS and infant mortality prevention is discussed as one of the educational components of the visit. During the home visit, the project developer has often questioned if the new mother understands the importance of a safe sleep environment, or if the proposition of changing the baby's sleep environment is possible. Observing the families in their home settings, the responsibility of caring for the infant is not only the parents' responsibility, but the responsibility of the whole family. This includes aunts, uncles, grandparents and cousins. Because of this family dynamic, the environment that the newborn baby is in is also affected. Selanders (2010) quotes Florence Nightingale saying "The environment can be altered in such a manner as to improve conditions so that the natural laws of healing can occur" (p.84). Creating a safe sleep environment for the newborn baby to prevent SIDS is creating a "Sacred" place for the baby to sleep.

Currently, the PHN Department at the Pine Ridge IHS receives referrals to do home visits for health promotion and disease prevention on all post-partum and newborn patients discharged from the Pine Ridge IHS Hosptial. This also includes referrals from Rapid City Regional Hospital if the patient was referred out of Pine Ridge because of high-risk status. The project developer proposes combining the current patient education for SIDS prevention, promoting a safe sleep environment, with motivational interviewing to be used in the home visit setting for the postpartum mothers and newborn babies living on the Pine Ridge Indian Reservation. Many

of the current patient education materials used by the PHN Department have been developed by the Aberdeen Area Infant Mortality Review Board. These materials are sensitive to the culture of Native Americans, stating that babies sleep in many places, often based on cultural, traditional or personal reasons. Regardless of where they sleep, all babies need a safe sleep environment (Indian Health Service, 2009).

This project encompasses training the PHN staff on the technique of motivational interviewing and combining the technique with the current patient education materials used to promote a safe sleep environment for the infant. The project developer has also done work with motivational interviewing, using this tool when counseling patients interested in tobacco cessation. Motivational interviewing (Dart, 2011), is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence (a state of uncertainty). Dart (2011) quotes Rollnick and Miller stating, "Motivational interviewing is a communication, connection, and interaction between nurse and patient (p.2). The home visit setting was chosen as the potential distractions of the hospital setting would not be encountered, more time is available to the nurse to do the proposed combination of motivational interviewing with the safe sleep environment education and hopefully the mom and baby are rested after the hospital stay and are doing well in the home setting. Futhermore, infants in homes that had a visit by a PHN were one-fifth less likely to die of SIDS than those in homes that were never visited by a Public Health Nurse (Solomon, Randall, & Welty, 2002, p. 2721).

For the proposed project, the safe sleep enviroment consists of:

1. Always placing the baby on its back for sleep
2. Place the baby on a firm sleep surface.
3. Keep soft objects, toys and loose bedding out of sleep area.

4. No smoking around the baby.
5. Do not let the baby overheat during sleep.
6. Place the baby in a crib or bassinette when going to sleep.

The concept of using motivational interviewing as an additional tool for patient education was chosen to promote a change from the nurse asking questions from a check list which are often yes and no questions, such as "Do you sleep with your baby?" or "Does anyone smoke around your baby?" Motivational interviewing involves using open-ended questions (answers are not yes or no), affirmation of the patients answer, reflection of the current situation and proposed change and summary (Dart, 2011). Using these tools to promote improved communication with the patient ideally will move the patient from potential resistance to eventual motivation. Motivation is what drives us (and the patient) to make choises and take actions. Moviational interviewing offers a way to help patients evaluate their rituals and what it means to release them (Dart, 2011, p. 27).

Florence Nightingale's Theory of Nursing Practice and Madeline Leininger's Culture Care Theory will be used in conjunction with this project proposal. In Florence Nightingale's Theory of Nursing Practice, she states the environment can be altered to improve conditions that the natural laws can allow healing to occur. The model for Nursing Practice consists of observation, identifying the needed environmental change, implementing the change and then identification of the current health state (Selanders, 2010). For the purpose of this proposal, the sleeping environment of the infant is the potential change needed. Leininger's Culture Care Theory uses the Sunrise Enabler to discover culture care using economic, educational, religious factors, social and cultural values and beliefs (Leininger & McFarland, 2006) will be utilized to

determine if these factors and beliefs are a barrier to mothers on the Pine Ridge Indian Reservation to understand and implement the patient education presented to them.

Evaluation of the effectiveness of the addition of motivational interviewing will be done by informal discussions with the selected PHN staff, which have been trained in motivational interviewing. The incorporation of motivational interviewing with the patient teaching, any goals that were set and identification of the modifiable SIDS risk factors of the infants sleep environment will be evaluated. After the initial home visit is completed, a follow- up home visit will be scheduled. During the follow-up home visit, the public health nurse will re-assess the sleeping environment of the newborn and follow-up on the proposed plan of change discussed in the initial postpartum home visit. The results of this project have the potential of changing the existing patient education protocols used at the Pine Ridge IHS Hospital as well as throughout the Aberdeen Area, as well as the potential of saving the lives of Native American infant babies from dying from SIDS in Pine Ridge, SD and potentially the entire Aberdeen Area of IHS.

Chapter 2

Literature Review and Significance

Sudden Infant Death Syndrome

Hunt & Hauck (2006) define Sudden Infant Death Syndrome (SIDS) as the sudden death of an infant under one year old that is unexpected by history and unexplained after a thorough postmortem examination, including a complete autopsy, investigation of the scene of death and review of the medical history (p. 1862). In autopsies performed according to a research protocol, infants who died of SIDS were found to have several identifiable changes in the lungs and in brainstem structure and function. Findings of tissue markers of pre-existing, chronic low-grade asphyxia were found. SIDS infants have been found to have structural and neurotransmitter alterations in the brainstem, consistent with abnormalities in autonomic regulation (Hunt & Hauck 2006, p.1862). Up to 60% of SIDS cases have been found to show evidence of receptor abnormalities that involve several receptor types relevant to autonomic control (Hunt & Hauck 2006).

There are a number of risk factors, both modifiable and not that have been found to have significant associations with SIDS. The modifiable environmental risk factors, specifically infant sleep care factors will be emphasized in this project proposal. The American Academy of Pediatrics recommends avoiding known SIDS risk factors, including soft sleep surfaces, pillows, quilts, blankets, comforters, parental use of substances that may impair arousal, and tobacco use (Lahr, Rosenberg & Lapidus 2005).

The risk factors with the greatest potential for modification include prone sleep position, sleeping on a soft surface, maternal smoking and overheating. Prone sleeping has been recognized as a major risk factor for SIDS, with odds ratios ranging from 1.7 to 12.9 in various

well designed epidemiologic studies. The Academy of Pediatrics recommended in 1992 that infants be placed on their backs to reduce the risk of SIDS. Since that time the SIDS rate has decreased by 40% (Kattwinkel, Brooks & Keenana 2000, p. 650). Subsequent studies from England and New Zealand have shown that side sleeping has a slightly higher risk than the supine position, although the side-sleeping position still seems to be considerably safer than prone. Infants placed on their sides usually roll to their backs, the risk of rolling to the prone position from the side is significantly greater than rolling to the prone position from the back (Kattwinkel, Brooks & Keenana 2000, p. 651).

A cross-sectional prevalence study was done in four primary care clinics and four Native American clinics, all in North Dakota to determine the prevalence of prone, supine, and side sleeping position in white and Native American infants. Questionnaires for 325 infants (259 white and 66 Native American babies) were completed by the infants' mothers. It was reported that Native American infants slept prone 46.9% of the time compared with 74.4% of white infants (Burd, 1994). A difference was observed in the race of infants who used a pillow. Less than 2% of the white infants slept with a pillow on the night before the questionnaire were completed, but 21% of Native American infants did. Of the infants who slept on pillows, 7 of the pillows were 1 inch and 10 were 2 or more inches think (Burd, 1994, p. 448). Burd (1994) also states, "In addition to prone sleeping position, several other infant care practices including the use of pillows, mattresses and overdressing may be potential SIDS risk factors" (p.449).

Similarly, Hunt and Hack (2006) also state soft mattresses, older mattresses and soft, fluffy bedding such as comforters, pillows, sheepskins and polystyrene-bean pillows have been associated with a 2-3 fold increased risk of SIDS (p.1863). Combinations of risk factors result in even higher risk. Prone sleeping in soft bedding has been associated with a 20-fold increased

risk of SIDS (p.1863). Several reports described that in a significant number of SIDS cases, the heads of the infants, including some infants who slept supine, were covered by loose bedding. Adult bedding material can be dangerous for infants, and infant/parent co sleeping may expose an infant to this risk (Carroll & Siska 1998). Sullivan & Barlow (2001) also concluded that a plausible hypothesis, supported by some modeling studies, is that soft bedding with poor weight resistance will have a tendency to form pockets and predispose the prone infant to rebreathing expired air, resulting in hypoxia and hypercapnia (p. 152). The common finding that significant numbers of SIDS victims are found dead with their heads completely covered by bedclothes suggests this is an important risk factor (Hunt & Hack 2006).

The first study to investigate maternal smoking as a risk factor for SIDS was carried out in Canada. Since then, over 40 studies have examined the effects of maternal smoking. The majority of these studies have confirmed a positive association between SIDS and maternal smoking, either before and/or after the birth of the infant and less consistently a smaller positive association with father or others smoking (Sullivan & Barlow 2001, p. 170). In studies comparing SIDS rates before and after risk-reduction campaigns, infants of mothers who smoked were about 3 times more likely than those whose mothers did not smoke to die of SIDS before implementation of the campaigns and 5 times more likely after the campaigns. Most studies have shown that the risk of death is progressively greater as daily cigarette use increases, but the accuracy of self-reported cigarette use data is uncertain (Hunt & Hack 2006). An independent effect of postnatal exposure to tobacco smoke has been found in a small number of studies as well as a dose response for the number of household smokers, people smoking in the same room as the infant, cigarettes smoked and the time the infant was exposed. These data suggest that keeping the infant free of environmental tobacco smoke may further reduce an infant's risk of

SIDS. Bed sharing has been found to be extremely hazardous when other children are in the same bed, when the parent is sleeping with an infant on a couch or other soft confining sleep surface and when the infant is less than 4 months age (Hunt & Hauck 2006, p. 1863). The addition of bed sharing or co-sleeping further increases the risk of SIDS.

The Pine Ridge Indian Reservation has an unemployment rate of aproximately 83-85%, with the median income is approximately $2600 to $3500 per year. There is an estimated average of 17 people living in each family home, 33% of the reservation homes lack basic water and sewage systems. Life expectancy on the reservation is 48 years old for men, and 52 years old for women, compared to the United States average life expectancy of 77.5 years (Schwartz, 2006, para. 4). The impact of the economy on the Pine Ridge Indian Reservation has an impact on the SIDS rate as new parents' may not be able to purchase a crib or bassinette to sleep in, therefore necessitating the newborn baby to co-sleep with the parent.

In the New Zealand Cot Death Study, analysis of the data to control for parental smoking revealed a strong interaction of bed sharing with maternal but not paternal smoking. There was no increase in risk associated with bed sharing in infants whose mothers did not smoke. The risk associated with bed sharing was significantly raised in infants where either the mother smoked or both parents smoked cigarettes. The interaction between maternal smoking and bed sharing was such that the combined risk from both was greater than the sum of either risk alone (Sullivan & Barlow 2001, p. 172). In a population-based control study of SIDS infants among the Northern Plains Indians in SD, ND, NE and IA, it was found that a higher percentage of case mothers reported smoking cigarettes during the 3 months prior to pregnancy, decreasing during each of the subsequent trimesters, and increasing after delivery to almost prepregnancy levels (Iyasu, Randall, Welty & al. 2002, p. 272). More than half of the infants usually shared a bed with their

parent at night in the 2 weeks preceding the case infant's death. Bed sharing is routine among Northern Plains Indians (Iyasu, Randall, Welty & al. 2002, p. 272). Further evidence for the effect of maternal smoking comes from a study of differences in the incidence of SIDS among Native Americans. Between 1984 and 1986, the incidence of SIDS was 4.6 per 1000 live births among the Native Americans in the northern region of the United States. The incidence among Indigenous groups in the southwestern states was 1.4 per 1000 live births. Differences in socio-economic status, maternal age, birth weight or prenatal care were not significant among the Indigenous populations in the two areas. The differences were explained by the high prevalence of maternal smoking during and after pregnancy among the northern groups and Alaskan Natives but low among the southwest populations (Blackwell et al. 2004).

In the population based case-controlled study of the SIDS infants among the Northern Plains Indians, 3 factors were identified that were amendable to public health action: (1) visits by a Public Health Nurse (PHN), (2) periconceptional maternal alcohol drinking and first trimester binge drinking, and (3) infant layers of clothing. It was found that infants who had 2 or more layers of clothing or covers were at an increased risk of SIDS more than 6-fold. (Iyasu, Randall, Welty & al. 2002) Overheating has been associated with increased risk of SIDS based on indicators such as increased room temperature, high body temperature, sweating and excessive clothing or bedding. Some studies have identified an interaction between overheating and prone sleeping, with overheating increasing the risks of SIDS 6 to 10 fold only among infants sleeping in the prone position (Hunt & Hauck 2006).

It was also found in the SIDS study of the Northern Plains Indians, that infants in homes that had any visit by a PHN before or after birth were one-fifth less likely to die of SIDS than those in homes that were never visited (Iyasu, Randall, Welty & al. 2002, p. 2721).

Culture Care Theory

Madeline Leininger developed the nursing theory of Culture Care. She was a nurse in the 1950's, when nurses were concerned with learning medical symptoms, taking care of physicians and caring out the orders written by the physician. The concepts of care and culture were virtually unknown at that time. Care and culture were the invisible and unknown phenomena that had been patently ignored as essential knowledge and skills to advance nursing as a discipline and profession even though care had linguistic usage (Leininger, 1997, p. 32). She saw the need for nurses to have a theory related specifically to culture and care. She felt this was needed to establish a solid background for the field of transcultural nursing. The Culture Care Theory was needed to advance transcultural nursing knowledge and practices (Leininger, 1997).

The Ethnonursing research method, designed by Leininger, was created by the theorist to facilitate the discovery of data focused on the Theory of Culture Care. Ethnonursing refers to a qualitative research method focused on naturalistic, open discoveries, and largely inductive modes to document, describe, explain, and interpret informants' worldview, meanings, symbols, and life experiences as they bear upon actual or potential nursing phenomena (Leininger, 1997). This method of research is an open mode, meaning that the researcher must enter the informant's world of knowledge and learn from them about their knowledge. Both emic (insider) and etic (outsider) are studied in this research method.

Leininger asserted that there were two different types of care, generic and professional that needed to be studied (Leininger, 1997), generic care meaning traditional cultural healing, indigenous or nonprofessional care. She asserted that if nurses fully understood the generic care in different cultures, particularly in the setting a nurse is working, and used it appropriately with

professional care, a healing or beneficial outcome would be observed. The central purpose of the theory of Culture Care was to discover, document, interpret, explain and even predict some of the multiple factors influencing care from an emic and etic view as related to culturally based care. The goal of the theory was stated to provide culturally congruent care that would contribute to the health or well-being of people or to help them face disabilities, dying, or death using the three proposed modes of nursing care actions and decisions (Leininger & McFarland 2006).

Leininger and McFarland (2006) define three theoretically predicted action and decision modes of the culture care theory

1. Culture Care preservation and or maintenance referred to those assistive, supportive, facilitative or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face handicaps and death (p.8).
2. Culture Care accommodation and or negotiation refers to assistive, accommodating, facilitative or enabling creative provider care actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe and effective care for their health, well-being, or to deal with illness or dying (p.8).
3. Culture Care repatterning and or restructuring refers to professional actions and mutual decisions that would help people to reorder, change, modify or restructure their life ways and institutions for better health care patterns, practices or outcomes (p.8).

These three action-decision care modes were unique and were not found in other theories, or in current nursing and health practices (p. 8). These modes, whether one or all, need to fit with the informant's life ways. This is done by using the Sunrise Model. The Sunrise Model is a guide to discover new knowledge or to confirm knowledge of cultural informants (Leininger &

McFarland 2006). The upper level of the sunrise model resembles a rising sun with rays representing the cultural and social structure dimensions of a culture care worldview. These dimensions include technological factors, religious and philosophical factors, kinship and social factors, cultural values and life ways, political and legal factors, economic factors and educational factors. Additional areas for understanding include linguistic, environmental and historical dimensions (Benkert et al. 2007). They are also the basis elements of a cultural assessment. The model suggests that decisions about and actions pertaining to nursing care should be based on integrated knowledge of generic and professional care systems. The lower level of the model depicts the three types of nursing action and decision modes listed earlier. Deliberate planning and implementation of nursing strategies based on cultural assessment leads to the desired outcome of culturally congruent nursing care (Nelson, 2006).

Most human beings believe they are endowed with rights to live, were created by a supreme being, and need to be cared for by other human beings, including nurses. The Culture Care theorist holds that respecting human beings from a spiritual, cultural, and holistic perspective while caring for them is essential for human care and caring (Leininger & McFarland, 2006, p. 10). The healing beliefs of the Oglala Sioux Tribe are deeply intertwined with spirituality, meaning belief in the Great Creator. They believe we need to respect Mother Earth and all she has created. The Oglala Sioux people have a culture unique to their tribe. A study published in the Journal of Transcultural Nursing regarding substance abuse in African American Women stated, "Nurses' knowledge about African American women's religious, spiritual, philosophical, and cultural values and life way's social structure factors would need to be preserved to facilitate nurses in caring for these women" (Ehrmin, 2005, p. 124). The

participants in this study believed that they had been mistreated not just from the substance abuse, but because of their cultural identity as well as their current socioeconomic status.

Felgen (2004) states that Leininger's Theory of Culture Care enables the nurse to better understand and care for the patient using her action-delivery modes and utilizing the sunrise enabler model. Felgen (2004) also states the Theory of Culture Care addresses care for people from a broad range of cultures. The theory validates the natural human attachment to one's heritage, language, norms, and customs. Leininger's theory holds caring as an essential human need crossing every culture (p. 293). Leininger's theory guides nurses in discovering the cultural health patterns and caring practices of an individual or group in order to provide culturally congruent nursing care (Leuning, Swiggum, Weigert & Zander, 2002). This nursing theory focuses solely on culture and care combined.

Culture pervades the mundane and influences the extraordinary moments of human lives. The ways in which people experience and interpret the world are largely determined by the cultural contexts they inhabit. Cultures are constantly evolving in response to new environments and ever-changing physical, social, economic, and political realities (Benkert et al. 2007).

The environment of the newborn baby is influenced by the cultural practices used by past generations in the home. "It is an accepted practice on our reservation, sleeping with our babies. It has been practiced for many generations. Now things are changing, we are finding out it may not be the safest place for our little ones. We have more than one generation living in one household. If the grandmother tells her grand-daughter she is being a good mother by sleeping with her baby, and then it is accepted" (MM personal communication 10-19-2010).

The notion of creating a safe sleep environment is not a new idea or theory. Environment was the umbrella concept in the Nightingale theory of nursing. It was her

contention that the environment could be altered in such a manner as to improve conditions so that the natural laws would allow healing to occur. The general definition of environment is anything that, through manipulation, assists in putting the individual in the best possible condition for nature to act (Selanders 2010, p. 84). Felgen (2004) also maintained that Nightingale believed that the role of the nurse was to help patients attain the best possible condition so that nature could act and self healing could occur (p. 294).

Motivational Interviewing

Motivational Interviewing (MI) is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Ambivalence is a state of uncertainty (Dart, 2011, p. 2). The transtheoretical model of the stages of change developed by Procheska and DeClemente is a framework for understanding how people change behavior and the theory for MI. The premise of the model is that most families do not seek information from the health care provider expecting to change patterns of behavior that are well established. This model focuses on the process of becoming ready to make the necessary changes to adhere to a health plan (Gance-Cleveland, 2007). Dart (2011) explains the stages of change as (a) precontemplation, (b) contemplation, (c) preparation, (d) action and (e) maintenance. The precontemplation stage occurs before an individual has considered the relevance of behavior change. The contemplation stage occurs in an individual who has identified that behavior change is relevant, but has mixed feelings (ambivalence) about undertaking that change. The preparation stage occurs when the individual considers behavior change more important than the status quo, and an action plan is identified. The action stage occurs when the individual implements the behavior change. The maintenance stage occurs after action is taken and the individual focuses on stabilizing the change and avoiding relapse. The

stages of change do occur in order, but it is not considered a linear process. The client may move back and forth, between successive stages in a cyclical, spiral manner (Ashford et al. 2009).

Dart (2011) states four main principles guide the MI technique: express empathy, support self-efficacy, develop discrepancy, and roll with resistance. These four main principles need to be maintained to have a therapeutic interaction with a patient. Expressing empathy allows the patient to feel comfortable opening up and sharing his or her personal perspectives. To support self-efficacy, the provider needs to be sure not to impose her own beliefs onto the patient and explore the patient perspectives. To develop discrepancy, the provider attempts to assist the patient in identifying current their status and future goals, and help the patient to examine a path to the goals. Rolling with resistance allows the patient to explore the perceived barriers, and increasing the patient's feeling of acceptance. Feeling acceptance promotes engagement and ultimately improves the chances of experiencing a therapeutic encounter (p. 4).

Therapeutic communication has always played a vital role in nursing practice. It is a respectful way of communication. It shows we are listening and is a way to show we care. The result is most successful when nurses and patients negotiate and agree on treatment goals (Rollnick, Mason & Butler, 1999). A therapeutic relationship is one in which the patient feels comfortable being open and honest with the nurse. A therapeutic relationship is one in which trust, co-existence, self-awareness, and empathy exist (Welch, 2005).

Dart (2011) contends MI fits perfectly into the nursing profession. As coaches, therapists, care providers and educators we need a caring respectful tool to promote behavior change. MI fits into each step of the nursing process, which is the compass that guides the nurse in her practice (p. 31).

Assessment-The first step in the nursing process is to assess or investigate. This occurs in MI when the conversation begins through to the end of the encounter. During the assessment, the nurse's task is to elicit information, accomplished by asking open-ended questions, reflecting and listening (Dart, 2011).

Diagnosis-To diagnose is to identify the problem. The key is to pay attention to the patient and what he or she is saying verbally and non-verbally. MI is the key that opens the door for behavior change. Through assessment, the nurse makes a diagnosis of motivation, ambivalence or resistance to change. The stages of change will also be utilized during the diagnosis process. Motivation is what drives us to make choices and take actions. Ambivalence is feeling two ways about something (Dart, 2011). Behind MI is the belief that most people are unsure about making a change, and the focus should be on resolving that ambivalence (Miller & Rollnick, 2003).

Planning-Nurses are accustomed to identifying steps the nurse and patient should take to improve the problem that was diagnosed. In motivational interviewing the patient participates in the planning. During the planning phase of the nursing process it is vital to create a plan together (Dart, 2011).

Implementation-The implementation stage is a time to follow through with the actions required to meet the patient's goals. In MI, it is the patient who is taking action. When the patient starts implementing the goals, the nurse's role is to reinforce the positive efforts and explore the negative aspects. During this step the nurse may provide education to help attain a goal (Dart, 2011).

A study comparing smoking in the presence of infants aged 0-10 months in the Netherlands was compared before and after the implementation of an education protocol

emphasizing parents to refrain from smoking in the presence of the child. The education protocol was done in well-baby clinics. The education materials were developed on the basis of an inventory of available prevention programs, a study of the factors influencing passive infant smoking and the theoretical construct Stages of Change. The materials of the education program were offered at a free of charge training. In this training the education program was explained and the nurses and doctors could practice the education in role-plays. Posters and stickers were mailed to parents of young children. Articles were published in magazines for (pregnant) parents. The study showed that the prevalence of passive infant smoking in the Netherlands more than halved after the national implementation of an education program aiming at its reduction (Crone, et al, 2003).

A study was done to determine whether MI for smoking parents of young children would lead to reduced household passive smoke exposure. Project KISS (Keeping Infants Safe from Smoke) was used, targeting low income families with young children (Emmons et al, 2001). The families were randomly assigned to MI or Self Help. Follow-up assessments were conducted at 3 and 6 months. The MI consisted of a 30 to 45 minute session at the patient's home with a trained health educator. Four follow-up phone calls were also done. Participants in Self Help received a copy of the smoking cessation manual, passive smoke reduction tip sheet and resource guide in the mail. The 6-month nicotine levels were significantly lower in MI households. Repeated measures analysis of variance across baseline, 3-month, and 6-month time points showed a significant time-by-treatment interaction, whereby nicotine levels for the MI group decreased significantly and nicotine levels for the Self Help group increased but were not significantly different from baseline (Emmons et al, 2001, p.8). This study targeted a large sample of racially and ethnically diverse low-income families, in whom both exposure and

disease burden is likely to be significant. These findings have important implications for pediatric health care providers, who play an important role in working with parents to protect children's health. Providers can help parents work toward reducing household passive smoke exposure using motivational strategies and providing a menu of approaches regardless of whether the parents are ready to quit (Emmons et al, 2001).

Research suggests that MI is an evidence-based approach that effectively helps patients change behavior. MI has been used in the treatment of various lifestyle problems and diseases both psychological and physiological. Research shows that it outperforms traditional advice giving and can be effective in brief encounters of only 15 minutes (Gance-Cleveland, 2007, p. 88). MI offers a skill set to accomplish behavior change in various settings in which there is little time to work. Brief interventions can be accommodated by interviewing techniques and result in positive behavior change (Dart, 2011).

Chapter 3

Development of the Practice Model

Introduction

The postpartum/newborn home visit done by the Public Health Nurse (PHN) is like no other home visit. The welcoming of the newborn baby into the home is almost always a joyful occasion. It is an honor for the PHN to be allowed into the home of a new mother and newborn baby on the Pine Ridge Indian Reservation. The Oglala Lakota culture does emphasize honoring of the elders but also uplifts the children as they are the next generation that will carry and embrace the Lakota traditions. Because the Oglala Lakota culture honors the newborn baby, as its place in the mother's womb is sacred, the baby's sleep environment should also be considered sacred. Discussing the identified Sudden Infant Death Syndrome (SIDS) risk factors, and enhancing the concept that the creation of a safe sleep environment for the newborn to prevent SIDS is creating a sacred place for the baby to sleep.

Current Model of Patient Education

The PHN department currently receives referrals for all postpartum and newborn patients born in Pine Ridge and Rapid City, SD. During the referral process, the pt is asked by the postpartum nurse if she would like a home visit. The postpartum mother does have the option to decline the visit at anytime. The PHN arranges for a time to come into the patients' home and health education is done with the mother for her own postpartum needs as well as the newborn baby. The referral should be completed ideally within two weeks of hospital discharge. The patient education material used for the home visit covers a wide area of health needs. The Government Performance and Results Act (GPRA), provides the guidelines as to the health topics that need to be covered and documented for the patient. GPRA requires Federal agencies

to demonstrate that they are using their funds effectively toward meeting their missions. The law requires agencies to have a 5-year Strategic Plan in place and to submit Annual Performance Plans and Reports with their budget requests. The Strategic Plan describes long term goals of the agency and the Annual Performance Plan describes what the agency intends to accomplish toward those goals with their annual budget. Thus, the Plan contains specific performance measures for a 1-year period. The Annual Performance Report then describes how the agency measured up against the performance targets set in the Performance Plan (Indian Health Service, 2006).

Because the Aberdeen Area Indian Health Service (IHS) has a high rate of SIDS/Infant Mortality, special emphasis is put on SIDS prevention at the postpartum/newborn home visit. The Aberdeen Area IHS has an Infant Mortality Review Board which reviews the cases of all infant deaths annually. Patient education material specific to SIDS/Infant Mortality has been developed from theses reviews. The patient education materials are then distributed to the various IHS Service Units to be used on the postpartum unit as well as PHN during the home visit. The educational materials are culturally sensitive to the Native population (Indian Health Service 2009). Specific areas are addressed in the education material:

1.) Dangers of co-sleeping-promoting infant placed in crib, bassinette or playpen

2.) Placing newborn on the back for sleep

3.) No over-wrapping with blankets-infant sleeper and one blanket

4.) No soft pillows, stuffed animals, or bumper pads in crib.

5.) Dangers of using ETOH or Illegal drugs in presence of newborn.

6.) Promotion of breastfeeding.

Currently, when the patient education material is presented to the patient, it seems to be in a list form, where as the nurse checks off a list of things that need to be asked and documented for the home visit. The questions asked for the most part are not open-ended, many requiring yes or no answers. The nurse does get the needed information for documentation purposes, but often times the plan for a successful lifestyle change is not developed with the patient's input, but simply telling the new mother what to do and why she should do this for the health and safety of the baby.

Motivational Interviewing-Staff Training

The PHN staff will be trained in the use of motivational interviewing in one of two ways. Ideally, the staff would be sent for a 3 day workshop, learning the concepts and practicing motivational interviewing for example, the training offered on the website Motivational Interviewing-resources for clinicians, researchers or trainers (Motivational Interviewing, 2011). But because of budget constraints, the writer of this proposed educational model would take the training, and become a trainer, training two PHN's in the Pine Ridge PHN department the concepts of motivational interviewing, with an emphasis on brief interventions. The current patient education materials would then be presented to the staff using the concepts of motivational interviewing and the nursing process. The transtheoretical model of the stages of change developed by Procheska and DeClemente will be used to determine the readiness for change if needed in the postpartum patient, keeping in mind that the postpartum patient may move from one stage to the other during the home visit (Ashford et al. 2009). The four main principles guide the motivational interviewing technique: expressing empathy, support self-efficacy, develop discrepancy, and rolling with resistance. These four main principles need to be maintained to have a therapeutic interaction with a patient. Ideally, with proper communication

the patient and nurse establish a rapport to work together toward a common goal-the well-being of our patients (Dart, 2011, p. 11).

Culture Care Theory and Motivational Interviewing

The public health nurse will need to gather information to promote a potential change in the newborn's sleep environment using motivational interviewing and the Culture Care Theory to provide culturally congruent care. This culturally congruent care will contribute to the health or well being of the Oglala Lakota people to help them face health and wellness issues using the three theoretically predicted action and decision modes of the Culture Care Theory:

1.) Culture Care preservation and or maintenance.

2.) Culture Care accommodation and or negotiation.

3.) Culture Care repatterning and or restructuring.

These modes, whether one or all, need to fit with the informant's life ways. This is done by using the Sunrise Model. The Sunrise Model is a guide to discover new knowledge or to confirm knowledge of cultural informants (Leininger & McFarland 2006). The cultural and social dimensions used to determine which action and decision mode of the Culture Care Theory are:

1.) Kinship and social factors.

2.) Economic factors.

3.) Cultural values, beliefs and life ways.

4.) Environmental and historical dimensions.

The proposed educational model combines motivational interviewing and the Culture Care Theory components to guide the public health nurse visit to promote behavior change and including the steps of the nursing process for a patient centered problem solving approach.

During the home visit with the new mother and baby, the steps of the nursing process are followed. The first step is the assessment. During the assessment, the public health nurse's task is to elicit information. The sleep environment of the infant will be explored, gathering as much information as possible to identify any possible risk factors. With motivational interviewing, the PHN encourages the patient to participate, and take responsibility in her and her baby's health care. Questions asked by the PHN should be limited to promote therapeutic communication within the motivational interviewing model as well as looking at the cultural relevance of the questions being asked. Looking to the patient and at times the patient's family verbal and non-verbal reactions to the material and questions for guidance is also a valuable tool for the assessment. The following is an example of assessment presented by the PHN using the tools of motivational interviewing:

1.) Can you explain to me where your baby sleeps?

2.) When you lie your baby down for a nap or at bedtime, what position is the baby in?

3.) What kind of blankets and clothing does your baby wears to bed?

4.) How many people smoke in your home and where do they smoke?

5.) Let's talk about what kind of pillows or toys the baby has when he/she is sleeping?

The second step is to diagnose or identify the potential problem. Through assessment, the PHN will determine a diagnosis of motivation, and assessing the patient's readiness to attempt change. Behind motivational interviewing is the belief that most people are unsure about making a change and the focus should be on resolving that ambivalence (Miller & Rollick, 2003). The PHN's role is to help the patient get past the ambivalence stage and into change talk- when the patient verbalizes that she is considering making positive steps toward behavior change. This can be done by discussing and exploring the risk factors of SIDS, and what the

positive and negatives of making a change and not making a change are. Introducing the concept of creating a safe sleep environment is creating a "Sacred" place for the baby to sleep would be discussed at this time. The new mother will need time to explore her feelings, as well as the feelings of her family that may be sharing the home with her and the baby. There may be resistance from the new mother with the proposed change, maintaining empathy, understanding and nonjudgmental attitude is the needed approach. Also the reason for the resistance by the new mother should be explored. The cultural values and life ways present for the mother needs to be respected and observed during the home visit and taken into consideration if resistance to the potential changes in the newborn's sleeping environment is met. The following statements are examples of diagnosing the new mother's desire and motivation for potential change:

1.) So, you have told me that you baby sleeps with you in your bed during the night. Where do you think the safest place for your new baby to sleep is?
2.) You have mentioned that the baby's father and grandmother both smoke cigarettes in the house. How do you think you can protect the baby from the second-hand smoke in the home?
3.) How many blankets do you think are enough to keep the baby warm while she is sleeping?

The next step is the planning stage. In motivational interviewing, the patient participates in the planning. Goals set during this stage should be attainable and realistic for the new mother. The PHN and the new mother work together as a team toward meeting the goal. In this instance, the goal would be creating a safe sleeping environment for the newborn to prevent SIDS. The following is an example the PHN including the new mother in the planning for the potential change:

1.) You have told me that your grandmother and cousins are smoking cigarettes in the house and that you know it is not good for the baby. (Patient agrees) It is sometimes hard to ask people to go outside or to put the cigarette out, do you have any ideas of how you will be able to talk to your family members about not smoking around your baby?

The implementation stage is completed by the patient. The PHN would provide the needed education to attain the goal. Potential problems and roadblocks will need to be identified by the PHN and the new mother in the creation of the safe sleep environment. Environmental factors such as many people living in the home, elders not agreeing with the sleeping arrangements for the newborn baby, substance abusers living in the home are common findings on the Pine Ridge Indian Reservation due to the acute housing shortage and extreme poverty on the reservation.

The evaluation stage allows evaluation of what has been effective and what has not. This determines in which direction the encounter will go and possibly identifying other problems that need to be assessed and a plan of action to be determined. During the home visit, if potential SIDS risk factors have been identified in the baby's sleep environment and a change plan has potentially been created by the nurse and patient, a follow-up home visit would be offered to the patient by the PHN. At this home visit the PHN would re-assess the sleep environment of the infant, discuss the changes in the sleep environment that have been changed or not changed with the mother and assess for any other potential needs the new mother and baby may have.

Chapter 4

Evaluation/Discussion

The additions of motivational interviewing to the current patient education taught by the public health nursing department will help new mothers to create a safe sleeping environment for the newborn baby, preventing a death from Sudden Infant Death Syndrome (SIDS). The Public Health Nurse (PHN) that has received the training in motivational interviewing would pick 3 patients from the postpartum referrals received. The PHN would complete the initial postpartum home visit. If during the home visit, modifiable risk factors for SIDS have been identified in the sleeping environment and a change plan has been implemented by the patient and the PHN, a follow-up home visit would be discussed with the new mother. The follow-up home visit would be completed two weeks after the initial home visit is completed.

During the follow-up home visit, the PHN would re-assess the sleeping environment of the new baby. The goals that were set at the initial home visit would be assessed, met or not met. If modifiable SIDS risk factors were identified at the initial home visit, were they decreased or completely removed from the sleeping environment. The PHN would also ask the new mother if she noticed a change in the way the patient education was presented during the home visit, and if it was a positive or negative change. If the goals were met, the nurse would again interview the mother for any other potential hazards in the baby's sleeping environment. If the goals were not met, the risks and benefits of the proposed sleeping environment would again be discussed, using motivational interviewing to involve the mother in the change process, re-evaluating the readiness to change stage that the mother is in and complete another brief intervention with the mother promoting a safe sleep environment for the new baby. The PHN's would then review the results of the follow-up home visits. Emphasis on the changes of the sleep environment would

be assessed. The aspect of providing culturally congruent care would also be examined. As discussed earlier in this proposed method of patient education, Leininger's Sunrise Model would be used to include the cultural and social dimensions determining which action mode of the Culture Care Theory would be used to provide culturally congruent care. If the changes did indeed create a safer sleep environment for the Lakota newborn, the motivational interviewing training would be presented for implementation for the remaining PHN staff. After the implementation is completed in the PHN department at the Pine Ridge IHS hospital, the motivational interviewing with patient education model would be presented to the nursing staff in the obstetrics clinic and postpartum floor of the Pine Ridge IHS Hospital for possible implementation.

The arrival of a new baby into the home of a member of the Oglala Sioux Tribe is an exciting time for the family. Kinship is traditionally a very important part of life on the reservation. Often times during a home visit, not only is the new baby's grandmother present but also a great-grandmother may also be present. This also may be due to the economic factor of poverty on the reservation. Including kinship and social factors during the visit and in the proposed follow-up visit for evaluation is key for success in the patient and family to be involved in the decision making process. Discussing the historical precedence of co-sleeping and the newly discovered evidence of the dangers of co-sleeping to the newborn baby must be discussed, but done so in a way that is not offensive to the mother, and family. Honoring the culture and traditions of the family is key to establishing a trusting relationship where the proposed change is accepted by the family and not rejected. Knowledge of the Lakota culture combined with knowledge of SIDS prevention will direct the PHN to promote a "Sacred" sleeping environment. This is where the use of motivational interviewing can be a very useful tool, as the patient and

family are involved in the conversation and are taking the lead in creating the potential change in the baby's sleep environment.

The patient education combined with motivational interviewing needs to change with each patient. The plan of care will need to be individualized for each patient and potentially the patient or new mother's family as well. Traditionally, the members of the Oglala Sioux Tribe are quiet, stoic, avoiding eye contact with strangers. The topics covered at the home visit will need to be discussed at the level that each patient is comfortable with. The writer is familiar with the need to change the conversation, knowing that periods of silence does not mean failure, but that the patient will talk when she is ready and comfortable. The conversation between the nurse and new mother leading into the topic of a safe sleep environment will be different with each patient that is encountered. For example, a multi-gravid mother, who has slept with all of her new babies with no bad outcomes, will require different questions and responses compared to a first time teen mother who is very quiet, shy and scared. The presentation of the risk factors needs to be addressed with both patients, just in an individualized, respectful, culturally relevant manner to achieve the most productive outcome for the new mother and newborn baby.

Aberdeen Area of IHS has the highest rate of SIDS and the high rate of poverty that is on the Pine Ridge Indian Reservation. The rate of SIDS is higher for the Native Americans in the Northern Plains. The United States SIDS rate for all races was 10.7 deaths per 1000 live births. The All IHS rate was 18.1 deaths per 1000 live births; the Aberdeen Area rate was **27.6 deaths per live births.** SIDS is the leading cause of infant deaths in the Aberdeen Area, accounting for more than one fourth of the infant deaths (EagleStaff, Klug, & Burd, 2006, p. 141). The Pine Ridge Indian Reservation has an unemployment rate of aproximately 83-85%, the median income on the reservation is approximately $2600 to $3500 per year. There is an estimated

average of 17 people living in each family home, 33% of the reservation homes lack basic water and sewage systems (Schwartz, 2006). These statistics cannot go unnoticed and need to be adressed during the post-partum home visit. Discussing the preventable risk factors of SIDS, and determining what type of influence the poverty of the reservation has on the new mother will vary also from patient to patient. The fact that the mother is sleeping with her baby may be out of necessity as there is no room for a crib or bassinette in the home because of the multiple family members living in the home, or the presence of substance abuse in the home can be another reason a new mother feels the safest place for the baby to sleep is with her in her bed. These factors will need to be addressed on a case by case basis. The need for the PHN to be non-judgemental and to be objective during the visit is very important. The patient will not be open to change if she feels that she is being judged or looked down upon because of the living conditions of the home.

The health disparities on the reservation are not unknown to the new mother and her family as they live with them everyday. It is the job of the health care professional to educate the new mother and possibly her family in a positive way, the safe sleep environment, to promote positive behavior changes in the home and to prevent the newest member of the family from dying a preventable death.

Chapter 5

Conclusion

The addition of motivational interviewing to the current Sudden Infant Dealth Syndrome (SIDS) prevention materials used by the Public Health Nursing (PHN) department is a unique and new idea. The concept of having the patient assist is the goal making process is not unheard of, it has been used in substance abuse counseling and tobacco cessation counseling for many years. But, it is a change in the style of presenting patient education by the PHN nursing staff. The PHN department does focus on health promotion and disease prevention, and a large focus of the nursing practice is the postpartum/newborn home visit. The group of patients selected for this projected is viewed by the writer as a motivated group with a higher motivation to change because of the newborn being an addition to the home and the desired safety of the newborn by the post partum mother and family.

In the future, the addition of motivational interviewing to the patient education utilized by the postpartum staff on the obstetric unit at the Pine Ridge Indian Health Service (HIS) Hospital as well as the nursing staff in the prenatal clinic would potentially be proposed to the nursing adminstration at the Pine Ridge (IHS) Hospital. The concept of the patient creating a "plan of change for a Sacred sleep environment" when she is pregnant, ideally having the plan implemented prior to delivery, would be ideal for the newborn baby when coming home from the hospital. The PHN department would still be seeing the newborn and mother in the home, receiving information on the referral that is needed to assist the postpartum mother further in the creation of the safe sleep environment for the newborn baby using motivational interviewing as a tool. The use of Leininger's Sunrise Enabler, using the kinship, social and ecomonic factors to

ensure culturally competant care is given to the new mother and baby would be included in the nursing education presented by the postpartum and prenatal clinic nursing staff.

Reflection

While I was doing the reading for the literature review for this proposal, the statistics for SIDS still are daunting to me. The thought that these new babies are possibly dying a preventable death was the reason for me creating a proposed change in the current patient education teaching that is done in the home with the new mother and family. I was reminded of this during a recent home visit with a new mom and baby. This was her fifth child, and she has practiced co-sleeping with all of them. I asked her if she had a crib or bassinette for the baby to sleep in, she stated "My mother says no babies can sleep in cribs in this house. My niece died of crib death because she was afraid of the crib" (RRS personal communication 3/17/2011). The reason I became a nurse so many years ago was I had a desire to help people live a better, healthier life. That same desire is still there. After developing this proposed change in the presentation of patient education, it has given me a new hope that I can potentially save a life. I do not know if my coworkers in the Public Health Nursing Department here in Pine Ridge will embrace this idea that I am proposing. Motivational Interviewing does take some practice and time to get implemented into your nursing practice. When I started to use motivational interviewing on the postpartum patients that I see, I did have to stop and rephrase my statements and questions more than once. But the more that I practice it with each home visit, the more I have become at ease with this type of nurse-patient interaction. The historical trauma by the United States Government that is documented with the Native Americans in Pine Ridge has made patients mistrustful of IHS and the idea of being told what to do and why, does not work with the patient population living in Pine Ridge. I am hopeful, that having the patient discover

what a safe sleep environment is through motivational interviewing done in a caring and culturally respectful way and the use of the culturally relevant patient education materials that are specific to address the safe sleep environment will decrease the number of babies dying a preventable death.

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