

Using appreciative inquiry to enhance family centred care in the neonatal intensive care unit

Suza Trajkovski

This thesis is submitted to fulfil the requirements for the degree

Doctor of Philosophy (PhD)

Western Sydney University

2016

Dedication

I would like to dedicate this thesis to the fragile yet strong neonates that fight for life each and every day and to the parents that watch over their infant/s helplessly as their dreams and wishes of having a normal pregnancy and term deliver are shattered. To the health professionals that work tirelessly each and every day to care for these neonates and their families during what would be one of the parents and neonates most difficult times in their life.

Acknowledgements

I would like to extend my deepest gratitude to my family, friends and colleagues that were by my side to make this thesis possible. I would like to sincerely thank my supervisors Professor Virginia Schmied, Professor Margaret Vickers and Professor Debra Jackson for sharing your knowledge and expertise, supporting and remaining with me throughout my candidature, and for believing in me every step of the way. You gave me the guidance and encouragement I needed to get through the PhD journey. I am grateful to have wonderful supervisors and I am sure our professional relationships will extend beyond the life of this thesis. Your amazing work ethic and dedication to research is truly inspirational and admirable.

To the Western Sydney University, School of Nursing and Midwifery staff and fellow PhD students, thank you for your ongoing encouragement, support and words of wisdom throughout this journey. A big thanks to Rhonda Griffiths and Cecily Hengstberger-Sims for your ongoing support and guidance both professionally and personally. I am so grateful to the staff that believed in me, and all the opportunities that came my way. Your support gave me the strength to continue with my studies. The corridor conversations and banter made daily processes easier and reminded me to have fun along the way.

In addition to the staff that supported me in the academic environment, I would like to acknowledge the people that have supported me throughout my PhD journey outside the University environment. I would like to sincerely thank the staff and parents from the neonatal intensive care unit at Liverpool hospital and the Miracle Babies foundation. Thank you for giving up your time to share your personal experiences so openly and honestly. Thank you for believing in this study and contributing to the future possibilities for neonates and their families.

To my dear friend Jan, we started off as work colleagues and a true friendship was formed. Thank you for seeing 'something' in me. You were willing to share your worldly knowledge and always encouraged me to take what I would call 'risks' and you would call 'stepping stones'. You planted the seeds in my mind to engage in research and to pursue a career in academia. Thank you for believing in me. I will cherish our friendship forever.

To my amazing family, without your endless support I would not have been in a position to start nor complete this thesis. Your kindness, encouraging words and unconditional love is gold. You put things into perspective for me and bring peace and joy to my life.

To my parents, Pejo and Neda Trajkovski, Thank you so much for your unconditional love, generosity and lifelong support. I feel so blessed that I have wonderful parents as role models that have shaped the person I am today. To dad, the visionary man you are, for always being there for me, giving me honest career and life advice and most of all believing in me every step of the way. To mum, for you too were a mother who gave birth to a premature newborn baby (me) and remained strong when the outcomes of premature babies were not so great. You have loved me unconditionally since the day I was born. You always know the right words to say without effort, you are truly the most kind and caring person I have ever met.

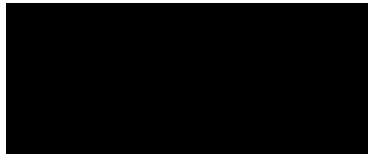
To my dearest sister Violeta and family Russell, Stacey, James and Nathan, I extend my deepest gratitude. Thank you so much for being there for me at any time of day or night with your honesty, support, and patience. You have given me strength and encouraged in me, determination and drive. You have been with me not only through my PhD journey, but my life journey.

To my brother Lupco and family Suzana, Monique and Emily, thank you for providing your help whenever I needed it. You have always been there for me especially when I was at my wits end with technology and felt like stomping on my computer. You would effortlessly fix something I struggled with for days in a mere few clicks of a button.

Above all, I would like to acknowledge my biggest love, strength and inspiration for everything I do, to my beautiful daughter Chelsea. Thank you for all the times you sat quietly while I worked at home on my thesis, for coming to conferences with me and for offering to help write my thesis when you were just a mere four years of age. Your ongoing feedback when I would be practicing my conference presentation at home, for being my biggest fan and just being the kind, loving and generous daughter that you are. Your hugs give me a strength I never thought was possible. Your smiles and laughter gives me the greatest joy. You are everything plus more than I have ever dreamed of in a daughter. You truly make me a proud mother and for that I am eternally grateful.

Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.



.....
Suza Trajkovski

2016

Thesis Outcomes

This thesis is presented as a series of four published manuscripts and a fifth manuscript has been accepted and is currently in press. Each paper has been submitted and accepted by highly ranked peer reviewed international journals. Findings of this study have been presented at distinguished national and international conferences. Publications, merit awards and oral conference presentation are listed below.

Publications

- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2015). Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian*, (in press) doi: <http://dx.doi.org/10.1016/j.colegn.2015.05.004>
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop. *Journal of Child Health Care*, 19(2), 239-263. doi: 10.1177/1367493513508059
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Implementing the 4D cycle of appreciative inquiry in health care: A methodological review. *Journal of Advanced Nursing*, 69(6), 1224-1234. doi: 10.1111/jan.12086.
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Using appreciative inquiry to transform health care. *Contemporary Nurse*, 45(1), 95-100. doi:10.5172/conu.2013.45.1.95
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspectives of family-centred care: A qualitative study. *Journal of Clinical Nursing*, 21(17-18), 2477-2487. doi: 10.1111/j.1365-2702.2012.04138.x.

International published abstracts

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspective of family centred care in the NICU. *Journal of Paediatrics and Child Health* 48 (suppl.1) 2-169. [abstract].

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2010). Using appreciative inquiry to enhance family centre care in the neonatal intensive care unit. *Journal of Paediatrics and Child Health* 46 (suppl.1) 7-55. [abstract].

International and national conference presentations

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). *Neonatal nurses' perspectives of family centred care: A qualitative study*. Westmead International Update on Advances in Perinatal Care. Westmead, Australia. Invited Speaker.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). *Neonatal nurses' perspective of family centred care in the NICU*. Presented at, 17th Congress of the Federation of Asian and Oceania Perinatal Societies and the 16th Annual Congress of the Perinatal Society of Australia and New Zealand. Sydney Convention and Exhibition Centre, Darling Harbour, Sydney, Australia.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2011). *Family centred care in the NICU*. Presented at, 'High-risk mothers and babies'. Association of Neonatal Nurses of NSW 22nd Annual Conference. Sydney Marriott Hotel, Sydney, Australia.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2011). *Enhancing family centred care in neonatal intensive care: Workshop outcomes*. College of Health Science, School of Medicine, University of Western Sydney, Campbelltown, Australia.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2011). *Using appreciative inquiry to bring mothers' and nurses' together to implement family centred care*. Presented at, 'Mothering: challenges, change and hope'. University of Western Sydney, Parramatta, Australia.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2010). *Using appreciative inquiry to enhance family centre care in the neonatal intensive care unit*. Presented at, Perinatal Society of Australia and New Zealand 14th Annual Congress. Wellington Convention Centre, Wellington, New Zealand.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2009). *Parent-nurse relationships in the neonatal intensive care unit*. Presented at, 'What lies ahead: The future for Neonates, Families & Nurses'. Association of Neonatal Nurses of NSW, Sheraton on the Park, Sydney, Australia.

Awards

Trajkovski, S. (2013). *Using appreciative inquiry to enhance family centred care in the neonatal intensive care unit-Tina's story*. School of Nursing and Midwifery. University of Western Sydney, Parramatta Campus.

- UWS 3 Minute Thesis School of Nursing & Midwifery Final Contestant Winner

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2010). *Using appreciative inquiry to enhance family centred care in the neonatal intensive care unit-PhD overview*. College Research Futures Postgraduate Forum. University of Western Sydney, Werrington South, Penrith Campus.

- Awarded First Place for best presentation in the 'Sustainable Health and Wellbeing Research Theme'.

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2010). *Family centred care in the neonatal intensive care unit*. Sydney South West Area Health Service. Liverpool Hospital. International Nurses' Day.

- Nurses and Midwives achievement award 'In recognition of valuable contributions made to nursing and Midwifery Services' related to research and conference presentation.

Table of contents

Dedication	ii
Acknowledgements	iii
Statement of Authentication	v
Thesis Outcomes	vi
Publications	vi
International published abstracts	vii
International and national conference presentations	vii
Awards	viii
Table of contents	ix
List of tables	xiii
Abbreviations	xiv
Abstract	xv
Prologue	xvii
Chapter 1: Introduction	1
1.1. Framing the study	1
1.2. Background	2
1.3. Parents experiences in the NICU	3
1.4. Developmental care and kangaroo care	5
1.5. Family centred care	6
1.6. Challenges implementing FCC	8
1.7. Aim of the study	9
1.8. Significance of the study	10
1.9. Structure of the thesis	10
1.10. Conclusion	12
Part A	13

Theoretical framework, methodology and research methods	13
Chapter 2: Using appreciative inquiry to transform health care	14
2.1. Publication	14
2.2. Introduction and relevance to thesis	14
2.3. Conclusion	22
Chapter 3: Implementing the 4D cycle of appreciative inquiry in health care: a methodological review	23
3.1. Publication	23
3.2. Introduction and relevance to thesis	23
3.3. Conclusion	35
Chapter 4: Methodology and research methods	36
4.1. Introduction	36
4.2. The research process	36
4.3. Study setting	36
Phase 1: Discovery phase	37
Phase 2: Dream and design	40
Phase 3: Destiny phase	42
Study rigour	44
Ethical considerations	47
4.4. Conclusion	49
Part B	51
Findings	51
Chapter 5: Neonatal nurses' perspectives of family-centred care: a qualitative study	52
5.1. Publication	52
5.2. Introduction and relevance to thesis	52
5.3. Conclusion	64
Chapter 6: Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop	65

6.1. Publication	65
6.2. Introduction and relevance to thesis	65
6.3. Conclusion	81
Chapter 7: Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: the destiny phase of an appreciative inquiry project.....	82
7.1. Publication	82
7.2. Introduction and relevance to thesis	82
7.3. Conclusion	92
Chapter 8: Researcher's reflection	93
8.1. Reflections on the study	93
Great Expectations	94
Negotiations around role boundaries	96
Progressing the agenda.....	102
Ongoing challenges for nurse-led initiatives	103
8.2. Conclusion	104
Chapter 9: Discussion.....	105
9.1. Synthesis of findings.....	105
9.2. Using AI to promote organisational change in the NICU	107
Learning Organisations.....	111
Network structures and professional relationships	112
Collaborations with parent consumers.....	114
Nature of FCC as an innovation	114
New directions in NICU care.....	118
9.3. Implications for nursing practice	118
9.4. Strengths and limitations of the study.....	119
9.5. Directions for future research	120

9.6. Concluding thoughts.....	120
References.....	121
Appendices	130
Appendix 1: UWS HREC approval	131
Appendix 2: SSWAHS HREC (western zone) approval	132
Appendix 3: Invitation to participate notice (nurses).....	134
Appendix 4: Invitation to participate notice (parents)	136
Appendix 5: Participant information statement.....	138
Appendix 6: Participant consent form.....	141
Appendix 7: Interview/focus group question (discovery phase)	145
Appendix 8: Workshop Program (dream/design phase)	146
Appendix 9: Workshop questions.....	147
Appendix 10: FCC working party meeting topics	148
Appendix 11: Interview/focus group questions destiny phase.....	151
Appendix 12: Publication acceptance letter-Collegian	152

List of tables

Table 1.1: Nine elements of FCC.....	7
--------------------------------------	---

Abbreviations

AI:	appreciative inquiry
DC:	developmental care
FCC:	family centred care
FIC:	family integrated care
IFCC	institute of family centred care
IPFF	institute of patient and family centred care
KC:	kangaroo care
NBC:	newborn care
NICU:	neonatal intensive care unit
NIDCAP:	newborn individualized developmental care and assessment program
SCN:	special care nursery

Abstract

A preterm or complicated birth and the subsequent hospitalisation of the neonate can be a traumatic and stressful experience for both parents and neonates. Parents often encounter challenges to the development of their parenting roles while in the neonatal intensive care unit (NICU), potentially resulting in immediate and long-term impacts on the neonate and overall family functioning. To support and meet the needs of parents experiencing a NICU admission, family centred care (FCC) has been developed and acknowledged as the 'best way' of caring for hospitalised children. The philosophy of FCC focuses on the health and wellbeing of the newborn and their family, through the development of respectful partnerships between health care professionals and parents. A general consensus exists in the literature regarding the value and importance of FCC. However, published research identifies major barriers in the implementation of this philosophy into clinical practice.

An appreciative inquiry (AI) approach was used in this study to bring neonatal nurses and parents together to examine their perceptions and experiences of FCC and to collaboratively develop innovative strategies to improve care for the neonate and family. AI is a theoretical research perspective, an emerging research methodology and a world-view that builds on action research, organisational learning and organisational change. AI offers a unique, positive participatory strength-based approach to promoting organisational learning, facilitating change and building effective partnerships. AI consists of four phases known as the 4D cycle (discovery, dream, design and destiny).

The discovery phase of the study set out to explore neonatal nurses' and parents' perceptions of FCC. This phase consisted of four focus groups and five face-to-face interviews with 33 neonatal nurses and one focus group with six parents (total n=39). Data were analysed using inductive thematic analysis and four dominant themes emerged 'Getting to know parents and their wishes', 'Involving family in the day to day care', 'Finding a happy medium' and 'transitioning across the continuum'.

The dream and design phases consisted of one full day workshop that brought neonatal nurses and parents together to collectively explore FCC in the neonatal intensive care unit (NICU). The workshop consisted of nine neonatal nurses and six graduate NICU parents (total n=15). During this phase parents and nurses developed collaborative insights about optimal FCC that could be built upon to support neonates

and families. Data were analysed using inductive thematic analysis. One overarching theme emerged 'sharing experiences and stories' that comprised four sub themes: 'discovering what works well'; 'dreaming of the ideal'; 'fixing things'; and, 'destiny, projections for the future'. As a result of the workshop a FCC working party was formed where parents and nurses agreed to meet on a monthly basis to develop and implement strategies to enhance FCC in the NICU. Researcher reflective field notes were thematically analysed and the following themes emerged 'great expectations'; 'negotiations around role boundaries'; 'progressing the agenda'; and 'ongoing challenges for nurse led initiatives'.

The destiny phase of the study reports on the progress and experiences of the FCC working party two years from when the working party was formed. Two focus groups and four individual face-to-face interviews were held (n=12 participants). Data were analysed using thematic analysis. Four dominant themes emerged 'creating a physical and mental space'; 'building and maintaining momentum'; 'ongoing organisational support'; and, 'continuing collaborations'.

This is the first known study that has used an AI approach to bring neonatal nurses and parents together to collaboratively develop strategies to strengthen FCC in the NICU. This original research aimed to improve neonatal outcomes and contribute to a body of knowledge surrounding FCC in the NICU. The findings of this study revealed that while neonatal nurses report a commitment to FCC, there continues to be incomplete or inconsistent applications of FCC principles in neonatal care. While nurses report the need to deliver FCC, the study revealed that successful implementation of FCC in the NICU is difficult and requires time, education, resources and ongoing organisational commitment and support. This study highlighted the importance of developing social networks and the need for interdisciplinary collaborations that includes both health professionals and families. AI provided a useful framework for this study and created opportunities for the exchange of information, networking and developing partnerships and collaborations.

Prologue

I am a neonatal intensive care nurse and have worked in a tertiary neonatal intensive care unit (NICU) for over 15 years. Prior to working in the NICU I gained general nursing experience in various generalised and specialised hospital wards and nursing home facilities. Like many nurses when initially entering the NICU I was overwhelmed by the fragile newborn babies requiring specialised neonatal care. I received clinical training and academic achievements in special care and neonatal intensive care nursing.

My interest in neonatal care began in 1973 when I was born prematurely. Ten years preceding my birth, neonatal care had significantly changed and neonatal units were being established in most developed countries. When I asked my mother about my birth, she described a time of both extreme joy and sadness. Relatively new in Australia, mum had very limited English and no immediate family or support systems to call upon, except for my dad and older sister who was two years of age at the time. Mum was seven months pregnant when she unexpectedly went into labour. She was sent home from work and dad made it home just in time to drive mum to the nearest hospital. Arriving at the birthing unit, dad was asked to wait outside as this was during an era when men were not permitted to view the birth of their baby. Mum gave birth to me as she was being escorted into the birthing suite.

The first time my mother and father saw me was through a viewing window, in an incubator lined up alongside several term babies in cots. Mum describes her experience of feeling helpless and scared, unsure of whether I was going to live or die. She described hearing other people at the viewing window talking about me saying, 'that baby is just too small' and 'I don't think she will survive'. Mum and dad described this as a difficult time in their lives and over 40 years later mum still gets tears in her eyes as she retells her story.

When I commenced work at the neonatal intensive care unit I became more inquisitive and wanted to learn more about my birth, the delivery, the hospital and the type of care I received. Ironically, the hospital where I was born was the same hospital I was later employed in.

The hospital has since grown in size and technology has significantly advanced. Nowadays, baby-viewing windows no longer exist. Fathers, families and friends are permitted to view the birth of a baby and unrestricted visiting policies for parents are in

place. Mothers no longer remain in hospital for weeks at a time following the birth of their newborn, but are discharged within a couple of days, some even within a few hours post-delivery.

The stories my mother shared about her experience over 40 years ago resonated with many stories I was hearing from mothers in the current neonatal unit context. I felt compelled to explore this phenomenon in more detail and more importantly identify and develop ways of helping neonates and their families during a potentially difficult time in their lives. To this end, I present this thesis.

Chapter 1:

Introduction

1.1. Framing the study

The birth of an infant requiring neonatal care is a traumatic and stressful experience for both parents and the neonate. The normal parental process and preparation for parenthood is interrupted and parents are often not prepared physically, psychologically, or emotionally for such an event (Jiang, Warre, Qui, O'Brien, & Lee, 2014). Over the last 15 years significant efforts have been made to strengthen models or approaches to care to address infant and family needs. Neonatal units have shifted from restrictive hospital policies that previously excluded families, to policies emphasising the need to meet individual family needs and position parents as partners in the care of their infant (Coyne & Cowley, 2007).

Family Centred Care (FCC) is an approach to care and philosophy that has been well reported in the literature as the ideal way of caring for hospitalised children. FCC was primarily developed for hospitalised children and families in paediatric wards and later adopted into neonatal settings. However, little is known about neonatal nurses' and parents' understanding of the philosophy of FCC in a neonatal context. While partnership is a core principle, little research has been conducted that brings both neonatal nurses and parents together to jointly develop strategies or interventions that may improve neonatal care. This thesis responds to this by using an appreciative inquiry (AI) methodology as a pedagogical tool for enhancing FCC in the NICU. This thesis will report on the four phases of an AI project (discovery, dream, design and destiny) and identify implications for future practice.

To frame this study, this introductory chapter provides the background to the study undertaken for this doctoral thesis including the history and evolution of neonatal care, an overview of the literature surrounding FCC, and introduces the philosophical and theoretical underpinnings of the study. The research aims and objectives, significance of this study and structure of the thesis will be provided.

1.2. Background

Prior to the industrial revolution premature neonates were born and cared for in the home without any medical interventions and either survived or passed away (Thomas 2008). Complications from premature birth were first documented as early as the 17th century however, it wasn't until 1922, when hospitals began to group neonates into one area in the hospital (Thomas 2008). Today this is known as the neonatal intensive care unit (NICU) (Thomas 2008). Neonatal care changed significantly and rapidly following the highly publicised desperate struggle to save the life of neonate Patrick Bouvier Kennedy in 1963, the son of sitting President John F. Kennedy and Jacqueline Kennedy (Baker, 2010; Phillip, 2005). Sadly, little Patrick passed away. From this point on, coupled with earlier significant advancements made by Parisian doctors Stephane Tarnier (father of the incubator) and Pierre Budin (importance of breast milk, mothers/infant attachment, father of modern perinatology) and the controversial public display of infants as a side show attraction in Coney Islands Fair by Martin Couney the discipline of neonatology was born (Baker, 2010; Phillip, 2005).

The term 'neonatology' was first coined in the 1960's by Alexander Schaffer M.D., and by the 1970's neonatal units were established in most high income countries (Phillip 2005). The emergence of sophisticated neonatal technologies and more aggressive clinical management transformed neonatal care forever (Manley, Doyle, Davies & Davis, 2014; Phillip 2005). As doctors showed greater interest in childbirth and the development of increased monitoring systems, by the 1980s more than 90% of births were taking place in hospitals rather than homes (Phillip, 2005). Greater knowledge was gained by observing the neonate and monitoring interventions became areas for further observation and research.

Much was learnt about the importance of keeping the neonate warm (Mance, 2008; World Health Organisation, (1997), the negative impact of high concentrations of oxygen levels resulting in infant blindness (Burloiu, 2015; Terry 1942), the importance of breast milk and small, frequent feeding regimes (Meier, Engstrom, Patel, Jegier & Bruns, 2010) and the introduction of pulmonary surfactant therapy, allowing oxygenation and ventilation of underdeveloped lungs (Enhoring & Robertson, 1972; Lopez, Gascoin, Flamant, Merhi, Tourneux & Baud, 2013). During this time infants were cared for exclusively by health professionals where physicians adopted an authoritarian role, nurses' became the infant's carer and families were bystanders (Harrison, 2010).

Remarkable advances in the care of infants born prematurely resulted in a significant reduction in infant mortality rates. In Australia, premature births make up 8.3% of annual births and approximately 15.3% of live born infants require neonatal care (Li, Zeki, Hilder, & Sullivan, (2013). Globally, the current average rate of premature births is approximately 11.1% and rising (Evans, Whittingham, Sanders, Colditz & Boyd, 2014). Infants previously considered non-viable are now being treated resulting in reduced neonatal morbidity and mortality rates (Redshaw & Hamilton, 2010). Prior to the establishment of neonatal units, infants born less than 30 weeks gestation and less than 1400 grams rarely survived. Whereas, today, infants approximately 500 grams and 24 weeks gestation have a fair chance at survival (Als & McAnulty, 2011).

Unfortunately, the social and emotional care and support of these infants and their parents lagged behind technological advancements, raising questions in the 1980's about the human and economic costs of too much technology (Redshaw & Hamilton, 2010). The importance of the mother-infant relationship was emphasised with seminal works on the phenomenon of bonding and attachment theories (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1982; Klaus & Kennell, 1976). The Platt report (1959) highlighted the negative effects of separating parents from their sick children. Bowlby (1969) reported the high levels of stress and anxiety experienced by children and their families caused by their separation during periods of hospitalisation. This work has led to more liberal NICU hospital visiting policies.

1.3. Parents experiences in the NICU

Infant admission to a neonatal unit is known to be a very stressful experience for parents (Fegran, Fagermoen & Helseth, 2008; Whittingham, Boyd, Sanders & Colditz, 2014). Descriptions from mothers when first seeing their infant in the nursery is that of relief and happiness coupled with shock, fear, anxiety, guilt, alienation, grief and despair (Erlandsson & Fagerberg, 2005; Gangi, Dente, Bacchio, Giampietro, Terrin & De Curtis, 2013; Hall, 2005). Parents often struggle with the unfamiliar and intimidating NICU environment (Fegran, Fagermoen & Helseth, 2008; Gangi et al., 2013) and have reported feeling overwhelmed by the busy, bright, over-crowded and noisy environment, and extensive monitoring systems (Heermann, Wilson & Wilhelm, 2005).

A systematic review conducted by Obeidat, Bond and Callister (2009) and meta-synthesis by Aagaard and Hall (2008) exploring NICU parents experiences reported studies of mothers feeling distressed at the inability to hold, help, care and protect their infant. Mothers have expressed feelings of frustration, loneliness and depression and

describe oscillating between feelings of hope and hopelessness (Goutaudier, Lopez, Sejourne, Denis & Chabrol, 2011; Whittingham et al., 2014). Mothers have reported on the challenges in transitioning to their parental role when their infant is in the NICU and describe the NICU experience like being in an alien world, a visitor and a spectator to their infant's care (Hall, 2005; Obeidat, Bond & Callister, 2009).

Studies have shown that mothers have a strong desire to be 'close to' and the need to 'get to know' their baby (Fenwick, Barclay & Schmied, 2001) while others have expressed ambivalence and fear of attachment due to uncertainties of whether their infant will survive (Hall, 2005). The process of shock, denial, anger, guilt, acceptance and adjustment are classic grief reactions experienced by NICU parents (Saunders, Abraham, Crosby, Thomas & Edwards, 2003; Whittingham et al., 2014).

Research has suggested that these experiences may have long-term effects on the health of individuals (particularly mothers) and on overall family functioning (Talmi & Harmon, 2003; Whittingham et al., 2014). Longitudinal studies of NICU families suggested that for at least some time following the infant's discharge, families' may experience difficulties in their day-to-day activities and in their ability to cope with infant care (Talmi & Harmon, 2003; Holditch-Davis, Bartlett, Blickman & Miles, 2003; Shaw, Deblois, Ikuta, Ginzburg, Fleisher & Koopman, (2006). Issues stem from stress caused by the hospitalisation itself and may lead to symptoms of acute stress disorder (ASD), a precursor to post traumatic stress disorder (PTSD) (Holditch-Davis, Bartlett, Blickman & Miles, 2003; Shaw et al., 2006). Analyses of specific sources of stress indicate that alteration in the parental role was most strongly associated with the symptoms of ASD. Reported outcomes of disrupted parenting include higher than average rates of child abuse, neglect and increased incidence of family breakdown (Talmi & Harmon, 2003; Shaw, et al., 2013; Feeley, Zelkowitz, Cromier, Charbonneau, Lacroix & Papageorgiou, 2011). Such families have been identified as having a higher risk of financial difficulties and divorce.

Over the last 15 years, significant efforts have been made to develop models or strengthen approaches to address the needs of infants and parents. These include the efforts of the Institute of Patient and Family Centred Care (IPFCC), March of the Dimes NICU family support and developmentally supportive care initiatives such as newborn individualized developmental care and assessment programme (NIDCAP).

1.4. Developmental care and kangaroo care

As part of the broad context of FCC, developmental care (DC) and kangaroo care (KC) were reported in the mid 1980's. DC was introduced due to concerns about the potential negative impacts of the environment on neonatal morbidity and strategies were introduced to minimize iatrogenic effects in order to support preterm neuro-maturation (Als, 1986). Strategies include protecting the infant from the environment and external stimuli such as adjusting noise and lighting levels; promoting soothing behaviours through minimal handling, positioning techniques, pain management, non-nutritive sucking and cue based cares (Als, 1986).

Originally, DC primarily focused on the infants' physical developmental needs, and later incorporated the importance of parent-infant interactions in facilitating infant growth and development. It is suggested parents have an intuitive understanding of their infants' behavioral signals and can positively contribute to their infants care (Als, 1986; Kleberg, Hellström-Westas, & Widström, 2007). Reported benefits of DC from quasi-experimental studies include a reduced need for respiratory support (Als, 1986; Brown & Heermann, 1997) improved weight gain (Brown & Heermann, 1997), improved feeding practices (Als, 1986), decreased incidence of interventricular haemorrhage (Als, Lawhon, Duffy, McAnulty, Gibes-Grossman & Blickman, 1994) and improved developmental outcomes indicating improved motor competency and increased visual and physical contact with the parent (Kleberg, Westrup & Stjernqvist, 2000). Reduced hospital stays and decreased hospital costs have also been reported (Als, 1986). Randomised control trials of infants that received DC strategies, such as NIDCAP interventions in the NICU reported at eight years of age, children had significantly improved right hemisphere and right frontal lobe functions both neuropsychologically and neurophysiologically compared to infants that did not receive NIDCAP interventions (Mc Anulty, Bulter, Bernstein, Als, Duffy & Zurakowski, 2010).

DC interventions include practices such as KC to encourage positive parent-infant interactions. KC is skin-to-skin, chest-to-chest contact between the infant and parent by placing the infant on the maternal or paternal bare chest (Boukydis, 2011). KC was initially introduced in an attempt to lower the high mortality rates of premature infants in countries with limited neonatal resources. However, the staggering reduction in mortality rates from 70%-30% following the implementation of KC resulted in the introduction of KC in resource-rich countries by the 1980's (Aucott, Donohue, Atkins & Allen, 2002; Smith, 2007). Reported benefits identified in a systematic review of KC include increased maternal breast milk supply and improved infant digestion,

temperature, heart rate and respiratory stability, increased infant weight gain and improved parent-infant bonding and interaction (Conde-Agudelo, Belizan & Diaz-Rossello, 2011).

Other reported benefits of DC and KC include increased infant comfort levels and reduced infant stress during hospitalisation resulting in improved long-term developmental outcomes (Ludwig, Steichen, Khoury & Krieg, 2008). This has led to greater attention on NICU ward design and more recently a shift from traditional open plan 'baby barn' style neonatal units to single room/pod and double room/pod designs. Reported benefits of the single room pods are less over stimulation of the infant and a quieter more spacious and private environment for the neonate and the family (Carter, 2008 p.827). However, despite the reported benefits of DC and KC, parents are often excluded or limited to the amount of involvement in DC and KC practices in the NICU.

1.5. Family centred care

In order to meet the needs of parents experiencing an NICU admission, the concept of FCC has been adopted from paediatrics into neonatal units and broadly promoted as an ideal standard of care (Redshaw & Hamilton, 2010). The concept of FCC was developed based on the seminal work by Bowlby (1959) and the Platt Report (1959) that highlighted the detrimental physical and psychological effects of separating a child from the family.

The Institute for Family Centred Care (IFCC) was formed in 1992 to develop strategies and resources to facilitate a FCC approach. FCC is a philosophy of care that can be described as "a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients" (Shields, Pratt & Hunter, 2006 p.1318). FCC acknowledges the emotional, developmental and social needs of infants and the family (Shields, Pratt & Hunter, 2006).

In 1987, Sheldon created a framework and developed eight elements of FCC (Shields, Pratt & Hunter, 2006). A further element was later added. The nine elements for FCC are listed by the IFCC as:

Table 1.1: Nine elements of FCC

- recognising the family as a constant in the child life;
- facilitating parent-professional collaboration at all levels of health care;
- honouring the racial, ethnic, cultural, and socio-economic diversity of families;
- recognizing family strengths and individuality and respecting different methods of coping;
- sharing complete and unbiased information with families on a continual basis;
- encouraging and facilitating family-to-family support and networking
- responding to child and family developmental needs as part of health care practices;
- adopting policies and practices that provide families with emotional and family support; and
- designing health care that is flexible, culturally competent, and responsive to family needs.

(Shields, Pratt & Hunter, 2006 p. 1318).

A core principle of FCC is the need to develop collaborative partnerships between parents and health professionals promoting health and wellbeing of individuals and their family by restoring dignity and control to parents (Institute for Patient and Family Centred Care, 2012). Communication and information sharing, joint decision making, respect and trust is considered fundamental in building relationships (Institute for Patient and Family Centred Care, 2012).

The philosophy of FCC encourages greater consumer involvement, autonomy, respect, collaboration and empowerment (Smith, Swallow & Coyne, 2015). The notion of partnership in care implies an equal relationship between families and health care professionals where information is shared, care negotiated and skills acknowledged (Casey, 1988; Wiggins, 2008). Such partnerships are characterised by a shift in the nurses' role from being 'the expert' to one of guidance (Lee, 1999; Reis, Rempel, Scott, Brady-Fryer & Van Aerde, 2010). Reported benefits of successful partnerships included improved health outcomes, (Hook, 2006), and more empowered, knowledgeable and confident parents (Bidmead & Cowley, 2005; Hook, 2006).

FCC is a partnership approach to health care decision-making between families and health professionals and has been considered integral in improving the outcomes of neonates and their families (Bidmead & Cowley, 2005; Goutaudier et al., 2011; Whittingham et al., 2014). Principles underpinning FCC promote parents as the 'constant' in the infant's life and stresses the importance of the parent-infant's

relationship for growth and development. Within this philosophy, mothers and family members are considered the best people to care for and nurture their infants.

A plethora of literature exists supporting FCC including policy documents, commentaries and literature reviews. There is recognition and endorsements by state and federal legislative bodies, and FCC is the second guiding principle in the international neo baby-friendly hospital initiative for neonatal wards (Hutchinson, 2015).

1.6. Challenges implementing FCC

Consensus exists in the literature regarding the value and importance of FCC however implementing the family centred approach is proving difficult. Discrepancies exist between definitions of FCC along with difficulties in executing FCC into daily practice (Kuo, Houtrow, Arango, Kuhlthau, Simmons, & Neff, 2012; Coyne, O'Neil, Murphy, Costello & O'Shea, 2011). There is a lack of consensus in the literature for what constitutes parent participation in the neonatal nursery. Studies have shown inconsistencies in implementing FCC, indicating busy workloads, disempowerment, poor communication, ambiguity about parental and nurse roles, lack of role negotiation and level of involvement in care resulting in a disorganised approach to FCC (Wilson, McCormack & Ives, 2005; Coyne & Cowley, 2007; Darbyshire, 1995). Organisational barriers such as health system design, lack of emotional support for staff, restrictive hospital/unit policies, the physical environment and inadequate education have been reported as contributing factors (Hutchfield, 1999; Kuo, et al., 2012; Petersen, Cohen & Parsons, 2004).

Research indicated that neonatal nurses have experienced difficulties in supporting and facilitating parental participation while parents are struggling to identify what nurses expect from them (Coyne & Cowley, 2006). This is supported by the discovery phase findings of this study (see chapter 5). Parents have expressed a desire to participate in care however report a lack of information, poor role negotiation and unclear instructions are hindering this progress (Coyne, 1995, Blower & Morgan, 2000, Halstrom & Runeson, 2001). A study conducted by Darbyshire (1994) found that parents felt they were under surveillance and 'parenting in public' whilst nurses felt as though they were 'nursing in public'. Kawick (1996) reported nurses' reluctance to relinquish control to parents. Similarly, a more recent systematic review by Obeidat, Bond and Callister (2009) report parents feel a loss of control and fluctuate between feelings of being included and excluded in their infants care. Whilst other studies have reported that parent's resent being made to perform nurses' work, particularly when it is

not driven from a philosophical choice rather as a result of staff shortages (Coyne, 2007, Shields 2010).

Darbyshire (1994) suggested that FCC is a wonderful ideal, but difficult to implement and over 20 years later it still appears to be challenging. Shields, Pratt and Hunter (2007) attempted a Cochrane review to assess the effectiveness of FCC, however were unable to draw any conclusions as no studies met their inclusion criteria. This suggested that FCC required further exploration as it is currently unclear whether FCC is implemented in its true sense, works or even makes a difference. While rigorous evidence does not exist regarding the effectiveness of FCC, research has not identified any harm caused by implementing FCC principles. Parents and health professionals agree that increased parental participation in decision making and planning of the infants care is extremely important (Shields, 2010).

The general public and media have become less tolerant of poor health care resulting in rising consumer demands to be included in health policy development (Fradin, 2015). There is greater emphasis in the need to develop partnership and collaborations across sectors and community groups with greater responsibility and accountability to, and involvement of health consumers (Gregory, 2008). The neonatal unit in this study was shifting from a medical model of care to a FCC approach. However, there is no research that brings both neonatal nurses and parents together to jointly develop strategies or interventions that may improve neonatal care. As partnership is a core principle of FCC, the focal point of this study was developing effective partnerships or collaborations between parents and health professional in order to develop innovative strategies to enhance FCC in the NICU.

1.7. Aim of the study

The aim of this study was to use an AI process to bring neonatal nurses and parents together to examine their perceptions and experiences of FCC and to design innovative strategies to implement FCC principles and improve neonatal care.

The studies objectives were to:

- Explore the neonatal nurses' and parents' understanding of partnership and the philosophy of FCC
- Describe how neonatal nurses viewed their role and the parents' role in FCC
- Describe how parents viewed both their role and nurses' role in FCC

- Examine factors that facilitate the implementation of FCC
- Develop strategies to strengthen FCC in the neonatal unit.

Appreciative Inquiry was selected for this study as AI offers a unique, positive participatory strength-based approach to promoting organisational learning, facilitating change and is reportedly effective in building partnerships/collaborations. AI is a theoretical research perspective, an emerging research methodology and a world view that builds on action research, organisational learning and organisational change. AI shifts from traditional problem solving orientations and focuses on possibilities for the future.

1.8. Significance of the study

This study is significant because it will provide greater understanding of neonatal nurses' and parents' perspectives of FCC in the NICU. The findings of this study will improve the working relationships between neonatal nurses and parents and strengthen FCC in the NICU, improve neonatal care and family outcomes and add to the current literature on issues surrounding FCC.

This study will assist in identifying the support and education that parents and health professionals require when caring for an infant requiring neonatal care. In addition, this study will highlight whether an innovative positive participatory approach such as AI can be used to develop collaborations needed to devise actions plans that can form a catalyst for organisational change in health care practice and research. This is the first known study that brings parents and nurses together to collectively explore FCC and develop strategies to enhance FCC. This study also outlines in detail all the steps and strategies in the AI process that is not documented in many other studies.

1.9. Structure of the thesis

This thesis consists of a series of five publications where each published paper is embedded within the thesis chapters. This is consistent with Western Sydney University PhD rule (Clauses 95-96). I collected and analysed data, prepared manuscripts for publications and developed this thesis under the guidance of three highly experienced and engaged research supervisors. Each manuscript has been through a rigorous peer review process and has successfully been published in highly ranked international journals.

This thesis consists of an introduction, part A (theoretical framework, methodology and research methods), part B (findings), a discussion and a conclusion. **Chapter one**, 'Introduction', provides an overview and rationale for the study and details key concepts and relevant background literature. Research aims, significance of the study and thesis structure are addressed.

'Part A' consists of three chapters and describes the theoretical framework, methodology and research methods used in this study. **Chapter two** presents the *first* published paper in this series of papers. The paper provides the theoretical framework and methodology for the study and discusses how an innovative participatory approach such as AI can be used to promote workforce engagement and organisational learning, and facilitate positive organisational change in health care.

Chapter three presents the *second* published paper. The paper provides a methodological review of AI and informs the methods for this study. This paper examines and critiques how the phases of the 4D cycle (discovery, dream, design and destiny) have been implemented in a health care context.

Chapter four outlines the research methods used in this study. The approach to recruitment, data collection, data analysis, ethical considerations and strategies employed to maintain rigour and quality of research in this study.

'Part B' presents the findings of the study and consists of four chapters. The findings will be presented in line with the AI phases (discovery, dream, design and destiny). **Chapter five** consists of the *third* published paper in the series and presents the discovery phase findings. The paper reports the findings of neonatal nurses' perspectives of their role in facilitating FCC in the NICU.

Chapter six presents the *fourth* published paper and consists of both the dream and design phases. Building on from the previous phase, this paper presents the findings of a collaborative one-day AI workshop used to bring neonatal nurses and parents together to enhance FCC in a NICU in Sydney, Australia.

Chapter seven presents the *fifth* published paper reports the destiny phase findings. This paper builds on the previous phases and reports the progress and experiences of neonatal nurses and parents who worked collaboratively over a two-year period in an AI project to enhance FCC in the NICU.

Chapter eight titled 'researcher reflections' reports my critical reflections as a researcher on the AI process used in this study. Researcher field notes and

observations were collated and analysed and four dominant themes that emerged are presented.

The 'Discussion' **Chapter nine** draws together the findings of the study synthesising key findings with reference to the current literature, while it highlights new knowledge this study has generated. The implications for future nursing practice, limitations of the study and directions for future research will be discussed. This chapter brings this thesis to a close with concluding thoughts.

1.10. Conclusion

This chapter has provided an overview of the background and history of neonatal care and parents experiences in the NICU. Practices such as DC, KC have been identified and the challenges implementing FCC in the NICU has been discussed. This chapter identifies the aim and significance for conducting this research study. The thesis structure was outlined according to the chapters of this thesis. The following chapter will present the published paper 'Using appreciative inquiry to transform health care'. This paper provides the theoretical framework and methodology for this study.

Part A

Theoretical framework, methodology and research methods

The deepest principle in human nature is the craving to be appreciated

William James (1842-1910)

Chapter 2:

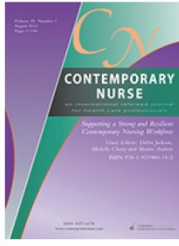
Using appreciative inquiry to transform health care

2.1. Publication

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Using appreciative inquiry to transform health care. *Contemporary Nurse*, 45(1), 95-100.
doi:10.5172/conu.2013.45.1.95

2.2. Introduction and relevance to thesis

Health care leaders are constantly required to develop new and innovative ways to bring about change that will sustain health care systems. Health care professionals try to adapt to these changes while attempting to provide high quality nursing care. The first published paper presented in this thesis provides the theoretical framework and methodology for the study and discusses how innovative, positive, participatory approaches, such as AI, may be used to promote workforce engagement, organisational learning, and facilitate positive organisational change in health care. This paper also identifies how AI can be used as a research method and, therefore, contributed to the theoretical framework of this study.



Using appreciative inquiry to transform health care

Suza Trajkovski, Virginia Schmied, Margaret Vickers & Debra Jackson

To cite this article: Suza Trajkovski, Virginia Schmied, Margaret Vickers & Debra Jackson (2013) Using appreciative inquiry to transform health care, *Contemporary Nurse*, 45:1, 95-100, DOI: [10.5172/conu.2013.45.1.95](https://doi.org/10.5172/conu.2013.45.1.95)

To link to this article: <http://dx.doi.org/10.5172/conu.2013.45.1.95>



Published online: 17 Dec 2014.



Submit your article to this journal [↗](#)



Article views: 53



View related articles [↗](#)

Full Terms & Conditions of access and use can be found at
<http://www.tandfonline.com/action/journalInformation?journalCode=rcnj20>

Download by: [Western Sydney University]

Date: 15 November 2015, At: 17:34

Using appreciative inquiry to transform health care

SUZA TRAJKOVSKI*, VIRGINIA SCHMIED*, MARGARET VICKERS† AND DEBRA JACKSON¹

*Family and Community Health Research Group, School of Nursing and Midwifery, University of Western Sydney, Sydney, NSW, Australia; †School of Business, University of Western Sydney, Sydney, NSW, Australia; ¹University of Technology Sydney, Sydney, NSW, Australia

ABSTRACT: Amid tremendous changes in contemporary health care stimulated by shifts in social, economic and political environments, health care managers are challenged to provide new structures and processes to continually improve health service delivery. The general public and the media are becoming less tolerant of poor levels of health care, and health care professionals need to be involved and supported to bring about positive change in health care. Appreciative inquiry (AI) is a philosophy and method for promoting transformational change, shifting from a traditional problem-based orientation to a more strength-based approach to change, that focuses on affirmation, appreciation and positive dialog. This paper discusses how an innovative participatory approach such as AI may be used to promote workforce engagement and organizational learning, and facilitate positive organizational change in a health care context.

KEYWORDS: appreciative inquiry, health care, organizational change, nurses, culture

Organizational change in the health care sector is a complex non linear process often stimulated by shifts in social, economic and political environments (Richer, Ritchie, & Marchionni, 2010). Health care professionals are constantly required to adapt to the rapid pace of change in contemporary health environments while continuing to deliver high quality and ethical health care (Eagar, Cowin, Gregory, & Firtko, 2010). The general public and the media have become less tolerant of poor levels of health care resulting in rising consumer demand for involvement with health policy development. New reforms such as Australia's National Health and Hospital Reform Commission (NHHRC) 'A healthier future for all Australian's' (2009), North America's Department of Health and Human Services (HHS) Affordable Care Act (2010) and the United Kingdom's Department of Health and National Health Services Corporate Plan (2012) show greater emphasis on developing partnerships and collaborations across sectors and community groups with greater responsibilities, accountability to and involvement of consumers.

It is becoming increasingly evident that traditional methods of managing contemporary health care are limited in meeting the needs of patients, health care workers and organizations. This paper discusses how an innovative

participatory approach such as appreciative inquiry (AI) may be used to facilitate workforce engagement, and promote organizational learning and positive organizational change in the health care context.

BACKGROUND

Upward pressures on costs from factors such as technology and increasing consumer demands along with downward economic pressures such as fiscal constraints often result in health organizations seeking new and more efficient ways of delivering health care (Eagar et al., 2010). Developing new cost-cutting measures and health service reorganization are strategies that are often used to respond to these pressures. With increased fiscal constraints, traditional nursing roles and responsibilities are being challenged (Eagar et al., 2010). The expectations of the nursing workforce are transforming with nurses seeking positive rewards and effective professional relationships within their work environment. A meta analysis conducted by Zangaro and Soeken (2007) reported nurses are dissatisfied in many areas, and highlighted nurse job satisfaction as strongly correlated with job stress levels, collaboration with health care professionals and level of nurse autonomy.

Aiken, Clarke, Sloane, Lake, and Cheney (2008) reported improved staffing numbers,

higher levels of nurse education and improved care environments as factors that are associated with lower patient mortality. Similarly, Havens, Wood, and Leeman (2006) identified improved communication and collaborations across disciplines and sectors and increased nurse involvement in decision making processes as key to successful recruitment and retention of nurses and the delivery of high quality care. Factors affecting work performance and negative organizational culture or sub cultures are also reported to effect workplace efficiency, effectiveness, and safety of both health care professionals and patients (Aiken et al., 2008; Kennerly et al., 2012).

To promote significant and sustainable changes, health care leaders need to search for ways to fully engage their workforce and open up new opportunities to improve the quality of work life and organizational performance. Kennerly et al. (2012) suggests working within a positively toned cultural environment is important to achieve high quality health care outcomes. Additionally, nurses are not only participants in the labor force, but also accumulators and producers of knowledge who are well positioned to be leaders in driving organizational change and building healthy, humanly sustainable organizations (Richer, Ritchie, & Marchionni, 2009). Moving away from a traditional problem solving approach to one of appreciation and openness to future possibilities offers a new approach for health care professionals to bring about positive change in health care.

APPRECIATIVE INQUIRY

AI is a relatively new and innovative approach to organizational learning, organizational change and research. First coined in 1986 by Cooperrider, AI adopts a social constructionist view based on affirmation, appreciation and positive dialog (Cooperrider, 1986). AI is reported to have significant transformational potential that shifts the focus from problems to be solved to discovering and building on what works well within an organization and using that as the beginning point for change (Koster & Lemelin, 2009; Reed, 2007). As an ethos, AI implies a shift in the assumptions

that drive the organization and its members in the process of change (Richer et al., 2009). It searches for what gives 'life' to living systems, and acknowledges the best in people, the organization and the world around them (Carter, 2006; van der Haar & Hosking, 2004).

Adopting a participatory approach, AI offers a flexible framework to facilitate change from the grass roots up. It lends itself to building effective partnerships and collaborations that can be used to meet particular needs of an organization (Koster & Lemelin, 2009; Reed, 2007). AI supports an egalitarian post-bureaucratic form of organization (Cooperrider & Srivastva, 1987). Based within the socio-rational realm of human affairs, AI acknowledges that different social realities co-exist within groups and considers peoples' voice and contributions as equally valid and important (regardless of social status) resulting in a stance of freedom, liberation, solidarity and social construction (Cooperrider & Srivastva, 1987). Encouraging less hierarchical structures and more equalized power and input into decision making processes, individuals and groups are empowered to improve their situation and move toward visions for a more egalitarian future. Organizations engaging in AI are reported to have increased system-wide collaborative competence (Barrett, 1995).

AI has been used in various settings including businesses, education, military services, not-for-profit organizations, prison, communities, religious institutions and more recently in health care settings (Carter, 2006; Havens et al., 2006; Liebling, Eliot, & Arnold, 2001). It has been reported to be effective in engaging groups and promoting a unified approach to change (Lavender & Chapple, 2004). AI is also being used as a research approach and can reframe research, moving away from a problem orientation to a positive theory of inquiry (Koster & Lemelin, 2009; Reed, 2007). As a research methodology, AI roots lie in action research and social constructionism (Carter, 2006).

Five underpinning principles of AI as developed by Cooperrider and Whitney (1999) are the constructionist, simultaneity, poetic, anticipatory and positive principles. The

constructionist principle suggests human knowledge and organizational destiny are interlinked (Cooperrider & Whitney, 1999). Dynamic human constructs need to be understood and analyzed by managers and leaders to be effective (Cooperrider & Whitney, 1999). Therefore, before change can be initiated leaders and managers need to begin with an understanding of individuals within the organization. The principle of simultaneity recognizes that inquiry and change occurs simultaneously and emphasizes the implicit nature of questions asked and dialog used (Cooperrider & Whitney, 1999). It is suggested that change begins from when the very first question is asked. The poetic principle suggests organizations are open to endless interpretation and reinterpretation where stories evolve or new stories are inspired (Cooperrider & Whitney, 1999). The anticipatory principle suggests reframing people's vision of the future may result in moving toward the envisioned future. The positive principle suggests the more positive the question the greater the change effort (Cooperrider & Whitney, 1999).

The power of positive dialog is emphasized in AI suggesting that such dialog has the ability to positively influence organizational growth (Gergen, Gergen, & Barrett, 2004). Generating collective visions and actions are considered an essential component in bringing about change when using the AI process. Underpinning assumptions of AI are that in *'every group, society or organisation something works; things we focus on become our reality; language and dialogue influences the group and our reality; multiple realities exist and are created in the moment; valuing differences is required and lastly, when people have more confidence moving to the future, they will carry forward positive aspects of the past'* (Hammond, 1998, p. 13–21).

The 4D cycle

AI consists of four iterative phases (discovery, dream, design and destiny) known as the 4D

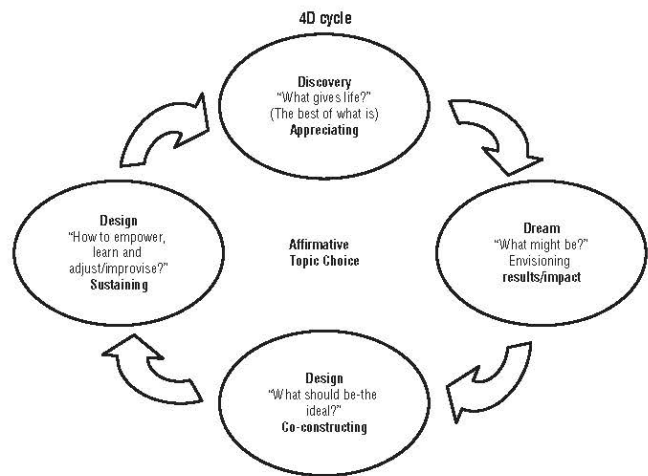


FIGURE 1: APPRECIATIVE INQUIRY: 4D CYCLE (ADAPTED FROM COOPERRIDER ET AL., 2008, p. 5)

cycle (see Figure 1) (Cooperrider & Whitney, 1999; Cooperrider, Whitney, & Stavros, 2008, p. 5). At the core of the 4D cycle is an affirmative topic choice which is considered a significant component of the AI process highlighting change is implicit in the very first question asked (Cooperrider & Whitney, 1999).

The discovery phase seeks to explore 'what gives life' to individuals, their work and the organization, through appreciation and valuing what is best of what is or has been (Cooperrider & Whitney, 1999; Cooperrider et al., 2008, p. 5). The dream phase seeks to elicit insights into individuals and practice through the generation of affirmative stories usually focusing on recalling peak experiences or high points. The dream phase focuses on envisioning 'what might be' through affirmative exploration (Cooperrider & Whitney, 1999; Cooperrider et al., 2008, p. 5). When using an AI approach, often miracle or magic wand questions are used to encourage participants to visualize how things might look like if a miracle occurred, or if they had a magic wand. Provocative propositions are also developed which are confident and assertive statements of what the organization hopes to achieve. The design phase focuses on working together to construct the ideal of 'what should be' (Cooperrider & Whitney, 1999; Cooperrider

et al., 2008, p. 5). Finally, the destiny phase focuses on sustaining the envisioned future (Cooperrider & Whitney, 1999; Cooperrider et al., 2008, p. 5).

Participants or team members are considered experts or co-researchers. The AI process allows team members to exchange tacit and explicit knowledge to transform their organization. The flexible AI framework allows the specific aims and needs of an organization to be addressed in the context of the organization being reviewed (Cooperrider & Whitney, 1999; Cooperrider et al., 2008, p. 5).

Studies are reporting AI as a catalyst for positive organizational change and development (Lavender & Chapple, 2004) and a new way of reframing research practice (Carter, 2006). Most applications of AI have been reported in business, not-for-profit organizations, government and community groups. A review of the limited numbers of papers of AI in health care conducted by Richer et al. (2010) reports AI has been used to evaluate and change organizational or clinical processes, explore professional development initiatives, define public health-care services, create team visions and improve health care work environments. A key strength of AI is the inclusive and collaborative nature of this form of inquiry (Carter, 2006; Richer et al., 2009). AI is reported to be effective in facilitating change through collaborations and developing partnerships (Lavender & Chapple, 2004). Collaborations and partnerships varied from use in single units (Lazic, Radenovic, Arnfield, & Janic, 2008) to 'whole system' events engaging multiple stakeholders across disciplines and large geographical areas (Lavender & Chapple, 2004).

AI shares philosophical values with nursing as they both seek to explore the uniqueness, wholeness and the essence of human life (Cowling, 2001). Originally designed as a research method and then a method of practice, AI is a good fit with the discipline and profession of nursing blending research and practice toward a potential praxis (Cowling, 2001). An AI approach fosters innovative ideas and allows nurses the opportunity to exchange

knowledge to build a more positive future for the team, unit or organization (Richer et al., 2009). Nurses' are presented with opportunities to develop effective social networks, high levels of engagement and interdisciplinary collaborations. Additionally, AI acknowledges that attention must be given to both micro-level social structures for networking in the production of innovation along with a larger systems perspective (Richer et al., 2009).

Literature reports the need for improved communication and increased nursing involvement in decision making; however minimal guidance exists in how to achieve this (Havens et al., 2006). Havens et al. (2006) suggest AI offers nurses a framework to implement and sustain these features in practice. The inclusive and collaborative nature of AI promotes ownership of the change process and draws on the collective experience, wisdom and resources within the group. Honoring diversity, AI allows all members to have a voice in the change process leading to richer solutions and greater willingness to strive toward mutually beneficial goals.

AI is quality oriented and can be used to set new benchmarks and best practices in nursing and health care (Havens et al., 2006). A key feature is that quality may be explored as it occurs within settings and organizations. The AI process may guide nurses in critical reflection on existing quality practices. Furthermore, Marchionni and Richer (2007) report that AI can serve as a transformational change process to promote evidence-based practice in health care, where nurses can serve as advocates, supporters and agents of change. AI offers nurses the opportunity to identify areas to promote change in the organizations strategic values through reflexivity and action.

As a research method, AI has been reported to complement traditional forms of action research through its ability to inspire generative learning (Barrett, 1995; Carter, 2006; Richer et al., 2009). Carter (2006) reports participants tend to 'come on side' more easily than with traditional research methods and approaches (Carter, 2006). Reed, Pearson, Douglas, Swinburne, and Wilding (2002) noted that focusing on positives

appeared to reduce participant defensiveness and encouraged open discussion in complex environments (Reed et al., 2002).

As with all approaches, there are also risks identified in using AI. For example, some individuals may find it difficult starting from and maintaining a positive stance (Richer et al., 2010) while others may feel that problems identified are being dismissed (Reed et al., 2002). The flexible nature and lack of methodological consistency and rigor may also be viewed as a limitation of AI. While Jones (2010) implies AI has many attributes of a management 'fad' and consists of 'grey data' it was also suggested that strong anecdotal evidence exists highlighting the benefits of using an AI approach across disciplines and settings (p. 116).

CONCLUSION

While further rigorous studies are needed to explore AI processes in various healthcare contexts, AI is an innovative strategy worth considering in contemporary nursing. It provides managers and researchers a constructive new way forward, shifting from a negative and problem-based approach, to a positive form of inquiry that can be tailored to the specific needs of the individual, a ward or unit or an organization. The inclusive nature of AI lends itself to building effective partnerships and collaborations. AI provides a way forward to initiate change in the fast paced contemporary health environment and allow management, health professionals and consumers the opportunity to positively influence the work, design and management of health care organizations.

REFERENCES

- Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E. T., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration, 38*(5), 223–229.
- Barrett, F. J. (1995). Creating appreciative learning culture. *Organizational Dynamics, 24*(2), 36–49.
- Carter, B. (2006). 'One expertise among many' – Working appreciatively to make miracles instead of finding problems: Using appreciative inquiry as a way of reframing research. *Journal of Research, 11*(1), 48–63.

- Cooperrider, D. L. (1986). *Appreciative inquiry: Toward a methodology for understanding and enhancing organizational innovation*. Cleveland, OH: Western Reserve University.
- Cooperrider, D. L., & Srivastva, S. (1987). *Research in organizational change and development* (Vol. 1, pp. 129–169). Greenwich, CT: JAI Press.
- Cooperrider, D. L., & Whitney, D. (1999). Appreciative inquiry: A positive revolution in change. In P. Holman & T. Devane (Eds.), *The change handbook: Group methods for shaping the future* (pp. 245–261). San Francisco, CA: Berrett-Koehler.
- Cooperrider, D. L., Whitney, D., & Stavros, J. M. (2008). *Appreciative inquiry handbook: For leaders of change* (2nd ed.). Brunswick, OH: Crown Custom.
- Cowling, R. W. (2001). Unitary appreciative inquiry. *Advances in Nursing Science, 23*(4), 32–48.
- Department of Health and National Health Service. (2012). *Corporate plan*. Retrieved from <http://corporateplan2012.dh.gov.uk/>
- Eagar, S. C., Cowin, L. S., Gregory, L., & Firtko, A. (2010). Scope of practice conflict in nursing: A new war or just the same battle? *Contemporary Nurse, 36*(1–2), 86–95.
- Gergen, M. M., Gergen, K. J., & Barrett, F. (2004). Appreciative inquiry as dialogue: Generative and transformative. *Advances in Appreciative Inquiry, 1*, 3–27.
- Hammond, S. A. (1998). *The thin book of appreciative inquiry* (2nd ed.). Plano, TX: Thin Book Publishing Co.
- Havens, D. S., Wood, S. O., & Leeman, J. (2006). Improving nursing practice and patient care: Building capacity with appreciative inquiry. *Journal of Nursing Administration, 37*(10), 463–470.
- Jones, R. S. P. (2010). Appreciative inquiry: More than just a fad? *British Journal of Health Care Management, 16*(3), 114–122.
- Kennerly, S. M., Yap, T. L., Hemmings, A., Beckett, G., Schafer, J. C., & Borchers, A. (2012). Development and psychometric testing of the nursing culture assessment tool. *Clinical Nursing Research, 21*(4), 467–485.
- Koster, R. L. P., & Lemelin, R. H. (2009). Appreciative inquiry in rural tourism: A case study from Canada. *Tourism Geographies, 11*(2), 256–269.
- Lavender, T., & Chapple, J. (2004). An exploration of midwives' views of the current system of maternity care in England. *Midwifery, 20*(4), 324–334.

Lazic, J., Radenovic, M., Arnfield, A., & Janic, D. (2008). Implementation of a nurse education programme in paediatric oncology using appreciative inquiry: A single centre experience in Belgrade, Serbia. *European Journal of Oncology Nursing*, 15(5), 524–527.

Liebling, A., Eliot, C., & Arnold, H. (2001). Transforming the prison: Romantic optimism or appreciative realism? *Criminal Justice*, 1(2), 161–180.

Marchionni, C., & Richer, M. C. (2007). Using appreciative inquiry to promote evidence-based practice in nursing: The glass is more than half full. *Nursing Leadership*, 20(3), 86–97.

National Health and Hospital Reform Commission. (2009). *A healthier future for all Australians final report*. Retrieved from <http://www.health.gov.au/internet/nhhrc/publishing.nsf/content/nhhrc-report>

North America Department of Health and Human Services. (2010). *Affordable care act*. Retrieved from <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

Reed, J. (2007). *Appreciative inquiry: Research for change*. Thousand Oaks, CA: Sage.

Reed, J., Pearson, P., Douglas, B., Swinburne, S., & Wilding, H. (2002). Going home from hospital: An appreciative inquiry study. *Health and Social Care in the Community*, 10(1), 36–45.

Richer, M. C., Ritchie, J., & Marchionni, C. (2009). 'If we can't do more, lets do it differently!': Using appreciative inquiry to promote innovative ideas for better health care work environments. *Journal of Nursing Management*, 17(8), 947–955.

Richer, M. C., Ritchie, J., & Marchionni, C. (2010). Appreciative inquiry in health care. *British Journal of Health Care Management*, 16(4), 164–172.

van der Haar, D., & Hosking, D. M. (2004). Evaluating appreciative inquiry: A relational constructionist perspective. *Human Relations*, 57(8), 1017–1036.

Zangaro, G. A., & Soeken, K. L. (2007). A meta-analysis of studies of nurses' job satisfaction. *Research in Nursing & Health*, 30, 445–458.

Received 05 November 2012 Accepted 14 March 2013

ANNOUNCING

LONGEVITY: SOCIOLOGICAL PERSPECTIVES ON HEALTH, ILLNESS AND SERVICE PROVISION

A special issue of *Health Sociology Review* – Volume 23 Issue 1 – ii + 126 pages – ISBN 978-1-921980-25-1 – March 2014

Guest Editors: **Pauline Savy** (La Trobe University, Australia), **Anne-Maree Sawyer** (La Trobe University, Australia) and **Jeni Warburton** (La Trobe University, Australia)

This special issue of *Health Sociology Review* examines the possibility and actuality of living to very old age. In our times, cultural discourses to do with maintaining health and independence for as long as possible pervade social policy and the personal narratives of ageing. Sociologically, these raise interesting, and often contentious, questions about the role of structural support systems, the delivery of appropriate health care, and the phenomenological experience of ageing and dealing with frailty and decline.

Theoretical and empirical submissions contribute to sociological discussion and analysis from across relevant disciplines within Australia and overseas – providing insight and critical discussion of a broad range of topics relevant to the health of aged persons – for example, immediate health matters as experienced by individuals and particular groups through accounts of the lived experiences of ageing, managing health problems and negotiating health care. Articles focus on or incorporate critical analysis of policy, the work of health care professionals and wider social factors such as access and equity in service provision – as well as showcase and advance methodologies used in researching the health and illness experiences of old individuals whose lives are significantly compromised by illness. Topics include:

- Ageing and health of particular groups eg Indigenous, migrant, gendered groups, rural and remote populations
- Evaluation of specific care provision and levels eg acute hospital care, community care, long-term care and health promotion programs
- The ageing body, decline, dying and death
- Health and illness in the oldest generation
- Ageing and medicalisation
- Dementia
- Living with common and chronic conditions including psychiatric conditions
- Family relationships in old age and ill health
- Professionalisation and specialisation, for example, changing role boundaries in aged care, workforce situations and impacts
- Social, structural factors that promote or oppose longevity and wellness

<http://hsr.e-contentmanagement.com/archives/vol/23/issue/1/marketing/>

www.e-contentmanagement.com

2.3. Conclusion

This chapter presented the published paper 'Using appreciative inquiry to transform health care'. This paper outlined the theoretical framework and methodology for this study and discussed how positive participatory approaches, such as AI, can facilitate organisational learning and positive organisational change in health care. The next chapter presents the second published paper of this thesis 'Implementing the 4D cycle of appreciative inquiry in health care: a methodological review'. This paper reviews the methodological approach used for this study and examined and critiqued how phases of the AI process have been implemented by other researchers in a health care context.

Chapter 3:

Implementing the 4D cycle of appreciative inquiry in health care: a methodological review

3.1. Publication

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Implementing the 4D cycle of appreciative inquiry in health care: A methodological review. *Journal of Advanced Nursing*, 69(6), 1224-1234. doi: 10.1111/jan.12086.

3.2. Introduction and relevance to thesis

The essential nature of research is to create new knowledge through a process of systematic enquiry. In order to generate new knowledge researchers must determine which methodological approaches are best for answering the research question. The second paper of this thesis reviewed the methodological approach that underpins this study. This is the first known methodological review that examined and critiqued how the phases of the 4D cycle (discovery, dream, design and destiny) have been implemented in health care contexts. The findings of this review identified how AI could be used to guide this study.

REVIEW PAPER

Implementing the 4D cycle of appreciative inquiry in health care: a methodological review

Suza Trajkovski, Virginia Schmied, Margaret Vickers & Debra Jackson

Accepted for publication 15 December 2012

Correspondence to S. Trajkovski:
e-mail: s.trajkovski@uws.edu.au

Suza Trajkovski RN BN
PhD Candidate
Family and Community Health Research
Group (FaCH), School of Nursing and
Midwifery, University of Western Sydney,
Australia

Virginia Schmied PhD RN RM
Professor
Family and Community Health Research
Group (FaCH), School of Nursing and
Midwifery, University of Western Sydney,
Australia

Margaret Vickers BBus MBA PhD
Professor
School of Business, University of Western
Sydney, Australia

Debra Jackson PhD RN
Professor
Faculty of Nursing, Midwifery, and Health,
University of Technology, Sydney, Australia

TRAJKOVSKI S., SCHMIED V., VICKERS M. & JACKSON D. (2013) Implementing the 4D cycle of appreciative inquiry in health care: a methodological review. *Journal of Advanced Nursing* 69(6), 1224–1234. doi: 10.1111/jan.12086

Abstract

Aim. To examine and critique how the phases of the 4D cycle (Discovery, Dream, Design, and Destiny) of appreciative inquiry are implemented in a healthcare context.

Background. Appreciative inquiry is a theoretical research perspective, an emerging research methodology and a world view that builds on action research, organizational learning, and organizational change. Increasing numbers of articles published provide insights and learning into its theoretical and philosophical underpinnings. Many articles describe appreciative inquiry and the outcomes of their studies; however, there is a gap in the literature examining the approaches commonly used to implement the 4D cycle in a healthcare context.

Design. A methodological review following systematic principles.

Data sources. A methodological review was conducted including articles from the inception of appreciative inquiry in 1986 to the time of writing this review in November, 2011. Key database searches included CINAHL, Emerald, MEDLINE, PubMed, PsycINFO, and Scopus.

Review methods. A methodological review following systematic principles was undertaken. Studies were included if they described in detail the methods used to implement the 4D cycle of appreciative inquiry in a healthcare context.

Results. Nine qualitative studies met the inclusion criteria. Results highlighted that appreciative inquiry application is unique and varied between studies. The 4D phases were not rigid steps and were adapted to the setting and participants.

Conclusion. Overall, participant enthusiasm and commitment were highlighted suggesting appreciative inquiry was mostly positively perceived by participants. Appreciative inquiry provides a positive way forward shifting from problems to solutions offering a new way of practicing in health care and health research.

Keywords: appreciative inquiry, appreciative inquiry phases, 4D cycle, nursing, health care

Introduction

Facilitating organizational change continues to be one of the major challenges facing health systems and healthcare professionals (Plsek & Greenhalgh 2001). Participatory approaches such as appreciative inquiry (AI) offers the potential to facilitate change from the ground up. A plethora of literature exists reporting researchers' experiences when using AI to bring about change in organizations and a rise in studies reporting that AI is being used to reframe research practice (Carter 2006). However, there is only limited literature that examines the approaches used to implement the 4D phases of the AI process. The purpose of this article is to report the findings of a methodological review that examined and critiqued how the phases of the 4D cycle (Discovery, Dream, Design, and Destiny) of AI are implemented in a healthcare context.

Appreciative inquiry is a relatively new social research method and organizational development intervention. Evolving primarily in the field of organizational development, from Cooperrider's (1986) doctoral dissertation, AI adopts a relational constructionist view based on affirmation, appreciation, and dialogue. It is suggested that AI has significant transformational potential and the ability to enhance organizational growth. A theoretical research perspective, research method and world view, AI is influenced by Lewin's (1959), Gergen's (1985), and Vickers' (1980) research exploring human perceptions, social constructionism, and appreciative systems (Koster & Lemelin 2009). AI's roots lie in action research and builds on organizational learning and organizational change shifting the focus from a problem-based research paradigm to a positive theory of inquiry based on future possibilities and performance (Reed 2007, Koster & Lemelin 2009). With underpinnings in the ontological position of social constructionism, critical theorists work from the premise that knowledge, language, and action are interlinked (Koster & Lemelin 2009). AI seeks what gives 'life' to a living system and searches for the best in people, their organization, and the world around them, while actively acknowledging and celebrating their successes (Carter 2006, Van Der Haar & Hosking 2004).

An underlying process of AI is the assumption that dialogue is inherent in change practices and acknowledges the immense power of dialogic forms of inquiry having the potential to enhance or inhibit organizational growth (Gergen *et al.* 2004). Goldberg and Comins (2001) suggest that relational narratives can increase positive factors in an organization while problem-orientations drain energy, focus on the negative, and reduce the ability for positive change in an organization. Focusing on problems provides detailed

knowledge of problems and focuses on the negative, whereas the study of successes, such as achievements, strengths, positive choices, resources, assets, and energy, can assist in discovering what is actually working and facilitate further positive developments and the sustainability of existing strengths (Carter 2006). AI encourages organizations to look within themselves and offers a flexible framework to meet the specific needs of the organization (Carter 2006).

The underpinning assumptions of AI are that 'in every group, society, or organization something works, things we focus on becomes our reality, language and dialogue influences the group and our reality, multiple realities exists and are created in the moment, valuing differences is required and lastly, when people have increased confidence moving to the future, they will take forward positive aspects of the past' (Hammond 1998, pp. 13 21). The creation of collective visions and actions in an organization is considered a vital component in initiating change. AI lends itself to building a partnership or collaboration and has the potential to enhance effective practice (Carter 2006). Furthermore, AI has been shown to be effective in generating organizational and management change (Cooperrider & Barrett 1990, Cooperrider & Whitney 1999), team building (Bushe 1995), professional and leadership development (Goldberg & Comins 2001, Keefe & Pesut 2004, Whitney *et al.* 2010), cultural change (Liebling *et al.* 2001), capacity building (Postma 1998), community change (Finegold *et al.* 2002), and the reframing of research (Lavender & Chapple 2004, Carter 2006).

The 4D cycle

Appreciative inquiry consists of four phases known as the 4D cycle (Figure 1). The discovery phase ('what gives life' to the organization, that is, appreciating and valuing what is best of what is or has been), the dream phase (envisioning 'what might be', affirmative exploration), the design phase (co-constructing 'what should be', the ideal), and lastly, destiny (sustaining what will be, envisioned future) (Cooperrider *et al.* 2008, p5, Cooperrider & Whitney 1999). At the core of the 4D cycle is the affirmative topic choice which is considered a significant part of the AI process suggesting the seeds of change are implicit in the very first question asked (Cooperrider & Whitney 1999). The choice of an affirmative topic may appear to be an easy task. However, in practice, this may create difficulties for a novice AI researcher, as the starting point for most research begins with identifying and framing a problem. AI requires the researcher to move away from the traditional problem

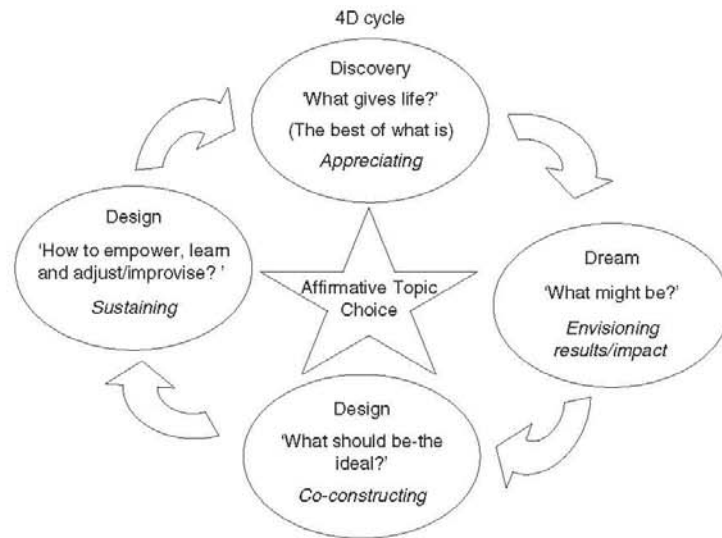


Figure 1 Appreciative inquiry: 4D cycle.

orientation to an appreciative approach. Selecting the topic of inquiry should reflect the positive core of an organization and, according to Cooperrider *et al.* (2008), should consist of the following characteristics: be affirmative or stated in the positive, desirable and able to be identified with the objectives people want, topics that the group genuinely wants to explore, and move in the direction that the group wants to go. Choosing an affirmative topic is the first step in guiding this process and leads into the 4D cycle.

The discovery phase involves discovering through inquiry, exploration, and appreciation of what 'gives life and energy' to individuals, their work, and the organization (Cooperrider *et al.* 2008, p5). The focus of the discovery phase is to provide insights and exploration through the generation of affirmative stories. This process usually includes discussions surrounding the chosen topic area and may be conducted in the form of interviews, storytelling, and discussions groups. The dream phase seeks to explore 'what might be' and builds on the outcomes of the discovery phase (Cooperrider *et al.* 2008, p5). Participants work together in this phase to develop ideas of what the future could look like or be. This phase requires the participants to think of a strategic focus, a desired future, a vision of the 'ideal' organization encouraging individuals to think big and outside their usual boundaries where a 'miracle' or 'magic wand' question may be used. 'Provocative propositions' may also be developed which are confident and assertive statements of what the organization hopes to achieve. The design phase focuses on 'what should be', creating an

ideal organization based on the known past successes and achievements of the organization (Cooperrider *et al.* 2008, p5). Participants work together to design plans for the future and decide what needs to happen to realize the provocative propositions developed. The destiny phase focuses on sustaining the envisioned future, where energy moves towards action planning, making commitments to tasks and processes, creating networks and structures paving affirmative new ways while letting go of the negative (Carter 2006).

Appreciative inquiry has been envisaged as a cyclical non-linear process that is continuous and repeated as an organization evolves and develops. These cycles are an operationalization of AI thinking and stem from the AI way of thinking about change. As cautioned by Cooperrider *et al.* (2008), AI should not be seen as just a set of cycles or processes. A central component of AI is discovering and enhancing the positive core of an organization: a core which comprises organizational goals, strengths, and achievements. Building on the positive core, AI provides a flexible framework that can be used to meet the differing organizational aims and needs. Equally important is considering the reflective nature of AI, meaning the process of developing questions and the approaches used are the product of thoughtful responses to particular situations and contexts. AI critics may argue that the flexibility, transferability, and unclear instructions describing how to undertake AI research could suggest that it is potentially flawed (Carter 2006). However, a plethora of literature exists reporting AI

as a catalyst for positive organizational change and development in organizations and a rise in studies reporting the application of AI to reframe research practice. This review seeks to explore the commonalities in approaches when implementing the AI 4D cycle in the context of health care.

The review

Aim

The aim of this methodological review was to examine and critique how the phases of the 4D cycle (Discovery, Dream, Design, and Destiny) of appreciative inquiry are implemented in a healthcare context.

Design

A methodological review following systematic principles was undertaken to identify studies that applied AI as a methodology and that reported in detail the methods used to implement all four cycles of AI. The review is presented as a narrative summary (Dixon-Woods *et al.* 2005) and critique.

Search methods

A methodological review following systematic principles was conducted to identify articles that used an AI methodology from the inception of AI in 1986 to November, 2011. The search was limited to articles that were published in English in peer reviewed journals. Studies were included if they described how the researcher implemented the four phases of the 4D cycle of AI in the healthcare context. The following databases were searched CINAHL, Emerald, MEDLINE, PubMed, PsycINFO, and Scopus. A boolean/phrase search or medical subject headings (MeSH) and key words included 'appreciative inquiry', 'appreciative inquiry phases', '4D cycle', and 'health care'. The key terms were entered both individually and in combination.

Search outcome

The search strategy identified a total of 753 papers (CINAHL 100, Emerald 46, MEDLINE 59, PubMed 150, PsycINFO 215, Scopus 183). Duplicates were removed. Titles and abstracts of these papers were reviewed and were excluded if they were opinion or discussion papers. This resulted in 35 papers for inclusion that were then read in full to ensure their relevance to this review. Papers

were eliminated at this stage primarily because they did not describe how they implemented the four phases of the 4D cycle, further reducing the number of papers to nine. A back-chaining (Downe *et al.* 2009) method was used where the reference list of papers were read to identify any additional relevant research. This resulted in three additional papers, however, these did not meet the criteria (Figure 2).

Quality appraisal

As all the identified papers reported qualitative data, we evaluated the rigour, credibility, and relevance of the studies selected for inclusion using the Critical Appraisal Skills Programme (CASP) tool for quality assessment of qualitative research (CASP International Network 2012). Papers included in the study met the majority of the CASP criteria (see Table S1). Although each paper examined did not describe the method of data analysis or in some cases com-

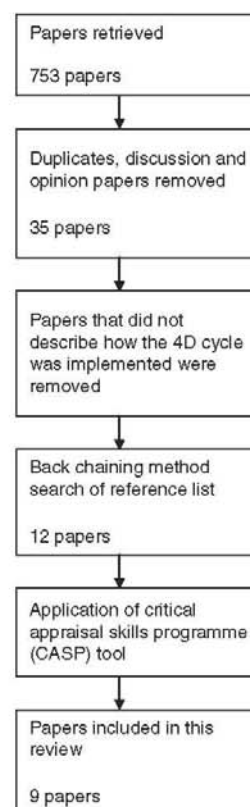


Figure 2 Flow chart of search strategy.

prehensive findings, they all did give a clear description of how the four phases were implemented in their studies. When examining the approaches used by the researchers implementing the 4D cycle it was important that the theoretical framework for the study and methods used in each phase of the 4D process were clearly described. Caution was required when reviewing these papers to ensure that the whole 4D process was being described and not just applying the AI spirit. Studies needed to have a clearly identified aim, an affirmative topic choice, and a detailed outline of how the AI phases were implemented. Critical reflection was an important source of rigour of the AI phases (Cooperrider & Whitney 1999). Observations were made about the strengths and weaknesses in interpretation, implementation, validity and reliability. This approach provided a comprehensive and transparent perspective surrounding the topic under review.

Data abstraction

Each paper was individually reviewed to determine how the included studies implemented the 4D phases of AI. A data abstraction table was developed (Table 1). Each column has distinct fields and was arranged in a logical sequence to facilitate the review and analysis process. The table was specifically designed for the review and focused on the AI phases. Once the relevant studies were retrieved, differences and commonalities across studies were highlighted (Dixon-Woods *et al.* 2005).

Findings

Appreciative inquiry is a process which takes shape differently in different contexts or organizations. The focus of the studies reviewed varied from initiating changes in a specific area of practice in a single unit to 'whole system' events including participants across disciplines, communities, and large geographical locations (Table 1). For example, Lazic *et al.* (2011) describe how AI was used to build multidisciplinary collaboration, nurse education, and development in one unit, while Lavender and Chapple (2004) explored the views of midwives on the system of maternity care sampling across 14 sites in England.

Each study reviewed was examined to determine the sequence and implementation of the 4D cycle in a healthcare context. All studies used a qualitative data method and were grounded in real life experiences. The focus of the study influenced the approaches researchers used in the four phases of AI. Topic choices in each study were limited and precise enough so that it reflected the organizational

context from which it is derived. Each of the studies used AI as a way of facilitating change and acknowledged that organizational change is a social process.

Discovery phase

Studies began by using open dialogue to allow individuals to discover or rediscover their strengths, assets, or greatest achievements. They were built on core aspirations that existed in human system to achieve collective goals. Generative questions were used in conversational interviews to encourage storytelling about experiences, values, and shared history. Participants were required to report on peak moments when individuals and groups had experienced successes or high points. For example, Havens *et al.* (2006) asked participants to think back to and describe peak or high point moments (e.g. 'Please tell me the story of that high point?' p98), explaining what made them high point moments (e.g. 'What was it about you and others around you that made it a peak experience?' p98).

The most common approach used in the discovery phase was the use of stories to highlight what makes a system work and showcase appreciation and valuing. In line with AI principles, prescriptive interview agendas were avoided by researchers allowing participants to discover their own stories and help develop a comprehensive view of each other's world view in the context of their organization or setting (Reed *et al.* 2002).

Positively framed questions were developed by either the researcher or key personnel where participants mostly interviewed each other. Carter *et al.* (2007a) adapted the AI process in their study where the researchers undertook the interviews rather than participants. While authors noted they did not use AI in its 'purest' form suggesting it may have compromised the richness of exchange between participants, they also highlighted that informal contact between researchers and participants are important (Carter *et al.* 2007a, p. 536). The nature of the interactions allowed the researcher to discuss the research process, develop a shared understanding of AI, and increase disciplinary understanding particularly with the data (Carter *et al.* 2007a). This can be attributed to increased commitment to research and developing collaborative working relationships between service users. Carter *et al.* (2007a) reported that while in their study the appreciative interviews were successful, a limitation was the nature of single point in time interviews suggesting there may be benefits in undertaking repeated interviews. The most commonly reported approaches used during the discovery phase were interviews and focus group sessions (Carter *et al.* 2007a,b, Havens *et al.* 2006, Lazic *et al.* 2011, Lavender & Chapple 2004, Reed *et al.* 2002,

Table 1 Studies using appreciative inquiry.

Study/location	Aim	Method	Phase 1: Discovery	Phase 2: Dream	Phase 3: Design	Phase 4: Destiny
Carter <i>et al.</i> (2007a), UK	To explore multi-agency working practice with families and people working with children with complex needs.	Interviews Workshops: five nominal and five consensus groups Total sample size: 69 (two counties).	Twenty-nine individual face-to-face narrative interviews (56 trigger statements developed. Positively framed questions used.	Five Nominal group workshops in five different locations. Miracle questions used. Provocative propositions developed.	Five Consensus workshops across two counties. Consensus statements refined into 10 'best practice' guidelines.	Merged phases into 3. Liaised with participants and key stakeholders to ensure envisioned futures were being sustained.
Carter <i>et al.</i> (2007b), USA	Describe the application and experiences of AI in primary care practices.	Interviews Meetings Total sample size: 3 physicians, 1 physician assistant, 1 medical assistant, and 21 clinicians.	Participants asked to reflect on two positively framed questions and paired with colleagues to share their high point stories.	Participants asked to imagine how practice might look if peak experiences shared in discovery phase occurred. Miracle questions and provocative propositions used.	Two teams formed: (1) team work group and (2) proactive care group. Action teams had 6 weeks to carry out projects and report back at the destiny meeting.	Destiny meeting. Group agreed to report back at monthly meetings and an AI meeting in 6 months. Action plans developed.
Havens <i>et al.</i> (2006), USA	To improve communication and collaboration among nurses and other health professionals.	Interviews Team meetings Total sample size: 6 community hospitals.	Core staff from each hospital received AI training and identified topics of inquiry. Positively framed questions developed.	Stories and positive core attributes were presented to the hospital team and asked to expand on the positive core and articulate dreams and desires. Dream identified and developed by team.	Focus on processes and structures that needed to be put in place for dream to become reality. AI principles guided project activities.	Action plans developed. Focus on sustaining AI approach and projects put in place. Follow-up from project team 1–2 times a year.
Lazic <i>et al.</i> (2011), Serbia	To explore and develop working relationships in paediatric oncology.	Meetings Total sample size: 18 nurses.	Analysis of current practice.		Education session scheduled twice a week. Education programme developed.	Action plans developed. Entire dream not achieved but collaboration established.
Lavender and Chapple (2004), UK	Exploring midwives views of the current maternity system in England.	Fifteen Focus groups Total sample size: 126 people across 14 sites in England.	One Positively framed question. Phases 1, 2, and 3 merged into a focus group.	One Question used to frame dream phase. Miracle question used.	One Question used to frame design phase.	Not reported.
Reed <i>et al.</i> (2002), UK	'Whole system event' aimed at improving hospital discharge for older people.	Thirty-five Interviews, Three workshops, one focus group. Total sample size: 71 from 37 organizations.	Introduced AI and planned research. 35 Participants interviewed twice. 1 Focus group.	Miracle question used. Provocative propositions developed.	Provocative propositions developed into action plans.	Not reported.

Table 1 (Continued).

Study/ location	Aim	Method	Phase 1: Discovery	Phase 2: Dream	Phase 3: Design	Phase 4: Destiny
Seebohm <i>et al.</i> (2010), UK	To increase social inclusion and voice of older people with dementia or mental health problems and their carers.	Interviews and meetings Total sample size: 12 design groups, 60 interviews, 120 people.	Twelve Design groups 60 people shared stories. Group carers interviewed frontline practitioners.	Participants shared stories and experiences of making choices about care.	120 people met for further inquiry. More discovery stories were shared. Miracle questions and visions created.	Action plans developed.
Shendell-Falik <i>et al.</i> (2007), USA	To enhance patient safety through improved patient handoff processes. Focused on collaborations.	Interviews and working session Total sample size: 1 hospital (2 wards).	Extra 'definition phase' to identify inquiry topics and interview questions. Nurses interviewed each other.	Dialogue used to create visions/dreams of desired future. Story boards and skits used.	Dream translated into specific changes of roles, systems, structures. A metaphor of play used.	Group agreed on 'ultimate handoff process'. Action plans and follow-up processes developed.
Yoon <i>et al.</i> (2011), Canada	To determine the impact of an AI approach in nurses facilitating oral care services.	Two Modules. One Questionnaire Total sample size: nine nurses from five care units.	Identified need for best practice oral health guidelines. Participant stories shared.	Didactic presentation of best oral care.	Provocative propositions and visions developed.	Key stakeholders identified for promoting excellent oral care. Action plans developed.

Seebohm *et al.* 2010, Shendell-Falik *et al.* 2007, Yoon *et al.* 2011).

Sharing stories proved to be an effective strategy in gathering rich qualitative data. Content or thematic analysis was the most common approach used for data analysis (Carter *et al.* 2007a,b, Havens *et al.* 2006, Lazic *et al.* 2011, Lavender & Chapple 2004, Reed *et al.* 2002, Seebohm *et al.* 2010, Shendell-Falik *et al.* 2007, Yoon *et al.* 2011). On average individual interviews were reported to take approximately one hour each and focus group sessions lasted between 2 to 3 hours each.

Dream phase

It is reported that ideally the discovery and dream phase takes place at the same meeting so meaning of personal stories reported in the discovery phase can immediately inform and energizes the vision for a transformed future (Carter *et al.* 2007a). This was the case for most of the studies reviewed. The dream phase offered participants the opportunity to explore collectively their hopes and dreams for their team or organization. Participants were asked to create positive and compelling images for the future.

Generative questions known as 'miracle questions' were often used where participants were asked to visualize or imagine what things would be like if a miracle occurred and the best was always happening. Seven studies reported the use of a miracle question (Reed *et al.* 2002, Lavender & Chapple 2004, Havens *et al.* 2006, Carter *et al.* 2007a, b, Shendell-Falik *et al.* 2007, Seebohm *et al.* 2010) while others used positive framing of research questions (Lazic *et al.* 2011, Yoon *et al.* 2011). For example in Reed *et al.* (2002) study participants were asked to imagine a miracle occurred overnight that helped hospital discharge go well every time. Participants were then asked to articulate what would be different following the miracle.

Carter *et al.* (2007b) drew upon the positive energy generated in the discovery phase to imagine transformed practice. Participants were carefully selected based on their role and formed small groups to brainstorm the dream and then present the dream to the larger group. The first group used pictures to portray their vision, the second used statements to describe its practice of the future and the third group developed a collective image. Each group presented their vision and then the entire group was challenged to identify a collective vision of its ideal practice. Shendell-Falik *et al.* (2007) used story boards and skits to assist in developing the dream. Carter *et al.* (2007a) and Reed *et al.* (2002) used nominal group technique fostering collective inquiry where participants had equal opportunity to present their individual ideas and allowed generative data to be effectively

aggregated so a consensus could be reached. Four studies reported developing provocative propositions in this phase, while others develop provocative propositions in the next phase (design). The most common approaches used in this phase were workshops and group meetings with time frames mostly ranging from 3 (Lavender & Chapple 2004) to 7 hours (Shendell-Falik *et al.* 2007).

Design phase

The design phase focused on working together to design plans for the future. Building on the previous two phases, the design phase required participants to make choices as to how the envisioned future will be achieved. This often required commitment and involvement of key stakeholders across disciplines and organizations. Action teams were formed and action plans were developed. Building collaborations and partnerships were key features in the aims of the studies reviewed. These collaborations included key stakeholders such as multidisciplinary healthcare service providers, service receivers, policy-makers, managers, and community groups. A review of the studies highlighted that AI was used at both micro and macro levels where collaborations occurred across different disciplines, services, management structures, and across large geographical areas (Lavender & Chapple 2004, Havens *et al.* 2006, Carter *et al.* 2007b). Shendell-Falik *et al.* (2007) suggest AI fits well in healthcare organizations because it uses people's experiences to help build relationships among key stakeholders. How collaborations were formed and the challenges of building these collaborations were not discussed in detail. Time frames between studies varied considerably between a few hours (Yoon *et al.* 2011) to days (Seebohm *et al.* 2010) and months (Carter *et al.* 2007a).

Destiny phase

The destiny phase allowed participants and researchers to review and celebrate accomplishments. Shendell-Falik *et al.* (2007); however, used the destiny phase to organize projects and prioritize initiatives to move their vision into daily practice, discuss future projects, staff allocations, and potential impact of project implementation. The group agreed on developing a timeline of activities, communication strategies, and a list of measures to monitor the impact of project efforts. Carter *et al.* (2007b) met with participants 6 weeks following the implementation action plans and used this phase to monitor group progress. A destiny meeting held used this phase to report their accomplishments and reflections on what they have learnt along the way through the use of the destiny meeting. Carter *et al.* (2007b) reports that while sustaining transformative change

can be challenging, promoting a practice atmosphere that encourages continuous change through AI was considered possible. Encouraging practice members to reflect on past successes and apply the skills learnt to new issues can assist participants to envision new possibilities for the future. Time frames varied between studies from a single follow-up session (Yoon *et al.* 2011) to monthly meetings with an AI review meeting 6 months later (Carter *et al.* 2007b) and others with meetings 3 times a year and a 5-year action plan (Havens *et al.* 2006).

Discussion

Appreciative inquiry is reported to be a powerful tool for facilitating change by crossing boundaries, engaging groups, and promoting a united approach to organizational change (Lavender & Chapple 2004). Key strengths of AI, is the engaging, inclusive, and collaborative nature of this mode of inquiry. It is intended that participants engage in a meaningful process that acknowledges their experiences, skills, and enthusiasm. The power of dialogue and reflection on successes and achievements are key components. It is argued that by focusing on the positive core, there will be a shift from the traditional problem orientated to a blame-free environment.

Overall, AI offers an alternate method for bringing about change in health care and health research (Reed *et al.* 2002, Carter 2006). AI is reported to have a lot to offer as an exercise for network building (Reed *et al.* 2002) and is highlighted as an additional and stimulating approach to research worthy of consideration (Reed *et al.* 2002, Carter 2006).

While participant enthusiasm and commitment have been highlighted suggesting AI is positively perceived by participants (Carter *et al.* 2007b) some researchers found starting from a positive stance presented challenges as participants were wanting to focus on problems (Havens *et al.* 2006). The focus on a positive core may also expose AI researchers to being accused of 'glossing over' problems (Reed *et al.* 2002, p. 45). There is also a risk that if researchers leave the setting before the newly created visions are embedded, false hopes may be raised (Carter 2006). Furthermore, success of the dreamed destiny may be at odds with the organizations elements and demands compromising the overall outcomes (Carter 2006).

Lazic *et al.* (2011) who used AI to implement a nurse education programme in a single paediatric centre, reported their entire dream was not achieved through the AI process. It was also noted in their study, participant enthusiasm declined when staff realized the expectations and increased

What is already known about this topic

- Appreciative inquiry is an organizational philosophy that has been found to be an effective approach to changing organizational culture and has recently been used as a way of reframing research.
- Appreciative inquiry shifts the focus from problems to be fixed to celebrations of successes while acknowledging the power of dialogue.
- There is growing literature highlighting the potential of applying appreciative inquiry principles commonly associated with business to health care and health research.

What this paper adds

- Provides an overview of the approaches used by researchers when implementing the 4D cycle.
- Highlights the varied time frames used by researchers when implementing the 4D cycle
- Provides guidance for novice appreciative inquiry researchers when working in the flexible appreciative inquiry framework.

Implications for practice and/or policy

- Adopting an appreciative inquiry approach can contribute to creating a more affirmative future for individuals and organizations
- Appreciative inquiry offers an interesting, creative, and stimulating way of researching
- Appreciative inquiry provides a positive way forward shifting from problems to solutions offering a new way of practicing in health care and health research.

workload required to prepare and present education sessions as part of their project. Participants found difficulties in keeping to the twice-weekly time schedule due to shift patterns and staff absences (Lazic *et al.* 2011). However, they did report success in bringing multidisciplinary professionals to work together with improved communication and a standardization of knowledge. It was expected that this will be sustained in the team.

The lack of methodological consistency in undertaking and reporting AI and reliable methods of measuring change when using an AI approach is a limitation. Certain parts of the AI process were not best explicated and studies were limited in the way in which the four phases were reported. It is important to highlight that every application of AI is unique and the phases were not undertaken in rigid steps

but transferred and adapted to the setting and participants. In the included studies, AI phases were not seen as a set of procedures but rather, each phase was built on the previous phase. The cyclical, iterative nature of the AI process suggested that AI should be used as an ongoing process and that AI does not conclude when the phases were completed. Rather, it is an operationalization of AI, stemming from the AI way of thinking about change. This is consistent with the way AI was used in its original context as an organizational development tool (Cooperrider & Whitney 1999).

Limitations

Limitations of this review are while several studies reported valuable information in the use of AI, many studies were excluded from this review as they did not describe in detail how they implemented the 4D phases. This may be due to limited journal word length resulting in these articles being excluded. Additional information may be gained by looking at detailed executive reports and thesis's using AI.

Conclusion

This article highlighted the diverse application of AI in a healthcare context. Overall, there are no single means of applying the AI phases, as it needs to be specific to the needs of the participants and the organization. As an organizational development strategy and research method AI is an approach worth considering. The 4D cycle offers a flexible framework that may be used by facilitators and participants to assess their progress. This article can be used as a guide for researchers and managers who may be considering using the AI approach to guide research and bring about organizational change.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the IC-MJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

Supporting Information Online

Additional Supporting Information may be found in the online version of this article:

Table S1. Critical appraisal of included papers.

References

- Bushe G.R. (1995) Advances in appreciative inquiry as an organizational development intervention. *Organization Development Journal* 13(3), 14–22.
- Carter B. (2006) 'One expertise among many' – working appreciatively to make miracles instead of finding problems: using appreciative inquiry to reframe research. *Journal of Research in Nursing* 11(1), 48–63.
- Carter B., Cummings J. & Cooper L. (2007a) An exploration of best practice in multi-agency working and the experiences of families of children with complex health needs: what works well and what needs to be done to improve practice for the future?. *Journal of Clinical Nursing* 16(3), 527–539.
- Carter C.A., Ruhe M.C., Weyer S., Litaker D., Fry R.E. & Stange K.C. (2007b) An appreciative inquiry approach to practice improvement and transformative change in health care settings. *Quality Management in Health Care* 16(3), 194–204.
- CASP International Network (2012) Critical Appraisal Skills Programme: Making sense of evidence about clinical effectiveness. 10 questions to help you make sense of qualitative research. Retrieved from http://www.casp-uk.net/wp-content/uploads/2011/11/CASP_Qualitative_Appraisal_Checklist_14oct10.pdf on 4 January 2013.
- Cooperrider D., Whitney D. & Stavros J.M. (2008) *Appreciative Inquiry Handbook: For Leaders of Change*, 2nd edn. Crown Custom Publishing, Brunswick, OH.
- Cooperrider D. (1986) *Appreciative Inquiry: Toward a Methodology for Understanding and Enhancing Organizational Innovation*. Western Reserve University, Cleveland, OH.
- Cooperrider D. & Barrett F. (1990) Generative metaphor intervention: a new approach for working with systems divided. *Journal of Applied Behavioural Science* 26, 2.
- Cooperrider D. & Whitney D. (1999) Appreciative inquiry: a positive revolution in change. In *The Change Handbook: Group Methods for Shaping the Future* (Holman P. & Devane T., eds), Berrett-Koehler Publishers, Inc., San Francisco, pp. 245–261.
- Dixon-Woods M., Agarwal S., Jones D., Young B. & Sutton A. (2005) Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research and Policy* 10(1), 45–53.
- Downe S., Finlayson K., Walsh D. & Lavender T. (2009) 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries. *BJOG: An International Journal of Obstetrics and Gynaecology* 116(4), 518–529.
- Finogold M.A., Holland B.M. & Lingham T. (2002) Appreciative inquiry and public dialogue: an approach to community change. *Public organization review: A Global Journal* 2(3), 235–252.
- Gergen K. (1985) The social constructionist movement in modern psychology. *American Psychologist* 40, 266–275.
- Gergen M.M., Gergen K.J. & Barrett F. (2004) Appreciative inquiry as dialogue: generative and transformative. *Advances in Appreciative Inquiry* 1, 3–27.
- Goldberg D. & Comins M. (2001) Struggling with partners: the use of the term 'partnership' in practice. *Anthropology and Medicine* 8(2–3), 255–264.
- Hammond S.A. (1998) *The Thin Book of Appreciative Inquiry*, 2nd edn. Thin book Publishing Co., Plano, TX.
- Havens D.S., Wood S.O. & Leeman J. (2006) Improving nursing practice and patient care: building capacity with appreciative inquiry. *Journal of Nursing Administration* 36(10), 463–470.
- Keefe M.R. & Pesut D. (2004) Appreciative inquiry and leadership transitions. *Journal of Professional Nursing* 20(2), 103–109.
- Koster R.L.P. & Lemelin R.H. (2009) Appreciative inquiry and rural tourism: a case study from Canada. *Tourism Geographies* 11(2), 256–269.
- Lavender T. & Chapple J. (2004) An exploration of midwives' views of the current system of maternity care in England. *Midwifery* 20(4), 324–334.
- Lazic J., Radenovic M., Arnfield A. & Janic D. (2011) Implementation of a nurse education programme in paediatric oncology using appreciative inquiry: a single center experience in Belgrade, Serbia. *European Journal of Oncology Nursing* 15(5), 524–527.
- Lewin K. (1959) *Psychologie Dynamique*. PUF, Paris.
- Liebling A., Elliot C. & Arnold H. (2001) Transforming the prison: romantic optimism or appreciative realism. *Criminal Justice* 1(2), 161–180.
- Plesk P.E. & Greenhalgh T. (2001) The challenge of complexity in health care. *British Medical Journal* 323, 625–628.
- Postma W. (1998) Capacity-building: the making of a curry. *Development in Practice* 8(1), 54.
- Reed J. (2007) *Appreciative Inquiry: Research for Change*. Sage Publications, Thousand Oaks, CA.
- Reed J., Pearson P., Douglas B., Swinburne S. & Wilding H. (2002) Going home from hospital: an appreciative inquiry study. *Health and Social Care in the Community* 10(1), 36–45.
- Seeborn P., Barnes J., Yasmeen S., Langridge M. & Moreton-Prichard C. (2010) Using appreciative inquiry to promote choice for older people and their carers. *Mental Health and Social Inclusion* 14(4), 13–21.
- Shendell-Falik N., Feinson M. & Mohr B.J. (2007) Enhancing patient safety: improving the patient handoff process through appreciative inquiry. *Journal of Nursing Administration* 37(2), 95–104.
- Van Der Haar D. & Hosking D.M. (2004) Evaluating appreciative inquiry: a relational constructionist perspective. *Human Relations* 57(8), 1017–1036.
- Vickers G. (1980) *Responsibility: Its Sources and Limits*. Intersystems, CA, USA.

Whitney D., Trosten-Bloom A. & Rader K. (2010) *Appreciative Leadership: Focus on What Works to Drive Winning Performance and Build a Thriving Organisation*. McGraw-Hill, NY, USA.

Yoon M.N., Lowe M., Budgell M. & Steele C.M. (2011) An exploratory investigation using appreciative inquiry to promote nursing oral. *Geriatric Nursing* 30(5), 326–340.

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- **High-impact forum:** the world's most cited nursing journal, with an Impact Factor of 1.477 – ranked 11th of 95 in the 2011 ISI Journal Citation Reports (Social Science – Nursing).
- **Most read nursing journal in the world:** over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 3,500 in developing countries with free or low cost access).
- **Fast and easy online submission:** online submission at <http://mc.manuscriptcentral.com/jan>.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).

3.3. Conclusion

This chapter has presented the second published paper of this thesis 'Implementing the 4D cycle of appreciative inquiry in health care: a methodological review'. This paper examined and critiqued how phases of the AI process have been implemented in a health care context and identified how AI could be used to guide this study. This review found that few studies articulated the methods used in each phase of the AI process. The following chapter presents the methods used in each phase of the AI methodology in this study including the research process, participant recruitment, data collection process and analysis, study rigour and ethical considerations.

Chapter 4:

Methodology and research methods

4.1. Introduction

Nursing research aims to provide new insights into clinical practice and improve/challenge/test the effectiveness of care practices to benefit patients, families and communities. Essentially, researchers seek to explore new insights into the world and generate new knowledge. This is achieved through a process of systematic enquiry, governed by scientific principles and is known as the research process (Gerrish & Lathlean, 2015). This chapter outlines the research process used for this study; participant and recruitment strategies; data collection and analysis techniques; study rigour; and ethical considerations.

4.2. The research process

Qualitative research is a form of scientific inquiry that provides detailed descriptions of the research topic area, is exploratory in nature and can be useful in investigating organisational functioning and relationships between individuals, groups and social environments (Curry, Nembhard, & Bradley, 2009). This study used qualitative methods as it is an effective way of gathering rich in depth data about individual experiences and practices and the meanings individuals attribute to these experiences. The research process provides a series of steps including mental activities that are designed to increase what is known about a certain phenomenon (Cormack, 2000).

4.3. Study setting

This study was conducted in a 32-bed tertiary referral neonatal unit that consisted of twelve (level five) neonatal intensive care beds (consisting of critical ill infants requiring assisted ventilation) and 20 (level four) special care beds (requiring minimal or no respiratory support). This particular neonatal unit was chosen for this study as it was a large tertiary neonatal unit and consisted of infants and families that required varied levels of care (intensive care and special care) and nurses with varied skill levels that

ranged from novice to experts in the specialty. In this neonatal unit care was based on the medical model of care but was moving towards embedding a philosophy of FCC. The neonatal unit had an open-plan design where nurses initially began working in special care and were trained up to work in the neonatal intensive care area. Staff members were graded according to individual nurse skill levels, completion of competency assessment tasks and work performance review. Therefore, the varied experience and skill levels of staff had been captured. This particular neonatal unit was also selected as it was a very busy neonatal unit, often working at full capacity and the majority of neonatal staff had been employed on a permanent full time or part time basis with very few casual/agency staff. The following sections details participants, data collection and analysis used in each AI phase.

Phase 1: Discovery phase

Aim of discovery phase

The aim of the discovery phase was to explore neonatal nurses' and parents' understandings of partnership and the philosophy of FCC. This phase explored neonatal nurses' perspectives of their role and the parents' role in FCC and parents view of their role and the nurses' role in facilitating FCC.

Participants and recruitment

Purposive sampling (a non-probability sampling technique) was used to recruit participants for this study with the expectation that each participant would provide unique information and bring value to the study. Purposive sampling selects participants based on the particular purpose of the study and relies on the researcher's judgement regarding the people, events, organisations, or pieces of data that will be studied (Polit & Beck, 2012). Initially, the nurse unit manager and director of neonatology were approached prior to commencing the study. The researcher presented six information sessions at varied times throughout the day and night to introduce the study to all NICU staff. Posters were placed on walls in meeting and staff tearoom (see appendix 3). Parents were recruited through an independent parent support group using snowball sampling techniques. Snow ball sampling is also a non-probability sampling technique where existing study participants assist in recruiting future participants from their acquaintances, therefore the study sample appears to grow like a rolling snow ball (Polit & Beck, 2012). This technique was used to recruit

NICU parent's as it was the most efficient way of recruiting parents that had already been discharged from the neonatal unit. Fliers were also posted in the independent support group office area (see appendix 4).

Nurses

Nurses in this phase of the study were neonatal nurses currently employed in the neonatal unit and graduate NICU parents. A total of 33 neonatal nurses participated in the study. Nurses recruited were women aged between 25-64 years. Nurse tenure ranged from first year post graduate nurses to senior experienced nurses with more than 15 years of service in this neonatal unit. Skill level ranged from junior to senior levels, in special care and neonatal intensive care areas. More details about the characteristics of the nurses are presented in the published paper titled 'Neonatal nurses perspectives of family centred care: a qualitative study' (see chapter 5). Ethical considerations were adhered to and consent received. Neonatologists and allied health were invited to participate.

Parents

A total of ten NICU parents participated in this study. To avoid adding any additional stress to parents currently experiencing a neonatal admission, only NICU parents that had infants cared for and then discharged from the neonatal unit were recruited into this study (within 5 years of hospital discharge). Parents were recruited through an independent parent support group formed by parents who previously had their infant in the neonatal unit where the study was conducted. The researcher approached the founder of the parents support group and asked for assistance in recruiting participants. To ensure currency of experiences reported, parents were only recruited if their infant had been discharged from a neonatal unit within the last 5 years. Both mothers and fathers were invited to participate in this study. However, only women chose to participate. Women recruited were between 28-35 years of age, and had given birth to a singleton, twins or quadruplets requiring neonatal intensive care treatment for more than one week. Infants' gestation ranged from 24 weeks to 36 weeks on admission. Two pregnancies were the result of in vitro fertilization (IVF) and the other infants were conceived naturally. Six participants required an emergency caesarean section while others delivered spontaneously.

Phase 1: Data collection

Data were collected in phase 1 via focus group interviews (see appendix 7). A focus group is an interview with a small group of people where experiences and opinions are solicited simultaneously (Polit & Beck, 2012). Following a literature review, semi structured interview questions were developed to guide the focus group discussions and interviews. The research questions were designed to elicit neonatal nurses' and parents' understanding and reflections of FCC and the perceptions of their roles in facilitating FCC.

Four focus groups were conducted in the NICU staff meeting room. The NICU staff meeting room was considered an appropriate site as it was located outside the clinical nursery area but close enough so staff could attend a focus group session. Each focus group lasted between 1.5-2 hours and had between six to eight nurses per group. Individual interviews were offered to staff who either preferred not to participate in a focus group or who were unable to attend one of the scheduled focus group sessions. One focus group was conducted with parents in a meeting room away from the hospital setting at the neonatal parent support offices. This site was considered appropriate as parents were familiar with this site, was away from the nursery, had easy access and free parking. Data collection for the discovery phase went over a two month period.

Data Analysis

Data from health professionals were transcribed verbatim and analysed using inductive thematic analysis. Braun and Clarke's (2006) thematic analysis process was selected as it is a comprehensive and robust model that can be applied within a range of theoretical frameworks. Data analysis was guided by Braun and Clarke's six step process of thematic analysis focusing on identifying themes and patterns of experiences or behaviours (Braun & Clarke, 2006; Braun & Clarke, 2013). Text was examined closely, line by line, read and re-read to facilitate microanalysis of the data. Open coding was used to allow grouping of categories and the emergence of themes (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Broad themes were identified and grouped together and then further categorised into sub-themes. Preliminary patterns in the data helped shape questions asked in the later focus groups discussion allowing further examination. Emerging patterns were examined by moving backwards and forwards between transcripts, field notes and research literature. The rigorous data analysis process contributed to the trustworthiness of these findings. Data were

managed electronically using NVIVO software. Data analysis revealed four dominant themes.

As only one focus group was conducted with parents, there was insufficient data to publish a separate paper. However, the focus group discussion confirmed the experiences of parents already reported in the literature including findings from a meta-synthesis conducted by Aagaard and Hall (2008) and outlined in the Introduction of this thesis (see Chapter 1). Therefore, following discussions with my supervisors a consensus was reached to not publish this data separately but to use the preliminary findings from the parent focus group to develop key statements to inform the next phase of the study. These key statements were presented to participants in the dream and design-workshops (in workshop Phase 2) to confirm whether statements were captured and reflected accurately (see Chapter 6 'statement from focus groups'). Key findings from the nurses' focus group interviews were also captured and presented back to the participants at the workshop.

Phase 2: Dream and design

Aim of dream and design phases

The next two phases of the AI process consisted of the dream and design phases. Initially the key statements from the previous discovery phase (conducted separately between nurses and parents through focus groups and interviews) were presented to all participants in a one-day workshop. The aim of the workshop were to bring neonatal nurses and parents together to collectively examine their own and others perceptions and experiences of FCC and to examine factors that facilitate the implementation of FCC. Participants in these phases dreamed and designed what FCC could look like in the NICU environment and began designing innovative strategies that could be implemented to improve FCC in the NICU.

Participants and recruitment

Purposive sampling was used again in the dream/design phase to recruit parent and nurse participants from the previous held focus groups. The same participants from the discovery phase were invited to participate in the dream and design phases. It was important to recruit the same parents as findings from the discovery phase were used to identify provocative propositions. The discovery phase findings were presented back

to the group at the workshop (phase 2) for 'member checking' to ensure initial findings were captured accurately. Recruiting participants from the previous phase also commenced the process of bringing about change in the neonatal unit. Fliers were posted throughout the neonatal unit including the staff tearoom area, notices placed in the staff communication book, and the study was promoted at staff meetings. Snowball sampling was used to recruit parents and fliers placed at the independent support group offices. Participants from the focus groups conducted in the discovery phase were asked to attend. Interested participants contacted the researchers and dates and times to meet were scheduled. Ethical considerations were adhered to and consent received.

Data collection

The workshop was held at the office of an independent parent support group located approximately 15 minutes driving distance from the NICU where the nurses work. The location was selected as a result of a collaborative decision made between the parent and nurse groups. Participants agreed on this location as it was away from clinical ward distractions, easy for parents and nurses to travel to, parking was free of charge. The meeting room had an open plan space design which allowed for small and large group work that facilitated researcher observation.

The workshop was structured according to the AI phases (see Chapter 6 and appendix 8). Data were collected throughout the workshop where small and large group discussions were digitally recorded (see appendix 9 for workshop questions). Small group work required participants to write down key points on sheets of butcher's paper and present findings to the larger group. Large group discussions focused on identifying consensus statements. The researcher and co-facilitator observed interactions of participants within large and small group discussions. My PhD supervisor suggested she assist as a co-facilitator during the workshop. Similar to focus groups, it is usual practice to have two facilitators in a workshop and it was important to record both the process and content as this was the first known study to bring neonatal nurses and parents together to explore FCC. I had previously met all the staff and parent participants prior to the workshop however the co-facilitator had not established a prior relationship with all participants. The co-facilitator also assisted with the logistics of the day, which would have been difficult for one person to execute. While I led the group discussion, the co-facilitator ensured time schedules were followed, assisted in facilitating small group discussion and taking field notes. Aspects

such as seating positions, participants who led the topics of conversation, participants' choice of words, voice tones and non-verbal communication were observed and recorded in field notes by the researchers. The field notes outlining the environmental and non-verbal communication were analysed with the verbal interchange in focus groups, workshops and working group meetings. The field notes were particularly important in writing my reflections about the AI process presented in Chapter 8. Researcher field notes were recorded during and after the workshop. In this phase, participants were asked to confirm key assertive statements from the discovery phase, dream what FCC would look like in an ideal world, develop provocative propositions, design strategies that would enhance FCC, and identify how the envision future would be sustained (see chapter 6). At the end of the workshop participants decided it was important to form a FCC working party and continue to meet on a monthly basis.

Data Analysis

Inductive thematic analysis (Lincoln & Guba, 1985) was used to condense raw data comprising of recorded transcripts from group discussions, participants' notes recorded on butchers' paper and field notes taken by researchers. As with the previous phase, text was examined closely, open coding used to identify broad themes and data relevant to these broad themes further categorised into sub-themes bringing together participants ideas and experiences to form a comprehensive picture of their collective experience (Braun & Clarke, 2006). To ensure trustworthiness of the data, clarity and agreement occurred throughout the data analysis process between researchers where key concepts were captured and explored. Throughout the workshop process, the researchers asked participants to clarify and refine ideas that emerged during the workshop discussions. For example, the provocative propositions were presented back to participants to ensure key findings were captured accurately. The rigorous and iterative data analysis process and cross examination between the researchers (that is myself and my supervisors) contributed to the trustworthiness of these findings (see section on study rigour on page 45).

Phase 3: Destiny phase

Aim of destiny phase

The aim of the destiny phase was to develop, implement and report on the progress and experiences of neonatal nurses and parents who worked collaboratively over a two

year period to design and implement innovative strategies to strengthen FCC in the NICU. The progress of the working party was explored and feedback on the AI approach used.

Participants and recruitment

Purposive and snowball sampling were used to recruit participants in the destiny phase. Parent and nurse participants from the previous workshop and staff that were a part of the FCC working party that was formed as a result of the workshop were invited to participate in this phase. Two parents, six nurses and the researcher formed the working party. Overtime, five more nurses including the nurse unit manager, team leader and educator joined, plus three allied health members including a physiotherapist, occupational therapist and a social worker, joined the group. Ethical considerations were adhered to and consent received.

Data collection

The FCC working party group met fortnightly initially and then agreed to move to monthly. Monthly meetings usually consisted of participating nurses (n=8) were aged between 25-64 years, parents (n=2), physiotherapist (n=1), occupational therapist (n=1) were aged between 25-35 years. Nurses' experience levels ranged from junior special care staff to senior, experienced neonatal intensive care staff with more than fifteen years of service in neonatal care. Both the physiotherapist and occupational therapist had over five year's neonatal experience. Parent participants (n=2) had experienced an infant requiring neonatal care in the last five years. Initially FCC working party rotated meeting locations between the NICU staff room and the independent support group offices, however after a year, it was deemed easier for staff to attend if it was held in the NICU staff room. Meeting minutes were typed and left in a folder in the NICU for all staff and parents to access. Researcher field notes were gathered either during or after each meeting. A total of 19 meetings were held. (Please see appendix 10 for key topic areas discussed and participant attendance).

Two years after the working party was formed two focus groups (four neonatal nurses in the first group and two neonatal nurses, one physiotherapist and one occupational therapist in the second) and four individual face-to-face interviews were conducted (two neonatal nurses and two graduate NICU parents). Data collected from these interviews and focus groups were digitally recorded and transcribed verbatim. Questions focused on the progress of the working party (see chapter 7 and appendix 11).

Data Analysis

Consistent with the previous phases, inductive thematic analysis (Lincoln & Guba, 1985) was used to condense raw data from the interviews and focus groups. Data were read line-by-line, broad themes identified and data relevant to these broad themes further categorised into sub-themes. The rigorous data analysis process contributed to the trustworthiness of findings. Data were managed electronically using NVIVO software. Four dominant themes emerged (see Chapter 5).

Study rigour

In the past qualitative research has often been criticised for lack of rigour, due to the lack of control over the validity and reliability of findings (Shenton, 2004). In order to overcome this, measures of trustworthiness, reliability and dependability have been suggested. As a concept rigour refers to the quality of the research process. A more rigorous research process will result in less errors and more trustworthy findings.

A number of strategies were used in this study to increase the rigour and trustworthiness of this qualitative study; 1) through careful planning, developing, analysing and evaluating each step of the research process and 2) applying the well documented components of rigour in qualitative research. Specific strategies used to achieve rigour in this study included engagement and participation from parents and nurses throughout the process, communication methods that developed mutual trust, ongoing evaluation, rigorous data analysis and thorough reporting processes and evaluations.

Developing relationships based on mutual trust and open communication was vital in engaging the NICU staff and parents in the AI process also providing richer data. In addition this assisted with valuable feedback on analysis and interpretation of data. Gathering relevant data on participant characteristics (gender, age and role) enable more accurate assessment of the diversity of participants. Attention was given to the type of questions asked, the research method/methodology selected and data analysis techniques employed. Using a carefully selected methodical approach and being attentive to and confirming information throughout the research process allowed for accurate presentation of findings. Lincoln and Guba's (1985) criteria for scientific rigour in qualitative studies, the principles of credibility, transferability, dependability and conformability and how they have been applied to this study, are discussed below.

Credibility

Credibility relates to the truthfulness and believability of findings from the perspectives of participants and others involved in the study (Lincoln & Guba, 1985). As qualitative research aims to describe or understand the phenomena of interest from the participant's view point, it is only participants that can legitimately judge the credibility of results (Lincoln & Guba, 1985). Therefore, throughout this study, findings were presented to participants to ensure key statements were captured accurately. For example, findings from the focus group sessions and interviews (discovery phase) were presented to participants at the beginning of the workshop (dream and design phase) to ensure data were reflected accurately. At the end of the workshops key points were again summarized and presented to the group as a whole to ensure credibility of the data. Having the opportunity to meet the participants on several occasions and being part of the monthly FCC meetings (formed as a result of this study), I was able to engage in member checking both, on the spot and throughout the study, to verify and clarify researcher's interpretations of participant's experiences and constructions.

While participants can judge the credibility of results, the credibility of the research process can be achieved through peer debriefing. The purpose of peer debriefing in constructivism is allowing the researcher to reflect on the whole research process (Frels & Onwuegbuzie, 2012; Lincoln & Guba, 1985). Debriefing require the researcher to provide information about the implementation and evolution of the research project to an impartial colleague (Lincoln & Guba, 1985). This process allowed other researchers and practitioners to critically review information presented at one or more stages throughout the study and provide feedback on the appropriateness of the study design, methodology used, data collection process, data analysis techniques, trustworthiness and completeness of the researchers findings and provide feedback on the overall progress of the study (Frels & Onwuegbuzie, 2012; Lincoln & Guba, 1985).

Throughout this study, feedback was sought from supervisors, academic peers and fellow PhD students to facilitate discussions and develop insights and understanding of the research process and assisted in refining thoughts and findings. This study was presented to academic colleagues, at local, national and international conferences. The study findings have been published in journals opening this body of work to peer review.

Reflexivity was an important means for personal evaluation throughout this study. Reflexivity is 'the process through which a researcher recognises, examines, and understands how his or her social background and assumptions can intervene in the research process' (Hesse-Biber & Leavy, 2007 p.129). The participants from this study were recruited from the neonatal unit where the primary researcher previously worked. Therefore, the primary researcher had previous experiences in the neonatal unit and had already established professional relationships with most participants.

Having pre-existing membership of the group provided ease of access to the study settings, early rapport building and increased understanding of the culture and language used allowing for synchronization between participant behaviour and the study setting. This also allowed for thick descriptions of experiences, as time wasn't wasted trying to understand NICU terminology or factors such as explaining NICU ward processes. While benefits of being an 'insider' were recognised, I was conscious at all times that I needed to observe with an etic 'outsider' lens to ensure that I maintained an analytical perspective at all times to ensure I captured participants experiences accurately and were not influenced by my perspectives or interpretations (Burns et al., 2010).

Transferability

Transferability refers to the degree in which qualitative research can be transferred to other settings or contexts (Lincoln & Guba, 1985). Transferability in this study was enhanced by thoroughly describing the research context and methodology that were central to this study. Clear descriptions of the study settings, participant characteristic, time frames and approaches to data collection and analysis have been outlined. Each phase of the AI process is described and findings are clearly presented. Sufficient contextual information is provided allowing the reader to determine transferability. The research approach and findings have been presented at local, national and international conferences and published in peer review journals.

Dependability

Dependability ensures the research findings are consistent and could be replicated or repeated (Lincoln & Guba, 1985). Dependability has been achieved in this study by providing the reader with clear and detailed descriptions of all aspects of this study including the research process, methodology details, data collection techniques and analysis processes. Such detail has been provided to enable future researchers to

repeat the work whether in a similar or different context. As reported previously, a reflexive journal was kept detailing the research process and including methodological decisions made throughout the study.

Confirmability

Confirmability refers to the degree to which the results can be confirmed or corroborated by others (Lincoln & Guba, 1985). This study used several strategies to enhance confirmability through processes such; as checking and rechecking the data, keeping an audit trail of the methodological process, and, by being aware of any potential researcher biases. My researcher's positioning was clearly identified and steps were taken to ensure the study findings were the result of participants and not my personal characteristics or experiences. As mentioned I kept a reflexive journal. Finally to ensure confirmability, I have written in this thesis a reflective commentary on the study's process titled 'Researchers reflections'.

Ethical considerations

This study was approved from the University of Western Sydney Human Research Committee (see appendix 1) with additional approval obtained from Sydney South West HREC (Western zone) (see appendix 2) a local health district in accordance with the legislative requirements of the relevant state.

Consent

A guiding principle for researchers is to ensure an individual's decision to participate in research is voluntary and based on sufficient information and adequate understanding of the proposed research and the implications (both benefits and risks) of participating in the research (National Health and Medical Research Council, 2007). The study consent form and accompanying information form clearly explained the purpose of the study, written in everyday language, using the University of Western Sydney (UWS) ethics committee template (see appendix 5 and 6). Participants were informed prior to their participation in each phase of the study they had the right to withdraw from the study at any time without ramifications or negative consequence.

Participants were provided with contact details should prospective participants wish to obtain further information or if they wished to withdraw from the study. Once

participants read the information form and signed consent, subsequently they were recruited into the study. Prior to data collection, participants were again informed about the purpose of the research and confirmed participation was voluntary. A separate consent form was used for each stage of data collection for the study. Verbal consent was also received prior to the recording of interviews or focus groups. Participants were informed that if they participated in a recorded focus group and later decided to withdraw from the study, every effort would be made to remove their responses however, advised some content (up to the withdrawal) may still be reported on due to the complexity of identifying and removing one voice from a group of voices in a focus group session.

Autonomy

The concept of autonomy refers to the individual's right to decide. In this study all participants were over the age of 18 and were able to make informed decisions regarding participation in the study. Participants were made aware of the right to withdraw from the study without penalty. Under the principle of justice, participants have the right to be treated fairly. Throughout the research participants were treated with respect. Participants were provided with information about the study in a timely manner and contact details of appropriate counselling services were provided.

The principle of beneficence

Beneficence refers to 'doing good'. This study aims to do good by exploring parent and nurse experiences in the aim of improving neonatal and family outcomes. It is hoped that the dissemination of these findings will inform policy development and facilitate collaborations between nurses and NICU families.

The principle of non-maleficence

Non-maleficence refers means to 'do no harm'. As researchers we should always act in ways that do not inflict harm to others. Researchers should not cause intentional or avoidable harm. Participants were made aware prior to commencing the study that participation may trigger some physical or psychological discomfort (eg, headache, tiredness, anxiety or emotional distress) when sharing or reliving their stories. When conducting the interviews, focus groups and workshops, harm was avoided by conducting these sessions in a sensitive and considerate manner.

A list of counselling provider details was given to all participants at the commencement of the data collection process. A counsellor was available after the interview and focus group sessions if needed. Participants were informed they could withdraw from the study at any time. Participants were reassured that participation in the study would have no effect on nurses employment and parents were reassured that participation in the study would have no effect on future associations with the health service.

Confidentiality

Participants were assured that confidentiality would be maintained at all times and focus group participants provided verbal consent to maintain and respect confidentiality including not discussing who was present or content raised during the focus group sessions. The researcher ensured anonymity was maintained in published documents at all times and ensured data collected was safely stored. Participant consent forms, transcripts and researcher field notes were kept in a locked cabinet with a key held by the researcher. All digital data including audio data and data saved on a computer under security password. Members of the research team were the only persons with access to the participant interview and focus group data.

The criteria of authenticity

In the aim of establishing authenticity, researchers sought reassurance that both the conduct and evaluation of research was genuine and credible. This not only include participants lived experiences but must also consider the wider political and social implications of research. Throughout this study the researcher has faithfully and fairly described the participants' experiences. As this research adopts a constructionist approach, this research is grounded in the realities of the individual and social constructs. Participants report feeling more empowered as a result of this research and have initiated the forming of a FCC working party. The political and social implications of this research have been addressed when reporting the future implications of this study.

4.4. Conclusion

This chapter presented the AI methodology and methods used for this study including the research process, participant recruitment into the study, data collection processes and analysis, study rigour and ethical considerations. The following chapter presents

the third published paper titled 'Neonatal nurses' perspectives of family-centred care: A qualitative study' exploring neonatal nurses' perceptions of FCC in the NICU.

Part B

Findings

The future depends on what we do it the present

Monhandas Karamchand (Mahatma) Ghandi (1869-1948)

Chapter 5:

Neonatal nurses' perspectives of family-centred care: a qualitative study

5.1. Publication

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspectives of family-centred care: A qualitative study. *Journal of Clinical Nursing*, 21(17-18), 2477-2487. doi: 10.1111/j.1365-2702.2012.04138.x.

5.2. Introduction and relevance to thesis

Neonatal nurses are at the forefront of delivering neonatal care and spend most of their time at the bedside with neonates and their family. Research is highlighting implementing FCC is difficult. The relevance of this paper is to explore neonatal nurses' understanding of the philosophy of FCC, perceptions of the nurses' role in facilitating FCC, and the importance nurses place on implementing FCC principles. This paper reports the findings of the first phase of the AI process. Findings from this initial phase were used to form key statements that were presented back to participants in the next phase of the study.

Neonatal nurses' perspectives of family-centred care: a qualitative study

Suza Trajkovski, Virginia Schmied, Margaret Vickers and Debra Jackson

Aims and objectives. The aim of this study is to explore neonatal nurses' perspectives of their role in facilitating family centred care in the neonatal intensive care unit.

Background. The philosophy of family centred care focuses on the health and wellbeing of the newborn and their family, through the development of a respectful partnership between the health care professional and the infant's parents. Many studies report family centred care in the context of paediatric care; however, few studies explore neonatal nurses' perspective of family centred care in the context of neonatal care.

Design. Qualitative interpretative approach.

Methods. Four focus groups and five individual face-to-face interviews were conducted with neonatal intensive care nurses (total $n = 33$) currently practicing in a tertiary Neonatal Intensive Care Unit in Australia. Each focus group and face to face interview was audio-taped and transcribed. Data was analysed using thematic analysis.

Results. Four dominant themes emerged from the data: (1) Getting to know parents and their wishes (2) Involving family in the day to day care (3) Finding a 'happy' medium (4) Transitioning support across the continuum.

Conclusion. These findings revealed a general understanding of family centred care principles. Nurses reported the potential benefits and challenges of adopting a family centred care approach to deliver optimal care for neonates and their families. The study highlighted that nurses need ongoing organisation support, guidance and further education to assist them in delivering family centred care effectively.

Relevance to clinical practice. Family centred care is a central tenet underpinning neonatal care. Understanding neonatal nurses' perspectives will be useful when developing strategies to strengthen family centred care in the neonatal intensive care unit, and potentially improve neonatal care and family outcomes.

Key words: family centred care, neonatal care, neonatal nurses, parent-nurse relationships, parents' experiences, partnerships in care

Accepted for publication: 12 February 2012

Introduction

The philosophy of family-centred care (FCC) is considered a fundamental principle in providing neonatal care (Gooding *et al.* 2011, McGrath *et al.* 2011). FCC requires a partnership approach, empowering and involving parents in the care

of their infant (Cooper *et al.* 2007). Published research suggests there are difficulties in implementing FCC principles into daily practice (Corlett & Twycross 2006, Gooding *et al.* 2011). The aim of this study was to explore neonatal nurses understanding of the philosophy of FCC in the neonatal context and describe how neonatal nurses view their role in

Authors: Suza Trajkovski, RN, BN, PhD Candidate and Lecturer, Family and Community Health Research Group (FaCH), School of Nursing & Midwifery, College of Health Science, University of Western Sydney, Sydney; Virginia Schmied, RN, RM, PhD, Professor, Family and Community Health Research Group (FaCH), School of Nursing & Midwifery, University of Western Sydney, Sydney; Margaret Vickers, MBA, BBus, PhD, Professor, School of

Business, University of Western Sydney, Sydney; Debra Jackson, RN, PhD, Professor, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, Australia

Correspondence: Suza Trajkovski, PhD Candidate and Lecturer, Locked Bag 1797 Penrith, NSW 2751, Australia. Telephone: +61 2 4620 3363.

E-mail: s.trajkovski@uws.edu.au

facilitating FCC. This will assist in identifying factors that facilitate FCC and identify areas where further education or organisational change may be needed.

Background

When faced with the admission of their infant to a neonatal intensive care unit (NICU), parents often struggle with the unfamiliar, intimidating, public and medically oriented setting that is characteristic of such a unit (Fegran *et al.* 2008). Parents report being overwhelmed by the environment, which includes sounding alarms and extensive technology and monitoring systems (Lupton & Fenwick 2001, Heerman *et al.* 2005). Descriptions from mothers when first seeing their infant in the NICU are that of relief and happiness coupled with fear, anxiety, guilt, grief and despair (Jackson *et al.* 2003, Erlandsson & Fagerberg 2005, Hall 2005). Mothers express distress related to their inability to comfort, care for, protect and share their new infant with their families (Shaw *et al.* 2006). They also report a strong desire to be 'close to' and the need to 'get to know' their baby (Lupton & Fenwick 2001, Hall 2005). Aagaard and Hall (2008) report some mothers' express ambivalence and fear of attachment because of the uncertainty of whether their infant will survive. Others report feelings of alienation and liken their experience to being an outsider or 'spectator' to their infants' care (Fegran *et al.* 2008).

Research suggests the NICU experiences and challenges may have long-term effects on the health of individuals (particularly mothers) and on family functioning (Talmi & Harmon 2003). Longitudinal studies of NICU families suggest that for at least some time following the infant's discharge, families' may experience difficulties in their day-to-day activities and in their ability to cope with infant care (Holditch-Davis *et al.* 2003, Talmi & Harmon 2003, Shaw *et al.* 2006, Feeley *et al.* 2011). Issues stem from stress caused by the hospitalisation itself and may lead to symptoms of acute stress disorder (ASD), a precursor to post-traumatic stress disorder (Holditch-Davis *et al.* 2003, Shaw *et al.* 2006). Analyses of specific sources of stress indicate that serious threats to the parental role were most strongly associated with the symptoms of ASD. Such families have also been identified as being at increased risk of divorce and financial problems (Carter *et al.* 2005).

Over the last 15 years, significant efforts have been made to strengthen models or approaches to care to address infant and parent needs. These include efforts from the Institute of Patient and Family Centred Care (FCC), March of Dimes NICU family support, and developmentally supportive care initiatives such as newborn individualised developmental care

and assessment programme and family-centred developmental care (Gooding *et al.* 2011, McGrath *et al.* 2011).

Family-centred care has been well recognised, accepted and reported in the literature as the best way of caring for hospitalised children and their family (Hughes 2007, McGrath *et al.* 2011). FCC is an approach to care that can be described as:

a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients (Shields *et al.* 2006, p. 1318)

One of the core principles promoted in FCC is the need for a partnership between parents and health professionals (Shields *et al.* 2006). Such a partnership is characterised by a shift in nurses' role from being 'the expert' to one of guidance (Lee 1999). The reported benefits of developing a successful partnership include improved health outcomes (Hook 2006), more empowered, knowledgeable and confident parents (Bidmead & Cowley 2005, Hook 2006, Gooding *et al.* 2011) and enhanced job fulfilment (Lee 1999).

Despite consensus in the literature regarding the value and importance of FCC, a systematic review conducted by Shields *et al.* (2007) found no published research met their inclusion criteria to assess the effectiveness of FCC. Further qualitative studies highlighted difficulties in the implementation of FCC (Darbyshire 1995, Fenwick *et al.* 1999, Petersen *et al.* 2004, Coyne & Cowley 2007, Harrison 2010). There is a lack of detail regarding what constitutes parent participation in the NICU (Petersen *et al.* 2004). Ethnographic (Fenwick *et al.* 1999) and descriptive studies (Petersen *et al.* 2004) reveal nurses' difficulties in implementing FCC into daily practice. Studies indicate factors such as poor communication, ambiguity about parent and nurse roles, and lack of negotiation together with busy workloads result in disorganised or inconsistent ways of implementing FCC (Darbyshire 1995, Wilson *et al.* 2005, Coyne & Cowley 2007). Furthermore, organisational barriers such as health system design, restrictive hospital/unit policies, and a lack of education have also been reported as factors contributing to the difficulties in implementing FCC (Petersen *et al.* 2004, Schroeder & Pridham 2006, Macguire *et al.* 2007, Wingert *et al.* 2008). Some studies suggest neonatal nurses are less likely to implement FCC compared to paediatric nurses (Petersen *et al.* 2004).

Despite the challenges, neonatal nurses have the unique opportunity to be able to assist families through facilitating parental involvement during this difficult period. With increasing consumer (parental) demand to be included in their infants care and efforts made over the last 15 years to

address these needs, it is evident that neonatal nurses' perspectives of FCC in the NICU and their roles in the current context require further exploration. This may assist in identifying areas where further education and support are needed to improve neonatal care and family outcomes, while also adding to the current literature on issues surrounding FCC.

Aim

The aim of this study is to explore neonatal nurses' understanding of the philosophy of family-centred care in the neonatal context and to describe how nurses view their role when delivering FCC.

Methods and design

A qualitative interpretative approach was used to elicit information about neonatal nurses' perceptions of FCC. Four focus groups and five face-to-face individual interviews were held in a tertiary NICU in Sydney, Australia. Data were audio recorded, transcribed verbatim and analysed using inductive thematic analysis (Braun & Clarke 2006, Fereday & Muir-Cochrane 2006).

Setting

This study was conducted in a 32-bed tertiary referral neonatal unit that consisted of 12 (level 5) neonatal intensive care beds and 20 (level 4) special care beds. The unit has an open-planned design where nurses begin working in special care (level 4) and are then trained to work in the intensive care (level 5) area. Staffing is graded according to individual skill level, completion of competency assessment tasks and performance review with the nurse manager. For staffing acuity, nurses are grouped into senior level 5 (critical infants requiring ventilator support), junior level 5 (stable continuous positive airway pressure) staff, senior level 4 staff (minimal to no ventilator support such as nasal prong

oxygen) and junior level 4 staff (nil respiratory support). Nurses were categorised according to their skill level in this particular neonatal unit (see Table 1) The current model of care used in this NICU is a medical model of care that is moving towards embracing the philosophy of FCC. A multidisciplinary team approach is used, where the nurses' role included working as part of a multidisciplinary team and with family members to provide optimal care for the neonate and the family. This particular unit has an unrestricted family visiting policy for the immediate family (mother/father/siblings).

Participants

Thirty-three currently practising neonatal nurses participated in this study. This included nurses providing direct clinical care including a clinical nurse educator. All nurses who participated in this study were women and aged between 25–64 years. Nurses' tenure in the neonatal unit ranged from first year postgraduate nurses to senior experienced nurses with more than 15 years of service in this particular neonatal unit. Twenty-eight nurses participated in the focus group sessions, and five individual interviews were conducted resulting in a total of 33 participants.

Ethical considerations

Following institutional ethics approvals, written consent was obtained from participants prior to commencing the study. Participants were informed that the overall aim of this research was to improve care practices for neonates and their family. Assurances were given that participation would have no effect on employment. Participants were advised they could withdraw from the study at any time. However, focus group participants were advised that data collected to the point of withdrawal from the study would still be included because of the complexities of identifying and removing one voice from a focus group recording. For these same reasons, direct quotes published in this study will be presented as

Table 1 Nurse characteristics

Focus Group	Group 1	Group 2	Group 3	Group 4	Individual interview
Level 5	S – 3	S – 2	S – 3 (incl. CNE – 1)	S – 3	S – 2
Intensive care	J – 2	J – 4	J – 0	J – 2	J – 1
Level 4	S – 1	S – 0	S – 3	S – 0	S – 1
Special care	J – 1	J – 2	J – 1	J – 1	J – 1
Total	7	8	7	6	5

S, senior; J, junior, CNE, clinical nurse educator.

either focus group or individual interview material. This will ensure protection of participants' confidentiality and anonymity.

Data collection

Following a literature review, semi-structured interviews questions were developed to guide the focus group discussions and interviews. The research questions were designed to obtain nurses' understanding and reflection of FCC and the nurses' perception of their role and the parents' role in FCC. Data were collected over a two-month period. The first author approached the Nurse Unit Manager and the Director of Neonatology prior to commencing the study and was given permission to present six information sessions to introduce the study to the staff. Staff had previously been presented with an outline of the aims of the study, what participation involved and the commencement date of the study. Posters providing brief information about the study and the dates and venue for focus group discussions were placed on wall in meeting room and staff areas. These sessions were performed at different times throughout the day and night with the aim of recruiting staff from all shifts.

Four focus groups were conducted in the unit during staff overlap time. Each focus group lasted between 1.5–2 hours and included between 6–8 nurses. Individual interviews were offered to staff who either preferred not to participate in a focus group or who were unable to attend one of the scheduled focus group sessions. All participants who attended the face-to-face interviews were asked whether a face-to-face interview was a preferred choice. Each participant reported choosing this method to fit in with their own time schedule as they were not rostered on duty during the scheduled focus group times. The focus groups and face-to-face interviews were digitally recorded and later transcribed verbatim. A co-facilitator was present for two focus group sessions to offer the primary facilitator support in the initial stages and was not required for the following focus groups.

Data analysis

Transcribed data were analysed using thematic analysis focusing on identifiable themes and patterns of experiences, or behaviour (Braun & Clarke 2006, Fereday & Muir-Cochrane 2006). The data analysis was inductive; themes were derived from the data and were not imposed upon by ideas previously held by the research team. Text was examined closely, line by line, read and re-read to facilitate microanalysis of the data. Focus group and interview data were open coded allowing grouping of categories and the

emerging of themes (Braun & Clarke 2006, Fereday & Muir-Cochrane 2006).

First, patterns of experiences were identified as broad themes. Data that were relevant to these broad themes were grouped together and then further categorised into subthemes bringing together participant ideas and experiences to form a comprehensive picture of their collective experience (Braun & Clarke 2006). Preliminary patterns in the data helped to shape questions asked in the later focus group discussions, and these emerging patterns were further examined by moving backwards and forwards between transcripts, field notes and referring to research literature. Analysis of the interview data also confirmed the themes that emerged from the focus group data. The rigorous data analysis processes contributed to the trustworthiness of these findings and the construction of a story line as described in this analysis (Braun & Clarke 2006, Fereday & Muir-Cochrane 2006).

Results

In this study, nurses working in the NICU agreed that it is important to provide care to the infant and the family as a whole unit. Participants identified the critical need for nurses to develop effective relationships with parents and they revealed a general understanding of family-centred care principles. Nurses reported the potential benefits and challenges of adopting a FCC approach. Four dominant themes emerged from the data: (1) Getting to know parents and their wishes, (2) Involving family in the day-to-day care, (3) Finding a 'happy medium' and (4) Transitioning support across the continuum.

Getting to know parents and their wishes

Participants reported a desire to do their utmost for the well-being of both the infant and the family when delivering neonatal care. Spending most of their time by the cot side caring for the infant, nurses reported the importance of 'getting to know' parents needs to deliver care that is individualised and specific to the needs of the family. During a focus group session, one nurse stated:

Just getting to know them... who they are as people and just trying to go with their wishes as much as we possibly can without placing too much stress on the baby and on them (Focus Group 4)

Conscious that nurses spend considerable amounts of time with the infant, nurses in different focus groups acknowledged the need to develop and build trusting relationships with the parents:

It's important to build a meaningful relationship with the parents in order to assist these parents in a difficult time in their lives. Parents have no choice but to leave their babies in our hands so it's important they feel as though they can trust us. In order to build this trust and meet their needs we need to develop a meaningful relationship (Interview 2)

To build relationships and to meet parents' need, nurses' reported intermingling conversations with parents by talking about their infant and neonatal care with general conversations:

We hear their whole life story and we listen to what the parents are also going through outside of the nursery. We tend to provide a lot of encouragement and support, more than say the medical staff when they don't really have time to sit down and say: 'So, how's life at home', whereas while we're doing things for the baby, we tend to talk to the parents and help relax them a little (Focus Group 3)

Nurses in this study acknowledged that each family has different needs and bring with them different experiences, knowledge, personality traits and come from varied cultural backgrounds:

Not everyone has the same skills, they (parents) all bring their individual expertise...talents...To provide the best care (Interview 3).

The nurses, however, also highlighted that working with diverse families presented challenges for them:

Sometimes interacting with parents can be difficult. I feel as nurses we are not adequately prepared or trained in caring for the social aspect of the family. Most of our training focuses on caring for the infant. So dealing with the diverse needs of families is often hard work and sometimes it's just easier to refer them on to the social worker (Interview 1)

Involving family in the day-to-day care

The need to involve the family in the day-to-day care of the infant, share information and guide families were highly regarded aspects of the nurses' role. Nurses also acknowledged that parents are able to significantly contribute to the physical care of their infant and begin to 'bond' with their infant soon after birth. The central place of parents was highlighted in one focus group:

Without parents you can't have babies. You can't exclude them because they brought us the baby so they need to understand what's going on and they need to feel involved (Focus Group 3)

The nurses recognised that parents wanted to be involved in their infant's care:

Parents are more knowledgeable of how things go, so they don't demand in the sense that, 'I want it done now', but they want to get involved. They want to work with you for that common goal. They realise: 'I can't do the intensive stuff, but I can do other stuff. I can do the nurturing stuff' (Focus Group 3)

Participants also emphasised the importance of facilitating the parent-infant relationship:

It's up to us nurses to work closely with the family, to involve and include parents in their babies care...It's really important that parents begin to develop a relationship with their baby soon after birth. Mothers and babies need to be close and they need to bond with their baby (Interview 4)

There was general consensus among participants of the need to include the entire family and not merely focus on the mother as care giver and decision-maker. Family-centred care included mothers, fathers, siblings and extended family such as grandparents.

I think we do involve fathers a lot more and even grandparents, we involve them a lot more too. We quite often offer the dads kangaroo cuddles as well as mums (Focus Group 3)

It was also considered very important that both parents had an active presence in the NICU. One nurse said, '*Parents' need to be here*' and another added:

We encourage the mums and push the dads a bit too, because they're the ones that actually seem to be more standoffish than the mums (Focus Group 2)

Some strategies implemented by nurses to include the family were scheduling infant care times with the family, ensuring that both mothers and fathers were able to participate in kangaroo cuddles and encouraging sibling involvement.

Participants also acknowledged that involvement occurs across a continuum that requires the participation and contributions of many members of the multidisciplinary team:

Involving all the allied health workers too...with family. It's a bit broad really, all sorts of people are coming in, involved in taking care of that baby, you're not the only one (Focus Group 3)

Nurses' also spoke about the 'right' or appropriate times to include family. While nurses acknowledged that this was based on individual needs and circumstances, many nurses reported the best time to include the family was when performing tasks.

I think at the time, when you're actually touching a baby and doing things, is a good time to involve the parents (Focus Group 3)

While the needs of the infant and family influenced the times to include the infants' family, so did the skill level of the

neonatal nurse. More experienced and confident nurses found it best to talk to the parents and provide a basic explanation of tasks being performed with rationales to the parents throughout the admission and infant stabilisation process. A senior nurse stated:

It's a bit hard to explain to parents...we haven't really got time to talk to you because we're concentrating on your baby. Although that's what they want, at the same time they are going to want to know what's going on (Focus Group 3)

Another nurse reflects:

The more experience and confidence I developed...routine tasks became easier giving me more time to help parents and the family. You are more informed and less scared the more experienced you become (Interview 5).

However, less experienced or less confident nurses' felt their main focus was to stabilise the infant in the first instance and then include the family when the nurse felt ready and able. A junior intensive care nurse reflects:

During an admission I can only focus on the baby....but....I see the senior nurses in intensive care and their putting tubes down or suctioning the infant and talking to the parents at the same time explaining what's going on with their infant. I'm so amazed when I see them in action. Me, I don't have the confidence yet to do that but I'm sure with experience that with come... or at least I hope it does (Interview 4)

Less experienced or less confident nurses expressed admiration for nursing staff that were able to effectively include the family throughout the admission process.

Finding a 'happy medium'

Involving the parents was the key phrase that was used; however, the analysis indicates that there was tension between nurses wanting parents to be involved and indeed expecting them to be involved but still wanting to retain control and be able to dictate when and what parents did. Participants, therefore, found they needed to find a 'happy medium' as depicted by one nurse who said:

We [nurses] have to negotiate with the parents to have that happy medium happening between nurses and parents (Focus Group 4)

Given that 'Involving the parents' was central to how participants described FCC, there was a sense of frustration when parents were not available to be involved at appropriate times. For example, participants described when scheduling times with parents to do infant cares, it was crucial that parents be punctual. Feelings of frustration and resentment were reported

when parents arrived late, reflecting they believed, a lack of consideration for the infants needs and nursing staff workload.

While these nurses considered involving the family as a high priority, they also placed caveats on involvement:

They have a responsibility being a parent to the baby, which means being here and being reliable (Focus Group 4)

While nurses in this study acknowledge that parents had a 'life outside the NICU', they highlighted the importance of daily family presence in the neonatal unit or at the least telephone contact with the NICU staff:

Parents need to be here to be part of family centred care. If they can't be here, I think they have a responsibility to at least ring (Focus Group 3)

In focus group discussions, it was highlighted that FCC was often delivered in a sporadic manner where some families were more involved than others. A lack of staff guidelines, nurse/parent personality types and time constraints were considered influencing factors. Nurses reported on the various experiences of facilitating family-centred care described as rewarding, challenging and difficult:

I feel it's important to include families in their babies care, I find it rewarding interacting with them and seeing them interact with their infant. I do find however... some nurses are better than others at delivering family centred care. Some nurses involve the family more than others and some people just have personalities that click better with certain parents (Interview 2)

However, in other groups, participants highlighted that some nurse displayed mixed messages to parents' potentially resulting in confusion and frustration:

We encourage them but sometimes I think we discourage them a little bit too (Focus Group 4)

You like to involve them but sometimes you've just got to keep them away a little bit too (Focus Group 4)

While nurses strive to meet the family's needs, this can prove challenging:

There is a time when you have to be flexible and then there is a time when you just can't (Focus Group 4)

Participants acknowledged that nurses are in a powerful position, sometimes controlling what parents can and can't do:

If the mother comes in to do cares you should just let them do it. It's their baby. I think sometimes we take control of the baby more than the mothers have control (Focus Group 2).

Another participant challenged this view saying:

If the baby had a rough morning and the mum comes in and says 'can I do cares or cuddles' and if that means the baby may need to go back onto CPAP, no I won't do it...I think I am the baby's advocate. So I always put the baby first, I must say, and I'm the first to take the baby out for cuddles as well, but if I think the baby's not going to tolerate it, I won't. So I will apologise to the parents but I won't do it (Focus Group 2)

While other nurses did report their primary concern was the health and well-being of the infant, nurses in this study also highlighted that caring for families was just as important:

It's easy to explain to parent's what's going on, but it would be difficult to be in their position, for us to say: we've been touching your baby all day, so you're not allowed to touch him because he needs his rest. I think that would be difficult from a parent's perspective, to have to hear that (Focus Group 3)

Being mindful of the parents' situation, the nurses often spoke of the need to negotiate with parents' to find a happy medium. They consulted with parents regarding care times to suit parents' schedules, changes in clinical practices and report progress of the infants' condition:

It's got to be a sort of happy medium between everybody. So it's just basically talking to them and just getting to know what they want and then coming to a compromise situation (Focus Group 4)

The nurses agreed that communication was vitally important and found that providing explanations was a useful strategy when negotiating with parents:

We explain the reasons why and you can usually negotiate that way (Focus Group 2)

Participants felt a sense of responsibility to adequately prepare parents for life after the NICU. One nurse describes this by saying:

Often you have first time parents...who haven't got those mother craft skills or parent craft skills...and you give them this baby and they're like: "I haven't changed a nappy; I haven't fed the baby"...It's a bit unfair to take all that away and then hand them a baby and say... "Off you go, have a nice life" and expect them to know what to do (Focus Group 3)

While nurses in this study considered working with parents important, they also challenged the ideology of partnerships suggesting there is an imbalance of equity whereby nurses have greater control of the boundaries of care than parents:

You feel like the nurse is dictating more. Partnerships I think implies that it's equal and I don't think it's necessarily equal. Although you

try to get the parents to help you with things, I think they still always see that you have the control, no matter how much you try to get them involved in at the end of the day. I think it's true because you're the one that is dictating when it's okay for the baby to come out, when it's okay for them to help because the baby is stable enough. Here in the nursery, you discuss things with the parents, but it's usually after you've discussed it with the doctors and the team here and then you discuss it with the parents and say 'okay, this is what we think, and what do you think?'. And then, we go ahead with what I think anyway, but yet with consultation. So in other words, you inform them of what you're going to be doing but ultimately, it's your decision no matter how much we try and make it nice. No, it's what we think is best and that's the reality of it. (Focus Group 2)

Transitioning support across the continuum

Nurses' in this study reported their role included caring for the infant from sickness to health while simultaneously caring for the family from admission where parents are often scared and anxious to the point of discharge where families felt empowered and more confident in caring for their infant. These neonatal nurses described the NICU journey as a trajectory with varied focal points, where all stakeholders are striving to achieve a common goal:

I think in intensive care the really acute medical issues sort of come first and so that's what everyone stresses on. Down in special care the focus of baby's care is a bit different because now we're working towards going home; establishing feeds, not just keeping them breathing – which is pretty much what you tend to do. So I think it is a little bit different here. We all work towards the same goal at the end, but I think we all have different focus point along the way (Focus Group 3)

Parental involvement, parent–nurse interactions and support were described by the participants as a fluid and constantly changing process that evolved over time. There was an interchanging of roles and responsibilities where nurses were initially 'in control' of the infants' care with minimal involvement of parents' initially to a point where parents' become independent caregivers with support by nurses at discharge.

During admission into the neonatal unit, these nurses reported taking control of the situation and provided emergency neonatal care with minimal involvement by parents. Nurses in this study were aware of the need to include and support parents, but focused on the infant initially:

During admission to the unit...you see the parents' faces sometimes and they look so scared. Sometimes the nurses are so busy because

you've got to get them on oxygen and whatever, it's like they're outside and nobody's looking at them (Focus Group 3)

Participants stated that they used their expertise and experience to empower parents by acting as role models, facilitators and educators to parents. As parents became more familiar with the NICU environment and the infant stabilised, parental involvement, support and interaction increased. Parents became more informed and empowered:

A lot of the times we are the first ones to teach parents how to change a nappy; they've never changed a nappy before. We do a lot of education actually. We're continually educating them in certain skills, in parent craft skills (Focus Group 3)

Parents' participation increased and gradually they took over the normal care that had been previously provided by nurses. Parents become independent care takers while the nurses' role is supportive. Nurses reported a sense of accomplishment when they witnessed parents becoming more confident and competent when caring for their infants:

Seeing the difference and the change in the parents from this terrified, fragile, frightened family to this really strong family, being able to make their own decisions for their own babies, is rewarding (Interview 2)

While the parents and nurses role shifts throughout the NICU trajectory, nurses did highlight the need for more education, training and skill development when working with families and knowing when to shift from 'the doing' role to that of a 'supporting and guiding' role of the neonatal nurse.

Discussion

These findings highlight the importance these neonatal nurses placed on implementing FCC principles to delivering optimal care for neonates and their families. From the perspectives of these participants, there appears to have been a shift from the 'old model' of neonatal care excluding families to what Casey (1998) suggested was needed over a decade ago where nurses have a professional responsibility to parents. It is also suggested here that nurses who deliver care that focuses on both the infant and the family lead to better overall care and are better able to assist the family during this difficult time (Gooding *et al.* 2011, McGrath *et al.* 2011).

Nurses describe a key component of their role included developing a relationship with families. It was recognised that establishing a relationship was as a means through which they can provide high-quality nursing care for both the neonate and the family. Developing partnerships is considered an important element of FCC and regarded as important

by nurses. Analysis revealed that nurses' attitudes, communication skills and parental understanding were all influencing factors in developing effective partnerships in the neonatal unit. Nurses also highlighted that the relationship with parents or partnerships is diverse, non-static entities that evolve over time (Fegran *et al.* 2008). However, some nurses' in the study highlighted that partnerships can be difficult to establish and question whether a partnership is even possible. This is supported by Coyne and Cowley (2007) who suggest parents could never be partners in care as control of boundaries ultimately lies with the nurse.

Nurses reported a need to 'get to know the family' in order to build a relationship and deliver effective FCC. They used social conversation as a clinical tool by which they developed a rapport and built trusting relationships. This was first described in studies conducted by Fenwick *et al.* (2001) who identified 'chatting' as a social interaction to engage women and make them feel 'at home' in the nursery. A study conducted by Jones *et al.* (2007) found parents regarded nurse communication as more effective when nurses made the interaction more equal and where nurses adapted to the behaviour or conversational needs of parents. They also highlighted the importance of communication that is both nurturing and shares the exchange of information (Jones *et al.* 2007). Participants in this study also described negotiation as a strategy used to find a 'happy medium' between the parents' social world and the social order of the ward (Coyne & Cowley 2007); research suggests that ineffective communication, professional expectations and issues of power and control often inhibit mutual negotiation between parents and nurses (Corlett & Twycross 2006).

While tensions remained for some nurses, a shift from the traditional biomedical approach to a family centred and partnership approach is changing the role of the neonatal nurse. Supported by other studies (Kawick 1996, Tiedman 1997, Gooding *et al.* 2011), this study suggests that nurses feel more empowered to include parents as caregivers when they can identify and understand the positive effects of working with parents in the neonatal unit. As with both Casey (1998) and Smith (1995), this study reveals that nurses can assist to empower parents by providing them with support and education. Nurses also reported that parents participated more when they felt included and welcomed as part of the team (Palmer 1993). While participants spoke highly of the need to involve the family in decision-making, they also revealed the belief that parents had varying ability to be involved in the care of their infant and associated decision-making processes.

Petersen *et al.* (2004) reported that less experienced nurses identified elements of FCC as more important and imple-

mented them into practice more consistently than the more experienced nurses. However, our study showed that more experienced nurses felt greater confidence when delivering FCC. This was attributed to their increased knowledge and confidence in performing daily tasks and their ability to shift from these tasks to meeting the social needs of parents. This is supported by Brown and Ritchie (1989) who suggested the education level of individual nurses influenced practice and perceptions of FCC and Franck and Callery (2004) who suggest the skill level and confidence of the nurse influence the degree to which FCC is practised. There appears to be a shift in the role of the nurse previously described as didactic, controlling and patient or task focused (Fenwick *et al.* 2003) to a more supportive approach that focuses on the family unit. Tensions, however, remained for some nurses on how to best support the needs of the infant and the family within the current working environment.

Conclusions

The findings of this study suggest while nurses' report a commitment to FCC, there is still incomplete or inconsistent application of FCC principles in neonatal care. While nurses highlighted the need to deliver FCC, the study revealed that nurses need ongoing organisation support, guidance and further education to support nurses to deliver effective FCC in the NICU.

Strengths and limitations of the study

The strength of this study was the focus group and interview method outlined earlier. This was an effective tool in uncovering nurses' perspectives and understanding of their role and delivering FCC in the neonatal unit. Information provided was very useful to the service setting where the study was undertaken. As a result of this study, a FCC working party has been established in that unit for further improvements in implementing FCC principles. As the study was conducted in one neonatal unit in Australia, the homogeneity of the participants could be a limitation suggesting findings cannot be generalised.

References

- Aagaard H & Hall EOC (2008) Mothers' experiences of having a preterm infant in the neonatal care unit: a meta-synthesis. *Journal of Pediatric Nursing* 23, 26–36.
- Bidmead C & Cowley S (2005) A concept analysis of partnerships with clients. *Community Practitioner* 78, 203–208.
- Braun V & Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77–101.
- Brown J & Ritchie JA (1989) Nurses' perceptions of their relationships with parents. *Maternal Child Nursing Journal* 18, 79–96.
- Carter JD, Mulder RT, Bartram AF & Darlow BA (2005) Infants in a neonatal

Relevance to clinical practice

The findings of this study highlight that nurses understand and value the philosophy of FCC; however, it also suggests implementing FCC is difficult and proving challenging. In order for FCC to be effectively implemented, ongoing organisational and managerial support and commitment are required. Policies need to reflect a multidisciplinary team approach to FCC and have nurse and parent representatives in hospital committees or advisory forums. Staff and parent roles need to be clearly defined. Nurses need to be provided with adequate resources to implement FCC effectively. Workloads and staff-to-patient ratio should reflect the time needed by staff when working with families. This study provides valuable information for staff development and skills training. Further, nurse education is required for nurse skill developments such as effective communication, developing relationships, family needs assessment, negotiating skills, support role development and strategies (moving from a 'doing' to a 'guiding' role) along with conflict resolution strategies. Nurses required adequate resources, education and multidisciplinary and organisational support to provide FCC.

Acknowledgements

The authors would like to thank the Nurse Manager and the Director of Neonatology for supporting this study. A very special thank you to all the neonatal staff for sharing their personal experiences and generously gave their time to participate in this study.

Contributions

Study design: ST, VS, MV, DJ; data collection and analysis: ST, VS, MV, DJ and manuscript preparation: ST, VS, MV, DJ.

Conflict of interest

To the authors best knowledge there is no conflict of interest to declare.

- unit: parental response. *Archives of Disease in Childhood* 90, 109–113.
- Casey A (1998) A partnership with child and family. *Senior Nurse* 8, 8–9.
- Cooper LG, Gooding JS, Gallagher J, Sternesky L, Ledsky R & Berns SD (2007) Impact of a family-centered care initiative on NICU care, staff and families. *Journal of Perinatology* 27, 32–37.
- Corlett J & Twycross A (2006) Negotiation of parental roles within family-centred care: review of the research. *Journal of Clinical Nursing* 15, 1308–1316.
- Coyne IT & Cowley S (2007) Challenging the philosophy of partnerships with parents: a grounded theory study. *International Journal of Nursing Studies* 44, 893–904.
- Darbyshire P (1995) Family centered care within contemporary British paediatric nursing. *British Journal of Nursing* 4, 31–33.
- Erlandsson K & Fagerberg I (2005) Mothers lived experiences of co-care and part-care after birth, and their strong desire to be close to their baby. *Midwifery* 21, 131–138.
- Fecley N, Zekowitz P, Corimier C, Charbonneau L, Lacroix A & Papageorgiou A (2011) Posttraumatic stress among mothers of very low birthweight infants at 6 months after discharge from the neonatal intensive care unit. *Applied Nursing Research* 24, 114–117.
- Fegran L, Fagermoen MS & Helseth S (2008) Development of parent-nurse relationships in neonatal intensive care units – from closeness to detachment. *Journal of Advanced Nursing* 64, 363–371.
- Fenwick J, Barclay L & Schmied V (1999) Activities and interactions in level II nurseries: a report of an ethnography study. *Journal of Perinatal and Neonatal Nursing* 13, 53–65.
- Fenwick J, Barclay L & Schmied V (2001) “Chatting”: an important tool for facilitating mothering in the neonatal nursery. *Journal of Advanced Nursing* 33, 583–593.
- Fenwick J, Barclay L & Schmied V (2003) The role of nurses in the special care nursery: what they consider their primary responsibility to be. *Journal of Neonatal Nursing* 9, 6–11.
- Fereday J & Muir-Cochrane E (2006) Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods* 5, 1–11.
- Franck LS & Callery P (2004) Re-thinking family-centred care across the continuum of children’s healthcare. *Child: Health and Development* 30, 265–272.
- Gooding JS, Cooper LG, Blaine AI, Franck LS, Howse JL & Berns SD (2011) Family support and family-centered care in the neonatal intensive care unit: origins, advances, impact. *Seminars in Perinatology* 35, 20–28.
- Hall EOC (2005) Being in an alien world. Parents lived experiences when a small or newborn child is critically ill. *Scandinavian Journal of Caring Sciences* 19, 179–185.
- Harrison TM (2010) Family Centered paediatric nursing care: state of the science. *Journal of Pediatric Nursing* 25, 335–343.
- Heerman JA, Wilson ME & Wilhelm PA (2005) Mothers in the NICU: outsider to partner. *Paediatric Nursing* 31, 176–181.
- Holditch-Davis D, Barlett TR, Blickman AL & Miles ML (2003) Post traumatic stress symptoms in mothers of premature infants. *Journal of Obstetric, Gynecology & Neonatal Nursing* 32, 161–171.
- Hook ML (2006) Partnering with patients – a concept ready for action. *Journal of Advanced Nursing* 56, 133–143.
- Hughes M (2007) Parents’ and nurses’ attitudes to family-centred care: an Irish perspective. *Journal of Clinical Nursing* 16, 2341–2348.
- Jackson K, Thernstedt BM & Scollin J (2003) From alienation to familiarity: experiences of mothers and fathers of preterm infants. *Journal of Advanced Nursing* 43, 120–129.
- Jones L, Woodhouse D & Rowe J (2007) Effective nurse parent communication: a study of parents’ perceptions in the NICU environment. *Patient Education and Counseling* 69, 206–212.
- Kawick L (1996) Nurses’ and parents’ perceptions of participation in caring for a hospitalised child. *British Journal of Nursing* 5, 430–434.
- Lee P (1999) Partnership: what does it mean today? *Journal of Child Care Health* 3, 28–32.
- Lupton D & Fenwick J (2001) “They’ve forgotten that I’m the mum” – constructing and practicing motherhood in special care nurseries. *Social Science and Medicine* 53, 1011–1021.
- Macguire C, Bruil J, Wit J & Walther F (2007) Reading preterm infants’ behavioural cues: an intervention study with parents of preterm infants born <32 weeks. *Early Human Development* 83, 419–424.
- McGrath J, Samra HA & Kenner C (2011) Family-centered developmental care practices and research: what will the next century bring? *Journal of Perinatal and Neonatal Nursing* 25, 165–170.
- Palmer SJ (1993) Care of sick children by parents: a meaningful role. *Journal of Advance Nursing* 18, 185–191.
- Petersen M, Cohen J & Parsons V (2004) Family-centered care: do we practice what we preach? *Journal of Obstetric, Gynecology & Neonatal Nursing* 33, 421–427.
- Schroeder M & Pridham K (2006) Development of relationships competencies through guided participation for mothers of preterm infants. *Journal of Obstetric, Gynecology & Neonatal Nursing* 35, 358–368.
- Shaw RW, Deblouis T, Ikuta L, Ginzburg K, Fleisher B & Koopman C (2006) Acute stress disorder among parents of infants in the neonatal intensive care nursery. *Psychosomatics* 47, 206–212.
- Shields L, Pratt J & Hunter J (2006) Family centred care: a review of qualitative studies. *Journal of Clinical Studies* 15, 1317–1323.
- Shields L, Pratt J & Hunter J (2007). Family centred care for children in hospital. *Cochrane Database of Systematic Reviews*, Issue 1, Art. No.: CD004811. Doi: 10.1002/14651858.CD004811.pub2.
- Smith F (1995) *Children Nursing in Practice: The Nottingham Model*. Blackwell Science, Oxford.
- Talmi A & Harmon RJ (2003) Relationships between preterm infants and their parent: disruption and development. *Zero to Three* 24, 13–20.
- Tiedman ME (1997) Anxiety responses of parents during and after their hospitalisation of their 5–11 year old children. *Journal of Paediatric Nursing* 2, 111–119.
- Wigert H, Hellstrom A & Berg M (2008) Conditions for parents’ participation in

the care of their child in the neonatal intensive care unit. *BioMed Central Pediatrics* 8, 1–9.

Wilson V, McCormack B & Ives G (2005) Understanding the workplace culture of

a special care nursery. *Journal of Advanced Nursing* 50, 27–38.

The Journal of Clinical Nursing (JCN) is an international, peer reviewed journal that aims to promote a high standard of clinically related scholarship which supports the practice and discipline of nursing.

For further information and full author guidelines, please visit JCN on the Wiley Online Library website: <http://wileyonlinelibrary.com/journal/jocn>

Reasons to submit your paper to JCN:

High-impact forum: one of the world's most cited nursing journals and with an impact factor of 1.228 – ranked 23 of 85 within Thomson Reuters Journal Citation Report (Social Science – Nursing) in 2009.

One of the most read nursing journals in the world: over 1 million articles downloaded online per year and accessible in over 7000 libraries worldwide (including over 4000 in developing countries with free or low cost access).

Fast and easy online submission: online submission at <http://mc.manuscriptcentral.com/jcnur>.

Early View: rapid online publication (with doi for referencing) for accepted articles in final form, and fully citable.

Positive publishing experience: rapid double-blind peer review with constructive feedback.

Online Open: the option to make your article freely and openly accessible to non-subscribers upon publication in Wiley Online Library, as well as the option to deposit the article in your preferred archive.

5.3. Conclusion

This chapter presented the third published paper titled 'Neonatal nurses' perspectives of family-centred care: A qualitative study' and presented the findings of neonatal nurses' perceptions of FCC in the NICU. Findings revealed that nurses had a general understanding of FCC however nurses report needing ongoing organisational support, education and guidance to deliver FCC effectively. The following chapter presents the fourth published paper 'Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop'. This paper reports the findings of a one day collaborative AI workshop that consisted of both nurses and parents.

Chapter 6:

Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop

6.1. Publication

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop. *Journal of Child Health Care, 19*(2), 239-263.
doi: 10.1177/1367493513508059

6.2. Introduction and relevance to thesis

A core principle of FCC is the need to develop effective partnerships with parents. AI is a positive participatory framework that can be used to engage groups and build collaborations. This paper reports the findings of the next phase of this AI study where nurses and parents met for a one day AI workshop. This was the first known study that brought both neonatal nurses and parents together to collectively explore FCC in a neonatal context.

Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop

Journal of Child Health Care
2015, Vol. 19(2) 239–253
© The Author(s) 2013
Reprints and permission:
sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1367493513508059
chc.sagepub.com



Suza Trajkovski, Virginia Schmied and Margaret Vickers

University of Western Sydney, Australia

Debra Jackson

University of Technology, Australia

Abstract

Family-centred care (FCC) has been well recognised, accepted and reported in the literature as an optimised way of caring for hospitalised children. While neonatal units strive to adopt this philosophy, published research suggests there are difficulties implementing FCC principles in daily practice. Appreciative inquiry (AI) is a philosophy and methodology that offers a unique, strength-based approach to promoting organisational learning and positive organisational change. As a participatory approach, AI facilitates change from the ground up and lends itself to building effective partnerships or collaborations. This article reports the findings of a one-day workshop using an AI methodology to bring neonatal nurses and parents together to enhance the FCC within a neonatal intensive care unit in Sydney, Australia. Participants ($n = 15$) developed collaborative insights of optimal FCC that can be built upon to support neonates and their families in the future. Shared visions were formed, strategies identified and a development plan made for ongoing collaborations and partnerships. AI provides a flexible framework that enables the mandatory collaboration needed to develop action plans that can form the catalyst for organizational change in health-care research and practice.

Keywords

Appreciative inquiry, family-centred care, neonatal care, neonatal nursing

Corresponding author:

Suza Trajkovski, Family and Community Health Research Group (FaCH), School of Nursing and Midwifery, University of Western Sydney, Locked Bag 1797 Penrith NSW 2751, Sydney, Australia.

Email: s.trajkovski@uws.edu.au

Introduction

Advances in obstetrics and neonatology have resulted in significant improvements in the survival rates of infants born prematurely. Neonatal units have gradually shifted from restrictive hospital policies that exclude families to recognising the need to position parents as partners in the care of their infant (Coyne and Cowley, 2007). While a general consensus exists in the literature regarding the value and importance of family-centred care (FCC), published research highlights difficulties in incorporating FCC principles in daily practice (Corlett and Twycross, 2006, Gooding et al., 2011). This article reports the findings of a one-day workshop using an appreciative inquiry (AI) methodology to bring neonatal nurses and parents together to enhance the uptake of FCC within a neonatal intensive care unit (NICU) in Sydney, Australia. This one-day workshop was the second stage of a larger study (Trajkovski et al., 2012).

Background

Described as an approach to care, FCC recognises and embraces the whole family when planning care for the individual/child/infant; it is considered to be a fundamental principle when providing neonatal care (Author et al., 2012; Institute for Patient and Family Centred Care, 2012). Respectful partnerships between parents and health-care professionals are fundamental to FCC (Institute for Patient and Family Centred Care, 2012; Shields et al., 2006). The notion of partnership in care implies an equal relationship between the family and nurses, where values and information are shared (Gallant et al., 2002), care is negotiated (Casey, 2008; Coyne, 1995) and each partner's competence and skills are acknowledged and utilised (Wiggins, 2008). Ultimately, the goal of the partnership is to share responsibility for care and to facilitate informed, joint decision-making (Bidmead and Cowley, 2005; Hook, 2006).

Working in partnerships is challenging. A qualitative study conducted by Coyne and Cowley (2006) found that nurses experience difficulties in supporting and facilitating parental participation, while parents struggle to identify what nurses expect from them. Parents express a desire to participate in care but report that a lack of information, poor role negotiation and unclear instructions hinder this progress (Blower and Morgan, 2000; Coyne, 1995; Halstrom and Runeson, 2001). Further, research on the relationships between parents and nurses in FCC models within the NICU confirms that the contributions made by both parties evolve throughout the hospitalisation (Cahill, 1996; Coyne, 1995; Fegran et al., 2008; Fenwick et al., 1999; Hutchfield, 1999), making the delineation of their respective roles even more challenging.

At the time of admission to the NICU, because of the health status of the infant, medical and nursing staff assume control over care of the newborn. However, over time, there needs to be a shift in control where the parent's responsibility and involvement in care increases and the nurse's role becomes more focused on supporting the parents to take over the care of their infant (Fegran et al., 2008).

Despite these challenges, parents are increasingly seeking to be included in the care of their infant requiring neonatal intensive care and this is worthwhile. Reported benefits of working with families have included improved health outcomes for the infant, for example, lower behavioural stress cues (Byers et al., 2006), reduced length of hospital stay or readmissions (Forsythe, 1998) and improved breastfeeding rates (Furman et al., 2002); more satisfied, empowered, knowledgeable and confident parents with higher levels of psychological well-being (Bidmead and Cowley, 2005; Gooding et al., 2011; Hook, 2006; Van Riper, 2001); and increased nurse job satisfaction (Lee, 1999). Further

exploration of the core principle of building partnerships/collaborations between neonatal nurses and parents is required so as to better implement FCC within the NICU environment.

Method

The methodology chosen for this study is AI, as it offered a theoretical and participatory framework that can be used to identify and to meet the specific needs of the organisation. Participatory approaches such as AI provide powerful tools for crossing boundaries, engaging groups, building partnerships/collaborations and can promote a unified approach to organisational change (Cooperrider, 1986; Lavender and Chapple, 2004).

AI has been implemented in both professional and community settings (Lavender and Chapple, 2004). For example, Carter et al. (2007a) used AI in health care to explore best practice in multi-agencies working together and the experiences of families and children with complex needs. Liebling et al. (2001) used AI when working with people in prisons, and World Vision, a private volunteer organization used AI when working across the world to provide relief from famine, war and natural disasters while helping communities to develop agriculture and improve health and education (Lavender and Chapple, 2004; Mantel and Ludema, 2000). AI has been reported to be an effective method in generating organisational and management change (Cooperrider and Barrett, 1990; Cooperrider and Whitney, 1999), developing and building teams (Bushe, 1995), developing leadership (Whitney et al., 2010), capacity building (Postma, 1998), bringing about cultural change (Liebling et al., 2001) and reframing research (Carter, 2006; Lavender and Chapple, 2004).

The foundations of AI lie in action research, organisational learning and organisational change. AI adopts a social constructionist view based on affirmation, appreciation and dialogue, and it is reported to have significant transformational potential in its ability to shift the focus from a traditional, problem-based research paradigm to a positive theory of inquiry based on future possibilities and performance (Cooperrider, 1986; Koster and Lemelin, 2009; Reed, 2007).

Central to the success of AI is acknowledgement of the immense power of dialogue, and its potential to enhance or inhibit organisational growth (Gergen et al., 2004). AI enables researchers to search for the best in people, their organizations, and the world around them while actively acknowledging and celebrating success (Carter, 2006; Van der Haar and Hosking, 2004). Creating collective visions and actions within an organisation is considered a vital component in initiating change under the AI process.

Projects using AI usually adopt four phases known as the 4D cycle. This consists of the Discovery phase ('what gives life' to the organisation, or appreciating and valuing what is best of what is or has been); the Dream phase (envisioning 'what might be' or affirmative exploration); the Design phase (co-constructing 'what should be' or the ideal); and finally, the Destiny phase (sustaining what will be or envisioned future) (Cooperrider and Whitney, 1999; Cooperrider et al., 2008: 5). At the core of the 4D cycle is an affirmative topic choice that is considered a significant component of the AI process, that will assist facilitators in planting seeds of change that are implicit in the very first question asked (Cooperrider and Whitney, 1999).

Study design

This study used an AI approach. A one-day workshop was held with neonatal nurses and parents. Data were audio recorded and the interactions and process observed. Data were examined using a qualitative, thematic analysis (Braun and Clarke, 2006; Lincoln and Guba, 1985).

Setting

A one-day workshop was held at the office of an independent parent support group located approximately 15 minutes driving distance from the NICU where the neonatal nurse participants worked. The location was selected as the result of a collaborative decision made between the parent and nurse groups. They agreed on this location as it was away from clinical ward distractions, easy for both nurses and parents to travel to, parking was free of charge, and the room had an open plan design (allowing participants to meet as a larger group and having optimal space to allow participants to break out for group work). The open plan design of the room also facilitated researcher observation of participant interactions.

Participants and recruitment

Prior to this workshop, a series of focus groups and interviews were conducted with parents and nurses (see Author et al. 2012). Participants from the previous focus groups and interview sessions (Author et al. 2012) were invited to attend this one-day workshop. Participating nurses ($n = 9$) were aged between 25 and 64 years; participating parents were aged between 25 and 35 years. Nurses' experience levels ranged from junior special care nursery staff to senior, experienced neonatal intensive care nurses with more than 15 years of service in neonatal intensive care. Parents ($n = 6$) were recruited if their infant required NICU care within the last 5 years.

Ethical considerations

Local health district and Human Research Ethics Committee approval, along with participant written consent, were obtained prior to commencing the workshop. Participants were informed of the overall aim of this workshop: to bring parents and nurses together to improve care practices for neonates and their family and were advised that they could withdraw from the workshop at any time. Nurses were reassured that participation would have no effect on employment. Parents were reassured that participating in this workshop would have no effect on future associations with the health service. Participants were assured that confidentiality and anonymity would be maintained at all times when reporting the data. A list of free counselling support service provider details were given to all participants should they require professional debriefing following the workshop session.

Research rigor and reflexivity

A specialized nurse (ST) recruited participants from a unit where she previously worked. Because she had established professional relationships with most participants, rigor and reflexivity was carefully applied throughout the research process. While no longer employed in the NICU at the time of data collection, having pre-existing membership of the group provided benefits from an insider perspective (Burns et al., 2010). Factors such as ease of access to the study setting, early rapport building and increased understanding of the culture and the language used allowed for synchronization between the study setting and participant behaviour (Burns et al., 2010). While benefits of being an 'insider' were recognized, there was a need to observe with an etic (outsider) lens to ensure an analytical perspective was maintained (Burns et al., 2010).

Table 1. Workshop program.

Using appreciative inquiry to enhance family-centred care in the NICU	
Workshop Program	
April 22 2010	
0900–0930	Coffee/Tea
0930–1000	Welcome and Workshop Overview
	AI process (Phase 1,2,3,4)
	Introduction
	Defining Key Terms
	Key Assertive Statements from the Discovery Phase (Phase 1)
1000–1030	Small group work-Dream (Phase 2)
	Magic Wand
1030–1100	Feedback to larger group-Dream Phase
1100–1120	Provocative Propositions developed in larger group
1120–1140	Morning Tea
1140–1230	Small group work-Design Phase (Phase 3)
1230–1300	Lunch
1300–1400	Feedback to larger group-Design Phase
1400–1500	Larger group work-Destiny Phase (Phase 4)
1500–1515	Evaluations
Thank you for participating	

Data collection

Data were collected throughout the one-day workshop where small and large group discussions were digitally recorded. The workshop program (see Table 1) illustrates the time frames and stages of the workshop. Participants began in a large group with parents and nurses together, followed by being divided into smaller groups and then reforming again as a larger group. Small group work required participants to write key points on sheets of butcher's paper and present findings to the larger group. Large group discussions focused on identifying consensus statements within the group. The researcher and co-facilitator observed the interactions of participants within the small and large group discussions. Aspects such as seating positions, who dominated or controlled the topic of conversation, participant choice of words, voice tones and non-verbal communication was also observed by the researchers. Researcher field notes were recorded during and after the workshop.

An AI workshop

Workshop activities were focused around the 4D cycle.

Discovery. The workshop began with parents and nurses forming a large circle in the room and opening remarks were led by the research team. A workshop overview, participant introductions, key terms and AI phases were introduced (see Table 1). Participants were given a selectively coloured piece of paper by the researchers that posed two questions: (1) Why did you decide to attend this workshop? (2) What do you want to achieve by participating in this workshop? Each participant presented their answers to the larger group. Discussions surrounded the topic of FCC in the NICU, and participants started their dialogue by highlighting appreciation and valuing.

Table 2. Statements from focus groups (stage 1).

<p>Nurses: We recognize that . . .</p> <ul style="list-style-type: none"> ● <i>parents bring their best talents, skills and knowledge to the team</i> ● <i>nurses have an important role in supporting the family in the NICU, and often are the go-between parents and doctors</i> ● <i>encouraging mothers to do cares, provides a sense of importance in the NICU</i> ● <i>sharing information with parents, explaining procedures and education is a vital aspect of our role</i> ● <i>each family has different needs and we need to meet these individualised needs</i> ● <i>nurses need to be culturally competent when meeting parents needs</i> ● <i>we need to involve dads too</i> ● <i>parents have a life outside the NICU</i> ● <i>the importance of encouraging kangaroo care (skin to skin contact) as soon as possible</i> ● <i>nurses, doctors, allied health and parents all work towards a common goal . . .</i> ● <i>parents are different and want different levels of involvement</i> ● <i>the importance of working with and alongside the parent during the NICU experience in order to prepare for life outside the NICU</i> 	<p>Parents: We really like it when . . .</p> <ul style="list-style-type: none"> ● <i>we are involved in our infants care</i> ● <i>staff encourage us to write our story through journals in books, taking photo's and collecting keepsakes such as baby's first gown, bonnet and booties. Particularly when we look back at it 6 months later</i> ● <i>we have realistic and accurate information about our babies progress and potential outcome that is given in a timely and sensitive way</i> ● <i>we are seen as important in the NICU</i> ● <i>nurses encourage us to do mothering activities such as baths, cares, cuddles while nurses provide the medical-nursing support to our baby</i> ● <i>we are involved in special occasions such as the first bath, weighs, transitioning from intensive care to special care, crib to cot</i> ● <i>fathers are encouraged to do kangaroo care. They get excited and feel more involved</i> ● <i>nurses know who you are so you don't have to repeat our story over and over again</i> ● <i>we talk to the social worker and other parents who have experienced a NICU admission as it gives us another perspective and may also give us an idea of long term outcomes</i>
--	--

NICU: neonatal intensive care unit.

Discovering what 'works well' with FCC was discussed. The findings from focus groups that were held in phase one of the study with neonatal nurses' and parents' (separately) were then presented to the group (as a whole) in the form of 'Discovery Key Statements' (see Table 2). Participants were asked to read through the statements, identify key statements that accurately reflect their ideas and asked whether additions or amendments needed to be made. No amendments or changes were requested by participants. After 30 minutes, the group was ready to move to the next phase.

Dream. Participants were then asked to form four smaller groups. The colour-coded paper (with the two questions on it), previously given to participants, guided how the three smaller groups were formed. The colour coding ensured each small group had representation from both parents and nurses. Participants were then asked to find a matching coloured magic wand that had been strategically placed around the room to begin smaller group work. Participants were given the opportunity to change groups if they preferred, but all participants chose to remain in the group they were assigned. The researcher then posed the 'magic wand' question to the groups: 'If the wand in front of you had magical powers, and you could have anything you want, what would family-centred care look like in the neonatal intensive care unit?'

This playful approach encouraged the participants to be creative within their groups. Participants were given a digital recorder, marker pen and large pieces of butcher's paper to record key points for feedback to the larger group. Individuals were asked to 'think big' and outside their usual

boundaries. Visions, ideals and hopes were discussed and recorded. The researchers observed and took field notes of the interactions and discussions occurring in the small group work. After 30 minutes, the large group reformed and ideas and discussions from the smaller groups were shared. Sharing the dream phase in the larger group took a further 30 minutes. The larger group then progressed to collectively developing 'provocative propositions' that were a list of confident and assertive statements about what the group hoped to achieve. Developing provocative propositions took a further 20 minutes to complete. Participants were advised that the provocative propositions needed to be practical and achievable.

Design. Following morning tea, participants returned to their smaller groups and worked on the design phase. This phase focused on designing 'what should be'. After identifying a list of strategies to enhance FCC in the NICU, participants were then asked to explore processes and structures that needed to be implemented for their dream to become a reality. Participants explored, What needs to be done? Who needs to be involved? How will it be done? What resources are required? and How long it will take? Over a 50-minute time period, participants worked collaboratively to design plans for the future. Ideas were documented onto butcher's paper and discussions recorded. After lunch, the larger group reformed and shared their design plans with each other. This process took a further 60 minutes to complete.

Destiny. The destiny phase focused on how the envisioned future would be sustained and deciding what needed to happen to realise the provocative propositions developed. The focus here moved towards making commitments and action planning to set up processes and networks for the future. Participants decided that an FCC working party needed to be formed and set a date to meet within the month to follow-up on design plans. It was agreed that the destiny phase was yet to be realised and time was required to operationalise strategies identified and to monitor progress and effectiveness of the group and the resultant change. This phase took a further 60 minutes to complete.

Data analysis

Inductive thematic analysis (Lincoln and Guba, 1985) was used to condense raw data comprising of recorded transcripts from group discussions, participants' notes recorded on butcher's paper and field notes taken by the researchers. Data analysis focused on identifying themes, patterns of experiences and behaviours based on valid interferences and interpretations. Texts were examined closely, read line by line, several times to facilitate microanalysis of the data. Open coding was used to allow grouping of categories and the emergence of themes (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006). In the first instance, patterns of experiences were identified as broad themes. Data relevant to these broad themes were grouped together and then further categorised into sub-themes bringing together participants ideas and experiences to form a comprehensive picture of their collective experience (Braun and Clarke, 2006).

To ensure reliability and validity of the data, clarity and agreement occurred throughout the data analysis process between researchers where key concepts and ideas were captured and explored. Throughout the workshop process, the researchers asked participants to clarify and refine ideas that emerged during workshop discussions.

Results

The data analysis revealed an overarching theme of 'sharing experiences and stories', that comprised four sub-themes: 'discovering what works well', 'dreaming of the ideal', 'fixing things' and 'destiny, projections for the future'.

Sharing experiences and stories

Parents and nurses came together to share experiences and stories and began a process of collaboration, focused on valuing and appreciation. Initially, participants were reminded by the researchers to focus on success stories and achievements. As stories were told, participants reminded each other to focus on valuing and appreciation. Initially, participants focused on others' successes where parents praised nurses and nurses praised parents. This shifted as stories were told and participants began to describe both personal and group successes. The open and honest dialogue that filled the room was positive and enlightening, yet confronting for both nurses and parents.

I'm a little bit blown away by this process. It's really interesting to hear the different perspectives, because you go to work with one idea [a nurse perspective] and you're not necessarily thinking about the parents' perspective. It's really good for insight. (CD Nurse)

Another nurse agreed, stating:

Yes, it's really good for me too, because I have only been nursing for about five years so it's my first career out of high school and I'm not quite sure. I haven't had all this wonderful life experience to bring to the role and I haven't been a mum so I don't really know what that feels like. I don't! I have no idea what that's like and I have no idea how hard it must be to leave your child with a stranger, with a nurses uniform on. It's really good to hear that we nurses are important to parents, what we do is important to you. And how we react and interact with you is important too. (EM Nurse)

Nurses also reported being unaware of just how much impact they had on parents. For example, one mother described a time where a nurse said to her baby 'Jessie, mummy's here to see you' (PK Mother). She continued to describe the profound effect this had on her as this was the first time someone had referred to her as a mother. The participant also described how she appreciated the nurse communicating with her baby stating it was showing 'respect' (PK Mother) to her as a mother and her newborn infant as a human being. Nurses listened attentively and welcomed the feedback they were receiving through the workshop discussions, examples and interactions with comments such as, 'This workshop is great!' 'We should have these more often' (CD Nurse) and 'It would have been good if all the nurses in the nursery could be here to listen to these stories and be a part this process' (HC Nurse).

Parents also acknowledged the positive impact of bringing parents and nurses together, to hear nurses' perspectives while also having the opportunity to share a parent's perspective of having a newborn requiring neonatal care:

It's good for us parents too. It puts things into perspective for us as and gives parents a better insight and understanding of the nurses' role, their actions and the processes within the unit. (PK Mother)

The collaborative nature of the workshop was highlighted by a parent who was part of a neonatal parent support group stating 'This workshop is a good way of getting nurses and parents really working together' (CM Mother). The positive nature of the workshop allowed for open, honest and constructive communication in an environment with limited distractions.

Discovering what works well

Parents and nurses shared their own stories and listened to the stories of other participants to develop a comprehensive understanding of each other's world view on FCC in the NICU. Positive experiences were discussed where nurses felt they had delivered exceptional FCC or when parents felt they had received exceptional FCC. High point examples were shared by participants where nurses and parents felt trusting relationships had been formed and responsibilities shared. Parents and nurses described the benefits experienced when developing relationships. One mother described the physical and emotional impact of developing a positive rapport with a nurse, 'I had a good rapport with the nurse, so I was more content and I could sleep better at night' (SS Parent). Another mother described when she developed a good relationship with the nurses she felt she could 'trust the nurses' (FC Mother) with her child. Parents highlighted the importance of feeling connected to nurses and enjoyed it when they 'worked together with nurses' (JJ Mother). Nurses agreed that having mutual respect and developing partnerships was important, stating 'working together and understanding family and nursing needs are equally important' (HT Nurse). Nurses also described feeling 'rewarded' (HC Nurse) when they felt they were able to deliver care for the whole family.

Hearing parents stories of 'what works well' triggered positive self-reflection from nurses. One nurse stated, 'When you think about it, we do really well in some areas' (RR Nurse). When listening to stories by parents, nurses identified areas that parents found helpful and responded with, 'That's easy! We can do more of that' (FJ Nurse), 'We can share these ideas with other staff members in the nursery' (HC Nurse) and 'We didn't know that meant so much to parents' (HC Nurse). The positive dialogue that was generated in the room made nurses feel valued and appreciated, 'It's good to hear that we do have strong points and it just validates why I like working in the neonatal unit' (RR Nurse). Many nurses' confidence increased as stories were shared and a sense of enlightenment and rejuvenation as a result of the transformational dialogue followed.

Dreaming of the ideal

In smaller groups, participants began the dream phase through a 'magic wand' question. Participants were asked, 'If the wand in front of you had magical powers, and you could have anything you want, what would family-centred care look like in the neonatal intensive care unit?' Almost every person in the smaller groups picked up the wand that was positioned in the centre of the group. Two groups passed the wand around clockwise to each member in the group, where the person holding the wand articulated their dream and then passed the wand to the next person. Participants encouraged each other to 'think big' and beyond usual boundaries, many waving the wand around, saying, 'If this wand had magical powers and I could have anything I want with regard to family-centred care I would ...' (DC Nurse), 'I wish that ...' (CM Parent) or 'In an ideal world family-centred care would look like ...' (EM Nurse).

Observation of small group discussions showed balanced participation by nurses and parents. Feedback to the larger group highlighted that participant's dreams were similar between

Table 3. Provocative propositions.

-
- To prepare mothers and families for the NICU experience
 - To facilitate mother/baby connection
 - To improve communication
 - Close the gap between neonatal nurses and parents
 - To facilitate peer, parent and staff support
 - Consultation and collaboration between parents and health professional
 - Facilitate parent access to babies
 - To respect the baby and the parent's right to privacy
 - To be culturally competent
-

NICU: neonatal intensive care unit.

participants and groups. There was consensus amongst the groups about parents and nurses working together to provide optimal care for neonates and their families. Compelling and collective visions for the future were formed. The whole group decided to create the following vision statement to be displayed in the NICU, 'To promote the well-being of babies, families and carers in a harmonious, respectful and safe environment through support, communication and education'. This captured the group's dreams, hopes and passion and set the future direction for FCC in the NICU.

Fixing things

The 'fixing things' theme appeared throughout the workshop and reflected the need for participants to develop provocative propositions (see Table 3) and identify strategies that would fix FCC and lead to change (see Table 4). One nurse stated, 'We have identified both easy and more complex tasks, but most are achievable, we just need the time and resources' (FJ Nurse). A parent responded pragmatically, 'We can work through the list one at a time. It's ok if we can't do them all, but something is better than not doing anything at all' (CM Parent). Participants highlighted the need to have a shared understanding of areas that require fixing, and commitment to working together to address these areas suggesting once this is achieved the group can then move onto action planning. The group worked together to decide what needed to happen to realise the provocative propositions developed. The focus was on making commitments and developing action plans, setting up processes and networks.

Destiny, projections for the future

The destiny phase focused on the groups' projections for the future. Including how the envisioned future would be sustained. The group decided there was a need to form an FCC working party that would meet monthly to further operationalise some of the strategies and ideas raised in the workshop. To keep the momentum going one nurse said, 'We need to plan it now while the nurses and parents are here. Let's commit; let's set a date and time to meet in a month' (JC Nurse). Participants agreed that a timeline of activities, communication strategies and a list of measures to monitor the impact of project efforts, needed to be established. Participants also reported the need to continue to be inclusive and involve junior and senior nurses, allied health professionals and parents.

Table 4. Strategies to enhance FCC in NICU.

-
- Welcoming environment (reception area, greeted on arrival, directions to nursery and baby, welcoming decor and wall colouring)
 - Reception area with a hand washing sink at the entrance of the neonatal unit (parents and nurses like everyone entering unit to wash hands regardless of whether they are/are not handling an infant)
 - Vision/mission statement for unit
 - Provide information for parents antenatally (e.g. visit by nursing and medical staff, tour of neonatal unit)
 - LCD slide show for information sharing with parents and visitors displayed throughout neonatal unit
 - DVDs provided for parent education antenatally and throughout the different stages of the NICU journey
 - Removing excessive signs/posters stuck on wall as it looks messy and parents don't read them
 - Clearly defined roles for nurses and parents
 - Assessing specific families needs and design care to meet the needs of both the neonate and family
 - Being available to answer parents questions in a timely and honest manner
 - Single room, pods or cubicles that have the ability to be opened or closed (allowing privacy yet not being completely separated and isolated)
 - More space in between beds (for kangaroo cuddles, visitors etc.)
 - Infant remains in same bed location throughout hospitalisation
 - Shelving for parents to store belongings with a small display cabinet to personalise infant bed area
 - A designated room for private times for baptism and deteriorating infants
 - Encourage parents to engage in collecting momentos and keepsakes, for example, hand and feet moulds, journaling, photos, recording milestones and so on
 - Facilitating closeness between neonate and the family
 - Referring parents to appropriate support services, for example, social workers and psychologists
 - Referral to parents support groups (linking parents with similar situations)
 - Facilities for siblings, for example, crèche within close proximity to the neonatal unit to allow parents to spend one on one time with their newborn
 - Parking that's free or affordable (or breast milk drop off area to avoid parking fees)
 - Photo boards in nursery with before and after baby pictures with a story line attached by parents
 - Cafeteria (descent meal outlets for parents after hours)
 - Comfortable seating arrangements for families when in nursery (light weight chairs that are easy to move)
 - Separate toilet and shower facilities for families
 - Sufficient privacy screens for mothers breast feeding
 - Limit visitor numbers and display that visitors are not to walk around and look at other babies
 - Nurses to remind parents to also look after themselves and advocate for them in difficult situations
 - Individual lighting for babies with dimming features
 - A quiet environment for babies
 - Music therapy for babies (or parent recorded reading placed in crib for baby to hear)
 - Well-qualified staff 24 hours including neonatologists after hours supporting medical fellows, all neonatal nurses to be trained to work in both special care and intensive care areas
 - Consistency in nursing practice
 - Consistency in nurses looking after same baby (dedicated team for consistency in care)
 - Equipment that is current and working
-

FCC: family-centred care; NICU: neonatal intensive care unit; LCD: liquid crystal display; DVD: digital video disk.

Discussion

This workshop created opportunities and support for neonatal nurses and parents to engage in networking, sharing information and building relationships to bring about positive change. Requiring a paradigm shift from deficit to affirmative thinking, participants in this workshop were initially reserved about praising their own efforts, beginning by praising others' strengths before

they could praise themselves. Hearing others' stories, nurses in this workshop began to open up and report what they did well and were able to share aspects of their work that made them feel valued and proud. Engaging in the workshop, participants appreciated others' contributions and participants' confidence increased.

Similarly, Carter found participants in their study were initially 'reticent in talking about success and their achievements' (2006: 58). Liebling et al. stated participants were not good at 'singing their own praises' (2001: 168) and Havens et al. reported nurses were reluctant at saying what they did well and had an 'overdeveloped sense of humility' (2006: 467). Moore and Charvat (2007) suggest the fundamental criteria of human motivation are met when inquiry is constructed around aspects that assist people to remember their capabilities and competencies. Focusing on positive aspects reduced participant defensiveness while simultaneously encouraging open discussions in complex networks.

As the workshop continued, discussions increased, and innovative ideas began to emerge, parents and nurses were contributing equally, and their shared ideas and perceptions were vital in the development of high-quality information. There was a genuine exchange of information, enthusiasm and support. According to Richer et al. (2009), this process of knowledge exchange aligns with Nonaka's (1991) proposition that the emergence of innovative ideas or new knowledge always begins with individuals; is embedded in values, beliefs and ideals and is created when tacit knowledge is made explicit. Sharing individual knowledge transforms into organizational knowledge that may lead to innovations or the creation of something new (Nonaka, 1991; Richer et al., 2009).

Parents and nurses indicated that the workshop offered a real opportunity to contribute to a better understanding of how things could work in the neonatal unit and felt their expertise and insights were being valued. Exploring current practice undertaken by those living in that reality (the neonatal clinical environment) provided true insights into current neonatal care and allowed for the acknowledgment of existing good practice. Brookfield (1987) suggests the chaotic, holistic and a non-linear approach to inquiry becomes a catalyst for action. Participants also engaged in the process of reflection which, according to Wilson (2005), is an important and effective strategy in teaching family sensitive care to nurses.

The inclusive nature of the workshop facilitated relationship building, collaboration and building partnerships. As with Carter's et al. (2007) study, aspects such as information sharing, trust, respect, involvement and human relationships were considered crucial to ensuring the delivery of high-quality integrated health care. Throughout the workshop, parents and nurses developed collaborative insights of optimal neonatal care that can be built upon to support neonates and their families in the future. As reiterated by other studies (Reed et al., 2002; Richer et al., 2009), organisational support is a key factor when initiating changes in the work environment and multilevel interventions are required.

Overall, participants were overwhelmingly positive in their evaluation of the workshop and reported they would be willing to continue with the AI process. Participants were keen to set ongoing meeting dates and begin the process of implementing strategies identified from the workshop.

Limitations

This study was conducted with nurses, who were currently practicing in one neonatal unit in Australia, and parents of infants who were predominantly cared for in that particular unit;

therefore, the homogeneity of participants could be viewed as a limitation. Although both mothers and fathers were invited to attend the workshop, only mothers participated in the workshop. Therefore, discussions about fathers were from maternal or nurse perception of fathers' needs. A further limitation was that medical or allied health-care workers were not represented at the workshop. However, despite these limitations, participants were enthusiastic, positive and committed to the workshop.

Implications for practice

AI has important implications for nurse leaders who are seeking to bring about transformational change. The inclusive and collaborative nature of AI provides opportunities to initiate and guide change. A major implication is the importance of organisational support to maintain the momentum engendered by the process and to allow proposed ideas to develop and evolve. AI was a useful methodology for exploring FCC; however, this methodology is not limited to FCC and can be used to bring about positive change in other aspects of neonatal care. It is an important tool for staff motivation and may assist in ongoing reflective practice.

Conclusion

This workshop initiated a process that builds on the positives and acknowledged existing good practice. Bringing nurses and parents together to explore their strengths and successes inspired hope and determination to bring about change. AI is a method to create change and build on an organisation's most important asset, its people. This workshop is a good example of collaborative research and contributes to the body of knowledge of adopting new and innovative ways to bring about change in health care.

Acknowledgements

This AI project would not have been possible without the commitment and hard work of the parents and health professionals involved. The research team expresses gratitude to the participants for sharing their ideas, expertise and experiences.

Authors' Note

All the authors contributed equally in various aspects (study design, data collection and analysis and manuscript preparation) to the current paper.

References

- Bidmead C and Cowley S (2005) A concept analysis of partnerships with clients. *Community Practitioner* 78(6): 203–208.
- Bushe GR (1995) Advances in appreciative inquiry as an organizational development intervention. *Organization Development Journal* 13(3): 14–22.
- Brookfield SD (1987) *Developing Critical Thinkers*. San Francisco, CA: Jossey-Bass.
- Blower K and Morgan E (2000) Great expectations? Parental participation in care. *Journal of Child Health Care* 4(2): 60–65.
- Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3: 77–101.

- Burns E, Fenwick J, Schmied V and Sheehan A (2010) Reflexivity in midwifery research: The insider/outsider debate. *Midwifery* 28: 52–60.
- Byers JF, Lowman LB, Francis J, Kaigle L, Lutz NH, Waddell T, et al. (2006) A quasi-experimental trial on individualized, developmentally supportive family-centered care. *Journal of Obstetrics, Gynecology and Neonatal Nursing* 35(1): 105–115.
- Carter B (2006) 'One expertise among many' – working appreciatively to make miracles instead of finding problems: Using appreciative inquiry to reframe research. *Journal of Research in Nursing* 11(1): 48–63.
- Carter B, Cummings J and Cooper L (2007a) An exploration of best practice in multi-agency working and the experiences of families of children with complex health needs: What works well and what needs to be done to improve practice for the future? *Journal of Clinical Nursing* 16(3): 527–539.
- Carter CA, Ruhe MC, Weyer S, Litaker D, Fry RE and Stange KC (2007b) An appreciative inquiry approach to practice improvement and transformative change in health care settings. *Quality Management in Health Care* 16(3): 194–204.
- Cahill J (1996) Patient participation: A concept analysis. *Journal of Advanced Nursing* 24(3): 561–571.
- Casey AA (2008) Partnership with child and family. *Senior Nurse* 8(4): 8–9.
- Cooperrider D (1986) *Appreciative Inquiry: Toward a Methodology for Understanding and Enhancing Organizational Innovation*. Cleveland, OH: Western Reserve University.
- Cooperrider D and Barrett F (1990) Generative metaphor intervention: A new approach for working with systems divided. *Journal of Applied Behavioural Science* 26: 2.
- Cooperrider D and Whitney D (1999) Appreciative inquiry: A positive revolution in change. In: Holman P and Devane T (eds) *The Change Handbook: Group Methods for Shaping the Future*. San Francisco, CA: Berrett-Koehler Publishers Inc, pp.245–263.
- Cooperrider D, Whitney D and Stavros JM (2008) *Appreciative Inquiry Handbook: For Leaders of Change*. 2nd ed. Ohio, OH: Crown Custom Publishing, Brunswick.
- Corlett J and Twycross A (2006) Negotiation of parental roles within family-centred care: Review of the research. *Journal of Clinical Nursing* 15(10): 1308–1316.
- Coyne IT (1995) Partnership in care: Parents views of participation in their hospitalized children's care. *Journal of Clinical Nursing* 4: 71–70.
- Coyne IT and Cowley S (2006) Using grounded theory to research parent participation. *Journal of Research in Nursing* 11(5): 501–515.
- Coyne IT and Cowley S (2007) Challenging the philosophy of partnerships with parents: A grounded theory study. *International Journal of Nursing Studies* 44: 893–904.
- Fegran L, Fagermoen MS and Helseth S (2008) Development of parent-nurse relationships in neonatal intensive care units from closeness to detachment. *Journal of Advanced Nursing* 64(4): 363–371.
- Fereday J and Muir-Cochrane E (2006) Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods* 5(1): 1–10.
- Forsythe P (1998) New practices in the transitional care centre improve outcomes for babies and their families. *Journal of Perinatology* 18(6Pt 2 Suppl): S13–S17.
- Furman L, Minich N and Hack M (2002) Correlates of lactation in mothers of very low birth weight infants. *Pediatrics* 109(4): e57.
- Fenwick J, Barclay L and Schmied V (1999) Activities and interactions in level II nurseries: A report of an ethnography study. *Journal of Perinatal and Neonatal Nursing* 13(1): 53–65.
- Gallant MH, Beaulieu MC and Carnevale FA (2002) Partnership: An analysis of the concept within the nurse-client relationship. *Journal of Advanced Nursing* 40(2): 149–157.
- Gergen MM, Gergen KJ and Barrett F (2004) Appreciative inquiry as dialogue: Generative and transformative. *Advances in Appreciative Inquiry* 1: 3–27.

- Gooding JS, Cooper LG, Blaine AI, Franck LS, Howse JL and Berns SD (2011) Family support and family-centered care in the neonatal intensive care unit: Origins, advances, impact. *Seminars in Perinatology* 35(1): 20–28.
- Havens DS, Wood SO and Leeman J (2006) Improving nursing practice and patient care: Building capacity with appreciative inquiry. *Journal of Nursing Administration* 36(10): 463–470.
- Halstrom I and Runeson I (2001) Parental needs during hospitalization. *Journal of Nursing Theories* 10(3): 20–27.
- Hook ML (2006) Partnering with patients: A concept ready for action. *Journal of Advanced Nursing* 56(2): 133–143.
- Hutchfield K (1999) Family centred care: A concept analysis. *Journal of Advanced Nursing* 29(5): 1178–1187.
- Institute for Patient and Family Centred Care (2012) Available at: <http://www.ipfcc.org>. (accessed 23 September 2012).
- Koster RLP and Lemelin RH (2009) Appreciative inquiry and rural tourism: A case study from Canada. *Tourism Geographies* 11(2): 256–269.
- Lavender T and Chapple J (2004) An exploration of midwives' views of the current system of maternity care in England. *Midwifery* 20(4): 324–334.
- Lee P (1999). Partnership: What does it mean today? *Journal of Child Care Health* 3(4): 28–32.
- Liebling A, Elliot C and Arnold H (2001) Transforming the prison: Romantic optimism or appreciative realism. *Criminal Justice* 1(2): 161–180.
- Lincoln YS and Guba EG (1985) *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications Inc.
- Mantel JM and Ludema JD (2000) From local conversations to global change: Experiencing the worldwide web effect of appreciative inquiry. *Organizational Development Journal* 18: 42–53.
- Moore SM and Charvat J (2007) Promoting health behaviour change using appreciative inquiry: Moving from deficit models to affirmation models of care. *Family Community Health* 30(1 Suppl): S64–S74.
- Nonaka I (1991) Knowledge creating company. *Harvard Business Review* 69(6): 96–104.
- Postma W (1998) Capacity-building: The making of a curry. *Development in Practice* 8(1): 54.
- Reed J (2007) *Appreciative Inquiry: Research for Change*. California, CA: Sage Publications.
- Reed J, Pearson P, Douglas B, Swinburne S and Wilding H (2002) Going home from hospital: An appreciative inquiry study. *Health and Social Care in the Community* 10(1): 36–45.
- Richer MC, Ritchie J and Marchionni C (2009) 'If we can't do more, let's do it differently!': Using appreciative inquiry to promote innovative ideas for better healthcare work environments. *Journal of Nursing Management* 17: 947–955.
- Trajkovski S, Schmied V, Vickers M and Jackson D (2012) Neonatal nurses' perspectives of family-centred care: A qualitative study. *Journal of Clinical Nursing* 21(17-18): 2477–2487.
- Van Der Haar D and Hosking DM (2004) Evaluating appreciative inquiry: A relational constructionist perspective. *Human Relations* 57(8): 1017–1036.
- Van Riper (2001) Family-provider relationships and well-being in families with preterm infants in the NICU. *Heart and Lung* 30(1): 74–84.
- Wiggins MS (2008) The partnership care delivery model: An examination of the core concept and the need for a new model of care. *Nursing Management* 15(5): 629–638.
- Whitney D, Trosten-Bloom A and Rader K (2010) *Appreciative Leadership: Focus on What Works to Drive Winning Performance and Build a Thriving Organisation*. USA: McGraw-Hill.
- Wilson V (2005) Improving the effectiveness of patient care: An emancipatory practice development approach. *Neonatal, Paediatric and Child Health Nursing* 8(3): 4–11.

6.3. Conclusion

This chapter presented the fourth published paper 'Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop'. This paper reported the findings of a one day AI workshop with parents and nurses. The workshop provided a good example of collaborative research and identified strategies that can be implemented to enhance FCC in the NICU. Participants reported the workshop provided a real opportunity to explore practice in the neonatal unit along with providing a platform to build meaningful relationships and collaborations required to bring about change. As a result of the workshop a FCC working party was formed. The following chapter presents the fifth published paper 'Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project'. This paper reports the progress and experiences of neonatal nurses and parents who met over a two year period to work collaboratively to enhance FCC in the NICU.

Chapter 7:

Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: the destiny phase of an appreciative inquiry project

7.1. Publication

Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2015). Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian*, (in press) doi: <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

Article in press (see appendix12)

7.2. Introduction and relevance to thesis

This paper reports on the progress and experience of neonatal nurses and parents who worked collaboratively to enhance FCC in the NICU with a focus on the destiny phase (two years after the workshop was held). The relevance of this paper was to highlight how a positive participatory approach, such as AI, was used to create the exchange of information, and create the networking and collaboration required to bring about change in the health care system. The paper also presented the challenges and feedback on the AI process.



Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/colli



Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project

Suza Trajkovski, RN, BN, PhD^{a,*},
Virginia Schmied, RN, RM, PhD^a,
Margaret H. Vickers, MBA, BBus, PhD^b,
Debra Jackson, RN, PhD^{c,d}

^a Family and Community Health Research Group (FaCH), School of Nursing and Midwifery, University of Western Sydney, Australia

^b School of Business, Centre for Positive Psychology and Education (CPPE), University of Western Sydney, Australia

^c Faculty of Health and Life Sciences, Oxford Brookes University, United Kingdom

^d School of Health, University of New England, Australia

Received 5 April 2014; received in revised form 19 May 2015; accepted 27 May 2015

KEYWORDS

Appreciative inquiry;
Family centred care;
Neonatal nursing;
Neonatal care

Summary

Aim: The aim of this paper is to report on the process and experiences of neonatal nurses and parents who worked collaboratively in an appreciative inquiry (AI) project to enhance family centred care (FCC) in the neonatal unit with a focus on the destiny phase.

Background: The concept of FCC is internationally recognised as an ideal way of caring for hospitalised children however, research suggests health professionals experience difficulties integrating FCC principles into daily practice. A fundamental principle of FCC is the need to develop respectful partnerships between health professionals and parents of infants requiring neonatal care. AI offers a positive, strength based, participatory approach that promotes organisational learning and positive organisational change. AI facilitates change from the ground up and lends itself to building effective sustainable partnerships and collaborations.

Design: Qualitative interpretive approach.

Methods: Two focus groups (4 neonatal nurses in the first group and 2 neonatal nurses, 1 physiotherapist and 1 occupational therapist in the second) and four individual face-to-face interviews

* Corresponding author at: University of Western Sydney, School of Nursing and Midwifery, Locked Bag 1797, Penrith, NSW 2751, Australia. Tel.: +61 02 4620 3363.

E-mail address: s.trajkovski@uws.edu.au (S. Trajkovski).

<http://dx.doi.org/10.1016/j.colegn.2015.05.004>

1322-7696/© 2015 Australian College of Nursing Ltd. Published by Elsevier Ltd.

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

were conducted (2 neonatal nurses and 2 parents of infants previously discharged from the neonatal unit) (total $n=12$). Data were analysed using thematic analysis.

Results: Data analysis revealed four key themes: 'creating a physical and mental space', 'building and maintaining momentum', 'ongoing organisational support' and 'continuing collaborations'.

Conclusion: Parents and health care professionals worked collaboratively to facilitate FCC.

Implications for future practice/research: AI provides a framework that enables parent–nurse collaboration needed to develop action plans that can form the catalyst for organisational change in health care research and practice.

© 2015 Australian College of Nursing Ltd. Published by Elsevier Ltd.

1. Introduction

Family centred care (FCC) principles resonate with many policy initiatives that focus on 'patient led' health care and the drive to consider patients in the context of their family (Staniszewska et al., 2012). Over the past few decades, policy directives for services have called for increased collaboration across health, social and independent sectors including community involvement such as parent representative organisations (Australia's National Health and Hospital Reform Commission, 2009). Neonatal units have shifted from restrictive hospital policies that previously excluded families, to policies that place parents and the family at the centre of care. Increased emphasis has been placed on the need to recognise individual needs of families and position parents as partners in the care of their infant (Coyne & Cowley, 2007). The aim of this paper is to report on the process and experiences of neonatal nurses and parents who worked collaboratively in an appreciative inquiry (AI) project to enhance family centred care in the neonatal unit. This paper will focus on the destiny phase which is the last phase of the reiterative cyclical process known as the AI, 4D cycle.

2. Background

FCC is reported in the literature as a philosophy (Franck & Callery, 2004), a paradigm (Hall, 2005), a model of care (Shields, Pratt, & Hunter, 2007), or referred to as a practice theory (Hutchfield, 1999). Current literature positions FCC as a highly abstract concept that is yet to reach its developmental maturity (Mikkelsen & Frederiksen, 2011; Staniszewska et al., 2012). The underlying philosophy of FCC recognises and embraces the whole family when planning care for the individual/child/infant (Institute for Patient and Family Centred Care, 2012; Trajkovski, Schmied, Vickers, & Jackson, 2012). Developing respectful partnerships between parents and health care professionals is considered a core principle of FCC (Institute for Patient and Family Centred Care, 2012; Shields, Pratt, & Hunter, 2006). The notion of partnership in care implies mutual dependency and shared responsibility in caring for the neonate. Information is shared (Gallant, Beaulieu, & Carnevale, 2002), care is negotiated (Casey, 2008; Coyne, 1995) and skills and competence are acknowledged and utilised (Wiggins, 2008). These measures ultimately result in shared responsibility for care of

the neonate and family and enhance informed collaborative decision making (Bidmead & Cowley, 2005; Hook, 2006).

Working in partnerships can be challenging and is reported to have both positive and negative consequences (Mikkelsen & Frederiksen, 2011). Coyne and Cowley (2006) found supporting and facilitating parental participation was difficult for nurses, and while parents were keen to participate, parents struggled to identify what nurses expected from them. Poor role negotiation, lack of information and unclear instructions are identified as barriers (Blower & Morgan, 2000; Coyne, 1995; Halstrom & Runeson, 2001). However, when working successfully with families, the reported benefits are significant. These include improved overall health outcomes for the infant resulting in fewer behavioural stress cues, increased breast feeding rates, reduced length of stay and more knowledgeable, empowered and confident parents (Bidmead & Cowley, 2005; Byers et al., 2006; Forsythe, 1998; Furman, Minich, & Hack, 2002; Gooding et al., 2011; Hook, 2006; Van Riper, 2001).

Strengthening consumer engagement, increasing community participation, building health literacy and empowering consumers in decision-making is a key focus of new national and international health reforms (Australia's National Health and Hospital Reform Commission, 2009; North America's Department of Health and Human Services Affordable Care Act, 2010; United Kingdom's Department of Health and National Health Services Corporate Plan, 2012). These imperatives highlight the need for increased partnerships and collaborations within and across sectors and community groups. Partnerships need to occur at an individual, service, network and a systems level, and include key elements such as sharing of information, consultation, involvement, collaboration and empowerment. Working together to build effective partnerships and collaborations between neonatal nurses and parents is required to better implement FCC principles within a neonatal intensive care unit (NICU) environment.

3. Method

An AI methodology was chosen for this project as it offered a theoretical and participatory framework that allowed specific needs and aims to be addressed within the context of the organisation being reviewed (Cooperrider, Whitney, & Stavros, 2008; Cooperrider & Whitney, 1999). AI draws on action research, organisational change and innovative

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

theories, and adopts a social constructionist perspective based on appreciation and positive dialogue (Cooperrider, 1986; Koster & Lemelin, 2009; Reed, 2007). AI shifts the focus from problems to successes and future possibilities (Cooperrider, 1986; Koster & Lemelin, 2009; Reed, 2007). Working together and creating collective visions and actions within the team is considered an important component in initiating change using the AI process.

Participants or team members were considered experts or co-researchers in this project. The AI process allowed members to exchange both tacit and explicit knowledge required to build the desired future for the team. The inclusive and collaborative nature of AI and its ability to incite generative learning are key strengths of the AI process (Barrett, 1995; Carter, 2006; Richer, Ritchie, & Marchionni, 2009).

Most applications of AI use a cyclical process that consists of four phases known as the 4D Cycle: the Discovery phase focuses on an affirmative exploration of the organisation; the Dream phase focuses on envisioning a desired future; the Design phase focuses on co-constructing the ideal; and lastly, the Destiny phase focuses on sustaining the envisioned future (Cooperrider et al., 2008; Cooperrider & Whitney, 1999). At the core of the 4D cycle is an affirmative topic choice. AI requires the researchers to shift from the traditional problem orientation to a positive participatory approach. Choosing an affirmative topic area the group genuinely wants to explore is considered an important component in the AI process (Cooperrider & Whitney, 1999). It is believed that change begins with the very first questions asked. An AI approach recognises the power of positive language and communication and advocates collective inquiry which lead to the group, organisation or community's desired future (Cooperrider & Whitney, 1999).

This paper reports on the process and experiences of neonatal nurses and parents who worked collaboratively in an AI project to enhance family centred care in the neonatal unit with a focus on the destiny phase. This paper is part of a larger study and builds on from the previous AI phases (Discovery, Dream and Design see Trajkovski et al., 2012; Trajkovski, Schmied, Vickers, & Jackson, 2013) exploring FCC in the NICU. The FCC working party was formed as the result of a one day workshop that was previously held with neonatal nurses and parents as part of the study (Trajkovski et al., 2012, 2013). Participants highlighted the need to form a working party that meets monthly to continue discussions around FCC and begin the process of developing strategies and initiating action plans.

4. Study design

This study used a qualitative interpretive approach (Thorne, Kirkham, & MacDonald-Emes, 1997). While there are no specific AI guidelines as to the methods or best times to measure the resultant change, the researchers agreed that two years allowed an appropriate time lapse to follow up with this working party. This timeframe was chosen as it allowed the working party sufficient time to implement strategies and monitor the experiences and progress of the working party. Two focus groups (4 neonatal nurses in the first group and 2 neonatal nurses, a physiotherapist and an occupational

therapist in the second focus group) and four individual face-to-face interviews (2 neonatal nurses and 2 parents of infants previously discharged from the neonatal unit) (total $n=12$) were conducted. Focus group and face-to-face interviews were digitally recorded and transcribed verbatim. Data was examined using a qualitative, thematic analysis approach (Braun & Clarke, 2006; Lincoln & Guba, 1985).

4.1. Setting

Monthly meetings were held with participants either at the office of an independent parent support group or in the conference room attached to the neonatal unit. Meeting locations were selected on a monthly basis through collaborative decisions made between the working party group members. Focus groups were conducted in a quiet room outside the NICU and face-to-face interviews were held either at the quiet room outside the neonatal unit or a quiet room at the independent parent support group office.

4.2. Participants and recruitment

Nurse and parent participants were recruited from the workshop previously held as part of this study (Trajkovski et al., 2012) and allied health care workers (physiotherapist and occupational therapist) who joined the working party through the monthly meetings. Participating nurses ($n=8$) were aged between 25 and 64 years, participating parents ($n=2$), physiotherapist ($n=1$), occupational therapist ($n=1$) were aged between 25 and 35 years. Nurses' experience levels ranged from junior special care nursery staff to senior, experienced neonatal intensive care nurses with more than 15 years of service in neonatal intensive care. Both the physiotherapist and occupational therapist had over 5 years of neonatal experience. Parent participants ($n=2$) had experienced an infant requiring NICU care within the last five years.

4.3. Ethical considerations

Ethics approval was obtained from the local health district and relevant Human Research Ethics Committee and written consent was obtained from participants. Nurses were reassured participation in the study would have no effect on employment and parents were reassured that participation in this study would have no effect on future associations with the health service. Participants were assured that researcher confidentiality would be maintained at all times and focus group participants provided verbal consent to maintain and respect confidentiality including not discussing who was present or content discussed during the focus group sessions. The researcher ensured anonymity was maintained in published documents and public presentations at all times and ensured data collected was safely stored. A list of counselling provider details was given to all participants at the commencement of the data collection process.

4.4. Research rigour and reflexivity

The first author is a specialised neonatal nurse (ST) who recruited participants from a neonatal unit where she

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.collegn.2015.05.004>

Table 1 Destiny phase interview and focus group questions.

1.	First could you describe the progress of the working party? (Prompts – is the working party still meeting; how often; who chairs?)
2.	Can you describe the achievements of working party (Prompt – were the goals of the group met)?
3.	In your opinion what helped the working party achieve its goals?
4.	Can you describe any barriers faced by the working party?
5.	In what way did the AI approach facilitate or hinder the working party's progress?
6.	What may have helped or hindered the AI process?
7.	How will you use the AI process in the ongoing work of the FCC working party?

previously worked. Due to professional relationships previously established with most participants, research rigour and reflexivity were carefully applied throughout the research process. An analytical perspective was maintained throughout the process based on ongoing self-critique, self-appraisal and attention to the politics of researchers' positioning and location (Burns, Fenwick, Schmied, & Sheehan, 2010; Fereday & Muir-Cochrane, 2006). Preliminary data analysis identifying broad themes and sub themes was undertaken by the first author. Transcripts and coding were reviewed by the other authors and consensus on the themes and sub themes was reached through discussion with all the research team.

4.5. Data collection

Two years after the working party was formed, 4 individual face to face interviews and 2 focus groups were conducted. Interview and focus group questions explored the progress of the working party since the commencement of the working party and feedback on the AI approach and process (see Table 1). Data collected from these interviews and focus groups were digitally recorded and transcribed verbatim.

4.6. Data analysis

Inductive thematic analysis (Lincoln & Guba, 1985) was used to condense raw data from the interviews and focus groups. Data analysis focused on identifying themes, patterns of experiences and behaviours. Texts were read line by line. Open coding was used for grouping of categories and the emergence of themes (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Patterns of experiences were identified as broad themes initially. Data relevant to broad themes were grouped together, then categorised into sub themes bringing together participants' ideas and experiences to form a comprehensive picture of their experience (Braun & Clarke, 2006). The integrity and trustworthiness of the data was ensured by clarity and agreement between researchers throughout the data analysis process where key concepts and ideas relevant to the research aims were captured and explored.

5. Results

The data analysis focused on the AI process and revealed four dominant themes: 'creating a physical and mental space', 'building and maintaining momentum', 'ongoing organisational support' and 'continuing collaborations'.

5.1. Creating a physical and mental space

Participants reported the need to create a physical and mental space that encouraged dialogue, built trust and created links between health professionals and parents. A welcoming and inviting space was required where nurses and parents felt they were able to share ideas, develop collective goals and implement innovations. Creating a physical space, with dedicated locations, dates and time frames was considered a method of formalising the process for parents and nurses to begin working together:

I think it's great that we have our meetings at both parent group offices and at the hospital. It keeps us connected. Parents are engaged with nurses and nurses engaged with parents. Going to the parent group offices for meetings, we as nurses can see first-hand what the parent group does and vice versa (Interview 3: Nurse).

In addition to the physical space, creating a mental space was considered equally important. Creating a space provided opportunities for nurses and parents to talk, share ideas and be creative when developing innovations and strategies to improve FCC. Participants reported feeling 'welcomed' (Interview 2: Parent), 'included' (Focus group 2: Allied health 1), 'valued' (Focus group 1: Nurse) and 'empowered' (Focus group 1: Nurse) as a result of this process:

This study gave parents and nurses the opportunity to come together. The fact that it started, was more than you could ask for. I just think from having nothing, to something, in whatever shape or form is unbelievable. I think that's where the biggest steps have been taken. It's really opened the doors for everything that we've been able to do (Interview 1: Parent).

Participants also reported greater understanding of each others' roles, expectations and needs within the current health system design:

It's good to hear both sides... It now makes more sense why nurses do things a particular way... As a parent I would never have considered the reasons behind some of the things nurses do (Interview 2: Parent).

A nurse stated:

It was important speak to the parents and get a better understanding of what they thought their role is in the nursery and then work together with them to learn how we can support them. (Focus group 1: Nurse).

Changing the mindset to a more positive stance was highlighted when a participant stated, 'There are aspects of family centred care we do really well and we need to focus and build on those strengths and not just focus on the negatives' (Interview 4: Nurse). Another nurse said:

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

It can be so draining when you do so many good things and people tend to focus on the one thing that wasn't so good. I think we are getting better at acknowledging what we are doing well now and get that feeling that we can make a positive difference (Interview 4: Nurse).

Conversely, another nurse highlights the importance of acknowledging what strategies or interventions are less effective, so attention can be directed to the aspects that are working:

If we are wasting our time on particular strategies and interventions in the unit, I think we need to mention it so we can continue to focus on the things that are effective and working. So many times we do the same things over and over again, even though we know it doesn't work. It's crazy really. This study gave us the platform to be able to think about these things and to share our opinions and ideas in a constructive way (Interview 4: Nurse).

5.2. Building and maintaining momentum

Developing and following through on proposed ideas was considered an important aspect of the process. Participants highlighted the need to focus on 'what we can do for the here and now and into the future' (Focus group 2: Allied health 2). Strategies for linking short-mid- and long-term goals along with making everyday decisions were considered important in moving towards the envisioned future. One participant highlighted the importance of understanding the impact of staff actions, suggesting small interventions can have significant impacts as described by a parent:

'Small changes can make a big difference. For example, waiting for parents to do the first bath or asking parents if they would like to keep their baby's first outfit. It's simple enough. The outfits are donated, and new ones are delivered all the time. Every parent wants that first outfit but do not want to ask, so having a nurse offering the outfit shows that nurses care and are thinking about us. It just means so much to a parent.' (Interview 2: Parent).

Seeing innovations that come to life was rewarding for participants: 'We have great ideas that are very practical with do-able strategies, its good to see them work' (Interview 3: Nurse). Reflection was considered an important strategy when reviewing the effectiveness of the group. As one participant said:

It's important to sit back and think of where we were when we started and where we are up to now. Although some strategies take longer than others, we are implementing them one at a time. To date, there isn't one thing we could say was really a waste of time (Interview 4: Nurse).

Another participant highlighted the importance of the meetings stating: 'If we didn't see the value of the family centred care working group, we wouldn't keep coming to the meetings' (Interview 2: Parent). Building and maintaining momentum was considered an important component in building progress with FCC:

We need to keep building on what we want to achieve with family centred care. We need to keep the

conversations going, build on action plans and keep having regular meetings. Otherwise, it becomes like everything else, and nothing gets done. It needs to be at the forefront, embedded in what we do everyday and not just an after thought (Focus group 1: Nurse).

Another nurse stated:

We don't want it to fizzle out like a lot of the other meetings and initiatives around here. It can be hard to find the time to keep meeting, but we need to commit to keep these meetings going (Focus group 1: Nurse).

5.3. Ongoing organisational support

The need for ongoing organisational support was considered an important element in implementing ideas generated by the group. One participant said: 'While we have good ideas, we need the ongoing support from the management team to put these ideas into practice' (Interview 4: Nurse). Without managerial support participants report implementing ideas would be 'difficult' (Focus Group 1: Nurse), and needed to have 'approval to proceed' (Focus Group 1: Nurse). The type and level of support varied according to the group's needs:

Sometimes we need resources such as equipment or funding, other times we need to be given the time to go to meetings and to be given dedicated time away from the ward to be able to develop and implement family centered care properly (Interview 4: Nurse).

Another nurse highlights the need for reassurance from management:

Sometimes we just need management to reassure us, support us and give us the 'ok' in what we are doing. When management can see what we are doing and support it, then that makes it easier for us to continue (Interview 4: Nurse).

The presence of management at the FCC meeting was considered valuable. One nurse said:

It's good that our manager comes to the meetings and is letting us run with it. She comes to meetings when she can, and she passes vital information to all staff through our staff meetings and offers ideas and support where needed. She is not dominating the group which I think has been really important (Interview 4: Nurse).

A nurse highlights the empowering nature of the process:

I think it's great that we have a say and we can drive our ideas, what we want to see happen and be a key part of it. After all, we are the ones that work with the families and babies (Focus group 1: Nurse).

Nurses also highlighted the need for training and to develop the appropriate skills to effectively implement FCC strategies when working with families:

We need to receive training on how to best implement family centred care. Working with families can be challenging and we need to develop the skills to effectively work with families to get the best possible outcomes. Our training mainly focuses on the neonate and there is not

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

enough training on how to work with families or strategies we can use. We need management to support us to get the training we need (Interview 4: Nurse).

5.4. Continuing collaborations

The need to stay 'connected' (Focus Group 1: Nurse) and 'involved' was considered an important element for ongoing collaborations.

It's really important to keep the conversations going between health professionals and parents. Keeping the lines of communication open is needed, to be able to share information, ask questions and make decisions (Interview 2: Parent).

Participants reported the need to 'keep up to date' (Interview 2: Parent) with current information and practices, 'networking' (Interview 1: Parent), and interacting with people that have a 'common interest' (Interview 2: Parent). Engaging in open and frequent communication was considered an essential element to building relationships between health professionals. The need to stay connected and continuing conversations was highlighted when a participant said:

It's important to keep the connections and conversations going. Where we were, to where we have come to, it gives me goose bumps. We are now being invited to join other research projects and conferences, not only nursing but also medical conferences and this stems from the relationships we built (Interview 1: Parent).

In order to have continued collaborations, highly regarded aspects included mutual respect, effective communication and joint decision making:

Working together, being respectful and making joint decisions is necessary. We have built a rapport with the parents in the family centred care group and it's really great that we are genuinely open and honest with each other. We listen to what the parents are saying, we are making joint decisions and we want to continue to work together. What I realise, is that ultimately, we all want the same thing (Interview 3: Nurse).

To initiate change, the need to be inclusive was highlighted. Whether staff were junior or senior, their contributions were considered equally valuable and important:

It's good to get all the staff involved, to hear each others' ideas and see the different perspectives. I think it was important that all staff were part of the process, or at the very least know what we were doing and why we were doing them. It really helps to have everyone on board and involved and, it makes it easier to implement strategies (Focus group 2: Nurse).

It was also reported that ongoing collaborations allowed for ideas to evolve and actions be implemented:

The meetings helped us to talk about the things we thought were important. We did the workshop which was a great experience and we listed a lot of great ideas. The ongoing family centred care meetings gave us the

opportunity to work together to put some of the ideas into action (Interview 4: Nurse).

Participants reported a sense of 'commitment' (Focus group 2: Nurse) and 'confidence' (Interview 2: Parent) in bringing about positive change. It was also reported, the AI process had 'opened the doors for other collaborations' (Interview 2: Parent). The collaborative nature of AI was highlighted when a participant said:

I feel in the last 18 months to 2 years we've built that respect with health professionals and we are seen in such a different light now. All of that stems from the relationship built...from the health professionals actually accepting parents in a different capacity to just being patients and now valuing our opinion...and also asking for it. It has opened up amazing doors...It is definitely positive (Interview 1: Parent).

6. Discussion

The findings of this study indicate neonatal nurses and parents value the philosophy of FCC, however, the need for continuing education, collaboration and organisational support is required to effectively implement FCC principles. Families are increasingly demanding to be included and involved in their infants' care (Staniszewska et al., 2012). This study provides valuable information needed when working with families including the need for effective communication, relationship building and negotiations skills. Developing a greater understanding of the needs of parents and working collaboratively with parents was required (Institute for Patient and Family Centred Care, 2012).

AI provided an impetus to bring health care professionals and parents together to collectively explore FCC in the NICU. The findings of this study contribute to the body of knowledge of AI in health care, in particular, developing and implementing ideas and innovations, the importance of developing partnerships or collaborations and the need to build effective social networks to bring about change in health care.

The results of this study showed AI provided a way of involving and bringing health care professionals and parents together to initiate change processes and create an opportunity for innovative ideas to emerge and evolve. Participants were part of a learning organisation with regular communication and interactions between neonatal parents and health care professionals. Ideas and innovations were shared and strategies developed and implemented to facilitate learning and service development. Beginning with individuals, the process of knowledge exchange, sharing of values and beliefs systems and the process of making tacit knowledge, explicit, is reported to allow innovative ideas and new knowledge to emerge (Nonaka, 1991; Richer et al., 2009).

In order to continue to meet the ongoing organisational needs within health care systems, individuals and organisations depend on an ability to learn. Theories of organisational learning generally either focus on learning by individuals within an organisational context (Argyris, 1983; Senge, 1990) or focus on individual learning as a model for organisational learning and action (Levitt & March, 1988). For example, seminal work by March and

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

Olsen (1976) focused on experiential learning of individuals within organisations and Argyris and Schon (1978) examined the action of members (agents) of the organisation. Both these approaches based their understanding of organisational learning on the cognitive aspect of individual learning (Cook & Yanow, 1993). This included an explicit or implicit understanding of what it means for an individual to learn, and an approach for organisations to improve their adaptability and effectiveness.

This study concurs with seminal work surrounding organisational learning including tacit knowledge (Polanyi, 1967) and the learning organisation (Cook & Yanow, 1993). Polanyi's phenomenon of 'tacit knowing', suggests 'we can know more than we can tell' (p. 4) and includes the ability to recognise something without being able to describe it (Doing, 2011). Nonaka and Takeuchi (1995) suggested tacit knowledge is personal, subjective and context specific, whereas explicit knowledge is more formal, systematic, codified, and easy to communicate. Nonaka and von Krogh (1991) suggest knowledge creation occurs in two dimensions: an epistemological dimension (from tacit to explicit and explicit to tacit) and an ontological dimension through knowledge conversions from individuals to group to organisations. It is reported that tacit knowledge of key personnel within organisations can be made explicit or externalised through the organisational manuals, products and processes or, conversely shifts from explicit to tacit, where individuals internalise an organisation's procedures, rules and other forms of explicit knowledge (Nonaka, Toyama, & Konno, 2000; Nonaka & von Krogh, 1991).

In line with Cooperrider's (1990) positive principle, this study focused on positive feelings to allow for building and sustaining momentum for change. Research shows individuals that focus on the positive are more flexible, integrative, creative, and are more efficient thinkers (Isen, 2000). Another study showed positive dialogue is related to building quality relationships, cohesion, improved decision making and greater success of overall social systems (Fredrickson & Losada, 2005). Creating a space offered a place for positive generative dialogue to occur and to allow the development and sharing of common goals while also providing the platform required for innovations to emerge (Richer et al., 2009).

The findings of this study support the views of Richer et al. (2009) and Staniszewska et al. (2012), regarding the importance of developing social networks and the need for interdisciplinary collaborations. The successful implementation of FCC requires ongoing organisational commitment and support (Staniszewska et al., 2012), and requires organisations to give equal attention to both multi-level structures and larger systems perspectives (Richer et al., 2009). The collaborative approach to include parents is a more effective method in addressing the expectations and needs of parents, and may contribute to higher quality clinical care for the infant and their family. Parents' willingness, expectations and individual abilities to be involved need to be carefully examined and respected.

A major implication for management is the importance of offering support and allowing ideas and innovations to be implemented (Richer et al., 2009). A core aspect of AI is the generative nature of this approach that may allow new ideas, theories and models to emerge (Gergen, 1978).

It leads people to choose new actions which can be transformational (Gergen, 1978). While the commitment, legitimacy and passion of the people charged with leading AI efforts are reported to make a difference (Bushe, 2007), multi-level organisational support is reported to be a key factor in changing work environments (Richer et al., 2009). In this project AI provided a way of engaging both health professionals and parents in change efforts and allowed innovative ideas to emerge and be implemented.

7. Limitations and future research

This study was conducted with nurses who were currently practicing in one neonatal unit in Australia, and parents of infants that were predominantly cared for in that particular unit; therefore the homogeneity of participants could be viewed as a limitation. From a methodological perspective, AI is commendable as an organisational developmental strategy. However, tracking and measuring change (often beyond the project's lifespan) can be difficult due to the subtle yet ongoing nature of the changes. Action plans developed as a result of the AI process ideally require separate evaluations, to determine their impact or effectiveness. However, as action plans change and evolve over time, determining the most appropriate times where conclusions can be drawn about their effectiveness, becomes obscure. While it is difficult to measure change with an AI model, these qualitative findings are both informative and useful for developing a greater understanding of how change takes place in health care.

Recommendations for future practice require continued collaborations between neonatal parent's and health care workers. Parents need to be acknowledged and embraced as integral members of the multidisciplinary neonatal team. Collaborative decision making on hospital designs and health-care practices is needed. Ongoing collaborations require parents to be included as research partners and contributors to policy development.

8. Conclusion

In this study AI offered a positive strength based approach to exploring FCC in the NICU. AI provided a useful framework to bring neonatal parents and health care professionals together to work collectively to develop ideas and innovations to enhance FCC in the NICU. The AI approach has created opportunities for the exchange of information, networking and developing partnerships and collaborations. Parents of NICU patients have contributed as equal partners throughout the project, where their ideas and expertise were valued. As a result of this study, some innovations identified by the group (for example: updated information displayed on liquid-crystal display slides in between infant bed spaces for parents and sibling packs) have been implemented in the clinical environment and participants continue to meet on a regular basis.

Authors' contribution

ST, VS, MV, DJ involved in study design, data collection and analysis, and manuscript preparation.

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

Acknowledgement

The research team would like to thank the participants for sharing their ideas, expertise and experiences.

References

- Argyris, C. (1983). Action science and intervention. *Journal of Applied Behavioral Science*, 19, 115.
- Argyris, C., & Schon, D. (1978). *Organizational learning: A theory of action perspective*. Reading, MA: Addison-Wesley.
- Australia's National Health and Hospital Reform Commission (NHRC). (2009). *A healthier future for all Australians final report*. Retrieved from <http://www.health.gov.au/internet/nhrc/publishing.nsf/content/nhrc-report>
- America Department of Health and Human Services (HHS). (2010). *Affordable Care Act*. Retrieved from <http://housedocs.house.gov/energycommerce/ppacacon.pdf>
- Bidmead, C., & Cowley, S. (2005). A concept analysis of partnerships with clients. *Community Practitioner*, 78(6), 203–208.
- Barrett, F. J. (1995). Creating appreciative learning culture. *Organizational Dynamics*, 24(2), 36–49.
- Blower, K., & Morgan, E. (2000). Great expectations? Parental participation in care. *Journal of Child Health Care*, 4(2), 60–65.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.
- Burns, E., Fenwick, J., Schmied, V., & Sheehan, A. (2010). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery*, 28, 52–60.
- Bushe, G. R. (2007). Appreciative inquiry is not (just) about the positive. *OD Practitioner*, 39(4), 30–35.
- Byers, J. F., Lowman, L. B., Francis, J., Kaigle, L., Lutz, N. H., Waddell, T., et al. (2006). A quasi-experimental trial on individualized, developmentally supportive family-centered care. *Journal of Obstetrics, Gynecology and Neonatal Nursing*, 35(1), 105–115.
- Carter, B. (2006). 'One expertise among many'-working appreciatively to make miracles instead of finding problems: Using appreciative inquiry to reframe research. *Journal of Research in Nursing*, 11(1), 48–63.
- Casey, A. A. (2008). Partnership with child and family. *Senior Nurse*, 8(4), 8–9.
- Cook, S., & Yanow, D. (1993). *The tacit dimension*. New York, USA: Anchor Books.
- Cooperrider, D. (1986). *Appreciative Inquiry: Toward a methodology for understanding and enhancing organizational innovation*. Cleveland, OH: Western Reserve University.
- Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivastva, & D. L. Cooperrider (Eds.), *Appreciative management and leadership*. San Francisco: Jossey-Bass Publishers.
- Cooperrider, D., & Whitney, D. (1999). Appreciative inquiry: A positive revolution in change. In P. Holman, & T. Devane (Eds.), *The change handbook: Group methods for shaping the future*. San Francisco: Berrett-Koehler Publishers Inc.
- Cooperrider, D., Whitney, D., & Stavros, J. M. (2008). *Appreciative Inquiry handbook: For leaders of change* (2nd ed.). Brunswick, OH: Crown Custom Publishing.
- Coyne, I. T. (1995). Partnership in care: Parents views of participation in their hospitalized children's care. *Journal of Clinical Nursing*, 4, 71–79.
- Coyne, I. T., & Cowley, S. (2006). Using grounded theory to research parent participation. *Journal of Research in Nursing*, 11(5), 501–515.
- Coyne, I. T., & Cowley, S. (2007). Challenging the philosophy of partnerships with parents: A grounded theory study. *International Journal of Nursing Studies*, 44, 893–904.
- Doing, P. (2011). Tacit knowledge: Discovery by or topic for science studies? *Social Studies of Science*, 41(2), 301–306.
- Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80–92.
- Forsythe, P. (1998). New practices in the transitional care centre improve outcomes for babies and their families. *Journal of Perinatology*, 18(6 Pt 2 Suppl.), S13–S17.
- Franck, L. S., & Callery, P. (2004). Re-thinking family-centred care across the continuum of children's healthcare. *Child: Care, Health & Development*, 30(3), 265–277.
- Fredrickson, B. L., & Losada, M. F. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist*, 60(7), 678–686.
- Fuman, L., Minich, N., & Hack, M. (2002). Correlates of lactation in mothers of very low birth weight infants. *Pediatrics*, 109(4), e57.
- Gallant, M. H., Beaulieu, M. C., & Camevale, F. A. (2002). Partnership: An analysis of the concept within the nurse-client relationship. *Journal of Advanced Nursing*, 40(2), 149–157.
- Gergen, K. J. (1978). Toward generative theory. *Journal of Personality and Social Psychology*, 36, 1344–1360.
- Gooding, J. S., Cooper, L. G., Blaine, A. I., Franck, L. S., Howse, J. L., & Berns, S. D. (2011). Family support and family-centered care in the neonatal intensive care unit: Origins, advances, impact. *Seminars in Perinatology*, 35(1), 20–28.
- Hall, E. O. C. (2005). Being in an alien world: Danish parents' lived experience when a newborn or small child is critically ill. *Scandinavian Journal of Caring Sciences*, 19(3), 179–185.
- Halstrom, I., & Runeson, I. (2001). Parental needs during hospitalization. *Journal of Nursing Theories*, 10(3), 20–27.
- Hook, M. L. (2006). Partnering with patients – A concept ready for action. *Journal of Advanced Nursing*, 56(2), 133–143.
- Hutchfield, K. (1999). Family centred care: A concept analysis. *Journal of Advanced Nursing*, 29(5), 1178–1187.
- Institute for Patient and Family Centred Care. (2012). *Developing patient- and family-centered vision, mission, and philosophy of care statements*. <http://www.ipfcc.org>
- Ison, A. M. (2000). Positive affect and decision-making. In M. Lewis, & J. M. Haviland-Jones (Eds.), *Handbook of emotions*. New York: Guilford.
- Koster, R. L. P., & Lemelin, R. H. (2009). Appreciative inquiry and rural tourism: A case study from Canada. *Tourism Geographies*, 11(2), 256–269.
- Levitt, B., & March, J. (1988). Organisational learning. *Annual Review of Sociology*, 14, 319–340.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications Inc.
- March, J. G., & Olsen, J. P. (1976). *Organisational learning and the ambiguity of the past. In ambiguity and choice in organisations*. Oslo, Norway: Universitetsforlaget.
- Mikkelsen, G., & Frederiksen, K. (2011). Family-centred care of children in hospital-A concept analysis. *Journal of Advanced Nursing*, 67(5), 1152–1162.
- Nonaka, I. (1991). Knowledge creating company. *Harvard Business Review*, 69(6), 96–104.
- Nonaka, I., & Takeuchi, H. (1995). *The knowledge creating company*. Oxford, UK: Oxford University Press.
- Nonaka, I., Toyama, R., & Konno, N. (2000). Sect, ba and leadership: a unified model of dynamic knowledge creation. *Long Range Planning*, 33, 5–34.
- Nonaka, I., & von Krogh, G. (1991). Tacit knowledge and knowledge conversion: Controversy and advancements in

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

- organisational knowledge creation theory. *Organization Science*, 20(3), 635–652.
- Polanyi, M. (1967). *The tacit dimension*. New York, USA: Anchor Books.
- Reed, J. (2007). *Appreciative inquiry: Research for change*. California: Sage Publications.
- Richer, M. C., Ritchie, J., & Marchionni, C. (2009). 'If we can't do more, let's do it differently! Using appreciative inquiry to promote innovative ideas for better healthcare work environments. *Journal of Nursing Management*, 17, 947–955.
- Senge, P. (1990). *The fifth discipline: The art of practice of the learning organization*. New York: Double Day.
- Shields, L., Pratt, J., & Hunter, J. (2007). Family centred care for children in hospital. *Cochrane Database of Systematic Reviews*, CD004811. <http://dx.doi.org/10.1002/14651858.CD004811.pub2> (1 Art.No.)
- Shields, L., Pratt, J., & Hunter, J. (2006). Family centred care: A review of qualitative studies. *Journal of Clinical Nursing*, 15, 1317–1323.
- Staniszewska, S., Bret, J., Redshaw, M., Hamilton, K., Newburn, M., Jones, N., et al. (2012). The POPPY study: Developing a model of family-centred care for neonatal units. *Worldviews on Evidence-Based Nursing*, 4, 243–255.
- Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 20, 169–177.
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2012). Neonatal nurses' perspective of family-centred care: A qualitative study. *Journal of Clinical Nursing*, 21(17–18), 2477–2487.
- Trajkovski, S., Schmied, V., Vickers, M., & Jackson, D. (2013). Using appreciative inquiry to bring neonatal nurses and parents together to enhance family-centred care: A collaborative workshop. *Journal of Child Health Care*, 19(2), 239–253.
- United Kingdom's Department of Health Corporate Plan (2012). Retrieved from <https://www.gov.uk/government/publications/department-of-health-corporate-plan-2012-to-2013>
- Van Riper, M. (2001). Family-provider relationships and well-being in families with preterm infants in the NICU. *Heart and Lung*, 30(1), 74–84.
- Wiggins, M. S. (2008). The partnership care delivery model: An examination of the core concept and the need for a new model of care. *Nursing Management*, 15(5), 629–638.

Please cite this article in press as: Trajkovski, S., et al. Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project. *Collegian* (2015), <http://dx.doi.org/10.1016/j.colegn.2015.05.004>

7.3. Conclusion

This chapter presented the fifth published paper 'Experiences of neonatal nurses and parents working together collaboratively to enhance family centred care: The destiny phase of an appreciative inquiry project'. This paper reported the progress and experiences of neonatal nurses and parents who met over a two year period to work collaboratively to enhance FCC in the NICU. Findings highlighted the need for effective social networks, collaborations and organisational support to bring about changes in the NICU. The following chapter presents my researcher reflections on this study and the AI process.

Chapter 8:

Researcher's reflection

8.1. Reflections on the study

An essential component of rigorous inquiry is the ability of researchers to provide a transparent account of the research journey and process. An integral part of the social construction process is reflecting on moments, listening to different constructions and dialoguing what people want to evaluate (Burr, 2015). Reflecting on the AI process included the when and how events occurred, whose voices dominated group discussions, setting/seating arrangements, what worked well, and so on. Therefore, my reflections on the AI process provided a behind-the-scenes view of how this qualitative AI research project was conducted.

As a researcher I was obligated to explore approaches, philosophies and methodologies that would best suit the focus of inquiry. After hearing about AI from a visiting scholar I was intrigued and compelled to explore this method of inquiry further. I was mostly drawn to the AI approach due to the collaborative approach of this research and the notion of working with people rather than just writing about them. Following further readings and discussions with my supervisors about AI methodology, helped to secure my convictions that using a positive participatory approach such as AI provided a strong philosophical starting point for this research.

This chapter presents a descriptive analysis of field notes kept during the AI process. I reflect upon the progress of the working party (that met over a two year period) and the AI process. Field notes and meeting minutes were taken immediately after interactions with participants to capture activities, behaviours and events and included descriptive information (date, time, locations etc.) Reflective information was also gathered recording, thoughts, ideas, impressions, questions and concerns identified. These reflections were then used to inform the discussion in Chapter 9.

The discovery phase findings provided rich qualitative data from nurses and parents separately about their perceptions of FCC in the NICU. Participants were generally open and willing to share their experiences and were respectful when others were

sharing theirs. The workshop brought nurses and parents together for the first time. As a researcher, I felt quite unsure how this approach would be received and was surprised at the open, positive dialogue and teamwork between nurses and parents.

Following on from the workshop, a working party was formed and met for two years on a monthly basis. Attendees at the monthly meetings primarily consisted of 3-4 clinical nurses, the nurse manager and two parents from an independent parent support group. Participants came together to develop and implement strategies to enhance FCC in the NICU. Meeting notes were taken and were made available to all participants and neonatal staff in the form of meeting minutes. Researcher field notes were taken immediately after interactions with participants to capture activities, behaviours and events of the working party. Descriptive information was gathered including: date; time; locations; participant behaviour and actions, and, conversations were observed. Reflective information was also gathered recording, thoughts, ideas, impressions, questions and concerns. Data gathered were analysed using thematic analysis. Four dominant themes and two sub themes emerged from the data: (1) 'great expectations'; (2) 'negotiations around role boundaries' with subthemes; 'insider/outsider my role as a researcher and known neonatal nurse' and; 'role boundaries-nurse, parent and allied health'; (3) 'progressing the agenda' and (4) 'ongoing challenges for nurse led initiatives'. Below, are my critical reflections as a researcher on the research AI process and the progress of the FCC working party.

Great Expectations

Participants reported a need to explore FCC in the NICU during the discovery phase of this study. Participants appeared to be enthusiastic and willing to bring about change. During the workshop held on 22 April 2010, participants agreed that a working party should be formed. Participants felt the FCC working party should meet monthly to develop and initiate ideas raised during the workshop. Following the workshop, the group appeared to be on a 'high', positive, motivated and keen to contribute to bringing about change to enhance FCC in the NICU.

While I was enthusiastic about the topic area, it was great to see that parents and nurses also shared the same level of enthusiasm. They appeared excited and wanting to make a difference for neonates and their families. (Researcher's Field Notes 13)

Many staff reported the positive experience of the workshop. Hearing each other's stories appeared to be an enlightening experience for both nurses and parents. As a researcher, I was unsure of what to expect or what the outcomes would be when bringing parents and nurses together to share their experiences and work together in a workshop environment. I did not expect the open, honest and constructive dialogue that occurred between the nurses and parents.

I was somewhat surprised today at the honesty of responses nurses provided parents and just how openly parents responded to what the nurses were saying. I was mortified today when one nurse said to a parent 'we don't really think about the impact on families...it's just a job for us' and I thought how can a nurse say such a thing directly to a parent. However, the parent responded with 'I know what you mean, it's like when I go to work...' and the conversation continued in a positively tone and a constructive manner (Researcher's Field Notes 13).

The AI process appeared to provide a positive, narrative, rich environment where nurses were able to hear the emotions of parents first hand, away from the busy clinical environment in a situation that focused on dialog surrounding parents' feelings, strengths and ideas. Comments such as 'this is great', 'I'm so happy I'm a part of this' and 'let's keep the momentum going' filled the room. Parents also had the opportunity to hear the different challenges nurses' faced in their role that were reported as 'not obvious' to the parents while their infant was in the clinical environment.

The level of enthusiasm from people who were in the workshop today surprised me. Parents made comments such as '...is that why you do that', 'now I get it' and 'that's really helpful information and we can share this information with other parents' (Researcher's Field Notes 13).

Parents and nurses wanted to be part of the FCC working group and were enthusiastic and keen to set a date for the first meeting. Once the first meeting was set, participants were keen to meet on a monthly basis initially to generate ideas and create a list of activities to address. Topic areas were prioritised in order of importance and level of achievability (see appendix 10). Meetings were later changed to fortnightly to allow for more time for strategies to be developed and then presented at the FCC meetings. A total of 19 meetings were held (please see appendix 10). Participants agreed that achieving smaller, less complex, activities first could lead to the initiating of more complex tasks. Participants believed that completing some smaller tasks initially would give them a sense of achievement and drive to tackle the more complex tasks.

Participants did report feeling however, that both smaller and larger tasks were all achievable.

At the end of the workshop today, there was a level of excitement surrounding participants. Ideas are being generated and participants want to help out. (Researcher's Field Notes 15)

Participants appeared keen and freely volunteered to help and take on additional tasks. Follow up actions were put in place and time lines originally set were being met. Information was being relayed to the neonatal clinical staff in a timely manner.

Negotiations around role boundaries

I commenced the monthly FCC meetings by organising and booking the venue, developing and sending out meeting invitations (to staff and parents) and developing agenda items. I discussed with the group the idea of sharing the role of chair for the working party amongst them. I advised the group that I did not want to chair the meetings. However, in the spirit of collaboration, I was happy to start the meetings if that was what they wanted.

Initially, I chaired the FCC meetings as requested by the working party. As time progressed it became evident, that staff did not want me to relinquish my role as the chair person. It seemed they preferred it that way. It appeared to me that delaying tactics were repeatedly used by participants to avoid appointing a new chair-person for the FCC monthly meetings.

Despite emphasising at the meeting today the importance of sharing the role of the chair, the group remained reluctant to change the chair and again put off nominating a new chair. Statements such as 'you are doing a good job of it', 'just do a few more meetings', and 'could you just chair another meeting' were repeated. I feel as though the working party, are putting off this responsibility but still want the group to continue to make progress. I wonder if they lack the confidence and the skills to take on such a role. Time constraints and lack of resources available appeared to be a main concern for not taking on the role. (Researcher's Field Notes 29)

Inside/outsider, my role as a researcher and known neonatal nurse

Throughout the study, I also found there was a blurring of my role as the researcher as it appeared there were expectations from participants that I continue to guide, lead and

implement FCC changes. It appeared as though they were looking to me for strategies and answers to the challenges they faced in the clinical environment. The nurses continued to treat me as though I was still an employee of the neonatal unit and it appeared as though I had a greater say or ability to implement change. This made it difficult for me as I felt as though I couldn't help the staff as much as I wanted to and I felt that I was letting the staff down.

Having previously worked in the neonatal unit did, however, have some benefits. As relationships were already established, staff could open up to me and knew that I was aware of the neonatal unit dynamics, terminology and ward processes. When references were made about professional roles, equipment used in the neonatal unit and neonatal specific terminology, participants were not required to spend extensive amounts of time explaining the meanings to me. Rather, it gave me as a researcher more time to explore the concepts identified in more depth.

Having worked as a clinician, I was aware of the many challenges nurses face on a daily basis when working with neonates and their families. I had experienced first-hand what it's like to work in a very busy tertiary neonatal unit which employed many novice nurses in an often understaffed environment. Having performed in a leadership/governance role as acting Nurse Manager, I was aware of the challenges and constraints managers faced on a daily basis including the time, costs and labour associated with employing, training and retaining nursing staff.

While there were benefits of having pre-existing relationships and experiences with staff and parents in the neonatal unit, as a researcher, there were also challenges associated with this. I had to be fully aware and conscious at all times of any personal bias I had. For example, I had to ensure my personal perceptions of FCC and ward practices were not colouring what the data were saying. Other challenges I encountered were staff treating me as though I was still an employee of the neonatal unit. At times it seemed as though staff expected me to implement changes and had perceptions that I had some control over processes in the unit.

I'm typing up the meetings minutes, writing in the staff communication book and trouble-shooting how to load the parent information slides onto the NICU screens. These tasks should be performed by NICU staff and not me as a researcher. I reminded the staff that I am no longer employed by the health service as a neonatal nurse rather I am performing the role of a researcher. I delegated these responsibilities back to the staff. (Researcher's Field Notes 35)

When a nurse finally accepted to take on the FCC chair role FCC, she initially required substantial support and encouragement. This had become an extra task for this staff member, which was a greater responsibility and increased workload to the nurse's already busy schedule.

I am helping the new chair-person settle into the FCC working party role. I am guiding her for the first few meetings to ensure the meetings are organised and productive. (Researcher's Field Notes 33)

Role boundaries- nurse, parents and allied health staff

During the destiny phase of the study it became evident that there were tensions between nurses and allied health staff in relation to their role in facilitating FCC. The physiotherapists, occupational therapist and the ward social worker were invited to attend the FCC working party on several occasions by the research team and the ward manager. The invitations were initially declined and they did not attend the FCC meetings. However, there was a shift from non-involvement to involvement when the physiotherapist and social worker came to a scheduled FCC meeting asking if they could join the meeting. The physiotherapist and social worker said they decided to come to the meeting due to the ongoing 'talk' and 'hype' in the nursery about the FCC working party and the fact the group had not disintegrated within the first few months (like many other meetings held within this particular unit). My initial impression when the physiotherapist and social worker attended the FCC meeting was a 'scoping out' session, trying to find out 'What the meeting was all about?', 'Who was there?' and 'Why it was still meeting?'

Today the physiotherapist and social worker came to the meeting together. My immediate impression was that they came to seek information but with no real plan to join the meeting. The social worker said 'We've heard so much about this meeting, so we thought we should come and see what this is all about. What's its purpose? And why do we really need it when we already have a DC group?' (Researcher's Field Notes 26)

On reflection, I felt quite agitated about their attitude towards the working party. To me, it felt as though both the physiotherapist and social worker were 'protecting their roles' and their purpose within the neonatal unit. It appeared the physiotherapist was trying to hold onto and guard their roles and positions in the neonatal unit, particularly the work they were engaged in surrounding the concept of DC.

Today the physiotherapist emphasised how much time and effort she and her team have dedicated to DC in the neonatal unit, stating the physiotherapists were the only staff in the unit properly trained to implement DC. The physiotherapist spoke of the importance of DC and was unsure why we needed a FCC working party when they already had physiotherapists implementing DC (Researcher's Field Notes 26)

It seemed as though there was an ownership by the physiotherapists regarding DC practice in this particular neonatal unit. It appeared that DC was a stand-alone concept rather than being sub-sued in FCC. While the physiotherapists spoke of DC and working with families, it appeared that staff did not embrace a holistic collaborative approach. The social worker also appeared to be 'protecting her role' from the parent support group. It appeared the social worker felt that parents could not support other NICU parents as effectively as a social worker as they were 'not properly trained' or 'qualified' in offering counselling and support services.

I thought today, the social worker appeared defensive, arms crossed and very direct with responses. Initially she used single word responses such as 'yes' or 'no', followed by statements defending her role and qualifications, 'I have received proper training to work with these families. I've seen it all. I know how to help these families. These families need the support of a professional. That's what we are trained for, and that's why we are here' (Researcher's Field Notes 26)

As the FCC group meetings progressed, the physiotherapist and social worker realised the purpose of the FCC was to work collaboratively with allied health care workers and parents. The physiotherapist and social worker understood the FCC working party was not a threat to their role rather the FCC group supported their role and valued and respected their expertise and contributions to care for neonates and their family. The tone of the conversations changed and dialogue became less defensive and more constructive.

I recognised that the physiotherapist and the social worker were apprehensive about the purpose of the FCC working party. I made time today to discuss any concerns they have and to reassure them that the FCC working party are not here to 'tread on any ones toes' and want to work together to ultimately improve the care for neonates and their family. I asked if we could incorporate work already created by the physiotherapist team. I suggested physiotherapists continue to work on the DC aspects and feed the information to the working party.

The social worker expressed concern regarding increased workload due to a rise in neonatal admissions and more complex family needs. Parents offered ways in which they could support the social worker. Ideas were raised and strategies discussed. The social worker highlighted the potential benefits of being part of the FCC working party suggesting the parent support group could help lessen some of her heavy workload (Researcher's Field Notes 38).

Over time, the physiotherapist and social worker were more accepting of the FCC working group, and willing to share their expertise and resources. Information provided by the physiotherapist and social worker was included in FCC strategies implemented in the neonatal unit for example, DC information on the parent information LCD slides. The physiotherapist also realised that the FCC working party could relay DC information to the nursing team which they found challenging in the past. The physiotherapists reported feeling 'included' and 'valued' in the FCC working party.

While participants reported a greater understanding of each other's roles, expectations and needs within the current health system design, they also struggled to work within the current health system due to limited resources and lack of time. Although nurses reported feeling empowered as part of the AI process, it became evident that nurses often struggled to attend meetings or implement strategies as efficiently or effectively due to time constraints and other ongoing work commitments. This resulted in delays in progressing agenda items and implementing strategies in a timely manner.

While many staff members reported practicing FCC, the majority of staff had only implemented some components of FCC independently, overlooking the importance of implementing all aspects of FCC. It also became evident that all the FCC principles were not being embedded in the overall role and care for the infant and their family.

Although staff reported their role and commitment to FCC in the neonatal unit, only one nurse interviewed reported being aware of the FCC principles set by the Institute of Family Centre Care (Researcher's Field Notes 32).

Staff embraced the AI process and was receptive to bringing about change. However, it became evident that a multi-level and multidisciplinary approach would be required to be effective. Over time, the working party received support from the neonatal unit management team, nurses, physiotherapist, social workers and parents.

Today the nurses and allied health worked together and shared information. There appeared to be a shift from protecting information to building resources together (Researcher's Field Notes 46).

The two newly appointed clinical nurse educators however, frequently struggled to attend the meetings. As an educator of the unit, I would have expected that this would be a priority for staff in the NICU and would be a part of their role. However, I attributed their lack of attendance to adjusting to their newly appointed role.

Parents took their role in the FCC working party seriously and appeared very dedicated to contribute and bring about change. There was a parent representative at every FCC working party meeting. Parents were keen and motivated to be part of the working party and provide assistance where possible

Parent representatives came prepared again today and followed up on strategies identified at the last FCC meeting. Sibling packs were developed as promised and follow up phone calls had been initiated (Researcher's Field Notes 31).

Parents reported feeling valued and considered an integral member of the FCC team. Parents were included and their ideas and suggestions were heard.

Parents reported feeling their role was important and they felt valued and respected. They were being heard and their ideas and strategies implemented (Researcher's Field Notes 37).

As the parents had been part of an independent parent support group. There appeared to be a dual role between representing the needs of NICU parents and one of governance role in being a consumer group representative.

Maybe the needs of a parent by the bedside of their baby in the NICU, is different to the governance needs of a consumer group representative. Introducing newly graduate NICU parents could contribute to current bedside experiences and provide some feedback on strategies implemented as a result of the FCC working party (Researcher's Field Notes 53).

The neonatologists in the unit were verbally supportive of the study. However, throughout the two year period only one out of the five neonatologists in this particular unit attended a FCC meeting. This same neonatologist was very supportive of the study, but did suggest it was a predominantly a nurse focused area. Another neonatologist dismissed this study as it was qualitative in design.

Progressing the agenda

The working party met for over 2 years and some strategies were developed such as parent information slides and the development of sibling packs. Strategies identified appeared to take a long time to progress.

I found that most of the work involved in the development of the parent information slides occurred during the FCC monthly meeting with little progress in between meetings (Researcher's Field Notes 42).

Some things that did help progress the agenda were scheduling monthly FCC meetings at least six months in advance and not allowing other activities to override or take place during our scheduled meeting times. Seeking timely feedback on strategies implemented would allow modifications to be made as required. Setting clear guidelines, goals and completion dates were helpful in not only identifying what needed to be done, but also highlighted to the group when completion dates were not being met and demonstrated how long tasks were taking to complete.

The FCC working party projected 4 months to complete the parent information slides. While the slides look great, have vital information and receive positive feedback from staff and parents, it has taken over a year to get the slides uploaded to the screens in between infant bed spaces. I was hoping the accompanying parent educational video would have been completed by now, but work on this hasn't even started. (Researcher's Field Notes 51).

Difficulties encountered were staff shortages that prevented staff from attending meetings on a regular basis due to clinical work commitments. A lack of designated work time to complete and implement tasks could have also hindered the progress of the group. It would have also been beneficial if clinical team leaders, clinical educators and the clinical consultant were present at meetings on a regular basis. This would have allowed for greater contribution and assist in staff and parents receiving consistent information. Greater contribution of all staff could have assisted in moving agenda items.

The clinical consultant and nurse educators infrequently attend the FCC meetings. Having all staff involved could assist in progressing agenda items (Researcher's Field Notes 44).

Parents appeared surprised at the barriers nurses faced on a daily basis and more specifically the time it took for strategies to be implemented in the NICU.

The parent representatives were shocked today at how simple strategies are difficult to implement in the hospital system. They were shocked at the processes and approval levels required to bring about simple changes. As time evolved so did the parents enthusiasm progressing agenda items (Researcher's Field Notes 47).

Balancing increased autonomy and responsibility was required for the FCC group to progress. What did stand out throughout the workshops and follow up process was that both nurses and parents continually strived to do what they thought was best for the infant and parents at all times in the current context.

Other challenges presented included keeping the nurses focused on an AI approach when they are predominantly trained in using a problem solving model. Nurses, in particular, would unconsciously begin to focus on problems. As a researcher and a nurse, I was also required to be conscious that I, too, would not revert to a problem solving approach and needed to redirect the focus back to an AI approach.

I found myself getting drawn into negative talk and problems within the unit today. I needed to redirect the focus back to an AI approach otherwise I felt this could become destructive to all the work achieved so far. The formal and informal contact between the FCC working party participants and me as the researcher was helpful in building relationships and gaining participants ongoing commitment not only to the research, but also being part of a process to bring about change. This collaboration between parents and nurses provided new insights, allowed for acting interdependently and appears to be creating a positive environment for learning (Researcher's Field Notes 53).

Ongoing challenges for nurse-led initiatives

I was invited as a guest speaker at a conference surrounding FCC. At this conference I presented the progress of this AI study. A visiting international Neonatologist presented findings from their study that also focused on including families in the care of their neonate whilst in the neonatal unit. This whole system approach to include families was led by Neonatologists and generated interest amongst Australian neonatologists. At one round table discussion, Australian neonatologist's agreed in principle to implement

this new approach in some Australian neonatal units. This included neonatologists from the unit where this study occurred.

I am amazed to see neonatologists (including the neonatologist from this study) showing a strong interest in FCC concepts when presented by a member of a medical team. It appears as though neonatologists are more receptive when the ideas came from a fellow medial officer rather than from nursing staff (Researcher's Field Notes 49).

The round table experience highlighted to me, as a researcher and a nurse, the ongoing challenges nurses face in attempting to implement change in the clinical environment. While this study incorporated an AI 'ground up' collaborative approach in a hierarchical health system, it became evident that the AI change process does require the support of key personnel to bring about change. For example, the manager did not dominate the FCC working party (in line with the AI 'ground up approach) however I believe it would have helped if she played a more active role in some aspects of the process. For example, I had to ask the manager if she would disseminate information from the FCC meetings to the general staff meetings.

Another barrier faced, was the difficulty experienced in recruiting new participants to the FCC working party. This is primarily because people did not have time to commit. The manager played a passive role and the parents who attended were not recent NICU parents rather graduated NICU parents. In order to achieve positive, whole system organisational change, the active support of all health professionals including the medical team is required. A positive aspect of using a ground up approach is that it provided a platform for health professionals to engage in positive conversations and develop partnerships and collaborations.

8.2. Conclusion

In this chapter, I presented my reflections on the study and AI process. In the following chapter I will discuss key findings in relation to extant literature and will highlight the significance of this study in contributing new knowledge surrounding FCC in the NICU. Implications for nursing practice, strengths and limitations of the study, directions for future research and concluding thoughts are presented.

Chapter 9:

Discussion

This study set out to explore FCC in the NICU. This is the first known study that has used an AI approach to bring neonatal nurses and parents together to collectively develop strategies to strengthen FCC in the neonatal unit. This chapter will discuss key findings of this qualitative study in relation to existing literature and highlight the significance of this study in contributing to new knowledge surrounding FCC and the AI process. Reflections on the research journey, the working party progress in implementing changes and lessons learned along the way will be discussed.

9.1. Synthesis of findings

The aim of this study was to use an AI process to bring neonatal nurses and parents together to examine their perceptions and experiences of FCC and to design innovative strategies to implement FCC principles and improve neonatal care. The researcher met with participants regularly over a two year period. During this time there were many high points where participants engaged and worked collaboratively to improve care for the neonate and the family.

Initially, the study explored neonatal nurses' and parents' perceptions and experiences of FCC. The discovery phase findings revealed four dominant themes 'Getting to know parents and their wishes', 'Involving family in the day to day care', 'Finding a happy medium' and 'transitioning across the continuum'. These findings indicated there was a shift from a traditional biomedical model of care excluding families to nurses reporting a professional responsibility to parents.

The discovery phase findings revealed nurses had a general understanding and valued FCC, however, only some FCC elements were being implemented, and often it was delivered in a sporadic or ad-hoc manner. The discovery phase findings provided valuable information regarding the development and skills training required by nurses when working with families. For example, the need to develop effective formal and informal communication skills, performing family needs assessment, learning negotiation skills, developing conflict resolution strategies, and offering support to parents (shifting from a 'doing' to a 'guiding' role). Tensions remained for some nurses to relinquish control to parents, however, nurses reported feeling more empowered to

include parents when they could identify and understand the positive effects of working collaboratively with parents in the neonatal unit.

The dream and design phases consisted of one full day workshop that brought neonatal nurses and parents together (for the first time) to collectively explore FCC in the neonatal intensive care unit (NICU). This was a pivotal moment in the study where parents and nurses openly shared their experiences. The AI workshop used in this study provided opportunities and support for nurses' and parents' to engage in meaningful dialogue, share stories and started to build relationships that facilitated better understanding of parent and nurse perspectives and experiences.

The dream and design phases did however require a paradigm shift from a deficit approach to affirmative thinking. The findings of this study indicated that nurses were initially reserved in praising their own efforts and often started from a negative perspective. This changed throughout the AI process when nurses were encouraged to focus on what worked well when providing FCC. Nurses found it easier initially to praise other nurse efforts before their own. During the workshop parents and nurses developed shared insights about optimal FCC that could be built upon to support neonates and families. One overarching theme emerged 'sharing experiences and stories' that comprised four sub themes: 'discovering what works well'; 'dreaming of the ideal'; 'fixing things'; and, 'destiny, projections for the future'.

Sharing stories increased nurses' awareness of their impact on parents, resulting in greater efforts to bring about changes in clinical practice. For example, parents were involved in the design of strategies to improve FCC. Parents also found the workshop helpful as it not only provided an opportunity to express their feelings and experiences, but develop greater understanding of procedures and processes required and challenges faced by nurses.

The inclusive nature of the workshop created opportunities for nurses and parents to engage in networking, sharing information, facilitated collaborations and helped to build relationships. Parents' and nurses' indicated the workshop provided a real opportunity to develop a greater understanding of each other's experiences and how things could work in the neonatal unit. Open dialogue throughout the workshop motivated and encouraged participants to generate new ideas and begin to develop strategies. As reiterated by other studies (Reed, Pearson, Douglas, Swinburne, & Wilding, 2002; Richer, Ritchie, & Marchionni, 2009) organisational support was considered a key factor when initiating change. Adequate time, resources and multilevel interventions were required.

The destiny phase of the study reported on the progress and experiences of the FCC working party two years from when the working party was formed. Four dominant themes emerged 'creating a physical and mental space'; 'building and maintaining momentum'; 'ongoing organisational support'; and, 'continuing collaborations'. Initiatives such as creating parent information slides on screens in between bed spaces, development of sibling and memento packs were implemented. Finally, major challenges faced by the working party were described in Chapter 8 (researcher reflection). These included tensions with role boundaries between nurses, allied health and parents, time and financial constraints (inability to attend meetings or implement strategies) and the difficulties faced for nurse led initiatives in health care. Analysis of my reflective field notes revealed the following themes 'great expectations'; 'negotiations around role boundaries'; insider/outsider-my role as a researcher and known neonatal nurse'; 'professionals and role boundaries-nurses, parents and allied health'; 'progressing the agenda'; and 'ongoing challenges for nurse led initiatives'.

The ability to bring about organisational change is challenging, but considered crucial to the success of organisations, particularly in the current changing health system environments (Gesme & Wiseman, 2010). In this next part of the discussion key factors that facilitated or hindered change in the NICU are examined.

9.2. Using AI to promote organisational change in the NICU

Appreciative Inquiry is reported to be a powerful tool for facilitating change by engaging groups, crossing boundaries, and promoting a united approach to organisational change (Lavender & Chapple, 2004). A key strengths of AI, is the engaging, inclusive and collaborative nature of this approach. Using AI for this study created opportunities and support for neonatal nurses and parents to engage in networking, sharing of information and building effective relationships. Participants engaged in a meaningful process that acknowledged their experiences, knowledge and enthusiasm.

Many theoretical frameworks and approaches exist to guide and inform organisational practice change (Grol & Grimshaw, 2003). However, many argue that some approaches such as participatory approaches are more effective in bringing about change in a health care settings and assist in bringing evidence into practice (Brownson, Fielding & Maylahn, 2009). Healthcare is both a practical discipline and a social phenomenon that refers to individuals and group interactions, behaviour and interrelationships; therefore participatory approaches such as action research and AI

are considered appropriate strategies when implementing change (McKeown, Fortune & Dupuis, 2015).

This study used AI to bring about change as AI adopts a grassroots approach that is deemed to be emergent and generative rather than programmed and directed. Based within a socio-rational realm, health professionals are viewed as rational individuals and will most likely adapt to change if they believe in the research or where proposed change is based on sound evidence or research (Greenhalgh, 2015; Cooperrider & Srivastva, 1987). It is suggested that change doesn't require key leaders directing or driving change rather it focuses on the questions asked and the voluntary efforts of individuals/ teams to bring about positive change.

AI appeared to be a good fit for this study due to the inclusive collaborative nature of the AI process. In addition, traditional top down approaches to change without concomitant bottom up approaches have proven ineffective in bringing about change in health care (Manley, McCormack & Wilson, 2008). Thompson, Bilson & Dykes (2012) suggests a 'heart and minds' (p.258) approach to change which embodies both emotional and rational engagement of staff on all levels may assist in moving from traditional top down approaches to drive change in health care.

Based on Roger's (as cited by Cameron & Green, 2015) seminal work on the stages of change and Prochaska and Di Clemente (1984) transtheoretical model, individuals and organisations can occupy a range of positions from pre-contemplation (where there is no recognition for the need for change) to contemplation (acknowledging there is a problem but not sure or not ready to make a change) to preparation/determination (getting ready to change), action/will power (changing behaviour), maintenance (maintaining the behaviour change) and relapse returning to old behaviours and abandoning new changes). Participants in this study initially appeared to be in the contemplation phase where they realised there was a need for change. It became evident that while some FCC strategies had been implemented to include families prior to the commencement of this study, staff wanted a more consistent approach to implementing FCC practices rather than the ad-hoc approach that was being used. Parents in the study by Finlayson, Dixon, Smith, Dykes & Flacking (2014) exploring parents' experiences of NICU and FCC, reported staff inconsistencies as one of the most upsetting aspects of care they received.

The AI process appeared to shift participants from the contemplation phase into a preparation/determination phase when the initial study was introduced and the AI approach was proposed. Enthusiasm to be involved in the study and to bring about

change increased. While health care professionals claimed they were implementing FCC, discovery phase findings (see Chapter 5) indicated that not all participants had a good understanding of FCC principles or tended to apply some of the principles and only in some cases. Similarly, Peterson, Cohen & Parsons (2004) found nurses identified elements of FCC as important but many nurses did not apply FCC elements consistently in daily practice. Gooding, Cooper, Blaine, Franck, Howse, & Berns, (2011) found inconsistencies exist both within and amongst neonatal units. Reis et al., (2010), suggests nursing care that is provided in a manner that optimises consistency and continuity of care may assist in developing parent nurse relationships.

During the discovery phase of this study it was established that the neonatal unit did not have a FCC policy or FCC vision for the unit. Participants reported that it was important to develop a FCC vision and policy for the neonatal unit. The discovery phase, focus group interviews, generated many stories about positive aspects when delivering or receiving FCC in the neonatal unit. Others have found positive participatory approaches such as AI useful in sharing stories and engaging groups. For example, Lavender and Chappel (2007) reported using AI as opposed to a problem orientated approach to share stories as it prevented nurses feeling vulnerable and was believed to create an upward rather than downward spiral. Carter, (2006) reported discovering 'a rich untapped mine of success stories' (p.58), and purports most stories about what works well in organisations are often untold as organisations do not have mechanisms to share success.

Early discussions and sharing individual stories in this study, created interest and enthusiasm in the AI process and started to change the discourse in the setting shifting from difficulties when delivering FCC to strategies or approaches that were effective when working with families. This proved consistent with AI theory (Bushe, 2011) where stories were described as powerful and impactful in capturing participant's attention and generated positive dialogue. Ruhe et al., (2009) reported in their study exploring primary care practices, participants developed greater understanding of themselves as individuals and their group to enable practice change. Similarly, Wilson, McCormack & Ives (2005), suggest understanding individual values and beliefs are important in understanding the workplace culture in a special care nursery.

The synergistic process of the discovery phase and the workshop was a highpoint in the study, reflecting the learning experience for participants that later led to some changes in the neonatal unit. For example, staff shifted from a focus on problems to acknowledging the positive aspects and strategies used when delivering FCC.

Participants in the workshop demonstrated a shift in their language from problems to identifying what they did well when caring for infants and their families. The dream and design phases that occurred during the one-day workshop also led to the development of provocative propositions (eg. consultation and collaboration between parents and health professionals) and quality detailed statements (eg. nurses have an important role in supporting parents) that were also a good source to guide the working party. During the workshop, parent and nurse participants decided to create a FCC vision (see appendix 10) and form a FCC working party to meet monthly. The FCC vision was widely displayed throughout the unit for staff and participants to see. The main purpose of the FCC working party was to develop partnerships between health professionals and parents and to collectively implement strategies to bring about change and improve FCC in the neonatal unit.

Participants showed initial enthusiasm and commitment to bringing about change, identifying innovations and implementing and modifying strategies suggesting participants entered the maintenance phase (Rogers, 2004). While a core group of nurses within the neonatal unit were keen to bring about change, it was difficult to recruit more nurses into the FCC working party (see researcher's critical reflections on experience of the FCC working group). Commitments to action and implementation proved challenging and faded with time suggesting the participants may have entered the relapse phase during the study.

Nurses struggled to attend FCC meetings as they were often inundated with clinical tasks and commitments. The same participants would attend meetings and recruiting new participants proved difficult. Structural barriers such as staffing and limited practical support from NICU leaders both medical and nursing for change were identified. Participants attending often took a long time to implement or progress strategies to achieve desired goals. This is demonstrated in the minutes and my field notes where the same topics were repeatedly discussed over many meetings with little action or progress (see appendix 10). Lazic (2011) who used AI to implement a nurse education program in a paediatric centre reported that not all their dreams were achieved when participants realised the work, effort and time required to bring about change. It became evident that, while AI respects the autonomy of individuals to adopt change, participants needed to be ready to learn and be prepared to bring about change. In addition, organisations need to put mechanisms in place to transfer individual learning into a learning organisation.

Learning Organisations

Most organisations tend to focus on problems within their settings (Cooperrider, 1990). In addition, most research approaches (including action-research), no matter whether using a qualitative or quantitative perspective, start from the position of identifying a problem that needs to be addressed. Participants in this study were required to shift their thinking from a negative, deficit, pessimistic, problem oriented approach and change to one that is creative, supportive, optimistic and focused on what works well within the organisation. This paradigm shift required neonatal nurses and parents to think in a new way and through a new lens rather than the reactive or adaptive approaches often used.

It is suggested acknowledging existing effective practice provides a platform for envisioning and developing improved health care practice (Carter, 2006). It became evident from the discovery phase findings that the neonatal unit needed to create contexts in which nurses and parents can continually learn (eg. about each other's roles, needs and expectations), question practices and models of care, engage in meaningful dialogue, and create visions that encourage action. To create this dynamic context, individuals (nurses/parents/allied health staff and middle managers) need to be supported by a learning organisation. This broader organisational context in this study impacted on the leadership displayed by managers, the type of network structures and professional relationships that existed and the capacity of health staff to collaborate with parents/consumers.

Leadership

For several decades, change management leaders have argued that change will only occur if participatory approaches are used to encourage the involvement of individuals in all levels of the change process (Wallerstein, & Duran, 2006). This is in contrast to the traditional top down, power-coercive, authoritarian approaches often used to bring about change in many organisations despite their reported ineffectiveness (Bengoa, 2013). Some suggest a blending of both bottom up and top down approaches to bring about change (Bengoa, 2013) while others suggest four levels of change management including individuals, teams or groups, the organisation and larger systems in which the organisation are embedded (Cummings & Worley, 2015).

The nurse unit manager in this study facilitated nurses to embrace a ground up approach to implementing FCC, however, it became evident that key agents or leaders

were central to change processes and change would only occur when leaders showed commitment to the change. The nurse unit manager supported the FCC meetings and encouraged staff to participate in implementing strategies to bring about change. However, despite the ground up approach promoted in AI, it became evident in this study that there needed to be a clear leader who was able to drive the AI process. This process required the nurse leader to invest the time and energy to facilitate organisational change, encourage creativity and maintain the positive energy required to create new directions in neonatal care. Nurses, both in the working group and outside of it also needed to motivate themselves to take action and create opportunities to bring about change. The difficulties in being able to relinquish my role as the chair of the FCC working party meetings indicated nurses required training, skills, time, will, energy, confidence and support to drive change.

AI theory suggests organisations are social constructs and can be limited by human imagination, focusing on problems or shared beliefs of an organisation (Bushe, 2011). It can be argued that nurse managers are at the centre of the knowledge management process as they are the core of the vertical and horizontal flow of information within the organisation. Neonatal nurse managers must recognise the important role they play in creating space, time and resources to develop and implement new ideas and innovations. Consistent with Richer, Ritchie and Marchioni (2009), this study reiterates that organisational support is a key factor in creating changes in the work environment, and highlights that multilevel interventions are needed.

Network structures and professional relationships

Network structure is considered important in the adoption of innovations and is strongly influenced by social networks. Traditionally, doctors work in informal, horizontal networks and nurses work in more formal vertical structures. Vertical networks are used for cascading of information and passing on authoritative decision whereas, horizontal networks have been reported as more effective in spreading peer influence and supporting the construction and reframing of meanings (Greenhalgh, 2015).

Participatory approaches such as AI are motivated by pragmatism and concerns of equity. To be successful, however, participatory approaches such as AI and action research require individuals to recognise the need for change within organisations, be actively involved in all levels of the change process and be prepared to develop the skills and education required to initiate change. In addition, individuals are required to

actively participate in research, project design and policy development. The findings of this study support the views of Richer, Ritchie & Marchioni (2009) and Staniszewska, Brett, Redshaw, Hamilton, Newburn, Jones & Taylor, (2012), regarding the importance of developing social networks and the need for interdisciplinary collaborations. The successful implementation of FCC requires ongoing organisational commitment and support (Staniszewska et al., 2012), and organisations providing equal attention to both multi-level structures and larger systems perspectives (Richer, Ritchie & Marchioni, 2009). For example, providing nurses with resources and the time required to initiate change and foster multidisciplinary support across services.

Developing professional networks and relationships is important for advancing neonatal care. Dialogue is reported to have enormous potential for transformation and generative dialogue is reported to enable coordination that leads to organisational growth (Gergen, Gergen & Barrett, 2004). In line with Cooperriders (1990) positive principle, this study focused on positive feelings to allow for building and sustaining momentum for change. Research shows individuals that focus on the positive are more flexible, integrative, creative, and are more efficient thinkers (Isen, 2000). Another study showed positive dialogue is related to building quality relationships, cohesion, improved decision making and greater success of overall social systems (Fredrickson & Losada, 2005). Creating a space for participants in this study, offered a place for dialogue to occur and to allow the development and sharing of common goals while also providing a platform required for change or innovations to emerge (Richer, Ritchie & Marchioni, 2009).

However, power differentials were evident amongst nurses, where nursing staff in a position of power or those who had more flexibility in their working day were able to attend the FCC meetings yet, nurses directly involved with patient care often struggled to attend meetings due to heavy workloads. Physiotherapists appeared to take ownership of DC practices in the neonatal unit while the social worker appeared to be protecting her role from the parent/consumers. Neonatologists in this unit declined participation in this study however agreed to participate in a neonatologist lead study on family integrated care (FIC). It appeared that medical professionals continue to have greater influence in driving change in health care. The medical staffs' interest in participating in the new study may have been influenced by the persuasive power of an international leading neonatologist but it is also possible that this AI study had also raised the awareness and interest of medical staff in FCC even though they did not participate in this study.

Collaborations with parent consumers

One of the core concepts of FCC is the need to develop effective relationships with parents. Partnership can occur on two different dimensions. For example, partnerships between the NICU staff and consumer groups such as parents in the AI working party in this study, and partnerships developed between nurses and parents during the infants stay in hospital. Involving parents and consumer groups in health care and policy development has been viewed as a democratic or ethical requirement (Nilsen, Myrhaugh, Johansen, Oliver & Oxman, 2007; Staniszewska et al., 2012). Parents recruited into this study were graduate NICU parents who were part of an independent parent support group. The collaborative approach to include these parents was effective in addressing some of their expectations and needs. It was hoped that these relationships would contribute to collaborative decision making and higher quality clinical care for infants and their family.

Parent participants in this study were dedicated, motivated and willing to share their stories and assist to bring about change. They expressed a desire for partnerships and joint decision making regarding neonatal care and policies and practices. A number of the strategies suggested were designed to achieve this goal. Participants in the study wanted nurses and parents in the NICU to work collaboratively but this they believed required clearly defined parent and nurse roles and this was not achieved by the working group.

Research is indicating increased emphasis is being placed on parents assuming greater responsibilities in their infants' care. Other approaches such as family integrated care advocate care that is led by parents, suggesting parents are experts in the care of their child, while a health professional role is that of a consultant (Jiang et al., 2014). Coyne and Cowley (2007) claim however, the 'pendulum of parent participation' in paediatric services in Britain has swung from excluding parents to making parents completely responsible for the care of their child whilst in hospital (p.893). Other studies report the expectations placed on parents in the early stages of admission is too high, and some parents are showing resentment at being asked to perform nursing duties when it is not driven from a philosophical choice, rather as a result of staff shortages (Coyne & Cowley, 2007; Shields, 2010; Zhou, Shields, Watts, Taylor, Munns & Ngune, 2012).

Nurses in this study recognised the importance of the role of families in the NICU and wanted care to be more inclusive and family focused. However, nurses also reported

that sharing care with parents through a partnership in the clinical environment is different to working with parent consumer groups due to the power imbalances that exist between neonatal nurses and parents when their infant is receiving neonatal intensive care. Nurses questioned whether the notion of partnership and collaboration with parents in the NICU is possible. Coyne and Cowley (2007), also challenged the notion of partnership, suggesting parents could never truly be equal partners in care as control of boundaries ultimately lie with the nurse.

Nature of FCC as an innovation

There is no doubt that FCC is a complex intervention or system of care. Health professionals and system leader's continue to develop theoretical approaches and conceptual frameworks to guide models of care and gain greater understanding of successful implementation of strategies. Optimism exists surrounding the theoretical basis of models of care and how these can reduce the practice theory gap. However, change theorists such as Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou (2004) suggest complex interventions or innovation frameworks such as FCC can be difficult to implement because often there is limited support, details or instructions on how to implement principles in different health care settings. Greenhalgh et al., (2004) also suggests implementation of models of care such as FCC is influenced by factors such as social networks, organisational characteristics and complex adoption processes.

Drawing on the work of Rogers (2004) and a systematic review conducted by Greenhalgh et al., (2004) key characteristics influencing the adoption of innovation are relative advantage; compatibility; trialability; observability; complexity; task issues; reinvention; fuzzy boundaries; risk; knowledge required to use it; and augmentation/support These characteristics and related challenges were evident in the findings of his study.

Relative advantage and compatibility

Greenhalgh et al., (2004) suggests innovations that have clear advantages in effectiveness including cost effectiveness are more easily adopted. Participants in this study considered it important to include families in the care of their infant and valued the philosophy of FCC. The reported benefits of implementing FCC include improved health outcomes for the infant and family and more empowered, competent and knowledgeable parents (Cooper, Gooding, Gallagher, Sternesky, Ledsky, & Berns,

2007). There appeared to be no doubt that nurses in this study needed to work with families and that parents wanted to be included in the care of their infants.

Innovations that are compatible with individual and group values, norms and needs are reported to be readily adopted (Greenhalgh et al., 2004). Innovations to include families in the care of their infant, is generally compatible with professional and social norms within Australian neonatal units and viewed as a democratic and ethical requirement (Nilsen, Myrhaugh, Johansen, Oliver & Oxman, 2007; Staniszewska et al., 2012).

Trialability and observability

The ability to try innovations for a limited time first is reported to assist in implementing innovations (Greenhalgh et al., 2004). FCC however, is difficult to try in its entirety as demonstrated by a systematic review conducted by Shields, Pratt, Davis, & Hunter (2007) indicating a lack of studies that met their inclusion criteria regarding the effectiveness of FCC. A consensus remains about the importance of FCC and the relative advantages when implementing FCC principles despite the reported difficulties of implementing FCC in clinical practice.

Participants in this study had implemented some FCC strategies previously and were keen to implement new innovative strategies. Using an AI approach in the discovery phase of this study allowed participants to develop an insight into the type of relationship possible with parents was demonstrated at the workshop. Positive participatory approaches have been reported as an effective method in bringing about change in health care (Carter, 2006). Greenhalgh et al., (2004) suggests innovations are more easily adopted if benefits can be seen. The reported benefits when working successfully with families included improved outcomes for the neonate and the family, increased breast feeding rates and reduced length of hospital stay along with strengthening consumer engagement (Gooding et al., 2011; Holditch-Davis et al., 2003). Participants wanted to initiate innovations that were visible in the clinical environment. For example, parent information displayed on LCD screens in the neonatal unit in between bed spaces.

Complexity and task issues

Greenhalgh et al., (2004) suggests innovations that appear simpler to implement are more readily adopted. FCC is a complex model of care primarily designed for paediatric hospitalised children and later adopted into neonatal care (Shields, Pratt, & Hunter, 2007). Minimal instructions exist on how to best implement FCC principles into

neonatal care. However participants in this study, felt they were receiving or delivering some FCC. Participants in this study saw the value of providing consistent information for parents and staff and felt that developing resources for parents and staff will result in less repetition and information dissemination in a consistent manner.

Participants wanted to implement strategies that were simpler and less complex first (for example parent information LCD slides) and the more complex tasks were to be addressed at a later stage (for example organising multidisciplinary staff and parent training sessions). According to Greenhalgh et al., (2004) if the innovation is relevant to the user task or makes the job easier, innovations are more readily implemented.

Reinvention and fuzzy boundaries

Innovations that can be modified or refined to suit individual or organisational needs are reportedly more easily adopted (Greenhalgh et al., 2004). In addition, innovations that have hard core elements with soft peripheries that can be adapted are more likely to be implemented (Greenhalgh et al., 2004). FCC has clearly defined core principles, however many participants in this study only implemented some principles. FCC was designed for paediatric services therefore making it difficult to implement directly in a NICU environment.

Risk and knowledge required to use it

Greenhalgh et al., (2004) states the lower the risk level of the innovation, the more likely the innovation will be implemented. Despite findings from a Cochrane review conducted by Shields, Pratt, Davis & Hunter (2007) indicating a lack of high quality quantitative studies about the effects of FCC, no detrimental effects of implementing FCC have been identified. While this may be considered low risk, some nurses' feel giving control to parents is a high risk situation. In addition if FCC is not delivered effectively, the potential negative effects on parents may also be perceived as high risk. Participants in this study however lack the knowledge and time to implement FCC principles effectively. Ongoing education and increasing autonomy is often identified as key facilitators for initiating change, given its power to modify behaviours and practices (Cooperrider, 2000). Therefore knowledge is required to implement innovations especially if the innovation can be codified or is transferred to other contexts (Greenhalgh et al., 2004).

Augmentation/support

External support and training is considered a facilitator in adopting innovations (Greenhalgh et al., 2004). The findings of this study indicated that neonatal nurses and parents value the philosophy of FCC however sustainability of initiatives implemented requires organisational support, continuing education and ongoing collaborations. A major implication for management is the importance in offering support for idea and innovations to be implemented. AI provided a way of engaging nurses and parents in change efforts and provided a platform for individuals and organisations to learn.

New directions in NICU care

Many challenges have been reported in shifting the power and control over babies from nurses to parents. However, this study was a collaborative effort to make that change. Other researchers and service providers are also examining whether the design of the NICU can influence a change in relationships and power dynamics between nurses and parents (Flacking, Lehtonen, Thomson, Axelin, Ahlqvist, Moran, Ewald & Dykes, 2012). Parents and nurses in this study reported neonatal unit design and physical space were important factors for enhancing FCC. For example, participants identified the need for a welcoming environment that has nice decor, more bed space (for kangaroo care/equipment/visitors), and comfortable seating arrangements (see Chapter 6).

Flacking, Lehtonen, Thomson, Axelin, Ahlqvist, Moran, Ewald & Dykes, (2012) highlight the importance of spatial physical closeness and emotional closeness between the infant and parent in the long term physical, emotional and social well-being of both infants and parents. There is a growing trend shifting from open plan designs to single or dual pod style rooms (Shahheidari & Homer, 2012). Participants in this study reported NICU designs need to be individualised and take into account infant, family and staff needs. Service managers need to take into considerations parent and health professional environmental needs and include parent and nurse representatives when designing or updating neonatal units.

9.3. Implications for nursing practice

NICU parents value and expect a partnership or relationship with health professionals. The findings of this study highlight that nurses and parents understand and value the philosophy of FCC; however, FCC is multifaceted and implementation of FCC is

proving challenging. In order for FCC to be effectively implemented, ongoing managerial and organisational support and commitment is required. Policies need to reflect a multidisciplinary team approach to FCC and have nurse and parent representatives in hospital committees or advisory forums. Staff and parent roles need to be clearly defined. Nurses required adequate resources, education and multidisciplinary and organisational support to provide FCC. Workloads and staff-to-patient ratio should reflect the increasing acuity level and time needed by staff when working with families and sick neonates. This study provides valuable information for staff development and skills training. Further, education is required for nurse skill development and socialisation into this type of role such as effective communication, developing relationships, family needs assessment, negotiating skills, support role development and strategies (shifting from a 'doing' to a 'guiding' role) along with the development of conflict resolution strategies. Health care systems need to provide an environment that caters for neonate, family and staffing needs.

AI has important implications for nurse leaders who are seeking to bring about change. The inclusive and collaborative nature of AI provides opportunities to initiate and guide change. A major implication is the importance of organisational support to maintain the momentum engendered by the AI process and to allow proposed ideas to develop and evolve. AI was a useful methodology for exploring FCC however this methodology is not limited to FCC and can be used to bring about positive change in other aspects of neonatal care. It is an important tool for staff motivation and may assist in ongoing reflective practice.

9.4. Strengths and limitations of the study

This study was conducted with nurses that were currently practicing in one neonatal unit in Australia, and parents of infants that were predominantly cared for in that particular unit, therefore the homogeneity of participants could be viewed as a limitation suggesting findings cannot be generalised. Although both mothers and fathers were invited to be part of the study, only mothers chose to participate. Therefore discussions about fathers were from maternal or nurse perception of fathers' needs. A further limitation was that neonatologists were not represented in the study. Tracking and measuring change beyond the life of the project was not possible but is necessary due to the subtle ongoing nature of changes. However, despite these limitations, participants that attended were enthusiastic, positive and committed to bringing about change for neonates and families. The collaborative, fair and inclusive nature of the AI approach was a strength of this study. The Participants were able to engage in a

meaningful process they understood and developed a commitment to. Information generated as a result of this study was used by the service where the study was undertaken to bring about change in practice. AI provided a positive way forward for nurses and parents who shifted from problems to solutions and offered a new way of practicing in health care and health research. AI also offers a creative and stimulating way of bringing about change in health care and research.

9.5. Directions for future research

Research seeks to develop a greater understanding of an issue or phenomenon and this study was successful in achieving what it set out to do. However, as with all research it mostly raises questions that require further inquiry. Given that FCC has been around for a very long time and remains difficult to implement, are new models or approaches to working with families required? Future studies need to include the influence of culture and ethnicity on the level of family centeredness along with the need to explore the changing dynamics of family structures. In addition cost analysis as well as time, staffing and ongoing parent/infant/family outcomes are required.

9.6. Concluding thoughts

This study set out to explore FCC in the NICU and used a relatively new and innovative approach to bring about change. Overall, this study achieved its aims. Throughout the life of this study, many interesting findings have emerged about the complexities of FCC as a model of care and AI as an approach to bringing about organisational change. While AI is not a panacea for all the problems in the health system, it does provide a way forward for, acknowledging good practice, organisational change and the reframing of research.

References

- Aagaard, H., & Hall, E.O. C. (2008). Mothers' experiences of having a preterm infant in the neonatal care unit: A meta-synthesis. *Journal of Pediatric Nursing, 23*(3), 26-36. doi:10.1016/j.pedn.2007.02.003
- Ainsworth, M.D.S., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, New Jersey: Lawrence Erlbaum Associates Inc.
- Als, H. (1986). A synactive model of neonatal behavioural organization: Part 1: Framework for the assessment and support of the neurobehavioural development of the premature infant and his parents in the environment of the neonatal intensive care unit. *Physical & Occupational Therapy in Pediatrics, 6*(3-4), 3-53. doi.org/10.1080/J006v06n03_02
- Als, H., Lawhon, G., Duffy, F.H., McAnulty, G.B., Gibes-Grossman, R., & Blickman, J.G. (1994). Individualized developmental care for the very low-birth-weight preterm infant: Medical and neurofunctional effects. *The Journal of American Medical Association, 272*(11), 853-858.
- Als, H., & McAnulty, G.B. (2011). The newborn individualized developmental care and assessment program (NIDCAP) with kangaroo mother care (KMC): Comprehensive care for preterm infants. *Current Women's Health Reviews, 7*(3), 288-301. doi:10.2174/157340411796355216
- Aucott, S., Donohue, P.K., Atkins, E., & Allen, M.C. (2002). Neurodevelopmental care in the NICU. *Mental Retardation and Developmental Disabilities Research Reviews, 8*(4), 298-308.
- Baker, J.P. (2010). The incubator and the medical discovery of the premature infant. *Journal of Perinatology, 20*(5), 321-328. doi.org/10.1038/sj.jp.7200377
- Bengoa, R. (2013). Transforming health care: An approach to system-wide implementation. *International Journal of Integrated Care, 13*(25), 1-4.
- Bidmead, C., & Cowley, S. (2005). A concept analysis of partnership with clients. *Community Practitioner, 78*(6), 203-208. Retrieved from <http://www.communitypractitioner.com/>
- Bowlby, J. (1969). *Attachment and loss*. London, United Kingdom: Hogarth Press.
- Bowlby, J. (1982). *Attachment and loss: Vol 1 attachment* (2nd ed). New York, USA: Basic Books.
- Bowlby, J. (1959). Separation anxiety. *International Journal of Psycho-analysis, XLI*, 1-25.
- Boukydis, Z. (2011). Parent-infant skin-to-skin contact: Parents views versus nurses views. *Acta Paediatrica, 100*(5), 638-640. doi: 10.1111/j.1651-2227.2011.02195.x

- Blower, K., & Morgan, E. (2000). Great expectations? Parental participation in care. *Journal of Child Health Care*, 4(2), 60-65. doi: 10.1177/13674935000400203
- Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi.org/10.1191/1478088706qp063oa
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: Sage Publications Inc.
- Brown, L.D., & Heermann, J.A. (1997). The effect of developmental care on preterm outcome. *Applied Nursing Research*, 10(4), 190-197.
- Brownson, R.C., Fielding, J.E., & Maylahn, C.M. (2009). Evidence-based public health: a fundamental concept for public health practice. *Annual Review of Public Health* 30, 175-201. doi 10.1146/annurev.publhealth.031308.100134
- Burr, V. (2015). *Social constructionism* (3rd ed.). Routledge, East Sussex, UK. Retrieved from <http://www.ebilib.com>
- Burloiu, A. (2015). Retinopathy of prematurity. *Journal of Pediatric Surgical Specialties* 9(2), 1-52. Retrieved from <http://www.jpss.eu/index.php/current-issue/item/268-retinopathy-of-prematurity>
- Bushe, G.R. (2011). *Appreciative inquiry: Theory and critique*. In Boje, D., Burnes, B. and Hassard, J. (eds.) *The Routledge Companion to Organizational Change* (pp. 87103). Oxford, UK: Routledge.
- Cameron, E. & Green, M. (2015). *Making sense of change management: A complete guide to the modes, tools and techniques of organisational change* (4th ed.). London, UK: Kogal Page.
- Carter, B. (2006) 'One expertise among many'-working appreciatively to make miracles instead of finding problems: Using appreciative inquiry to reframe research. *Journal of Research in Nursing*, 11(1), 48-63. doi: 10.1177/1744987106056488
- Carter, B.S., Carter, A., & Bennett, S. (2008). Families' views upon experiencing change in the neonatal intensive care unit environment: From the 'baby barn' to the private room. *Journal of Perinatology*, 28, 827-829. doi:10.1038/jp.2008.102
- Casey, A. (1988). Partnership with child and family. *Senior Nurse*, 8(4), 8-9.
- Conde-Agudelo, A., Belizan, J.M., & Diaz-Rossello, J. (2011). Kangaroo mother care to reduce morbidity and mortality in low birth weight infants. *The Cochrane Database of Systematic Reviews*, 16;(3): CD002771. doi:10.1002/14651858.CD002771.pub2.
- Cook, S.D.N., & Yanow, D. (2008). Culture and organizational learning. *Journal of Management Inquiry*, 2(4), 373-390. doi: 10.1177/105649269324010
- Cooper, L.G., Gooding, J.S., Gallagher, J., Sternesky, L., Ledsky, R., & Berns, S.D. (2007). Impact of a family-centred care initiative on NICU care, staff and families. *Journal of Perinatology*, 27,S32-S37. doi: 10.1038/sj.jp.7211840.

- Cooperrider, D. L. (1990). *Positive image, positive action: the affirmative basis of organizing*, in Srivastva, S. & Cooperrider, D.L. *Appreciative management and leadership*. San Fransisco, USA: Jossey-Bass Publishers.
- Cormack, D. (2000). *The research process in nursing* (4th ed.). Malden, Massachusetts.: Blackwell Science Ltd.
- Coyne, I.T. (1995). Partnership in care: Parents' views of participation in their hospitalized child's care. *Journal of Clinical Nursing* 4(2), 71-79. doi.org/10.1111/j.1365-2702.1995.tb00014.x
- Coyne, I., & Cowley, S. (2006). Using grounded theory to research parent participation. *Journal of Research in Nursing*, 11(6), 501-515. doi: 10.1177/1744987106065831
- Coyne, I., & Cowley, S. (2007). Challenging the philosophy of partnership with parents: A grounded theory study. *International Journal of Nursing Studies*, 44(6), 893-904. doi:10.1016/j.ijnurstu.2006.03.002
- Coyne, I., O'Neill, C., Murphy, M., Costello, T., & O'Shea, R. (2011). What does family-centred care mean to nurses and how do they think it could be enhanced in practice. *Journal of Advanced Nursing*, 67(12), 2561-2573. doi.org/10.1111/j.1365-2648.2011.05768.x
- Cummings, T.G., & Worley, C.G. (2015). *Organisational development & change* (10th ed.). Stamford, Connecticut: Cengage Learning.
- Curry, L.A., Nembhard, I.M., & Bradley, E.H. (2009). Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation*, 119, 1442-1452. doi:10.1161/CIRCULATIONAHA.107.742775
- Darbyshire, P. (1994). *Living with a sick child in hospital: The experiences of parents and nurses*. London, UK: Chapman & Hall.
- Darbyshire, P. (1995). Family-centered care within contemporary British paediatric nursing. *British Journal of Nursing*, 4(1), 31-33. Retrieved from <http://info.britishjournalofnursing.com/>
- Evans, T., Whittingham, K., Sanders, M., Colditz, P., & Boyd, R.N. (2014). Are parenting interventions effective in improving the relationship between mothers and their preterm infants? *Infant Behaviour and Development*, 37, 131-154. doi.org/10.1016/j.infbeh.2013.12.009
- Erlandsson, K., & Fagerberg, I. (2005). Mothers' lived experiences of co-care and part-care after birth, and their strong desire to be close to their baby. *Midwifery*, 21(2), 131-138. doi:10.1016/j.midw.2004.09.008
- Feeley, N., Zerkowitz, P., Cormier, C., Charbonneau, L., Lacroix, A., & Papageorgiou, A. (2011). Posttraumatic stress among mothers of very low birthweight infants at 6 months after discharge from the neonatal intensive care unit. *Applied Nursing Research*, 24(2), 114-117. doi:10.1016/j.apnr.2009.04.004
- Fegran, L., Fagermoen, M.S., & Helseth, S. (2008). Development of parent-nurse relationships in neonatal intensive care units: From closeness to detachment.

Journal of Advanced Nursing, 64(4), 363-371. doi.org/10.1111/j.1365-2648.2008.04777.x

Fenwick, J., Barclay, L., & Schmied, V. (2001). "Chatting": An important clinical tool in facilitating mothering in neonatal nurseries. *Journal of Advanced Nursing*, 33(5), 583-593. doi.org/10.1046/j.1365-2648.2001.01694.x

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigour using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80-92. doi: 10.1177/160940690600500107

Fradin, G. (2015). *Consumerism and value creation in American Healthcare*. Lulu. Retrieved from: https://books.google.com.au/books?id=46nGCQAAQBAJ&dq=consumerism+and+value+creation+in+healthcare&source=gbs_navlinks_s

Fredrickson, B.L. & Losada, M.F. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist*, 60(7), 678-686.

Frels, R.K. & Onwuegbuzie, A., (2012). Interviewing the interpretive researcher: An impressionist tale. *The Qualitative report*, 17(60), 1-27.

Gangi, S., Dente, D., Bacchio, E., Giampietro, S., Terrin, G., & De Curtis, M. (2013). Post-traumatic stress disorder in parents of premature birth neonates. *Procedia - Social and Behavioural Sciences*, 82, 882-885. doi:10.1016/j.sbspro.2013.06.365

Gergen, M.M., Gergen, K.J., & Barrett, F., (2004). Appreciative inquiry as dialogue; Generative and transformative. *Advances in Appreciative Inquiry*, 9, 3-27.

Gerrish, K., & Lathlean, J. (2015). *The research process in nursing* (7th ed.) West Sussex, UK: John Wiley & Sons.

Gesme, D., & Wiseman, M. (2010). How to implement change in practice. *Journal of Oncology Practice*, 6(5), 257-259. doi:10.1200/JOP.000089.

Goutaudier, N., Lopez, A., Sejourne, N., Denis, A., & Chabrol, H. (2011). Premature birth: Subjective and psychological experiences in the first weeks following child birth, a mixed methods study. *Journal of Reproductive and Infant Psychology*, 29(4), 364-373. doi:10.1080/02646838.2011.623227

Gooding, J.S., Cooper, L.G., Blaine, A.I., Franck, L.S., Howse, J.I., & Berns, S.D. (2011). Family support and family-centred care in the neonatal intensive care unit: Origins, advance, impact. *Seminars in Perinatology*, 35(1), 20-28. doi:10.1053/j.semperi.2010.10.004

Gregory J. (2008). Engaging consumers in discussion about Australian health policy: Key themes emerging from the AIHPS study. *Australian Institute of Health Policy Studies*, Melbourne, Australia. Retrieved from: <http://healthissuescentre.org.au/images/uploads/resources/Engaging-consumers-in-Australian-health-care-policy-decisions.pdf>

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organisations: Systematic review and

- recommendations. *The Milbank Quarterly*, 82(4), 581-629. Retrieved from <http://www.jstor.org/stable/4149085>
- Greenhalgh, T. (2015). Health literacy: Towards system level solutions. *British Medical Journal*, 350, h1026. doi: 10.1136/bmj.h1026
- Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients care. *Lancet* 362(9391), 1225-1230. doi:10.1016/S0140-6736(03)14546-1
- Hall, E. (2005). Being in an alien world: Danish parents' lived experiences when a new born or small child is critically ill. *Scandinavian Journal of Caring Sciences*, 19(3), 179-185. doi:10.1111/j.1471-6712.2005.00352.x
- Harrison, T.M. (2010). Family-centered pediatric nursing care: State of the science. *Journal of Pediatric Nursing*, 25(5), 335-343. doi:10.1016/j.pedn.2009.01.006
- Heermann, J. A., Wilson, M.E., & Wilhelm, P.A. (2005). Mothers in the NICU: Outsider to partner. *Paediatric Nursing*, 31(3), 176-181, 200. Retrieved from <http://www.pediatricnursing.net/>
- Hesse-Biber, S.N., & Leavy, P.L. (2007). *Feminist research practice: A primer*. Thousand Oaks, California: Sage Publications Inc.
- Holditch-Davis, D., Barlett, T.R., Blickman, A.L., & Miles, M.L. (2003). Posttraumatic stress symptoms in mothers of premature infants. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 32(2), 161-171. doi: 10.1177/0884217503252035
- Hook, M.L. (2006). Partnering with patients - a concept ready for action. *Journal of Advanced Nursing*, 56(2), 133-143. doi:10.1111/j.1365-2648.2006.03993.x
- Hutchfield, K. (1999). Family centred care: A concept analysis. *Journal of Advanced Nursing* 29(5), 1178-1187. doi.org/10.1046/j.1365-2648.1999.00987.x
- Hutchinson, B. (2015). Importance of establishing neonatal BFHI standards in neonatal unit. *Newborn and Infant Nursing Reviews*, 15(4), 167-168.
- Institute for Patient- and Family- Centred Care. (2012). *Developing patient- and family-centered vision, mission, and philosophy of care statements*. Retrieved from <http://www.ipfcc.org/resources/guidance/index.html>
- Isen, A.M. (2000). *Positive affect and decision-making*. In M. Lewis & J.M. Haviland-Jones (Ed.). *Handbook of Emotions*. New York, USA: Guildford Press.
- Jiang, S., Warre, R., Qui, X., O'Brien, K., & Lee, S.K. (2014). Parents as practitioners in preterm care. *Early Human Development*, 90(11), 781-785. doi:10.1016/j.earlhumdev.2014.08.019
- Jones, L., Woodhouse, D., & Rowe, J. (2007). Effective nurse parent communication: A study of parents' perceptions in the NICU environment. *Patient Education Counsel Journal* 69(1-3), 206-212.
- Klaus, M. H., & Kennell, J. H. (1976). *Maternal-infant bonding*. Saint Louis, USA: C.V. Mosby.

- Kleberg, A. Hellström-Westas, L. & Widström, A.M. (2007). Mothers' perception of Newborn Individualized Developmental Care and Assessment Program (NIDCAP) as compared to conventional care. *Early Human Development*, 83(6), 402-411.
- Kleberg, A. Westrup, B. & Stjernqvist, K. (2000). Developmental outcome, child behaviour and mother-child interaction at 3 years of age following Newborn Individualized Developmental Care and Intervention Program (NIDCAP) intervention. *Early Human Development*, 60(2), 123-135.
- Kuo, D.Z., Houtrow, J., Arango, P., Kuhlthau, K. A., Simmons, J.M., & Neff, J.M. (2012). Family-centred care: Current applications and future directions in pediatric health care. *Maternal and Child Health Journal*, 16(2), 297-305. doi: 10.1007/s10995-011-0751-7
- Lavender, T., & Chapple, J. (2004). An exploration of midwives' views of the current system of maternity care in England. *Midwifery* 20(4), 324-334. doi:10.1016/j.midw.2004.01.005
- Lazic J., Radenovi, M., Arnfield A., & Janic D. (2011). Implementation of a nurse education programme in paediatric oncology using appreciative inquiry: A single center experience in Belgrade, Serbia. *European Journal of Oncology Nursing*, 15(5), 524-527. doi:10.1016/j.ejon.2011.02.002
- Lee, P. (1999). Review: Partnership: What does it mean today? *Journal of Child Health Care*, 3(4), 28-32. doi: 10.1177/136749359900300406
- Li, Z., Zeki, R., Hilder, L., & Sullivan, E.A. (2013). Australia's mothers and babies 2011. Perinatal statistics series no. 28. Cat. No. PER 59. Canberra, Australia: AIHW National Perinatal Epidemiological and Statistics Unit. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545698>
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, California: Sage Publications Inc.
- Lopez, E., Gascoin, G., Flamant, C., Merhi, M., Tourneux, P., & Baud, O. (2013). Exogenous surfactant therapy in 2013: What is next? Who, when and how should we treat newborn infants in the future. *BioMed Central Pediatrics* 13, 165. doi: 10.1186/1471-2431-13-165
- Ludwig, S., Steichen, J., Khoury, J., & Krieg, P. (2008). Quality improvement analysis of developmental care in infants less than 1500 grams at birth. *Newborn and Infant Nursing Reviews*, 8(2), 94-100.
- Mance, M.J. (2008). Keeping infants warm: Challenges of hypothermia. *Advances in Neonatal Care*, 8(1), 6-12. doi: 10.1097/01.ANC.0000311011.33461.a5
- Manley, B.J., Doyle, L.W., Davies, M.W., & Davis, P.G. (2014). Fifty years in neonatology. *Journal of Paediatrics and Child Health*, 51(1), 118-121. doi:10.1111/jpc.12798
- Manley, K., McCormack, B., and Wilson, V. (2008). *International practice development in nursing and healthcare*. Oxford: Blackwell Publishing.

- Mc Anulty, G.B., Butler, S.C., Bernstein, J.H., Als, H., Duffy, F.H., & Zurakowski, D. (2010) Effects of the newborn individualized developmental care and assessment program (NIDCAP) at age 8 years: Preliminary data. *Clinical Pediatrics*, 49(3) 258-270. doi: 10.1177/0009922809335668
- McKeown, J.K.L., Fortune, D., & Dupuis, S.L. (2015). "It's like stepping into another world": Exploring the possibilities of using appreciative participatory action research to guide culture change work in community and long-term care. *Action Research*, 0(0)1-17. doi:10.1177/1476750315618763
- Meier, P.P., Engstrom, J.L., Patel, A.L., Jegier, B.J., & Bruns, N.E. (2010). Improving the use of human milk during and after the nicu stay. *Clinicals in Perinatology*. 37(1) 217-245. doi:10.1016/j.clp.2010.01.013
- National Health and Medical Research Council (2007). *National statement on ethical conduct in human research*. Canberra Australia. Retrieved from: http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e72.pdf
- Nilsen, E.S., Myrhaug, H.T., Johansen, M., Oliver, S., & Oxman, A.D. (2007). Methods of consumer involvement in developing health care policy and research, clinical practice guidelines and patient information material. *Cochrane database of systematic reviews*, 19(3), CD004563
- Obeidat, H.M., Bond, E.A., & Callister, L.C. (2009). The parental experience of having an infant in the newborn intensive care unit. *The Journal of Perinatal Education*, 18(3), 23-29. doi:10.1624/105812409X461199
- Petersen, M., Cohen, J., & Parsons, V. (2004). Family-centred care: Do we practice what we preach? *Journal of Obstetrics, Gynecology & Neonatal Nursing*, 33(4), 421-427. doi: 10.1177/0884217504266772
- Platt Report. (1959). The welfare of children in hospital. London: Ministry of Health, Central Health Services Council. *British medical journal* 17(1) (5115), 166-169.
- Polit, D. F., & Beck, C. T. (2012). *Nursing research: generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, USA: Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Prochaska, J.O., & Di Clemente, C.C. (1984). *The transtheoretical approach: Crossing traditional boundaries of change*. Homewood, Illinois: Dorsey Press.
- Redshaw, M.E., & Hamilton, K.E. (2010). Family centred care? Facilities, information and support for parents in UK neonatal units. *Archives of Disease in Childhood. Fetal and Neonatal Edition*, 95, F365-F368. doi:10.1136/adc.2009.163717.
- Reed, J., Pearson, P., Douglas, B., Swinburne, S., & Wilding, H. (2002). Going home from hospital: An appreciative inquiry study. *Health and Social in the Community*, 10(1), 36-45.
- Reis, M.D., Rempel, G.R., Scott, S.D., Brady-Fryer, B.A., & Van Aerde, J. (2010). Developing nurse/parent relationships in the NICU through negotiated partnership. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 39(6), 675-683. doi: 10.1111/j.1552-6909.2010.01189.x.
- Richer, M.C., Ritchie, J., & Marchionni, C. (2009). 'If we can't do more, let's do it differently!': Using appreciative inquiry to promote innovative ideas for better

healthcare work environments. *Journal of Nursing Management* 17(8) 947-955. doi.org/10.1111/j.1365-2834.2009.01022.x

Rogers, E.M. (2004). *Diffusion of innovations*. New York, USA: Free press.

Ruhe, M.C., Bobiak, S.N., Litaker, D., Carter, C.A., Wu, L., Schroeder, C., Zyzanski, S.J., Weyer, S.M., Werner, J.J., Fry, R.E., & Stange, K.C. (2011). Appreciative Inquiry for quality improvement practices. *Quality Management in Health Care*, 20(1), 37-48. doi: 10.1097/QMH.0b013e31820311be

Saunders, R.P., Abraham, M.R., Crosby, M.J., Thomas, K., & Edwards, W.H. (2003). Evaluation and development of potentially better practices for improving family centred care in neonatal intensive care units. *Pediatrics*, 111(Supp. E1). 437-449. Retrieved from http://pediatrics.aappublications.org/content/111/Supplement_E1/e437.full

Shahheidari, M. & Homer, C. (2012). Impact of the design of neonatal intensive care units on neonates, staff, and families: A systematic literature review. *Journal of Perinatal and Neonatal Nursing*, 26(3), 260-266.

Shaw, R. J., Deblois, T., Ikuta, L., Ginzburg, K., Fleisher, B., & Koopman, C. (2006). Acute stress disorder among parents of infants in the neonatal intensive care nursery. *Psychosomatics*, 47(3), 206-212. doi:10.1176/appi.psy.47.3.206

Shenton, A.K. (2004). Strategies for ensuring the trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63-75.

Shields, L., Pratt, J., Davis, L., & Hunter, J. (2007). Family centred care for children in hospital (Review). *The Cochrane Database of Systematic Reviews*, (Art. No.: CD004811. doi:10.1002/14651858.CD004811.pub2).

Shields, L., Pratt, J., & Hunter, J. (2006). Family centred care: a review of qualitative studies. *Journal of Clinical Studies*, 15(10), 1317-1323. doi.org/10.1111/j.1365-2702.2006.01433.x

Shields, L. (2010). Questioning family-centred care. *Journal of Clinical Nursing*, 19(9), 2692-2693. doi:10.1111/j.1365-2702.2010.03214

Smith, K.M. (2007). Sleep and kangaroo care: clinical practice in the newborn intensive care unit: where the baby sleeps. *The Journal of Perinatal and Neonatal Nursing*, 21(2), 151-157.

Smith, J., Swallow, V., & Coyne, I. (2015). Involving parents in managing their child's long-term condition- A concept synthesis of family centred care and partnership in care. *Journal of Pediatric Nursing*, 30(1), 143-159.

Staniszewska, S., Brett, J., Redshaw, M., Hamilton, K., Newburn, M., Jones, N., & Taylor, L. (2012). The POPPY study: Developing a model of family-centred care for neonatal units. *Worldviews on Evidence-Based Nursing*, 9(4), 243-255. doi:10.1111/j.1741-6787.2012.00253.x.

Talmi, A., & Harmon, R.J. (2003). Relationships between preterm infants and their parent: Disruption and development. *Zero to Three*, 24(2), 13-20. Retrieved from <http://www.zerotothree.org/about-us/areas-of-expertise/zero-to-three-journal/?referrer=https://www.google.com.au/>

- Terry, T.L. (1942). Extreme prematurity and fibroblastic overgrowth of persistent vascular sheath behind each crystalline lens: *American Journal of Ophthalmology*, 25(2), 203-204.
- Thomas, L.M. (2008). The changing role of parents in neonatal care: A historical review. *Neonatal Network*, 27(2) 91-100. doi:http://dx.doi.org/10.1891/0730-0832.27.2.91
- Thompson, G., Bilson, A., & Dykes, F. (2012). Implementing the WHO/UNICEF baby friendly initiative in the community: A 'hearts and minds' approach. *Midwifery*, 28(2), 258-264. doi:10.1016/j.midw.2011.03.003.
- Wallerstein, N.B. & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice*, 7(3), 312-323. doi: 10.1177/1524839906289376
- Wiggins, M.S. (2008). The partnership care delivery model: An examination of the core concept and the need for a new model of care. *Nursing Management*, 15(5), 629-638. doi.org/10.1111/j.1365-2834.2008.00900.x
- Wilson, V., McCormack, B., & Ives, G. (2005). Understanding the workplace culture of a special care nursery. *Journal of Advanced Nursing* 50(1), 27–38. doi.org/10.1111/j.1365-2648.2004.03346.x
- Whittingham, K., Boyd, R.N., Sanders, M.R., & Colditz, P. (2014). Parenting and prematurity: Understanding parent experience and preferences for support. *Journal of Child and Family Studies*. 23(6), 1050-1061. doi: 10.1007/s10826-013-9762-x
- World Health Organisation, (1997). *Thermal protection of the newborn: A practical Guide*. World Health Organisation, Geneva. Retrieved http://apps.who.int/iris/bitstream/10665/63986/1/WHO_RHT_MSM_97.2.pdf

Appendices

Appendix 1: UWS HREC approval

From: Kay Buckley
Sent: Tuesday, 9 March 2010 1:45 PM
To: Virginia Schmied
Subject: Ethics External Approval H7774

Notification of UWS approval for a project with external approval

Email on behalf of the UWS Human Research Ethics Committee

Dear Virginia

I'm writing to advise you that the University of Western Sydney Human Research Ethics Committee has agreed to provide reciprocal approval for the following project.

Title: Using appreciative inquiry to enhance family centred care in the neonatal intensive care unit

PRs: Associate Professor Virginia Schmied, Professor Margaret Vickers, Professor Debra Jackson, Suza Trajkovski - PhD candidate

Approved by: Sydney South West Area Health Service HREC (Western Zone)

External Approved from 15 December 2009, HREC/09/LPOOL/210 Local No 2009/145

The UWS Protocol Number for this project is **H7774**. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:

- 1) The approval will expire on **9 March 2011**. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer (humanethics@uws.edu.au) prior to this date.
- 2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.
- 3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/ors/ethics/human_ethics
- 4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/ors/ethics/human_ethics

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.
Yours sincerely

Associate Professor Janette Perz
Chair, Human Research Ethics Committee

[Kay Buckley](#)
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
http://www.uws.edu.au/research/ors/ethics/human_ethics

Appendix 2: SSWAHS HREC (western zone) approval

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Human Research Ethics Committee (Western Zone)

Locked Bag 7017, LIVERPOOL BC, NSW, 1871
Phone: 02 9612 0614
Facsimile: 02 9612 0611

December 15, 2009

Associate Professor Virginia Schmied
University of Western Sydney
College of Health Science
School of Nursing & Midwifery
Locked Bag 1797
PENRITH SOUTH DC 1797

Dear Associate Professor Schmied,

HREC NO HREC/09/LPOOL/210
Local No 2009/145
Title: Using Appreciative Inquiry to enhance Family Centred Care in the Neonatal Intensive Care Unit

Thank you for submitting the above project which was first considered by the SSWAHS HREC (Western Zone) on 28th September, 2009. This HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

Following review of your correspondence dated 16th November, 2009, I am pleased to advise that the Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the HREC:

Subject Information Statement	5/11/2009 -Version 2.0 AB/12474/1
Consent Form - Parent Phase 1 (Please note that the numbering for this document should state 1 of 1).	5/11/2009 - Version 2.0 AB/12474/1
Consent Form - Parent Phase 2,3,4 (Please note that the numbering for this document should state 1 of 1).	5/11/2009 - Version 2.0 AB/12474/1
Consent Form - Nurse Phase 1 (Please note that the numbering for this document should state 1 of 1).	5/11/2009 - Version 2.0 AB/12474/1
Consent Form - Nurse Phase 2,3,4 (Please note that the numbering for this document should state 1 of 1).	5/11/2009 - Version 2.0 AB/12474/1

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
 - any serious or unexpected adverse events; and
 - unforeseen events that might affect continued ethical acceptability of the project.

2. The Principal Investigator will report proposed changes to the research protocol, conduct of the research, or length of HREC approval to the HREC in the specified format, for review.
3. The Principal Investigator will inform the HREC, giving reasons, if the project is discontinued before the expected date of completion.
4. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

HREC approval is valid for 12 months from last day of the month when the HREC met and a progress report will be required by 30th September, 2010.

Should you have any queries about your project please contact Mrs Jennie Grech, HREC Executive Officer on the telephone number listed above. The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the SSWAHS website:

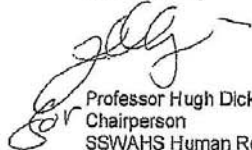
<http://www.swsahs.nsw.gov.au/areas/ethics/default.asp>

You are reminded that this letter constitutes ethical approval only. You must not commence this research project until separate site specific authorisation has been granted.

Please quote the Local HREC reference 09/145 in all correspondence.

The HREC wishes you every success in your research

Yours faithfully



Professor Hugh Dickson
Chairperson
SSWAHS Human Research Ethics Committee

Appendix 3: Invitation to participate notice (nurses)

An invitation to participate

If you are interested in this research we would like to invite you to participate in the study. We will hold the workshops in the neonatal unit's conference room.

What do you do next?

If you would like to know more about the study and/or you might be interested in participating, please call or email Suza Trajkovski. This is not a commitment to participate.

Suza Trajkovski

Phone: 02 4620 3286

Email: s.trajkovski@uws.edu.au

OR

A/Professor Virginia Schmieid

Phone: 02 9685 9505

Email: v.schmeid@uws.edu.au

College of Health and Sciences
Locked Bag 1797
Penrith South DC NSW 1797



Do you want to be part of Research surrounding Family Centred Care in the Neonatal Intensive Care Unit?

- Are you a neonatal nurse interested in improving neonatal outcomes & influence clinical practice?
- Would you be happy to talk to us about your experiences of providing Family Centred Care in the NICU?



We are a group of researchers from the University of Western Sydney and we are interested in talking with neonatal nurses' and parents' about your experiences and perceptions surrounding Family Centred Care in the neonatal unit.

Who can participate?

You can participate if you are a nurse currently working in the neonatal unit.

What would you be asked to do?

If you agree to participate you will be asked to participate in group discussions and workshops in order to develop strategies that will assist in improving neonatal care.

This study will consist of 4 phases. Phase 1 will include either participation in a group discussion consisting of 5-8 people or a one to one semi structured interview lasting between 1-2 hours. Participation in Phase 1 would involve nurses and parents talking separately about your experiences and perspective of the value of family centred care in

the neonatal unit. Participants in phase one will be invited to participate in the next 3 phases. These will consist of 1 full day workshops and then one follow up focus group or individual interview.

Participation in the workshop will involve bringing parents and nurses together to work collaboratively to develop strategies to strengthen family centred care in the neonatal unit. With your permission, we will record the discussions using digital video/audio recorders.

Are there any benefits?

While there are no direct personal benefits from participating in this study, you may be contributing to positively influencing neonatal care and improving neonatal outcomes for other families.

Are there any risks?

There is a chance you may feel uncomfortable or upset talking about your experiences. If this happens we encourage you to seek support from available counselling or support

services. Remember participation in this study is completely voluntary and you can withdraw at any time without any consequences.

What else should I know?

- Your participation is completely voluntary.
- You may withdraw from the study at any stage.
- Recruitment is completely confidential
- If you do participate, all identifying information will be removed from transcribed data
- Consent forms will be confidential and privacy will be maintained by storing consent forms in a locked cabinet at the University of Western Sydney.

Appendix 4: Invitation to participate notice (parents)

An invitation to participate

If you are interested in this research we would like to invite you to participate in the study. We will hold the workshops in the neonatal unit's conference room.

What do you do next?

If you would like to know more about the study and/or you might be interested in participating, please call or email Suza Trajkovski. This is not a commitment to participate.

Suza Trajkovski

Phone: 02 4620 3286

Email: s.trajkovski@uws.edu.au

OR

A/Professor Virginia Schmied

Phone: 02 9685 9505

Email: v.schmeid@uws.edu.au

Morning or afternoon tea will be provided

Do you want to be part of Research surrounding Family Centred Care in the Neonatal Intensive Care Unit?

- Are you a parent that has had an infant requiring neonatal care?
- Would you be happy to talk to us about your experiences of Family Centred Care in the NICU?



College of Health and Sciences
Locked Bag 1797
Pennrith South DC NSW 1797



We are a group of researchers from the University of Western Sydney and we are interested in talking with parents' and neonatal nurses' about your experiences and perceptions surrounding Family Centred Care in the neonatal unit.

Who can participate?

You can participate if you are a parent that has previously had a newborn infant that required neonatal intensive care.

What would you be asked to do?

If you agree to participate you will be asked to participate in group discussions and workshops in order to develop strategies that will assist in improving neonatal care.

This study will consist of 4 phases.

Phase 1 will include either participation in a group discussion consisting of 5-8 people or a one to one semi structured interview lasting between 1-2 hours. Participation in Phase 1 would involve nurses and parents talking separately about your experiences and perspective of

the value of family centred care in the neonatal unit. Participants in phase one will be invited to participate in the next 3 phases. These will consist of 1 full day workshops and then one follow up focus group or individual interview.

Participation in the workshops will involve bringing parents and nurses together to work collaboratively to develop strategies to strengthen family centred care in the neonatal unit. With your permission, we will record the discussion using digital video/audio recorders.

Are there any benefits?

While there are no direct personal benefits from participating in this study, you may be contributing to positively influencing neonatal care and improving neonatal outcomes for other families.

Are there any risks?

There is a chance you may feel uncomfortable or upset talking about your experiences. If this happens we encourage you to seek support from

available counselling or support services. Remember participation in this study is completely voluntary and you can withdraw at any time without any consequences.

What else should I know?

- Your participation is completely voluntary.
- You may withdraw from the study at any stage.
- Recruitment is completely confidential
- If you do participate, all identifying information will be removed from transcribed data
- Consent forms will be confidential and privacy will be maintained by storing consent forms in a locked cabinet at the University of Western Sydney.

Appendix 5: Participant information statement



Project ID
UWS: H7774
SSWAHS: HREC/09/LPOOI/210
Local No 2009/145

Participant Information Statement

Project Title: USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTRED CARE IN THE NEONATAL INTENSIVE CARE UNIT

What is the study about?

You are invited to participate in a research study that aims to explore Family Centred Care in the Neonatal Intensive Care Unit. Researchers from the University of Western Sydney and our partner investigators hope to learn more about Family Centred Care and ways in which to improve care for neonates and families requiring neonatal intensive care.

What does the study involve?

If you agree to participate you will be asked to be involved in group discussions and workshops in order to develop strategies that will assist in improving neonatal care. This study will consist of 4 phases. Phase 1 will include either participation in a group discussion consisting of 5-8 people or a one-to-one semi structured interview lasting between 1-2 hours. Participation in Phase 1 will involve nurses' and parents' talking *separately* about your experiences and perspectives of the value of family centred care in the neonatal intensive care unit. Participants in Phase 1 will be invited to participate in the next 3 phases of the study. These will consist of 3 workshops. Each workshop will be approx 1-2 hours long.

Participation in the workshops will involve bringing *parents' and nurses' together* to work collaboratively to develop strategies to strengthen family centred care in the neonatal intensive care unit. With your permission, we will record the discussions using digital recorders. A facilitator will also take notes of key points made by the group. Participants will then be asked to confirm a summary of these key points on completion of each session.

How much time will the study take?

The study will occur in four phases. Participation in the first phase will last no more than 2 hours. Participants from the first phase will be invited to the following three

phases. These phases will occur two weeks apart and will last no more than two hours each session.

Will the study benefit me?

While there are no direct personal benefits from participating in this study, you may be contributing to positively influencing neonatal care and improving neonatal outcomes for other families.

Will the study involve any discomfort for me?

There is a chance you may feel uncomfortable or upset talking about your experiences. If this happens we encourage you to seek support from available counselling or support services. The researcher will provide appropriate referral details.

Will anyone else know the results? How will the results be disseminated?

To protect your privacy and the privacy of others, any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. If you give us permission by signing the participant consent form, we plan to publish and disseminate the results in relevant professional forums (such as peer reviewed journals and conferences). Individual participants will not be identifiable in such reports. The recordings, handwritten and transcribed notes of interviews, group discussions and workshops you participate in will be securely archived for five years after publication and only members of the research team will have access to this data. The information will be stored securely at the University of Western Sydney.

Can I withdraw from the study?

Participation in this study is entirely voluntary. You are not obligated to be involved and if you do participate in this study you can withdraw at any time without giving any reason and without consequences. If you have participated in a group discussion or workshop and chose to withdraw from the study, data up to the point of withdrawal will be used.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the chief investigators contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

Consent to participate in this study:

If you agree to participate in this study you will be asked to sign the attached Participant Consent form.

What if I require further information?

When you have read this information, Suza Trajkovski will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Suza Trajkovski on 0431 554 315.

What if I have a complaint?

This study has been approved by the University of Western Sydney Human Research Ethics committee and the Sydney South West Area Health Service Human Research Ethics Committee HREC: [AB/12474/1]. Complaints may be directed to the Ethics committee through the UWS office of research services on Tel 02-4736083 or email humanethics@uws.edu.au or the Ethics Secretariat (Western Zone), SSWAHS Area Health Service, Locked Bag 7017, LIVERPOOL BC NSW 1871 Tel: 9612 0614 Fax 96160611 email jennie.grech@sswahs.nsw.gov.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

Appendix 6: Participant consent form



SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Project No UWS: H7774
SSWAHS HREC/09/LPOOI/210
Local No 2009/145

CONSENT FORM- Parent Phase 1

USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTERED CARE IN THE NEONATAL INTENSIVE CARE UNIT

1. I.....of....., agedyears, agree to participate as a subject in the study described in the subject information statement attached to this form.
2. I acknowledge that I have read the Subject Information Statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.
3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.
4. My decision whether or not to participate will not prejudice my present or future treatment or my relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating me. If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice.
5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.
6. I agree to being digitally recorded for the purpose of this study.
7. I understand that if I have any questions relating to my participation in this research, I may contact the study doctor, Dr Schmied on telephone 9685 9505, who will be happy to answer them.
8. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics committee through the UWS office of research services on Tel 02-4736083 or email humanethics@uws.edu.au or the Ethics Secretariat (Western Zone), Sydney South West Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9612 0614, fax 9612 0611, email jennie.grech@sswahs.nsw.gov.au jennie.grech@sswahs.nsw.gov.au).

Signature of subject _____ Signature of witness _____

Please PRINT name _____ Please PRINT name _____

Date _____ Date _____

Signature(s) of investigator(s) _____

Please PRINT Name _____

Date: _____

Project No UWS: H7774
SSWAHS HREC/09/LPOOI/210
Local No 2009/145

CONSENT FORM- Parent Phase 2,3,4
USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTERED CARE IN THE NEONATAL
INTENSIVE CARE UNIT

1. I.....of.....
....., agedyears, agree to participate as
a subject in the study described in the subject information statement attached to this form.
2. I acknowledge that I have read the Subject Information Statement, which explains why I have
been selected, the aims of the study and the nature and the possible risks of the investigation, and
the statement has been explained to me to my satisfaction.
3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating
to any possible physical and mental harm I might suffer as a result of my participation. I have
received satisfactory answers to any questions that I have asked.
4. My decision whether or not to participate will not prejudice my present or future treatment or my
relationship with Sydney South West Area Health Service or any other institution cooperating in
this study or any person treating me. If I decide to participate, I am free to withdraw my consent
and to discontinue my participation at any time without prejudice.
5. I agree that research data gathered from the results of the study may be published, provided that
I cannot be identified.
6. I agree to being digitally recorded for the purpose of this study.
7. I understand that if I have any questions relating to my participation in this research, I may
contact the study doctor, Dr Schmied on telephone 9685 9505, who will be happy to answer them.
8. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics committee through the UWS office of research services on Tel 02-4736083 or email humanethics@uws.edu.au or the Ethics Secretariat (Western Zone), Sydney South West Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9612 0614, fax 9612 0611, email jennie.grech@sswahs.nsw.gov.au jennie.grech@sswahs.nsw.gov.au).

Signature of subject _____ Signature of witness _____

Please PRINT name _____ Please PRINT name _____

Date _____ Date _____

Signature(s) of investigator(s) _____

Please PRINT Name _____

Date: _____

Project UWS: H7774
SSWAHS HREC/09/LPOOI/210
Local No 2009/145

CONSENT FORM- Nurse Phase 1
USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTERED CARE IN THE NEONATAL
INTENSIVE CARE UNIT

1. I.....of.....
....., agedyears, agree to participate as
a subject in the study described in the subject information statement attached to this form.
2. I acknowledge that I have read the Subject Information Statement, which explains why I have
been selected, the aims of the study and the nature and the possible risks of the investigation, and
the statement has been explained to me to my satisfaction.
3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating
to any possible physical and mental harm I might suffer as a result of my participation. I have
received satisfactory answers to any questions that I have asked.
4. My decision whether or not to participate will not prejudice my present or future treatment or my
relationship with Sydney South West Area Health Service or any other institution cooperating in
this study or any person treating me. If I decide to participate, I am free to withdraw my consent
and to discontinue my participation at any time without prejudice.
5. I agree that research data gathered from the results of the study may be published, provided that
I cannot be identified.
6. I agree to being digitally recorded for the purpose of this study.
7. I understand that if I have any questions relating to my participation in this research, I may
contact the study doctor, Dr Schmied on telephone 9685 9505, who will be happy to answer them.
8. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics committee through the UWS office of research services on Tel 02-4736083 or email humanethics@uws.edu.au or the Ethics Secretariat (Western Zone), Sydney South West Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9612 0614, fax 9612 0611, email jennie.grech@sswahs.nsw.gov.au jennie.grech@sswahs.nsw.gov.au).

Signature of subject _____ Signature of witness _____

Please PRINT name _____ Please PRINT name _____

Date _____ Date _____

Signature(s) of investigator(s) _____

Please PRINT Name _____

Date: _____

Project UWS: H7774
SSWAHS HREC/09/LPOOI/210
Local No 2009/145

CONSENT FORM- Nurse Phase 2,3,4
USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTERED CARE IN THE NEONATAL
INTENSIVE CARE UNIT

1. I.....of.....
....., agedyears, agree to participate as
a subject in the study described in the subject information statement attached to this form.
2. I acknowledge that I have read the Subject Information Statement, which explains why I have
been selected, the aims of the study and the nature and the possible risks of the investigation, and
the statement has been explained to me to my satisfaction.
3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating
to any possible physical and mental harm I might suffer as a result of my participation. I have
received satisfactory answers to any questions that I have asked.
4. My decision whether or not to participate will not prejudice my present or future treatment or my
relationship with Sydney South West Area Health Service or any other institution cooperating in
this study or any person treating me. If I decide to participate, I am free to withdraw my consent
and to discontinue my participation at any time without prejudice.
5. I agree that research data gathered from the results of the study may be published, provided that
I cannot be identified.
6. I agree to being digitally recorded for the purpose of this study.
7. I understand that if I have any questions relating to my participation in this research, I may
contact the study doctor, Dr Schmied on telephone 9685 9505, who will be happy to answer them.
8. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.

Complaints may be directed to the Ethics committee through the UWS office of research services on Tel 02-4736083 or email humanethics@uws.edu.au or the Ethics Secretariat (Western Zone), Sydney South West Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9612 0614, fax 9612 0611, email jennie.grech@sswahs.nsw.gov.au jennie.grech@sswahs.nsw.gov.au).

Signature of subject _____ Signature of witness _____

Please PRINT name _____ Please PRINT name _____

Date _____ Date _____

Signature(s) of investigator(s) _____

Please PRINT Name _____

Date: _____

Appendix 7: Interview/focus group question (discovery phase)



Project Title: USING APPRECIATIVE INQUIRY TO ENHANCE FAMILY CENTERED CARE IN THE NEONATAL INTENSIVE CARE UNIT

QUESTIONS FOR PARENTS

Family centered care (FCC) is an important concept in neonatal nursing. What does FCC mean to you?

Think about your experience in the nursery. How does your experience reflect the concepts of FCC?

What is your understanding of partnership in care?

From your perspective what is the nurses' role in FCC?

From your perspective what is the parents' role in FCC?

What do you think facilitates or inhibits FCC in the neonatal unit?

What positive strategies will strengthen FCC in the NICU?

QUESTIONS FOR NURSES

Family centered care (FCC) is an important concept in neonatal nursing. What does FCC mean to you?

Think about your nursing experience with FCC. What are the strengths and limitations of FCC in the NICU?

What is your understanding of partnership in care?

From your perspective what is the nurses' role in FCC?

From your perspective what is the parents' role in FCC?

What do you think facilitates FCC in the neonatal unit?

What positive strategies will strengthen FCC in the NICU?

Appendix 8: Workshop Program (dream/design phase)

Using Appreciative Inquiry to Enhance Family Centered Care in the NICU

Workshop Program

22nd April 2010

0900-0930	Coffee/Tea
0930-1000	Welcome and Workshop Overview
	AI process (Phase 1,2,3,4)
	Introductions
	Defining Key Terms
	Key Assertive Statements from the Discovery Phase (Phase 1)
1000-1030	Small group work-Dream (Phase 2)
	Magic Wand
1030-1100	Feedback to larger group-Dream Phase
1100-1120	Provocative Propositions developed in larger group
1120-1140	Morning Tea
1140-1230	Small group work-Design Phase (Phase 3)
1230-1300	Lunch
1300-1400	Feedback to larger group-Design Phase
1400-1500	Larger group work-Destiny Phase (Phase 4)
1500-1515	Evaluations

Thankyou for participating

Appendix 9: Workshop questions

Workshop Questions

NURSE

Tell me about a time when you felt you provided excellent FCC?

What made it so special?

Who was involved?

What happened that made it a special experience?

What skills/qualities did you use?

From your own experience what do you personally value most about FCC?

Why do you think FCC is important?

What is the best thing that family centred care has contributed to neonatal care?

PARENT

Tell me about a time when you felt you received excellent FCC?

What made it so special?

Who was involved?

What happened that made it a special experience?

What skills/qualities did you use?

From your own experience what do you personally value most about FCC?

Why do you think FCC is important?

What is the best thing that family centred care has contributed to neonatal care?

Miracle Question

Take the magic wand that is placed in front of you. If you could make a wish for what family centred care would look like in the neonatal unit, what would it be?

Appendix 10: FCC working party meeting topics

<p>Develop FCC vision statement</p>	<p>Agreeing on a vision statement for the NICU and display throughout unit for staff, parents and visitors to see:</p> <p>Vision statement developed collaboratively with parents and nurses:</p> <p><i>“To promote the wellbeing of babies, families and carers in a harmonious, respectful and safe environment through support, communication and education”</i></p>
<p>Meeting parents before arriving to NICU</p>	<p>NICU team to meet parents antenatal (where possible) to introduce themselves and begin developing relationships/partnerships with parents, gain an understanding of parents needs/wishes. Answer parent questions and offer an organised tour of the neonatal unit</p>
<p>Dedicated team pre, during and post NICU experience</p>	<p>Dedicated team to follow parents through their NICU journey antenatal and throughout NICU admission, preparation for discharge and post discharge follow up (as required).</p>
<p>Develop information- LCD screens</p>	<p>Developing parent education information to be displayed continuously in NICU on LCD screens and bedside computer screen savers throughout the unit (slides specific to level of care eg. intensive or special care)</p>
<p>Develop information-DVD</p>	<p>Develop parent information DVD that builds on LCD screen information that can be viewed by parents in the antenatal/ post-natal ward or given to parents to take home to watch. Information on DVD to include information on neonatal care and neonatal unit. DVD can also be used for training staff new to the NICU and for consistency in information provided to parents</p>
<p>Engaging with NICU staff</p>	<p>Information sharing from meetings</p> <p>Encouraging and involving staff to engage in developing and introducing FCC strategies</p>
<p>Staff FCC training</p>	<p>Staff training based on FCC principles and working with parents in the clinical environment to develop knowledge, skills (including communication skills) and competencies when working with families.</p>
<p>Develop individualised family focused negotiated care plans</p>	<p>Staff to receive training for assessing evolving family needs throughout the NICU trajectory and develop methods on how to best implement FCC strategies to meet infant and family needs</p> <p>Individualised negotiated care plans to be developed with the family, that are specific to family needs and according to the level of involvement the family feel comfortable and able to engage in</p>
<p>Momentos/ Keepsakes</p>	<p>Encouraging families/staff to engage in developing mementos and keepsakes eg. journaling (books/ electronic), keeping key items such as umbilical clamp, first outfit, photo’s, foot and hand prints,</p>

	documenting milestones
Parent-to-Parent buddy system	Paring up of parents in the NICU with parents that have previously had a baby in the NICU (with similar situation) for parent-to-parent support
Policy development -mum to see baby before extended family	A policy to be developed where the mother will see her infant before extended family visits (unless requested by mother)
Sibling support	Develop packs to support siblings in NICU. Strategies include colouring stencils, pencils, activity books and technological devices eg. portable DVD players with disposable earphones. Short stay crèche centre
Staff release to attend meetings	Strategies to allow staff to be release from work to attend FCC meetings and dedicated time given to develop and implement FCC strategies
Parent information sessions	A multidisciplinary (medical staff, nurses, physiotherapist, occupational therapist, social worker, parent support staff etc.) approach to provide face-to-face parent information sessions and provide parents an opportunity to ask questions
Information sharing	Use of media (eg. Blogs or wikki's) for dissemination of general information
Staff to patient ratio's	To consider family needs and infant needs on a daily basis when determining staff-to patient ratio
FCC working party	Ongoing FCC meeting with parent representatives and multidisciplinary health care workers presence

Example: Topics discussed during FCC meeting

Date	Location	Present	Topics Discussed									
			FCC vision	LCD screen	DVD	Engaging NICU staff	Memento/ keepsake	Parent to Parent buddy system	Policy mums to see babies before extended family	Sibling packs	Parent education/ information sessions	Nurse education
19/8/10	MB	Nurse-N Parent-P Social Worker-S Physio-P	✓			✓	✓	✓		✓		
26/8/10	NBC	4N/2P	✓	✓		✓	✓	✓		✓		
2/9/10	MB	4N/2P	✓	✓		✓	✓	✓		✓		
16/9/10	NBC	4N/2P	✓	✓		✓	✓	✓	✓	✓		
23/9/10	MB	5N/2P	✓	✓		✓	✓	✓	✓	✓		
7/10/10	MB	3N/2P	✓	✓	✓	✓	✓	✓		✓	✓	
21/10/10	MB	3N/2P	✓	✓	✓	✓	✓	✓		✓		
4/11/10	NBC	6N/2P	✓	✓	✓	✓		✓	✓	✓		
14/12/10	NBC	3N/2P		✓	✓	✓	✓	✓	✓	✓	✓	✓
13/1/11	NBC	3N/2P SW/P		✓	✓	✓	✓	✓	✓	✓	✓	✓
11/2/11	NBC	3N/2P/1P		✓	✓		✓	✓		✓	✓	✓
10/3/11	NBC	3N/2P		✓	✓		✓	✓	✓	✓	✓	✓
4/4/11	MB	4N/2P/2P		✓	✓	✓	✓	✓	✓	✓	✓	✓
12/5/11	NBC	4N/2P		✓	✓	✓	✓	✓		✓	✓	✓
16/6/11	MB	3N/2P		✓	✓	✓	✓	✓		✓	✓	✓
14/7/11	NBC	2N/2P		✓	✓	✓		✓			✓	✓
18/8/11	NBC	4N/1P		✓	✓	✓		✓			✓	✓
22/9/11	NBC	3N/2P		✓	✓	✓		✓			✓	✓
21/10/11	NBC	3N/2P		✓	✓	✓	✓	✓			✓	✓

Appendix 11: Interview/focus group questions destiny phase.

Destiny phase interview and focus group questions

1. First could you describe the progress of the working party? (Prompts - is the working party still meeting; how often; who chairs?)
2. Can you describe the achievements of working party (Prompt - were the goals of the group met)?
3. In your opinion what helped the working party achieve its goals?
4. Can you describe any barriers faced by the working party?
5. In what way did the AI approach facilitate or hinder the working party's progress?
6. What may have helped or hindered the AI process?
7. How will you use the AI process in the ongoing work of the FCC working party?

Appendix 12: Publication acceptance letter-Collegian

Suza Trajkovski

From: ees.coll.0.3183e3.b45f5211@eesmail.elsevier.com on behalf of collegian@acn.edu.au
Sent: Wednesday, 27 May 2015 10:32 AM
To: Suza Trajkovski
Subject: Your Submission

Ms. Ref. No.: COLL-D-14-00046R3

Title: Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: the destiny phase of an appreciative inquiry project

Collegian: The Australian Journal of Nursing Practice, Scholarship and Research

Dear Ms. S Trajkovski,

I am pleased to inform you that your paper "Experiences of neonatal nurses and parents working collaboratively to enhance family centred care: the destiny phase of an appreciative inquiry project" has been accepted for publication in Collegian: The Australian Journal of Nursing Practice, Scholarship and Research.

Thank you for submitting your work to Collegian: The Australian Journal of Nursing Practice, Scholarship and Research.

Yours sincerely,

Lisa McKenna, RN PhD FACN
Editor-In-Chief
Collegian: The Australian Journal of Nursing Practice, Scholarship and Research

Comments from the editors and reviewers:

For further assistance, please visit our customer support site at <http://help.elsevier.com/app/answers/list/p/7923>. Here you can search for solutions on a range of topics, find answers to frequently asked questions and learn more about EES via interactive tutorials. You will also find our 24/7 support contact details should you need any further assistance from one of our customer support representatives.