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DEVELOPING RELATIONSHIPS IN SPECIAL CARE BABY UNITS

A Conference held at the King's Fund Centre
on 30 March 1979

Report by Pat Young

DEVELOPING RELATIONSHIPS IN SPECIAL CARE BABY UNITS

The importance of 'bonding' between an infant and its parents and how this process can be made or marred by the attitudes of staff and methods of organisation, was the focal point of the conference on 'Developing relationships in special care baby units' held at the King's Fund Centre on Friday 30 March, chaired by Mrs Snell, Divisional Nursing Officer (Midwifery), Chelmsford Health District.

Speaking first, to set the scene, was Mrs P Hale, Nursing Officer, Neonatal Paedicatrics, City Hospital, Nottingham, who took it as her brief to consider the group of people who make the most substantial contribution to the livelihood of special care baby units: the nurses. There are in England today, she said, 252 such units, ranging from small ones to large units with more than 30 cots and each with its own staff establishment. there are no regional or national norms to help the nursing officer to determine the number of grades and ratio of staff her unit requires; the only available reference is the 1971 report from the expert group on special care for babies which suggests that in intensive care areas there should be three experienced nurses to one non-experienced nurse, at a ratio of three nurses to one cot; and in special care areas there should be three experienced to five non-experienced nurses, at a ratio of 1 to 1.5 nurses per cot. These ratios may not be ideal and it is very much the job of the nursing officer or other person in charge to determine the standards of care she has to meet and to calculate her establishment accordingly.

The staff establishements of most neonatal units are small, not related to work through-put and allow insufficient job satisfaction to staff. How, then, should these units ideally be staffed? First, each one should have its own nursing officer but if this is not possible and the nursing officer is responsible for another specialist unit, there must be a sister-in-charge who is recognised as a co-manager, with sufficient authority to do the job properly. This sister must be trained in all aspects of neonatal care, be familiar with unit needs and conversant with unit policies and philosophies.

Second, the maximum part of the staffing allowance should be spent on supporting sisters, to ensure that there is at least one sister on duty throughout the 24-hour period. It must be remembered that the sister is the single most important individual in the staffing of this type of unit: she must co-ordinate activities and be responsible for maintaining a balance in the constantly changing pattern of work.

Third, careful selection of other grades of staff is vitally important. They must be girls of quality, both professionally and emotionally and they must want to work in this specialty. They must be familiar with and have a clear understanding of, all the neonatal needs and conditions; have the ability to assess problems; and be skilled in carrying out certain technical procedures, often involving active resuscitation.

Nursery nurses and nursing auxiliaries can be part of the ward team and play a valuable part but they must not be placed in a position where they are expected to carry out the duties of a State Registered or Enrolled nurse. They should also be kept in the minority among staff, so that a correct balance is maintained.

Post basic students taking Joint Board of Clinical Nursing Studies courses should not be part of the work force and it has been a point of controversy that they have been supernumerary to unit requirements. It would be preferable for half the group of post basic students to be supernumerary, giving direct nursing care and the other half studying, reading, joining in rounds, etc.

It has become essential for centres running Joint Board courses to have a clinical teacher in post. This is primarily a supportive post, providing students with someone to encourage and assist them, to whom they can relate and who is readily available.

Looking at neonatal units across the country, Mrs Hale continued, although they should be a popular choice there is a general shortage of nursing staff in post. Some units have a very rapid turnover of staff and the quality of those employed fluctuates. While the reason for this may be that staff move to be near the family, or a boy friend, it may also be that the conditions and the work are too demanding, which poses the question: are nurse managers meeting the needs of individual nurses and managing their staff effectively? There are several factors to consider if the unit is to function effectively and provide a harmonious and satisfactory environment for the girls who work there.

To begin with, nurse managers must ensure that some shifts are not the 'poor cousins' of others in terms of nurses, their capabilities, their designations and their actual numbers. In some units patient care during the day is excellent but at night is poor, because there are insufficient personnel to carry out the same degree of care. So all shifts should be equal in terms of nurses, their numbers and their capabilities.

Second, every unit should have some form of internal rotation, so that the nurses appreciate the problems of each shift and the 'them and us' situation between permanent night and day shifts is eliminated and there is continuity of care by informed nurses.

Third, part-time staff must be kept up to date with any changes or improvements occurring when they are not able to be present for learning purposes.

Fourth, it is ideal to group the babies together according to the level of nursing care each one requires: for example, babies receiving intensive care can be grouped in the high-dependency area and those who have got over their initial difficulties can be grouped in the low-dependency area. Staff can be rotated on a controlled basis in both areas, giving them a change of working environment and in the type of demands made on them.

Fifth, every unit today should be practising patient allocation: the system whereby one nurse has the total nursing care of a certain number of babies through out the shift period.

In Mrs Hale's view, task orientation has no place in neonatal units today, as it brings with it its own problems of frustration, dissatisfaction and disinterest. Nurses should no longer be doing jobs according to their status, or to the clock. Limited time and energy prevent one nurse from being all things to all patients: how much better that her energies be directed towards two or three patients only.

It is advantageous, Mrs Hale went on, to divide unit nursing staff into two teams, one for the high-dependency and the other for the low-dependency areas. Basically the team members would be co-equals but each must have a leader who would not give nursing care herself but would interpret and co-ordinate the care plans passed to her team. One of her important tasks would be to monitor the type of baby each girl is assigned to, to give her ample opportunity to exercise and develop her skills. Every sister in neonatal units should have a set period of being in sole charge of the entire unit for a predetermined period - of weeks, not shifts. Sisters cannot otherwise develop the required amount of knowledge, ability and experience demanded.

Mrs Hale then turned to what she described as the 'tools of learning'. The first tool is adequate induction and orientation for new members of staff, regardless of their designation: this should entail taking a nurse away from her nursing care duties so that she can concentrate fully on the new staff member, pass on information in placid circumstances, assess that girl's competence and judge where she most needs help.

Secondly, nurse managers must ensure that the experience of their existing staff is still fully appropriate, in the light of the rapid changes in the neonatal field. Staff should be encouraged to take Joint Board courses, or other mini-courses such as study days. Mrs Hale suggested that units could hold their own study days by inviting staff from nearby units to come and exchange ideas about patient care. It is important also to gear study days to the level of staff: for instance, nursery nurses should not be expected to attend the same seminars as sisters. And doctors and nurses should hold patient-centred seminars on an informal basis, to plan and evaluate the care of a particular baby being nursed in the unit. The greatest input of knowledge comes from doctors and nurses must create opportunities to learn from them. Patient management meetings should also be held with doctors in order to make policies for patient management and running units.

The nursing contribution to neonatal intensive care is very substantial, so nurses must partake in decision-making and put ideas forward for patient care. The physical, mental and emotional stress of this specialised work is very great and nurse managers should make sure their nursing staff have added relaxation time above the normal limits.

Mrs Hale ended by saying that the staffing of neonatal units depends for its success on a common awareness by all levels of nursing management of the needs of the babies, the nurses and the unit. All units should have high standards and be considered good places to work, so all neonatal nurses should be examining their roles in terms of improved patient care.

The second speaker, Miss C Whitby, Nursing Officer, Neonatal Unit, Cambridge Maternity Hospital, took as her title 'Going into action', and took the audience down to the cot or incubator side. The most important relationship to develop in the special care baby unit, she said, is that between mother and baby and between the family; but also important is the relationship between the family and the nurses and doctors looking after the child.

Relationships are established right from the moment of birth; midwives are aware of the dangers of separating a baby from its mother and from the rest of the family and Miss Whitby herself firmly believes in a policy of non-separation except on medical grounds. This is not easy to put into effect, demanding hard work, flexibility and adjustment to change. She quoted from the book, Separation and Special Baby Care Units, by Brimblecombe, Richards and Roberton (Dr Roberton being a consultant paediatrician at Cambridge). In Chapter 8. the authors present a list of unjustifiable causes for admission to special care units as follows: forceps delivery, Caesarian section, breech delivery, malpresentations, mild birth asphyxia, short gestation but birthweight above 2.1 kg, multiple pregnancies, adverse previous obstetric or gynaecological history, perinatal death, stillbirth, rhesus negative or positive mothers without antibodies, maternal illness or therapy (ie. epilepsy or steriod therapy), meconium staining, traumatic cyanosis, ?cold, ?blue, minor malformations, odd facial appearance, small for dates, jittery, jaundice level rate below 18 mg, minor feeding problems, mucousy, single non-significant vomit, minor infections (of the urinary tract or skin, for instance), social problems. This list is controversial, Miss Whitby pointed out, but it is important to define what babies do not require special care, because any period of separation - from one minute upwards - can be detrimental to the mother/baby relationship later.

The problem then arose, Miss Whitby continued, of coping with the small well babies and at Cambridge an intermediate or transitional care area has been introduced where all well babies weighing 2 kilos and over are admitted, with their mothers. This is an ordinary post-natal ward below the special baby care unit, where all these mothers and babies, as well as mothers with babies in special care and ordinary full-term post-natal mothers, are admitted, if sufficient beds are available. There are no special staff on this ward and although some babies need such procedures as tube feeding and dextrastix estimations, the mothers are taught how to do these procedures and the babies do very well. Although the midwives were horrified at this innovation initially, now they welcome it because they see how satisfactory it is for mothers to be in charge of their own babies during the day, so that the bonding process can continue uninterrupted.

It is more difficult to foster the relationship between parents and babies in special care but there are ways of achieving this: first by early contact with the father. At Cambridge the father is able to be with his baby within an hour of birth. When he comes into the special care unit he is encouraged to look at and touch his child, whatever its condition, to give it a name and to be given clear and truthful information about its condition by the doctor or sister in charge. Then the baby is photographed and the prints are clipped to a booklet about the unit which gives the father information about how the unit is run and what to expect when visiting it in the way of machinery, equipment and noise and what the nursing staff are doing. The type of camera used at Cambridge is a Kodak EK 100, costing £24.00 which takes an instant picture developed in 3 minutes. Films cost £4.49 and flash bulbs £1.55 (or 10 for £8.00). The cost per photograph is approximately 50p. If hospital funds are not available, parents can be encouraged to donate a camera to the unit, or the hospital League of Friends can be approached, or the National Association for the Welfare of Children in Hospital. There is now a Government recommendation that babies in special intensive care should be photographed for their parents, Miss Whitby added.

The photograph will also be sent down to the mother in the ward to keep by her while she is separated from the baby; she can show it off to the other mothers and it will reassure her that her baby is alive, as she may be afraid it has died. Staff must emphasise the picture is for her alone, as only too frequently photographs are given to the rest of the family to take home!

The father is told he can visit the unit at any time, with other members of the family, so that contact with the baby can be established early on. Then the mother is brought together with her child as soon as possible: either by taking the infant to the ward, or the mother to the unit. The mother must be encouraged to see, touch, talk to and if possible, cuddle her baby. If it is very ill, she will need to have the courage to open the ventilator door and stroke her child and it is important that nursing staff should give her the help and reassurance she needs, tell her the baby knows she is there and that the sister or a doctor should give her clear, truthful information. These initial contacts are all-important, Miss Whitby emphasised.

Next, the mother must be encouraged to breast feed, as this is a real morale booster for her. It is also essential for the baby and staff in post-natal wards must understand the importance of early expression of breast milk. The mother should be helped to express by hand 6 to 8 hours after birth. Then she should be put on to the humelactor four-hourly; she must watch her own milt going down the tube. Humelactors can be hired from the National Childbirth Trust at £5.00 deposit and £5.00 for the first five days (ie.50p per day).

The mother should be encouraged to do as much as she can for her baby. As soon as it is stable she can help to change its nappies, tube feed and bath it with Hibitane cream once daily, change its bedding and later give it a water bath. The baby should be taken out of the incubator as soon as possible and the mother can then dress the infant ready for its cot. To encourage her to participate in care she should be given a 'visiting sheet' - a list of things to be done for her child, which she can tick off as she does them.

Babies are transferred back to the referring hospital as soon as possible to minimise the expense of travel for the parents but this can cause problems, Miss Whitby said, if the staff do not have the same approach to the parents. When mothers had told her they felt their babies no longer belonged to them but to the hospital, she had felt all her efforts to encourage bonding had been in vain. She reiterated that the atmosphere in the unit and the doctors' and nurses' attitudes to parents, can make all the difference. They must be made to feel welcome, they must be able to trust staff to tell them the truth about their babies, they must be encouraged to make friends with other parents and they must always be made to feel the baby is theirs and has not been taken over by the unit.

Miss Whitby ended by quoting from the same book: 'Suggestions for the future: there is a need for more research on the growth of social relationships between infants and parents in the immediate neonatal period. Confirmation of the short and long-term psychological advantages of the greater early contact between babies and parents would, in our opinion, be important evidence with which to influence changes in nursing practice in maternity units and changes in the policy regarding the admission of babies to special care. The ideal goal is flexible health care service which allows parents to retain responsibility for their children and to play an active part in their care against a background of expert medical and nursing care and support."

The parents' point of view was eloquently expressed by Mrs Angela Roques, Nurse Tutor at the Hospital for Sick Children, Great Ormond Street, 'Speaking as a mother', and by her husband. Mrs Roques told the meeting that her baby Peter came into the world at 27 weeks' gestation, weighing 1.05 kilos. It had been a very traumatic time for her, as she was still at work and had not begun to prepare for the baby. Her membranes had ruptured when she was asleep in bed; she had telephoned the hospital and was told to come in straight away, although it was 3.00 a.m. She had to locate her husband, who was away from home, so that her two-year-old child would be looked after. She was convinced she would lose the baby; she was not concerned about the new child but about her husband and other child and how they would cope without her.

Mrs Roques's baby was born two days after she was admitted to hospital and she was apprehensive, knowing that there would probably be something wrong with it. She had no desire to see it and it wasn't until 36 hours after the birth that she was able to bring herself to ask to see the baby. The prospect of its death did not worry her; rather she viewed the possibility with relief as it would remove a burden from her. The consultant paediatrician, whom she had worked with in another hospital, had been supremely helpful and supportive, keeping her informed of the child's progress, although Mrs Roques said she was incapable of taking in the information. Finally, when there was a chance the baby might survive, she broke down, not knowing how to cope and a nurse had asked her "What are you crying for?" When she went home the baby was transferred to another special unit, which she found positively awe-inspiring. She had complete confidence in all the staff and was immediately reassured when the sister told her: "We are not at all concerned about him". The fact that the staff were not worried about the baby meant that she too could have confidence in its future.

In this unit Mrs Roques never had to go to the staff to ask about her baby's progress and stressed that to do so requires courage. She also said how important it is for parents to see their baby's face, as they can relate to this in the midst of all the impersonal equipment. Although she was not able to handle the baby until he was about four weeks old, she was made to feel he really belonged to her. She said that parents need to be encouraged to visit a sick infant, as they feel helpless and wonder what good they can do as the baby cannot recognise them. The strongest link with her baby was breast feeding. She used a humelactor and was delighted when she was told she could feed him orally; but it was a shock to go into the unit and find he had been bottle fed. The staff had neglected to tell her it was their policy always to give one bottle feed to ensure that all was well. After that, things went well and she was proud to be told she was only the second mother to take her baby home from that unit breast feeding.

Parents rely on small things, such as a minute weight increase, to give them hope for the future, Mrs Roques said. She had been thrilled, for instance, to walk into the unit on Christmas Day to find a note pinned to a cot which read: "Please, Mummy, will you put me in a cot". It was a sensitive touch on the part of the nurse who did this. When she took the baby home she found the bonding process was well established, for when, six weeks later, the baby caught whooping cough and had to return to hospital, she found the effect emotionally devastating.

Mr Roques confirmed all that his wife had said, adding that she had had a double loss, because after she returned home their older child had rejected her; this was a point staff might take into consideration when dealing with parents. He underlined the importance of being given true, factual information. His own bonding with the infant had been delayed by the circumstances following his birth, as he had been unable to handle him for several weeks and had also had to give most of his attention to Michael, his older son, when they were visiting the unit. Perhaps he might have been given more help and encouragement from the unit staff. He challenged the policy of non-separation from the mother, pointing out that his wife had completely rejected her newborn baby and didn't want to be reunited with it. At the same time, he had been impressed by the words of the consultant paediatrician, who had told them: "It is better that you love your baby and if it dies mourn for it. At the end of the day you will be a more complete person".

Referring to the information booklet for parents, Mr Roques suggested that a short 8-mm film made at the unit would be more helpful in preparing them for the noise and the welter of machinery and equipment surrounding their child. And there are moments, in his opinion, when it is better not to tell a parent the truth if the truth would give him cause for anxiety.

'Going home' was the subject of the talk which began the afternoon session, given by Mrs D J Hyde, Nursing Officer, Community Special Care Baby Service, Brunswick Health Centre, Manchester. She started by emphasising that parents go through a traumatic experience during the initial period after the baby leaves hospital. Community special-care baby sisters have a unique opportunity to see some of the barriers most commonly obstructing the development of the bonding relationship between mother and baby in the special care unit and to help them when they return home.

The Community Sister makes her initial contact with mother and baby as soon after the birth as possible, while they are still in hospital: sisters visit special care baby units and post-natal wards daily. A home assessment is made as soon as possible after delivery and well in advance of the baby's discharge, to enable the sister to advise the mother about home preparations and ensure that there is adequate heating, for instance.

During her visits to the mother in hospital, the community sister obtains details of her medical history and social background and also monitors the baby's progress. Proper preparation of the home, particularly with regard to heating, is vital in preventing infant mortality through hypothermia. If any problems present themselves, the social services and the health visitor are contacted. Every baby is referred on discharge to the health visitor, who may visit the mother's home with the community sister.

When the mother and baby are discharged from hospital they are visited on the first two consecutive days and thereafter as frequently as the community sister thinks necessary. This service continues for as long as the mother needs individual support and the community sister may call up to four times daily to give help to mothers with very small babies, those with heart defects, feeding problems, or congenital abnormalities. All staff attend a daily report meeting to ensure adequate monitoring of cases and good communications.

Health education is an important part of the community sister's work; many women in social classes 4 and 5 (from which a high percentage of low-birthweight babies come) do not attend parentcraft classes and have little ante-natal care. There is easy access to paediatricians and in Manchester there is a Regional Neonatal Flying Squad whose services are extended to community sisters and midwives should they need it. Contact can be made by radio telephone, which all sisters carry.

Turning again to the mother/baby bonding relationship, Mrs Hyde said that common sense and simplicity are needed in handling tense, anxious parents and in overcoming the barriers to establishing relationships. High on her list of barriers came fear and ignorance. While in hospital, mothers are often too fearful of asking those in authority for help and advice but in the relaxed atmosphere of home they will consult the community sister freely. They are also fearful about giving medications, even though they have been issued with written instructions and often delay doing so until the community sister's first home visit.

Ignorance of language, or inability to read, are other barriers and a practical demonstration is often needed. Babies frequently need at least three forms of medication and if the mother cannot follow written instructions, mistakes are inevitable. For example, one mother tried to give Vitamin drops via the nostrils, as she connected drops only with eyes, ears and nose.

Many mothers require help in the preparation of feeds, particularly in measuring quantities if they have not mastered the metric system. Finding the right type of teat is also important and it would be helpful to give the mother two hospital teats routinely on discharge, so that she knows the type to use. Clothing the baby is another matter on which she may require advice: after the warmth of hospital she may not realise her baby will need extra clothing if her home is not so warm. The baby's own clothing should be used when the mother 'rooms in' with the baby.

Social barriers to the development of the bonding relationship may be present at home in the form of worry about a husband (or lack of one), other children, poverty, or poor housing conditions. The single girl may have anxiety about her relationship with her own parents.

Most of the visiting done by the community sisters is to families with a high risk of not developing good bonding relationships, Mrs Hyde said, because they have had a period of separation while the baby was in the special care unit, because many are from the lower social classes and because many are illegitimate. The community sisters are often able to alert the other services involved if relationships are not developing well in a certain family. They attend case conferences frequently, sometimes long after the baby has been transferred to the health visitor, because case workers often want information about the early stages of the family's relationships.

In conclusion, Mrs Hyde referred to the theme of the conference: 'How can we improve our relationships in special care baby units?' So far as continued care was concerned, there must be co-operation and communication all along the line. "We are living in a technological age", she said, "and this is good but let us always be aware of the human needs for simplicity in times of stress".

A learned dissertation on research into parent-child relationships was the final talk of the day, given by Mrs Joyce Prince, a Nursing Officer at the Department of Health and Social Security. She said that there was undoubtedly a large 'learned' component in affection between parents and their children and that affectionate responses could be distorted or disrupted by physical separation. It has been accepted for some years that bad care of children can have bad effects on their later years but attention has only recently been focussed on the possible effects of temporary separations between mother and baby immediately after birth.

Studies with subhuman species have shown that distortions in normal patterns of behaviour could result from unusual early experiences. For instance, young goslings, ducklings and chickens become 'imprinted' on the first thing they see between 24 and 48 hours after hatching and normally follow their mother. If they should become imprinted on some other creature or object, this normal behaviour pattern might be permanently impaired. Baby rhesus monkeys have been reared with surrogate mothers made of wire and towelling and despite the fact that food was available on the wire surrogate mother, the baby monkeys became attached to the more comforting soft towel 'mother'. When they became adults, these monkeys made disastrous parents.

Many primitive societies ensured a close relationship between mothers and their babies by segregating them from the village community for up to 40 days. Kennell and Klaus (1975) had challenged the view that bonding takes several months, suggesting that there is a unique period soon after delivery when the human mother is especially sensitive to her baby and most ready to become attached to it. The results of a study showed that mothers who had had extended contact with their babies immediately after birth stood nearer to their babies when they were being examined, showed more soothing behaviour and more eye-to-eye contact. When the children were two years old these mothers talked more to them and at five years the children had higher IQs than those of the control group. Extended contact also appears to affect infants' weight gain and the success of breast feeding.

These and other studies indicate, Mrs Prince continued, that the events at and immediately after birth may have profound consequences and the separation between mother and baby at this time should not be undertaken lightly. The authors of a study of special care baby services in the North West Thames Region (1979) concluded that disturbingly large numbers of infants are admitted to special care units for observation and that this is no longer justifiable in view of the adverse effect on the mother/baby relationship. Where seriously ill infants were admitted to intensive care, while mortality and morbidity are thus undeniably reduced, the effects of the abnormal environment of an incubator on the baby and of the unit on the parents, must be considered. Mrs Prince had herself observed the behaviour of parents whose babies were in incubators in a unit with an 'open-door' visiting policy, where parents were encouraged to touch the infant in the incubator. 37 babies and their 'caretakers' and visitors were observed for 219 four-hourly periods. The results of this study are shown in Tables I to V. Factors which the observers considered important in increasing contact between parents and babies were (1) material confidence, and (2) an experienced and sensitive nurse or midwife who can build up a mother's confidence and provide a good role model.

Other studies had found that parents have to overcome very high levels of anxiety to visit the special care baby unit; and that the emotional crisis of producing a small, ill, baby is often not resolved for some time after the baby comes home. There is first a 'honeymoon' phase, then a phase of exhaustion when the mother complains about the baby and a final 'recovery' phase. Yet another study (Hawthorne et al, 1978) of the special care baby unit in Exeter, had pointed out the overriding importance of social factors in parental visiting: ie., the number of other children in the family, the distance of the home from the unit and the cost of travel. In this sample of 200 babies, almost 30% had not seen either of their parents in the 48 hours after birth (Table VI).

Looking to the future, Mrs Prince said that more needs to be known about the growth of social relationships in the post-natal and the long and short-term effects of different kinds of contact and stimulation. Further research is required into the sensory capacities and abilities of the immature infant; the effect of different kinds of support or provision for parents needs further investigation; and a greater use of special care by medical and nursing staff in the general maternity wards would reduce the number of babies being separated from their mothers for special care.

Before the lunch interval the audience had divided into groups to discuss three questions:

1. How can staff best prepare relatives for their first encounter with a special care baby unit?

2. What problem do you think is in most urgent need of research if relationships are to be improved in special care baby units?

3. What are the difficulties in getting access to research findings and implementing them?

Group leaders reported at the end of the day the points that had emerged from their discussions.

Group D. thought that few hospitals would have the facilities to make a film of the special care baby unit to show to parents, as Mr Roques had suggested but agreed that a small display unit would be practical and useful. They were more concerned with helping nursing staff to improve their communication skills, both verbal and non-verbal, so that they could be of more help and support to parents. They suggested research should be done into whether counselling services can improve the quality of relationships; and - on a more practical note - that an incubator should be developed which looks less intimidating and more like an ordinary cot.

On the subject of improving communications, Miss Whitby commented that nurse managers should take the initiative by encouraging their staff to express their feelings. Mrs Hale added that nurses need greater understanding of the art of communication and that the Joint Board of Clinical Nursing Studies is at present working on a guidance document. Sensitivity is the key, she emphasised.

Group B. considered research into staffing levels would help to improve relationships between staff and parents. Nurses are aware of the problems, they said, but could cope more efficiently with more staff and less pressure of work.

Group C. commented that a common excuse for limiting visiting to special care baby units was the risk of infection and asked if research had been done in this area. One of the speakers replied that is was believed that free visiting brought no increased danger of infection.

Group E. pointed out that one of the chief problems is the long distance many parents have to travel to regional special care units. It is often up to 14 days before some mothers see their babies if there are no beds available for overnight stay in hospital. The expense of travel is also a deterrent, as well as the problem of siblings. The group wondered what the solution to these problems might be. Miss Whitby suggested that early transfer back to the referring hospital was one solution; sending the parents photographs of their baby was another. Mrs Hale advocated provision of better 'hotel accommodation' for parents to enable them to visit their sick babies and said that in Nottingham parents could travel and telephone free of charge. A member of the audience remarked that in the United States there is a free-phone service into the special care baby unit and the nurse in charge can travel up to 200 miles to visit parents and discuss the baby's treatment with them. It was generally agreed that more beds for mothers within units were required.

Another delegate asked if enough is being done for fathers. Mr Roques replied that if making a film is out of the question, a soundtrack of the noise in a special care unit would help to prepare them for visiting. Miss Whitby added that fathers must be given the same opportunities as mothers to see, touch and cuddle their babies.

The question of establishing a bonding relationship with adoptive parents was raised and it was agreed that this could and should be done in exactly the same way as with natural parents. Another delegate asked for views on involving siblings in special care units; Mrs Hale replied: "As much and as often as possible please!" There are no problems about infection and there should be no barriers. She added that, should the baby die, siblings should also be given the opportunity to grieve.

Group F. asked if there is a shortage of money for nursing research. Mrs Prince answered that there is no shortage of funds, only a shortage of nurses to do the research. She recommended the RCN's publication on grants and bursaries as a useful information source and said many drug companies also make funds available for research. Sadly, only 2% of research funds is taken up by nurses. She also pointed out that there is a nursing research section within the DHSS Nursing Division (of which she is a member) which is always willing to give advice and help. The chief difficulty, in her view, is that the people who can see the problems and should be doing research have neither the time or the expertise. She said Polytechnics and Universities are useful sources of information and guidance; they can help to present a research project so that it will have a good chance of attracting funds. She pointed out that it is part of the duties of Regional Nursing Research Liaison Officers to advise in the setting up of research projects.

Another group asked how a nurse should answer the direct question, "Is my baby normal?" when a doctor is not available. Miss Whitby replied that the answer should be given by a sister, who should be prepared to tell the truth gently. She should be sensitive but honest and positive: a positive approach is far better for the parents, even if the baby dies, in helping them to come to terms with the situation. Mrs Roques confirmed this view. Mrs Prince commented that no one can predict exactly what the future holds and it is always worth making the point to parents that no matter how severe the baby's handicap, a loving environment will help to improve it, thus giving them a positive approach to their problems.

The Chairman closed the conference by remarking that it had been a day of learning and sharing. Certain words had been reiterated throughout: flexibility, home, love, linking. These were all words to keep in mind in order to give the best service to patients.

TABLE I

Time Spent in Special-care Unit

Days	1	2	3	4	5	6	7	9	11	13	15	16	17	26	28	Total
Boys	2	3	2	1	0	2	0	0	1	0	1	1	1	1	1	16
Girls	11	3	0	2	1	0	1	1	0	1	0	0	1	0	0	21
Total	13	6	2	3	1	2	1	1	1	1	1	1	2	1	1	37

One boy died at two days old and one girl at five days - a mortality rate of 5.4 percent. The mean length of stay for the girls was 3.6 days and 8.9 days for the boys. Moreover, the boys were more likely to spend three days or more in an incubator ($\chi^2 = 5.2$, 2df, $p < 0.025$).

Table I shows the number of babies and their length of stay.

TABLE II

Time spent in Nursery (minutes)	No. of Observation Periods (N = 219) Mothers' Visits		Fathers' Visits	
	No.	%	No.	%
None	167	76.3	196	89.5
<5	2	0.9	6	2.7
5-9	14	6.4	7	3.2
10-14	8	3.7	3	1.4
15-19	2	0.9	1	0.5
20-29	11	5.0	2	0.9
30-39	6	2.7	4	1.8
40-49	4	1.8	0	0.0
50-59	3	1.4	0	0.0
>60	2	0.9	0	0.0

Table II shows the number of observation periods that parents visited and the time they stayed in the nursery. No visits by siblings were observed. The time was not spent exclusively with their baby as can be seen from Table III.

TABLE III

Time Spent in Contact with Special-care Infants

Contact Time per four Hours (minutes)	Mother		Father		Nurse		Doctor		Other	
	No.	%	No	%	No.	%	No.	%	No.	%
None	167	76.3	198	90.4	15	6.8	126	57.5	196	89.5
1	4		2		9		47		10	
1-2	3		4		7		26		9	
3-5	5	8.6	2	6.4	17	26.9	6	39.3	1	10.0
6-9	7		6		26		7		2	
10-14	4		1		34		1		1	
15-19	3		2		25		0		0	
20-24	7	15.1	3	3.2	30	66.3	3	3.2	0	0.5
25-34	11		0		24		0		0	
⩾ 35	8		1		32		3		0	

This shows the time in contact with the infant.

For comparison four normal mother-baby pairs in the lying-in wards of the hospital were observed.

TABLE IV

	Time in Contact per Four Hours (Minutes and seconds)					
	Mother	Father	Nurse	Doctor	Other	Total
Baby A	0.0	1.20	9.32	0.0	0.0	10.52
Baby B	22.20	0.0	9.08	0.0	0.0	31.28
Baby C	70.12	3.28	0.0	0.0	0.13	73.53
Baby D	83.40	0.0	17.36	0.0	0.25	101.01
Mean	44.03	1.12	9.04	0.0	0.095	54.28

Table IV shows the results. The major source of attention for a normal baby even when in hospital is the mother and as can be seen, even though this was a 24 hour observation schedule (i.e. including night time) an average of 45 minutes per four hours is spent with contact between mother and infant.

TABLE V

Percentages of Types of Contact with Special-care Babies

Type of Contact (minutes)	Mother %	Father %	Nurse %	Doctor %
Looking				
None	79.5	90.4	47.5	63.5
≤ 9	13.2	5.9	45.2	35.6
> 9	7.3	3.7	7.3	0.9
Touching				
None	94.5	99.1	33.0	63.5
≤ 9	4.1	0.9	58.0	35.6
> 9	1.4	0.0	9.0	0.9
Handling				
None	96.3	100.0	23.7	98.6
< 9	3.2	0.0	49.3	0.9
> 9	0.5	0.0	26.9	0.5
Cuddling				
None	90.7	98.6	83.6	100.0
< 9	4.1	0.9	12.3	0.0
> 9	5.0	0.5	4.1	0.0
Bottle-feeding				
None	95.9	99.5	57.5	100.0
< 9	1.4	0.0	13.7	0.0
> 9	2.7	0.5	28.8	0.0

Table V shows the kind of contact which parents, nurses and doctors make with the babies. Most of the contact with parents is looking. This is not the normal en face looking which is important in the development of social relations.

TABLE VI

LENGTH OF BABIES STAY AND VISITING

	7 days N = 81	8 - 14 days N = 57	15 days + N = 62	Total N = 200
Visited by mother only	15%	12%	8%	12%
Visited by father only	6%	2%	0%	3%
Not visited by either parent	20%	9%	3%	11%
Visited by both parents	59%	77%	89%	74%

Table VI shows the % visits for different lengths of stay.