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ORIGINAL ARTICLE

Health care professionals' experiences of parental presence and participation in neonatal intensive care unit

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Abstract
In a neonatal intensive care unit (NICU), the care is carried out not only by health care professionals but also by parents. The aim was to describe from a lifeworld hermeneutics approach, health care professionals' experience of parents' presence and participation in the care of their child in the NICU. Twenty health care professionals in two NICUs were interviewed. The interpretations of four themes indicate that the care personnel in NICU were ambivalent towards the presence of parents and set limits including dictating conditions for parental participation. In the encounter with the parents, they balanced between closeness and distance and had difficulty in meeting worried parents. There was little ability to deal with parents in crisis in the correct manner and sometimes an avoiding attitude was present. The care environment obstructed the personnel's endeavours to involve the parents in the care of their child. The result shows there is a need to train personnel in the art of dealing with parents in crisis. This should include developing the care environment to allow parents to be present and take part in the care of their child but also give personnel the prerequisites to make this possible.

Key words: *Health care professional, parental participation, newborn caring, neonatal intensive care unit, lifeworld, hermeneutics*

Introduction

Ten per cent of all newborn children in Sweden need care in a Neonatal Intensive Care Unit (NICU), usually due to premature birth, respiratory disturbance and infection. The length of hospital care varies from a few hours to several months, with an average of 12 days (Swedish Association for Paediatricians, 2000). The mother-child relationship is central for the development of the child. This has been shown during decades of research (Bowlby, 1969; Ainsworth, 1973; Klaus & Kennell, 1982) and is still confirmed (Adshead & Bluglass, 2005; Kennell & McGrath, 2005). When the newborn child needs hospital care, this essential relationship should be supported by allowing parents the possibility to be present and take an active part in the care of their child day and night (UNICEF, 1989; NOBAB, 1992).

When neonatal hospital care was established in the 1960s with the aim of increasing the survival for the mother and child they were treated at the same unit. Gradually, the care became more and more medico technical, neonatal care was separated from obstetric care and mother and child were treated in different units (Davis, Mohay & Edwards, 2003). Recently published research shows that mothers of children who have been treated in the NICU felt left out, neither belonging to the maternity unit nor the neonatal unit. This feeling negatively affected their identity as mothers and was still present years afterwards (Wigert, Johansson, Berg & Hellström, 2006). Although integrated care of mother and child is more frequent today, it is still not common (Davis et al., 2003).

Parents who have a child in NICU are fragile. They have not yet established the relationship with their child and the way health care professionals as experts in the care of the child, treat them is significant. By reaching out to the parents, informing and supporting them, they may gain a feeling of well-being and control in the situation (Cescutti-Butler & Galvin, 2003). There is a lack of similar research

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regarding the experiences of the personnel in the NICU context. In order to improve the care of the whole family, the aim of this study was to elucidate health care professionals' experience concerning parental presence in NICU and participation in their child's care. Participation here includes commitment, involvement, actively taking part as well as participation in decision-making concerning care and treatment of the child (c.f. Swedish-English Dictionary, 2006).

Method

The study was carried out with a lifeworld hermeneutic approach, which offers the researcher a base to analyse the world as human experience and communicate it. The research begins with lived concrete descriptions of everyday life experiences (Dahlberg, Drew & Nyström, 2001), in our study health care professionals' everyday life in NICU. The hermeneutic philosophy highlights the importance of interpretation for understanding and stresses that the being in the world is the basis for understanding where the language is an essential tool as it gives access to another person's experiences (Gadamer, 2004). Hermeneutic lifeworld research requires that the researcher has an open and sensitive attitude towards the phenomenon in focus, and bridles the pre-understanding through a distancing and reflective attitude to new experience (Dahlberg et al., 2001).

The first author (HW) has clinical experience as a paediatric nurse in NICU. This experience is a base for the study; including the whole process from definition of research question through selection of informants, data collection, analysis and description of result.

Participants and data collection

The operational managers and unit managers at the two NICUs were contacted and they gave their approval for the study. All the health care personnel at the respective units were given oral and written information about the study with the purpose of gaining comparable representation from all care personnel categories; physicians, nurses and paediatric nurse assistants. Eleven people expressed an interest in participating, and nine people were included through suggestions from the personnel. In total 3 male and 1 female physician, 9 female nurses and 7 female paediatric nurse assistants were included. The personnel were aged between 31 and 63 years, the median age was 44. The respondents' working experience within NICU varied between 2 and 32 years with a median period of 14 years. All the physicians were specialists in neonatology, 8 of the nurses were specialists in paediatric nursing, and all paediatric nurse assistants had the nursery nurse exam.

Tape-recorded interviews were carried out in the respondent's home or at the hospital. In the open interviews the respondents were encouraged to describe their experience as vividly and in-depth as possible. Two main questions were the guide for the interviews; How do you feel about parents participating in the care of their child in NICU and, What do you do to facilitate that participation? Attendant questions were posed: What do you mean? Could you tell us more? The duration of the tape-recorded interviews varied between 45 and 90 min and they were transcribed verbatim to text by the interviewer (HW).

Analysis

The analysis was based on principles described by Dahlberg et al. (2001) who emphasize that lifeworld hermeneutic approach does not use any predetermined hypotheses, nor any theories or other interpretive sources decided upon beforehand. Focus for the analysis was on meanings in the text that were condensed, compared and grouped. Clusters evolved and they were sorted into sub-themes that were compared, contrasted and finally formed as four themes. This work with themes of meaning was followed by a tentative interpretation for each theme in order to identify underlying conditions for the phenomena. An open and critical reading of the text was used in order to find explanations. Openness and pliability were thus complemented with a distancing, reflective and critical approach. Interpretations of the parts were constantly compared with the interpretation of the whole in order to decide whether there was a discrepancy between understanding of the parts and understanding of the whole. Finally, all valid tentative interpretations were compared resulting in a main interpretation describing health care professionals′ experience of parental presence and participation in the care of their child in NICU.

Ethical considerations

Ethical approval and permission to undertake the study was obtained from the Research Ethics Committee, at the University of Göteborg, Dnr Ö 591–03. The personnel were informed that participation was voluntary, all information would be treated confidentially and the tape-recorded and transcribed interviews would be locked securely in a fireproof place.

Result

The result is presented in two stages. First, the four themes are described one by one with a consequent interpretive analysis. Thereafter, a main interpretation integrated with a discussion is presented. The description contains coded quotations numbered from 1–20 with a letter for each occupational group (N = Nurse, PNA = Paediatric Nurse Assistant, P = Physician). An outline of the themes and sub-themes is given in Table I.

Theme 1. To train parents in parenthood

The personnel felt a responsibility to form a family in function with competent parents having prerequisites to deal with the strain at home.

Guide the parents

The parents became involved by being included in the practical duties with the child and by being informed continually of the child's condition and treatment. Here the dialogue with the parents was seen as central, with time for explanations to help them understand what had and would happen with the child.

> ... being allowed to do as much as possible as early as possible and participate in everything, and by that I mean not only purely practical duties in taking care of their child but even involved in what we discuss. (P 12)

The personnel wanted to mediate to the parents that their presence was important for the child's health and development and that they as parents in particular had a responsibility to satisfy their child's unique needs. Each family had their own set of prerequisites; some parents needed more support than others did, which could be time-consuming.

> To guide the parents and make sure that they become parents is actually the most important job in the unit. (N 9)

The care personnel frequently commented that the child they were caring for was not their child but the parents child. At the same time, they found it difficult not to push the parents aside and take over the care of the child in order to get things done faster.

> You understand that the parents have an important role to play in the care and the longer you've worked the more you feel that it is actually their child you're taking care of. (N 19)

Give the parents permission to care for their child

The care personnel gave the parents permission to participate in the care of their child. First, they needed to ensure that the parents were capable of carrying out tasks such as feeding and washing their child. It was important to explain to the parents what was expected of them, both when they should come and what they should do. If they did not come in time before feeding, they could miss the possibility to perform tasks such as nappy changing. It was also important to set limits for what was permissible or not for the parents although this was felt to be difficult. This included making clear that they as professionals had the main responsibility and control of the child's health, including the nursing care. If the limits for parental involvement were not marked, there was a risk that the parents would do something which was not permitted. However, the more time that passed, the more the parents were allowed to take over caring activities, including certain special tasks such as turning off the monitor alarm. They were considered as experts in the caring of their child. However, ultimately the child's condition placed a limit on the participation of the parents. The priority was the survival of the child and when a child was very sick, there was sometimes no place for the parents.

> It is very important that the parents also understand what role they should take, set limits. Otherwise it is easy for the parents to take over, they start doing things they shouldn't. (N 19)

Table I. Outline of the themes and sub-themes.

Themes	Sub-themes
To train parents in parenthood	Guide the parents
	Give the parents permission to care for their child
	As an expert show the way
To use oneself	Sense the unique
	Balance between closeness and distance
	Dealing with worry
	Give support
Participating parents both facilitate and obstruct care work	Facilitation and enrichment
	Obstruction
The care environment both facilitates and obstructs	Premises
	Staffing
	Care organization

As an expert show the way

The care personnel saw themselves as experts in nursing care and thus it was natural to instruct the parents on the care of the child. Simultaneously they were aware that the expert role could be a hindrance between child and parent.

> We know the behaviour of the child. We know it better than the parents. (PNA 14)

> They are of course in a position of dependence, having their child in NICU but we know how to care for the child. (N 10)

As experts, the care personnel also knew what was best for the parents. They were welcome to come to the unit at any time but they should also try to be at home, taking time out for themselves and each other and for any children at home. At the same time, there was concern about parents who did not came to the unit. While a delicate matter, it was thought important to ask the parents why they were not with their child.

> They also need time for each other, they don't need to be here, and at the same time you have to say that the parents are needed for their child. (N 1)

Tentative interpretation of the theme "To train parents in parenthood"

The care personnel felt a responsibility to care for the whole family; both child and parents, in order to give the best prerequisites for care at home. As experts in caring they "knew" the characteristics of a "good parent" and the parents had to first show that they could take care of the child, take their "parental driving licence" before they were allowed to take over responsibility to care for their own child. The care personnel thus functioned as a "gatekeeper", setting the limits for when and what the parents should be permitted to do with their child. An essential limit for parental participation was the condition of the child. The personnel wanted to involve the parents in the care, but at the same time, they wanted to carry out the care themselves as they knew how it should be done and they could do it faster. They also expressed concern about parents being too much involved in the care of their child, taking over the carer's tasks.

Theme 2. To use oneself

This theme focuses on the care personnel's use of themselves in the encounter with the parents. The basis for assessing a suitable level of involvement for the individual parent was the unique situation, personality, needs and resources, but the personnel's own experiences.

Sense the unique

The personnel wanted to consider everyone's equal worth and have a unique dialogue with each parent in order to find the best level of parental participation. Each relationship with parents was unique. When in tune it was easy to take time for the parents while the relationship with critical parents became stricter focusing only on the medico technical part of the child's care.

> The parents who are classed as lively, nice or happy get more of the personnel's time. You think about everyone's equal worth. (N 4)

To sense the unique parent included recognizing the ability of the parent's to participate in the child's care. Some were unable to be with their child as much as they wanted due to other children at home or being single parents. Even the parents' physical and psychological health could be a hindrance for their participation, they could be shocked that their newborn child was sick or the mother could suffer from complications after delivery. The parents then had to wait until they felt ready and able to absorb information and be involved in the care of their child. To sense the unique also meant recognising the unique child's needs. If the parent was considered to be insufficiently with their child, the personnel increased their care to meet the child's requirements of human closeness.

> You just feel that you want to pour out feelings for the little child when you feel that the mother and father maybe don't really care as much as you would like. (N 15)

Balance between closeness and distance

The personnel tried to find a balance between closeness and distance in the relationship with the parents. One way to be able to meet the parents was for the personnel to put themselves in the parents' position and think how they would like to be treated. Personnel who were parents or whose children had been treated in NICU found this experience important as it made it easier to identify with the parents and their needs. Sometimes the professional role was put aside in favour of a more personal relationship with the parents and the personnel telling about own private experiences.

The ambition was to treat each parent equally but at the same time, it was clear that increased closeness was given to the parents whose child was cared for during a longer period. To work closely with the families could be felt as an emotional strain, difficult to shut off. However, coming close to the family could also give energy and job satisfaction.

> It is awful to say that you don't put emotions in all the children but you don't. (N15)

> You can't just walk out the door and forget everything. That's what you should do if you are professional but that doesn't work when you work with your heart. (PNA 5)

Dealing with worry

A central task for the personnel was to face and receive the parents' worry, both the hidden and openly shown. It was especially difficult to meet the parents of children who were seriously ill or in critical condition, difficult to answer their questions and to give a prognosis for the future. To meet the parents' disappointment and grief was also difficult. If the child did not recover or developed permanent damage the personnel felt guilty for not being able to cure. They wanted guiding principles regarding how to meet parents.

> When you hand over a child who is not going to get well, that there are multiple handicaps, that is hard, you can almost feel guilty sometimes. (PNA 14)

> It is actually not that child they want to take home. It is hard. You have to get them to accept that it is their child. (N 15)

The personnel saw themselves as fellow men in the relationship with the parents and thus preferred to refer them to psychologists and welfare officers when they needed further counselling. In meeting these parents, several attitudes were described, one was avoidance.

> You can avoid eye contact, you can be asked questions that you don't really know how to answer or it takes too long and that is a characteristic you shouldn't have in neonatal care. (N 4)

> You look down when the parents come to avoid meeting their eyes. (N 19)

Give support

To give support was a central part of using oneself, which could be expressed in different ways. In the encounter with parents of a seriously ill child, there was not so much to say and the support could mean just being available. A central part in the support was to instil trust. This could be conveyed through caring, talking, giving information and promoting continuity in the care, that the same care personnel took care of the same child. Support also included boosting the parents' self-confidence in their role as parents, to feel like competent parents. Central in the support was also to instil hope in the parents. This could be done by telling them about other children who had been sick and recovered, to point out the positive such as the slightest improvement in the child's condition, and emphasize that: "children are totally incredible at recovering" (N 18).

Tentative interpretation of the theme "To use oneself"

In this theme, the importance of personnel's use of oneself in the encounter with the parents was apparent. Essential was to satisfy the unique parent's needs and resources and to find a balance between closeness and distance in the relationship, to in every encounter sense how close or how distanced they should be, with extremes from being very personal and sharing their own experiences to putting up a front towards the parents. This appeared as a process that demanded a lot of energy. The relationship became closer when parents had particular needs, when the child was treated for a longer period and when the relationship was in tune. A central part in the support was to instil trust and hope, to be a fellow man. However, uncertainty was expressed regarding encounters while a feeling of certainty was present concerning the medico technical care. In particular, it was difficult to meet parents when worries about prognosis were present, and when it was not possible to "deliver" a healthy child. In these situations, there were feelings of guilt and one way to handle the situation was to avoid eye contact with the parents. Thus, when the parents were in greatest need, the care personnel found it most difficult to encounter them.

Theme 3. Participating parents both facilitates and obstruct care works

The personnel experienced that participating parents could sometimes facilitate and sometimes obstruct their work.

Facilitation and enrichment

The staffing was planned from a viewpoint that the parents to a certain degree would take care of their child. Parents could therefore reduce the workload of the personnel when there was a shortage of care personnel. The parents also represented a continuity of care, which the personnel were unable to do due to their working schedule. Sometimes the parents had the most information about their child, which could be used when checking the health of the child, for example.

> We don't have the resources to take care of the child completely, it is built on the fact that the parents should take care of their child as well. (P 12)

The relationship with every new parent was seen as an enriching and learning experience. Something new was always learnt, knowledge of people was developed which developed their professional role. Parents who gave encouragement and appreciation increased satisfaction and energy to continue working.

> You become enriched every time you meet the parents. As long as we work we are going to get different experiences, different reflections surrounding this concerning our own work. You are never fully trained. (N 1)

> You also receive something purely emotionally yourself when you come close to people in this. (N 9)

Obstruction

The presence and participation of the parents in the NICU could also be experienced as an increased workload, when besides taking care of the child the carer also had to take into consideration the parents. A number of the personnel felt troublesome they were being judged by the parents who observed and compared their actions. Parents who wanted to push their way in and decide how the child was cared for were considered tiresome, and the relationship with these parents became different from with those who praised the care personnel. The presence of the parents could even obstruct the personnel from carrying out their work. It was cramped in the rooms and when the parent was present, the carers could be forced to wait to carry out their work such as giving the child an injection or changing the drip.

> You become tired sometimes, we are observed seven out of eight hours at work. You are judged and evaluated. (PNA 14)

Present and involved parents also reduced the care personnel's own time with the child. Parents who slept at home at night gave the carers a better chance to be on their own with the child. A need to talk freely with colleagues without having to think about professional secrecy was also evident.

> You are never alone, you feel that you need to talk amongst your colleagues and there are always at least two pairs of ears in the vicinity. It is a strain but at the same time it is important that they are with their child. So it is very ambiguous. (N 15)

Tentative interpretation of the theme "Participating parents both facilitates and obstructs"

Parents' presence and involvement was both an asset and an encumbrance. It was enriching to meet new unique parents and parents could relieve some of the care workload. At the same time, it diminished the personnel's chance to be on their own with the child or forced them to wait with tasks, which in turn contributed to increased workload. Being observed all the time by parents was tiresome. Though the carer knew at the same time that the presence of the parents was important for the child this resulted in ambivalence.

Theme 4. The care environment both facilitates and obstructs

The care environment both facilitated and obstructed the personals effort to involve the parents in the care of their child. Care environment here includes premises, staffing and care organisation in NICU.

Premises

The care personnel stressed the importance of the premises in the care. The units were not optimally suited for parents' involvement in the care of their child. It was cramped and often several children were being cared for in the rooms, which made it difficult for the parents to get next to their child. In the intensive care rooms there were a lot of carers and parents, it was noisy with a lot of running back and forth, which made it difficult to take the child out of the incubators and into the parent's arms. However, the personnel tried to found a comfortable chair for the parents and create some sort of seclusion for the family.

> You try to screen off the parents so that they have a little corner for themselves and it is of great importance where in the room the child is placed. If you know that it is a bad situation with sad parents then you don't place them nearest to the door. (N 10)

> There are no chairs, comfortable chairs, you have to fight over chairs and almost have to book who should have what chair. (N 19)

At one of the units, there was little opportunity for the parents to stay overnight and there was no parents′ room where they could rest and care for their child themselves. There was not even a room where the mother could sit undisturbed and breastfeed her child. The room that was available for breastfeeding was combined with a play area for siblings where they could for example watch video films. At the same unit, there was even a lack of rooms where the personnel could speak privately with the parents.

Staffing

The large workload together with lack of time was seen as a hindrance in involving the parents in the care of their child. Lack of time also diminished the opportunity to satisfy the parent's need for information.

> It takes an awful long time to show a parent so maybe you don't wait for a mother who may arrive shortly instead you feed the baby before. (N 10)

> You can't repair it afterwards, you can't use a quiet period to repair what you didn't have time for when there was a lot to do. (P 17)

Several of the nurses felt that the medical technical tasks were the first priority and delegated the task of involving the parents to the paediatric nurse assistants.

> I am very focused on doing the job the physician ordered. But still I am responsible for the care, it sounds good but there is no time. (N 9)

> There have been so few nurses so I feel a bit that we've lost that opportunity and in many cases that is handled by the paediatric nurse assistant. (N 15)

Care organisation

The care routines varied between the two units. In one, the children were transferred to another unit when their condition improved and need for intensive care was eliminated. This prevented the personnel from gaining a complete picture of how things were going for the child and the family. They preferred to follow the child through the whole time in care and feedback from meeting the family at their next visit was in great demand.

> Then you have it confirmed, they became quite well and many of them are doing well . . . it's enough for you to continue working in some way. (N 19)

A prerequisite for being able to work with the whole family was to co-care with the maternity wards where parents could be given the opportunity to live in the ward with their child.

> It would be good if there were more co-care wards where you could care for more mothers and children together when they (the children) are a little bigger, where they could be a little more involved. (P 7)

The increase of parental involvement in the care of their child gave cause for discussion amongst the care personnel concerning when and how parents should be participative.

> We have just discussed this morning that night personnel don't think you should take out the child (of the incubator to their parents) in the evening when they come because it doesn't suit them, but if it suits the parents then I think it should be encouraged. (N 16)

The personnel from both units expressed a need for response from their management for the work they carried out: "you always want more appreciation from the management" (N 10), not only from the parents. They were tired of reorganizations and economical cutbacks and felt that they had little chance of being able to influence their job, instead they felt forced to suit the job.

> Grateful parents, that's the reward, that's what we all live on, why we stay, I think. Some reward from somewhere else is non-existent. (P 17)

Tentative interpretation of the theme "The care environment both facilitates and obstructs"

There were more obstacles than facilities in the care environment to involve the parents, particularly in one of the units. A main problem was that the rooms were not designed for the parents′ needs which the care personnel tried to compensate for. If there were enough parents′ room the need for "specific rooms", e.g. for conversation, breastfeeding could diminished. The personnel expressed that they wanted a different model of care organization which presupposed the needs of the family, both child and parents. This longing can also be looked upon as a wish to be confirmed for their skills by the management. Instead, they searched for affirmation from the parents. A feeling of powerlessness was present which caused different opinions amongst the staff. Perhaps this caused the vivid discussion and different opinions about care routines related to parent's participation in the care of their child.

Main interpretation and discussion

The interpretations of the four themes indicate that the care personnel in NICU were ambivalent towards parents' presence and set limits including dictating conditions for parental participation. In the encounter with the parents, they balanced between closeness and distance and had difficulty meeting worried parents. The care environment obstructed the personnel's endeavours to involve the parents in the care of their child.

The care personnel's ambivalence consisted of an awareness of the necessity of parental participation and at the same time a need to carry out the care themselves. When there was a shortage of staff, the parent's participation diminished workload but their presence also meant being constantly observed and having comments on their work. An ongoing discussion arose among the personnel whether or not to involve the parents in the care of their child. This result is in accordance with Brodén (2004) who has stated that nursing care of a child at hospital is mainly carried out by paediatric nurses and paediatric nurse assistants who can be an obstacle for parents to care for and interact with their newborn child.

The care personnel's ambivalence and limit setting for the parents′ participation corroborates with research by Fegran (1996) who also has found that indistinctness often arose where the limits of where the allocation of responsibility between care personnel and parents go, and who "owns" the child. She declares that a clearer allocation of responsibility would contribute to reducing stress and frustration in both parties. In our results, the fact that the care personnel wanted to strengthen the parents' trust in themselves and encourage them to develop their own routines in the care of the child stood out. At the same time, the personnel wanted to decide when the parents were ready to participate in the child's care and how they should do it. Consequently, there were contradictory messages. Setting limits for how much the parents should be involved is a form of exercising power, which can be compared to the relation between a driving instructor and pupil in the process to passing a driving licence, in this case a parenting licence. To set limits is maybe also a way to mark one's professional preserve.

Another aspect of setting limits for the parents was apparent when the personnel tried to find a balance between closeness and distance, to be close enough including personal and emotional engagement, without being too close but preserve the "professional distance". Closeness or distance in the relationship was also determined by what signals the parents sent out regarding approval or disapproval. Those who did not question the personnel seemed to be awarded with closeness while the critical ones were treated strict including a minimal of dialogues only focusing on the medico technical part of the care.

The difficulty for the personnel to meet the worried parents and only see themselves as ordinary "fellow men" is noteworthy. To be a professional carer in NICU should by definition also include being able to meet people in crisis and clearly shows the need for further training to strengthen the personnel and increase their competence in this important part of the care. One way to behave when confronted with the parents' worry was to avoid, which was expressed in avoiding eye contact with the parents. This attitude is described by the philosopher Sartre (2003) who states that people can make themselves adversaries by in a difficult situation, avoiding it. One's own feelings then become hostile and are obliterated, in this way people become their own self-obliterators. These are strong words that carers need to be confronted with but in a safe, calm environment, perhaps in organized reflection groups for care personnel.

The basis for all caring is the caring relationship, i.e. the encounter between the person who needs care and the person who performs care. A prerequisite in a caring relationship is that the carer shows interest and allows the person in concern to express her/his needs (Eriksson, 2000). The parents in our study can be seen as both in need of care and practitioners of care. In the results, it was apparent that the carers saw themselves as experts in caring. When they determined the parents' needs and resources, and the degree of closeness and distance in the relationship, they used their own experience

and how they would like to be treated if placed in a similar situation. The philosopher Lögstrup (1997) has illustrated this and states that we in the encounter with another person can allow our own interpretation to go against the other's expectations and desires which can give the impression that we believe we know what is best for the other. From our own instinct concerning what benefits the other best, we decide over the other if with good intent. Lögstrup states that it is an encroachment that from one's own understanding of life to believe that we know what is best for the other, and emphasizes that there must be a will to allow the other to decide for her/himself and to give the prerequisites to enable a decision (Lögstrup, 1997). To avoid such an "encroachment" the personnel should, in their meeting with the parents in NICU, repeatedly ask parents about their needs and to what degree they want to be involved and participative in care of their child.

A prominent task for the care personnel was to instil hope and give comfort to the parents. This is interesting as it has been shown that there is considerable strength in instilling hope which is an essential and supreme motivational power of life nurtured in human relations (Lögstrup, 1994) and can both ease suffering and transform suffering into a strength which creates faith, courage and trust (Eriksson 1994).

Parents have in their qualities of being people a basic care competence and capacity that can be developed through the care personnel's information and instruction. As care becomes ever more governed by advanced technology where the professional care personnel develop their competence, the parents' trust in practicing the caring of the child diminishes (Kirkevold, 2003). It is, therefore, a great challenge for the care personnel to find suitable methods and styles to strengthen the parents' confidence in their own resources and knowledge.

The care in NICU is based on the parents taking care of their child but our study shows that they are not given sufficient prerequisites to do so. A large obstacle is the exterior environment, which does not give the conditions to fulfil the United Nations Children's Convention (UNICEF, 1989) or Nordic Association for Sick Children in Hospital (NOBAB, 1992). One of the significant obstacles for the parents is the separation from their child and the impossibility to be alone with their child. According to Ericsson (1994), significant distress can arise when no opportunity of being alone exists. The study was performed at two different units with very different premises. At one of the units there was a significant lack of opportunity to be secluded, however, the personnel tried to create this seclusion for the family, even if it was only to give them their own corner of the room. The care environment's failings caused an unnecessary suffering for the carers as well. Even they needed to be able to withdraw and not always to be exposed to the parents' looks and comments. The results of the study reinforce earlier research concerning the interaction between care personnel and parents in NICU which shows that it is complex and demanding for both parties and that the physical environment can limit both parties' possibility to withdraw (Fegran, 1996).

The result of the study has given increased knowledge and understanding concerning the care personnel's situation and stresses the need to train personnel in the art of meeting and, for example in organised groups, to reflect over their own actions and attitudes to the parents. Furthermore, the results highlight the need for a care environment that gives optimal conditions for parents to be present and involved in the care of their child in NICU and which satisfy the needs of the care personnel to be able to carry out quality care.

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