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A Program Evaluation of the Social Service Interventions in the Neonatal Intensive Care Unit at Valley Medical Center:

How Satisfied Are Monolingual Spanish Parents with the Interventions They Receive?

By

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I. Introduction

This study is a program evaluation of the social service interventions in the Neonatal Intensive Care Unit (NICU) at the Santa Clara Valley Medical Center (VMC). Valley Medical Center has had a social worker serving in this unit for seventeen years with no major changes in service delivery methods. The purpose of this research project is to assess the level of satisfaction with the social service interventions of a particularly vulnerable population: the monolingual Spanish parents of severely premature and ill babies in the NICU. Because of its concern about how the interventions are affecting this population, the study is a summative evaluation (Monette, Sullivan, and DeJong, 1993).

These monolingual Spanish parents not only have to cope with the tragedy of a sick newborn, they also deal with acculturation issues and the problem of discrimination against those who are recent immigrants. Their lack of mastery over the English language adds to their stress, putting them at increased risk for developing dysfunctional behaviors and emotional problems (Rodwell and Blankebaker, 1992). By analyzing how these parents feel about the services they receive, one can use the information obtained to improve on service delivery to them.

It is the hope of the researcher that the message presented here will be addressed to by VMC's Social Service Department. Others who need to take note of the results of this study include medical social workers in NICUs everywhere who are working with monolingual Spanish parents. The data reported will be of interest to them as it describes the cultural, emotional, medical, and physical aspects of having a sick or premature infant, as well as supports the idea that bilingual social workers are needed for this population.

II. Context of Services

The Santa Clara Valley Medical Center is a fully-accredited, 390-bed general hospital affiliated with Stanford University. The purpose of the hospital is to provide inpatient and outpatient health care for all residents of Santa Clara County regardless of their ability to pay. Besides offering routine medical services, VMC operates a Level III Neonatal Intensive Care Unit, the largest renal dialysis unit in the county, a poison control unit, a trauma unit, a spinal cord injury unit, a burn unit, and the largest rehabilitation center in northern and central California.

Under the leadership of the Santa Clara Valley Health and Hospital System (SCVHHS), VMC and several community clinics saw 16,000 inpatients and 44,000 outpatients in the fiscal year 1994 (West, 1995). These patients were seen by the hundreds of medical professionals that are employed by SCVHHS, as well as medical students, interns, and residents, since VMC is a teaching hospital.

Among the professionals at VMC are eighteen full time social workers, two part time social workers, two clerical workers, two MSW interns, and one Director of Social Services. Each of these individuals reports to the Director, except for the interns. They both are assigned to their supervisor, an LCSW on staff.

VMC's Level III Neonatal Intensive Care Unit is one of four in Santa Clara county. As stated in the NICU policy manual, the purpose of the NICU is "to provide critical care for neonates in a specially designed and equipped unit" (SCVMC, 1995). A unit such as this has some requirements to meet up with Level III standards. One requirement is that an attending neonatologist be on the premises of the hospital at all times. VMC's NICU has four of these doctors that rotate through the unit. Another requirement is that the unit must have up-to-date equipment for the care of severely premature neonates.

A full-time social worker is assigned to the NICU, as well as a part-time bilingual social worker who also practices in the Maternal and Infant Care Center. In addition, two MSW interns also practice mostly in the NICU. In 1983, the National Association of Perinatal Social Workers laid the foundation for these social workers by establishing what the goals of an NICU social worker should be. They are:

1. To alleviate the stress of the infant's hospitalization;
2. To maximize the infant's potential for optimal growth and development;
3. To maintain gains made by the infant via an effective network of services.

With these goals of both the NICU and the NICU social workers presented, the types of services that they provide can be examined. First, the NICU provides services 24 hours a day, seven days a week. There are four rooms in the NICU, each with a different level of care. Room one provides the most intensive care, with a ratio of one to two babies per nurse. Each room graduates to a lesser level of care until in room four, there are four to five babies per nurse.

The full-time NICU social worker provides 40 hours of service a week. In the case of an emergency when the NICU social worker is not available, the staff can rely on the on-call social worker provided by the Social Services Department. Among the many different services performed by the social worker, maintaining a current psychosocial assessment is important. This assessment cannot be done in just one interview in the beginning because the situation of the family frequently changes between the time their baby is admitted and discharged from the NICU.

Counseling is another important function of the NICU social worker. The stress of having a sick infant in the hospital can bring up many unresolved issues for parents, such as marital conflict, difficulty in adjusting to American culture, or problems with their other children. The social worker needs to be able to make time to listen and counsel these families.

Resources referral and coordination is one more service that the NICU social worker provides. This requires that the social worker be aware of all programs that can be of benefit to the family. For example, if the parents were undocumented immigrants, low on cash, and having difficulty breast-feeding, a referral to the Women, Infants, and Children Program would be appropriate *and* necessary.

The last major function of all NICU social workers is to facilitate family conferences in order for the family to become as informed as possible about their baby's medical condition. During family conferences, parents are given the opportunity to ask the doctor any question they want, and hear what is going on with their baby in lay terms. The social worker is present at these meetings to ensure that the parents understand what is being told them, and also to assist the parents if a difficult decision needs to be made regarding the infant.

Besides the social worker doing the aforementioned services, the NICU has a plethora of other staff members, who work together as a team. The team consists of RNs, neonatologists, respiratory therapists, physical therapists, public health nurses, and the social worker. Representatives from each of these fields meets weekly (with the exception of respiratory therapists) to discuss the patients' care plans.

All medical personnel on this team are supervised by the Neonatal Unit Director, who is accountable to the Chair of Pediatrics. The nurses are more closely supervised by the Head Nurse, who reports to the Administrative Nurse IV. For a more detailed discussion of the chain of command in the NICU, see the NICU Organizational Chart (Appendix A).

Although there is no federal or state mandate requiring social service interventions in the NICU, other governing bodies have made it a necessary component of NICU services. One such organization is the California Childrens Services. This organization receives money from the state of California to subsidize the inpatient and outpatient costs of premature and disabled infants. One stipulation of their financial coverage is that the neonatal units where the babies are hospitalized have a social worker. Therefore, if VMC did not employ a social worker in the NICU, they would not receive any money from the California Childrens Services to help with the astronomical costs of caring for sick, premature babies.

Although perhaps not quite as motivating as a financial incentive, the American Academy of Pediatrics provides guidelines within which the NICU must operate. One objective of these guidelines is to "support and coordinate the activities of the social service department" (SCVMC, 1995). The coordination aspect of this guideline suggests the need for a social worker to practice on the unit.

In addition, the National Association of Perinatal Social Workers purports the following: "Every NICU should have social work services as an integral part of the health care delivery system" (NAPSW, 1983). In order to be an integral part of the NICU's system, the social worker must be placed there, rather than have the important, yet inconsistent services of an on-call social worker.

As this study is a program evaluation study, it is appropriate to look at what steps are currently being taken to evaluate how the patients and their families are feeling about the care that they receive from the social service staff. One measure that is already in place is a survey sent from the Social Service Department. Every quarter, each social worker gives the department secretary three names of people whom they have served in the last three months. There is no criteria for the selection of these people. Social workers can submit the names of those patients whom they think have been served the best. The survey is then sent to the patients in English or Spanish (Appendices B and C). When the surveys are sent back to the hospital, data about the quality of social service interventions can be analyzed. The problem with this method of evaluation though, is that the sample is not randomized, and therefore conclusions cannot be drawn from the data.

One more method for evaluating the quality of care that the social workers give the patients is through peer review. This method was instated many years ago, but has been discarded in the last year due to an overload of work on the social workers and a lack of time to invest in this. Peer review was held every quarter. All the social workers gathered in a large meeting room, bringing with them several of the charts from their work over the past three months. They would spend an hour looking over each other's history and progress notes, identifying areas of strengths and weaknesses based on these written reports. This method also renders an inability to draw conclusions, due to the lack of randomization in choosing the charts.

Another step that has been taken in the past to measure family satisfaction was a survey sent directly from the NICU. This survey focused on discharge teaching and did not include any questions that directly measured social service interventions. The survey was discontinued mid-1994 because it was found that families were pleased overall with the nursing care they received.

It would be helpful at this point to discuss the demographic characteristics of the families served by the NICU. Unfortunately, this information is unavailable. Neither the NICU social worker, the NICU nurse manager, nor the director of the NICU keep statistics that could describe these families. What can be gathered from VMC's Language Services, however, is that 50-70% of NICU parents do not speak English, and the majority of parents who do not speak English, speak Spanish (Meyer, 1991).

III. Theoretical Foundation and Literature Review

The ideas and information presented in this next chapter were written in order to provide a conceptual and empirical framework for this study. This framework will help clarify the problems that parents of premature infants face, as well as explain the social service interventions that are offered as a result. With that goal in mind, information about the discharge of premature infants, the emotional needs of the parents, what cultural sensitivity is and how it affects people, and how parents are affected by the sharing of medical knowledge will be discussed.

The transition from the hospital to the home many times is a difficult one for both the parents and the infant. Two scholars, Hanline and Deppe, have come up with four ways to make this easier (1990). One way to facilitate a smooth transition is to empower the parents to make an informed decision. This means that they need to be given information, as well as the power to decide, rather than have a decision made for them. Related to this method, is the intervention of developing a range of service delivery and support options. For example, the worker needs to make sure that the parents are presented with the most options possible. Intervening in this way makes it easier for the parents to make a decision.

One other way of making the transition from hospital to home easier is to create opportunities for the parents to receive support from other parents of premature infants who have already made the adjustment. An example could be a support group sponsored by the hospital for postdischarge parents. This group would be able to reassure the parents in a way that a social worker could not.

The last method to be suggested is to focus all discharge intervention goals on the needs that the parents themselves have identified. If a discharge plan were made for a baby to return to the hospital in a week for circumcision, but the parents wanted the priest from their church to do it in their home, this plan would have been made in vain. Plans need to be centered on what the parents need and want, taking into consideration the medical safety of the baby.

In addition to making the transition an easy one, it is also important to alert parents to the potential problems that could arise once the baby is home. Blackburn (1995) writes about these problems and mentions that premature infants are at higher risk for infection than full-term infants. This is because their mothers' antibodies did not have a chance to get passed through the placenta in sufficient amounts before birth. There is also the risk of sensory disorders, such as problems in vision, hearing, speech and language. Neurobehavioral and neuromuscular problems join this list, as well. The conclusion that this writer comes to is that parents need to be made aware of the problems for which their infants are at risk. The shock of not having perfect health at home for their baby when it was expected could make coping with the infant's sickness more difficult for the parents.

Clinical nurse specialist McKim (1993) discusses what factors could make the first week at home with a premature infant very difficult. These factors are a long stay in the NICU for the infant, no visit by the public health nurse, and apnea while the baby was in the hospital (this is when the baby forgets to breathe). Social service interventions need to acknowledge these factors and take special measures to take care of these families during the first week after discharge

In order for the baby to be discharged safely, the parents need to be led through what Robinson calls a "safety checklist" (1994). This checklist includes the following topics:

1. Bath
2. Changing Diapers
3. Feeding
4. Car Seat
5. Crib
6. Play
7. Anticipatory Guidance (e.g. poisons, cabinet latches, etc...)

While going through this list with a nurse, parents can be taught how to make each of these activities safe for their babies.

Having discussed issues surrounding the discharge of premature babies, information about the emotional needs of parents of babies in the NICU can be presented. Many authors have words to say about what those emotional needs are. Price (1994) gives a short list of them:

+ To feel there is hope;
+ To feel hospital personnel care about the baby;
+ To be assured the best possible care is being given to the baby.

Another Registered Nurse Clinician, Baker, adds another emotional need to that list: to fulfill the role of parent (1995). Feeling fulfilled in that role involves being able to make decisions about the baby's care. Baker admonishes NICU staff saying:

> We cannot allow ourselves to forget that the child's parents have the right - emotionally and legally - to make decisions on behalf of their infant. Our task is to encourage the development of parenting skills - including the skill of making decisions about their child's care - even when we disagree with the decisions they make (p. 9).

One more emotional need that parents of premature infants have is to bond, or attach to their babies. Attachment refers to the interaction that parents have with their babies, and the feelings they both share for each other. Haut, Peddicord, and O'Brien are three scholars who use the Roy adaptation model to understand, assess, and foster parental attachment (1994). This particular adaptation model measures four aspects of the parents' adaptation to premature childbirth.

The first mode of adaptation measured is the physiological adaptation. This mode looks at how the mother is feeling physically: her level of rest, proper nutrition, comfort, and general health concerns. The second mode is the self-concept adaptation. To assess this item one must ask about how the parents feel about themselves, in that they have had a premature delivery.

The next mode of adaptation analyzed is the role function adaptation. The authors measure this by discovering three things: 1) how the parents express themselves in the parental role, 2) the interest they have in providing care for their infant, and 3) to what extent the parents participate in the decision making during their baby's hospitalization. The last mode of adaptation is the interdependence adaptation. The expression of feelings of closeness to and love for the infant, as well as positive interactions are measured in this mode.

Using the results from the measurements, a judgment can be made as to how well the parents have bonded with their baby. If the parents have not bonded very well, social services can intervene where the parents are having the most difficulty.

Another group of authors, McCluskey-Fawcett et al (1992), offers more information on what the emotional needs of parents of premature infants are. After an extensive study they found that initially, most parents had feelings of helplessness and powerlessness. These feelings were brought on by "regimentation due to hospital routines, the obvious pain inflicted by necessary but unfamiliar medical procedures, physical separation from the infant, and the exclusion of parents from the primary caregiving role" (p. 155).

Intervention is necessary to address these negative feelings, and the authors suggest some ways to do that. The significance of the interventions is communicated through this statement by the authors: "Facilitating parental emotional adjustment and enhancing their competence and confidence are important to the developmental outcome of premature infants and must be seen as crucial components of NICU medical care" (p. 155).

Cultural sensitivity is another topic which requires description for this study. It is broached by Wenger (1993) who suggests that for effective teaching of culturally diverse parents, NICU staff must understand three things about the main ethnic groups represented in the hospital clientele. First, it is helpful to understand the role of parents, extended family members, and godparents. For example, within the Latino population, godparents have a special role. Latino NICU parents, therefore, might feel that the godparents need to be included when making an important decision about the baby.

Secondly, the status of babies within the culture is significant. In some cultures, babies are not recognized for several days, and then finally given a name. This attitude could affect medical practices concerning what rigorous methods should be used to preserve a baby's life directly after birth.

Lastly, the culture's way of knowing - its patterns of thinking, feeling, and acting should be known. In some cultures, for example, it would be disrespectful not to proclaim grief loudly. NICU staff would not be culturally sensitive if they were to make fun of or discourage this way of acting out grief.

Before going further, an explanation of what cultural sensitivity is should be presented. A professor from the University of California, San Francisco, Lieberman, defines it this way: "cultural sensitivity is a form of interpersonal sensitivity, an attunement to the specific idiosyncrasies of another person" (1990, p. 104). The author expands on this idea by giving it two major components. One component is discovering what constitutes the individual's idiosyncrasies. The second is keeping an attitude of openness to find out that which is not known. This definition is one example of the social work concept of empathy, put into practical terms.

Two researchers, Wilson and Simson, did a compelling research project that offers a reason why culturally sensitive practice is so important. They found that cultural sensitivity was ranked the number one priority needed to reduce health status disparity among minority populations (1991). This means that the gap in health status between the majority population and the minority population can best be reduced by more culturally sensitive practice by the medical community, which includes medical social workers.

There is another author who concurs with the aforementioned idea that it is important for NICU staff to understand how different cultures view childbirth. Callister (1995) writes that the positive outcomes of culturally sensitive practice include:

1. The promotion of feelings of self-actualization in the woman;
2. Maternal role attainment;
3. The fostering of a positive relationship with the woman's significant other;
4. The enrichment of the family perspective.

With these outcomes, it is hard to deny the importance of being culturally sensitive.

Cultural sensitivity necessarily involves communication with people from cultures other than our own. Nance (1995) describes this communication as occurring “whenever a message produced in one culture must be processed in another culture” (p. 255). She says that for NICU staff engaging in this type of communication, which is everyone, a stance of genuine cultural relativity is important. “Genuine cultural relativity means being able to acknowledge differences in other people as inevitable and valuable. Healthy intercultural communication begins with an authentic desire to understand someone else’s way of seeing the world and acting within it” (p. 255).

Adding to this pool of information on cultural sensitivity are authors Rodwell and Blankebaker (1992). They have produced a creative way to understand the affects of cultural insensitivity; they used wounding as a metaphor. According to them, people can be “wounded” when their culture is denied its importance and value, when the differences in cultures are denied, when they are evaluated by nonculturally relevant standards, when their difference is seen as a deficit, when their existence is denied, and when they are stereotyped.

The consequences of this cultural wounding are similar to the wounding that occurs with child abuse; it produces the same sense of unpredictability, unhappiness, and confusion, affecting both short and long term personal development. The authors mention two consequences specifically. Learned helplessness is one consequence. This is described as a lack of connection between a person’s behavior and the outcome of that behavior. This means that the person with learned helplessness feels that no matter what he or she does to try and help themselves, it will be of no consequence. They feel they are not the ones in control of their lives.

The second consequence mentioned by the authors is that the person treated with cultural insensitivity cannot form his own individuality very well. This undeveloped sense of self leads to relationship problems, with fear and dependency causing dysfunctional cycles to occur. It seems clear from the information that Rodwell and Blankebaker have presented that cultural insensitivity cannot be afforded, in the NICU or elsewhere.

The last area that needs to be examined for this study concerns how parents of babies in the NICU are affected by receiving or not receiving information about their babies' medical condition. An author previously cited, Price, gave a list of the emotional needs that parents may have(1994). Included in that list but not mentioned were important family needs pertaining to knowledge that was desired. Here are some of the issues that parents wanted to be informed about:

1. To have questions answered honestly;
2. To know the prognosis;
3. To know specific facts about the patient's progress;
4. To know exactly what is being done for the patient;
5. To know why things were done for the patient.

With this knowledge about what information is useful for parents, it would be helpful to understand how the information affects them. McCluskey-Fawcett et al. say that informing parents is a key for "successful parenting and positive feelings about the hospital experience" (1992, p. 154). They also say that hospitals need programs implemented that "provide parents with the information and skills they need to feel competent and empowered as parents" (p. 154). Those feelings of competency and empowerment are necessary as it has already been stated that parents usually enter the NICU feeling powerless and helpless.

Unfortunately, parents who are less educated receive less information from NICU staff because they are intimidated by the high-tech atmosphere and do not know how or do not feel comfortable enough to ask the right questions (McCluskey- Fawcett et al., 1992). At VMC, this could be a big problem because many of the parents are not well educated. Social service staff need to remember that even though parents do not ask a lot of questions, they still need to be told what is going on with their baby's medical condition.

Additionally, McCluskey-Fawcett et al. purport that training of the parents should begin when the baby is admitted, not just days before the baby is discharged home. Precious time has been lost if the training is begun so late. The authors support fully informing the parents with this strong statement:

> Parents who are well-informed, take an active role in their infant's NICU care, receive emotional and social support, establish good working partnerships with staff, and learn everything they can about their infant's care and needs are much more likely to be confident, successful parents when they take on full responsibility for their infants (p. 155).

Lastly, three professors of nursing, Miles, Funk, and Kasper (1992), contribute to the knowledge of the importance of informing parents about their babies. They have found that the highly technical sights and sounds of the NICU can cause stress in parents. They recommend that parents be informed about the nature of these sights and sounds, so as to alleviate the stress.

IV. Design of the Evaluation Study

The primary research question this study is trying to answer is, "What is the perception of monolingual Spanish consumers of the effectiveness of the NICU at

VMC's social service interventions?" The consumers measured the effectiveness of this program by answering questions concerning four main variables, using a Lickert scale type survey. These variables will be discussed here, as well as how each was measured.

The first variable looks at the degree to which the physical needs of having an infant in the home were identified and adequately prepared for. This variable is measured by questions 1 and 5 in the questionnaire (see Appendix D). Question 1 reads, "I had everything I needed to provide for my baby when I brought him or her home. For example: food, clothes, diapers, equipment, etc.". This question gets a direct response to the first variable. Question 5 is more indirect, reading, "I did not know what to expect from my baby when he or she came home." This question explores the degree to which the parent felt like he or she was prepared to take care of the baby's needs, which is perhaps more important even than having all the necessities.

The second variable identifies the degree to which the emotional needs of the parents were met while their baby was in the hospital, and is measured by questions 2 and 6 of the questionnaire. Question 2 is "I felt that the social worker understood the feelings that I had while my baby was in the NICU." As was clearly shown in Chapter 3, parents have a plethora of varying feelings during their baby's stay in the NICU. They need those feelings to be recognized, understood, and accepted. This question learns the degree to which this need was met.

"I did not feel that I could trust my social worker with my feelings," was question 6. An emotional need that parents have is that their feelings are accepted. Without the acceptance of the feelings by the social worker, the parent is not going to feel that he or she can trust that worker. This question is another way of measuring the second variable.

The third variable discovers how much the social service staff displayed cultural awareness and sensitivity to the family. When a social worker becomes involved with a family from a culture other than the worker's own, it is easy to feel frustrated with the different language, accent and/or norms. Question 3 discerns the family's thoughts about how the social worker dealt with those differences: "I felt that because I primarily speak Spanish, I was an annoyance to the social worker." Question 7 measures whether or not the social worker was aware of the difficulties involved in adjusting to an entirely new culture: "My social worker showed concern about how I have adjusted to life in the United States."

The fourth and last variable looks at the degree to which the family was able to understand the medical care that their infant received. This aspect of the study was asked directly in question 4 which reads, "I understood the medical condition of my baby all of the time that he or she was in the NICU." Because being able to explain to others demonstrates a genuine understanding of a subject, question 8 was included: "While my baby was in the NICU, I could not explain to my family and/or friends what his or her condition was, because it was not clear to me." Now, having described these variables and their concurrent measurements in order for the reader to understand the concept and purpose of this study, the details of the study call to be presented.

This summative program evaluation began with the development of a Lickert scale type survey. The goal of its development was to create a tool to gather relevant information for the study. Once the survey was produced, it needed to be translated into Spanish. The survey was given to Language Services at VMC in November, 1995. This branch of the hospital works solely to provide hospital staff with necessary assistance in communicating with the patients and families who do not speak English. A Certified Medical Translator translated the survey and returned it five weeks later.

Back, or Double Translation is a translation technique recommended by Marin and Marin in their book, Research with Hispanic Populations (1991, p. 90). This technique involves translating an instrument from the original language to the target language. Then, a different translator translates the instrument back to the original language. The researcher can then compare the two documents and look for inconsistencies. Due to time constraints, Back Translation was not an option for this study's survey.

The limitations of the survey caused by lack of Back Translation were compensated by the excellent skills of the translators at VMC. Each translator had to pass an extremely rigorous exam that tested both their language and translation skills (Garcia, 1996). One example of their commitment to accuracy is that they were concerned about mistakes in the original English survey. During the translation process they called and asked what to do about a verb that had not been conjugated correctly. They could have just translated what had been written, but they wanted the survey to be understood easily by the participant.

The Spanish survey (see Appendix E) was pretested on a man who was monolingual Spanish, high-school educated, but not a parent in the NICU. After having been told to pretend that he was a parent of a baby who had been very sick, this man took the survey. He commented that the survey was easy for him to understand (Informal interview, 1996).

The survey was also specifically designed to be as reliable as possible. Reliability refers to the extent to which the results gathered by the survey are as consistent and repeatable as possible (Wagner, 1995). An obstacle to this is reactivity. An example of reactivity is when a participant reacts to the way a survey is put together by answering incorrectly. This survey avoids that problem by presenting questions for each variable measured in two forms: a positive form and a negative form. For instance, the variable of the emotional needs of the parents being met while in the hospital is measured by a positive question: "I feel that the social worker understood the feelings that I had while my baby was in the NICU." It is also measured by a negative question: "I did *not* feel that I could trust my social worker with my feelings." Using both forms makes each question different, and reduces reactivity.

Another way that the design of the survey increases reliability is by measuring each variable in multiple forms. By asking two questions instead of one, the researcher is able to compare responses for consistency. If the responses to the questions above, for example, were inconsistent, then one could assume that there was some problem. Inattentiveness or illiteracy, among other things, could have influenced that particular participant and the survey could be thrown out.

This survey was intended to be given to every monolingual Spanish parent, from January 2 to February 28, 1996, at the time of the discharge of their baby. The parents would complete the surveys before they left to ensure that the surveys were done. However, a problem arose in early January. The 30 bed unit's population dropped unexpectedly to 10 babies - the lowest in a year. The population stayed low for a couple of weeks, with fewer than usual monolingual Spanish families. With doubts that enough surveys could be gathered for proper statistics (at least 30), the target of the survey had to shift.

It was decided instead to send out the questionnaire to every monolingual Spanish parent that had their baby discharged from the NICU between September 1, 1995 and January 3, 1996. The names, addresses, telephone numbers, discharge dates, and language ability were documented in reports kept by Joanne Rudinskas, LCSW and social worker in the NICU. From these reports a list of 67 parents was compiled. This sampling technique did not require any randomization, because every parent from that time period was needed to gather a sample big enough for data analysis.

One drawback to this sampling technique is that not every monolingual Spanish parent is included. Those who are not included are those parents whose babies were admitted on a Friday afternoon and discharged before Monday morning when the social worker could begin services to them. However, although these parents are left out, they would have had nothing to say about social service interventions because they had received none.

Due to the length of time that Language Services needs to translate documents, it was impossible to create a cover letter to go out with the survey. Instead, calls were made to each of the parents in order to seek permission to send the survey, to give instructions about it, and to assure that the correct address was obtained.

On January 11 and 16 the calls were made. Each call began with an introduction of the caller. The purpose of the call was then said to be twofold. The first reason was to see how their baby was doing, and usually, a conversation ensued regarding the baby's condition. Many times the parents had questions that the caller could answer or at least refer to someone who could help. This conversation helped to build rapport with the parents, paving the way for the second reason of the call: to ask permission to be able to send them a survey. The concept of a survey was explained, as many were confused about what it was. The survey's purpose was conveyed as gathering information so that services for those who only speak Spanish can be improved. Parents were told that filling out the survey would require about ten minutes of their time, but that there would be no monetary cost involved. An envelope and a stamp would be sent along with the survey. They were also told that their responses would be completely anonymous, and that term was explained to ensure the parents understood what it meant.

Once permission was received to send the survey, the address was verified. Then the parent was asked if the other parent would be interested in completing a survey as well. If the parent said yes, the name of the other parent was taken down. This was necessary because on the records kept by the unit social worker, the name of the father of the baby was not always documented. The parent was then told that the survey would be sent to them by the next day, and they were urged to send it back as soon as possible. The parent was graciously thanked before saying goodbye.

Within 24 hours of the initial call, a letter was sent to the parent. This letter included one or two surveys (depending on if the other parent of the baby was going to participate), one stamped envelope addressed to the Department of Social Services at VMC, and one or two 3 X 5 cards, attached with a piece of candy, saying thank you. Fifty-eight letters were sent from the original list of 67 parents. Nine people were excluded from the study due to not having a telephone, moving back to Mexico, or dying.

Seven days later, phone calls were made again to learn if the parents had returned their questionnaires, or if they had any questions. If the parents said that the survey had been returned, they were thanked again. If the parents had not returned the survey, they were asked if there were items in the survey which made it difficult for them to complete it. Their concerns were addressed, and they were asked permission for the caller to contact them in three or four days. Seventeen parents had sent the survey in, and 41 parents had not yet finished it.

When the next phone call was made to the remaining parents, if the parents had not yet finished the survey and sent it in, they were urged to do so. They were also told that if the surveys were not returned by the 31st of January, their input would not be counted for the study. No contact was made with them after this call. By February, 36 surveys out of the 58 surveys sent had been received.

When conducting a program evaluation with a survey such as this, validity is an issue that the researcher needs to be concerned. In this case, validity refers to having the data that is gathered by this survey really, truly, *actually* reflect what the participants are feeling about how they were served by the social service staff in the NICU.

One threat to the validity of this study stems from an Hispanic cultural value called *simpatia.* "Simpatia emphasizes the need for behaviors that promote smooth and pleasant social relationships" (Marin and Marin, 1991). This value emphasizes empathy on the part of the Hispanic for the person with whom they have a relationship, as well as harmony between the two.

This value could affect the study because the respondents want to maintain a pleasant relationship with the caller. The person who called the parents had been the social worker serving them in about 20% of the cases. Marin and Marin also say that simpatia "may be responsible for greater socially desirable responses by Hispanic respondents" (p. 12).

This threat, unfortunately, cannot be detected in the data gathered. It was minimized, though, by the caller emphasizing that their responses would be anonymous. The parents were told that there was no way possible for the caller to identify who responded in what way.

Along with validity, a researcher must always be concerned with the risks that the participants will be subject. This survey asks for seven items of demographic data:

1. age (asked in increments, e.g. 15-19 years);
2. sex
3. time baby spent in the NICU (asked in increments, e.g. 1-6 days);
4. time parents spent in the U.S. before giving birth (asked in increments, e.g. 1-11 months);
5. Spanish language ability of their social worker;
6. Whether or not they had a family conference; and
7. Their country of origin.

The data asked for could never be used to identify the respondent because it is not specific enough. Therefore, there was no risk to the participant. The only possible risk involved is that the parent might not get something accomplished due to the ten minutes of time that they take to do the survey.

V. Results

Beginning this chapter on results requires a reminder of what was researched, that being the perception of monolingual Spanish consumers of the effectiveness of the NICU at VMC's social service interventions. This was measured by four variables, in the form of eight questions. The results of the first variable are presented in Figure 1 on the next page.

What is evident is that the column with the most responses is the one for those with the highest satisfaction about how well they were prepared for the discharge of their infant. Twenty-two percent of the respondents felt low or the lowest degrees of satisfaction.

Figure 1: Measurement of Variable I

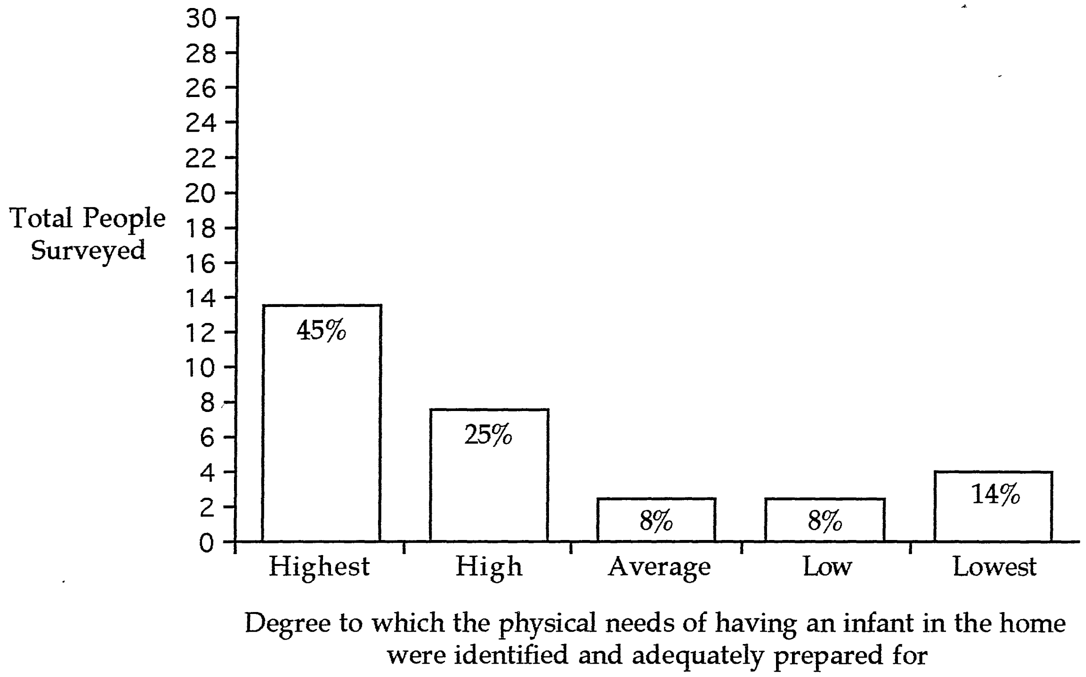
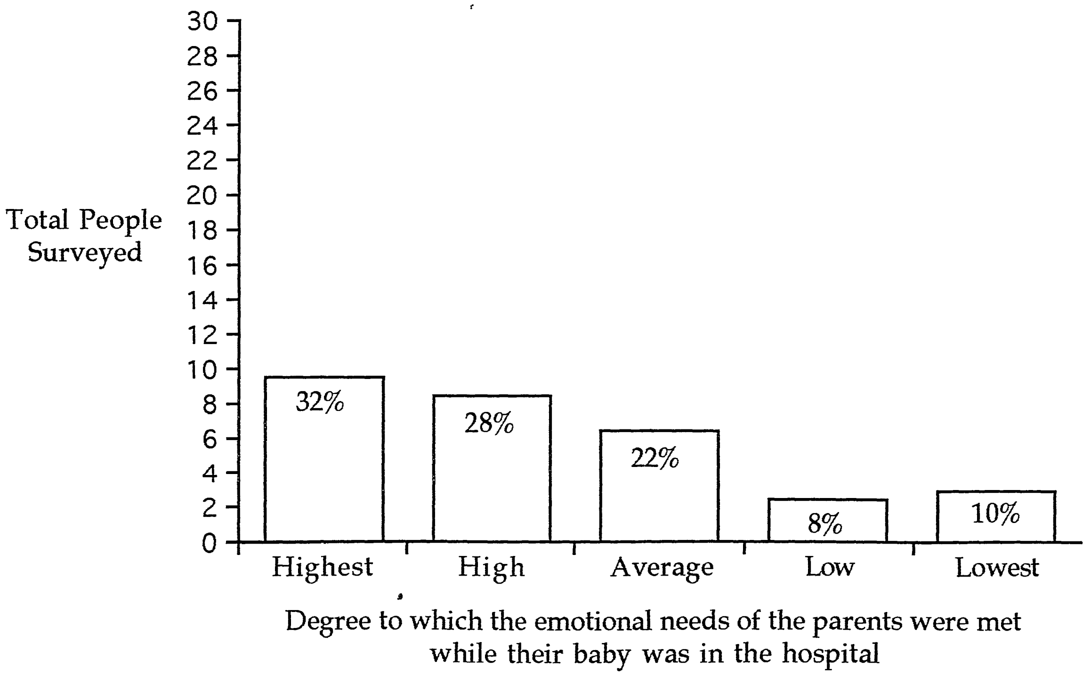


Figure 2: Measurement of Variable II



From Figure 2 on the previous page one can learn that the majority of respondents also felt either high or the highest satisfaction with how well their emotional needs were met while their baby was in the hospital. That is good news! There is a large group of respondents who felt only average satisfaction about this variable, though. One explanation for this could be that the respondents could not identify how their emotional needs had been met, and so responded neutrally.

Figure 3 on the next page demonstrates that 60% of the participants said they experienced either high or highest satisfaction with how the social service staff displayed cultural sensitivity and awareness to their family. Again, as in Table II, the quantity of persons responding that they felt average satisfaction was high: 23%. This could also have occurred because of their difficulty in defining specifically how their social worker acted culturally sensitive. Of all the variables examined, this is the variable with the least amount of respondents who felt their degree of satisfaction was either low or the lowest: 17%.

In the last table, Figure 4 on the following page, the column showing the highest degree of satisfaction has more respondents that any other column in any table. This means that people felt satisfaction about their ability to understand the medical care their infant received more than any other variable. Their high degree of satisfaction could be a result of the teamwork factor. This is when both the social service staff *and* the medical staff help to make the parents satisfied. With the other variables, parental satisfaction was a goal of the social worker more than it was a goal of the medical staff.

Figure 3: Measurement of Variable III

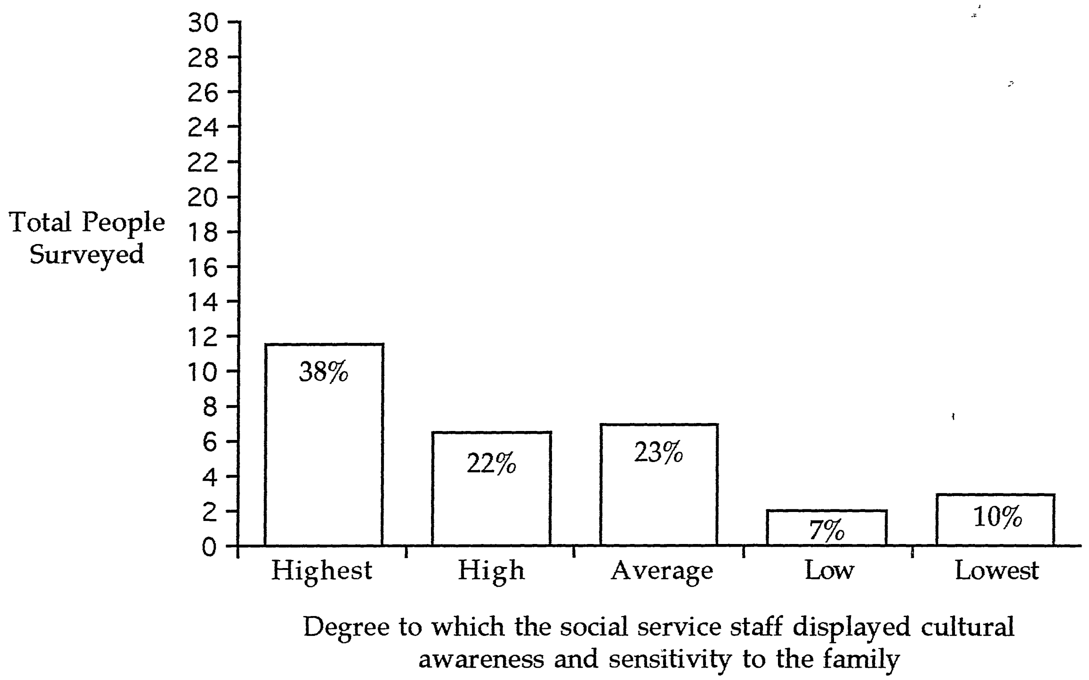
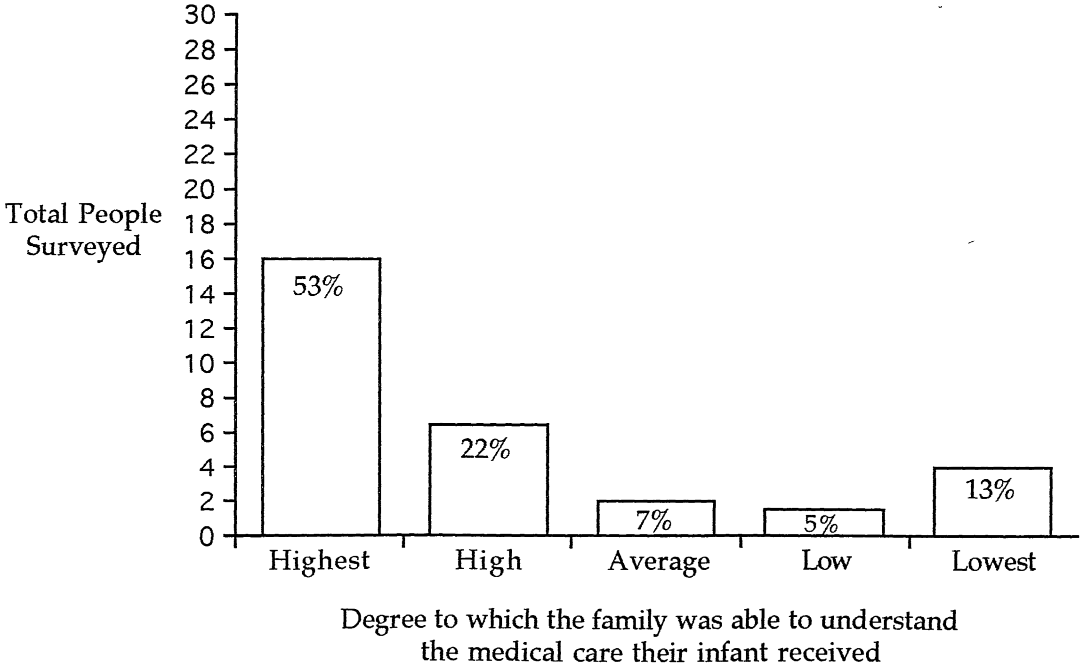


Figure 4: Measurement of Variable IV



VI. Discussion

The objectives of the NICU social worker were stated earlier in this paper, but it is appropriate to review them here, in order to assess the degree to which the results demonstrate that they are being carried out. Those objectives were to alleviate the stress of the infant's hospitalization on the parents, maximize the infant's potential for optimal growth and development, and maintain gains made by the infant via effective network of services. The variables that were studied in this research project centered primarily around alleviating the stress of the parents, which helps to create a more stable environment for the baby to come home to. Naturally, a more stable home environment maximizes, or at least contributes to an infant's potential for growth.

The majority of respondents indicated that their need for information, emotional and cultural support, and post-discharge support was satisfied. It can be deduced therefore, that the first two objectives of the NICU social worker are currently being met. The study did not directly address the third variable which called for effective network services.

Every researcher finishes a project and realizes what could have been done differently in order to obtain data that is more valid and reliable. In this study, it would have been helpful for the question on the survey, "Did your social worker speak Spanish?" to have read instead, "How well did your social worker speak Spanish?"

The results showed that 90% of the respondents thought that their social worker spoke Spanish. This means one of two things. The first possibility is that most of the surveys that came back were from the families who worked with the social worker who was fluent in Spanish. The second possibility is that the fragmented phrases and sentences spoken in Spanish occasionally by the other social workers caused these families to think that those workers spoke Spanish. It could also be a combination of these possibilities. However, if the question had been more clear, the data received could have been used more to make practical generalizations.

In spite of the problematic nature of that question, some things were clear from the 10% of participants who stated that their social worker did not speak Spanish. These families were much less satisfied by the social service interventions they received than those who thought they had a Spanish speaking social worker. For example, as to the degree to which the physical needs of having their baby at home were identified and adequately prepared for, only 50% of these respondents as compared to 75% of the other respondents had high or the highest level of satisfaction. Only 33%, compared to 60%, had high or the highest level of satisfaction when it came to the degree to which their emotional needs were met while their baby was in the hospital.

Additionally, when looking at the degree to which the family felt that the social worker displayed cultural awareness and sensitivity to them, the families without a Spanish-speaking social worker had a mere 17% high or highest level of satisfaction compared to 60% satisfaction with the other families. Lastly, the degree to which the family was able to understand the medical care that their baby received dropped from 75% high or the highest satisfaction with families with bilingual social workers, to 66% for the families without a bilingual social worker.

The first recommendation to be made to Valley Medical Center's Social Services Department, based on the results of this study, is to continue what is being done by the social workers in the NICU. Monolingual Spanish families are especially satisfied with the way in which they are prepared to take home their sick or premature infant, as well as with the way that medical information is communicated to them. Family conferences, team discharge planning, advocacy for family services, and review of the families' understanding of the medical condition of their baby are all activities which help them feel satisfied in those areas, therefore they should be continued.

Most of the monolingual Spanish families (60%) also felt that their emotional needs were being met, and that their social worker was sensitive and aware of their cultural identity. This is good, however their level of satisfaction could be better. One particular emotional need that was mentioned in the literature review of this paper is that the parents of a premature or sick infant need to feel at peace with themselves around the issue of having given birth to a less than perfect infant (Haut, Peddicord, and O'Brien, 1994). Since feelings of guilt are common with these parents, it is important to understand how they feel about the birth of their child. Then, the social worker needs to work consistently with them to educate them about the usual unavoidability of their babies' problems, and affirm in them the positive qualities and talents they bring to being parents. With increased attention to this emotional need, as well as to others, the satisfaction of monolingual Spanish parents will heighten.

One recommendation to the NICU social worker about how to increase the families' feelings that she is culturally sensitive is to acknowledge that they and she do things differently, and that that difference is positive (Rodwell and Blankebaker, 1992). One way to do that is to provide refreshments at the weekly support group (almost completely made up of Spanish-speaking parents) for them that they would enjoy. For example, instead of Pepperidge Farm cookies, provide pan dulce, the bakery treats that are immensely popular with Mexican-American people. This would demonstrate to them that she recognized they enjoy different food at meetings, and that she thought that was good and therefore brought them some. Possibly with this method and others, the monolingual Spanish families' satisfaction with the level of cultural sensitivity in the social worker would increase.

Another recommendation for VMC's Department of Social Services is to conduct further research on the impact of bilingual social workers on patient satisfaction. This study itself has offered a view that monolingual Spanish families are not nearly as satisfied with the social service interventions that they receive as English-speaking families. These results need to be confirmed through additional research.

In the meantime, it is recommended that at least one bilingual social worker continue to be assigned to the NICU. The 90% of respondents who felt that they did have a social worker who spoke Spanish, are mostly highly satisfied with the social service interventions they received. In order to avoid the lowering of their level of satisfaction to the level of those respondents who did not have a bilingual worker, a Spanish-speaking worker must be maintained on the NICU.

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Appendix A

SANTA CLARA VALLEY MEDICAL CENTER
NEONATAL INTENSIVE CARE UNIT POLICY MANUAL

NARRATIVE FOR ORGANIZATIONAL CHART

The foundation of the organizational structure of the Neonatal Intensive Care Unit is the Nurse Manager - NICU. She reports directly to the Director of Inpatient Acute Nursing who in turn reports to the Director of Nursing. The Director of Inpatient Acute Nursing is responsible for the supervision, direction and development of the Nurse Manager - NICU and serves as a resource person and role model. She helps establish and implement unit/department objectives.

The Nurse Manager - NICU's responsibility consists of the daily operation of the unit, which includes the coordination and collaboration with the department heads on and off unit, and all medical staff. Further, her responsibility encompasses the implementation of all elements of the Nurse Manager - NICU job description, as well as the creation of specific performance standards. Her focus is to consult with and assist the Assistant Nurse Managers in the direction and development of the nursing staff using standards and appropriate participatory, and supervisory methods, and the maintenance of an efficiently running unit. Together their goal is optimum patient care, which is achieved by working closely with the Director of Inpatient Acute Nursing and the Medical Director of the unit in creative resolutions of issues, development of standards and quality assurance activities.

The nursing staff of the Neonatal Intensive Care Unit consists of RNs in various steps of the Clinical Series who function in all areas of the unit at all times, and in sufficient quantity to assure optimum patient coverage and care. He/She assumes responsibility for the assessment, planning, implementation and evaluation of the patient care.

The Director of Nursing shall designate a Director of Inpatient Acute Nursing in the absence of the Director of Inpatient Acute Nursing. An Assistant Nurse Manager shall fill a vacancy of the Nurse Manager - NICU position. A Clinical Nurse with charge nurse experience shall fill a vacancy of the Assistant Nurse Manager position.

There is a Staff Developer assigned to NICU. He/She is responsible to coordinate/facilitate the inservice education, staff development, and cohesive clinical practice of all RNs assigned to the NICU. He/She reports directly to the Director of Education Advance Practice and Nursing Quality Improvement and works closely with the Nurse Manager - NICU and Assistant Nurse Managers to remain familiar with the issues and concerns regarding staff development.

Approved by:

Vickie Meyer RN — 7/5/95
Nurse Manager, NICU — Date

Shirley Mann, RN AADN — 7/6/95
Assistant Director of Nursing, MCH — Date

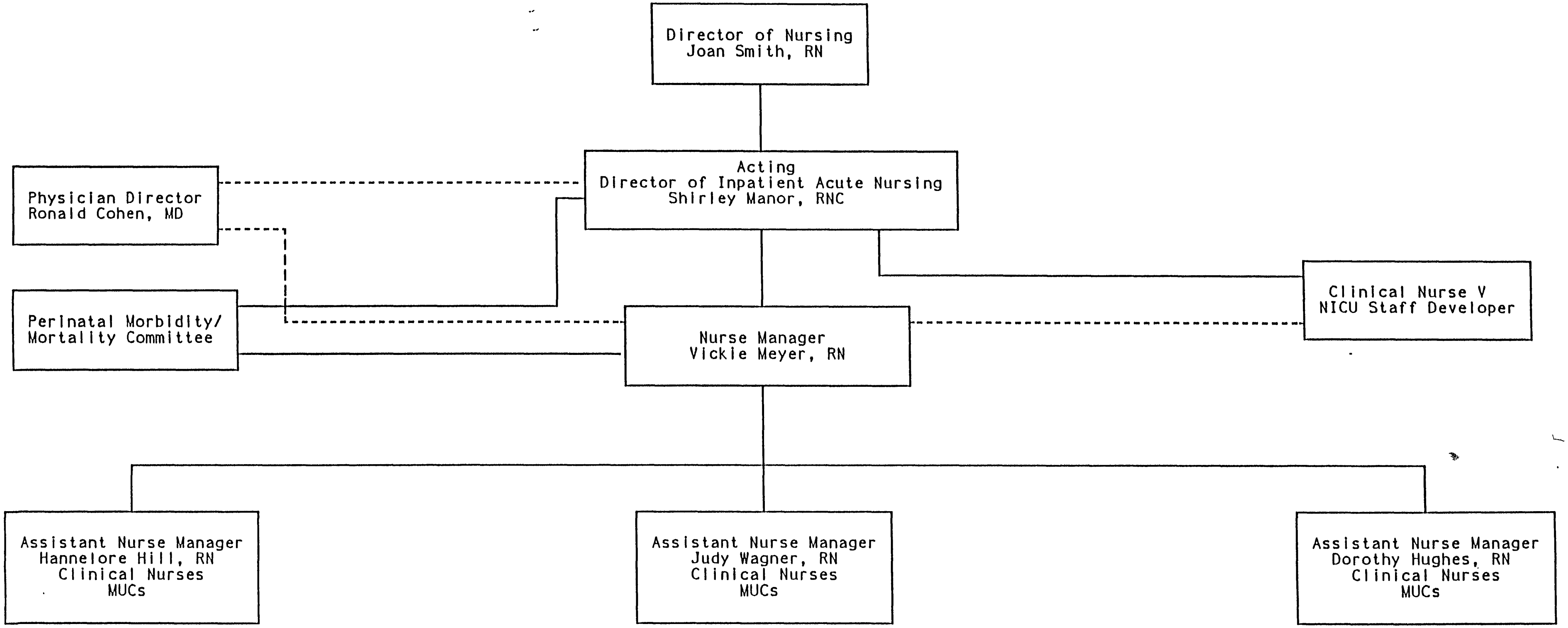
History: original 11/86; revised 7/87, 7/88, 10/89, 4/92, 12/93, 4/95, 6/95; reviewed 11/90.

SANTA CLARA VALLEY MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES

NEONATAL INTENSIVE CARE UNIT

ORGANIZATION CHART

Revised: June, 1995



Associate Director, Hospital & Clinics/Director of Nursing

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Appendix B

Indicator 7 Criteria

SANTA CLARA VALLEY MEDICAL CENTER

SOCIAL SERVICE DEPARTMENT

PATIENT FOLLOW-UP

Since you or a family member has received care from this facility, during the past few months, we would like your help in evaluating the social work services available to you or your family member.

1. Please give the name of the social worker who saw you or your family member: ______________________________.

2. What services did you or your family member receive: (check as many as necessary)

   _____ Discussion of your social situation and need for assistance.
   _____ Information about community or financial resources.
   _____ Help in getting information about your or a family member's health.
   _____ Emotional support during the medical crisis.
   _____ Other, please specify. ______________________________
   ____
   ____

3. Were you able to talk comfortably with the social worker?

   ______ Comfortably   _____ Uncomfortably

4. Do you believe the social worker understood your needs?

   _____ Yes   _____ No

5. Did you feel like the social worker had an adequate amount of time to talk with you?

   _____ Not enough time   _____ Enough time

6. Did you need, or want more help than you received?

   _____ Yes   _____ No

   If yes, please state the areas you would have liked additional help. ______________________________
   ____
   ____

Appendix C

SANTA CLARA VALLEY MEDICAL CENTER

DEPARTAMENTO DE SERVICIOS SOCIALES

ATENCION CONTINUADA DEL PACIENTE

Usted o un miembro de su familia ha recibido cuidado en este hospital durante los últimos meses. Por esta razón nos gustaría pedirle su ayuda para evaluar los servicios recibidos de los trabajadores sociales.

1. Por favor denos el nombre del trabajador social que lo vio a usted o al miembro de su familia:
   ____
   ____

2. ¿Qué servicios recibió usted o el miembro de su familia?: (marque todos los sean necesarios)

   _____ Discusión de su situación social y necesidad de ayuda.
   _____ Información acerca de los recursos financieros o de la comunidad.
   _____ Ayuda para obtener información acerca de su salud o la salud del miembro de la familia.
   _____ Apoyo emocional durante la crisis médica.
   _____ Otros, por favor especifique________________________________
   ____
   ____

3. ¿Pudo usted hablar cómodamente con el trabajador o la trabajadora social?

   _____ Cómodamente _____ Incómodamente

4. ¿Cree usted que el trabajador o trabajadora social entendió sus necesidades?

   _____ Sí _____ No

5. ¿Cree usted que el trabajador o trabajadora social tuvo el tiempo suficiente para hablar con usted?

   _____ No tuvo bastante tiempo _____ Tuvo bastante tiempo

6. ¿Necesita o quiere usted más ayuda de la que ha recibido ya?

   _____ Sí _____ No

   Si contesta sí, por favor indique las áreas en las que le hubiera gustado recibir ayuda adicional.________________________________
   ____
   ____

Appendix D

SANTA CLARA
VALLEY
MEDICAL CENTER

Dedicated to the Health
of the Whole Community

Santa Clara Valley Medical Center
751 South Bascom Avenue
San Jose, California 95128
Tel. (408) 885-5000

Thank you very much for your participation in this study! We are grateful because your responses will help us to be able to improve the services that we offer to other parents like yourself, who will have babies in the Neonatal Intensive Care Unit. Your answers will be kept annonymous, which means that no one will find out how you responded. Again, thank you for your time, your thoughts, and your care for those parents who come after you in the NICU.

For questions 1 - 12, please put an X in the box corresponding to your answer. Do not leave any questions blank.

1. I had everything I needed to provide for my baby when I brought him or her home. For example, food, clothes, diapers, equipment, etc...
[ ] strongly agree [ ] agree [ ] neutral [ ] disagree [ ] strongly disagree

2. I felt that the social worker understood the feelings that I had while my baby was in the NICU.
[ ] strongly disagree [ ] disagree [ ] neutral [ ] agree [ ] strongly agree

3. I felt that because I primarily speak Spanish, I was an annoyance to the social worker.
[ ] strongly agree [ ] agree [ ] neutral [ ] disagree [ ] strongly disagree

4. I understood the medical condition of my baby all of the time that he or she was in the NICU.
[ ] strongly disagree [ ] disagree [ ] neutral [ ] agree [ ] strongly agree

5. I did not know what to expect from my baby when he or she came home.
[ ] strongly agree [ ] agree [ ] neutral [ ] disagree [ ] strongly disagree

6. I did not feel that I could trust my social worker with my feelings.
[ ] strongly disagree [ ] disagree [ ] neutral [ ] agree [ ] strongly agree

7. My social worker showed concern about how I have adjusted to life in the U. S..
[ ] strongly agree [ ] agree [ ] neutral [ ] disagree [ ] strongly disagree

8. While my baby was in the NICU, I could not explain to my family and/or friends what his or her condition was, because it was not clear to me.
[ ]strongly disagree [ ] disagree [ ] neutral [ ] agree [ ] strongly agree

9. Your age: [ ] 15-19 [ ] 20-24 [ ] 25-29 [ ] 30-35 [ ] 36-45

10. Your gender: [ ] male [ ] female

OVER->

Appendix E

SANTA CLARA
VALLEY
MEDICAL CENTER

Dedicated to the Health
of the Whole Community

Santa Clara Valley Medical Center
751 South Bascom Avenue
San Jose, California 95128
Tel. (408) 885-5000

¡Muchas gracias por su participación en esta encuesta! Le estamos agradecidos porque sus respuestas nos ayudarán a mejorar los servicios que ofrecemos a otros padres de familia como usted que tengan sus bebés en la Unidad de Cuidados Intensivos para Recién Nacidos (NICU). Sus respuestas se mantendrán anónimas, esto quiere decir que nadie podrá saber de qué manera respondió usted. Una vez más, gracias por su tiempo, su buena voluntad y su preocupación por los padres de familia que vendrán despues de usted a NICU.

En las preguntas enumeradas del 1 al 13, por favor marque con una equis (X) los paréntesis que correspondan a su respuesta. Por favor, no deje ninguna pregunta sin contestar.

1. Yo tuve todas las cosas necesarias para mi bebé cuando lo llevé a la casa. Por ejemplo: alimentos, ropa, pañales, equipo, etc.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

2. Tengo entendido que la trabajadora social comprendió las preocupaciones que yo tenía mientras mi bebé estuvo en NICU.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

3. Yo pienso que fui una molestia para la trabajadora social, porque hablo español primordialmente.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

4. Durante todo el tiempo que mi bebé estuvo en NICU, yo tuve un claro entendimiento de su condición de salud.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

5. No sabía lo que podría esperar de mi bebé cuando el o ella se fue a la casa.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

6. No sentí que podía confiar mis sentimientos a la trabajadora social.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

7. Mi trabajadora social mostró interés en la manera como me he adaptado a la vida en los Estados Unidos.
   [ ] completamente de acuerdo [ ] de acuerdo [ ] no opino [ ] no estoy de acuerdo [ ] completamente en desacuerdo

Appendix F

San José State University
College of Social Work

Field Agency's Approval of Research Project Prospectus

Instructions: This form must be completed by all students participating in university related research projects, including S.W. 298 projects. The form should be completed and submitted to the student's S.W. 298 instructor or faculty sponsor. All students are expected to advise their agencies of the content of their research projects as well as plans related to their proposed methodology, data collection, and data analysis activities. Completion of this form does not remove the obligations of students to complete other college, university, or agency research review and approval procedures/policies.

If significant changes are made in the project a new form must be completed and submitted. All S.W. 298 students must complete and submit this form prior to commencing their actual research work with data collection or clients; and in any event before the end of their first semester of study.

The field instructor's or other agency representative's signature certifies that the student has discussed and shared their plans with the agency, and that the agency is not in opposition to the project. The S.W. 298 instructor and/or other college officials should be contacted if there are any concerns, questions, or objections.

Name of Student Laural V.K. Tubbs Name of Agency SCVMC

Field Instructor's Name Joanne Rudinskas F.I.'s Telephone # 275-4226

SJSU Instructor's Name Fred Prochaska Semester(s) Fall '95

Proposed Topic: Summative Program Evaluation

Brief Description of Project - Timelines, Sample/Subjects, and Methodology:

I will be administering a client satisfaction survey to all monolingual Spanish ~~clients~~ parents in the NICU, between Oct 31 and Jan. 25. I will then measure their degree of satisfaction based on 4 variables: 1. degree to which emotional needs of parents were m 2. degree to which they understood their baby's medical condition

Signature of Student Laural Tubbs Date 10-24-95

Signature of Field Inst./Agency Rep. Joanne Rudinskas Date 10/24/95

Signature of 298 Instructor/College Rep. Date 10/10/95

3. degree to which staff displayed cultural sensitivity 4. degree to which parent ~~was~~ adequately prepared for taking baby home.