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The History and Examination of the Shaken Baby Project

Scott Larue Slaton

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**THE HISTORY AND EXAMINATION OF THE SHAKEN
BABY PROJECT**

by

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B.A., Morehouse College, 2004
MBA, American InterContinental University, 2005

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

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Albuquerque, New Mexico

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Dedication

Cybill, the love of my life. From
childhood to now and beyond, I
have and do care deeply for
you. Because of you “my fate
they say has been determined”
and I found out it was
determined to be with you.
I am the lucky one. – Scott

(2 of 2)

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ABSTRACT

The History and Examination of the Shaken Baby Project looks at the use of a Child Abuse prevention program at a Southwestern Community Hospital. The origination of the program is researched that uncovers the inception of the curriculum used in the medical facility. The Administrative and Hospital Staff are surveyed to determine their viewpoint to the program's effectiveness to participating parents. The data from the surveys was extracted to determine the Administrative and Hospital staff current relationship to the implementation of curriculum.

Table of Contents

List of Graphs.....	ix
List of Tables	x
Chapter I Introduction and Purpose.....	1
The History and Examination of the Shaken Baby Project	1
Shaken Baby Syndrome (SBS)	2
Misdiagnosis Throughout the World	3
Types of Injuries	5
Terms of Parental Challenges	8
Non-Skull Fractures	9
Types of Abuse in the United States	10
Background of This Study	11
The New York Study.	12
The Southwestern Community Hospital's Program.	15
Chapter II Review of the Literature	17
The History and Examination of the Shaken Baby Project	17
History of Change Management	17
History of Change Theorists	19
Gabriel De Tarde.....	19
Kurt Lewin.	21
Fusion strength theories.	24
Diffusion of Innovation – Everett Rogers.....	25
Multicultural Theories	27

Issues in Organizational Change.....	28
Action Learning and Action Science	31
The Challenge of Change.....	32
Social cognitive theory.	35
Reasoned Action and Planned Behavior.....	36
Contemporary Theories of Change	36
Phases of change theory.....	36
Model of change behavior theory.	37
Stages of change.	38
Leadership and Change.....	38
Leadership's role.....	40
Servant and charismatic leadership structure.....	42
Learning and personal growth.	44
Softer Skills Needed for Change.....	47
Summary	48
Chapter III The Design of the Study.....	49
Background	49
Sampling Used in the Design.....	53
Archival Documents	53
Interviews.....	54
Surveys.....	55
Focus Group.....	56
Summary	57

Chapter IV Findings	58
Research Question	58
Interviews with Founding Member A.....	59
Outside help.	61
Challenges.....	63
Interviews with Founding Member B	64
Founding Member A Partnered with Founding Member B.....	66
The Surveys	67
Reliability.....	67
Validity.	68
Theoretical sampling.....	68
Guiding Question A	69
Staff Survey.	69
Analysis of Staff Survey.	71
Guiding Question B	72
Administrator's Survey.	72
Analysis of Administrator Survey.	74
Guiding Question C	75
Summary.....	79
Chapter V Discussion	81
Introduction.....	81
Connecting Literature	83
Summary of Findings.....	85

Finding 1.	85
Finding 2.	86
Finding 3.	87
Finding 4.	88
Limitations and Future Research	89
Future Research.	90
Summary	92
Appendix A: Supporting Documents	95

List of Graphs

Graph A-1 Staff – All Questions Responses..... 97

Graph A-2 Admin – All Questions Responses 98

List of Tables

Table 1 Founders' Introduction to the Program.....	59
Table 2 Staff Survey	70
Table 3 Administrator's Survey.....	73
Table A-1 Staff – All Questions Responses	95
Table A-2 Admin – All Questions Responses	96
Table A-3 Shaken Baby Survey-Staff.....	99
Table A-4 Survey – Staff	100
Table A-5 Shaken Baby Survey-Administrator.....	102
Table A-6 Survey – Administrator	103

Chapter I

Introduction and Purpose

The History and Examination of the Shaken Baby Project

This study is of The History and Examination of the Shaken Baby Project from its inception to the present day. The study was conducted in two units of a hospital located in the Southwest. The study consisted of: (a) historical records which included the reasons for initiating the project; (b) interviews with key personnel; (c) surveys of current employees working in the project; and (d) follow-up with focus groups to verify the findings; (e) a description of the change management that occurred over time

A historical examination of the Shaken Baby Project began with the reasons children suffer injuries that result in Shaken Baby Syndrome (SBS). The study involved the various types of injuries and presented the reasons for their occurrence. The research centered on injuries of this nature as they occurred in the United States in general, in India, and in New York City, and finally focused on two units of a community hospital in the Southwest that established a program with the aim of preventing violence of this nature.

The Shaken Baby Project was established at two units of a Southwestern hospital to prevent SBS in new-born infants. The hospital's approach involved changing the mindset of parents. During the process of teaching parents to change their ways of handling the unique child-related activities that could result in SBS, The hospital would like to benefit from the research in order to make changes in the their SBS program and to make the curriculum implementation better. An organizational and personnel change would occur within the two medical units involved in the process.

In this chapter, I will describe: Shaken Baby Syndrome, several case studies, types of injuries connected with SBS, parental challenges, types of child conditions that result from SBS, and the New York study that was the model for this dissertation.

Shaken Baby Syndrome (SBS)

Shaken Baby Syndrome (SBS) is a form of child abuse that affects children throughout the world. It is usually classified as a non-accidental head injury in infants. Three primary indicators of child hood related injuries are skull fractures, long bone fractures and thoracic or rib fractures (Lee, Gonzales-Izquierdo, & Gilbert, 2012). Non-accidental head injury in any person presents additional challenges for medical professionals in diagnosing the patient. Also, many learning difficulties are attributed to brain damage from head injuries. Epilepsy, blindness, and other states of disability are often the result of head trauma. In cases in which the victim is one year old or younger, physical abuse in the form of head trauma often results in life-threatening or even fatal injuries.

According to the National Clearinghouse on Child Abuse and Neglect (David, 2009), 41% of all cases of child abuse and neglect in 2004 involved head injury tragedies. Any form of violence to an infant's head—including head compression, deliberate impact, traumatic rotation and impact (shaken impact syndrome)—can result in brain injury to the child. Shaking by an adult is a leading cause of head injury among infants and young children. Although SBS is a generic term for non-accidental head trauma, this syndrome has many different components. Whether the result is internal trauma, skeletal injuries, external evidence of trauma, or neurological problems, this kind of child abuse has negative effects on the developing brain of an infant (David, 2009). It is worth noting that throughout the world,

countries use many different labels to describe these injuries. Unfortunately, in some cases the result is a misdiagnosis that eventually leads to death.

In many countries SBS is not readily recognized by medical professionals. A number of cases are misdiagnosed in the beginning due to lack of information. In most of the cases of SBS, time is of the essence, but doctors often have limited knowledge of the history of the patient. Developing nations are especially challenged due to lack of reporting standards or misunderstanding of the initial case (Lin, Chen, Chien, & Chan, 2012).

Misdiagnosis Throughout the World

A clinical brief from India (Babu, 2009) includes a distinctive case involving SBS. In this case, a 35-day-old male was brought to the emergency department of a county hospital in India. The victim suffered from multiple seizures and according to his parents, stopped eating 2 days prior to suffering from the injury. With no history of fever, trauma, or any kind of bleeding, the child's health was reported to have been fine until the day that he stopped eating. When he arrived at the emergency department, he was comatose with poor pupil response. Although there were no signs of bruising or other external evidence of injury, his comatose state indicated serious injury. While the seizures were apparent, the child had a series of tests that all returned normal. After more time passed and further investigations took place, an ultrasound showed evidence of compression of the head. This evidence led to further examination of the head that revealed a midline shift. The doctors were finally on the right track, but unfortunately, the child expired on the third day after his admission to the hospital. This case is an example of a missed instance of abusive head trauma. Documented cases of misdiagnoses exist not only in the developing nations, but also in the United States.

A 1999 study done in the United States analyzed missed cases of abusive head trauma (Jenny, Hymel, Ritzen, Reinhart, & Hay, 1999). The study found that in 173 cases involving infant head injuries, doctors did not correctly diagnose approximately 33% of the head-trauma cases until approximately 7 days after the injuries. To compound the problem, social workers and other professionals who interact with head-trauma victims often are not equipped to recognize the signs of such injuries. The Dias Study (Dias, 2005) in New York showed examples of the limitation. The City of Denver Colorado's (Jenny, 1999) study showed limitation resulted in 41% of brain-trauma victims experiencing other complications due to the delay in identifying the injury. It is worth noting that 4 of 5 deaths within the Colorado group mentioned could have possibly been prevented through earlier recognition of the abuse.

All these types of injuries are determined to be reactionary (Babu, 2009). Parents may feel that a baby's actions are premeditated but they are not. Parents may lose their temper and shake the baby because of the baby crying. As such, the spontaneous baby shaking is the result of the parent losing their temper.

Although the range of injuries in this area is vast, the people afflicting this harm on young children may have a history of violent behavior. Many cases are completely accidental – they happen when a parent is trying to soothe a crying baby. In some cases, the perpetrators have had previous contacts with the police and the court. A closer look at the types of incidents involving abusive head trauma will assist in identifying the types of people who cause such incidents.

Types of Injuries

It is not uncommon for an infant that presents with abusive head trauma to have one or more other injuries. An incident may include broken limbs, burns of various degrees, bruising, or cuts or puncture wounds. In the case of non-accidental injuries that pertain to the head or the tissue of or around the brain, the term traumatic brain injury is used. Repetitive rotational injury to the head, commonly referred to as the SBS, is the major cause of head injuries in infants and young children (American Academy of Pediatrics, Committee on Child Abuse and Neglect, 2001). An examination of the types of injuries will help the reader understand the many kinds of injuries that medical staff could encounter.

Acute Encephalopathic injuries are more commonly referred to as shaken impact syndrome. A frustrated parent or caregiver may inflict non-accidental injuries on the baby because of the child seemingly challenging his parents in the form of not eating, being fussy, or being difficult to handle. Internal injuries may be accompanied by external injuries such as bruising, cigarette burns, or lacerations. Such injuries may result in internal bleeding; a drop in blood pressure, shock, and the extremities of the baby's body may become extremely cold. The baby's natural reaction to the injury (crying, for example) may stop due to the body's attempt to deal with the trauma. The adult may then mistakenly think that the baby has become aware of his/her dissatisfaction and as such, stopped reacting,

Epileptic seizures may occur after the initial trauma. These seizures can be severe and drug-resistant if the child is not taken to the hospital immediately after being injured. Children are not commonly seen immediately after the trauma due to the parents' belief that they did not cause any physical harm to the infant; the child was only responding to their

misplaced guidance. The seizures normally cause the child to cease any initial reaction to the traumatic injury.

Hyperacute Cervico-medullary Syndrome results from a high level of shaking or forms of whiplash that infants may experience after an attack. Such an injury is commonly described as a broken neck or a broken brainstem and often results in hyper-flexion movements—whiplash damage. Since cases of this nature are normally not seen in time to prevent further damage, secondary brain injuries commonly occur after the trauma. Although the adults may never understand the harm that they just caused the child, internal bleeding may be taking place and long-term effects will probably occur.

Raised intracranial pressure (ICP) is a result of veins bursting in a child's head. A common result of this trauma is increased head circumference that is seldom recognized by the parent. An increase in ICP may trigger shock that a parent may not recognize, but which in turn may cause reduced blood pressure to the brain, which will result in further damage and other long-term disabilities. Severe shaking of a baby can damage veins in other parts of the baby's body and can cause irreversible brain damage and injury that a parent may never recognize.

Subdural Hematoma (SDH) is bleeding from subdural-bridging veins that have been torn due to non-accidental shaking injuries during the first year of life. This type of injury may possibly lead to long-term brain damage.

Consideration will now be given to the reasons that may cause parents and caregivers to inflict such injuries on babies. A malicious injury can be defined as any injury resulting from physical contact made with the intent to inflict pain. Parents may not intend to injure a child; in fact, they may be unaware of the amount of harm they may have caused. Many

parents are not troubled by their own injurious actions due to the fact that they view their actions as corrective behavior. In many cases these injuries are referred to as *disciplinary and frustration injuries*. Disciplinary injuries occur when caregivers attempt to correct a child's behavior that they consider abnormal. The term *frustration injuries* refer to cases where caregivers become frustrated at their inability to stop a child from crying or failing to respond in a desirable way. In both situations, caregivers may use excessive force that results in unintentional injuries.

Sometimes parents misinterpret a child's way of expressing a need for attention. Parents may feel that the child is deliberately trying to be annoying. Very few parents who face such challenges truly understand the harm that they can do to their child if they react by using force. Normal parental challenges such as lack of sleep, anxiety, or simply being overwhelmed by the unexpected continuous needs of the baby all contribute to the problem. In the case of someone reacting from the fight or flight response of the body, the threshold for reaction can be lowered due to any of the above challenges. However, this is only a simplistic way of looking at the challenges that may affect bonding with the child.

Any area of family development can prove to be too challenging for a parent who is not well equipped to deal with parenthood. A child in a family may be unwittingly singled out for parental abuse. A mother's reaction to an unwanted pregnancy may have a negative effect on the way she takes care of the child. Such a challenge can put stress on her relationship with her baby and may eventually lead to her seriously injuring the child. A child with developmental challenges such as inability to accept cuddling, the inability to smile or even the inability to make eye contact with the parent can result in the parent's inability to console the child. The adult may feel inadequate as a parent and become frustrated.

Terms of Parental Challenges

Munchausen Syndrome (David, 2009) refers to cases in which parents create symptoms to supposedly satisfy the child's need when in fact they are satisfying their own need to be convinced that they are good parents. If a child appears to be independent, a parent may react by over compensating with attention. Some parents enter into such a state of anxiety that their impulsive actions end up harming the child. These parents think they are helping the child, but they fabricate abnormalities to satisfy their own needs. A symptom of this nature may be caused by a Puerperal Psychosis (also called post-partum psychosis) (David, 2009). In cases of this nature, parents usually do not have a conscious intent to cause harm to the child, but rather have an overwhelming need to do something for the child. It is interesting that shaking injuries normally occur in children aged 6 months to 2.5 years when there is little to no connection between the children's needs and the parents' reaction to those needs. Various types of psychosis in a parent can result in an inability to protect the child and an ability to cause harm. In some extreme cases a parent may even allow "accidents" to occur.

One of the most common forms of accidents involves a toddler falling. Toddlers frequently fall short distances. However, a very low number of these falls result in the child's head hitting a blunt surface, which is the basis of many explanations of head injuries in children. Hitting a blunt surface can lead to skull fractures which are most commonly seen in non-accidental injuries. In the very first months of life, a baby's skull has not developed fully due to the fact that the bones have to mineralize as the baby is developing. The mineralization process (De Curtis & Rigo, 2012) hardens a baby's bones and gives them the ability to protect internal organs. It is important to note that a baby does not go through this

process until after the first few months of life. Therefore, shaking or forceful blows are very likely to cause a head trauma since the skull is unable to protect the brain. Many factors that contribute to protecting the skull's contents adequately in older children and adults are minimal or not present in infants and toddlers. For example, hair offers a certain amount of protection, and some babies do not have any hair for the first 3 months of life. Similarly, the lacks of development of the surrounding muscles that support the head make it easy for whiplash-like injuries to be inflicted. The elasticity of a baby's skull enables the skull to bend, thereby reducing the protection to the brain. Any violence to the baby's head may result in a type of non-accidental bone fracture in the skull. In this type of fracture, a portion of the skull bone may stretch from the impact and reach a baby's interlayer of the skull possibly effecting the Dura and or Arachnoid Mater thus affecting the brain and its early development (Wood, 2012).

Characteristics of non-accidental bone fractures vary widely and can easily be attributed to different circumstances. A growing skull fracture makes the bones in the skull react to expansion. This may occur in the reference phase of skull growth seen in children a year old and younger. Because the skull is growing at this time, it is susceptible to tears and fractures during this stage of development. Although on its own a skull fracture may be of minimal medical importance, disclosing that information to medical professionals is very important.

Non-Skull Fractures

SBS incidents feature heavily in non-skull fractures. Non-skull injuries in children less than 4 years of age are normally due to abuse (Hill, Dwyer, & Kaler, 2012). A metaphysical injury is commonly seen in child abuse. This form of injury is caused by

twisting a limb and is seen in many disciplinary injuries. A parent's poor ability to cope with a child's constant crying can lead to shaking, grabbing, or twisting an appendage of a child. Various ways of harming a baby are related to the various types of child abuse. In SBS cases, shaking makes the brain move rapidly within the skull, causing serious harm to the organ. The impact against the bones can actually damage the brain matter. This movement of the brain inside the skull may result in bleeding as blood vessels get torn. The change of the veins from the bleeding affects a child negatively in the development of their bodies. This type of abuse is common in the United States.

Types of Abuse in the United States

Abused children come from families of various religious, ethnic, and economic backgrounds. SBS can be classified under Disciplinary and Frustration injuries, although it is listed in other categories. Disciplinary injuries occur when parents attempt to change a behavior of the child that they view as abnormal. Frustration injuries are the result of the inability of adults to adapt to the unpredictable behavior of a child. Uneducated parents may think that these perceived abnormal behaviors of children need to be corrected. When a child cries constantly, parents may often feel that disciplinary actions should be taken to change the baby's behavior. In cases where there are no premeditated ideas to injure the child, it is sometimes thought that shaking a baby is less harmful than the physical abuse of spanking. Normally a disciplinary injury is not premeditated but results from the inability of a parent to handle a very stressful situation. In cases of disciplinary injuries, there are no intentions to hurt the child. In many sad cases, a parent who did not plan on injuring the child uses shaking as a means of discipline and ends up damaging the child for life. Not only does the child

suffer a life-long injury or disability, but also the parent imposes a life of grief on himself or herself for so hurting the child.

Reactions to being annoyed physically and emotionally are converted to different physical and emotional expressions. Angry parents may unintentionally inflict harm on a defenseless child. With the loss of self-control, a fight as opposed to flight response may envelope a parent who may then intentionally cause harm with unintentional results. A related area of research that needs to be studied is Attention Deficit Hyperactivity Disorder (ADHD) in adults, which involves poor control of a person's rage that may result in abusing a child.

Child abuse can exist in family structures in various settings. Weakness in the area of child/parent connectivity, resentment toward a child who is the result of an unwanted pregnancy, a child being singled out for abuse—all of these scenarios can potentially lead to violence against a child due to various psychological abnormalities that are not easily recognizable. In the Southwestern state used for this study, the need to treat a potential assailant is not easily recognized. Also, there is widespread resistance to accepting needed treatment. Many cases of shaking injuries involving children from new-born to 6-months old occur due to depressive disturbance (Tomba, Rafanelli, Grandi, Guidi, & Fava, 2012). An examination of SBS incidents in this state sheds light on the reasons that a community hospital decided to develop an SBS curriculum in two related units.

Background of This Study

Many infant deaths in the selected Southwestern state are related to SBS. It may be useful here to pinpoint SBS as a term that exemplifies the results of violently moving a child in a rapid manner in an attempt to stop unacceptable behavior. SBS results in preventable

childhood injuries. The physical forces exerted by an adult in distress can be from five to 10 times stronger than the normal forces by which children injure themselves. This form of shaking is a cause of great danger to infants since their skeletal and neck muscles have not completely developed. These violent movements have many negative effects on the child's body and are the number-one cause of childhood deaths. It is estimated that between 1,200 and 1,400 kids are hurt by SBS every year (Covington, 2011) with many of these incidents leading to the death of the child.

In 2006, the Southwestern community hospital selected for this study implemented a replication of a project done in New York City, New York pertaining to childhood injuries and deaths occurring from SBS. This study examined the development of the Southwestern project from its inception to the present time, as well as the areas of change experienced by management and in adult learning. The Southwestern community hospital used a study done in New York that documented promising results from a parent-based prevention program at a New York State hospital.

The New York Study. In December 1998, The Shaken Baby Prevention Program started in New York as a parent education program based in a local state hospital. The program's objective was to educate each parent of each child born in that hospital about SBS. The program was centered on educating parents of newborn babies to help prevent injuries that result from new parents' stress related to the first few months of the child entering their lives.

The program in New York provided educational materials to new parents and asked every parent to commit to preventing childhood injuries in their homes. The parents were asked to sign a commitment statement not to harm their children. They received materials to

help prevent any child abuse that could intentionally or unintentionally occur in their homes.

When the parents returned the statements of commitment to the hospital, their names and related information were documented. In November, 2004, the program was enacted into law in the State of New York. This marked the official start of the educational program sponsored by the Kaleida Health's women and children program in the state.

The model for SBS prevention created an interest for all the New York hospitals to work toward combating this form of child abuse. The shaken baby prevention program in New York was a catalyst and led to other programs using similar educational materials. As a result, 17 counties in New York started pilot programs. The programs focused on parents leaving the hospital with educational materials to help prevent incidents of abuse after the mothers were released from the hospital. The program picked up momentum after it was documented that infant-related injuries decreased if parents received this education before leaving the hospital with their babies. The program then started "booster shots" on the web that provided additional educational materials in the form of pamphlets and flyers to remind the parents of the commitment they made when they left the hospital. Other educational materials were also provided during the parents' first visit to the doctor after returning home with their baby.

Problems of parental abuse usually occurred after parents were released from the hospital. The newborn's form of expressing their dissatisfaction or discomfort often materialized in repeated actions of crying and other annoying infant behavior. The behavior shocked the parents and, due to poor parental coping skills, violent shaking was the most common parental response.

The results of the New York study were published in an article highlighting infant injuries and different forms of child abuse (Dias et al., 2005). The study's design was to determine if a hospital-based parental education program could equip new parents with the potential for preventing child abuse. The purpose was to provide parental educational materials on violent infant shaking. The information also provided different ways to take care of a child's continuous crying during the first few months of a child's life. The parents voluntarily signed a commitment form agreeing to accept and understand the materials to prevent child abuse.

The signatures confirmed the parents' access and compliance with the hospital study. Parents continuously received information from the hospitals, and seven months after the child's birth, a group of the parents was selected as a study subset. Telephone calls were made to access the parents' recollections of the material. Statistics were kept on any forms of child abuse committed by parents who were seen at the hospital. All incident rates of children's injuries were documented in the study.

The results proved to be significant. The 7-month follow-up telephone surveys indicated that 95% of participating families remembered receiving the information. At the same time, the incidence of head injuries decreased at the participating hospital. Before the study began, 41.5% of 100,000 babies born in this hospital returned to the hospital at some point suffering from head injury. After the study, only 22.2% of 100,000 live births resulted in injury. The 19.3% decrease (Dias et al., 2005) was attributed to the educational materials received by parents before their release from the hospital. The researchers concluded that a hospital-based adult-education program for parents could decrease the number of injuries to newborn infants.

The Southwestern Community Hospital's Program. In 2005, the Southwestern community hospital selected for this study started a Shaken Baby Syndrome Prevention and Awareness Program. This program was modeled after the program described in the New York study. The goal of the program was to provide educational materials pertaining to SBS to parents of newborn infants. The program would promote parents' understanding of the injuries a caregiver can inflict on a child by violent infant shaking. The hospital used the returned commitment statements to track parents who voluntarily participated in the program. The program was analyzed for its effectiveness as it related to regional incidents of SBS. It was decided that the SBS prevention program would be implemented as a standard, and materials were given to all parents of newborn infants before leaving the hospital. The parents were provided with a one-page leaflet, and asked to view an 11-minute video about preventing SBS.

The content of the 11-minute video and one-page leaflet documented the more than one million cases of children who were severely abused in this manner. This leading cause of injury and death of infants was estimated at approximately 1200 - 1400 babies nationwide annually suffering from preventable head trauma (Covington, 2011). An estimated 25% of babies so injured died from this head trauma, while the other 75% would require ongoing medical attention due to these injuries. The Southwestern community hospital defined SBS in the following ways: head injuries, a child being dropped or thrown, and violent shaking of a baby. It was determined that infants were particularly at risk for injuries due to their anatomy at this stage of their life. Although the hospital's nursing staff has written a publication on child injuries in the state (Capitano, 2005), this information primarily pertains to injuries of children in rural areas. The injuries in urban areas of the state are very similar

to the types of trauma the rural areas have experienced. However, rural areas have the additional challenge of not being close to medical care.

In this dissertation a review of the literature is examined in Chapter II.

Chapter II

Review of the Literature

The History and Examination of the Shaken Baby Project

The purpose of this study was to determine the effectiveness of a Southwestern hospital's efforts to engage parents in the Neonatal Intensive Care and the Newborn Nursery units in implementing a change-management system to prevent incidents of SBS. The understanding of change management will assist in analyzing the effectiveness of the SBS prevention program enacted by the hospital, as well as increasing knowledge of what must be accomplished to prevent this type of child abuse. In this chapter, the researcher examines background literature on both change management and adult learning. The purpose of a broad review of the literature is to understand the actions of change, change management, and ways to bring about lasting and significant change in people and in organizations. This researcher highlights the major theorists and their theories that are central to this study.

History of Change Management

Change management has been studied widely. Although this overview of change focuses on the theory of change, change is anything but theoretical in the lives of everyone in the world today: the effects of change are fundamental and material. For example, change affects how resources are distributed, who has access to education and healthcare, who gets to enter this country, which is forced to leave this country, how organizations are run, and which rules govern society and its institutions. Change affects core issues of human justice and fairness, or the violation of those principles—sometimes both at the same time, depending on the point of view of the onlooker.

Because the world is changing rapidly, people from diverse backgrounds, cultures, and beliefs are more interdependent. That interdependence creates the need for people to be in closer communication with each other than ever before. Individuals exist in particular contexts and come from unique backgrounds that influence their various beliefs. Consequently, the need for understanding change has increased. By understanding the conflicts that can arise in the process of implementing or resisting change, a better basis for implementing change can be reached.

Change may infringe on social practices that are tied to ethical beliefs, the division of economic and political resources, and status, as well as individual and group identity. Individuals imitate the people they admire, or who have achieved the results that they wish to achieve, while resisting being like the people whom they do not admire, or whose results did not achieve a certain goal. Because individuals are also members of groups—families, communities, organizations, political parties, nationalities, ethnicities, races, religions, etc.—there is always interplay between individual identity and group identity. This interplay enters into the process of change, whether that change is personal, political, social, economic, or organizational.

Leaders entrusted with managing the process of change must be aware of the interplay between individual and group processes. Some people embrace change quickly, while others actively resist change. The two extremes, according to Rogers (2003), are groups that he termed *innovators* and *laggards*. Any organization may have people who lie on various points of the bell curve that ranges from quick innovators to die-hard laggards. The way in which the leaders must communicate with people from those groups, as well as

the groups that lie in between the extremes, must be tailored to take into account people's degree of receptivity or resistance to change.

In the United States, some recent types of resistance to change can be seen in racial and gender politics. For example, debates over affirmative action, immigration policy, and gay marriage all involve some type of resistance to change. Many of the theoretical approaches to such issues shed light on fundamental challenges to change and the management of change.

Change and resistance to change hinge on people's views of reality, which many people forget are social constructs that exist in their minds, not objective realities that exist apart from human consciousness. These constructs of reality are beliefs that are linked to culture and history, not objective truths that are independent of social, political, historical, or personal context. For this reason, Thomas Kuhn's (2003) ideas of paradigms and paradigm shifts are informative for this theoretical exploration of change and change management. Change management is also tied in with leadership, which is the reason that this research explores the area of adult learning in managing change and in the area of organizational learning.

History of Change Theorists

Gabriel De Tarde. One of the first major theorists of change was the French researcher Gabriel De Tarde. Like many of the other theorists of change, De Tarde (1903) saw change as rooted in social practices, which is another way of saying that change is an essential part of human life. De Tarde wrote about what he termed the law of imitation. His book, *The Law of Imitation*, was published in 1903. De Tarde believed that imitation was a social mode of universal activity based on social phenomena of status, charisma, reputation, and emulation. He also felt that imitation was a natural social phenomenon and had

possibilities of endless repetition through what he termed the group mind. These theories led to detailed analysis of crowd behavior as well as the investigation of natural phenomena, cosmic philosophy, and social science.

De Tarde (1903) explored quantitative research. He was the original proponent of the S-shape diffusion curve. The S-Curve function used in many psychology, sociology, population studies, neurobiology, can also be used to describe De Tarde's change. The S-shape diffusion curve can be used to plot as well as measure change. An earlier work of De Tarde's was in the field of the laws of universal reputation in physical nature and in history. The process of the power and diffusion of reputation was described by De Tarde, as well as other specialists in the field, as a way in which elemental phenomena, undergoing endless repetition, are combined in concrete groups that develop mental constructs and social systems (De Tarde, 1903).

De Tarde's (1903) period of greatest scholarly output was during the early 1900s, long before the invention of the personal computer. Other researchers used De Tarde's work to increase the consensus understanding and general acceptance of change management. Karl Pearson, who highlighted De Tarde's work, became a major contributor to the area of change management (Bellhouse, 2009). The beginning framework of the theory of change is credited to these Pearson and De Tarde. However, the inception of their theory was in The Law of Imitation (De Tarde, 1903), which led to the area of diffusion research. Pearson is credited with taking De Tarde's research in a new direction. Pearson advanced De Tarde's research in the application of the S-shape rate of diffusion of innovation (Bellhouse, 2009).

Most innovations have an S-shape rate of adoption. The areas of adoption of innovation are crucial components in the framework of change theory and change

management as well as the premises behind them. The rate of diffusion shows how a specific idea enters the group's consciousness, moves through it, and then is accepted or rejected by the group. Research on change continued to progress through the 1900s with other researchers modifying and elaborating on the original thoughts and work of De Tarde and Pearson (Bellhouse, 2009).

The basis of diffusion research centers on the conditions that increase or decrease the probability that a new idea, product, or practice will be adopted by members of a given cultural group. The group may be a peer group, an age cohort, members of a profession, or adherents of a religion or political group.

Resistance to change can be approached from various theoretical perspectives. In organizations, as in groups of all kinds—families, classrooms, teams, nonprofit groups, etc.—factions may develop. People may oppose others on the basis of personality, principle, ideology, or any of the factors that have caused people around the world to experience conflict and factionalism. The introduction of change can bring to the surface preexisting tensions tied to factions and conflicts between people and groups of people whose interests may not be identical. One of the tasks of management is to get groups and factions to work together in a cohesive and coherent manner. The work of Kurt Lewin (Allport, 1947) emphasized research in this area.

Kurt Lewin. Many theories and applications of change and change management have been attributed to Kurt Lewin. The Lewin's theories applying to change and change management was dominant for four decades, but began to receive increasing critical scrutiny in the 1980s and 1990s (Burnes, 2004). Lewin viewed “behavior as a dynamic balance of forces working in opposing directions” (Burnes, 2004, p. 997). According to Lewin's theory,

a driving force has an outcome and effect on the employees' actions and outcomes to align the employee with the ultimate desired effect. Lewin's research in this area also determined that restraining forces may hinder change due to the force's ability to redirect employees. Ultimately, these forces must be considered and factored into the planned change. Applying Lewin's three-step model could prevent the forces from unbalancing the change by reverting it in the direction of the planned change.

According to Lewin (as cited in Burnes, 2004, p. 997), the first step in the process of changing behavior is to "unfreeze the existing situation or loosen the iron grip of the status quo." The status quo is considered the current state that requires change. The term *unfreeze* pertains to undoing the stresses of resistance and destabilizing the group's current condition so that it can be maneuvered to a new state of being. Unfreezing involves causing a shift in the pattern of actions or reasoning that is preexisting or currently established. The change must alter the status quo or present state of action to facilitate the desired outcome. The idea of working with participants to prepare individuals for change can assist in the group's understanding and the formation of a consensus or agreement about the need for change. The opportunities for participants to point out and highlight challenges with the current situation and work to find solutions to those challenges can assist in this area.

Three different ideologies or phases can assist in this process of change. The beginning phase works in the direction of influencing actions and to separate directions from the current norm. The second phase involves challenging potential or actual directions that move away from the status quo, but in ways or directions that are less than optimal or desirable. In Lewin's theory, these undesirable currents should be tagged. Tagging undesirable behaviors makes it possible to redefine the norm in appropriate and helpful ways.

In highlighting the various potential directions, it is possible to work with employees to decide whether the current norm enhances the overall outcome of the group. Reflecting on direction in this way may help encourage employees to explore leaving the current norm and to define a new direction that is more aligned with the new strategy. Once an employee has the ability to understand the benefits of the change, the employee can be encouraged to view the problem from a different perspective. In this phase, the ability to work together as a group with a common result for a new and different norm could connect past goals with the new direction to assist in this change. By supporting the actions to move from the status quo, the ability to move against the norm is strengthened.

The last of Lewin's phases in his three-step change theory pertains to working with each of the two methods to create new ideas by combining and redirecting actions to create a new direction. Lewin (as cited in Burnes, 2004) referred to this phase as *refreezing*. The concept of concentrating on the new idea for the change to become an acceptable norm helps to reorient the group in the new direction. Lewin determined that during this phase, it is easy for the past direction of entrenched beliefs and behaviors to resurface. The direction of the work is to integrate the new values into the current situation. Employees must assist in the process of gaining and keeping their support in this endeavor. The rationale to refreeze is to stabilize in the new direction that resulted from the change and to assist the organization so that it can reach the desired result. The desired outcome is to find equilibrium between the forces that prompted the new direction to confirm and reinforce the original belief that the change was essential. Lewin stressed the tendency for old entrenched ways to resurface. Therefore, for change to take root, the new direction must work to integrate new values into the current situation that came from previous change in a self-reinforcing loop. Once the

three steps have been completed, Lewin argued that both formal and informal works are needed in policy and procedural change to affect and stabilize the new norm.

How this model enforces or restrains change is clearly related to the change having the strength to overpower the challenge to revert to old ways. Lewin characterized ideas that increase or decrease of possibility of change as driving forces to promote change or restraining forces to oppose change (as cited in Burnes, 2004). The theory will only be fully implemented when the force to make the change is greater than the force opposing the change.

Lewin explored a planned approach that would incorporate change effectively into modern social scientific theory (as cited in Burnes, 2004). This model of change is thought to be a chief methodological approach in developing experiments in social scientific approaches to change. Lewin's model was criticized for its complexity and its simplicity. Some radical proponents of change believe that Lewin's three-step process is overly complex, while others argued that its simplicity—its alleged oversimplification of the process of change—makes it useless to many change ideas.

Fusion strength theories. Change management is a structured approach to shifting from a current state of being, rooted in entrenched paradigms and organizational practices, to a desired state, based on purposeful innovations. Change theory is a collection of the ideas about how to effect a difference in actions (operations, policies, procedures, and even constructions of reality) to cause a different result, condition, and way of doing things. The relevant framework and theory behind organizational change can be simplified to pinpoint different strategies that can be used to implement organizational change.

Two extremes in the strategies that pertain to implementing organizational change (Ayres et al., 2013) include elevating inquiry and fusion strength. Elevating inquiry, which is conceptual and intellectual, means defining values in change and in related areas. Fusion-strength theories focus not on the conceptual and intellectual aspect of change and change management, but on the emotions that govern people's actions. Fusion strength is based on the premise that positive emotions have the capability to alter people's motivations strongly enough to change their behavior so that they will take the necessary actions to reduce or eliminate the harmful effects of the problem being addressed by change, as well as the disruptions caused by the process of change itself. In both extremes, the rate of adoption of the innovative ideas and practices is paramount, as this tempo of change will affect whether the change succeeds or fails to take hold in social or organizational practice. The rate of diffusion of innovation and the saliency of the innovative ideas and practice can be understood through the lens of discovering a framework for change: why people resist or embrace change, what they believe that they have to gain or lose from the changes and the process of change, and the premises behind change theory and change management (Burnes, 2004).

Diffusion of Innovation – Everett Rogers. This area of change management also intrigued a young man who began his career as a sociologist studying the reasons that farmers were reluctant to adopt more efficient, productive, and profitable ways of farming, practices that would have made their jobs easier and their work more profitable. That man, who grew up in the farm state of Iowa, was Everett Rogers (2003).

Everett Rogers did not begin his life in academia. He turned to a scholarly way of life after making major decisions pertaining to his personal life and serving in the Korean War. His

personal decisions and life events led him into research to improve his understanding of ideas behind change and change theory. He was responsible for developing the concept of the diffusion of innovation. He later turned this research into the basis of a book that has gone through five editions, the most recent of which retains the original title, *Diffusion of Innovation* (Rogers, 2003). Rogers went into depth about the theories and areas of change management. He begins by exploring areas in which people managed to resist change so that the diffusion of the innovation in question did not occur smoothly or quickly reach widespread acceptance.

In discussing the diffusion of innovation, Rogers (2003) segmented the targeted change populations. First, he identified the people who embrace change quickly. He characterized them as venturesome and termed them *innovators*. Next came the "early adopters" of the change who are respectful of the ideas and purposes of the change. This group was followed by the "early majority," who are deliberate and thoughtful about changing their behaviors and practices. The "late majority," skeptical of change, tend to make changes only when further resistance to change would take conscious and deliberate effort. This group Rogers labeled as "laggards," who might be seen as die-hard traditionalists.

The rates of adoption can be captured in many instances in which innovation was diffused through successive groups and adopted. However, Rogers (2003) highlighted a few instances in which the rate of acceptance of a proposed innovation was never sufficient for that innovation to become adopted as the consensus belief or practice. Rogers found that rational arguments do not always prevail in human decisions and human actions; in many cases, the resistance to rational decisions can even have deadly consequences. Therefore,

leaders must not rest once they believe that they have figured out what others should do. Merely communicating information about rational decision-making is often insufficient to change human behavior, as illustrated by the anti-smoking campaigns which have taken decades to lower the rate at which adults in the United States smoke cigarettes.

Multicultural Theories

The literature on inclusiveness, inclusive language, and multiculturalism has been growing and has much to say about the huge range of issues and theoretical complexities in the area of change theory. Examples are: critical race theory, feminist theory, and the literature regarding social, political, and economic marginalization, including convergence theory and counter-storytelling to challenge hegemonic discourse (Nicolaisen, 2012). Change mobilizes both those who stand to gain from change and those who fear that change necessarily involves loss of power and status. One example is affirmative action and the theories that have been used to oppose affirmative action such as color-blind policies, meritocracy, etc. Theories of resistance and empowerment can do much to explain the process of change and how it affects the lives of everyone in society.

Paradigm Shifts. Thomas Kuhn's (2003) idea of paradigms (beliefs about reality, models of reality and how the world works) was originally presented in his book, *The Structure of Scientific Revolutions*. His work is central to understanding and conducting research on change and change management. Kuhn introduced the concept of a paradigm shift as exemplified in the shift in physics from Newton's universe to Einstein's through the advent of Einstein's theory of relativity. Similarly, huge shifts occurred in the social and political order in American history through events like the abolition of slavery and the gaining of the right to vote by women. Other paradigm shifts in society are underway,

although vehemently contested, in such areas as racial identity, gender identity, and sexual identity. The fact that gay marriage is legal in more than a handful of states and that the President of the United States recently voiced his personal support for the principle of gay marriage is another example of a paradigm shift. The concept of a paradigm shift is central to any theory of organizational change and will figure prominently in the proposed research project.

Transformational learning is one of the key theoretical components of change and change management. Transformational learning involves making people aware of their own assumptions and how those assumptions affect their behavior. A group of people may conflate their constructions of reality by mixing objective facts with the misperception of universal truths. Discourse theory and transformational learning are both important ways of approaching the management of change that includes dealing with people's individual subjectivity and their constructions of reality. Ideas can diverge widely from one cultural group to another, making communication difficult at times, particularly during periods of rapid change and massive disruption of traditional ways of living and working (Mezirow, 2000).

Issues in Organizational Change

Organizational leaders who are managing change need to identify the paradigms that exist within an organization; also, they must identify the central units that make up its workforce - suppliers, clients, investors, and others. An effective leader cannot afford to assume that everyone adheres to the same paradigm about what exists and how things should be. When people adhere to different paradigms about reality or justice, conflict can ensue and may become deeply entrenched in an organization.

Critical race theory challenges the tendency in some quarters to overlook the inequities in race, politics, education, private organizations, and in society, while scrutinizing how change is manipulated and portrayed to hide advantages or minimize grievances (Taylor, 1999). In a rapidly changing society, leadership must adapt, as concepts of what is fair and acceptable shift over time (Stringer, 1996). Transformational leaders sometimes must go out on a limb to rectify past wrongs and make systems work more equitably for all stakeholders (Terry, 1993). Sometimes leaders must draw attention to pain, suffering, and injustice in order to make stakeholders aware of the urgency for change and the justice that demands change. Being a change agent requires confronting complacency and self-serving denial and avoidance. Sometimes, the paradigms that are deeply embedded in individuals, groups, teams, and organizations may marginalize whole groups of people while ignoring the injustices that those groups have had to endure. Change and the desire for change usually emerge from the longings of the human heart for a better life, for greater social justice, for an increase in prosperity, or for some other worthy goal. Making the world a better place calls for transformational leadership and change.

Organizational change and organizational learning are particularly important in managing change when change involves confronting and challenging the cultural beliefs and practices that are embedded in an organization. It is important that these issues be addressed in systematic and comprehensive ways by leaders charged with organizational change. This is especially true for those who could be considered transformational leaders, particularly in organizations in which human interactions and connectivity between various constituencies are prominent issues (Allen & Cherrey, 2001).

Change management is a structured approach to shifting teams and organizations from their current state to a desired future state of being. Change management is an organizational process aimed at helping management and employees to accept and embrace changes in their current work environment. Change management refers to processes whereby change is formally introduced and approved. Kotter defined change management as the utilization of basic structures and tools to control any organizational change effort (Kotter & Cohen, 2002). One of the key goals of change management is minimizing the disruptive aspects of change that may negatively affect workers and other groups of stakeholders during the process of change.

Change affects organizations and members of organizations in many ways and may be necessary for various reasons. Change can occur in response to a competitive environment; due to demographic and cultural shifts in employees, customers, and management; due to the need for new policies, procedures, and internal paradigms; in response to the attitude and behavior of personnel; shifts in organizational mission or priorities; or required adjustments in technology, strategy, and operations.

Change management is a multidisciplinary practice that has evolved because of research (Stringer, 1996). Change management can begin with a systematic diagnosis of the current situation to determine both the need for change and the capacity to change. The objectives, content, and process of change should all be specified as part of a plan for managing change. Change-management processes may include innovative and targeted marketing to enable communication to be tailored to specific groups, such as innovators and laggards (Rogers, 2003). Additionally, change management should be tailored to a deep social understanding of the internal characteristics of the organization and its personnel,

including leadership styles, organizational culture, and group dynamics. Change management aligns groups to a common goal.

Action Learning and Action Science

Change management can be examined profitably through other theoretical lenses, including action learning research, action learning, and action science. Action learning and action science (Baranes & Oudeyer, 2013) both relate to the effects of action on learning and learning effectiveness. All the insights of action research can be applied to the dynamics of change and linked with theories of change and change management.

Action learning is used in group settings. However, the process of action affects not only groups, but also individuals and organizations. Learning is experiential, and affects all levels of experience in constructs that apply to change management. Action science is an intervention-oriented approach aimed at different levels of an organization to increase effectiveness in situations to heighten awareness and clarify assumptions (such as the paradigms embedded in organizational culture) that lie behind actions and interactions. Calls for deliberate questioning of existing perspectives and interpretations known as double-loop learning can be attributed to action science (Banta, 2011).

The constructs that apply to a theory of positive organizational change can be used to increase and disseminate an understanding of organizational change. A well-designed change can benefit management and various internal and external stakeholders to create a business innovation that works for all concerned, while monitoring the ongoing assumptions, the risks and disruptions, costs, return on investment and other factors both positive and negative. A portion of learning then occurs as people work in teams. Managing teamwork and the conflicts that emerge in teams is a critical component of change management.

Inevitably, problems dealing with conflict will arise within organizations and in interactions between the organization and constituencies outside the organization. Therefore, policies and procedures dealing with conflict need to be in place and subject to regular review. In addition, leaders should be charged with the responsibility of fostering constructive group and team interactions and positive collaboration.

The Challenge of Change

Change management is a multidisciplinary practice that was informed by various academic disciplines: business and organizational management, communication, history, marketing, political science, psychology, and sociology, among others. The theory of change management is evolving on an ongoing basis.

Change management processes include targeted communications to assist various groups of stakeholders to reach the goal of diffusion of innovation and to enable communication between change audiences (Puckett, 2010; Rogers, 2003). A visualized track for transformational change aligns a group's expectations, communications, effectiveness, and desires with key actions that result in change that is measurable, tangible, and effective. Change theory can make use of performance matrices, financial results, operational effectiveness, leadership commitment, communication effectiveness, and the perceived need for change.

Change is challenging, but change is also inevitable. It can evoke fear and disruption, but it can also raise hopes and increase the sum of human happiness while moving people closer to their own cherished ideals of fairness and justice. Cummings and Worley (2000) argued that leaders should "create readiness for change" by focusing on the strains caused by change, while highlighting the contrast between current conditions and the outcomes that

people desire. During this entire readiness stage, leaders should foster constructive and realistic expectations that are linked to the benefits that should ensue from the enactment of the proposed changes.

Change theories are rooted in many different ideas about human and organizational behaviors. As previously pointed out, theorists have examined change from many different perspectives and from many different academic disciplines. The lens used determines the focus and what is seen. For instance, psychology can focus on fear of change and resistance to change, as well as the flip side: motivation to change and empowerment through change. The sociology of change can look at social structures, organizational behavior, group norms, and embedded cultural practices. Change can be seen as an issue of communication, of disseminating information and using persuasive rhetoric so that stakeholders who at first may be indifferent to change or even hostile to it can become active agents of change.

The technology of communication has shifted radically in recent decades, affecting how people perceive the world and their relationship with others. The telephone was the first modern device of remote communication that enabled people to share thoughts and feelings in real time with others at a distance. Computers, the Internet, and cell phones now make it possible for news and information to be disseminated without recourse to hierarchies of power and control (Rogers, 2003). These communication technologies radically changed the views of human relationships and leadership that are acceptable to people. As a result, the way change occurs has been changed along with implications for its effective management and potential mismanagement.

Sometimes change is thrust upon an unwitting group of people, as was the case with the terrorist attacks in the US that occurred on September 11, 2001, at the World Trade

Center and the Pentagon. Before Americans had time to catch their breath and begin to figure out how society would need to change in response to this terrorist attack, the perception set in that the collective reality in which Americans lived had already changed and Rogers belief that, “uncertainty motivates individuals to seek information” (Rogers, 2003, p. 27) had come to pass. Because of the new communications technology of the Internet, both the terrorists and those who responded to them were able to communicate and disseminate information about change in a new way.

How can a leader change an organization that is mired in embedded practices and organizational culture and beliefs that may be increasingly out of step with its mission and with the communities and constituencies that it serves? As the American economy has changed, theories of leadership have changed. First, the U.S. economy was primarily agricultural, an economy of growing, harvesting, and tending to animals. Then it became mostly a manufacturing economy, an economy based on making things. Now it is primarily an information and service economy. As a result, communication skills have come to the forefront in managing people and in navigating change, with hierarchical structures of power giving way to the concept of empowering teams and individuals to be agents of change rather than cogs in a machine. As people’s jobs and occupations changed, their work relationships changed, and so did the types of leadership that were needed and that were effective.

Social behavior and transformation are the basis for another way of viewing change theory. In recent years, given the deeply entrenched behaviors within organizations that are tied to organizational culture, social scientists have increasingly been viewing organizational change through the theoretical lens of transformational leadership (Argyris, 2010). The theories of change and the theories of transformational leadership are rooted in the view of

humans as social beings who always operate within contexts that have established customs, procedures, and rules. Often, these contexts are conveyed, perceived, and assimilated through social interactions more or less unconsciously and uncritically. Changing an organization's culture places extraordinary demands on leaders' awareness, critical thinking abilities, and mastery of persuasive rhetoric and change theories (Gallos, 2006).

Social cognitive theory. Many theories of change are tied directly or indirectly to *social cognitive theory*, which is based on the ability to learn by direct experience, human dialogue, interactions, and observations (Bandura, 1997, as cited in University of Twente, 2012). As Bandura observed, social cognitive theory is linked to the concept of self-efficacy, the belief in one's abilities to master new challenges that provides the motivational force necessary to respond to the occasion (Ramirez, Kulinna, & Cothran, 2012). Social cognitive theory encompasses the ability to react to incentives and behaviors as they are presented. Social learning is based on motivation, on deriving a reward for the effort expended, based on "outcome expectations" (Ramirez et al., 2012, p. 304).

Social cognitive theory relies on the supposition that for learning to become apparent, a personal belief in the behavior will assist in moving the individual to accept the behavior and continue its use. In change theories, the ability to relate to or understand the change assists greatly in acceptance of the change. Resistance to change can be strong, especially when change requires abandoning deeply entrenched beliefs or patterns of habitual behavior, while reframing concepts and mastering new terminology and patterns of thought (Kuhn, 1962). The social cognitive theory's premise of the ability to learn by direct experience is used in education, as well as in the private sector. This type of learning enables employees, as well as students, to gain the ability to relate to differences while experiencing the change.

Reasoned Action and Planned Behavior

Another influential change theory is known as the *change theory of reasoned action and planned behavior*. This theory asserts that individual performance of a given behavior is primarily achieved due to a person's intentions to perform the behavior (Kritsonis, 2005). In other words, this theory rests upon self-awareness, conscious choice, and a positive desire for the change. The theory is based on the premise that a positive change will occur, following the process of considering the change, once the behavior is enacted. It also relies on the premise that the agent of change believes that he or she can control and direct the process of change. An example of this would be the difference between a group's collective intention to attend an event and the number of people from that group who actually attend the event. (Cooke & French, 2008).

Reasoned action is performed in those organizations in which change is inevitable and the response of employees directly affects the organization's productivity and growth in the desired direction. Once the awareness of the need for change has been understood and diffused through the organizational structure, reasoned action can occur (Rogers, 2003). The idea of planned behavior is also rooted in adjusting norms and redefining parameters of any previous behaviors. The new condition promotes direction away from the old norms, habits, or directions to elicit the new response or behavior.

Contemporary Theories of Change

Phases of change theory. Lippitt, Watson, and Westley (1958, as cited in Senft, 1960) created a theory known as the *phases of change theory* that expanded on Lewin's three-step change theory (Kritsonis, 2005). Lippitt et al. (as cited in Senft, 1960) defined a seven-step theory focused more on the role and responsibility of the initiator of change than

on the process of how change unfolds. In this area, understanding and other communication is increased to stabilize understanding and actions, and the exchange of information is continuous (Kritsonis, 2005). The seven-step process follows a well-defined pattern for change.

In the first step of Lippitt et al.'s (as cited in Senft, 1960) seven-step model of the phases of change, a diagnosis of the problem is defined with supporting reasoning and understanding of the current challenge. The reasoning behind the challenge and the way the challenge transpired is explored. The second step involves assessing the motivation and capacity to change all stakeholders and members of the organization who will be affected by the change. The resources and motivations of the change agent are defined in the third step. Step four includes the change agent's assurance in the power and stamina of the new direction. The choice of progressive change objects, plans, and strategies is established in step five. In step six, the change is maintained. This maintaining of change is achieved by promoting communication and feedback to explore the group's condition. The seventh and final step occurs once the change has become part of the organization's culture and the change agent withdraws from his or her role. One major point of this theory is that changes stabilize more efficiently if spread through the system (Kritsonis, 2005).

Model of change behavior theory. Prochesake and DiClemente's *model of change behavior* theory restated by Barnes (Barnes, 2004) is concentrated on behavioral change, originally just in the area of health-related behaviors, although later applied to other areas of human activity (Kritsonis, 2005). The two researchers defined the process of change as a sequence of stages: pre-contemplation, contemplation, preparation, action, and maintenance. They pointed out that these stages are more cyclical than linear because change is not

achieved for many people the first time around, but rather comes through repeated efforts, and relapses and changes in intention and motivation occur over time (Kritsonis, 2005). If misunderstanding of the problem persists, consideration should be given to appropriate training and education, as well as to rational consideration and staying within the bounds of the problem. Sometimes the belief is so widespread and entrenched that it is not possible to change, or that change is inevitably linked with adverse effects to the change agent. The resistance to change must be assessed and countered for any effective change to be possible.

Stages of change. In the model of change behavior proposed by Prochaska and DiClemente's restated by Burnes (as cited in Barnes, 2004), the model of changes function are as follows: pre-contemplation exists when the individual is either unaware of, or in denial about, the need for change. The attitude in this stage is that everything is fine as it is, so there is no need for change. Contemplation begins when the individual starts pondering the need for change or the reason change might be desirable. At this stage, no commitment to change or investment in the process of change yet exists. A following step in this stage is preparation, which is the first step that reflects any commitment. At this stage, the individual involved needs advice and encouragement. Next come action, which involves coping mechanisms and sacrifice to bring about the change. The final stage, maintenance, involves ongoing efforts to sustain the change (Kritsonis, 2005). At any stage, individuals can get off the change merry-go-round by deciding that they do not want to stay in the change process or to take the next step in changing and elicit ideas in change management.

Leadership and Change

Change management totals the process, the tools, and the techniques that are required to reach the desired effect in the organization or business by managing the human quotient.

This systematic approach to dealing with change from both the perspective of the organization and the perspective of the individual begins to surface at this point. Change management can have three points: adapting to change, controlling change, and effecting change. Every organization can have a different definition and interpretation of what change management means to them and how to implement it. Regardless of their interpretation, change management lives and breathes in the organization's ability to adapt to change (Kotter & Cohen, 2002). Effective change management helps leaders to define and implement the change so that they can lead the organization to fulfill its strategic goals. The more effective an organization is in adapting to change, the more likely are the individuals in the organization to thrive in the new environment (Nadler & Gallos, 2006). The area of adapting can include establishing methods for responding to change or establishing a structured methodology for responding to changes in the business environment, including fluctuations in the marketplace and competitive threats. Establishing effective coping mechanisms for responding to change helps produce better end results during the process of change.

Mission focus and strategic, operational, and technological changes are examples of areas an organization can utilize in applying change management. In order for an organization, or even an individual, to incorporate change management, the approach and application must be structured and logical. To implement change management, it is necessary to change the attitudes and behaviors of the individual or, within an organization, to change its staff and personnel. Change management is helpful in all aspects of transformation and alteration. Change management may include a modification in marketing, transformation of projects, and alignment of actions to a new overall

organizational goal. Goals must be redefined to align employees with an organizational direction to reach the desired change.

Leadership's role. Management of change involves leadership. All leadership methods affect change in a positive, negative, or neutral way. Although the theory of change research is vast (Funnell, 2011), all the research confirms that change is inevitable.

Therefore, effective leadership must consider this fact. One view of leadership that can create the vision and motivation to implement and sustain organizational change has become known as transformational leadership.

Transformational leaders are viewed as pioneers and visionaries. Stanfield (2000) defined transformational leaders as people who possess a sincere and deeply held concern to teach and lead others. Transformational leaders are those who make true and lasting change possible, who inspire others by sharing their vision of the need for change so that teammates, employees, and others feel motivated to become agents of change themselves.

Transformational leaders see opportunities for improvement and are courageous enough to follow through to implement all that is required to realize those opportunities. They recognize the time when social change and shifts in market forces and societal priorities present the need for change in organizational culture and practices. To become a change agent by taking on the role of being a transformational leader can be lonely or even daunting. Vulnerability is one of the costs of being in such a position. Because of its emphasis on the nurturing potential of collaborating with others while engaging in personal, professional, and organizational learning, developmental leadership is one way to pursue transformational leadership (Bunker, Hall, & Kram, 2010).

Transformational leadership and change are possible only through connecting with and understanding others and the social worlds and constructs of reality in which they believe they live. The more successful those transformational leaders are in including various constituencies and blocs of stakeholders, the more successful these leaders can be in effecting change that endures in their organizations (Fullan, 2001). As American society has become more demographically and culturally diverse, changing organizations now demands more from transformational leaders than in the past. Practicing empathy and showing understanding and respect for diverse groups of people are needed to bring about change and transformation. Effective leaders somehow succeed in getting people to set aside their differences to work toward common goals for the common good (Bass & Avolio, 1994).

Making changes in the world at large, especially in the large and complex organizations of modern society, requires making changes. Change management requires identifying and modifying personal, group, and organizational paradigms. When entrenched organizational and group practices gradually lose effectiveness, a tipping point may be reached that requires a break from past practices and beliefs. Managing change requires transformational leaders to practice self-care as well as nurturing and aiding others through the period of transition. Self-awareness and self-efficacy are concepts central to social cognitive theory (Kotter & Cohen, 2002; Ramirez et al., 2012).

Transformational leadership sounds lofty, but it occurs in common settings and everyday events. Even average people in ordinary circumstances can serve as transformational leaders and as effective agents of change, not necessarily through exercising power over other people, but simply through empowering other people to support common

goals (Sergiovanni, 2000). One concept about bringing about change via transformational leadership is the concept of servant leadership.

Servant and charismatic leadership structure. Servant leadership is based on the theory that any person in any surroundings or role can help to build shared values and a shared sense of purpose (Greenleaf, 1977). Self-efficacy and ongoing learning guide otherwise ordinary people into effectiveness as change agents based on their commitment to shared purposes in their interactions with coworkers and teammates. Shared experiences and shared goals inform the personal and group efforts that are driven by vision and commitment to change. The energy of such efforts can be so contagious that it amplifies the effectiveness of transformational leaders as agents of change.

Despite the role of charismatic leadership in professional and personal interactions, leaders must contend with organizational structures and institutional realities to bring about change. Organizational structures are often built around rewarding individuals (through performance evaluations and raises) rather than building a review of teamwork, shared systems, and stakeholder communities into the system of rewards as ways of empowering people (French, Bell, & Zawacki, 2005). Effectively managing change depends on receiving the institutional encouragement and authority needed for both individual and group empowerment.

As noted previously, the process of change can bog or slow down the change process. Individuals can lose heart and revert to old beliefs, old paradigms, and old practices. Ongoing learning, education, training, encouragement, and empowerment are needed to guide, sustain, and reinforce effective organizational change. Boverie and Kroth (2001) emphasized the importance of instilling commitment to change through strengthening a sense

of common purpose via ongoing learning that facilitates and reinforces mutual respect, shared identity, and engagement in the workplace. Leadership that empowers others brings about an effective change that takes root and thrives.

To guide change effectively, transformational leaders must take risks. Effective leaders must reward and encourage beneficial change, both in individuals and in team efforts. Leaders must be seen as capable and trustworthy in order to elicit from others the willingness to change. Thoughtfulness, dependability, and consistency are essential elements in managing change. Trust and integrity are pillars of transformation (Evans, 2000). The personal chemistry in the connection with others can elicit trust and respect, while upholding flexibility and empowering diversity of individual viewpoints and values in a shared enterprise. These values make cooperation possible in the multicultural environment in which most Americans work today. People can make their best efforts when they know that their willingness to embrace change while being themselves will be respected, encouraged, and empowered rather than discouraged or punished for taking risks. Equity and fairness can thrive in an environment that rewards thoughtfulness, risk-taking, and the exploration of multiple approaches, thus creating a safe environment. Exemplary character can emerge in such an environment. Leaders have to change themselves to make it possible for organizations to change and for others within the organization to change as well.

Teamwork requires eliciting different points of view. When leaders challenge the status quo, they encourage others to contribute to the process of constructive organizational change and transformation. Sharing the vision of change works both ways: from the leader to others and from others to the leader. The leader must create the space in which emotional intelligence can flourish, in which it is possible to visualize the ideal, despite organizational

and personal obstacles (Goleman, Boyatzis, & McKee, 2000). Exceptional transformational leaders do more than bring about change in organizations that proves to be effective; they not only value the insights of others, but also empower them to step into their own power and fulfill their own potential.

Learning and personal growth. Change is inextricably tied with learning and personal growth. Individuals learn, and organizations can learn as well when transformational leaders bring about changes in organizational practices and paradigms through empowering others to embrace a vision for change, despite all of the individual, social, and organizational forces that weigh in on the side of inertia and resistance to change. Leaders must tap into the power to change organizations through getting individuals to buy into the need for change and the possibilities of fulfilling their own highest aspirations through becoming agents of change themselves. The most effective change agents have the ability to view change through multiple lenses that enable them to see the perspectives that are needed to encounter and overcome resistance to change. Senge (1999), for one, recognized the need to see the challenges and opportunities involved in organizational change and transformation from multiple perspectives. In fact, this ability to see through many eyes is needed for leaders to transform organizations and to sustain the process of change to prevent reversion to old ways and to counter entrenched resistance to change in organizations. Getting others to cooperate in the process of change requires collaboration and fostering commitment in others from multiple perspectives and with multiple cultural frameworks and visions.

There is no one single style of leadership that is invariably effective in instituting change. Emerging leaders may embrace many different learning and leadership styles in

their efforts to foster change in individuals and in organizations. What may succeed in one setting may fail in another. Some people love change. Others hate change. Some are open to it, while others resist it, at least until they can be enticed to come on board by being made to see what could be in it for them. Views and beliefs of what a leader should be and how change should be implemented and managed are shaped by life experience, education, cultural background, and a host of other factors. Leadership approaches that worked in organizations up to now may no longer be working quite as well. This reality presents a challenge for everyone in organizations, especially if the shared culture is built on stories of past successes.

Change is complex. As a result, the process of change and models of change have been approached from many different perspectives based on many different factors. How individual and organizational behavior intersect, how people learn and resist learning, how leaders can inspire others, and how changing demographic and cultural practices are changing everything in society—these are all factors that need to be considered when approaching change management.

Often organizations in great crisis face their greatest opportunity for change. Mezirow (2000) viewed crisis and opportunity through what he termed the disorienting dilemma, a necessary precursor to transformation. Values that need to survive the disorienting dilemma and make it into a positive change include curiosity, courage, and faith or hope that improvement is possible. Curiosity is needed because it is precisely when things are not working well that a transformational leader needs to scrutinize the reasons that things that may once have worked no longer function as effectively. Courage is needed because at such times of disorientation, denial, blame, and avoidance are common coping mechanisms, and

resistance to change may be an instinctive reaction to a perceived threat. Faith and hope are essential because without them, individuals, teams, and organizations cannot develop the vision and commitment to shared values that are needed to bring the desired change into being.

Business organizations tend to be pragmatic. Feedback is often quantifiable through such things as sales revenues, profits, market share, and other measures that may be unambiguous about the way change affects the organization and the effectiveness of organizational leadership at meeting strategic goals. The marketplace and the competitive mix are constantly changing, so business and organizational management have long been interested in the phenomenon of change and how best to manage it. Smet, Lavoie, and Hioe (2012) examined the issue of how to develop better leaders of change. Many causes can make change necessary for a business, including “market maturation, a tough macro-economic environment, creeping costs, competitive struggles, or just a desire to improve” (Smet et al., 2012, p. 98).

Many answers to these challenges are familiar to students of business management: product innovation, cost cutting in manufacturing or service operations, corporate restructuring, bringing in a new management team, or other changes that are imposed from the top down in a hierarchical organization. These changes are based on old-school theories of top-down management that are remnants of an age in which people were generally more passive and deferential to people in positions of power. Recent generations have been more resistant to concentrations of power at the top, more critical of authority, and more demanding in approving of the way people and groups of people traditionally excluded from positions of power are treated and should be treated.

Softer Skills Needed for Change

Recent theorists of change have started to focus more on what might be termed the softer skills needed for change, including “the ability to keep managers and workers inspired when they feel overwhelmed, to promote collaboration across organizational boundaries, or to help managers embrace change programs through dialogue, not dictation” (Smet et al., 2012, p. 98). How do managers and leaders in today’s organizations confront attitudes of complacency, entitlement, and resistance to authority and change imposed from the top down? Workers can be disengaged and indifferent to organizational goals. If a premium is placed within the culture of an organization upon avoiding mistakes and failure, change can feel very threatening. In some instances “personal behavioral changes are needed to support the organizational ones” (Smet et al., 2012, p. 98). Getting people to sacrifice autonomy and independence in favor of shared goals can be a daunting task. Mistrust and suspicion can be rampant. Eliciting commitment to team goals and organizational objectives involves emotions, not just reasoning skills. Communication skills needed to manage change in such circumstances include keeping “discussions focused on solutions and [building] on existing strengths to overcome resistance” (Smet et al., 2012, p. 99). Sometimes change is more of a forced march than a stroll made by choice; Rogers (2003) cited the AIDS epidemic and global terrorism as examples of the sudden recognition of the need for change that was unwelcome but irrefutable. Sometimes people, organizations, governments, families, cultures, and other groups must change whether they like that fact or not. How can change best be accommodated or managed, especially under conditions of this type of response to an unwelcome crisis or disaster?

Summary

This chapter illustrated the effects, both positive and negative, of change management. Leadership's role in change management has also been discussed as a vital role in implementing lasting change. There are various ways to approach organizational change. The Shaken Baby Project that was implemented in this hospital was a major change in how new parents were educated before leaving the hospital with their newborn. This study involved an organizational change, unit changes, and individual changes. An in-depth look at change in the previous chapter gives a foundation for the null hypothesis of this study. The change management used to implement the Shaken Baby project at the community hospital was intertwined in change of the staff.

In this dissertation the design of the study was captured in Chapter III.

Chapter III

The Design of the Study

This study looked at the effects of implementing the Shaken Baby Program by the staff of the Intermediate Care Nursery and the Newborn Intensive Care units at a southwestern community hospital.

This research focused on an historical organizational case study at a community hospital in the Southwest. The main goal was to determine how the Shaken Baby Program at the hospital was started, examine its implementation, and measure its effectiveness. The data collected would be of great interest to the community hospital due to its usefulness in expanding the delivery outreach of the Shaken Baby curriculum to parents.

The study was designed to use four approaches:

1. An examination of the historical records of the program.
2. Interviews with two key personnel who started the program.
3. Analysis of surveys collected from employees involved in the program.
4. A follow-up focus group to verify findings.

An historical approach was considered appropriate because the goal was to determine how the Shaken Baby Program was initiated and implemented at the community hospital.

Background

At the request of the principal investigator, a meeting was held with two administrators – the Clinical Nurse Researcher and a Pediatrics Rehabilitation Physical Medic – at the southwestern community hospital. The purpose of the meeting was to design a study to capture the history and effects of the Shaken Baby Program on the staff at the community hospital. The discussion centered on the hypothesis that the introduction of the

Shaken Baby Program required change management among the staff in order to implement the program. The three-member Team decided that the study would examine the change management that was necessary for the implementation.

Once the decision was made to undertake the study, the Team then considered identifying the study group that would be required to measure the effects of the Shaken Baby Program. It was noted that ideally, the group participating in the study should be made up of volunteers from the nursing and the medical staff. The administrators on the Team determined that the staff of the Intermediate Care Nursery and the Newborn Intensive Care units would be the most favorable groups to participate in the study. This determination was based on the current direction of the two units, the level of care provided by the staff, and their experience assisting new born patients and their families. After careful consideration, the administrators agreed that in the past these two units had produced successful rates participating in studies of this nature.

The Team then made the following decisions:

1. The history of the Shaken Baby Program at the community hospital would be revealed by interviewing the founding members of the program.
2. The examination of documents pertaining to the history of the program needed to occur.
3. Research should be conducted to measure the administrators' and the staff's views of the Shaken Baby Program.
4. Additional assistance from the supervisory staff of the two units would be solicited to help with the research.

5. 75 staff members from the two units would constitute an appropriate research group.
6. These staff members would be asked to complete a survey based on the implementation of the Shaken Baby Program.
7. Participants would be asked to volunteer to serve as a focus group. This group would substantiate the answers to the survey and collect additional data pertaining to ambiguities.

The initial meeting set direction and guidance for all of the subsequent meetings. The second meeting was held with the Supervisors of the Advanced Clinical Care staff, the Clinical Nurse Researchers, Intermediate Care Nursery staff, the Newborn Intensive Care staff, and the Data Analysis staff of the hospital. This meeting provided all the involved staff members time to understand the project and meet on the matter. It was determined that the supervisors' team would assist with the survey and participate in a separate survey.

An outline was created to document the steps that needed to take place to put together the study. The following decisions were made:

1. A 10-question survey would capture the required data and the results from the staff members of the two units, while paying appropriate attention to their time and preventing any coercion.
2. To ensure receiving the most participation, the best way to pass out the survey, would be to allow the nursing supervisors to distribute them. The nursing supervisors would properly pass out and collect the surveys during a staff meeting while allowing adequate time for the staff to complete the survey during the meeting.

3. At an earlier staff meeting, participants would discuss holding a preliminary meeting with the supervisors. The purpose would be to ensure that no coercion was possible, and to emphasize the proper distribution and collection of the surveys as well as the instructions.
4. The 10-question survey was distributed to the staff by the charge nurses. Each charge nurse was in charge of only 10 staff members which would allow the proper distribution during a staff meeting. The staff of the Intermediate Care Nursery and the Newborn Intensive Care units constituted of over 75 members who participated in the survey. Ten members would be asked to volunteer to serve as a focus group.

The Team agreed that to show appreciation for the staff members who volunteered to participate in the study, as well as to acknowledge the time constraints, an incentive to complete the survey would be needed. It was decided unanimously that a motivating factor for the staff would be some type of incentive. The staff of the two selected units, as well as the hospital staff at large, was said to be very fond of a local coffee shop located in the hospital. A subsequent meeting with the owner of the establishment led to the coffee shop's agreement to accept a coupon for \$1.00 off any item in the store. The principal investigator would be allowed to create the coupons and accept responsibility for related expenses. A total cost of \$200 was incurred to pay the coffee shop to accept the coupons. A \$1.00 coupon would be given to each staff member who returned the survey as well as to the ten individuals who volunteered to participate in the focus group.

The design required collecting the surveys, and then tabulating the results of the survey in order to develop questions for the focus group. The plan was to document the

focus group's questions, tabulate the results, and then add the findings to the results of the overall study.

Sampling Used in the Design

The qualitative design component to triangulate the data was used. The triangulation of the data would occur through (a) examining the original historical documents; (b) interviews with the founding members; (c) the results of the surveys; and (d) participation of the focus group. Audio recordings were to be used in order to capture actual statements made by the founding members. It was anticipated that the triangulation of the data would contribute to a greater understanding of the implementation of the Shaken Baby Program in the two units of the hospital.

Purposeful sampling was used for all of the employees of the Newborn Intensive Care and the Immediate Care units so the grouping anticipation service would represent a varied range (Maxwell, 2005). Such a sampling would enable the researcher to select participants who represented a variety of work areas in the two involved units.

The survey results would provide an opportunity for theoretical sampling. This sampling would allow the researcher to select 10 focus group members from the 75 participants. The focus group would be used to develop challenges and define specific emerging categories/ outliers from results of the survey (Charmaz, 2006).

Archival Documents

The archival documents which were collected in the beginning of the study proved to be indispensable in organizing and developing this research. The documents (see the Appendix A) enriched the understanding of the program dramatically. A request for data from the archives was presented to the administrators of the Intermediate Care Nursery and

the Newborn Intensive Care units. Once the data was received and sorted, eight original documents were identified which had been used to start the Shaken Baby Program. The initial documents included several handouts such as “Never Shake a Baby,” “Take a Break Don’t Shake,” and “How to Cope with Crying Babies.” A special handout from the Shaken Baby Syndrome and Prevention Awareness Program included directions and a script for bedside nurses. There was also a sign-up sheet for parents who participated in the Prevention Awareness Program.

The documents were examined to increase the understanding of the initial reasons for creating the Shaken Baby Program at the hospital. They were also used to describe the parents’ exposure to the Program as well as the responsibilities of the employees who interacted with the parents. As a result, there was a clear picture of the means by which the parents received information about preventing the Shaken Baby Syndrome. In addition, the researcher viewed a video entitled “Portrait of Promise” which all parents had to watch before leaving the hospital with their babies.

Interviews

The constructivist grounded theory approach used in this study led to a logical merging of the historical records with the experiences of the founding members of the program at the community hospital. In the original discussion pertaining to the study, the two founding members of the Shaken Baby Program at the community hospital were identified. The founding members were asked to participate in individual interviews. The interviews revealed how each member was introduced to the program.

The first founding member became interested when a community organizer expressed grave concern about the frequent incidents of Shaken Baby Syndrome which were occurring

in the area. The community organizer successfully enlisted the founder's help in holding a meeting at the hospital which resulted in the start of the Shaken Baby Program. The second founding member had been active in another program, the Pediatric Acquired Brain Injury Program, and recognized the advantages of melding the two programs.

Surveys

To understand the implementation of the program, it was necessary to design surveys to capture the views of the administrators and the staff about the current state of the program. The surveys were distributed to the administrators and staff who work directly in the Intermediate Care Nursery and the Newborn Intensive Care Nursery units. The surveys focused on identifying the views of the employees about specific areas of the program. These areas were:

1. The importance of the program.
2. Success in teaching the Shaken Baby Syndrome curriculum to parents.
3. The education levels of the staff before teaching the curriculum.
4. The effectiveness of the video.
5. The staff understands of the curriculum.
6. The employees' attitude towards understanding the delivery of the curriculum.
7. Satisfaction with the hospital's support for the curriculum.
8. The need for more time to deliver the curriculum.
9. The importance of following up with parents after the curriculum was presented.
10. The extent to which the education provided increased awareness of the dangers of the Shaken Baby Syndrome.

The written surveys were administered to 92 participants – 14 administrators and 78 staff members of the Intermediate Care Nursery and the Newborn Intensive Care Nursery Units.

Focus Group

The focus group was to be comprised of 10 members of the two infant care units of the hospital. A group of four administrators and six hospital staff members were to be interviewed. The focus group assisted in the understanding of the data collected from the surveys. Specifically, the group would highlight the following points:

1. The data point from question five in the staff survey – *I feel parents understand the education provided concerning SBS.*
2. The data point from the first question in the administrator survey – *The hospital staff feels prevention of SBS is important to teaching parents of children born at the community hospital.*
3. The data point in the second question in the administrator survey – *I feel the hospital administration effectively transfers the SBS curriculum to the staff.*
4. The data point in the fourth question in the administrator survey – *The staff feels the video: Portrait of Promise” is a valuable tool in teaching SBS.*
5. The data point in the fifth, seventh, and ninth question of the administrator’s survey – *The staff understands the hospital’s SBS curriculum.*
6. *Generally the staff is satisfied with the support the hospital has displayed for the SBS curriculum.*
7. *I certainly feel that it is important to follow-up with the staff after they have instructed parents in the SBS curriculum.*

8. The data point in the sixth question of the administrator survey – *The staff of the Intermediate Care Nursery and the Newborn Intensive Care units has a positive attitude toward understanding how to deliver the SBS curriculum.*
9. The data point in the eighth question of the administrator survey – *I wish I could have more time to spend with the staff providing support concerning the SBS curriculum.*
10. The data point in the tenth question of the administrator survey – *At times I feel the education provided has increased the administration's awareness of the dangers to infants of SBS.*

The structured questions on these topics were to be asked in the same way to all of the two participants in five groups. The ideal of grounded theory methodology was expected to enhance emerging questions that were to assist in the data collection. From the mining of the data, the focus group was to be used to check the accuracy of the above eight areas in question.

Summary

The research methodology used in this grounded theory study has been described in this chapter. The methodology was based on the hypothesis that the application of a qualitative design would produce a clear understanding of the initiation of the Shaken Baby Program at the community hospital and would capture both the administrators' and the staff's current views of the Shaken Baby Program. The qualitative design was thought to enhance the main goal of this study - to examine the implementation of the program and gauge its effectiveness in order to identify the pathway to improvement.

In this dissertation the findings are captured in Chapter IV

Chapter IV

Findings

The Chapter 4 findings are a culmination of Chapter 3 results in order to better highlight and understand the findings. In Chapter 4 the findings of the study are addressed and the finding leads to a more direct understanding of the study's significance.

The findings from the History and Examination of the Shaken Baby Program at a southwestern community hospital were intended to increase the hospital's knowledge about the current state of the instructional program. Because the hospital did not have a definitive understanding of how employees viewed the Shaken Baby Syndrome (SBS) curriculum administered to parents, the researcher also intended to increase the understanding of the staff's views of the SBS curriculum currently presented to parents. The study consisted of historical records, interviews with key personnel, surveys of current employees working in the project, and follow-up focus groups to verify findings. In addition, the application of change management principles and the reasons for implementing them were considered.

Research Question

The following research questions were addressed in this study:

1. How was the Shaken Baby Program started at the southwestern community hospital?

The sub questions for this study were:

- a. What is the hospital staff's perception of the parents' acceptance of the curriculum?
- b. What is the administration's perception of the staff's acceptance of the program?
- c. What are the focus group's views on the staff's responses to the program?

The null hypothesis was:

1. The null hypothesis was that the staff would neither agree nor disagree.

The primary research question was approached by researching the initial call to bring the program to the hospital. This research led to the decision to interview two of the originators of the Shaken Baby Program. These interviews revealed the reason that the SBS program was started at the community hospital. In this study, the two originators were identified as Founding Member A and Founding Member B. Table 1 shows the founders introduction to the SBS curriculum and the results of the introduction.

Table 1

Founders' Introduction to the Program

Founder	Introduction	Results
A	Community Member	Gathered hospital staff to start the program.
B	Pediatric Acquired Brain Injury (PABI) plan	Started the prevention plan

Interviews with Founding Member A

Founding Member A explained that while attending a social gathering, she met a community leader who worked for the city's Children Youth and Family Department (CYFD). This community member was the liaison between CYFD and the families and represented family members in court cases. The CYFD employee told Founding Member A that a serious problem existed in the community. Many of the cases in family court involved injuries to babies and infants who had been shaken. It appeared that the perpetrators were

unaware of the negative effects of shaking the newborn. In addition, the CYFD representative expressed concern that the community hospital's nursing staff members were not being educated on how to help prevent such injuries. This conversation at a social gathering planted the seed which germinated into the Shaken Baby Program at the Southwestern community hospital.

At that time, the hospital had a new chief nursing officer. Founding member A called a meeting with the nursing officer, the nurses, and the physician who worked in the Newborn Intensive Care Unit and the Intermediate Care Unit of the hospital. The purpose of the meeting was to discuss the prevalence of SBS incidents in the city. References were made to a successful New York study which focused on preventing Shaken Baby related injuries. The author of the study was Dr. Dias. He worked with several hospitals in the New York area to prevent childhood injuries which were the result of young children having been shaken. Dr. Dias was responsible for the creation of a medical order for New York State which ensured that before leaving the hospital, the mother of a newborn would be educated on the possible negative results of shaking babies and infants.

Dr. Dias produced a CD on the negative results of shaking babies early in their life. He was convinced that educating parents would prevent them from causing harm to their children. To understand the possible negative effects of shaking children at an early age, the new parents were asked to watch the video. Seven months after returning home, the parents received a telephone call from a staff member of the hospital. The purpose of the call was to determine if parents remembered the curriculum taught to them before taking their babies home. The founding members receive this action from Dias's (2005) study. Consistent with Dias's study, most parents remembered the curriculum very well. In fact, they claimed that

the results of trauma that could be caused by shaking infants remained deep in their memory. The data showed that parents who had received the information were less likely to cause harm to their children. The immediate result of the educational program was a 50% decrease in childhood injuries resulting from shaking babies. Due to the positive results of the New York program, Dr. Dias launched a similar program in Philadelphia.

Outside help. Founding Member A contacted Dr. Dias and asked for permission to replicate his program at the community hospital. Dr. Dias responded enthusiastically and immediately sent copies of his work, the videos that he had produced, and various handouts for parents. Founding Member A asked Dr. Dias if the community hospital could use his handouts, and he agreed. The handouts were then uploaded to the hospital's database in order for replication to begin.

Starting the Shaken Baby Program at the community hospital presented many challenges that required attention. First, the hospital did not have the equipment to show the video to new parents. Then an unexpected, unavoidable problem developed. The hospital announced a move that required all of the staff's extra attention. Founding Member A was disappointed as approximately 1 year was lost while the move was completed. Shortly after the opening of the new hospital, work resumed on developing the Shaken Baby Program curriculum.

The first task considered was uploading the video on the hospital's internal video channel. The problem was that the design of the new hospital presented a major change in the patients' living conditions; previously, three to four patients shared a room. In the new hospital, each patient had her own room. The change was ideal for new parents to view the video, resulting in a more positive experience for the parents. Under the leadership of

Founding Member A, the hospital successfully applied for multiple grants so that Comcast could make the viewing easier for parents.

Founding Member A's determination to implement the Shaken Baby curriculum at the community hospital inspired her, and she worked with Comcast to correct all the problems related to viewing the video. Recognizing that carving out time to show the video was also a problem, she integrated the program with a very aggressive breast-feeding study that was already underway. As a result, there was a noticeable increase in the number of parents who viewed the video.

The hospital decided to add its own literature (see Appendix A) to the educational curriculum about preventing childhood related injuries. The hospital produced a packet which included handouts for parents such as *Take a Break...Don't Shake; Shaken Baby Syndrome Prevention and Awareness Program; and Coping with a Crying Baby*. A staff member created signs related to the topic which were prominently displayed. With the new literature and other related information, the program was then re-introduced to the staff. Meanwhile, Founding Member A was busy developing the latest edition of the Shaken Baby Curriculum - the new website. The website featured all the handouts for parents, information about the video, packets to reaffirm the instructional techniques, and the nurse's script. A compact disk that outlined the instructional techniques and other related items was given to the parents before leaving the hospital.

At this point, the community hospital faced another challenge within the two units involved with the SBS Program. After the handouts were delivered and the curriculum was presented to the parents, another was needed to ensure the effectiveness of the program. Before the parents were released from the hospital, they were asked to sign an agreement

stating they would not hurt their babies. They were also asked to participate in a survey 7 months after leaving the hospital. The purpose of the survey was to gauge how much of the curriculum each parent remembered.

Challenges. The hospital did not receive the amount of participation it had anticipated due to many factors. One of the primary factors was the fact that the nurses' responsibilities had increased hospital wide. While the SBS curriculum was introduced at the hospital, many other mandatory curriculums were introduced. The nurses were now expected to engage the parents in many different programs. It was determined from the Dias (2005) study that although the video was very effective in helping to prevent parents from causing harm to their children, the nurses found it extremely difficult to find time to show the video. While the Newborn Intensive Care Unit had a large percentage of families participating in the curriculum, in other areas of the hospital which dealt with newborn infants, the percentage was low.

In striving to increase parent participation rates and provide direction to the nursing staff to offer the program, the administration tried to establish a medical order for the Shaken Baby curriculum. The original program in New York (Dias, 2005), attempted to make "The Shaken Baby Curriculum" a medical order for the state. As stated earlier, Dias successfully established a medical order mandating that families view the video before leaving with their newborn child. Also, parents were asked if they agreed to receive a follow-up telephone call 7 months after returning home. Finally, before leaving the hospital, all parents were required to sign an acknowledgement of having received the Shaken Baby curriculum.

By that time, Founding Member A had set a new goal for the community hospital. She felt that once the participation rate of the Shaken Baby curriculum increased at the

hospital, the program should be expanded to all of the hospitals in the State. She envisioned that the rural health education activities that the hospitals participated in would assist in spreading the information throughout the State by utilizing the internal communication systems of hospitals. Once the curriculum was adopted statewide, it would be possible to measure the shaken baby incidents. According to Founding Member A, the largest single problem was to ensure nurses consistently offered the curriculum to new parents.

Founding Member A noted that the curriculum was translated into different languages to accommodate patients' needs. She expressed concern that although Vietnamese was a major language in the State, the curriculum was not translated into that language.

Interviews with Founding Member B

A nurse educator who recently joined the staff expressed great interest in working with the Shaken Baby Program. The nurse was referred to as Founding Member B. It was important to note that Founding Member B was introduced to The Shaken Baby curriculum through the Pediatric Acquired Brain Injury (PABI) plan which is a SBS Plan.

Fortunately, for the community hospital, Founding Member B was an international advisor for a Foundation in New York which supported the PABI plan. In 2011, the Foundation's founder went on a national tour to increase awareness about Shaken Baby and pediatric concussions. The director of the PABI plan visited every state to recruit people to organize special events in each states to increase knowledge of childhood related injuries and prevention. Founding Member B organized the events for the southwestern state used in this study. The PABI plan begins increasing child hood related injuries awareness at each state by direct contact with students in order to increase awareness of the abuse. The direct contact was a 3 days of events. The participants in the event included local high school

students. At these events, the Shaken Baby awareness items were offered to the participants free of charge. In offering the awareness items, Founding Member B's group had the opportunity to give local coaches and school groups DVDs and other information on concussions and related childhood injuries. The awareness program also offered participants dinner. The events included forums for the public that featured seven doctors, emergency room staff, and coaches from local elementary, middle and high schools in the areas students were familiar with. The presentations were very received by parents and the press.

To further increase awareness, Founding Member B treated participants to a baseball game. The parking lot of the baseball field became a venue to hand out free literature and other information while participants enjoyed the baseball game. All of the literature pertained to ways of preventing and decreasing childhood injuries related to the SBS.

Founding Member B took advantage of every opportunity to market the program. The topic was brought up during conferences at the hospital as well as at all youth related activities. Founding Member B revealed that because of this experience, her interest in the program increased. She realized that the literature was centered on what to do after a negative event occurred. She remembered wondering what would happen if more information became available to prevent the injuries from occurring. In the same year that her interest in preventing the childhood injuries increased, the hospital had an increase in Non-Accidental Traumas (NAT) that could also be classified as child abuse. The increase in the traumas called for action, and she told her supervisor in the Pediatric Department of the hospital that she would like to start a prevention program. Her supervisor gave her full permission to do so, and she started the prevention program at the hospital.

As Founding Member B reflected, she thought of the changes that had taken place since the program began. She observed that the biggest change she saw from the time that the program started was an increase in child related injuries. She believed that it was time to increase the awareness program. She pointed out that since the State was currently sixth in the nation for child abuse, and second in the nation for death from child abuse, this kind of program could make a difference. She felt strongly that the population was now more interested in this type of program due to all the instances of child related injuries that had occurred. From her point of view, it was clear that the increase in child related injuries increased awareness of the problem which had sparked an increase in programs.

Founding Member A Partnered with Founding Member B

The next year was spent planning the program with Founding Member A. The two Founding Members met at one of the early program events, a 5K walk /run. The media blitz featured public service announcements, which focused on ways to prevent non accidental childhood related injuries. Plans included organizing events occurring on the same day in different cities in the State so that the entire State would be aware of how to prevent instances of child abuse. The media event would also be supported by the State's CYFD.

At the end of the interview, both of the founders wanted to describe what they felt were barriers to the success of the program. The founding members agreed that one of the barriers was that the nurses' increase in work load decreased their ability to offer the program. This challenge coupled with the fact that the hospital was under-staffed, decreased the program's effectiveness over time.

The two founders' interviews offered valuable information about the Shaken Baby Program at the community hospital during their interviews. The founders pointed out that it

was important to capture the views of the two units in the hospital that use the curriculum and work with parents daily. They suggested speaking with a director of one of the units that used the curriculum on a regular basis.

The Surveys

The founders also provided input on the design and questions that should be asked to capture the hospital staff's views. A version of the survey used to understand cynicism pertaining to Organizational Change was used to develop the community hospital's survey. The survey would be used to measure the responses of the hospital administration and staff. The original survey, developed by Reicher, Wanous, and Austin (1997) was used to measure the responses of the administration and the staff. The surveys captured employees' views of the Shaken Baby curriculum as well as the change in the administrators' views of how the parents reacted to the delivery of the program.

Two surveys were used. The first survey was given to hospital staff members who worked with the parents on the Shaken Baby curriculum. The hospital staff questions centered on how parents viewed the Shaken Baby curriculum and its effectiveness. The second survey was given to the administrators. The administrator questions centered on how hospital staff viewed the Shaken Baby curriculum and on the effectiveness of the curriculum.

Reliability. By noting ambiguities in survey results and examining memos, the researcher ensured reliability. Data revealed ambiguities and a connection between data and themes from the survey. The data collected from staff and administrators developed areas of ambiguity or gaps in understanding the survey answers. By discovering gaps in the data collection, the reliability of the data was reinforced. Gaps in the data were then linked to questions for the focus group to allow ideas to surface (Charmaz, 2006). The answers to

focus group questions were not electronically captured by request of the participants. The collection of memo-writing was used to capture the response of the focus group. The memo writing assisted greatly in assuring data linkage between the original survey results and the focus group answers. The data analysis of the focus group data allowed themes and different ideas to influence the direction of the research and disclose the thoughts of the participants without bias.

Validity. The test for validity was accomplished through the validity measures for qualitative research (Charmaz, 2006). After discovering methods and themes (Creswell, 1998), the survey was prepared by using a modified version of the Reicher, Wanous, and Austin (1997) tool to measure the participants' perceptions. After many consecutive meetings spent questioning the reliability and validity of the questions as well as outcome measures of the survey, the questions were used to prepare two surveys, each consisting of 10 questions. The questions (see Table 1, 2) measured different aspects of the Shaken Baby curriculum including the staff and the parents' views and their understanding of the learning modules.

Theoretical sampling. The process of bringing together data that specifies areas of the topic already identified by the researcher is known as theoretical sampling. By focusing on a specific category, it is possible to bring together data identified by the researcher to focus and refine emerging theories which result in discovering new data. The theoretical sampling of 78 staff and 14 administrators created valid and reliable data that focused and refined theories that emerged from the data (Charmaz, 2006). The specified themes and categories materialized during data collection from the individual interviews, the surveys, and interaction with the focus group. The data collected was solidified through detailed and

specific steps followed in mining the data to discover themes and commonalities in participants' responses. The use of theoretical sampling ensured the collection of data highlighted in the researcher's hypothesis.

The hospital had 14 administrators who had been vetted to take the administrator survey and 78 staff members who were available to complete the staff survey. The 10 questions in each survey include a 5-point rating scale that ranged from strongly agree to strongly disagree.

The answers were assigned a numerical value in order to facilitate analysis. The raw numbers were run with percentages, mean, standard deviation, 95% confidence interval, p -value (from t -tests), and z -test. The data were also represented graphically. The p -value and z -test explored the null hypothesis that the staff *Neither Agreed nor Disagreed* with the statements.

The questions were then ready for distribution. The two sets of 10 questions were distributed to the appropriate employees in different areas of the hospital using the Shaken Baby Curriculum. Exit interviews with the participating staff and administrators were attempted but were not completed. Many challenges made the exit interviews difficult with the largest difficulty being that staff ran out of time because other duties needed their immediate attention. During the survey process, 10 staff members participated in a focus group.

Guiding Question A

What is the hospital staff perception of the parents' acceptance of the curriculum?

Staff Survey. As previously mentioned, the 10 questions in the staff survey used a 5-point Likert rating scale where 1 = *Strongly Agree* and 5 = *Strongly Disagree*. The most

frequently occurring response was referred to as the mode. The staff survey viewed how hospital staff's perception of the parents acceptance of the SBS curriculum. The Table 2 presents the staff survey questions. The possible reply to the questions were as follows; 1 Strongly Agree, 2 Agree, 3 Neither agree nor Disagree, 4 Strongly Disagree, 5 Disagree. The answers were tabulated to and the mode with its numerical value displayed. In this study only the raw data is presented to stimulate further areas of research.

Table 2

Staff Survey

Staff Survey			
Question	Mode	%	
1. I feel that the prevention of Shaken Baby Syndrome (SBS) is important to teach parents of new born at a community hospital	1	87.18%	
2. I feel the hospital staff effectively transfers the SBS education to the parents.	2	49.35%	
3. All in all, I am inclined to feel that the Units are well educated about SBS before they leave the hospital.	2	46.15%	
4. I believe the Video "Portrait of Promise" is a valuable tool in teaching the parents of about SBS.	1	60.26%	
5. I feel parents understand education provided concerning SBS.	1	46.15%	
6. I feel the parents of the new born children have a positive attitude toward understanding how to prevent SBS.	2	60.26%	

Table 2 Continued

Staff Survey			
Question	Mode	%	
7. Generally, I am satisfied with the support parents are provided concerning the SBS education.	2	47.44%	
8. I wish I could spend more time with the parents providing support concerning SBS information.	3	42.86%	
9. I certainly feel that it is important to follow up with parents after discharge from the hospital concerning SBS.	1	53.86%	
10. At times I feel the education provided has increased the staff awareness of the dangers to infants of SBS.	1	51.28%	

Analysis of Staff Survey. In the first staff survey question, “I feel that prevention of SBS is important to teach parents of newborns at a community hospital,” the mode was (1) *Strongly Agree*, with 87.18% of the participants choosing this answer. In the second staff survey question, “I feel the hospital staff effectively transfers the SBS education to the parents,” the mode was (2) *Agree*, with 42.35% of the participants choosing this answer. In the third staff survey question, “All in all, I’m inclined to feel that the parents in the units are well educated about SBS before they leave the hospital,” the mode was (2) *Agree*, with 46.15% of the participants choosing this answer. In the fourth staff survey question, “I believe the video ‘Portrait of Promise’ is a valuable tool in teaching the parents about SBS,” the mode was (1) *Agree*, with 60.26% of the participants choosing this answer. In the fifth staff survey question, “I feel parents understand the education provided concerning SBS,” the

mode was (1) *Strongly Agree*, with 46.15% of the participants choosing this answer. In the sixth staff survey question, “I feel the parents of the newborn children have a positive attitude toward understanding how to prevent SBS,” the mode was (2) *Agree*, with 60.26% of the participants choosing this answer. In the seventh staff survey question, “Generally, I am satisfied with the support parents are provided concerning the SBS education,” the mode was (2) *Agree* with 47.44% of the participants choosing this answer. In the eighth staff survey question, “I wish I could spend more time with the parents providing support concerning SBS information,” the mode was (3) *Neither Agree nor Disagree* with 42.86% of the participants choosing this answer. In the ninth staff survey question, “I certainly feel that it is important to follow-up with parents concerning SBS after they have been discharged from the hospital,” the mode was (1) *Strongly Agree*, with 53.85% of the participants choosing this answer. In the tenth staff survey question, “At times, I feel the education provided has increased the staff’s awareness of the dangers of SBS to infants,” the mode was (1) *Strongly Agree*, with 51.28% of the participants choosing this answer (see Graph 1, Table 3).

Guiding Question B

What is the administration’s perception of the staff’s acceptance of the program?

Administrator’s Survey. As previously mentioned, the 10 questions in the administrators survey used a 5-point Likert rating scale where 1 = *Strongly Agree* and 5 = *Strongly Disagree*. The most frequently occurring response was referred to as the mode. The staff survey viewed how hospital staff’s perception of the parents acceptance of the SBS curriculum. The Table 3 presents the staff survey questions. The possible reply to the questions were as follows; 1 Strongly Agree, 2 Agree, 3 Neither agree nor Disagree, 4 Strongly Disagree, 5 Disagree. The answers were tabulated to and the mode with its

numerical value displayed. In this study only the raw data is presented to stimulate further areas of research.

Table 3

Administrator's Survey

Administrator Survey		
Question	Mode	%
1. The hospital staff feels prevention of SBS is important to teaching parents of children born at the community hospital.	1	64.29%
2. I feel the hospital administration effectively transfers the SBS curriculum to the staff.	1	50.00%
3. All in all, I feel that the staff in the unit is well educated about SBS before teaching the parents the curriculum.	1	42.86%
4. The staff feels the video "Portrait of Promise" is a valuable tool in teaching SBS.	1	50.00%
5. The staff understands the hospital's SBS curriculum.	1	35.71%
6. The staffs of the Intermediate Care Nursery and the Newborn Intensive Care units have a positive attitude toward understanding how to deliver the SBS curriculum.	2	42.86%
7. Generally, the staff is satisfied with the support the hospital has displayed for the SBS curriculum.	1	35.71%
8. I wish I could have more time to spend with the staff providing support concerning the SBS curriculum.	4	42.86%
9. I certainly feel that it is important to follow-up with staff after they have instructed parents on the SBS Curriculum.	1	35.71%
10. At times I feel the education provided has increased the administration's awareness of the dangers of SBS to infants	1	50.00%

Analysis of Administrator Survey. In the first administrator survey question, “The hospital staff feels prevention of SBS is important to teaching parents of children born at the community hospital,” the mode was (1) *Strongly Agree* with 64.29% of the participants choosing this answer. In the second administrator survey question, “I feel the hospital administration effectively transfers the SBS curriculum to the staff,” the mode was (1) *Strongly Agree* with 50% of the participants choosing this answer. In the third administrator survey question, “All in all, I feel that the staff of the unit is well educated about SBS before teaching the parents the curriculum,” the mode was (1) *Strongly Agree* with 42.86% of the participants choosing this answer. In the fourth administrator survey question, “The staff feels the video ‘Portrait of Promise’ is a valuable tool in teaching SBS,” the mode was (1) *Strongly Agree* with 50% of the participants choosing this answer. In the fifth administrator survey question, “The staff understands the hospital SBS curriculum,” the mode was (1) *Strongly Agree* with 35.71% of the participants choosing this answer. In the sixth administrator survey question, “The staffs of the Intermediate Care Nursery and the Newborn Intensive Care units have a positive attitude toward understanding how to live the SBS curriculum,” the mode was (2) *Agree* with 42.86% of the participants choosing this answer. In the seventh administrator survey question, “Generally, the staff is satisfied with the support the hospital has displayed for the SBS curriculum,” the mode was (1) *Strongly Agree* with 35.71% of the participants choosing this answer. In the eighth administrator survey question, “I wish I could have more time to spend with the staff providing administrative staff support concerning the SBS curriculum,” the mode was (4) *Disagree* with 42.86% of the participants choosing this answer. In the ninth administrator survey question, “I certainly feel that it is important to follow-up with staff after they have instructed parents on the SBS

curriculum,” the mode was (1) *Strongly Agree* with 35.17% of the participants choosing this answer. In the tenth administrator survey question, “At times, I feel the education provided has increased the administration’s awareness of the dangers of SBS to infants,” the mode was (1) *Strongly Agree* with 50% of the participants choosing this answer.

See graph 2, Table 4

Guiding Question C

What are the focus group’s views on the staff’s responses to the hypothesis?

In this section of the dissertation, the staff questions were examined in relationship to the hypothesis of *Neither Agree nor Disagree* with the question. A two tailed test of statistical significance was used to test the null hypothesis. The null hypothesis (H_0) was (3) for the staff to *Neither Agree nor Disagree* with the question. The statistical values were based on the p value. If the p value was above .05, the null hypothesis was accepted. If the p value fell below .05, then the null hypothesis was rejected. By using a two tailed test, one can test the statistical significance of the upper and lower confidence interval to test the relationship.

In the first question pertaining to the staff’s belief that prevention of SBS was important to teaching parents of children born at the community hospital, the results of the survey indicated that the null hypothesis be rejected as $p = .000003$. The lower confidence interval of 1.005 and the upper confidence interval of 1.227 support these results. This result signified that the staff strongly felt that the SBS curriculum was important to the parents. In the second question pertaining to the belief that the hospital staff effectively transfers the SBS education to the parents, the p value was .023. The lower confidence interval of 1.516 and the upper confidence interval of 1.809 support this conclusion. Therefore, the hypothesis

was rejected again as .023 was below the p value of .05. In the third question pertaining to the staff's overall belief that the parents are well educated about SBS before they leave the hospital, the p value was .027 which is a clear indication that the null hypothesis was rejected. The lower confidence interval of 1.544 and the upper confidence interval of 1.841 support the rejection of the hypothesis. In the fourth question pertaining to the staff's belief that the video "Portrait of Promise" is a valuable tool in teaching the parents about SBS, the p value is low as well with a .007% confidence interval. The lower confidence interval of 1.324 and the higher confidence interval of 1.599 support this conclusion as well. Not only was the null hypothesis rejected, but also the participants *Strongly Agreed* with the question. In the fifth question pertaining to the parents understanding the education provided concerning SBS, the null hypothesis was again rejected since the p value was .022. The lower confidence interval of 1.494 and the upper confidence interval of 1.788 support this conclusion as well. In the sixth question pertaining to the parents of newborn children having a positive attitude toward understanding how to prevent SBS, the null hypothesis is again rejected with a .015% confidence interval. The lower confidence interval of 1.603 and the Upper confidence interval of 1.858 support this conclusion as well. The staff predominantly *agreed* that the parents had a positive attitude toward understanding how to prevent SBS. In the seventh question pertaining to being satisfied with the support parents are provided concerning the SBS curriculum, the null hypothesis was rejected with $p = .025$. The lower confidence interval of 1.476 and the upper confidence interval of 1.780 support the conclusion. In the eighth question, pertaining to the need to spend more time with the parents to provide support for the SBS curriculum, the null hypothesis was not accepted at a stunning 2.426 lower confidence interval. The upper confidence interval tabulated as 2.821; however, out of the

10 questions, it came the closest to *Neither Agree nor Disagree* with a p -value of .337. In the ninth question, the staff rejects the null hypothesis pertaining to the importance of follow-up with parents after their discharge from the hospital; the null hypothesis was rejected with a p value of .021. The lower confidence interval of 1.410 and the upper confidence interval of 1.718 support this conclusion as well. Finally, in the tenth question pertaining to the education increasing the staff's awareness of the dangers of SBS to infants, the null hypothesis was rejected with the lower confidence interval value of 1.440 and the upper confidence interval of 1.739 with a p -value .020.

In the administrator test, the hypothesis was that the administrators *Agree* with the null hypothesis (see Table 5). In the first administrator question pertaining to the hospital staff feeling that prevention of SBS is important to teaching parents of children born at a community hospital, the p value was significant at .059. The lower confidence interval of 1.125 and the upper confidence interval of 2.018. Therefore, the null hypothesis were accepted since the p value is .059. In the first test, the lower confidence interval is 1.125 while the upper confidence interval is 2.018. In the second administrator question pertaining to the hospital administration effectively transferring the SBS curriculum to the staff, the null hypothesis was accepted as well with the p value at .098. In the second test, the lower confidence interval of 1.318 and the higher confidence interval of 2.253. In the third administrator question pertaining to the belief that the staffs in the two units are well educated about the SBS curriculum for teaching the parents, the p value was of .201. The lower confidence interval of 1.510 and the upper confidence interval of 2.633 support the conclusion. Thus accepting the null hypothesis. In the fourth administrator question pertaining to the staff's belief that the 'Portrait of Promise' video is a valuable tool in

teaching the SBS curriculum, the lower confidence interval of 1.360 and the upper confidence interval of 2.354 supports the p value of .125 guaranteeing the acceptance of the null hypothesis. In the fifth administrator question pertaining to the staff's understanding of the SBS curriculum, the lower confidence interval of 1.720 and the upper confidence interval of 2.994 supports the acceptance of the null hypothesis to be accepted with a .303% confidence level. The sixth administrator question pertaining to the staff at the Intermediate Care Nursery and the Newborn Intensive Care unit having a positive attitude toward understanding the delivery of the SBS curriculum had a p value of .112. In this case the lower confidence interval of 1.589 and the upper confidence interval of 2.411. The confidence intervals accepted the null hypothesis. The seventh administrator question pertaining to the belief that the staff is satisfied with the support the hospital displayed for the SBS curriculum had a P value of .271. This P value of .271 was supported with the lower confidence interval of 1.689 and the upper confidence interval of 2.882 not only supported the null hypothesis but also confirmed the staff's satisfaction with the support the hospital had displayed for the SBS curriculum. The eighth administrator question pertaining to the administrators wishing they could spend more time with the staff to provide support for the SBS curriculum had a p value of .500 which made the null hypothesis acceptable with the lower confidence interval value of 2.419 and the upper confidence value of 3.581. The ninth administrator question pertaining to the importance of follow-up with the staff after they instructed parents on the SBS curriculum had a p value of .312. The lower confidence interval of 1.622 and the upper confidence interval of 3.026, Therefore, the null hypothesis were accepted. The 10th administrator question pertaining to the belief that the education provided increased the administrators' awareness of the dangers of SBS to infants had a

lower confidence interval of 1.367 and an upper confidence interval of 2.490. The p value of .168 confirmed the null hypothesis. In this study only the raw data is presented to stimulate further areas of research.

In examining the data, the following facts were also significant. In neither the questions answered by the staff nor those answered by the administrators, did anyone *Strongly Disagree* with any of the questions. The confidence intervals in the total 20 questions (both the administrator survey and the staff survey) were above 1.00, which confirmed the belief of the hospital employees in the curriculum. The z test was used to mine the data in this study. Although the tests averaged 1.00 throughout the study, the instances when the information fell under the whole number were highlighted in this research study. In the staff survey, question eight pertaining to the belief that the staff needed more time to provide support for the SBS curriculum; the z test measurement resulted in .500. In the staff survey, the values were all 1 except for question number eight where the z test measurement was an acceptable .999.

Summary

How do employees and supervisors view the Shaken Baby Program? The program is viewed quite favorably by both the staff and the administrators. The amount of work that a staff member has to complete before a patient is discharged is enormous. In recent years, a considerable number of duties have been added to the work which must be completed before releasing a patient. Consequently, trying to focus on one specific part of the process has become a formidable challenge. The focus group participants confirmed the fact that while the administrators and staff approach their responsibilities with zest, the amount of work

allotted for the completion of required tasks related to discharging a patient presents a challenge.

These findings are centered on the best effort of the community hospital to assist the parents in all ways possible to support their newborn while raising their awareness of unexpected challenges that may result in injuries to the infants. By educating parents about the dangers of SBS, the hospital works to prevent myriad injuries to babies and infants.

The previous chapter described the research methods employed in this dissertation. The definitive qualitative design and specific data collection (Charmaz, 2006) created and implemented a sound study of the administrators' and staff's use of the Shaken Baby Curriculum at the community hospital in order to assist in reducing preventable childhood related injuries. The focus on providing sound research may assist in uncovering opportunities for the hospital to expand and improve the Shaken Baby Program which has been developed for the benefit of parents of the newborn.

In this dissertation a discussion of the results of the research is found in chapter V.

Chapter V

Discussion

Introduction

The History and Examination of the Shaken Baby Project was a review of a South Western community hospitals application of a child abuse prevention model. The child abuse prevention model that originated in New York was applied to the Newborn Intensive Care Unit (NICU) and the Intermediate Care Unit (ICU) of the hospital. The administrators and staff of the hospital were sampled to discover their beliefs of the current SBS curriculum used at the hospital.

The research goal was to better understand two units of a committee hospital belief in applying the curriculum to parents. The research questions of; how the program was started, the hospital staff perceptions, the administrative staff perception and a better understanding of the survey results were discovered throughout this dissertation. The questions were answered using interviews of the founding members who started the program at the hospital, surveys of the hospital and administrative staff, and a focus group with hospital and administrative team members. This chapter will discuss the correlation between Dr. Dias's (2005a) study and the current study, restate the findings, explain how the findings connect to the literature, present the limitations of the study, and recommend future research.

This study discovered that the administrative and staff of the two units in a hospital greatly believed in the care provided to their patients. In the areas of parental education, the administrative team feels the hospital staff does an admirable job in conveying the curriculum to the parents (see Figure C) although challenges lie in the constant additions and/or changes of what the hospital would like the staff to convey. The hospital staff belief,

as it pertains to the parents understanding of the curriculum is positive, although language barriers, time constraints and curriculum addendum's create challenges to applying the curriculum.

The findings found from the survey administered to hospital staff and administrators work to provide additional understanding of the hospital staff understanding and feeling. These ideals were a different view of a previous study performed by Dr. Mark Dias (Dias, 2005) that centers on parents understanding and application of the various forms of preventing child abuse education. The information discovered in this study connects to Dr. Dias's study by explaining administrative the hospital staff views of the effects of the literature to the patients. Dr. Dias's study presents the effects of the curriculum to the parents. Both studies show direct strength and further areas of research. It was discovered that most of the literature came directly from the New York study and was applied to the southwestern community hospital. The results of the New York study explain the effects of the curriculum to the patients (Dias, 2005). The results of the current community hospitals study explain the effects of the curriculum to the administrators and staff of the hospital.

Current research does not give a definitive answer to the question of hospitals views of the SBS curriculum. This study was meant to contribute to understanding how administrators and staff feel about the implementation of the curriculum. The main purpose of the study was to provide information on how the staff viewed the benefits of teaching the curriculum to the parents as well as how the administrators viewed the staff's acceptance of the curriculum. Responses to the surveys used in the study indicated that more research was needed in order to increase the rationale for providing the prevention curriculum to parents. In the areas of the research that raw data is presented further research is recommended.

The fact that hospitals are trying to decrease SBS related injuries is indisputable. Evidence is available in the many publications which describe attempts to avert these preventable incidents. This study focused on identifying how the involved employees viewed the SBS curriculum. In considering the importance of offering the curriculum to parents, the hospital has to balance the implementation of the program with the needs of the parents.

Connecting Literature

In order to increase the hospital's ability to administer the SBS Program, the administrators and staff had to adapt to change and the effectiveness of needed change. A review of the history of change proved to be useful in recognizing ways of improving the effectiveness of the program at the community hospital. The first publication on change by De Tarde (1903) explained what was needed to make change occur as well as the relationship between change and increased effectiveness. De Tarde's theories of change led to measurements of how change occurs that are still used today by community hospitals that seek to change in order to improve service to their clients.

As De Tarde (1903) examined change, the same ideal applies to the community hospital. The change in how the community hospital conveys the different mandatory curriculums to the parents can follow the De Tarde's change model. The hospital currently has different curriculums that need to be studied in areas of where they can combine curriculums to encompass the overall meaning to parents. The change in presenting the curriculums will enhance the overall understanding of material by parents. In De Tarde's change model of how change occurs and De Tarde's theories of change led to measurements of how change occurs that are currently used today by community hospitals that seek to

change in order to improve service to their clients. Karl Pearson's keen understanding of De Tarde's work (Bellhouse, 2009), resulted in the design of instruments to measure change in order to increase effectiveness and efficiency. Many of those change instruments are still used today in order to gain understanding of new programs. In this study, the measurements were used to gauge the administrators' and the staff's views on the effectiveness of the SBS Program.

The researcher reviewed the history of change theorists and described the model of unfreeze, change, and refreeze created by Kurt Lewin. Understanding Fusion Strength, Multicultural Theories, Paradigm Shifts and Organizational Change was invaluable in examining the changes that took place at the community hospital as the SBS Program was being implemented. The hospital was very involved in action learning and action science in order to implement the SBS prevention curriculum. Manifestations of action learning and action science were evident in the basic concept of the education program. As challenges arose, the understanding of change management was needed to develop new directives for the hospital staff.

Hospital employees have many social interactions with parents which most likely include a social cognitive effect (Bandura, 1997) on the way parents view change and /or a curriculum. That change in the curriculum can be met by reasonable actions and planted behaviors that can be calculated and or reviewed to accomplish future innovations in assisting children. The theories and models of changing behavior, which were highlighted in the literature review, have a direct correlation with this study. The correlation centers on the attempts to change the behavior of parents and their interaction with children in order to decrease possible abuse.

Summary of Findings

The finding of the History and Examination of the Shaken Baby Project connects directly back to De Tarde's (1903) look at change and how Dias (2005) changed parents to decrease harm to infants from violent movements. In each finding a connection to previous literature is clearly presented in order to connect previous ideals to current challenges of the hospital.

The data was collected via interviews with the founding members and surveys administered to 78 staff members and 14 administrators. This data helped to create focus group questions to understand any outliers of the data from the survey. An understanding of the research questions assisted this undertaking. The understanding of how the Shaken Baby Program was started at the community hospital required answers to three questions:

1. How was the SBS Program started at the community hospital?
2. What was the hospital staff's perception of the parents' acceptance of the curriculum?
3. What was the administrators' perception of the staff's acceptance of the program?
4. What were the focus groups' views on the staff's and the administrators' responses to the survey questions?

Finding 1. How the founders started the SBS Program at the community hospital?

The focal point of the founders' introduction to the SBS Program centered on the community hospital work to improve parent's interaction with the children while reducing childhood related injuries. Each founder was introduced to the program in a different way. However, they shared the belief that the hospital could reduce SBS related injuries. Founder A still works at the hospital and remains involved with efforts to increase the effectiveness of the

program. The first finding connects to Dias findings of the severity in injuries and enormous social calls of people not receive information of the shaken baby program curriculum (Dias, 2005). In the current study, it was clearly understood how a social call had one of the original founding members contacted by a community resident that worked for the local Children Youth and Family Department (CYFD). The connection of the founding member with the local CYFD staff member presented a case that the hospital should direct more attention to the prevention of child abuse. The particular child abuse brought to Founding Member A from the CYFD member was in the form the abuse presented to children by being violently shaken. The education presented to parents had a proven track record of effectiveness by Dr. Dias's study, which led to founding member a contacted Dr. Dias. The following relationship between Dr. Dias and Founding Member A assisted in starting the shaken baby syndrome curriculum at the community hospital.

Finding 2. The hospital staff's perception of the parents' acceptance of the curriculum was mixed. Several approaches were used to uncover the staff's views on the parents' acceptance of the curriculum. Questions in the staff survey included the following topics: The parents' views of the hospital staff's effectiveness in providing the education; the video used to aide in the understanding of the SBS prevention curriculum; the parents' understanding of the curriculum; and the parents' satisfaction with the program and the education materials provided.

In the current study, the prevention curriculum views of the administrative staff ideas and how they convey those ideals to the hospital staff makes a distinction of the importance of this information to the parents. Like Dias's (2005) findings, this study found that many of the hospital staff felt the parents did receive a large advantage from being presented the

curriculum. The difference in the two findings was the view that the different curriculums needed additional time and or and overhaul to properly convey the understanding of all pertinent information to the parents. Like Dias's (2005) study the need for the curriculum is very apparent, yet in the current study the amount of information that is mandatory for parents to receive has challenged the effectiveness of the staff.

Finding 3. The administrators' perception of the staff's acceptance of the curriculum was beneficial. Several approaches were also used to uncover the administrators' perception of the staff's acceptance of the curriculum. Questions in the administrator survey included the following topics: the hospital staff's views of the prevention curriculum; the administrators' views of the hospital staff's effectiveness in providing the education; the staff's education level of the curriculum; the video used to present the prevention curriculum; the staff's understanding of the program; and the staff's satisfaction with the program and the education materials provided. In Dias's (2005) study, 93% of the parent's acceptance of the curriculum was measured by who returned the survey and acknowledged hearing previously about the dangers of infant shaking.

In the current study, the staff as well as the administrators' acceptance of the curriculum was studied. The administrative staff acknowledges that the curriculum was well received by the parents. The staff strongly agreed that the curriculum had a positive effect on the parents. In Dias's (2005) study of surveying the nurse managers each year, the positive use of brochures and posters positively affected the parents. The challenge in Dias's study was the viewing of the videotape. In the current study, this fact remained the same in understanding the challenge hospital had in low success rate in producing the video to the parents as well as the hospital had a challenge and originally making the video on the to the

parents. The challenge to the hospital in showing the video tape draws a direct correlation with the importance of the administrator's perception to the staff's acceptance of the curriculum. The acceptance of the curriculum level of importance is clearly determined.

Finding 4. The focus group considered one set of responses from the staff survey and several sets of responses from the administrator survey. The focus group was used to explore ambiguities in the hospital staff's answers to the survey questions. In general, the focus group confirmed that the staff members had the ability to conduct the SBS prevention program while performing other duties. From the viewpoint of the focus group, the hospital staff's responsibilities were spread between other mandatory educational related curriculums and the SBS prevention curriculum. Consequently, the situation presented a challenge for both the staff and the administrators. Identifying resources and managing time proved to be daunting tasks. Because the administrators and staff are pulled in many directions, it is extremely difficult to ensure favorable outcomes for all programs.

This finding connects to Dias's (2005) study. Dias indicated child abuse prevention was directed to hospital-based programming affecting parents. The same hospital-based program in the current study targeted the administrators use and how it affected the hospital staff of the prevention program. Dias determined that adults' comprehension increases when information can correlate with actions.

The relevant information for understanding the history and examination of the shaken baby project offered parents accepting the curriculum is apparent. We first examine how the information assisted the hospital. In a discussion with the administrative staff to distinct results will affect the hospital staff. The administrators' understanding of how the hospital staff use of the curriculum was greatly enhanced. A study of this nature had never been

conducted at the community hospital and the administrative staff now has a better understanding of their colleagues' views on the curriculum. In further discussions with the supervisors, the current study directed the hospital to examine the curriculum's correlation as well as a correlation of the curriculums to find a more robust and dynamic way to present the information and instruct the parents.

Limitations and Future Research

A major limitation of the study is clearly recognized by not interacting with the parents directly. This study did not engage the parents directly. The harm caregivers give to the abused children is the reason why Dias's (2005) study was conducted. Although the current study did not take this direction in its research, this direction should be explored further.

Another major limitation of the study is how the parent and or children should be addressed after the abuse has occurred. If children are challenged in this area, research should be conducted to address how to treat abused children. In addition, the corrective behavior as well as educational classes to parents that have caused harm to the children should be studied.

A problem that was discovered during the course of this research opens up another area for future research. A strong limitation of this research was how the staff and administration viewed the curriculum after changes are implemented. In Dias's (2005) study, the program affected 69% of newborn infants parents as a results of the posttest completed seven months after release of the hospital. In the current study, a 7 month follow-up with the administrative and hospital staff was not conducted. It is a strong recommendation that, once the hospital has determined its direction on enhancing the SBS curriculum, previous

participants are polled, in possibly 7 month after the change, to determine the effect on administration and hospital staff.

Another limitation was the ability of the staff to return the surveys. The administrative team attributed this challenge to the staff increased of mandatory teaching. The staff felt that they were overwhelmed by the constant additions to the teaching curriculum. Over time, more and more curriculums are added to the mandatory teaching to the parents, yet at no time are the curriculums studied for commonalities. During the focus group's many of the staff members did not want to express themselves. The focus group participants had a concern about their data being given back to the hospital.

Future Research. Looking forward, the hospital will find new ways to expose patients to the curriculum and instruct the staff in a more robust and efficient way to present the curriculum. A more inclusive curriculum should be determined in order to convey the vast number of information. This current study unveiled the need for future research in several areas. Some of these areas are:

1. Improvement in engaging parents in the different curriculums offered by the hospital during the same period.
2. Merging the curriculums in some way to provide the education to the parents while reducing competing priorities.
3. Identifying resources that could effectively convey all the data needed to be presented to the parents in a less time consuming way.
4. Improving communication between the administrators and the staff in reference to implementing various programs.

5. Examining the role of administrators in effectively supporting the staff members who teach the curriculum.
6. Expanding regular offering of the SBS curriculum beyond the two units used for this study.
7. The composition of the southwestern state's multicultural community.
8. The need to translate curriculum materials into Spanish, Vietnamese and other languages.

The primary findings in this dissertation research successfully met the requirements of the University, yet more research is needed on this topic. A detailed look at strategies that can have a greater impact on engaging parents and the community at large may successfully improve implementation and business processes.

Leaving aside the specific benefits of lowering incidents of child abuse while increasing care by teaching a SBS prevention program; the community hospital staff should ensure that the curriculum is taught to every patient. How to motivate the staff to teach the SBS curriculum consistently, while continuing to offer the excellent care they currently provide to patients, is a study in and of itself. This study was intended to provide the history and current implementation of the SBS Program in two specific units of the southwestern hospital. It is important to note that while SBS presents an imminent danger to children, parents can harm children in many other ways not addressed by this study.

Current research does not give a definitive answer to the question of why hospitals cannot increase the SBS curriculum. This study is meant to contribute to understanding how administrators and staff feel about the implementation of the curriculum. The main purpose of the study was to provide information on how the staff viewed the benefits of teaching the

curriculum to the parents as well as how the administrators viewed the staff's acceptance of the curriculum. Responses to the surveys used in the study indicated that more research is needed to increase the rationale for providing the prevention curriculum to parents.

The fact that hospitals are trying to decrease SBS related injuries is indisputable. Evidence is available in the many publications which describe attempts to avert these preventable incidents. This study focused on identifying how the involved employees viewed the SBS curriculum. In considering the importance of offering the curriculum to parents, the hospital has to balance the implementation of the program with the needs of the parents.

The role of administrators in effectively supporting the hospital staff to teach the curriculum has not been studied sufficiently. However, assuming that parents will receive a transformational experience from the Shaken Baby Syndrome curriculum without proper provision being made to present the curriculum may not be a realistic expectation. Evidence supports the fact that if no curriculum is offered to the parents, the possibility of childhood related injuries may increase (Dias, 2005). Although conflicting evidence shows that the probability of a positive change will increase through education, the population may not accept the education (Rogers, 2003).

Summary

This study was undertaken to reveal how hospital staff and administrators view a prevention curriculum currently used in the hospital. The findings confirm the fact that the community hospital's employees work tirelessly to provide the curriculum to parents. Also indisputable is the fact that the staff resources are spread quite thin. As the nursing staff

strive to effectively impart the SBS curriculum to parents, several other programs demand their time and attention.

The resources of the hospital staff and administrators are put to the test on a day-to-day basis. However, they manage to succeed in contributing to the overall goals of the hospital. This success makes it possible for parents to receive the SBS curriculum. Although resources are spread thin, the hospital successfully implemented the SBS curriculum in the two units examined in this study. The two units, the Newborn Intensive Care Unit and the Intermediate Care Unit, successfully found ways to implement the Shaken Baby Program while conducting additional programs enacted by the hospital.

This dissertation provided the southwestern community hospital with an initial documentation of the Shaken Baby Program from its inception to the present day. The study included the initial reason for starting the program, a description of its implementation, and the change management that was required. In addition, the study focused on the current implementation in two units of the hospital – the Intermediate Care Nursery and the Newborn Intensive care Units. It also provided insight into the administrators' and the staff's perceptions of the Program.

Seventy eight staff members and 14 administrators volunteered to participate in the study. The volunteers included a Clinical Nurse Researcher, a Pediatrics Rehabilitation Medic, and members of the Data Analysis staff. All of these volunteers who expanded their knowledge of the Shaken Baby Program and broadened their collaborative experience may be of invaluable assistance in future research efforts.

The principal investigator of this dissertation has laid a foundation for a planned approach towards continuous research and evaluation of the Shaken Baby Program. The

study lends support to the community hospital's interest in successfully implementing the Program.

Appendix A: Supporting Documents

Table A-1 Staff – All Questions Responses

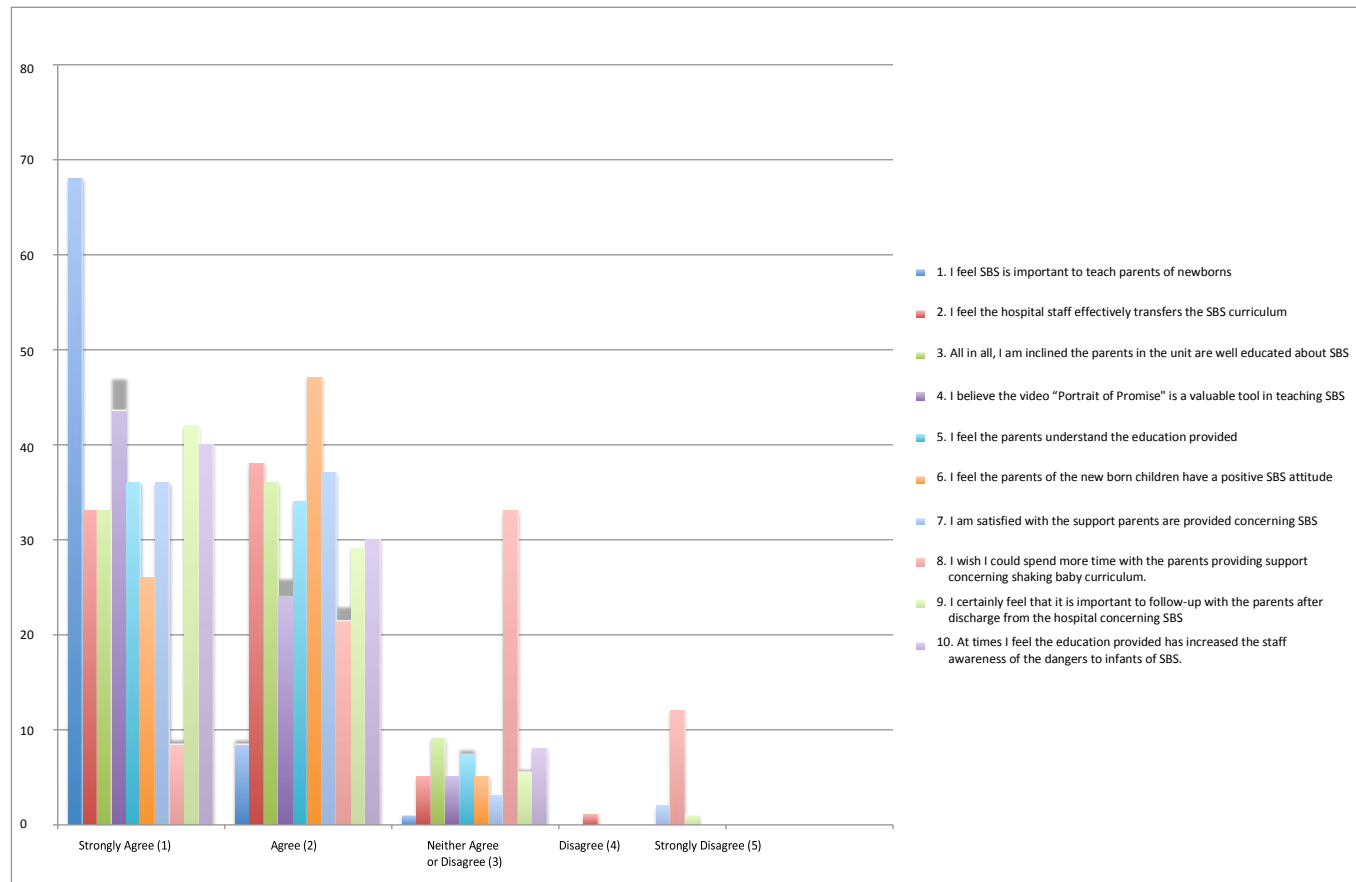
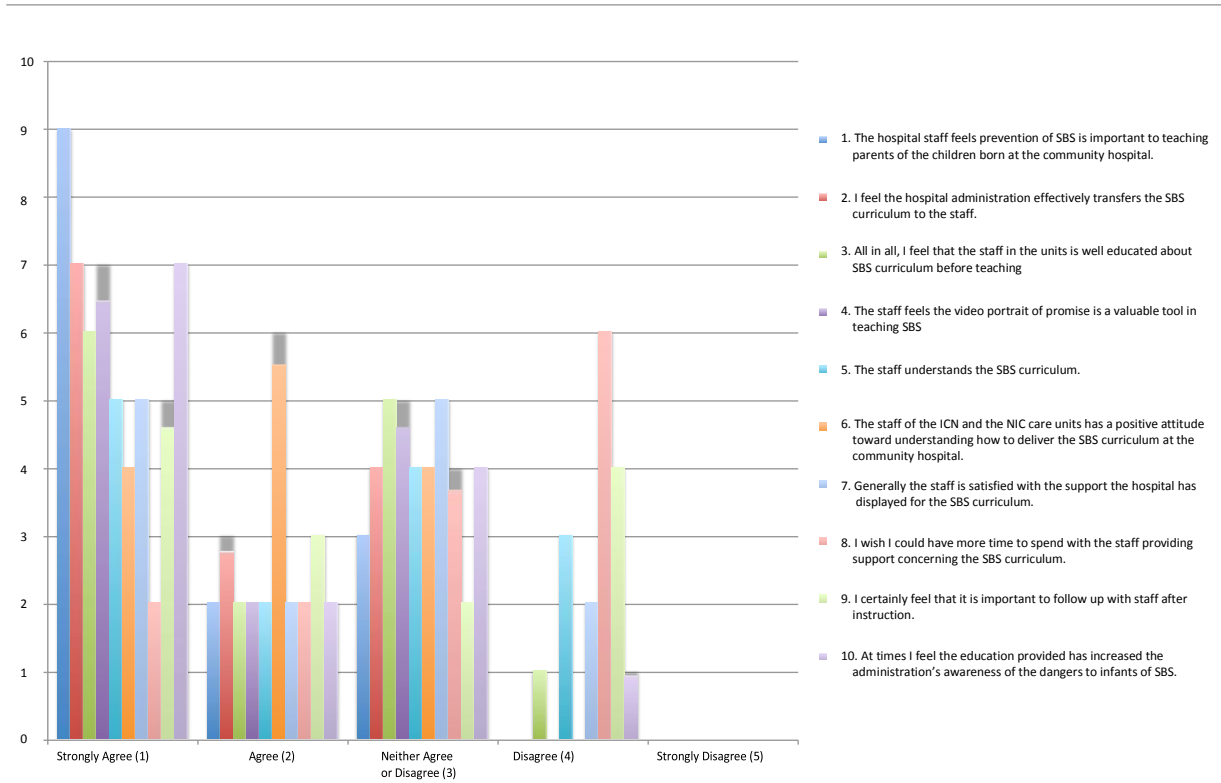
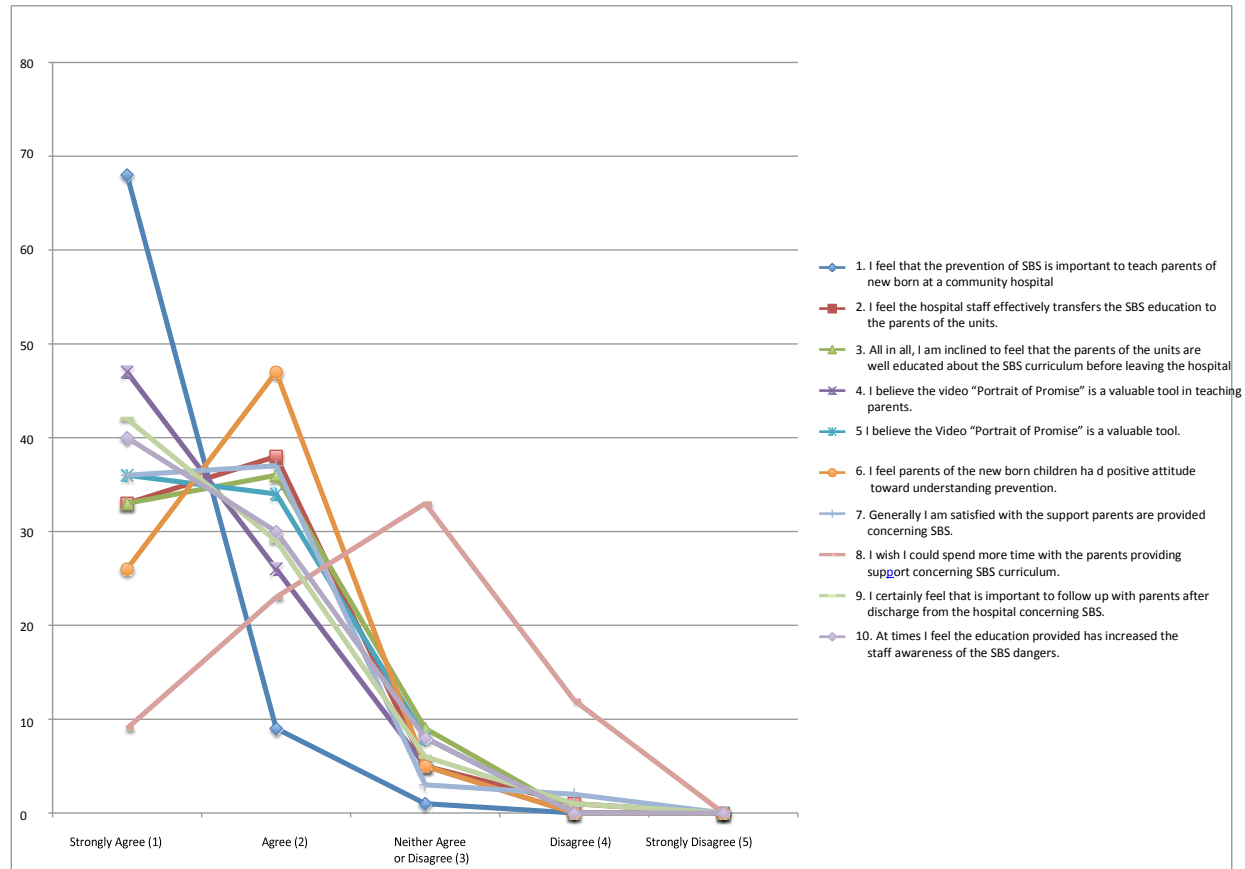


Table A-2 Admin – All Questions Responses



Graph A-1 Staff – All Questions Responses



Graph A-2 Admin – All Questions Responses

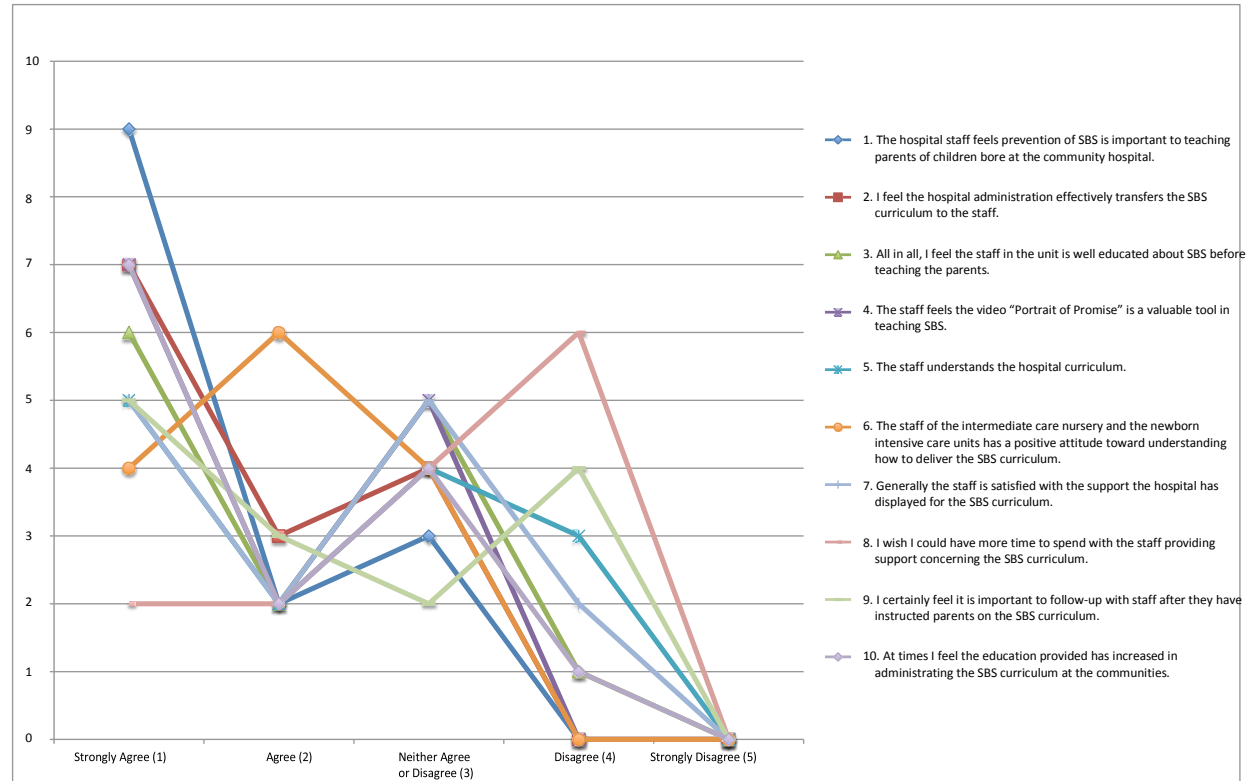


Table A-3 Shaken Baby Survey-Staff

Shaken Baby Survey - Staff
Intermediate Care Nursery
Newborn Intensive Care Nursery

n= 78
 NICU= 42
 ICN= 36

Ho: will respond (3) Neither agree or disagree

	Statement	Strongly Agree (1)	Agree (2)	Neither Agree or Disagree (3)	Disagree (4)	Strongly Disagree (5)	# who answered question	Mode	Mean	Standard Deviation	95% Conf. Interval	p-value	z-test
1	1. I feel that the prevention of SBS is important to teach parents of new borns at a community hospital.	68	9	1	0	0	78	1	1.141	0.386	1.055 1.227	0.00000352	1.00000000000000
		87.179%	11.538%	1.282%	0.000%	0.000%							
2	2. I feel the hospital staff effectively transfers the SBS education to the parents.	33	38	5	1	0	77	2	1.662	0.661	1.516 1.809	0.023	1.00000000000000
		42.86%	49.35%	6.49%	1.30%	0.00%							
3	3. All in all, I am inclined to feel that the parents in the units are well educated about SBS before they leave the hospital.	33	36	9	0	0	78	2	1.692	0.670	1.544 1.841	0.027	1.00000000000000
		42.31%	46.15%	11.54%	0.00%	0.00%							
4	4. I believe the video "Portrait of Promise" is valuable tool in teaching the parents about SBS.	47	26	5	0	0	78	1	1.462	0.618	1.324 1.599	0.007	1.00000000000000
		60.26%	33.33%	6.41%	0.00%	0.00%							
5	5. I feel parents understand the education provided concerning SBS.	36	34	8	0	0	78	1	1.641	0.664	1.494 1.788	0.022	1.00000000000000
		46.15%	43.59%	10.26%	0.00%	0.00%							
6	6. I feel the parents of the new born children have a positive attitude toward understanding how to prevent SBS.	26	47	5	0	0	78	2	1.731	0.574	1.603 1.858	0.015	1.00000000000000
		33.33%	60.26%	6.41%	0.00%	0.00%							
7	7. Generally, I am satisfied with the support parents are provided concerning the SBS education.	36	37	3	2	0	78	2	1.628	0.686	1.476 1.780	0.025	1.00000000000000
		46.15%	47.44%	3.85%	2.56%	0.00%							
8	8. I wish I could spend more time with the parents providing support concerning SBS information	9	23	33	12	0	77	3	2.623	0.889	2.426 2.821	0.337	0.9998992309241
		11.69%	29.87%	42.86%	15.58%	0.00%							
9	9. I certainly feel that it is important to follow-up with parents after discharge from the hospital concerning SBS.	42	29	6	1	0	78	1	1.564	0.695	1.410 1.718	0.021	1.00000000000000
		53.85%	37.18%	7.69%	1.28%	0.00%							
10	10. At times I feel the education provided has increased the staff awareness of the dangers to infants of SBS.	40	30	8	0	0	78	1	1.590	0.673	1.440 1.739	0.020	1.00000000000000
		51.28%	38.46%	10.26%	0.00%	0.00%							

Table A-4 Survey – Staff

Shaken Baby Survey													n-calculation
Tracking Number	ICN(I)/N ICU(N)	1.If I feel that the prevention of SBS is important to teach parents of newborn at a community hospital.	2.If I feel the hospital staff effectively transfer the SBS education to the parents.	3.All in all, I am inclined to feel that the parents in the units are well educated about SBS before they leave the hospital.	4.I believe the video "Portrait of Promise" is valuable to include in teaching the parents about SBS.	5.If I feel parents understand the education provided concerning SBS.	6.If I feel the parents of newborn children have a positive attitude toward understanding how to prevent SBS.	7.Generally, I am satisfied with the support parents are provided concerning the SBS education.	8.I wish I could spend more time with the parents providing support concerning SBS information.	9.I certainly feel that it is important to follow-up with parents after discharge from the hospital concerning SBS.	10.At times I feel the education provided has increased the staff's awareness of the danger to infants of SBS.		
15	i	1	1	1	1	2	2	1	1	1	1	10	
16	i	2	2	3	2	2	3	2	3	2	2	10	
17	i	2	2	3	1	2	2	2	3	2	1	10	
18	i	1	2	2	2	2	2	2	3	1	1	10	
19	i	1	4	3	2	3	3	4	2	1	2	10	
20	i	1	1	1	1	1	1	1	1	1	1	10	
21	i	1	2	2	1	1	2	2	2	1	1	10	
22	i	1	2	2	1	1	2	2	3	2	2	10	
23	i	1	1	1	1	3	2	1	1	1	2	10	
24	i	1	1	1	1	1	1	1	4	1	1	10	
25	i	1	1	2	1	2	2	1	3	3	3	10	
26	i	1	1	1	1	1	1	1	2	2	1	10	
27	i	1	1	1	1	1	2	1	4	1	1	10	
28	i	1	1	1	1	1	1	1	1	1	1	10	
29	i	1	1	1	1	1	1	1	1	1	1	9	
30	i	1	1	1	1	2	2	1	2	1	1	10	
31	i	1	2	2	2	2	2	1	3	2	2	10	
32	i	2	2	1	1	1	1	1	2	2	1	10	
33	i	1	1	1	1	1	1	1	1	1	1	10	
34	i	1	2	2	1	1	2	2	2	2	1	10	
35	i	2	2	2	2	2	2	2	2	2	2	10	
36	i	1	1	1	1	2	2	1	1	1	2	10	
37	i	1	1	1	1	1	2	1	4	2	2	10	
38	i	1	2	1	1	1	1	1	3	1	1	10	
39	i	1	2	2	2	2	2	2	3	2	2	10	
40	i	1	1	1	1	1	2	1	3	1	1	10	
41	i	1	2	2	2	2	2	1	4	2	2	10	
42	i	1	1	1	1	1	1	1	1	1	1	10	
43	i	1	1	1	1	1	1	1	2	1	1	10	
44	i	1	2	2	2	2	2	2	2	2	2	10	
45	i	1	1	2	2	2	2	2	3	2	2	10	
46	i	1	1	2	1	1	2	2	3	2	2	10	
47	i	1	2	2	1	1	2	2	2	2	1	10	
48	i	1	1	1	1	1	1	1	3	1	1	10	
49	i	2	2	2	2	2	2	2	3	2	2	10	
50	i	1	1	2	1	1	2	2	2	1	1	10	
51	n	1	2	2	1	2	2	2	2	1	2	10	
52	n	1	2	1	2	2	2	2	4	2	2	10	
53	n	1	2	2	1	2	2	2	3	2	2	10	
54	n	1	3	3	2	3	3	4	2	1	1	10	
55	n	1	2	2	2	2	1	2	3	3	2	10	
56	n	1	2	2	2	2	2	2	2	2	1	10	
57	n	1	1	1	1	1	1	1	3	1	1	10	
58	n	1	2	2	1	1	1	1	3	1	1	10	
59	n	1	2	2	2	2	2	2	2	1	2	10	
60	n	1	2	2	2	2	2	2	3	2	3	10	
61	n	1	1	1	1	1	1	1	2	1	2	10	
62	n	1	2	2	2	2	2	2	4	2	3	10	
63	n	1	1	1	1	1	1	1	2	2	2	10	
64	n	1	2	2	3	2	2	2	4	1	3	10	
65	n	1	1	2	2	2	2	1	2	1	1	10	
66	n	1	2	2	2	3	3	2	4	3	3	10	
67	n	1	3	2	1	1	2	2	3	2	1	10	
68	n	1	1	1	1	2	2	1	4	3	3	10	
69	n	1	1	1	1	2	1	1	3	1	1	10	
70	n	1	3	2	3	3	2	2	3	2	2	10	
71	n	2	2	3	3	2	2	3	3	2	2	10	
72	n	1	1	1	1	1	1	1	1	1	1	10	
73	n	1	1	1	1	1	1	1	3	2	2	10	

[illegible]

Table A-5 Shaken Baby Survey-Administrator

Shaken Baby Survey - Administrator
Intermediate Care Nursery
Newborn Intensive Care Nursery

n= 14
 NICU= 8
 ICN= 6

Ho: will respond (3) "agree"

	Statement	Strongly Agree (1)	Slightly Agree (2)	Agree (3)	Slightly Disagree (4)	Strongly Disagree (5)	# who answered question	Mode	Mean	Standard Deviation	95% Conf. Interval		p-value	z-test
1	1. The hospital staff feels prevention of SBS is important to teaching parents of children born at the community hospital.	9	2	3	0	0	14	1	1.571	0.852	1.125	2.018	0.059	1.000
		64.286%	14.286%	21.429%	0.000%	0.000%								
2	2. I feel the hospital administration effectively transfers the SBS curriculum to the staff.	7	3	4	0	0	14	1	1.786	0.893	1.318	2.253	0.098	1.000
		50.00%	21.43%	28.57%	0.00%	0.00%								
3	3. All in all, I feel that the staff in the unit is well educated about SBS before teaching the parents the curriculum.	6	2	5	1	0	14	1	2.071	1.072	1.510	2.633	0.201	0.999
		42.86%	14.29%	35.71%	7.14%	0.00%								
4	4. The staff feels the video "Portrait of Promise" is a valuable tool in teaching SBS.	7	2	5	0	0	14	1	1.857	0.949	1.360	2.354	0.125	1.000
		50.00%	14.29%	35.71%	0.00%	0.00%								
5	5. The staff understands the hospital's SBS curriculum.	5	2	4	3	0	14	1	2.357	1.216	1.720	2.994	0.303	0.976
		35.71%	14.29%	28.57%	21.43%	0.00%								
6	6. The staff of the intermediate care nursery and the newborn intensive care units have a positive attitude toward understanding how to deliver the SBS curriculum.	4	6	4	0	0	14	2	2.000	0.784	1.589	2.411	0.112	1.000
		28.57%	42.86%	28.57%	0.00%	0.00%								
7	7. Generally the staff is satisfied with the support the hospital has displayed for the SBS curriculum.	5	2	5	2	0	14	1	2.286	1.139	1.689	2.882	0.271	0.991
		35.71%	14.29%	35.71%	14.29%	0.00%								
8	8. I wish I could have more time to spend with the staff providing support concerning the SBS curriculum.	2	2	4	6	0	14	4	3.000	1.109	2.419	3.581	0.500	0.500
		14.29%	14.29%	28.57%	42.86%	0.00%								
9	9. I certainly feel that it is important to follow-up with staff after they have instructed parents on the SBS curriculum.	5	3	2	4	0	14	1	2.357	1.277	1.688	3.026	0.312	0.970
		35.71%	21.43%	14.29%	28.57%	0.00%								
10	10. At times I feel the education provided has increased the administration's awareness of the dangers to infants of SBS.	7	2	4	1	0	14	1	1.929	1.072	1.367	2.490	0.168	1.000
		50.00%	14.29%	28.57%	7.14%	0.00%								

Table A-6 Survey – Administrator

[illegible]

Attachment 1

**NEVER SHAKE A BABY**

Shaking a baby can cause blindness, permanent brain injury-even death.

Please, **NEVER SHAKE A BABY!**

Attachment 2

TAKE A BREAK...

Don't Shake
(Help Us Prevent
SBS)

Babies and Crying

Taking care of an infant can be challenging.

No one likes to hear a baby cry. It is irritating and frustrating.

Crying is the only way babies communicate their needs.

Why is your baby crying?

Some babies cry when they are hungry, tired or wet.

A fever or illness can make an infant fussier.

Sometimes they just want to be held. Check these basic needs and try to make the baby comfortable.

How to cope with your baby's crying:

If you have tried to calm your crying baby but nothing seems to work, it is important to stay in control of your temper. Here are some tips to help you with these frustrating moments when your baby won't stop crying:

- Put the baby in a safe place, like a crib or play pen and leave the room for a while.
- Check on the baby every 10-15 minutes.
- Listen to music, watch TV, exercise or just relax.
- Call a relative or friend. They may offer advice or watch the baby for a while.

All parents get stressed at one time or another. Be sure to set aside sometime for yourself. It's important to take care of your need, as well as your baby's, so you will be able to handle the most stressful situations.

Tell Everyone You Know...



REMEMBER, IT'S OK FOR BABIES TO CRY; IT'S NORMAL AND WON'T HURT THEM!

NEVER SHAKE A BABY!

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