Emotional communication between nurses and parents of a child in hospital

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student:

Date:

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Abstract

In contemporary child healthcare, there is an expectation that parents will be involved in the child's care and work collaboratively with nurses. Collaboration such as this requires that nurses relate to and communicate with both the child and parents. The central concern of this study is emotional communication between the nurse and parent, focusing on parent's feelings and affective responses as they are related to their child's hospitalisation. The aims of the study were to investigate nurses' and parents' experiences of this aspect of communication within the environmental and cultural context of the parent-nurse interaction.

A focused ethnography was conducted, given the importance of understanding the cultural context of nurse-parent interaction. Data collection occurred in a children's ward of a New Zealand hospital, and involved 280 hours of participant observation field work over 22 weeks, 228 informal interviews with parents and nurses, followed by 20 formal interviews with nurses and parents. Data analysis occurred simultaneously as data were interpreted inductively throughout collection.

The findings support the impact of ward and nursing culture as an influence that shapes nurses' behaviour and affect. Parents of a child in hospital were in a vulnerable position, required support and looked to nurses for an interpersonal connection. Parents wanted nurses to provide support and guide them through the hospitalisation journey, acting as cultural brokers. Nurses recognised and responded to parents' need for informational and instrumental support, however there was little acknowledgement that parents also needed emotional support. Nurses responded to parents' overt displays of emotion, but did not elicit emotional expression. The emotional labour that is required by nurses to manage both parents and their own emotions led nurses to engage in self-protection actions. The cultural context of the ward impacts emotional communication between parents and nurses, inhibiting and governing parents' actions and nurses' responses.

This work contributes to further understanding of the concept of cultural brokerage in nursing practice. Eliciting, acknowledging and confirming parents' emotional concerns are core elements of nurses' emotional communication. Organisations must value the labour required to emotionally support others, and recognise the vulnerability of parents and nurses as they work together on their mutual goal of improving the well-being of the child-patient.

Chapter 1: Setting the Scene

Introduction

The way in which nurses communicate with patients and their families is central to the provision of nursing care. When a child is hospitalised there is an expectation by the family and health professionals that the parent or primary caregiver will be involved in the child's care and work collaboratively with nurses (Corlett & Twycross 2006; Roden 2005; Shields & Coyne 2006). The effectiveness of this collaboration is dependent on interpersonal communication in order to establish mutual goals. Therefore in the field of child health nursing, the nurse needs to relate to both the child, who is a patient, and the child's parents or caregivers. The relationship the nurse develops with the parents is vital in the management of the child's care because most parents continue to parent their child and work alongside the nurse.

Parents staying with their child in hospital experience a range of emotions as the child journeys through the illness trajectory (Lundqvist & Nilstun 2007; Stratton 2004; Widger & Picot 2008). During the course of the child's stay in hospital, parents want relationships with nurses who not only give them information about their child's care but also display compassion, understanding and sense the parent's and child's concerns (Jones, Woodhouse & Rowe 2007; Snowdon 2000). The context of the nurse-parent interaction, both physical and cultural, can be problematic because managing emotional responses to the hospitalisation experience can be challenging for both parent and nurse (Avis & Reardon 2008; Jones et al. 2007; Snowdon 2000). Meeting these challenges requires effective interpersonal communication which builds a therapeutic relationship (Espezel & Canam 2003; Fisher & Broome 2011).

Aims and significance of the study

The aims of this study are to investigate nurses' experiences of emotional communication with parents of a child in hospital; to investigate parents' experiences of emotional communication with nurses in hospital; and to examine the environmental and cultural context within which the parent-nurse interaction occurs.

Three research questions drive this study:

1. how do nurses respond to parents in hospital who have emotional concerns?
2. what are parents' who are in hospital with their child, experiences of nurses' responses to their emotional concerns?

3. how does the context of the hospital environment shape the nurse-parent interaction?

The knowledge gained from this study may provide nurses with insight into responses to parents' emotional concerns, as well as a greater appreciation of the emotional issues faced by parents of a child in hospital (McArdle et al. 1996; Ulrich 2007). This knowledge may enhance nursing practice and education, and add to the body of nursing knowledge.

In this study the importance of interpersonal communication as an influence on emotion is argued. Nurses' responses to parents' emotions are evident in the interpersonal communication between nurse and parent. Therefore a consideration of nursing communication is required.

The New Zealand government has established that healthcare professionals, including nurses must be able to communicate effectively with patients in order to improve health outcomes for New Zealanders (Ministry for Disability Issues 2001; Ministry of Health 1998; Ministry of Health, 2001; Ministry of Health, 2002; Ministry of Health, 2005). Further, government policies have identified that effective communication will assist patients and their family and improve their well-being (Ministry of Health 1998; Ministry of Health 2004).

According to the regulatory body for nursing, the Nursing Council of New Zealand (2007) (thereafter termed Nursing Council), interpersonal relationships are one of the four core domains of competence for the registered nurse scope of practice. The ability of nurses to communicate effectively with parents of a child patient involves the need to be responsive to parents' communication. In this study the central focus is one aspect of nurse-parent communication that is focused on responding to parents' emotions, termed emotional communication.

This chapter elaborates on the issues of parents' care for hospitalised children, given that the understanding of parents' roles has changed over time. The importance of attending to emotional concerns for parents can be argued as a significant nursing imperative. In particular, the impact on the child's care is of prime importance to nursing interventions. Given that little has been documented in either formal or informal sources, the consideration of emotional care is a useful addition to the field of nursing communication.

Background to the topic

Nursing is a profession which requires interpersonal interaction with others. On a daily basis, nurses are required to communicate with patients, patient's families and friends, professional colleagues, managers and others. In a children's ward of a hospital, patients are children aged between birth and approximately 15 years of age. The child patient is usually accompanied to the ward by their parent or primary caregiver. In this study, the term 'parent' represents a parent or the child's primary caregiver (such as grandparent, other family member, or foster parent). The parent frequently stays with the child for the duration of the child's hospitalisation, and is a resident in the ward. Thus, when the nurse communicates with the child, the parent is usually present and is involved in the interaction.

Prior to the 1960s, parents were rarely allowed to stay with their child in hospital, and were given visiting rights only (Young 1992). Health providers' concerns regarding infection control gave way to worries that the parent may not provide the correct care and the child may suffer (Brain & Maclay 1968). Parental involvement in their child's hospital care became more acceptable following government lobbying by psychologists and parent groups, however, nurses struggled to accept parental presence in the ward (McKinlay 1981a). Nurses were also reluctant to give up the parenting role to the child, believing that they were better caregivers than the child's own parents (Meadow 1969; Young 1992). Nurses were so resistant to parents' presence in the ward that they would continue to provide all the care for the child, leaving the parent to sit watching (Chenery 2001; Pill 1970).

Broad labour force and economic changes, including a registered nurse workforce and health rationing, and parents' demands to be more involved in healthcare (Boyers, Schwartz, Jones, Mooney, Warwick & Davis 2000), have led to the current situation whereby parents are actively encouraged to stay with their child to attend the child's many needs and to provide support for the child. Nurses have been required to move from providing all the care for the child, to gradually handing the personal care of the child back to the parent (McKinlay 1981a). In some areas parents are also expected to be involved in the delivery of technical care (Coyne 2007). Thus the nurse has a relationship with the parent, and needs to work alongside the parent providing the care of the child, requiring the parent(s) and the nurse to communicate with each other to ensure the child's needs are met.

In this study, the focus is on the interaction between the nurse and the parent of a child in the context and culture of hospital, particularly when the parent has emotional concerns. The ability of nurses to communicate effectively with parents of a child patient involves the need to respond effectively to parents in a variety of ways, including parents' emotional concerns (emotional communication). The term 'emotion' has a variety of meanings, often depending on context. In the next section of this chapter, the concept of emotion is analysed in order to fully explicate this term and its connotations.

Emotions

Human emotions are variously described in the literature. The root word of emotion is 'motere', a latin verb meaning to move, with the prefix 'e', meaning to move away (Goleman 1996), thus emotions are impulses to act. Defining emotion is also diversely reported. The Shorter Oxford English dictionary defines emotion as "any of the natural instinctive affections of the mind…which come and go according to one's personality, experiences and bodily state…mental feeling as distinguished from knowledge and free will" (Stevenson, 2007, p. 363); whereas Stedmans medical dictionary provides further explanation, defining emotion as "a strong feeling, aroused mental state, or intense state of drive or unrest directed toward a definite object and evidenced in both behaviour and psychological changes, with accompanying nervous system manifestations" (Dirckx et al. 2012). While there are other approaches to defining emotions, Lazarus' (2006) description of the 15 emotions humans experience; anger, envy, jealousy, anxiety, fright, guilt, shame, relief, hope, sadness, happiness, pride, love, gratitude and compassion is a useful account. When a child is ill, and then hospitalised, parents can experience emotions ranging from anger, fright, and anxiety to guilt (Hopia, Tomlinson, Paavilainen & Åstedt-Kurki 2005).

In this study focusing on emotional communication, it is valuable to consider the prevailing view of emotion in the health profession, and to consider the impact of these views in establishing health professionals' expectations about emotion. McNaughton (2013) has identified three main discourses relating to emotion. The first is physiological where emotions are located inside a person as a universally experienced bodily state. Within this view emotions are a natural part of our physical makeup, the result of biological and neuro-chemical responses; too many or too little expressions of emotion are "signs of trouble" (McNaughton 2013, p.73). The second discourse views emotions as skills to be learned, and emotions as observable behaviours which can be assessed. The final view described by McNaughton is emotions as a "socio-cultural

mediator" (McNaughton 2013, p.73), in which emotion is a set of practices constructed by social, cultural and political arrangements. McNaughton states that medicine has traditionally viewed emotion from the first and second discourses, as a result of biological and neuro-chemical responses, or as skills to be learnt, and argues that emotions are about social life rather than internal states. The view of emotion as part of "an analytic discourse of observation, reflection and interpretation in which emotion is identified as a medium of exchange at the interface between the individual and his or her social context" (McNaughton 2013, p.76) is espoused in this thesis. This view is based on the premise that when a parent experiences emotion, how they express that emotion and the responses to the emotion will be governed by the social and cultural context of the situation, in this circumstance, a children's ward.

In adult patient studies, the context of care and the cultural climate in which the care takes place shape both patients' emotional expression and nurses' emotional communication (Froggatt 1998; James 1989). Henderson (2001) observes that the circumstances of a particular nurse/patient encounter can encourage or impede levels of emotional engagement. Inevitably people react to their particular situation based on their previous experiences as well as the social, cultural and political context in which they find themselves (McNaughton 2013). Mesquita and Delvaux (2013) argue that emotional labour and emotional management can only be fully understood in connection with the cultural context.

Literature on emotion offers a myriad of descriptors for emotional management; these are worth exploring in order to reduce confusion. Pellitteri (2002) states that an ability to recognise emotions in oneself and others is emotional perception; whereas emotional regulation is the ability to monitor and alter the intensity and direction of an emotion in oneself and others.

Emotional competence requires self-awareness, mood management, self-motivation, empathy and managing relationships according to Wilson and Carryer (2008), which has similarities with emotional intelligence. Emotional intelligence comprises knowing one's own emotions, managing emotions, motivating self, such as emotional self control, recognising emotions in others, having empathy, for example, handling relationships and managing emotions in others (Goleman 1996).

Nortvedt (1998) describes emotional understanding as having two components; affectivity, the immediate affective response to encountering another's pain, such as

being moved by another's state, and cognition, interpreting a person's actual condition and experience of illness. All the above terms related to emotions; perception, regulation, competence, intelligence and understanding require emotional labour, which involves managing one's own emotional response to others, to shape and suppress feelings in oneself (Hochschild 1979). Emotional labour is a term coined by Arlie Hochschild in 1983, who defined it as a form of emotion regulation that creates a publicly visible facial and bodily display within the workplace (James 1989). Froggatt (1998) notes that emotions and feelings are usually private and hidden.

With regard to nursing practice and emotional labour, there is general consensus in the literature that emotional involvement with patients causes nurses a great deal of anxiety (Bolton 2000; Minto & Strickland 2011; Morse, Bortorff, Anderson, O'Brien & Solberg 1992), and managing emotions is a drain and a burden on nurses (Froggatt 1998). However, managing emotions is an important aspect of coping with difficult situations (Lazarus 2006), and nurses may have a role to play in assisting parents cope with their emotions during their child's hospitalisation.

Positioning the research

Parents have been allowed into children's wards in most of the western world since the early 1960s, initially to provide emotional support to their children (Hutchfield 1999). Parents are now welcomed and accepted into hospital with their children, and are expected by nurses to participate in the care of their child (Shields & Coyne 2006). Hospitals accomodate parents, to provide parents with beds, refreshments, and a lounge, for example. Models of care have been developed which are inclusive of parents, such as the family-centred care model (Kelly 2007; Shields, Pratt, Davis & Hunter 2007).

In New Zealand nursing education since 1995 has provided nurses with knowledge about interpersonal relationships, and working collegially with families. However, it is evident in the literature that nurses struggle providing parents the emotional support during their child's hospitalisation that parents want (Avis & Reardon 2008; Hallström, Runeson & Elander 2002a; Roden 2005; Widger & Picot 2008). A survey of young New Zealand nurses has found that nurses were stressed by the high levels of emotional challenge in nursing for which they felt unprepared (Clendon & Walker 2011). In keeping with the broader government agenda and professional standards, nurse-patient communication and family communication is imperative to the delivery of nursing care. Nurses are expected to interact with parents in a collaborative care

arrangement. These interactions are full of emotions, especially on the part of the parents. Nurses work in a specific context; in this case the context is a hospital ward. Hospital wards have cultures that are unique to each setting. Therefore it is timely to investigate nurses' and parents' experience of emotional communication and the environmental and cultural context within which the parent-nurse interaction occurs.

In the next section of this chapter, how I came to be interested in this topic and engaged in this study is described.

Developing the question

Research interest is often initiated by clinical experiences. I have been a registered nurse for 33 years. My nursing education in the late 1970s was hospital-based which involved being employed by a large hospital as a student nurse, and having a study day one day a month. I gained entry to the register of registered nurses with a hospital certificate. Communication and interpersonal skills were absent from the nursing curricula. Early in my nursing career I practised as a nurse/counsellor in a residential drug addiction programme. This work led me to undertake an extensive counselling skills programme which introduced me to interpersonal communication knowledge and practice. This new knowledge changed the way I approached my nursing practice, giving me a greater awareness of my own communication style and the impact it had on my communication as a health professional. I also became more sensitive and alert to others communication styles/approaches, and, on reflection, I gained emotional competence and a strengthened emotional intelligence.

Following this practice, I completed a Masters research which focused on nurses' understanding of parenting in the children's ward. One of the recommendations arising out of my study was that nurses need to acquire communication skills, especially in conflict resolution (Crawford 2000). At around that time, the teaching of communication in nursing undergraduate programmes became more explicit, and the Bachelor of Nursing programme in which I taught, undertook a curriculum review. As a result, two communication courses were introduced into the programme and I developed and taught in both of them. Student feedback about the knowledge they gained in these courses was positive, as was the feedback received about the students' practice from the clinical environment, especially in relation to students' interpersonal skills.

In the early 2000s I had two experiences as an inpatient in a hospital both as an acute patient in the general medical/surgical area. Nurses were kind to me, but were very

focused on the task at hand, and rarely lingered long enough to move past superficial conversations. Nurses also made assumptions about my needs, without checking them with me. In both situations it was other health professionals, rather than nurses, who attempted to gauge and to meet my emotional concerns. I also had an overnight stay in hospital with my then 17 month old child, and discovered for myself the experience of being a parent with a sick child in hospital. I felt exhausted most of the time, isolated and lonely, and craved for someone to share my concerns.

In 2006, I returned to clinical nursing practice, as a registered nurse in a children's ward. I tried to be an effective communicator within the general hospital setting, to focus on being with the patient, rather than doing for them. I found to my dismay that this was a struggle at times as my workload increased and there was always so much to do and so many demands on my time. I wondered how nurses could be effective interpersonally, and respond effectively to the multiple needs of parents and patients. I talked to colleagues about my concerns, and found they experienced similar issues; lack of time; lack of preparation for emotional communication, and lack of skills to manage potential issues that may arise.

This research was therefore approached with interest in ways nurses respond to parents' emotional responses, and parents' experiences of nurses' emotional communication in the culture and context of hospital care. My own observations and in reading relevant literature led to the view that nurses have difficulty responding to parents' emotional concerns, use strategies to avoid emotion in parents, and feel uncomfortable when faced with parents' emotional concerns (Espezel & Canam 2003; Papadatou, Martinson & Chung 2001).

Nursing communication

This discussion begins with an overview of nursing's historical background, providing a context for nurse-patient communication, and leads into the development of communication competencies for registered nurses. In this discussion the focus is on the situation in New Zealand, where this study has been undertaken. Nurses' understanding of theoretical concepts regarding interpersonal relationships is a relatively recent phenomenon in New Zealand. A history of nursing education in New Zealand, and the development of nursing competencies, including communication, helps unravel nurses education and professional development regarding communicating with patients, and thus nurses' responses to emotional communication.

In New Zealand, the first training school for nurses was established in 1884, based on the English Florence Nightingale system. These early schools for nursing were established in the Nightingale style, emphasising the tradition of tending for the sick as a calling and a "service of special value in the eyes of God" (Buckingham & McGrath 1983, p.11). In the nineteenth century, the character of the nurse, rather than their skills, was promoted.

Nursing education at that time promoted fear and submission to authority, echoing the reality for women at this period in western history (Johnstone 1994). Early nursing curricula in New Zealand included basic science, nutrition, body systems, and human growth and development. It lacked any reference to interpersonal communication.

While New Zealand education and practice remained embedded in duty and submission, in the USA new ideas were emerging. In 1952 Hildegard Peplau presented her thoughts on nursing in a text for nurses, Interpersonal Relations in Nursing. In 1991, Peplau recalled that in the 1950s she believed that theories of interpersonal relations were relevant to the work of nurses, suggesting that "interaction phenomena occurring during nurse-patient relationships have a qualitative impact on outcomes for patients" (Peplau, 1991, p.v). Peplau recognised that nurses wanted to improve their understanding of interpersonal relations in nursing and her work gave nurses knowledge to understand and improve communication within the nursing profession. Twenty years later, Joyce Travelbee, also from North America, discussed nurses using their personality and knowledge to effect change in the ill person, and coined the phrase "therapeutic use of self" (Freshwater 2002). Travelbee posited "communication is a process which can enable the nurse to establish a human-to-human relationship and thereby fulfil the purpose of nursing" (Travelbee 1971, p.93).

Despite the advancement of new ideas in the northern hemisphere, within nursing practice in New Zealand little had changed. A survey in 1989 undertaken to describe the nature and organisation of nursing practice within hospital settings (Walton, 1989) found that only 6.5% of participants thought communication was the most important part of their work as a nurse.

Development of communication competencies

By 1994, changes in nursing education and practice were initiated. The Nursing Council recognised the need to develop a general set of competencies/standards for

registration (Nursing Council of New Zealand, 1994). Communication was one of those competencies. One driver in the development of communication competencies was changes in the nurse-patient relationship in the early 1990s, brought about by nurses advocating for patients, and changes in nursing delivery, such as primary nursing, in which nurses cared for individual patients, rather than delivering tasks to a number of patients (Porter 1998). The previous authoritarian nature of the nurse-patient relationship was being replaced by a friendlier, more relaxed atmosphere, in which patients were encouraged to question care and to communicate openly with the nurse (Porter 1998). Nurses therefore needed to be able to manage their communication with patients.

In 2001, the Nursing Council were advised that people skills were essential for nurses in the future, including: "the ability to communicate, consult and negotiate, to understand others points of view" (KPMG Consulting, 2001, p.45). Legislation passed in September 2003, (the Health Practitioners Competency Assurance Act 2003) which enabled Nursing Council to require evidence of competence to issue the annual practising certificate. Within the registered nurse scope of practice, four domains of competence were established; professional responsibility, management of nursing care, interpersonal relationships and inter-professional health care and quality improvement (Nursing Council of New Zealand 2007). Within the domain of interpersonal relationships there were three specific communication competencies: establishes, maintains and concludes therapeutic relationships with client, practises nursing in a negotiated partnership with the client where and when possible, and communicates effectively with clients and members of health care team (Nursing Council of New Zealand 2007). The only reference to communicating with family is in the second competency, which notes that the registered nurse will "acknowledge family/whānau[1] perspectives and supports their participation with services" (p. 26). This document signalled evidence of the burgeoning importance of interpersonal relationships in nursing.

Nursing in New Zealand had moved from a situation in which interpersonal skills were rarely discussed in education or practice, to the present in which nursing students are constantly and consistently evaluated on their interpersonal skills, and nurses in

[1] Whānau: central structure of Māori society, includes extended family and/or social structures such as school or church groups (Kidd, Butler & Harris 2014).

practice are required to provide evidence for meeting a range of indicators within the interpersonal relationships domain, one of which focuses on the wider family.

Under the legal framework of the Health Practitioners Competence Assurance Act 2003, the Nursing Council requires all nurses to "acknowledge family/whānau perspectives and support their participation" (Nursing Council of New Zealand 2007, p.26). The remainder of the competencies and indicators in the interpersonal domain of the competencies for registered nurses make reference only to the health consumer, defined as "an individual who receives nursing care or services…represents a patient, client, resident or disability consumer" (Nursing Council of New Zealand 2007, p.33).

Within child health, a model for practice is family-centred care which revolves care around the whole family, and regards the family as care recipients (Coyne, O'Neill, Murphy, Costello & O'Shea 2011). If a nurse is practicing in a clinical environment which is underpinned by the family-centred care model, the parent will also be regarded as the health consumer, the care recipient. If however the health consumer is only regarded as the child patient, with the parent outside that framework, the sole Nursing Council competency referring to parents of a child in hospital is acknowledgement and support.

This section of the chapter has provided a brief overview of the development of communication competencies for the registered nurse in New Zealand. Prior to 1995 there were no specific competencies for registered nurses at entry to practice, and since 2003 ongoing competencies in interpersonal communication have been required at entry to practice, and ongoing whilst in practice. It is, therefore, only in the past ten years that registered nurses have been legally required to demonstrate ongoing interpersonal competence in New Zealand. As 39% of registered nurses in New Zealand are over 50 years old, and 35% of all registered nurses gained their registration with a Hospital Diploma (Nursing Council of New Zealand 2011a), prior to the commencement of interpersonal competencies for the registered nurse scope of practice, many nurses practising in New Zealand completed their nursing education with minimal focus on interpersonal communication. Those registered nurses currently practising, who did not have any specific learning in communication in their education, have had to rely on professional development sessions provided in their place of work, to improve and up-skill their competence in this area.

In this study, the focus is on one aspect of communication; emotional communication, with a further emphasis on the interaction between nurses and parents of a child in hospital, within the culture and context of an inpatient hospital ward. Nurses are legally required to acknowledge family and support them, and parents in hospital are in need of nurses' support. This study provides an opportunity to further nursing knowledge on this central aspect of nursing practice.

Organisation of thesis

Chapter One provides the context and background of the study. The aims and significance of this thesis are followed by an exploration of emotions and nursing communication to introduce the topic and provide the reader with an overview of both concepts. The position of the research and how the question developed is outlined. The development of nursing communication through education and practice demonstrates that learning about the importance of communication in nursing, and some specific communication competencies are relatively recent in New Zealand.

An overview of the thesis and notes on style and a glossary of words are provided.

Chapter Two provides an outline of the extant literature on the topic of emotional communication between the participants of a healthcare episode involving patients, parents and nurses. The chapter begins with a discussion of the history of nurse-parent communication, and a description of nurse-parent models of practice. The chapter also encompasses patient/parent perspectives on communication with nurses, and themes arising from the literature. While the literature includes identification of some of the difficulties inherent in emotional communication from both the nurses' and the parents' perspectives, the gaps in our current knowledge are identified and provide rationale for the current study. Limitations regarding methods used in the reviewed literature also offer reasoning for the method choice in this study.

Chapter Three describes the research methods used in this thesis, namely a focused ethnography with an interpretive lens (Hammersley & Atkinson 2007; Morse 1994). This chapter details the decision processes undertaken to choose the research method. Describing the method gives an opportunity to review the research process, and provide an auditable route from beginning to end point of the study. Ethnography as a method is proven able to uncover and illuminate knowledge about nurse-parent interactions, and specifically the cultural processes surrounding those interactions.

Chapter Four describes the research setting, the children's ward of a regional hospital in New Zealand. A description of the physical environment, including population, structures, and organisation precede a discussion of the ward culture. This chapter provides the context of the study, the cultural environment in which nurse-parent emotional communication occurs, thus focusing on the ethnographic question "what's going on here?"

Chapter Five provides parents' perspectives of the children's ward, documenting parents' journey through the hospital experience; their expectations of nurses, with a final focus on parents' experiences of emotional communication with nurses.

Chapter Six focuses on nurses' experiences of emotional communication in the ward. The chapter is divided into two main sections: nursing in the ward and nurses' relationships with parents. Highlighted in this chapter are the dichotomy between nurses' positive views of working in the ward, especially the supportive nature of nurse-nurse relationships, with the problematic relationships nurses have with parents.

Chapter Seven details the nurses' experience of emotional communication with parents in hospital. Nurses' understanding of why parents may be emotional is outlined, nurses' responses to parents' emotional communication and finally nurses' perceptions of why they avoid emotional communication.

Chapter Eight is the discussion chapter, emphasising the salient features of the results chapters, and the relationship of those findings with extant literature. With a continued focus on the study objectives, the discussion highlights the significant study conclusions and draws on a synthesis of relevant and current knowledge as reflected in the literature. Recognition that the ward and nursing culture influence and shape nursing behaviour and affect, especially with regard to emotional communication is affirmed.

The final chapter, **Chapter Nine,** concludes the study. The central thesis is outlined; parents want emotional communication with nurses, and nurses struggle to acknowledge, confirm and respond to the emotions experienced by parents. The context and culture of a hospital ward influence nurse-parent engagement in such a way as to either impede or broker emotional support, thus emotional communication impacts on health experiences. Two conceptual models which arose from the results are presented: firstly, a diagrammatic representation of the findings of the study and

secondly, a future representation of the possibilities of culture shaping practice. The three broad findings from any research: the implications for practice, research and education will also be discussed in this chapter. Limitations of the study are noted, followed with a reiteration of the knowledge gained about this phenomenon, with a particular focus on "so what?" and "where to now".

Notes on style and language

Use of italics and quotations

Square brackets [...] are used to include words added to direct quotes to aid meaning, such as "*Mum appeared at office at 0230 shaking and crying. She voiced her concerns about* [name of child] *and how* [child] *would react to this. Mum also reported she was awake worrying about* [child's] *heart "stopping" and her electrolytes being "unbalanced".*

Words in italics are verbatim comments from participants.

Glossary of terms

Context: "provides the framework in which to understand cultural beliefs and practices…includes cognitive, symbolic, structural, and environmental elements relevant to a particular setting or situation" (Wenger 1995, p. 4)

Culture: "acquired knowledge that people use to interpret experience and generate social behaviour" (Spradley 1979, p. 5). Also patterns of behaviour, artefacts, and knowledge that people have learned or created, the organisation of things, and the meanings people give to objects (Cox 1987).

Emotional communication: communication between the nurse and the parent which focuses on the parent's feelings and affective responses related to their child's hospitalization.

Māori: indigenous population of New Zealand, comprising 24% of total population

Māori language is an official language in New Zealand, and is used as the first and second language of indigenous and non-indigenous people in New Zealand.

Marae: Māori word for the area people gather, usually including a sleeping area, eating area, and gathering area. The Marae is a communal area and is a sacred place.

Pacific: people who have immigrated to New Zealand from Pacific Islands close to New Zealand such as Nuie, Tonga, Western Samoa, and Rarotonga

Pākehā: a person who is not of Māori descent, a white person living in New Zealand

Parent: a parent or the child's primary caregiver (such as grandparent, other family member, foster parent).

Whānau: central structure of Māori society, includes extended family and/or social structures such as school or church groups (Kidd, Butler & Harris 2014).

Chapter summary

In this chapter the central concerns which have led to this study being undertaken have been asserted. Nurses practice alongside parents of children in hospital, within the confines of an inpatient hospital ward. The relationship between the nurse and parent has an impact on both nurses' and parents' experiences, as well as the child's care. Parents encounter a range of emotions during their hospitalisation, and nurses' responses to those emotions affect the parent and the nurse. The close relationship between the child and parent reinforce the imperative to improve the parent's experience of their hospital encounter. The culture and context of the ward is relevant to emotional communication as it can influence how people within the environment engage with each other. In the following chapter, the literature review provides a comprehensive review of the current knowledge of emotional communication.

Chapter 2: Literature review

Introduction

In this chapter the extant literature on the topic of emotional communication between the participants of a healthcare episode involving patients, parents and nurses is discussed. The chapter begins with an overview of the history of nurse-parent communication, followed by a description of nurse-parent models of practice. The discussion encompasses patient/parent perspectives on communication with nurses, and themes arising from the literature. The purpose of a review of the literature is to convey what is currently known about a topic in order to identify any shortcomings in the knowledge (Burns & Grove 2009). Reviewing the literature provides an opportunity to argue the importance of this research topic, as well as supporting the use of the methods used in this study. The reviewed literature on method and research content indicate limited understanding on how cultural context affects interactions between parents and nurses.

Literature for this review has been widely sourced using specific nursing databases: C.I.N.A.H.L., Cochrane Library, Joanna Briggs, ProQuest Central, Science Direct and Scopus. A manual search was also undertaken, accessing references in journal articles that were located and chosen. There were no year parameters on the literature searched. Key words guiding the original search were: *nursing communication; nursing communication with patients; nursing communication with patients with emotional needs*. To understand the intricacies of nurse-parent communication in the children's ward, the nurse-patient literature was explored to consider the nurse in a relationship trying to help an adult patient in hospital, thereafter called the patient. The review was then narrowed looking specifically for literature exploring nurses' experience of emotional communication with patients. A further refinement occurred when the topic emphasis changed from nurse-patient communication to nurse-parent communication. Key words used at this stage of the search were *nurse, communication or interaction, nurse-parent interaction, emotional communication.* The only exclusions to the search were that the studies had to be in English.

The literature was critiqued using critical review guidelines for quantitative and qualitative studies as suggested by Schneider, Whitehead, Lo-Biondo-Wood and Haber (2013) and Schneider, Whitehead, Elliot, LoBiondo-Wood and Haber (2007). The guidelines enabled questions to be asked of the studies reviewed, specifically

focusing on the title and abstract, the structure of the study, the sample, data collection and analysis processes, and findings.

Historical background of nurse-parent relationships in a children's ward

In this section of the review, the history of nurse-parent interactions in a children's ward are outlined, followed by an overview of nursing models of care for families in hospital. This historical overview has been sourced predominantly from western-based literature as this is where most of the literature describing the care of children in hospital has originated.

In the developed world, prior to the mid-19th century, family members, including children who were ill, were cared for at home by family and/or friends (Nethercott 1993). Hospitals were mainly for the poor, as the rich had the resources to be cared for at home (Anstice 1970).

The first hospitals for children were foundling hospitals for infants who had been abandoned by their families. However many babies admitted to these hospitals died of gastro-enteritis caused by cross-infection (Stapleton 1963). The response of health professionals to the problem of cross-infection was to isolate the child from everyone. General hospitals for sick children and adults were first built in the mid-19th century, and following a child's admission, parents moved from provider of care, to observer of care, but only when sanctioned into the hospital by hospital staff (Young 1992).

If a parent was allowed to visit, they sat with their child, while the nurse undertook all the care the child needed. There were some exceptions to this norm however. In the United Kingdom in 1925, Sir James Spence founded the Babies Hospital whereby the mother cared for the baby, with no nurse involvement (McCarthy, Lindsay & Morris 1962). This idea was quickly adopted by Dr. and Dr. Pickerill in New Zealand in 1927, a husband and wife plastic surgeon team who established a unit for mothers and babies at Wellington Hospital, as a means of countering cross infection (McCarthy et al. 1962). The Pickerills later opened their own hospital in Wellington whereby mothers undertook all the care of the child. The rationale for this scheme was that babies were born with passive immunity to the mothers' organisms, acquiring further immunity over the next few months, thus with the elimination of multiple nurses caring for the child, there would be less exposure to other organisms (Pickerill & Pickerill 1945). The Pickerills noted that mothers and babies were much happier being together than apart and also that

they had no cross-infection in the Unit (Pickerill & Pickerill 1954). Drs. Spence and Pickerills had different beliefs from the prevailing view of the time, and the wherewithal to follow through in those beliefs. Despite these successes, the conviction in the health sector was that children in hospital should be admitted on their own, with parents given visiting rights according to hospital policy.

By 1952 in the United Kingdom (UK), 300 out of 1300 hospitals that admitted children permitted daily visiting, and half the hospitals prohibited any visiting at all (Stapleton 1963). Cross-infection was a major contributor to visiting prohibitions. Prior to World War Two and the advent of antibiotics, diseases such as tuberculosis and polio were significant causes of morbidity and mortality, therefore maintaining strict infection control was paramount (McKinlay 1981b).

Another motive for parental exclusion was health professionals' beliefs that they were better caregivers of sick children than parents (Palmer 1993; Young 1992). According to Young (1992) this idea was prevalent because most nurses came from the upper middle classes, whereas the children they were caring for were often impoverished; and the wide social gulf between the nurse and the child led to a view that health professionals provided better care. Other factors affecting parental absence were the lack of acknowledgement of children's rights, lack of space for parents as children were cared for in adult wards, and parental lack of transport to often inaccessible hospitals (Cleary 1992).

Change to parents' exclusion from the ward was driven by a number of factors. The upheaval of World War Two led to many children being separated from their parents, and the effects this separation had on children were evident. Studies into the destructive effects of institutionalisation on children by psychiatrist John Bowlby in the late 1940s (Bowlby 1952), began a revolution in the way care of children in hospital was to be delivered. In 1952 Bowlby's colleague, British psychiatric social worker and psychoanalyst James Robertson produced a two minute film titled 'A Two Year Old Goes to Hospital', showing a happy, well-adjusted child being separated from parents and becoming a withdrawn, unhappy child (Bretherton 1992). Initially the film was revealed to health professionals only, then the film was shown on public television in 1961 in the United Kingdom, sparking public debate and leading to the founding of the National Association for the Welfare of Children in Hospital (now called Action for Sick Children) in the UK (Robertson 1970). A further factor influencing change in practice was that antibiotics were more readily available, leading to less need for isolation and

exclusion of outsiders (Cleary 1992). Researchers in the USA in 1953, (Prugh, Staub, Sands, Kirshbaum & Lenihan) demonstrated that more frequent visiting in hospital did not increase the risk of infection.

Instigated by these events in 1959 was a report commissioned by the British Government: The Welfare of Children in Hospital, (also known as the Platt Report, 1959). This report made a number of recommendations including: parents visiting children in hospital should be unrestricted, mothers should be able to be admitted with children under the age of five years, and parents should help as much as possible with the care of their child (McKinlay 1981b). The recommendations highlighted the recognition that children, especially young children, had emotional needs in hospital that could be relieved or lessened by the presence of a parent or primary caregiver (Hutchfield 1999). The Platt Report recommendations were adopted by the British government, and eventually filtered through to other countries in the western world, including New Zealand (McKinlay 1981a). By 1961 the New Zealand Government surveyed New Zealand hospitals and suggested that "there may be scope for some of the recommendations made in this report (Platt) to be adopted with advantage in this country" (Department of Health 1961). The survey also enquired about hospital policies in respect to child patients, item three of which was the visitors and visiting hours in children's wards (Department of Health 1961). As a result of these actions, parental visiting became more relaxed than previously, but visiting hours in children's wards remained rigidly imposed (McKinlay 1981a).

Health professionals struggled with how to fit in and manage parents in hospital. In New Zealand in 1963, a conference was held for professional groups, organised by the Canterbury Mental Health Council as contribution to the World Mental Health Year 1961. A professor of child health from Sydney, Australia noted that rather than being a parent substitute "nurses… realized that a large part of the child's treatment is treatment of the parents, … [was] education and reassurance" (Stapleton 1963, p.142). At the same conference a nursing tutor sister from Christchurch hospital New Zealand, Nan Kinross, was reported to have stated that nurses' reluctance to encourage parents visiting in hospital was because of cross-infection concerns, and also that nurses were meeting their own maternal instincts by taking over the mothering when a child was in hospital (Stapleton 1963).

Progress toward more parents accessing hospital and staying with their unwell child was slow (Darbyshire 1994). Nurses were particularly resistant to parents residing in

hospital with their child. A study in the U.K in 1968 evaluating claims that mother and child units were beneficial for children (Brain & Maclay 1968), found that senior nurses had initial doubts about the advisability of admitting mothers with children, and following the study, which involved mothers staying with their child in the ward, nurses were unanimous that they preferred children to be admitted on their own. Nurses' reasons for excluding parents were that it was easier to carry out nursing procedures when a child was alone, nurses were able to make more personal contact with children who were unaccompanied, and a few mothers were difficult and upset their own children and other mothers on the ward (Brain & Maclay 1968).

In New Zealand, a parent of a child in a hospital ward in the 1960s recalled that "abiding by the rules" was the dominant concern for parents (Chenery 2001, p.58). Parents felt like "interlopers" (Chenery, 2001 p. 71) as nurses and other staff worked around them, excluding parents from assisting with the care of their child. By that time there had been some relaxing of visiting hours, now parents were allowed to visit between 11am and 6pm, but parents were visitors only, and were not allowed to participate in any care of the child (Chenery 2001). Stapleton noted in 1963 that ward sisters believed that visiting time made their work more difficult.

A study in Wales, UK which aimed to establish inhibitors to living in a ward or visiting by a parent, and in which 32 children and mothers were interviewed and observed between 1965 and 1966 (Pill 1970), found that nurses' main contact with children was when undertaking basic nursing, such as washing, dressing and serving meals. Mothers were not permitted to undertake any routine care of the child and a mother would be observed sitting watching the nurse wash the child (Pill 1970).

A number of pressure groups developed to lobby for and encourage more parental involvement in their child's care. As well as the U.K. National Association for the Welfare of Children in Hospital (Stacey, Dearden, Pill & Robinson 1970), in Wales, parents formed the Association for the Welfare of Children in Hospital (Stacey et al. 1970). In New Zealand a group called the Working Party for Children in Separation was formed in 1974 following the visit to New Zealand by James (producer of a number of films about children in hospital including 'A Two Year Old Goes to Hospital') and Joyce Robertson of the Child Development Research Unit, Tavistock Institute of Human Relations, London (Children in Separation 1977). The Robertsons highlighted the need for children to make a close bond with one caring person (McKinlay 1981a). The Working Party for Children in Separation lobbied the New Zealand government for

better parental access to their hospitalised child (Children in Separation 1977), made representations to the Minister of Health, and contacted agencies involved with aspects of the hospitalisation of children. They also developed a brochure for the use of parents in preparing their child for a hospital stay (Children in Separation 1977). As a response to this lobbying in 1974 the New Zealand Health Department sent out a letter to hospital boards encouraging them to work towards the implementation of the aims of the Platt Report (McKinlay 1981a). Despite such government remits, the prevailing view of health professionals in inpatient children's units that parents were a hindrance to the provision of care remained.

Nonetheless there were nurses who refuted the established view that parents (usually mothers) were unwelcome with their children in hospital. By 1975 in New Zealand, McNeur, a ward sister in a children's ward, described her experiences of free visiting day and night, and rooming-in to parents of children under five years. She found that it was the parents who needed more care than the children at times (McNeur 1975), and went on to note that "if the parents are being awkward and difficult they usually have good reason and it is worthwhile getting to know them and making them feel accepted in spite of their difficulties" (McNeur 1975, p.20).

General acceptance of these changes continued to be slow (McKinlay 1981a). In New Zealand, Litchfield (1974) observed that it was accepted practice for parents to leave their child in hospital to the care of total strangers and hand over their child's responsibility. According to Litchfield, parents were left feeling guilty and anxious, doubting their ability as parents. Similarly in the U.K., Webb (1977), writing about experiences as a mother with her 11 month old child in a UK hospital, described having her child taken away from her, and listening to his screams for hours as burns dressings were changed. Other parents were seen in the ward to be in a distressed state, crying openly, and nursing staff were noted to avoid these parents (Webb 1977). Webb described parents' acceptance of written and unwritten rules about how to behave in the ward, believing that if they were a good parent and helped where they could, and did not cause any problems, they were ultimately helping their child get better.

By 1982 Casey and Whiley (1984) reported that the New Zealand Board of Health Report on Child Health and Child Health Services in New Zealand 1983, had noted that while some paediatric wards provided good living-in facilities for parents, others did not, and that conditions "lacked convenience and dignity for mother and child" (p. 22). The

Board of Health Report had recommendations specifically relating to nursing; noting a lack of understanding of children's health needs, gaps in nursing education, lack of adequate facilities for children in hospital and fragmentation of health services (Casey & Whiley 1984). The majority of nurses continued to believe that parents disturbed both the hospitalised child, and the efficiency of the ward (Casey & Whiley 1984).

In 1981 an extensive study was undertaken in New Zealand, examining different ways in which medical and nursing staff defined the mother's involvement in their child's hospital care, and the value they placed on the experience of mothering in the ward environment and to their own identity as professional carers (McKinlay 1981b). Health professionals' experiences were compared with the experiences of mothers in hospital with their child(ren). Twenty-three out of 75 hospitals offering inpatient care for children were visited during the study, with researchers speaking to 33 paediatric charge nurses, 12 nurses, 16 principal nurses, 18 paediatricians, 23 medical superintendents and an unspecified number of mothers of children. McKinlay found that the overriding belief of health professionals was that parents could make children more distressed and even make them sick (McKinlay 1981b). McKinlay observed tension in the ward between nurses and mothers, noting that accepting untrained mothers as caregivers made nurses uneasy, with mothers carrying out tasks that nurses believed nurses were trained to do. Nurses felt they needed to justify their status as a health professional by showing expertise mothers did not have (McKinlay 1981b). Mothers reported not knowing the rules of the ward, or what was expected of them. They had serious concerns about not getting enough information and also described being very bored (McKinlay 1981b).

This historical overview of nurse-parent relationships in the children's ward from the mid-century, when children were first admitted into hospitals in the western world, until the early 1980s, has demonstrated general reluctance by nurses to accept that parents needed to be with their child in the ward. Nurses had a number of concerns about parents' presence in hospital, including the risk of cross infection (Stapleton 1963); health professionals belief they were better at caring for sick children than parents (Palmer 1993; Young 1992); a belief that parents made children more distressed (McKinlay 1981a); nurses' own need to provide maternal care (Stapleton 1963); a belief that parental presence made it difficult to undertake procedures on children and some parents upset other parents (Brain & Maclay 1968); and that parents disturbed the efficiency of the ward (Casey & Whiley 1983). Despite government and parent

group lobbying, health professionals acceptance of parents into hospital with their child continued, albeit slowly.

Parents who were allowed into hospital described feeling guilty and anxious (Litchfield 1974); feeling like a hindrance (Chenery 2001), were not allowed to be involved in their child's care (Pill 1970); were bored (McKinlay 1981b) and were avoided by nurses (Webb 1977). Mothers did not know what they were allowed to do, and perceived that information about their child was withheld from them (McKinlay 1981b). Parents described trying to get on side with nurses, to be perceived as good parents in order for the child to get better (Chenery 2001; Webb 1977). The discord between parents and nurses centred on the parents' presence in the ward.

By the early 1980s, the prevailing belief amongst health professionals that children were better off in hospital without their parent(s) was beginning to wane, largely as a result of governmental pressure, parent group lobbying, and evidence from some hospitals that parent presence did not make the child sicker. Largely absent from the literature is any acknowledgement or discussion of the needs of the parents accompanying their child. Now that parents were in hospital, the next stage of the process of nurse-parent relationship, whereby nurses and parents were required to live and work alongside each other in the ward, heralded the advent of family-centred care and parental participation in care.

Parent participation to family-centred care

By the 1980s, the children's ward was very different to previous eras, and also developed a culture that was distinct from adult wards. Open visiting, that is allowing parents to visit at any time, and the constant presence of parents had changed the environment considerably. The wards were now noisy, sometimes chaotic, and lacked the organisation of a ward that was predominantly peopled by hospital staff and adult patients. As a result of parent lobbying and governmental requirements, parents in hospital wanted to be more involved in the care of their child in hospital (Boyers et al. 2000). The term 'parent participation' arose from the Platt Report (1959) and established that the child in hospital needs their parents' presence and participation in their care (Coyne 2007). In the early 1960s, central to parent participation was the idea that parents would be involved in the care of their child in hospital, mainly to provide the child emotional support (Coyne 1996).

Parent participation is described as the central tenet of paediatric nursing (Corlett & Twycross 2006; Coyne 1996; Coyne & Cowley 2007), and its meaning ranges from encouraging parents to stay with their child in hospital, involvement of parents into decision-making regarding their child's care and involvement of the whole family as a unit of care (Coyne 1996). Nethercott (1993, p.795) noted that "parent participation assumes rather than assesses the care to be provided by the family". Over time the term that related to parent participation changed from parental involvement, to partnership in care, to care by parent and most recently family-centred care (Coyne 1996). However Gill (1993) noted that parent participation was only one aspect of family-centred care and later Lee (2005) stated that partnership-in-care is part of the spectrum of family-centred care.

According to Espe-Sherwindt (2008), family-centred practice was originally mooted in the 1950s in the USA, notably amongst families with a child with a disability, and did not become widespread until the late 1980s. Family-centred care is defined as "a philosophy of care in which the pivotal role of the family is recognised and respected...in which families should be supported in their natural care-giving and decision-making roles...in which parents and professionals seen as equals" (Brewer, McPherson, Magrab & Hutchins 1989, p.1055). Nethercott (1993) describes family-centred care as care in which the family is viewed from a social, cultural and religious context; and roles of family members are evaluated to provide support for their physical and emotional needs. Family-centred care is a process in which the child and family are professionally supported in their journey through hospitalisation (Kelly 2007). Shields et al. (2007, p.2) note that the "foundation for family-centred approach ... is the belief that a child's emotional and developmental needs, and overall family wellbeing, are best achieved ... by involving families in the plan of care".

Ann Casey, a British nurse, developed a partnership model for paediatric nurses, encouraging nurses to focus on the structure, relationships, and forces affecting the family, but only as they affected the family's ability to care for their child in hospital (Casey 1988). In Casey's model, the family are the providers of child care, with the nurse assisting as required (Coyne 1996). However as Coyne (1996) argues, Casey's model contradicts the tenets of parent participation when nurses are only concerned with the family as carers of the child, rather than the nurse entering into a relationship with the family.

Acknowledging that the continuous involvement of the family is an integral element of the concept of parent participation and family-centred care, the implementation in practice has been problematic and difficult at times (Boyers et al. 2000; Darbyshire 1995; Gill 1987; Shields, Kristensson-Hallström & O'Callaghan 2003). In a study aimed at testing the elements of a family-centred philosophy at a medical centre, Boyers et al. (2000) found prohibitive factors to the implementation of family-centred care included: nurses' lack of knowledge regarding family-centred care, lack of organisational support for family-centred care, and staff perception that working collaboratively with families was inconsistent with or a threat to professional identity. A 2007 study by Coyne investigating parents' participation in their hospitalised child's care found that nurses expected parents to stay with their child and provide emotional care, child care and some nursing care for their child; and also expected parents to be co-operative, helpful and undemanding, to follow instructions and get involved in care (Coyne 2007). A further study by Coyne et al. (2011) into the meaning of family-centred care to nurses, found that nurses had difficulty supporting and facilitating parent participation in care because of their concerns about parents' abilities to perform care and be accountable, threats to nurses' loss of professional authority and role blurring, feeling intimidated by parents and fear of losing power and control. Kelly (2007) noted that other barriers to nurses implementing family-centred care were assumptions made by nurses that parents wanted to participate in their child's care without negotiation, and that nurses were concerned about parents' ability to carry out complex care and were unwilling to relinquish control over the child's care. In addition, nurses expected parents to be present and cooperative, to follow instructions and be actively involved in their child's care, when in reality parents felt stressed and anxious about caring for their child, in case their lack of experience harmed their child (Shields & Coyne 2006).

Darbyshire (1995 p. 33) noted that parent participation and family-centred care were "socially created phenomena...influenced by understandings, perspectives and practices of both parents and nurses". The public nature of parenting in hospital, and nursing children in hospital, was fraught with difficulty for participants in Darbyshire's 1994 study which examined parents' and nurses' perceptions of parenting in hospital. In a 2000 study into the different aspects of parental participation in hospital, Kristensson-Hallström found that when parents participated in their child's care by taking responsibility for feeding or hygiene, nurses were reluctant to relinquish control and responsibility. In Australia in 2005, Paliadelis, Cruickshank, Wainohu, Winskill and Stevens explored nurses' perceptions of their inclusion and involvement of parents, and found that nurses had a protective, paternalistic role which motivated them to

exclude parents at times. Nurses wanted to retain their professional role and felt threatened by parents' presence.

Despite accepting in theory the philosophy of parent participation and family-centred care, nurses have difficulty putting the philosophy into practice (Coyne et al. 2011; Mikkelsen & Frederiksen 2011; Paliadelis et al. 2005; Shields, Young & McCann 2008). Parents have consistently stated that they want to be involved in their child's care, but on their own terms and after negotiation with nurses (Corlett & Twycross 2006; Kristensson-Hallström 2000; MacKean, Thurston & Scott 2005; Power & Franck 2008; Shields et al. 2003). Major factors which have led to parent participation and family-centred care not working in practice include: nurses feeling threatened with a loss of professional identity (Boyers et al. 2000; Coyne et al. 2011; Espe-Sherwindt 2008; Gill 1987; Paliadelis et al. 2005); paternalistic attitudes towards parents (Coyne et al. 2011; Paliadelis et al. 2005); and concerns about parents' ability to provide care to their child (Boyers et al. 2000; Coyne et al. 2011; Kelly 2007). The history of nurse-parent relationships in a children's ward has led nurses to regard family-centred care as encouraging parents to take responsibility for that part of the child's care that nurses do not consider nursing, rather than the development of a collaborative nurse-parent partnership (MacKean et al. 2005).

Family Partnership Model

A further concept in parent participation is the Family Partnership Model, a multi-disciplinary model, focusing on interacting with families and increasing skills of staff, and improving staff communication in order to work with families (Braun, Davis & Mansfield 2006; Wilson & Huntington 2009). Within this model nurses, along with other health professionals, and parents work together collaboratively, enabling parents to improve their problem-solving abilities, thus improving their self-esteem, self-efficacy and interactions with their children (Keatinge, Fowler & Briggs 2007).

The Family Partnership Model has been used in the UK since the 1980s and was introduced to New Zealand by a Well Child provider in the community (Wilson & Huntington 2009). It is anticipated that nurses using this model will have an enhanced ability to communicate with patients and families, as it builds on communication skills in order to improve existing family support services (Wilson & Huntington 2009), however the model has yet to make an impact on the relationship between nurses and parents in hospital in New Zealand.

In this early section of the chapter, a historical overview of parents' presence in hospital with their child, followed by the rise in parent participation in hospital, is evidenced in the literature. Early history of parents' presence in hospital with their children was difficult for both parents and nurses (Palmer 1993; Stapleton 1963; Young 1992). Parents' desire to be with their child led to more parent participation which evolved into family-centred care. Authors have argued that parent participation/family-centred care is a complex concept and often difficult to implement in practice (Coyne et al. 2011; Mikkelsen & Frederiksen 2011; Paliadelis et al. 2005; Shields et al. 2008). Parent participation and partnership involves a relationship between nurse and parent, and human relationships always involve communication. Therefore in the next section of the chapter the combined nurse-patient/parent literature explaining interactions and communication is reviewed to enable better understanding of the nurse-parent complexities. The review highlights literature mainly from the early 1980s into the present.

Nurse-patient/parent communication

Before considering the nurse-patient or parent communication literature, general models of communication are presented, with the purpose of gaining an understanding of the phenomenon that is interpersonal communication in order to better locate emotional communication as part of this broader activity.

Communication models/frameworks

Communication between two or more people is a multifaceted construction, and models have been developed to try and reduce this complexity (Northouse & Northouse 1998). There are numerous communication models, any one of which a nurse could use to frame nursing care. One commonly known model is the Therapeutic model, which "emphasised the important role that relationships play in assisting clients and patients ... to move in the direction of health" (Northouse & Northouse 1998, p. 12). This model was influenced by work by psychologist Carl Rogers (1951) who proposed that practitioners need to be client-centred, using empathy, positive regard and congruence. Rogers established that therapeutic communication would enable the client to uncover their own worries, and, in doing so, feel understood and able to manage their own concerns (Rogers 1951).

Another model used in health care is the King Interaction model which focuses on interpersonal systems in healthcare. This model describes the interaction between nurse and patient as a cycle, whereby initially both make judgements about the other,

based on their perceptions of the situation. These judgements lead to actions which stimulate a reaction in the receiver, whereby new perceptions are made (King 1981).

Other writers prefer to describe the nature of the relationship between the nurse and the patient, rather than a model of practice. Balzer Riley (2000) discusses the helping relationship, which she differentiates from a social relationship, noting that the former is established for the client's benefit, to help the client achieve and maintain health. The idea of the nurse as helper has been taken much further by Egan (2014) who developed the Skilled-Helper framework, which has three stages: reviewing the current situation, developing a preferred picture and helping clients get where they want to be. Another approach is to focus on the skills of the nurse, such as communication competence, as described by Stein-Parbury (2014). Communication competence requires the nurse to have two specific skills: responsiveness and assertiveness. Stein-Parbury (2014) suggests that nurses who have high levels of assertiveness and responsiveness are able to express themselves and listen to others.

Egan (2014, p.220) notes, "all worthwhile helping frameworks, models or processes…help clients ask four questions: what's going on? what does a better future look like? how do I get there? and how do I make it all happen". The models described are some of the ways authors have attempted to explain the complexities of the helper/nurse-patient interactions. They were chosen as they all provide ways of discerning the interpersonal relationship between the nurse and patient. Both patients and parents of a child in hospital look to nurses for help, and rely on a connection with them in order to facilitate the journey through this phase in their lives. The interpersonal dynamics, therefore, are comparable.

Research on interpersonal communication between the nurse, and both patient and parent was found to be similar with consistent themes emerging across the literature. The bodies of literature contain a key commonality; both patient and parent were considered to be in a vulnerable situation. Being vulnerable includes being capable of being emotionally wounded, and easily persuadable (Knight 1991). Vulnerability developed because of the inability to maintain normal lives and roles, having little control, and being stressed because of concern about their own or their child's health status (Hallström et al. 2002a; Roden 2005; Simons & Roberson 2002; Snowdon 2000; Stratton 2004). Although the nurse-patient, and then nurse-parent literature has been subject to different research methods, the findings are similar to the point that it

can be argued the distinction becomes artificial. The level of vulnerability is the key commonality between them.

Vulnerability and context are intertwined. Examples of context and vulnerability being interwoven recur consistently in the literature, as accounts report both nurse and patient/parent grapple with their circumstances and the healthcare situation (Kristensson-Hallström 2000; Macleod Clark 1983; Morse 1991; Simons & Roberson 2002; Stockwell 1972; Suominen, Leino-Kilpi & Laippala 1995). Context refers to the situational variances and circumstances, including factors such as how sick the child or adult is, how long they have been in hospital, in addition to the organisation and culture of the environment in which the interaction takes place. There is evidence that what patients or parents want from nurses in terms of a relationship was dependent on context, and was also inextricably bound to the vulnerability of the patient/parent (Liu, Mok & Wong 2005; Suominen et al. 1995; Swallow & Jacoby 2001; Wilkinson 1991).

Research on emotional communication has been completed in different contexts, including a fertility clinic, hospital ward, paediatric intensive care, and using various methodologies, such as ethnography, qualitative descriptive, interpretive description and quantitative case control (Allan 2006; Snowdon 2000; Studdert et al. 2003; Thorne, Harris, Mahoney, Con & McGuinness 2004). Despite the variety of literature, consistent themes emerged. One of these themes is the patient and parent perspectives of their interaction with nurses.

Patient/parent perspectives on communication with nurses

There has been considerable research examining the patient's perspective of communication with the nurse, especially what they want from their interactions with nurses when feeling emotional (Avis & Reardon 2008; Blockley & Alterio 2008; Eriksson & Lauri 2000; Espezel & Canam 2003; Kvale 2007; McCabe 2004; Stratton 2004; Vydelingum 2000). Patients want nurses who are interpersonally competent (Eriksson & Lauri 2000; Fosbinder 1994; Suominen et al. 1995). Patients want to be listened to and seen as human beings, and also look for nurses who display warmth, concern and acknowledge their vulnerabilities (Blockley & Alterio 2008; Liu et al. 2005). Having their individuality recognised is also important (McCabe 2004) as is having nurses who are courteous, respectful and engaging (Thorne et al. 2004). However the situational variance of the nurse/patient interaction affects the type of

emotional communication patients want from nurses (Eriksson, Arve & Lauri 2006; Eriksson & Lauri 2000; Suominen et al. 1995).

Within the context of cancer treatment, patients and families want some level of emotional support from nurses and are disappointed when this does not occur (Eriksson & Lauri 2000). Emotional support is an aspect of social support (Arora, Finney, Gustafson, Moser & Hawkins 2007), and includes demonstrating empathy, reassurance, love and caring. Other aspects of social support are informational, the provision of facts or advice, and instrumental support (Tates, Meeuwesen, Bensing & Elbers 2002), offering or supplying behavioural or material assistance (Thoites 2011). Emotional support can affect physical health and psychological wellbeing (Thoites 2011).

Patients with breast cancer want informational and emotional support (Suominenen et al. 1995). However breast cancer patients do not receive enough emotional support from nurses (Suominenen et al. 1995), and Arora et al. (2007) found that emotional support is mainly provided by friends and family. Relatives of patients with cancer regard emotional support as important and want nurses to have time to talk to relatives and listen to their concerns (Eriksson & Lauri 2000). Mothers with illnesses were disappointed when healthcare professionals failed to talk to them about their mothering roles (Vallido, Wilkes, Carter & Jackson 2010). Eriksson and Lauri (2000) also found that most relatives were asked rarely, or not at all, whether they wanted to talk about their experiences. Describing the care relatives received before, during and after their relatives' death, relatives reported they rarely received emotional support from nurses (Eriksson et al. 2006). Parents of a child with cancer want to have their fear of hospitalisation recognised by nurses (May-Ching Yiu & Twinn 2001).

However, not all patients want the same level of emotional connection. Examining whether patients in an oncology ward want to talk to nurses about their emotional concerns, Kvale (2007) noted that patients wanted nurses to offer to talk with them, but patients themselves wanted to choose with whom to talk. Reasons for this included patients wanting to avoid conversation and distance themselves, choosing to live in the present and patients getting enough support from family and friends.

The discrepancy between patients who want an emotional connection with nurses and those who do not, may be explained by the level of involvement in the relationship between them. The level of involvement between the nurse and parent or patient can

affect their relationship. Morse (1991) and Ramos (1992) describe levels of connection between nurse and patient. Instrumental relationships according to Ramos involve the nurse completing tasks for patients and having brief superficial interactions with patients. For Morse (1991) this is a clinical relationship, whereby contact between the nurse and the patient is brief, superficial and courteous. The patient is usually satisfied with the care provided and there is little emotional involvement between nurse and patient. The second level of relationship as described by Ramos (1992) is protective, where the nurse is trying to appreciate the patients' emotional reaction to the situation they are in, and also endeavouring to control the process for the patient. According to Morse, this protectiveness would be therapeutic. Morse (1991) asserts that the third level of relationship is connected, and that in order to develop a connected nurse-patient relationship, the nurse needs to see the patient first as a person, and secondly as a patient. For Ramos (1992) the third level of relationship is reciprocal whereby the nurse cognitively and emotionally identifies with the patient. Morse notes that there is a fourth level of relationship which is not therapeutic, when the nurse becomes overly-involved in the patient's life, and oversteps patient/professional boundaries.

This work has been further developed by Williams and Irurita (2004) who undertook a grounded theory study to explore and describe the therapeutic effect of interpersonal interactions during hospitalisations. They found that emotional comfort (comfort associated with feelings of a person) is perceived by patients as enhancing their recovery. Therapeutic interactions facilitating emotional comfort are on three levels: security, whereby patients feel staff are competent and available; knowing, whereby knowledge or information about the environment is shared with the patient; and personal value, feeling valued by others, leading to more personal control and emotional comfort. This study has been further enhanced by Williams and Kristjanson (2008) who have added a fourth level of facilitation: connection, the degree to which patients felt connected to staff, the ability to have contact with staff and get to know each other as people. This fourth level links to Ramos (1992) and Morse's (1991) reciprocal, connected relationship.

The level of involvement between nurses and parents is affected by the context of the situation, such as when the child patient is acutely unwell (Espezel & Canam 2003), and also by either the nurse or the parents' willingness to engage with each other (Morse 1991; Ramos 1992; Williams & Irurita 2004). Parents were also found to want to have a connected relationship with nurses (Hopia et al. 2005; Jones et al. 2007;

MacKean et al. 2005; Sarajärvi, Haapamäki & Paavilainen 2006; Suominen et al. 1995).

In the context of hospitalisation of a child, parents consistently want interactions with nurses that are responsive and compassionate (Snowdon 2000; Swallow & Jacoby 2001). A number of studies found that communication is the most important link for parents in having a successful hospital stay (Aitkin, Mele & Barrett 2004; Avis & Reardon 2008; Fisher & Broome 2011; MacKean et al. 2005; Roden 2005). Parents want nurturing communication with nurses, and to be able to express themselves emotionally (Hopia et al. 2005; Jones et al. 2007). Parents desire and need nurses to acknowledge and support their emotional concerns (Avis & Reardon 2008; Chapados, Pineault, Tourigny & Vandal 2002; May-Ching Yiu & Twinn 2001; Pőlkki, Pietilä, Vehviläinen-Julkunen, Laukkala, & Ryhänen 2002; Power & Franck 2008). However parents do not always experience responsive emotional communication from nurses. Mothers describe the continual stress they experience as they seek to develop and sustain trusting relationships with staff (Swallow & Jacoby 2001). Mothers want nurses who listen to their concerns, and also believe their voices are not heard until they develop effective strategies for communicating and negotiating with staff (Swallow & Jacoby, 2001). Family members want to talk to someone about their child's illness and their own emotional experiences (Hopia et al. 2005; Shields et al. 2003). Parents have to explicitly explain their needs to staff, and want staff to be sensitive to their concerns (Hallström et al. 2002a). Similarly Stratton (2004) describe parents searching for signs in nurses that the nurse was compassionate.

Compassion is frequently expressed by empathy which is varyingly deliberated in the literature. Defined as a communication skill (Arthur 1999; Chant, Jenkinson, Randle & Russell 2002), and inferring "ability to perceive and reason, as well as the ability to communicate understanding of the other person's feelings and their attached meanings" (Reynolds & Scott 2000, p. 226), empathy is agreed to be part of emotional support (Arora et al. 2007). A good nurse-patient relationship will always include empathy, according to Breeze and Repper (1998). Goleman (1996) determines that empathy is part of emotional intelligence, and is a fundamental people skill, however later Goleman (2006) asserts that empathy involves emotional sharing between people, and is less likely if one of the participants was self-absorbed.

Recently a group of researchers in Verona, Italy have led a number of studies on emotional communication in clinical encounters, using the Verona Coding Definitions of

Emotional Sequences (VR-CoDES) (Finset, Heyn & Ruland 2013; Heyn, Finset & Ruland 2013; Kale, Finset, Eikeland & Gulbrandsen 2011). Focused on measuring the frequency and nature of emotional cues, (a verbal or non-verbal hint suggesting an unpleasant emotion), and concerns (a clear unambiguous expression of an unpleasant emotion which has been stated) (Finset et al. 2013), studies have been undertaken exploring clinician's responses to patients' emotional cues and concerns (Adams, Cimeno, Arnold & Anderson 2012; Del Piccolo, Saltini, Zimmermann & Dunn 2000; Del Piccolo, Putnam, Mazzi & Zimmerman 2004; Del Piccolo et al. 2005; Finset 2012b; Finset et al. 2013; Grimsbo, Ruland & Finset 2012; Heyn et al. 2013; Kale et al. 2011; Mazzi et al. 2013).

Responding to patients' emotional cues and concerns with empathy has been found to reduce distress, increase patient adherence and resolve symptoms, thus positively influencing health outcomes (Cherry, Fletcher & O'Sullivan 2013; Finset 2012a; Finset et al. 2013; Hsu et al. 2012). Kunyk and Olson (2001) discuss three stages of empathy as a communication process: firstly perceiving the client's emotions and situation, then expressing understanding of the emotions and situation and finally the client perceiving the understanding of the nurse.

Empathy is a natural response if a person listens to another's story, as listening involves imagining what the other is experiencing (Halpern 2001), however Kirk (2007) and Morse et al (1992) both argue that empathy does not fit well in nursing practice. For Kirk (2007) clinical intimacy is more relevant to the nurse-patient relationship as intimacy involves both behaviour and affect and empathy is more focused on affect, whereas Morse et al (1992) contend that empathy is mainly used for helping those in acute crisis, and nurses need to move into supporting patients to endure their suffering.

According to Morse and Pooler (2002) when a person is suffering, they have two distinctive emotional states: enduring, "a stoic state in which emotions are suppressed" and suffering, "an emotional state in which the person may sob or cry" (p.241). In the enduring phase the person suppresses any outlet of emotion, focusing solely on the here and now. When suffering, the emotions can no longer be contained, and people cry, sob and outwardly show their suffering (Morse & Pooler). Enduring is defined by Morse and Carter (1995) as "the capacity to last, to get through", whereas suffering refers to the "emotional response to loss" (p. 39).

Parents' suffering following their child's death was surveyed by Widger and Picot (2008), who investigated the quality of care provided to parents at this time. The authors found that a third of the parents surveyed feel avoided and abandoned. Roden (2005) found that nurses are insensitive, unsympathetic and rude. In a similar vein, Avis and Reardon (2008) established that parents' need for emotional support and information was unacknowledged by nurses, leading parents to lack trust in nurses.

Lacking trust in nurses was theorised by Robinson and Thorne (1984) following a number of qualitative studies involving families with a chronically ill child, and families with an adult member with cancer. Exploring the illness experience as a family phenomenon, Robinson and Thorne found that families worked through three distinct stages of trust during the hospitalisation of their child. When entering the hospital and establishing a relationship with family members, families expected to be informed, consulted and involved in the care of the family member. During this stage of naïve trust, the family is compliant, waiting to be included in decision-making and to fulfil the responsibilities they assume they will be given. If the family is not included in decision-making alongside health professionals, they start feeling dissatisfied with the healthcare received and more protective of their sick member, which leads to disenchantment. This is problematic as the family knows that they are dependent on staff to give them information, but unless they become more assertive, they will be left out of the decision-making process. This dilemma leads to the final phase, guarded alliance, whereby the family recognise the strengths and limitations of healthcare providers, there is more negotiation with them, and they learn to operate within the rules of the system (Robinson & Thorne 1984).

Understanding some of the causes of parental stress enables a stronger picture of the parent's experiences in hospital. Much of the focus of the research has been on interpersonal dynamics, rather than the cultural context of the nurse-patient/parent interaction. Many studies have also relied on what people say, which may be different to what they actually do, therefore research that captures actual practice in the clinical setting, focusing on context, is missing from the literature.

Parents' emotional needs and responses during a child's hospitalisation

A number of studies relating to hospitalised children focused on parents' perception of aspects of the experiences which caused them the most stress. Common stress-inducing themes reported in the research reviewed included feeling uncertain (Graves

& Ware 1990; Hallström et al. 2002a; Kristensson-Hallström 2000; Snowdon 2000; Suominen et al. 1995), powerless (Melnyk 2000; Robinson & Thorne 1984; Roden 2005), guilty about the child's hospitalisation (Graves & Ware 1990; Kristensson-Hallström 2000; Melnyk 2000), being in an unfamiliar environment, and experiencing poor communication between healthcare teams and families (Hong, Murphy & Connolly 2008) and an overriding fear (Hallström et al. 2002a; May-Ching Yiu & Twinn 2001; Pőlkki et al. 2002; Thomlinson 2002). Another cause of parental stress is uncertainty over their child's illness and recovery (Hallström et al. 2002a; Hong et al. 2008; Snowdon 2000). Disruption of their usual parental role and loss of control and independence is also a significant issue for parents (Coyne, 2006; Hallström et al. 2002a; Snowdon 2000).

Parents express a strong need to fit into the ward environment, to be compliant, to be liked by staff, and not to create difficulties (Coyne & Cowley 2007; Hallstrőm, Runeson & Elander 2002b). As a consequence of this need, parents hide their feelings from staff, and apologise for their emotions (Hallstrőm et al. 2002b). Coyne and Cowley (2007) found that parents pretended to cope in order to be seen as being good; believing that if they are perceived by nurses as compliant, their child would be more likely to be attended by nurses. Families worry about being a nuisance and repress their own needs (Lundqvist & Nilstun 2007).

Parents are usually accustomed to caring for their child without professional support, and to find that support is now needed, results in increased vulnerability, which in turn leads to an emotional response. Communication with the nurse that is emotionally supportive is important, and is not currently being provided consistently (Avis & Reardon 2008; Espezel & Canam 2003; Hopia et al. 2005; Jones et al. 2007; Roden 2005; Stratton 2004; Widger & Picot 2008).

Summary

Depending on the context and level of vulnerability, patients/parents want nurses who are responsive and ready to discuss their emotional concerns with them. Parents continually look for signs in nurses that indicate the nurse cares about them. Parents clearly need and want emotional communication with nurses in order to function effectively when their child is in hospital. Emotional support can affect emotional well-being, thus improve health outcomes.

Research reviewed in both nurse-patient and nurse-parent contexts have invariably focused on the patients' or parents' perceptions of their experiences in the ward. Patients and parents have been invited to share their experiences either during their hospitalisation or following discharge. The reviewed literature suggests that research focusing on actual interactions between nurses and parents is minimal. Situating the interactions in an actual interaction/relationship between a specific nurse and a specific parent may increase our knowledge of emotional communication between nurses and parents.

Literature themes

Despite the variety and difference in context between patients and parents, there are general themes in the literature that characterise both groups. The themes are identified as task orientation, emotional detachment, power issues, reasons for nurses not engaging with the patient/parent, and positive aspects of nursing communication, and are discussed in this next section of the review, in order to provide an overview of the current knowledge of factors inhibiting nurses from meeting emotional needs.

Task orientation

A feature in the literature is that nurses focus on the task they have to do, rather than the patient they are doing for. A selective review by Jarrett and Payne (1995) found that patients associate nurses with physical, rather than psychological care. When nurses approach patients, they spend very little time engaged in verbal interactions and when they do, the interactions are short, superficial and task oriented (Bond 1983; Espezel & Canam 2003; Jarrett & Payne 1995; Macleod Clark 1983; Stockwell 1972). Nurses' main focus is on the physical task, such as making the patient's bed, or administering medication, rather than patients' emotional concerns (Baggens 2001; Gordon, Ellis-Hill & Ashburn 2009; Macleod Clark 1983). Nurses' preoccupation with work routines is evident (Suominen et al. 1995), and task completion takes precedence over talking with their patients (McCabe 2004). Any emotional needs the parent may have are unacknowledged or ignored (Coyne & Cowley, 2007; Espezel & Canam 2003; Vandekieft 2001).

Similarly, appearing too busy to engage with patients also occurred in a healthcare facility in China, where patients avoided talking to nurses about their emotional concerns because they perceived nurses to be too busy and too focused on their tasks (Liu et al. 2005). Patients do not want to burden nurses with their worries or they

perceive that emotional communication is not nursing work (Kvale 2007; Liu et al. 2005; McCabe 2004). Likewise describing the stress factors and coping strategies of parents whose children had been treated by hemodialysis, Cimete (2002) found that some parents do not expect to share their emotional concerns with nurses.

There was a focus for nurses on giving information to patients and parents, driven by a belief that if the patient has information, they are less likely to be worried (Burnard & Morrison 1991; MacKean et al. 2005; Shin & White-Traut 2005). Nurses want time to educate parents and be seen as the expert in the child's care (Paliadelis et al. 2005). Giving information to parents and patients enables nurses to maintain their professional role, to be seen to be proficient and to have information which the patient needs and wants.

In the situation where the parent is emotionally affected by the hospitalisation, the parent is more vulnerable and may be more willing to engage at a reciprocal level with the nurse. Conversely if the nurse is focused on tasks and unaware of parents' needs as highlighted in this discussion, the interaction will remain at a superficial level (Morse 1991; Ramos 1992). Focus on tasks and information giving is apparent in the literature reviewed, what is not addressed, however, is the effect of the ward context and nursing culture on nurse-parent emotional communication.

Emotional detachment

Nurses' emotional detachment from patients/parents was another dominant theme in the literature (Allan 2006; Anstice 1970; Callery 1997; Coyne 2007; Kruijver, Kerkstra, Bensing & van de Wiel 2001; Lewis, Kelly, Wilson & Jones 2007; Macleod Clark 1983; Menzies 1960; Simons & Roberson 2002; Trovo de Araujo & Paes da Silva 2004), a phenomenon first described in seminal work by Menzies (1960). Menzies found that nurses avoid having emotional contact with patients, distancing themselves from their patients, and sometimes objectifying them as numbers with an illness (i.e. "the appendix in room 6"). There were reasons for this avoidance according to Menzies, including the anxiety experienced by nurses as patients' needs overwhelmed them, nurses' need to detach themselves from the patients' realities, especially as nurses rarely cared for the same person for more than two days, and the repetitive nature of nursing work. Halpern (2001) adds that physicians detach themselves from patients because they consider that detachment is the best way to maintain or regain objectivity, believing that emotions are inherently subjective. Emotional detachment is

also more common when paternalism and authoritarianism is prevalent, as noted in the historical literature (Palmer 1993; Young 1992).

In 1983 Macleod Clark described nurses distancing themselves emotionally and using a range of tactics to avoid communication with patients. One of those tactics was overwhelming patients with medical information (Krujver et al. 2001). Nurses described the nurse-patient interaction as emotion-laden, with the emotionally intense engagement being difficult for nurses (Sheldon, Barrett & Ellington 2006) leading to avoiding discussion of emotions.

In specific nursing environments, such as caring for dying patients in intensive care, nurses distance themselves from their patients (Bail 2007), and Bond (1983) found that nurses avoid encounters with patients when the patient is stressed. Caring for patients in an infertility clinic led to emotional distancing (Allan 2006). In a children's ward, Coyne (2007) found that nurses distance themselves by staying in treatment rooms or offices and persuading parents to take a break from the ward. Emotional detachment can be used by nurses as one way of avoiding patients'/parents' emotional concerns.

Nurses' responses to patient's emotional needs range from disregarding their anxiety (O'Gara & Fairhurst 2004), avoiding raising emotional issues themselves (Lotzkar & Bottorff 2001), to using humour and social conversation (Holmes & Major 2002-3). Interacting with parents who are upset or angry can lead to responses in nurses from detachment to feeling worthless, depending on the duration of the nurse-parent relationship, the state of mind of the nurse and the circumstances around the situation (Lewis et al. 2007). Nurses are said to be most skilled at offering support and information and least skilled at enabling release of tension and strong emotion (Burnard & Morrison 1991).

Nurses reported that their ability to facilitate conversations, especially in perceived difficult situations such as a patient having a recurrence of cancer, was poor (Wilkinson 1991). Poor communication is described as avoiding patients discussing their problems, and taking superficial nursing assessments, resulting in care planning which was mainly based on assumptions (Wilkinson 1991).

In another context, caring for children in pain, nurses struggle, believing that parents are well informed and supported while parents report that they are anxious and find it

hard to express their concerns to nurses (Simons & Roberson 2002). Similarly Avis and Reardon (2008) observed that nurses assume that the child's needs could be managed by parents, when parents actually need emotional and informational support. Withdrawal from parental contact when under stress is a further nursing response, as noted by Espezel and Canam (2003). When nurses do acknowledge parents' emotional concerns, they feel disempowered, and avoid/disengage from parents (Papadatou et al. 2001). Callery (1997) noted that spending time with parents threatens nurses' control over their workload, and places unpredictable demands on their time, thus they avoid the possibility of engagement.

Similar to Menzies (1960), Froggatt (1998) suggests that emotional distancing is a strategy to prevent nurses becoming over-burdened or drained by their work. More recently, Laschinger and Leiter (2006) noted that nurses avoided patients' emotions by dissociating from patients, which included distancing themselves from patients and depersonalising patients. Morse (1991) suggests that nurses depersonalise patients as a blocking strategy to inhibit the development of a connected relationship. Bolton (2000) offers insight into the nursing professions' ideological image of itself as being loving, kind and caring, which leads nurses to try to appear kind and caring, but also calm and detached.

The evidence reveals that nurses report emotional detachment and parents/patients also report nurses' detachment from them. However, nurses' and parents' experience of emotional communication, and the effect of detachment on nurse-parent interactions, are absent from the literature.

Power and control issues

A further theme evident in the literature is the power imbalance between nurses as health professionals and patients/parents in hospital and the controlling nature of the nurse-parent/patient relationship. Interpersonal relationships between nurses and patients/parents start on unequal terms as the nurse is usually seen as having knowledge and authority (Jarrett & Payne 1995; Thorne et al. 2004). As such there is a potential for the misuse of power in the relationship. Nurses have used power in a variety of ways, from controlling patients' access to information, to controlling the content and extent of the nurse-patient/parent interaction and omitting with intent (Hewison 1995). One study in an aged care setting, which focused on the way nurses used language and the effect language has on patients, found that nurses exerted power and control over their interactions with patients, with overt power, persuasion, or,

most commonly, controlling the agenda (Hewison 1995). Nurses frequently talked over patients, deciding when and how patients were to do something, with patient involvement kept to a minimum.

The controlling nature of the nurse-patient interaction is evident in a literature review by Jarrett and Payne (1995), where nurses are perceived by patients as controlling, restricting the course and topics of conversations. Blocking patients'/parents' access to information or withholding information is frequently noted in the literature. Duffin, (2000), reporting a national survey on National Health Service patients in England, found that nurses withheld information from patients. Nurses also controlled interactions by using strategies to block engagement with patients including maintaining a professional distance, and being disinterested in the patients' perspective or opinion (Thorne et al. 2004).

In a review of the literature about the ways nurses negotiate with parents in relation to family-centred care, Corlett and Twycross (2006) found issues of power and control prevent open communication between the nurse and parent. In this study, as well as control, nurses also had fixed ideas about what care the parent could participate in, and did not routinely negotiate with parents about their expectations. Nurses controlled the information they gave, the support they provided and the way they communicated with parents (Corlett & Twycross, 2006).

Control also affects nurses' perceptions of ideal parents. Snowdon (2000) found nurses prefer parents who appreciate and accept the nurse, are respectful and thankful, and participate in the child's care according to the nurse's direction. Darbyshire (1994) also found nurses have expectations of parents, including wanting them to cooperate, to help out with their child's care, to fit in with ward routine and to act appropriately. Nurses use their power and control to manage parents they consider not ideal, by adhering to rules and policies, and limiting their communication with parents. When under pressure, nurses become more controlling and coercive, leaving the parent feeling undervalued and not respected in the relationship (Snowdon 2000). With regard to patients nurses do not like, Stockwell (1972) described the tactics nurses use to avoid giving unpopular patients information and to control interactions with patients, limiting the quantity and depth of the conversation. Brown and Ritchie (1990) noted that nurses act as gatekeepers to the parental role in hospital, deciding what parents can and cannot do. Nurses consider parents difficult or problematic if

they do not fulfil expectations of the ideal parent (Coyne 2006-7; O'Haire & Blackford 2005).

Imbalances of power can result from the parent being unfamiliar with an environment in which the nurse feels comfortable, the stress the parent experiences with their sick child, and the emotional anxiety they feel. The nurse has the power in the relationship, deciding how much control the parent may or may not have (Corlett & Twycross 2006). Power imbalances can influence the way nurses talk to parents, and the responses parents might make to the nurse. Nurses usually initiate interactions with parents, and then dominate the interaction (Baggens 2001; Shin & White-Traut 2005). When parents perceive nurses are judging them negatively, they withdraw from the interaction (Lee 2005).

The power imbalance between the nurse and parent/patient has a significant impact on their interactions. Reflecting on the task orientation of nursing care, nurses' emotional detachment from patients/parents, and the inequity of the power relationship between nurses and patients/parents, leads into consideration of why nurses are not currently always engaging with the patient/parent, as discussed in the following section.

Reasons for nurses not engaging with patient/parent

Effective nurse-patient/parent emotional communication is the subject of a number of authors' work (Blockley & Alterio 2008; Fisher & Broome 2011; Robinson & Thorne 1984; Williams & Irurita 2004), in particular aspects that lead to nurses not engaging with the patient/parent. These aspects include self-protection, lack of preparation for emotional communication, managing emotions and organisational and cultural factors. Nurses desire to protect themselves from potential emotions is an important theme in the literature.

Self-protection

Choosing not to engage with patients or parents who have emotional concerns, either consciously or unconsciously, may be driven by a desire to protect oneself from anxiety. In the past nurses were encouraged by their managers to hide their emotions and maintain a professional barrier to protect themselves from the emotional concerns of the patients (Menzies 1960). Traditional health models were orientated to disease and disability rather than people, with strongly defined roles for professionals and families (MacKean et al. 2005). It was considered important to maintain a professional

self, to keep relationships with patients impersonal, to protect the nurse from being known by patients, and to prevent any inappropriate feelings the nurse may develop for patients (Jourard 1971).

Control of feelings is a lay/professional boundary according to McKinlay (1981b), advising that at that time (early 1980's) staff were "conditioned to suppress own feelings of distress and anxiety over patients to give disinterested efficient care" (p.222). Distancing themselves from emotional communication, especially in severely stressful situations, is a response driven by nurses' need to self-protect (Espezel & Canam 2003; Trovo de Araujo & Paes da Silva 2004). Professional training has encouraged nurses to wear a "mask, to limit their behaviour to the range that proclaims their professional status" (Jourard 1971, p. 178). Nurses who do not engage with parents'/patients' emotional concerns reflect the accepted norms until relatively recently, of the nursing culture. Encouraging nurses to be professional and not engage on an emotional level leads to nurses avoiding emotional communication.

Lack of preparation for emotional communication

Another reason for avoidance of emotional communication is nurses' lack of preparation. Nurses did not always feel ready or prepared to manage the emotional concerns of patients/parents, nor their own responses to the emotions expressed. Undergraduate education has not adequately prepared nurses for emotional communication. In a literature review of communication skills training in pre-registration nursing education, Chant et al. (2002) found an emphasis on the mechanistic aspects of communication, for example, listening skills, over relational aspects of communication. Barriers to effective relational communication included: the perceived dominance of biological and medical paradigms; medical and managerial discourses dominating nursing care and shaping the nurse-patient relationship; the hierarchical nature of health care; lack of communication skills training; and nurses' perceived lack of power in health care, leading them to exercise power and superior status over patients. In a study of nursing students, students had difficulty relating to patients who were lonely and depressed and also expressed anxiety, distress and feelings of inadequacy regarding their interpersonal difficulties (Suikkala & Leino-Kilpi 2001).

Context also affects preparation. Papadatou et al. (2001) reported that nurses experience a sense of helplessness when caring for dying patients, and stress at witnessing the emotional and spiritual distress of parents and children. Turner et al.

(2006) outlined the emotional demands on nurses when working with parents of children with advanced cancer. Nurses describe feeling they lack knowledge about the emotional impact of advanced cancer on parents, are afraid of making the situation worse, and lack confidence in their own communication skills. Bolton (2000) observed that the emotional involvement of caring for patients causes nurses most anxiety, but countering that, also has the potential for greater job satisfaction. Controlling or managing one's own emotions is necessary for nurses working with patients or parents to address their emotional concerns and evidence has demonstrated that nurses lack preparation for managing this important component of care. Managing own emotions is another important reason for nurses not engaging with the patient/parent.

Managing emotions

Managing emotions requires emotional intelligence, defined by Goleman (1996, p.34) as "having the ability to motivate self and persist; to control impulse and delay gratification, to regulate ones moods and keep distress from swamping the ability to think, to empathise and to hope". Emotional labour is the act of evoking, or shaping, as well as suppressing, feelings in oneself (Hochschild 1979). According to Hochschild, to tune into others emotions, a person needs to suppress their own feelings. This requires using feeling rules to guide how to feel, which arise from social conventions, reactions of others, or within selves (Hochschild 1979). Emotional display rules are also important, expressing the shared norms governing the expression of emotions used in the workplace (Diefendorff, Erickson, Grandey & Dahling 2011). Diefendorff et al. (2011) found that display rules can be shared by nurses working in the same unit, and are unique to that work place.

James (1993) compares emotional and physical labour, recognising that they are both difficult, skilled work, requiring experience, and affected by immediate conditions. Taking this further James (1989) suggests that emotion regulation is shaped by the place, people and organisation under which it takes place. Emotional labour is strongly connected to the cultural context of the interaction (Mesquita & Delvaux 2013). Feeling rules and emotional regulation varies across cultures, thus highlighting the importance of context in the nurse-patient/parent interaction.

Emotional labour, although difficult work, is often undervalued (Staden 1998), and not usually documented as part of nursing care (Bail 2007). It is generally regarded that nurses will undertake emotional labour, but it appears there is little organisational support for nurses, such as clinical supervision (Turner et al. 2006). Nurses describe

feeling overwhelmed, and switching off, putting up barriers and standing back in the relationship when trying to manage emotional labour (Froggatt 1998). The need to manage their own emotions with ineffective coping resources can lead nurses to emotional exhaustion, a component of the psychological state of burnout (Kravits, McAllister-Black, Grant & Kirk 2010).

The literature discussed suggests nurses continue to grapple with emotional labour when working with patients/parents (Bolton 2000). Emotional communication between nurses and parents requires nurses to manage their emotions. How nurses' process emotional labour (Hochschild 1979) when working with parents has been rarely observed in actual practice, and thus is an important ingredient of the current study. Organisational and cultural factors preventing nurses from engaging with parents on an emotional level are also noted in the literature.

Organisational and cultural factors

Some studies addressed organisational and cultural factors which hindered nurses' interactions with patients/parents, such as the way nurses' work was organised, the hierarchical nature of healthcare organisations, and required display rules expected of nurses. Historically Menzies (1960) noted that a heavy patient workload contributed to nurses avoiding emotional interaction. At that time Menzies also concluded that the institutions in which nurses worked inhibited and devalued nurse-patient interaction particularly of an emotional nature. Excessive workload is well documented as a major cause of nurses' stress (Hall 2004; Lambert, Lambert, Petrini, Li & Zhang 2007). The way nurses' work is organised with nurses approaching patients to carry out tasks of a physical nature, adds distance to the relationship, according to McQueen (2004).

The hierarchical nature of healthcare organisations, such as patients not knowing who to talk to about clinical matters, leads to poor nurse-patient interaction (Audit Commission 1993), and Morrison and Burnard (1989) asserted that the organisational culture discourages nurses to invite patients to talk about their problems. Emotional communication was not encouraged by management (Bond 1983) with the interaction between the nurse and parent being dependent on the culture of the organisation. When ward managers promote communication nurses are more likely to encourage patients to discuss their concerns with them (Wilkinson 1991) and when nurses work within a patient-centred approach, their interactions with patients improve. However if managers favoured a more task-oriented approach, assumed to ensure a greater

"standardization and predictability of nurse performance" (McCabe 2004, p.44), nurses communication with patients declines in both duration and quality.

According to Robinson and Thorne (1984) when faced with parents who have emotional concerns, nurses have been socialised not to respond effectively. Instead nurses defend the status quo, or blame someone else, punish the behaviour or ignore the parents' concerns.

Frequently in the literature, patients attributed nurses' poor communication with them as the result of the nurse being too busy (Balling & McCubbin 2001; Lewis et al. 2007; Liu et al. 2005; McCabe 2004; Vydelingum 2000). However Jarrett and Payne (1995) observed that nurses too used the excuse of being too busy as a reason for not spending time talking to patients, but did not use quiet, less busy times to talk to patients.

The findings in the literature regarding reasons why nurses do not engage with patients/parents included self-protection, lack of preparation, managing emotions and organisational and cultural factors. These findings highlight current knowledge and add impetus for this study which aims to investigate emotional communication from the perspective of the nurse and the parent. Further observation of nurses and parents in context will add to these understandings. Despite the evidence that supports the problematic nature of nurse-patient/parent communication, there were a number of positive aspects of nurse-patient/parent interaction.

Positive aspects of nurse-patient/parent communication

Several authors discussed positive components of nurse-patient/communication. In 1994, Porter reported that the relationship between the nurse and patient had changed over time, from one of authority to one where the gap in power and status was lessened and where free communication was valued by nurses. Mok and Chiu (2004) echoed this, suggesting that nurse-patient relationships had evolved from a professional relationship that emphasises functions, to a focus on mutual understanding.

In an ethnographic study using conversation analysis, Mallet (1997) found nursing communication was focusing more towards the needs of the patient, as the nurse worked toward understanding the patients' experiences. Breast cancer support nurses who encouraged patients to express emotion were found to make a difference to

patient outcome (McArdle et al. 1996). Using social talk and humour made patients feel more comfortable, reducing the stress of the interaction, and social chitchat was also found to help patients get to know staff and improve their emotional comfort (Holmes & Major 2002-3; Williams & Irurita 2004). Major and Holmes (2003) noted that the process of establishing rapport and expressing empathy are important for nurses preparing patients for procedures.

In addition, nurses have been found to acknowledge patient's emotional concerns. Lee (2005) acknowledged that nurses thought it was important that the child and family voice was listened to and that parents understood what was going on. Roden (2005) found that nurses accepted that parents have emotional reactions about their children and Henderson (2001) described nurses wanting to engage emotionally with patients and the more self-reflexive the nurse, the more they valued their emotional connections. One hundred percent of nursing staff in a study comparing the perceptions of needs of parents of hospitalised children with those of staff caring for them thought that it was important that parents had opportunities to speak privately with a doctor or nurse about their feelings and worries (Shields et al. 2008).

Some researchers have found that nurses are acknowledging the importance of the nurse-patient/parent interaction and working towards improving their responses to patients/parents. However the overwhelming majority of literature reviewed demonstrated that the interaction between nurses' and parents', particularly emotional communication, is difficult and problematic.

Chapter summary

This review of the literature has established that within both the nurse-patient and nurse-parent literature, there are commonalities. Both patient and parent are in a vulnerable situation and it is that vulnerability that is common (Aitkin et al. 2004; Hallström et al. 2002a; Melnyk 2000; Vydelingum 2000). When nurses are working with parents, the nurse has a professional responsibility to help the parent. This help includes offering emotional support. Emotional support affects emotional well-being, thus improving health outcomes (Thoites 2011). Parents want and need nurses to be there for them, to listen to them and to facilitate their expression of emotion being experienced such as fear, lack of control, and anxiety related to the unfamiliar environment (Graves & Ware 1990; Hallström et al. 2002a; Kristensson- Hallström 2000; May-Ching Yiu & Twinn 2001; Pőlkki et al. 2002; Snowdon 2000; Thomlinson

2002). The family-centred care model which is a central feature of contemporary child health nursing encourages nurses to provide support for parents' physical and emotional needs (Coyne 1996; Nethercott 1993).

Whilst differences in context create different responses from nurses to emotional communication, a number of factors have inhibited nurses from meeting these needs including the task orientation of nursing practice, nurses' emotional detachment, and power and control issues. Despite some of the more positive aspects of communication noted in the literature, nurses continue to protect themselves from parents' emotional concerns, due to their lack of preparation, the labour involved in managing emotions, and organisational and cultural factors. A fuller understanding of nurses' non-engagement with parents' emotional communication is urgently needed.

While the literature includes identification of some of the difficulties and problems inherent in emotional communication from both the nurses' and the parents' perspectives, there are a number of gaps in our current knowledge. It is not known how nurses and parents experience emotional communication in the context of an inpatient hospital ward. Limitations in both method and content in available research reduces our understanding into how the organisational and cultural context both constructs and is constructed by the interactions, especially as distancing has been attributed to organisational realities and patient characteristics.

It is not yet apparent how effective nurse-parent emotional communication could positively impact nurses' working experience, parent's experience of hospitalisation with their child or the child's physical and psychological response to their condition and their hospitalisation. In order to gain a fuller understanding of the complexities of nurse-parent relationship, emotional communication needs to be examined from both the nurse and parent perspective.

Chapter 3: Method chapter

Introduction

Methodology is concerned with the "how did you do it?" and "how did you know?" Both of these issues underpin a constant question asked when undertaking qualitative research; "are you sure?" (Morse 1994). According to Morse, the soundness of qualitative research, the certainty of the methodology, is imperative. In this chapter I establish how I addressed these issues. The methodology underpinning this study is described, incorporating the decision-making processes involved in choosing a method. My use of the method, focused ethnography, is detailed, providing the reader with an auditable route of the study process, along with a discussion of the rigour of the study. The strength of the ethnographic method to uncover hidden, taken-for-granted assumptions of the participants is revealed.

Research design starts with consideration of the purpose and aim of the research, as well as what is likely to offer the best fit for the process and outcomes (Whitehead, 2013). Nurse-parent emotional interaction is the central focus of this research and, as researcher, I was particularly interested in what was going on behind the nurse-parent interaction (the hidden aspects), as well as exploring the front (the observable aspects) of the interaction. I wanted to understand the cultural context of the interaction, in order to uncover not only what happens but also why and how it happens when nurses and parents of hospitalised children communicate and interact in relation to parents' emotions. Culture refers to the "acquired knowledge that people use to interpret experience and generate social behaviour" (Spradley 1979, p. 5). Cox (1987) attests that culture includes patterns of behaviour, artefacts, and knowledge that people have learned or created, the organisation of things, and the meanings people give to objects.

Nurse-parent communication is reported as less than satisfactory, especially in relation to the discussion of emotions (Avis & Reardon 2008; Hallström et al. 2002a; Hopia et al. 2005; Roden 2005; Shields et al. 2003; Swallow & Jacoby 2001), therefore this area of inquiry is problematic from the outset. Communication between people is more than the individual skills a person has, it is irrevocably bound within the cultural context in which it occurs (Liu et al. 2005; McCabe 2004; Wilkinson 1991) and, therefore, the context of the nurse-parent interaction was a central focus in this study. In this instance the context is the culture of the health care environment where nurses and parents interact, the children's ward of a hospital. The focus of previous research has been on interpersonal dynamics alone, not on the cultural context. Finding a research method

which would enable how best to address these issues was the next step in the research process.

Method

I required a method which would allow me as the researcher to look under the observable surface of the nurse-parent interaction to cultural factors influencing nurse-parent communication. I wanted to have an understanding of the context in which the interaction takes place, in this case a hospital ward. Hospital wards have cultures that are unique to each setting and I needed a method which would allow me as the researcher to first observe the relationship as an outsider looking in, thus attempting to understand what was going on between nurse and parent perspectives. This required a method allowing me as the researcher, entry into and the experience of the richness of the real world in which nurse-parent interaction takes place (Willis & Anderson 2010). I came to appreciate that an understanding of culture can be illuminated through exploring both the perspectives of nurses and parents, and through observing how they interact with each other. Ethnography was chosen to enable an uncovering of the hidden, taken-for-granted assumptions (Kleinman 1988; Mulhall, Le May & Alexander 1999) of nurses and parents in the health care environment. Ethnographic methods are designed to explicate and unravel elements in a culture (Ersser 1996; Lambert, Glacken & McCarron 2011), such as the culture of communication in the nurse-parent relationship. Specifically the ethnographic approach (Higginbottom 2011; Holloway & Wheeler 2010; Liamputtong 2010), which includes the use of an interpretive approach, emerged as an appropriate and logical choice. Interpretative approaches to ethnography and focused ethnography are elaborated on in the following sections.

The interpretive approach

The interpretive philosophical perspective was developed in the mid to late 19th century in Europe, as a reaction to the prevailing view at the time. This view held that to know something required explanation and prediction (Bentz & Shapiro 1998). Interpretive comes from the idea that the researcher is not just observing things, but also interpreting meaning (De Laine 1997). As Crotty (1998) explains early philosophers such as Max Weber (1864-1920) suggested that in order to know something, understanding is needed. In the natural sciences (also associated with the empirical or positivist approach) objects are investigated from the outside to the inside, whereas the human sciences depend on a perspective from the inside to the outside. “The natural sciences seek causal explanation, prediction, and control. The human sciences seek

understanding and interpretation" (Munhall 1994, p.12). An interpretive approach "offers a contextual relevance and richness...displays sensitivity to process...is driven by theory grounded in data...and takes full advantage of the human-as-instrument" (Guba & Lincoln 1982, p. 235). According to Morse (1994) interpretive ethnographers believe that ethnographic analysis needs to discover the meanings of observed social interaction.

In this study, the participant meaning of emotional communication was under investigation. I aimed to understand nurse-parent interaction where it took place. Taking an interpretive lens to this inquiry enabled the realities of the participants to be multiple, and intangible, and actions taken by participants were explainable in terms of "multiple interacting factors, events, and processes that shape [them} and are part of [them]" (Guba & Lincoln 1982, p. 238). Interpretive research is "the process of probing under the surface to examine social meanings and cultural motives lying at the base of social actions" (Field 1983, p. 3), leading the reader "through analyses of inferences and implications of behaviour in its cultural context" (Morse 1994, p. 193). As a participant observer, the researcher can learn the culture of the people being studied; thus enabling an interpretation of their world, in the same way the participants of that world know it (Hammersley & Atkinson 2007). A central focus of this study was to explore and uncover the underlying contextual factors which affect emotional communication, which has been established as problematic.

Ethnography

There are numerous definitions of ethnography in the literature. The word ethnography, first used in 1834, comes from the Greek 'ethnos' meaning nation or people, and 'graphein' meaning to write (Willis & Anderson, 2010). Ethnography translates as the 'written description of the folk' (Tripp-Reimer, Enslein, Rakel, Onega & Sorofman, 2006). Hammersley (1990) notes that ethnography is not clearly defined, but that as a methodology it has some common features including studying people's behaviour in everyday contexts; gathering data from a range of sources, particularly observation and informal conversations; an unstructured approach to data collection; a focus on a single setting or group; and analysis involving interpretation of meanings and functions of human actions. The aim of all observation is 'thick description', which Geertz (1973) describes as description that makes explicit the detailed patterns of social relationships and puts them in context, therefore giving readers a sense of the emotions, thoughts and perceptions participants experience (Field 1983).

The aim of ethnography is to discover cultural and contextual patterns of knowing, and by doing that there will be better understanding of social and health issues (Duffy 2005), not only the what, but also the why and the how. Oliffe (2005 p.395) asserts that ethnography as a "research methodology provides an effective means to learn about people, by learning from people". Field and Morse (1985) describe ethnography as a generalised approach to developing concepts to understand human behaviours from the emic (insiders) point of view. Using an ethnographic method, the researcher participates in people's daily lives for a period of time, watches what happens, listens to what is being said, asks questions through formal and informal interviews and collects documents and artefacts (Hammersley & Atkinson 2007).

Contemporary ethnography as a research method originated in the discipline of social anthropology in the early 20th century. At that time anthropologists were concerned that tribal groups in developing nations were disappearing and researchers wanted to study the cultural patterns and rules of these societies (Holloway & Wheeler 2010). Researchers of the time, including Malinowski, Boas and Mead, wanted to study human behaviour within the context of a culture, in order to more fully understand cultural rules, norms and routines (Holloway & Wheeler 2010). Traditionally researchers spent long periods of time within the culture, actively participating in the daily life of people being studied and carefully observing all aspects of life. The method worked toward documentary type evidence believed to be true and reflecting each member of the culture's view of reality (Tedlock 2005). The role of the ethnographer in data collection and interpretation was unacknowledged, and there was minimal recognition of the social relationship between the ethnographer and those people whose culture was being studied. This view was challenged in the latter part of the 20th century and a crisis in ethnography ensued.

The ethnographic crisis

Traditional anthropology was grounded in the logical-positivist view that knowledge of the world could only be justified by experience; that knowledge was grounded in particular observations, and nothing existed unless it could be observed (Hollis 1994), thus truth rests outside the human existence. By methodically and systematically studying human behaviour in different cultures, early ethnographers were trying to generalise about a theory of 'man', by describing their findings as a representation of an independent reality, separate to that of the researcher (Hammersley 1992). A crisis in ethnography, also termed the "reflexive turn" (Gardner & Hoffman 2006, p.4), was caused by a realisation that instead of producing a realistic, objective view of a culture;

in reality ethnographers were constructing a social world through their interpretation of it (Hammersley & Atkinson 2007). This construction is apparent when, for example, the data the researcher choses to use in the field are a product of their participation in the research, rather than a reflection of the phenomena studied (Hammersley 1992). Field (1983) observes that the recording of notes demonstrates what the researcher has chosen to select, and therefore interpret, described by Geertz (1973) as an interpretation of the actions and involvement of people on and with one another.

This recognition led to a shift within ethnography from an objective approach to an intersubjective one. Now the relationship between the researcher and those being studied is recognised as part of the research process (Angrosino 2005a; Hammersley & Atkinson 2007). There is active acknowledgement of the researcher's integral part of the social world being studied (Hammersley & Atkinson 2007; Mulhall et al. 1999; Pellat 2003). In the next section of the chapter, how I located myself in the research process, reflexivity, a characteristic of ethnographic research will be further discussed.

Reflexivity

The crisis in the research field of ethnography led to reflexive practice, as a central aspect of ethnography is the acknowledgement of the place of the researcher within the context of the group being studied. Davies (1999, p.4) defines reflexivity as "turning back on oneself, a process of self-reference". Reflexivity is a process that is used to recognise that the researcher is an integral part of the social world being studied (Ersser 1996; Hammersley & Atkinson 2007). Coffey (1999) describes reflexivity as having an ongoing conversation about the experience whilst consecutively living the moment. Ethnography consists partly of participant observation and partly of conversation or interview; it is the mix of these two that leads to reflexivity (Boyle 1994). Mulhall et al (1999) suggest the reflexive conversation asks the researcher these questions:

1. How have I affected the process and outcome of the research?
2. How has the research affected me?
3. Where am I now?

Addressing these questions throughout the research process enables researchers to position themselves within the research, their interpretation of the data, and add plausibility to the research findings.

As researcher I kept these questions at the forefront of my journaling and field notes. All three questions related to me as researcher and the effect of my presence on the research process. Throughout the planning of the research design, the field work, the analysis and the writing up phases of the study, I continually reflected on the impact I had made on the study. An example of my reflection is observed in this early notation from field notes,

> *RN talked to me re her reservations about this study. Worried that I would be "listening to everything nurses say". I assured her that I am not interested in particular nurses, rather the overall culture of the ward, also that I would be writing up my observations/interpretations and giving them back to staff for checking. She seemed reassured by this* (Field notes 18.3.11, p. 2, Book 1).

As the field work continued the field notes demonstrate a development in my ability to be reflexive. In this note, I was worried about the effect my presence may have had on a difficult situation between a parent and a number of nurses,

> *I would have liked to have been more involved in this situation, but felt like I didn't want to impose on Susan* [RN, pseudonym]. *I would have liked to have talked to her about this situation. I will try later when the situation is quieter* (Field notes 29.3.11, p. 8, Book 1).

As part of the reflexive process, researchers need to be cognisant of their own effects on the research process by identifying any biases brought into the field and their emotional response to their experiences (Roper & Shapira 2000). As researcher I was acutely aware of how I may be being perceived by the participants, and of the potential effect my presence may have had on their behaviour and concomitantly the effect on my behaviour of their presence. The nurses in the ward became aware that I was a nursing lecturer, and had practiced as a registered nurse in a children's ward. I was occasionally asked for advice regarding a difficult clinical situation, or in managing a particular task, such as using a capillary monitoring machine. Rather than give advice or demonstrate the use of machinery, I used strategies to assert my role as researcher and observer participant rather than active participant, such as asking the nurse what they thought, and assisting them to find out answers in other ways.

I journalled and reflected on my assumptions and biases throughout the research process. In the following field note, I noted my thoughts about parents' expectations,

So parents are asked to tell nurses how they feel but no expectation (according to this document) that nurses will be responsive to parent's feelings
Parents do not expect 'support' from nurses as they are not told this is available
Ward culture is that parents will work with family (be compliant with medical/nursing decisions), tell nurses what is going on for the child when the nurse is not there. Nurses want parents to help meet the child's needs (ie do the parenting). No expectation from parent that nurses are there for them, therefore (hunch) nurses and parents expect 'stereotypical' care from nurses – friendly, cheerful, do their work, responsive to child (Fieldnotes 13.4.11, p. 1 & 2, Book 2).

During field work I remained aware that my perceptions and observations were assumption-laden (Hammersley 1992). My role during data collection was explicitly noted, and the onus was on me as researcher to "establish mechanisms that guarantee honest and trustworthy research relationships" (Roper & Shapira 2000, p. 114). Rather than studying people, as a reflexive researcher, I aimed to learn from people, trying to grasp the emic point of view (Morse & Field 1996).

I actively examined how my involvement in the research process affected data collection and analysis. As noted by Thomas (1993 p. 46) ethnographic researchers are "active creators rather than passive recorders of narrative and events". Reflection during the analysis stage occurred at both the superficial level in terms of telling it as it was, and at a deeper level, attempting to identify what effect my own situation, interests, beliefs and value judgements have had on the work (Mulhall, 1997). During the writing phase I was aware that I was producing a "cultural artefact, a product of my intermingling with the participants at a certain time and space" (Mulhall 1997, p. 973). Closely aligned to reflexivity, a further distinguishing feature of contemporary ethnography is the emic/etic perspective.

Emic (insider)/etic (outsider)perspective

The emic (participant/insider) and the etic (researcher/outsider) perspectives are a significant characteristic of ethnography. The researcher is always going to be the outsider in the relationship, with participants always having an inside view, and how the researcher bridges the divide between the two is key. Angrosino (2005a) argues that the current trend in ethnographical research is acknowledging that it is unlikely the ethnographer will be able to "harmonize observer and insider perspectives…to achieve a consensus about ethnographic truth" (p. 733). Ethnography is a research approach which is neither subjective nor objective "but rather mediating two worlds (audience

and group studied) through a third (ethnographer)" (Lambert, Glacken & McCarron 2008, p.3093). Boyle (1994, p. 166, citing Werner & Schoepfle 1987) suggests this third dimension "rounds out the ethnographic picture". Having one foot inside the culture being studied and one foot outside it enables the researcher to understand social structures taken-for-granted by the participants (Kleinman 1988).

Trying to understand the emic/participant's perspective became a driver to shaping the questions asked of participants, interview participant selection, and who was engaged in informal conversations during field work for example. Observation was used to try and understand and explain the behaviour and beliefs of participants, and thus the culture in which the participants worked and lived (Hammersley 1992). In order to understand and explain behaviour and cultural patterns, the strength of the ethnographic method became apparent; there was a difference between what people said they do and what they actually did, and both of these perspectives are captured in ethnography (Morse 1994). The ability to compare data sources exposed discrepancies between stories nurses and parents told me, and the observations I made during field work.

Uncovering these discrepancies allowed multiple stories and realities to emerge (Allan 2006). A clear example of the difference between narrative and the reality of practice was nurses reporting to me that they did ask parents about their emotional state, and parent's reports and participant observation, which revealed rare and infrequent emotional communication between nurses and parents. Hammersley (1992) notes,

> *"to rely on what people say about what they believe and do, without observing what they do, is to neglect the complex relationship between attitudes and behaviour; just as to rely on observation without also talking to people...is to risk misinterpreting their actions" (p. 11-12).*

As a researcher, my responsibility was to observe nurse-parent interaction (etic), ask participants questions about what was going on (emic), then interpret the etic and emic perspectives, into a third dimension to round off the ethnographic picture. That picture was my interpretation of what was happening. The interpretations were then continually reported and discussed with the participants, to check that my understanding was also their understanding. An example of rounding off the ethnographic picture occurred when it was becoming apparent that nurses rarely approached parents about their emotions, and instead focused on the care of the child. I had an informal conversation

about my understandings with a parent who then described being upset the previous evening. This is an excerpt from my field notes,

> *I asked her if she had ever felt upset since she had been in hospital. She said she had last night when her daughter woke up at about 2200 distressed and short of breath. Mum had tears in her eyes. I asked if the nurses had noticed that and what did they do? She said she thought they did notice but that they just worked at looking after her daughter, and then said they would leave her to settle the daughter down* (Field notes 19.4.11, p. 14, Book 2).

Focused ethnography

Ethnography can take a number of forms, from a global (macro) ethnography whereby researchers spend several years in the field undertaking extensive study, to a more focused (micro) ethnography where the researcher studies a sub-culture such as a single ward or group of specialist nurses (Holloway & Wheeler 2010). According to Willis and Anderson (2010), a focused ethnography is different from traditional ethnography in that the topic is specific, and the researcher has an ability to enter and experience the "richness of the real of world of people within a particular setting" (p.96). Other features of focused ethnographies include: a single researcher; focus on a discrete community; focused on a problematic concern and context specific; limited number of participants; participants holding specific knowledge and episodic participant observation (Higginbottom 2011). Boyle (1994) notes that focused ethnographies help nurses "understand cultural rules, norms, and values and how they relate to health and illness behaviour" (p.172).

An understanding of culture can be illuminated through exploring the perspectives of both nurses and parents, and through observing how they interact with each other. This study is a focused ethnography as the aim is to examine the nurse-parent interaction, specifically emotional communication, within the context of a hospital ward. The topic is context specific, there is a single researcher; the scope is limited and the problem focused and context specific (Boyle 1994; Higginbottom 2011; Willis & Anderson 2010). In this study, the taken-for-grantedness in the nurse-parent interaction, and nursing practice surrounding the interaction was under examination. This study uncovered cultural norms, values, and practices that operate out of conscious awareness. A focused interpretive ethnography enabled the often unnamed and unnoticed social and cultural structures to be explored and understood. Bringing these cultural processes to

attention raised awareness among nurses as to what makes their communication with parents problematic.

Ethnography and nursing research

Ethnography has been widely used in nursing research since the latter half of the 20th century. Within nursing research, ethnography has been employed to understand the meaning of health and illness behaviours of patients and improve the cultural appropriateness of practice (De Laine 1997); to examine behaviours and perceptions in clinical settings to improve care and clinical practice (Holloway & Wheeler 2010); and to develop understandings about the organisation of health care and provide insights into nursing practice, specifically understanding the culture of the recipients of health care (patients) and the providers (nurses) (Morse & Field 1996). Ethnography helps nurses understand cultural roles, norms and values, and their relationship to health and illness behaviour (De Laine 1997).

Nurse ethnographers have argued that the method suits nurses because they possess well-honed observation, documentary and analytic skills (Oliffe, 2005). Ethnography has been employed by nurses in a diverse range of settings, for example: to explore children and families' experiences of long-term renal illness (Waters 2008); to observe social processes in relation to patients' and staff experiences in a fertility clinic (Allan 2006); to explore the experiences of families when a child with cancer relapses (De Graves & Aranda 2008); to explore caring and control in an acute psychiatric unit (Boddy 1992) and to examine factors affecting rural African women's participation in HIV prevention (Duffy 2005). Nurse ethnographies specific to nursing communication have uncovered the nature of the communication between nurse-patient (Fosbinder 1994; Mallet 1997); nurse-nurse interactions (Payne, Hardey & Coleman 2000); nurse-child communication (Lambert et al. 2008), and nurse-surgeon communication in the Operating Room (Gardezi et al. 2009).

Authors have highlighted many benefits to the data collection in this approach, such as the use of a reflexive diary to manage the researcher's emotions (Allan 2006) and track developing insights and understandings (De Graves & Aranda 2008); the ability to use multi-modes of data collection (Lambert et al. 2011) and the freedom of informal conversations to collect data, avoiding the rigidity of more structured interviewing (Lambert et al. 2008); and the collection of rich data revealing multiple dimensions of social and cultural life (Duffy 2005). Hughes (1992) suggests that the ethnographic method is like a "case study approach to understanding human behaviour" (p.448).

Holloway and Wheeler (2010) believe that ethnography in the nursing context allows the "examination of behaviours and perceptions in clinical settings, which leads to an improvement of care and clinical practice" (p.156). Addressing the insider (emic) view versus the outsider (etic) view, Simmons (2007) noted that nurse researchers already have an emic view, enabling them to quickly immerse themselves in the culture and context of the field as participant observers. This can be an advantage, however a drawback may be that the nurse researcher enters the field with preconceived notions of how people may behave and think (Fetterman 1989). Documenting assumptions and biases in field notes and reflexively observing thoughts and interpretations assist the researcher to manage this process.

Methods of data collection

Geertz (1973) notes that, data is "our own construction of other people's constructions of what they and their compatriots are up to" (p. 11). By writing down observations, the researcher changes a passing event existing in a moment, into an account (Geertz 1973). In this section of the chapter, the setting or context of the study and how data were collected for this research will be described.

Setting

The research was completed within a region in New Zealand. The region chosen for the study was a convenient one, meeting three requirements: having a large regional hospital with a separate children's ward, being within commutable distance from home and workplace, and being new to me as researcher. I had never been in the region's hospital, and was unknown to hospital staff and patients as either a registered nurse, or a nursing lecturer. This was important, as I was entering the field as a PhD student and did not want any confusion with my previous or current work roles.

The context of the research is a children's ward of a hospital and the cultural context is the culture of the ward, where nurses and parents interacted. The children's ward is a sub-culture of a larger organisational culture, the hospital and District Health Board. Hospital wards are separate organised units within a larger organisation. The larger organisation (hospital, district health board) provides the resources enabling the ward to function, but each ward has its own patterns of behaviour, artefacts and knowledge that could have only occurred in that particular setting.

The predominant dedicated space for nurse-parent interaction when a child is hospitalised is a children's ward of a hospital, consequently the field work component of the study was undertaken within a single setting, one ward of a regional hospital in New Zealand. The ward is a general paediatric ward with medical and surgical services, situated within a regional facility offering acute services. Institutional access to the hospital to conduct the study in a ward over period of time was negotiated and agreed upon with the Director of Nursing at the District Health Board. The Charge Nurse of the children's ward also gave approval for access.

Prior to the study being undertaken, and during the development of the research proposal, consultation occurred with the Service Manager at Māori Health, at the District Health Board. The Service Manager Māori Health was contacted by phone initially to discuss the study, and then sent a draft of the proposal. I then met with the manager before commencing the data collection. Approval for the study was verbally given prior to data collection, with written approval arriving at a later date due to clerical error (Appendix 1). A Locality Assessment form was approved by the District Health Board (Appendix 2). Ethical approval for the research was granted from the Regional Ethics Committee (Appendix 3) and the Human Research Ethics Committee at the University of Technology Sydney (Appendix 4).

Once all approvals were gained, I negotiated with the Charge Nurse of the ward, times to be present in the ward. Prior to the field work commencing, A4 fliers advertising the research were displayed in the ward, which were visible to both parents and nurses (Appendix 5). It was vital that all participants understood the purpose of the research and why I was present in the ward. One week prior to commencing field work I visited the ward twice, on two consecutive days to meet with nursing staff following am-pm handover at 3pm. I discussed the aims of the study and explained what I would be doing in the ward. I handed out Participant information sheets for nurses (Appendix 6) to those thirteen nurses who attended these meetings and answered questions about the study. I left Participant information sheets for nurses who were unable to attend the meetings, and for parents, Participant information sheets for parents (Appendix 7) were distributed throughout the ward.

The nursing staff at the information sessions were curious about the study, asking informed questions and were particularly interested in whether I would be delivering care to the children. I reminded them that I would not be delivering care as was not employed by the District Health Board as a registered nurse. Rather I was there as a

participant-observer of nurse-parent interactions within the context of the ward, further clarifying my role as an outside observer. I reiterated information on the Participant information sheet for nurses that each nurse had the right not to take part in the study.

Field work: participant observation

The key characteristic of an ethnographic study is the observation of the participants in the study, in order to study people's behaviour in everyday contexts (Hammersley, 1990). Observation requires the researcher to participate in ward activities at some level. Participation can be chosen from four levels (Simmons 2007). These are complete participation, moderate participation in order to observe and learn about behaviour, passive participation, predominantly observing with limited participation and complete observation with no interaction. In this situation where I had some knowledge of the context of the environment, a children's ward, but no knowledge of this particular setting, I determined that the most appropriate level for me was as a moderate participator/observer (Simmons 2007). As a moderate observer I collected written data, such as field notes, by observing events directly in context, and could assist with nursing care under the direction of a registered nurse where appropriate thus maintaining my identity as a nurse. Maintaining the distance of a researcher gave me time and space to record observations and ask questions (Simmons 2007). In reality, I mainly observed nursing practice, rather than participating in it.

Observation was facilitated by my status as honorary staff which was granted to me by the Director of Nursing, on my first day in the field. This status gave me access to staff areas, including the locked doors in and out of the hospital and the ward, and the drug room in the ward. It also gave me an ID badge with my name, title (PhD student), area of work (Child Health) and photo. When I met staff and parents for the first time, it gave me legitimacy and identified me as a researcher. I wore the badge at all times during field work.

Handwritten field notes based on participant observation was the primary means of data collection. The observation took three forms (Angrosino 2005a). The first form was descriptive in which all details observed were recorded in a naïve manner, taking nothing for granted. In this early stage I mapped out the physical elements of the ward space, as an understanding of the environment gives a sense of the cultural patterning of participants. I followed Roper and Shapira's (2000) advice at this early time of field work, purposely avoiding evaluating and judging what I observed, experiencing the environment without the usual nursing responsibilities. The second form was focused

observation whereby only material closely related to nurse-parent interaction were observed, concentrating on specific categories of the interactions. The third form was selective observation focused more specifically on rituals and patterns (Angrosino 2005a). One priority of participant observation was to probe under the surface to examine social meanings and cultural motives that underpin social actions (Geertz 1973). An example of probing transpired during an informal conversation with a young mother who stated that she felt nurses were *sniggering about her* (Field notes, 1.6.11, p. 1, Book 3). I asked the mother what this feeling meant to her and what she understood was happening between herself and nurses, for this to occur. Her understandings of this experiences helped me further appreciate the complexity of the nurse-parent interaction.

Field work commenced on 17 March 2011 and concluded on 27 July 2011. In the four months of field work, I visited the ward 44 times. The shortest visit was three and a half hours, and the longest was nine hours. The average visit length was six hours. Two hundred and eighty hours were spent in the field. All field work was undertaken between Monday and Friday inclusive, and mostly was completed between 6.30am and 9.30pm. Occasionally I stayed later if the ward was busy. In the initial few weeks, I visited the ward for the duration of all three shifts in order to experience the ward over the entire 24 hours, and attended the three shift handovers (7am, 2.30pm, and 10.45pm). During this orientation stage, I focused on exploring the ward. At that early stage of field work I wanted to experience the ward activity, nuances, and routines. Holloway and Wheeler (2010) note that this early period is the initial phase, a time of exploration.

My visits to the ward were usually Tuesday, Wednesday and Thursday of each week, starting on an afternoon shift on the Tuesday, then a full day on the Wednesday and a morning shift on the Thursday. Having a short break between field work visits (less than 12 hours usually) over these three days, enabled me to reconnect with parents who may have been admitted to the ward late one day, and then were discharged the following morning.

This level of immersion into the setting enabled me to meet the study's aims of understanding the cultural context of nurse-parent interaction, ensuring that the novelty of the research wore off for the participants, thus allowing me as researcher to be largely unnoticed, in my observational role. Staff and parents became used to having an outsider in the setting (Bolton, 2000). This time in the field allowed for the

development of rapport and trust between me, the researcher and the participants in the study (Lambert et al. 2008). There was a depth of immersion into the setting, and observation of the setting in a naturalistic way, with social and cultural processes being able to be observed in detail (Allan 2006). This enabled "'cultural patterning', (looking for repeated, identifiable thoughts and behaviours in various situations with various participants) and interpretation (incorporating specific context and meanings participants attribute to, and the researchers understanding of, the scene/event)" (Lambert et al. 2011, p.18).

In the initial period in the field it was apparent that some nurses were uncertain of my role in the ward, asking me what I wanted to see and what they needed to do when I was with them. As time progressed however they became more relaxed and I noticed more chatter when I was 'hanging around' (sitting in the nurses' station, for example). About mid-way through the field work participants accepted my presence in the ward, sometimes asking what I was finding, but generally getting on with their practice (nurses) or life (parents) without reference or regard to me, indicating that I was now seeing their authentic practice. One day a nurse noted that I was like part of the furniture which indicated to me that the staff had now fully accepted my presence in the ward. In the fourth month of field work, it became apparent that there was little new or different from the previous visit. I made a decision to conclude the field work, and termination of field work was carefully planned. As observed by Spradley (1979), taking leave is an important element of the ethnographic method. I advised staff that I would be leaving the following week and gave a date of my last visit. At the conclusion of that visit, I had an afternoon tea for the staff to thank them for having me in the ward.

Data sources: informal conversations

In the initial phases of the field work, I gave out the Participant information sheets for nurses (Appendix 6) to every nurse I met, and at the beginning of each shift. I talked to each nurse I met regarding my researcher role in the ward during the shift, and asked for verbal consent to be present during any interactions. After several weeks I had met all nurses who worked in the ward, and they all consented to participate in the research for the duration of the field work. Consent was ongoing during field work, in that I checked consent every time I shadowed a nurse, even if they had previously consented. During the first few weeks of field work I based myself in the central nurses' station and would accompany individual nurses when they left the station to attend to their work. Nurses were chosen randomly, or if they were attending a specific situation. However I found this process disjointed and chose instead to start each visit to the

ward with a ward handover to gain an overview of what was happening in the ward, and then asked one nurse if I could accompany her for the entire shift. All the nurses I asked agreed to this. Thereafter I would shadow (that is following the same nurse like a shadow) the same nurse during that visit. Shadowing the nurse meant that I would observe the nurse when she was interacting with parents and children, and when she was completing other nursing activities, or sitting in the nurses' station. I was then able to have ongoing informal conversations with the nurse, encouraging her to share reflections on her nursing practice with me. As observed by Lambert et al (2008, p.3094), informal conversations avoid a rigid question/answer framework and enable natural discussion of "here and now" experiences. Informal conversations also gave me opportunity to continually share my own observations and interpretations with nurses and to receive feedback on my initial interpretations. An example of sharing my own observations and receiving feedback was one evening when I was shadowing a nurse working in the Assessment Unit. I shared with her that I had not seen nurses asking parents what they wanted when they were admitted to the ward. She responded that,

> *sometimes she did* [ask parents about their needs] *if she had time, and felt like it but most times she didn't "cos I am lazy". She believes that nurses don't ask about parents' emotional concerns because they haven't had the education, they are worried about what the parents may say, they are not social workers* (Field notes, 19.7.11, p. 106-107, Book 3).

During field work, I accompanied a wide range of the nurses, to ensure that I observed and had informal conversations with a variety of different nurses. During quiet times, I hung around (Boddy 1992; Pawlich, Shaffir & Miall 2005), moving quietly between the nurses' station and the corridor, on the alert for any situation/event which may add to my understanding. In total I conducted 96 informal conversations with nurses, averaging two conversations each visit. Some conversations would continue throughout the visit, others would be shorter.

After the initial orientation weeks to the ward, I commenced undertaking informal conversations with parents. Each visit, I introduced myself to any parent on the ward whom I had not previously met, gave them a Participant information sheet for parents (Appendix 7), and asked to speak to them informally at a time convenient to them. If child who was able to read was present when I met the parent, I gave the child a Participant information sheet for children (Appendix 8) to ensure the child understood my presence. If the child was pre-reading, I explained to the child in plain language

what I was doing in the ward. During field work, three parents chose not to give consent for participant observation during their stay in hospital. No children refused consent. Following verbal consent, conversations with parents invariably occurred at the child's bedside, but occasionally if the child was asleep the parent and I would find a quiet place on the ward to talk, such as the parents' lounge, or an empty room. If I had met the parent previously, I would again visit, check consent was ongoing and ask if there was anything else they would like to discuss with me. These conversations totalled 142 separate encounters, averaging 3.5 informal conversations each visit to the ward.

As a researcher in the field, I endeavoured to spend as much time as possible with the two groups of people I was observing: nurses and parents. Shadowing a nurse each visit gave me an opportunity to see a range of different nurses interacting with a number of parents on a single shift. If I had chosen to 'shadow' a parent for an entire visit, I would have had less opportunity to observe nurse-parent interaction. It also may have been invasive to have spent a longer period of time with a parent who was in the ward to support their child. There were opportunities to 'hang about' with nurses as when they were not with patients, they were in the nurses' station, whereas there was nowhere else for parents to go except by their child's bedside.

During field work, I conducted seven digitally recorded informal conversations with different nurses following an observation of a nurse-parent interaction which I interpreted as particularly noteworthy, or following an important incident, or comment from a participant. Incidents I regarded as important were those where I had observed a parent being emotional and wanted to follow up with the nurse and parent their experiences, or I overheard (such as in handover) a nurse discussing an experience of managing parents' emotional communication.

I conducted one recorded parent interview while in the field following a situation in the ward. The conversations were recorded to ensure that I retained all the salient information being shared with me. Recording the conversation also demonstrated to the participants that the particular incident or situation being discussed was important to me as researcher. These informal conversations added depth to my data and enabled me to have a deeper understanding of the cultural norms and the taken-for-granted experiences and practices in the ward.

Data sources: written documentation

Supplementary data sources were accessed as part of data collection (Speziale & Carpenter 2003). Hammersley and Atkinson (2007) recommend that written texts and records are accessed as they provide information that cannot be gained by direct observation and questioning, and add knowledge about the group being studied. All written documentation on the ward was extensively read and noted in field notes to gain further insight into nurses' responses to parents, and the cultural context of the ward. The documentation I reviewed included public notices, ward notices, literature in the ward, staff folders, policies and procedure manuals and children's medical notes (in which nurses documented their patient care). Patient's medical notes were not read randomly, rather I would read patient's notes if I was aware that a parent had been emotional, or if I was aware of a particular situation, or had observed an interaction between a nurse and parent, and wanted to uncover the nurses' documentation of the incident.

Data sources: field notes

As has been mentioned field notes were taken as a record of my data collection. During field work I carried a hard cover notebook with me and made notes of every interaction, observation and also my reflections as the visit progressed. Field notes were taken throughout field work and included observations, copies of data sources, personal reflections and my responses to what I observed. It was important that during the research, participants' experiences take precedence, rather than my own expectations (Roberts 2007), therefore I focused on aspects of the interaction/relationship that participants appeared to find difficult to articulate or seemed to be unaware. An example of this is a situation where a parent was described in handover as being, for example, difficult or emotional. I then focused my attention on the nurse interactions with that parent, observing and noting what was going on. I followed up observations with informal conversations with both nurse and parent. I then shared my interpretations about what was happening to both parent and nurse to get feedback.

The notes incorporated everything I observed, using all senses. I noted initial impressions, the sounds of the ward, the smell, the colours, and the look and feel of the locale and people (Emmerson, Fretz & Shaw 1995). I recorded details about the big picture, such as how many people were in the ward, who they all were, and what they were doing at any one time. I noticed who was interacting with whom and what they were discussing. At other times, my view was narrowly focused on an interaction

between two or more people, body language observed, content, tone of voice. Bourgois and Schonberg (2009, p.12) discuss the “artisanal practices” of ethnography, referring to the researcher merging into the environment and participating in everyday life, whilst always mentally racing to note the significance of what is happening. Key incidents or events were noted, observed feelings, tone, impressions and interactions (Emmerson et al. 1995). Following a conversation with either a parent or nurse, I noted the interaction, summarising what was said, and, sometimes, noting the conversation verbatim.

I retreated to write my notes as soon as possible after an observation or a conversation, using either a seat in the nurses’ station, or preferably a parent chair in a vacant room as the latter was quieter. Emmerson et al. (1995) advises that the timing of writing field notes is dependent on the relationship between the researcher and participants in the field. For me, it was important to write the notes after every interaction or observation as I found that if I delayed writing I would sometimes forget important data. I was constantly intent in noting and noticing everything I observed as well as my reflexive responses to my observations and interpretations. At the end of each visit, I read through my notes for the day and reflected on my observations, also making notes of anything I needed to explore further during the next visit. Rereading the field notes later proved a powerful trigger for my memory, and I would be able to recall that specific time and place, the sound of the voices, and all that surrounded it.

Interviews

In order to gain a deeper understanding of underlying cultural norms and structures within the setting (Holloway & Wheeler 2010), ten parents and ten nurses with whom I interacted while in the field and who were willing to talk to me were invited to be interviewed following field work. Viewed as key informants, these were participants in the field who had special and expert knowledge of the group they identified with. Key informants were nurses and parents who had been in the ward for a period of time, and/or who were willing to talk to me about specific situations or incidents they recollected or that I had observed. The parent was no longer in hospital at the time of interview. Spradley (1979) notes that key informants have tacit knowledge, an awareness of the cultural norms and assumptions of those in the setting. Semi-structured interviews with key informants enabled me to take my initial interpretations and thoughts to the participants to check for accuracy, the member checking process (Sandelowski 1993). This further data collection process gave participants an

opportunity to validate, refute or elaborate the findings further, and added another layer/level to the data collected.

Ethical approval was gained to interview up to 12 parents and 12 nurses, however during field work, a decision was made to reduce the number to 10, as it proved difficult to access more than 10 parents following their discharge from hospital, and it was appropriate to have the same number of parent interviews as nurses. The selection of parents was based on my intention to interview a broad range of parents, from different ages, ethnicities, different socio-economic groups and different genders. Ages of parents interviewed ranged from 21 years to 53 years with the average age being 37 years. Of the parents interviewed, their child in hospital ranged from six months old to 14 years, with the average age being six years. Nine of the parents interviewed were mothers, one was a father, and one interview both mother and father were interviewed together. Two parents were Samoan, one was New Zealand Māori, and the remainder were New Zealanders of European descent (Pākehā). In one interview a grandmother (of the child in hospital) was present and responded to some of the questions.

With regard to nurse interviews, again I selected a range of nurses from new graduates to more experienced staff, from New Zealand registered nurses, to overseas registered nurses. Of the ten nurses interviewed, ages ranged from 21 to 47 years, with an average age of 34 years. Those nurses had worked in the ward from 10 months to 18 years, with the average time being six years. One nurse was newly graduated, one was an overseas registered nurse, and six had worked in the ward for more than five years. Nine nurses interviewed had a baccalaureate degree, and one had Diploma in Comprehensive Nursing. Two of the ten nurses had completed or were in the process of completing a post-graduate qualification in nursing.

Interviews commenced on 7 September 2011, six weeks after the conclusion of field work and concluded on 22 November 2011. The time between the end of field work and the beginning of interviews gave me time to review my field notes, develop my interpretations further and structure interview questions (interview schedule Appendix 9). Interviews were held either in the participant's home, a spare office at the hospital, and in one case in the motel where I was staying. Parent interviews were between 29 and 64 minutes, with an average of 52 minutes. Nurse interviews were between 28 and 77 minutes, with an average of 50 minutes. The interviews were recorded with a digital recorder and were transcribed verbatim by a professional transcriptionist.

Establishing trustworthiness in the research

Ascertaining validity, reliability and generalisability are conventional ways in which research is judged as rigorous and truthful. The onus is on the qualitative researcher to establish the accuracy of their findings, validity (LeCompte & Goetz 1982). Validity is the accuracy of the methods used to collect and analyse information collected during the research, and reliability means that methods of collecting the data are consistent, stable and repeatable (Roper & Shapira 2000). Generalisability is the extent to which the findings of the study can be replicated to the general population.

Reliability

LeCompte and Goetz (1982) provide a succinct discussion of and offer some useful strategies to address the problems of reliability in ethnographic research. They note that ethnographic research has been considered unreliable and suggest that ethnographers address validity and reliability from an ethnographic perspective. According to these authors, ethnographic research approaches, rather than attains reliability. To enhance reliability, LeCompte and Goetz recommend recognising and managing five problems: researcher status position, informant choices, social situations and conditions, analytic constructs and premises, and methods of data collection and analysis.

Researcher status position addresses the extent to which the researcher is a member of the studied group and the position held. Documentation about the research made public in the ward identified my previous roles. In my verbal introductions to all participants I identified myself as a researcher first, then as a nurse. As researcher, I am a children's nurse and have previously worked as a registered nurse in a children's ward. I was careful not to be seen as a nurse on the ward, wearing different clothes to the hospital staff (striped shirt, black trousers and shoes), having a name badge clearly identifying me as a PhD student and a hospital identification card which stated my honorary staff status.

How participants are chosen influences the results of the study. In this study all parents who were in hospital with their children were approached to participate in the study. All registered nurses were also participants, and I endeavoured to shadow a different nurse on every visit. Follow-up interviews were with key informants who were willing to talk about their experiences, and who had a range of experiences to discuss, within the constraints of participant availability. I deliberately sought out a wide range of

participants, in age, gender, ethnicity and socio-economic background, in order to provide variety and to reflect the diversity of the ward population.

Social situations and conditions influence the content of ethnographic data as participants may feel restrained discussing their experience in particular social situations. During informal conversations on the ward, I ensured that the conversation was held in private where possible. Sometimes the conversation would be interrupted, so we would stop and resume at a later time. Conversations with nurses were occasionally held in the nurses' station sometimes involving more than one nurse. Informal conversations with nurses were held in any situation where there was no child or parent.

From the first day of field work, nurses invited me to join them for their tea/meal breaks which involved leaving the ward together, walking to the cafeteria and sitting together for up to 30 minutes. During this time I did not carry my notebook, and did not take field notes, however sometimes observations and comments made by staff were noted on my return to ward, as these social interactions with staff added to my perceptions of the cultural context of the ward. These conversations assisted in my understanding of how the nurse participants actively constructed their world (Field 1983; Morse & Field 1996). Having this level of involvement with nurses added to my acceptance on the ward as participant observer. Staff clearly perceived I was a staff member (albeit honorary) and were welcoming to me. Physically moving from the ward where the study was being undertaken, to a more neutral area (the staff cafeteria) also allowed staff to ask me more personal questions about my own life. This mutual sharing enabled more in-depth responses to my questions and informal conversations when on the ward, a reciprocal relationship between myself as researcher and participants (Simmons 2007). The length of time in the field, the level of immersion and the relationship between myself and participants enabled me to experience nursing practice in its authentic state.

Analytic constructs and premises involve ensuring that definitions used are carefully defined in order to eliminate confusion. In this study, key terms used such as parent, child, nurse, culture have been clearly defined. Analysis categories are discussed in the results chapters. Methods of data collection and analysis need to be logically presented in order for the reader to be able to audit the processes followed. Data collection and analysis processes are detailed in this chapter.

There are other ways of establishing rigour in ethnographic research. Stewart (1998) suggests alternative criteria for evaluating truth in an ethnographic report, as he argues that validity, reliability and generalisability are not a useful fit within the ethnographic method. Stewart suggests reliability is replaced with objectivity as it is impossible for an ethnographic study to be replicable as suggested by reliability. The nature of ethnography as a "mode of continuous learning about people, cultures and their relationships" (Stewart, 1998 p.15) cannot be replicated. Instead Stewart argues that ethnographers need to aim for objectivity, as in being "alert, and receptive to the views of others, having empathy and being open-minded" (Stewart, p. 16). The question for the researcher related to objectivity is: "how well does this study transcend the perspectives of the researcher/informants?" (Stewart, p.16). In this study, both perspectives of reliability were encompassed, with the reflexive nature of ethnography enabling me as researcher to constantly question how my values and ideology may be influencing the data collection and data analysis. Avoiding taken-for-granted assumptions implicit in the interpretive approach to the study also enabled receptivity to the views of others and open-mindedness. The focus of the analysis was to move beyond description, and to reveal and explain aspects of social patterning (Morse & Field 1996), reflective of the culture being examined.

Validity

Internal validity is the extent to which the scientific observations are authentic representations of a reality, and external validity addresses the degree to which those representations can be compared with other groups (Le Compte & Goetz 1982). A strength of ethnographic research is the high internal validity (credibility) because the prolonged participant observation and data collection process allows for continual data analysis and constant refinement of categories (Le Compte & Goetz 1982). The length of time in the setting, the number of visits, the diversity of informal conversations, and multiple data sources all enabled validation of the data (Chenitz & Swanson 1986). The use of participant observation, which enabled me to witness behaviour and conversations simultaneously and in a detailed manner, also helped overcome the discrepancy between what people say and what they actually do (Lundqvist & Nilstun 2007).

As collected data were being simultaneously analysed, information from one source was verified with a number of other sources to check its validity. Verbal data were checked against written records. Clarification and elaboration of meaning and intention

from participants during field work was constantly sought, as a means of member validation or member checking (Sandelowski 1993).

Instead of validity, Stewart (1998) suggests veracity meaning 'power of conveying or perceiving truth'. The question the researcher needs to answer is "How well does this study succeed in its depiction?" or "Has the researcher really observed what their descriptions claim?" (Stewart, p.15). Guba and Lincoln (1982) suggest that the credibility of the research equates with internal validity, and recommends questioning whether data sources (usually human participants) find the researcher's analysis, formulation and interpretations to be credible.

As a further member check for the accuracy of the ethnographic account, following the completion of data collection a comprehensive summary of the initial findings (a 12 page summary) (Appendix 10) was emailed to all nurse participants and 10 parent participants, asking them if the findings were an accurate representation of their experiences, and requesting a response by mail, email or phone.

Further to this, the research findings were presented in the ward. Prior to the presentation, a flier was sent to the Charge Nurse advertising the presentation (Appendix 11). One week later the research findings were presented using a powerpoint presentation (Appendix 12) and I elaborated and discussed the slides with those present. The presentation was held following am/pm handover in the nurses' station. Sixteen people attended the presentation, including the Director of Nursing, the nurse managers of the ward, six staff who were in the ward when the data were collected, three nursing students, and three new registered nurse staff members. Written email responses to the written summary (one from nurses and two from parents) and verbal responses received following the ward presentation all confirmed that my interpretation of the setting was recognisable and rang true to the participants as their own experience. Credibility was further enhanced by my long involvement with participants, selection of participants who had extensive knowledge of the experience, persistent involvement in the setting and use of peer debriefing (Lincoln & Guba 1985).

The third criteria, generalisability is replaced by perspicacity, which gives the researcher opportunity to focus on whether the study has generated insights that could also be applicable to "other times, other places, in the human experience?" or "how fundamentally does this study explain?" (Stewart, 1998, p.16). Hammersley (1992) observes that ethnographic findings are not generalisable, but can produce theoretical

understandings, noting that "[ethnographic] description is the first stage in theory development" (p.22).

Stewart (1998) agrees with Hammersley (1992), explaining that given the nature of participant observation, recording cultures undergoing constant change, it is not possible to suggest generalisability. However perspicacity enables the researcher to develop an understanding of structures, processes and relationships that could be applied beyond the research setting. The first level of verification (Morse & Field 1996), the member checking processes and sharing the ongoing interpretations with the participants, during field work and again in the formal interviews, enabled insights and explained the cultural norms and expectations of this particular setting. The second level of verification with the related literature was also important in this process, whereby other research which had similarities with the results themes, became part of the analytic process (Holloway & Wheeler 2010). Analysing the results of this study, in comparison to other studies, enabled the revelatory nature of this study to transpire.

Data analysis

The goal of analysis is to produce rich ethnographic description as text (Waters, 2008). Within the analysis process, the researcher is searching for parts of a culture and their relationships, as conceptualised by the participants (Spradley, 1979), and moving beyond description to reveal and explain aspects of social patterns or observed conduct (Morse & Field 1996). One of the features of an ethnographic study is the copious amounts of notes collected including researcher's observations and reflections, interview transcripts, and documentary data (Roper & Shapira 2000). Hammersley (2008) asserts analysis places the researcher "between equally impossible ideals, seeking to portray a world as it is in all its diversity and complexity, and on the other hand, rendering it down to some coherent and stable representation" (p.45).

Data collection and analysis occurred simultaneously as data were interpreted throughout its collection. This process involved transcribing all field notes from notebooks into a word document, then uploading that document into a computer programme NVivo 8 (QSR International, Victoria, Australia), a qualitative data management software, which enabled me to store, manage, classify and order data. All data gathered were eventually uploaded into this software.

An inductive process was followed, paying close systematic attention to the data, then generating as many issues, topics and themes as possible (Emmerson et al. 1995). From the initial multiple sources of data, 189 'parent' nodes were established using NVivo 8. Nodes were descriptive labels given to "chunks of words, sentences or paragraphs" (Roper & Shapira 2000). The focus of the labels was always trying to answer the questions driving this study, explicitly emotional communication between nurse and parent and the environmental and cultural context of the nurse-parent interaction. This period of the analysis involved moving back and forwards, comparing and contrasting between the nodes being developed, and the original data, which adds credibility.

Each node represented categories, which were refined, constructed, deconstructed, and then reconstructed again. Categories were further broken into smaller categories, describing patterns and themes. Working back and forth, a classification system was developed working through "issues and concerns into categories of analysis and verifying meaningfulness and accuracy against data in the field notes" (De Laine 1997, p.215). Links between categories were refined and specified. This analysis is defined as an 'iterative process' (De Laine 1997); the ongoing analysis guided the continuing data collection, which in turn influenced the analysis. Spradley (1979) advised avoiding imposing categories from the outside to create order and pattern; more preferable is to discover the categories themselves. Categories were named by the words participants themselves used, and as each category developed, that is more and more data were added, patterns and themes emerged, The following excerpt from a parent interview, with my early interpretation and naming of category levels provides an example of the analysis process,

> *I'm not blaming the nurse because the nurse will just take as what we say. You know but the reality is they're* [parents] *not fine…according to what we're going through at the moment…why we didn't, you know let them* [nurses] *know of our feelings and that.* (Category: cultural barriers – tell the nurse they don't need help when they do; larger category: why parents don't seek emotional communication from nurses).

Further refinement of data analysis followed the process outlined by Holloway and Wheeler (2010); build, compare and contrast categories; search for relationships and group categories together; and lastly recognise and describe patterns, themes and typologies. Emmerson et al. (1995) state that analysis is not just a matter of

discovering out what the data contain, but also included selecting key incidents and events, giving them priority and understanding them in relation to others.

An important aspect of this study is that as a researcher, who is a registered nurse, I had some insider (emic) understanding of the setting, culture and environment. I used a process described by Bernard (1988, p. 320) as a "constant validity check" to illuminate this emic understanding. This involves moving back and forth between the etic perspective (my assumptions, ideas and questions) and the emic viewpoint (observations, participant's reports, and interviews) and testing the etic against the emic. I wrote up my field notes following field work, and then checked my interpretations and ideas with participants next time I was in the field.

De Laine (1997) suggested using strategies to enhance theoretical sensitivity to the data collection/analysis process. Theoretical sensitivity is the progression the researcher makes from description to theorising (De Laine 1997). Theoretical sensitivity assists in "breaking away from standard ways of thinking, taken-for-granted assumptions and implicit meanings that obscure one's vision" (De Laine, 1997, p.219). Asking a variety of questions and questioning the obvious is one strategy. Questions were then asked of the categories such as 'what is the culture here?' and 'what does that mean?' Analysis of words, phrases and sentences, systematically comparing different components, and avoiding taken-for-granted understandings was threaded throughout the analysis. A final stage of the analysis was the generation of fifteen major findings which had been constructed inductively from the analytical, iterative process. These findings represented interpreted meanings of the culture of the ward, and how the participants understood emotional communication (Roper & Shapira 2000). These findings will be discussed further in the results and discussion chapters.

Ethical considerations

The research is based on the belief that meeting appropriate ethical requirements is an essential part of research. This research was guided by three documents: from Australia, the National Statement on Ethical Conduct in human research (National Health & Medical Research Council 2007), and from New Zealand, Guidelines on Ethics and Health Research (Health Research Council 2005), and The Treaty of Waitangi (Waitangi Tribunal 2010). The research is underpinned by principles of the New Zealand Treaty of Waitangi, namely partnership, participation and protection.

Respect

Respect for the participants in the study is the overarching ethical principle in human research. Prior to seeking ethical approval, the consultation with Māori Health Service providers sought to ensure that the research process proposed was safe for potential Māori participants. Participants in the research entered into a partnership with the researcher. Participant Information sheets for parents and nurses detailed the purpose of the research, the criteria for being a participant in the study, what participating in the research involved, any discomforts, benefits, how privacy was protected, the costs (financial or otherwise) of participating in the research, and what to do if there were any concerns during the research process.

Informed consent

Consent was negotiated each time I approached someone in the field to ascertain if they were willing and able to talk to me at that time. As such, consent in ethnographic field work is an ongoing negotiated process; it does not occur in a one-off manner. Participants who were being observed were asked to give verbal consent to take part in the study. Participants who were interviewed were invited to sign a written consent form (Appendix 13) agreeing to participate in the study. Before commencing a structured interview, I again reminded the participant that all information is confidential, that a pseudonym will be used, that no identifying information will remain in the data, and that they could choose to withdraw from the study at any time.

The written consent form is underpinned by the ethical principles of: autonomy, the right to be treated as a responsible human being with the right to make free and informed decisions; beneficence, the research must be in the best interests of the participants and the community; non-maleficence, the positive decision to do no harm; justice/equity, fair treatment in the recruitment of participants and the review of the research (National Health and Medical Research Council 2007). The language used was clear and explicit to enable a reasonable person to understand the nature, purpose and methods of the research. Peer review of all documentation given to participants checked the language used. Protection of the participants was ensured in the following ways: the participants were able to withdraw at any time without being disadvantaged in any way; all participants were anonymous through the use of identification codes; all nurse participants are identified as female, regardless of actual gender; the transcripts of interviews had no names noted and the transcriber signed a non-disclosure form (Appendix 14).

Participants were asked if they wished to view the research findings before they were made public. All nursing staff in the ward and all participants who were interviewed post field work requested the research findings (Appendix 10) and these were sent to all participants prior to the presentation in the ward. Data has been stored in a password protected electronic file and a locked filing cabinet for the duration of the research and the preparation of thesis and publications.

Consideration of risk: nurses

There was a concern that registered nurses who consented to being observed and/or interviewed in the study may have felt their nursing practice was being judged by the researcher. Nurses may have been concerned that participating in the study might jeopardise their ability to provide safe nursing care. There may have been concerns about confidentiality and breaches of privacy. Nurses may have been worried about confidentiality and anonymity in the documentation arising out of the study, including field notes, recorded interviews and the final thesis. There may have been concerns that any observed unethical or unprofessional nursing behaviour may have been reported to ward management.

Consideration of risk: parents

Parents may have been concerned that if they did not agree to participate in the study or they did agree and then expressed concerns about the care they have received by nurses, that their child's care may have been compromised. They may also have been worried about the confidentiality of the study and whether they or their child may have been recognised in the documentation and/or final thesis. In the course of the research, participants may have experienced emotional pain and concern.

All risks noted above were addressed as detailed below in the section on ethical issues specific to ethnographic research. It is important to reiterate that participants were free to withdraw from the study at any time without consequence and that consent was continually negotiated. As researcher I encouraged participants to discuss any concerns about the research with me in order to allay any anxieties participants had. I was open and transparent with regard to the purpose of the study. Counselling facilities would have been arranged and financed by the researcher to be used if necessary by the participants. They were not required.

Ethical issues specific to ethnographic research

There are ethical issues specific to ethnographic research. These are premised by the ongoing interaction between the participants and the researcher, and that the researcher is the primary data collector.

Ersser (1996) notes four major areas of ethical consideration arising from ethnographic research. These are noted below in italics, alongside how these were managed in this research. The first is *avoiding or limiting deception.* I was transparent with regard to the research purpose, with documentation, fliers and ongoing verbal discussions with those interviewed, and for the children of parents who participated in the research. Staff and parents knew what I was doing in the ward, and interview participants were clear about the purpose of the interviews.

The second area noted by Ersser (1996) is *protecting the autonomy of the participants.* Protection is also a key component of the Treaty of Waitangi which is a guiding document for this research. Autonomy of the participants was protected by ensuring that participants were informed about the nature of the research and any implications for themselves of participating in the research, such as time and distraction. Consent was informed and freely given and was continually negotiated. Writing the study has relied on a range of participant's voices being heard. Verbatim quotes are given without reference to the codes used to identify participants in order to protect anonymity, and also because participants' comments are representative of the group response, of either parents or nurses. Material can be located by word search to original data sources for audit purposes.

Avoiding or limiting intrusion/respecting the welfare of participants is the third area noted by Ersser (1996). As Ersser suggests, ethnography involves making public the things said and done in private. As researcher I had an obligation to the participants to be as unobtrusive as possible, and to maintain the balance between pursuing meaning of observations and not unduly disrupting the ordinary quality of the exchanges observed. As a nurse researcher, I endeavoured not to interfere with any nursing care. Nursing care of the child and the family was of primary importance, and was always the first priority for me as a researcher.

As a registered nurse, I had an ethical responsibility to respond if I witnessed unethical/unprofessional behaviour from any nurse. The Participant information sheet for nurses (Appendix 6) detailed my assurance to nurses that I was not judging their

nursing care, and that in the unlikely event that I observed a practice that breached professional or ethical boundaries, I was required to report this, informing the staff member in question prior to discussing the issue with managers. During the field work I did not witness any unethical/unprofessional behaviour.

The final area noted by Ersser (1996) is *encouraging the ethical use of research findings*. Confidentiality was assured through the use of identification codes throughout the data collected and data analysis. The context of the ward environment is extensively detailed in the results chapters to remain true to the ethnographic method which aims to understand the context of behaviour, not simply the content of that behaviour (Angrosino 2005b). Angrosino further observes that cultural context includes all factors influencing the behaviour of people, including the people, groups, institutions, and physical environment. However key features in the ward have been changed to obscure the ward setting. The findings will be written up for publication in nursing and medical journals, ensuring that confidentiality is maintained.

Reflection on methods

When this research topic was first identified, a number of potential research methods to examine the phenomena were identified, such as interpretive phenomenology (Dean, Smith, & Payne 2006) and action research, particularly co-operative inquiry (Heron & Reason 2001). Using a phenomenological approach, the plan was to interview nurses only, to examine the nurses' experience in depth. This approach was discounted as it was apparent that parents' perspectives also needed to be gained, as well as a wider view of the context of the interaction. Co-operative inquiry was also discarded, as it was clear that more knowledge needed to be gained about the phenomenon before practice change was implemented.

Ethnography (Hammersley 1990) was chosen specifically to ensure that the cultural context of the interaction was understood, and also to gain entry into the world of the participants. Participant observation, informal and formal interviews, and written documentation on the ward were the mainstay of data collection. It was anticipated that institutional permission to enter into a ward may have been difficult, but this concern proved unfounded when the first hospital and ward approached agreed to entry. Further concerns were that nurses and parents in the ward may have been uncomfortable with my presence, observing their practices and interactions as they went about their activities, however the open nature of the observation, the documentation stating the purpose of the study, and the opportunities given to

participants to challenge me regarding my presence in the ward seemed to allay concerns, resulting in all nurses and all parents, except three, consenting to my observation.

As previously argued, focused ethnography (Willis & Anderson 2010) requires the researcher focus on a discrete community and to use episodic participant observation. Observation in this study was part-time, three days a week for four months. The length of time for participant observation was open-ended and it was up to me as a researcher to decide when to exit the ward. Terminating my relationship with ward staff was a difficult process for me, as I was concerned that I would miss something important. The final decision to leave the setting was made after a number of visits in which no new information was gleaned, and the data was becoming repetitious. I was also starting to feel too comfortable in the ward and was concerned I was in danger of *'*going native', thus no longer seeing those taken-for-granted aspects of culture that had been so apparent in the early weeks of observation.

The average length of stay in the ward for parents was two days, thus being in the ward each week for three consecutive days ensured that I was there for the majority of the parent's stay. Most of the nurses were part-time and I was able to spend at least one shift with most of the nurses employed on the ward. The decision made after several weeks of observation, to shadow one nurse for the entire visit enabled me to spend time with nurses when they were at the child's bedside (front stage) and in the nurses' station or utility rooms (backstage), which allowed more informal conversations with nurses discussing their previous interactions and more insight into their experiences. It may have been beneficial to have made that decision earlier in the field work, however those early weeks of observation were more a broad sweep of a setting, gaining an understanding of how things were done, and what went on in the setting.

The level and depth of analysis required in ethnography was a challenge and required extensive time commitment. Coding of copious notes, conversations and interviews was the beginning of a very lengthy analytic process. The analysis process is a strength of the method but as a researcher new to the process of ethnographic research, this was a considerable test.

Chapter summary

This chapter has detailed the decision processes undertaken to choose a research method, a focused ethnography with an interpretive approach. Central to the decision-making process was the need for a method which would illuminate the broader contextual factors of nurse-parent communication. An interpretive approach enabled an examination of social meanings and cultural motives (Field 1983), which led to awareness as to what makes nurses' communication with parents problematic.

Describing the method gives the researcher an opportunity to detail the research process, and provide an auditable route from the beginning to end point of a study. Salient features of this study were the various sources of data, use of informal conversations and formal interviews, and a lengthy analysis process which facilitated the representation of the participants world as it was, as understood by the participants' emic perspective, and my etic perspective, determining a third view, my interpretation of the culture of the ward. My interpretations have been subjected to continually asking myself 'are you sure?' meaning constant validation of the interpretation of the data with the participants. A further feature of this study is the reflexive nature of the study, always trying to learn from participants, to understand their point of view, whilst simultaneously acknowledging my own biases and assumptions, and the effect I myself have had on the data collected.

Ethnography as a method has proven able to uncover and illuminate knowledge about nurse-parent interactions, and specifically the cultural processes surrounding those interactions. With lengthy participant observation, and informal and formal conversations, I was able to unravel the difference between what people said they do and what they actually did.

In the following chapters, the ethnographic interpretation of the data will be presented, as the results.

Chapter 4: The Ward

Introduction

In this section of the results chapters, the context of the study, the children's ward of a hospital are described. A comprehensive and detailed description of the physical environment, including population, structures, and organisation is provided to enable faithful representation of the nature of the social phenomena under investigation (Hammersley 1992), that is, the children's ward of a hospital. This discussion of the ward is viewed through a focused ethnographic lens, focused on "what's going on here?" Data for this section of the chapter were gained from field work observational notes, extensive institutional documentation collected during field work and informal conversations with staff during field work. Some key elements of the physical description of the ward have been changed to ensure anonymity, however the general ambience of the ward is reflected accurately. In order to locate the data within a context that espouses culture, it is important to have a comprehensive understanding of the setting (context) of the study. *Words in italics* are verbatim comments from participants.

The research setting

This study was undertaken in a single setting, one ward of a regional hospital in New Zealand. The ward is a general paediatric ward with medical and surgical services, situated within a base hospital facility offering acute services. The children's ward (thereafter called "the ward") is a moderate sized unit, accepting children between the ages of birth to 14 years.

The physical layout of the ward

First impressions of any environment are lasting: initial impressions of the ward are olfactory, a slightly antiseptic aroma, reminding that this is a hospital. The visual introduction to the ward environment is large blocks of colour used in the decor. The entrance to the ward has colourful posters on the wall, toys on the floor, and brochures for parents. Main entry into the ward is through a large door with a high door handle. On the door is the following sign,

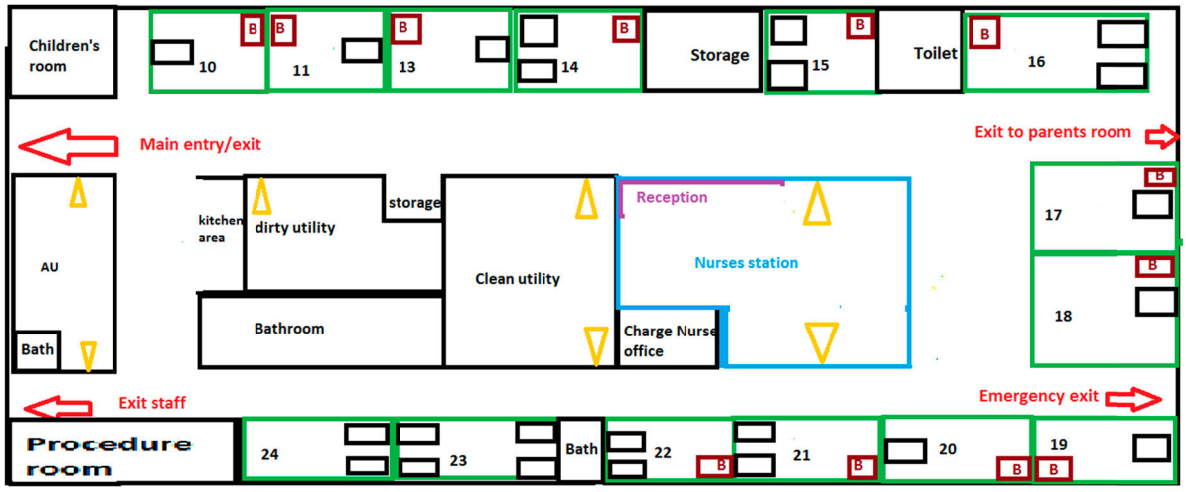
> *Children's ward: this is a safe place. Regardless of one's relationship to a patient,* [name of hospital] *security team will be called to remove any person from the hospital premises whose actions adversely affect the safety and well-being of all staff and patients.*

And another,

> *Welcome to the Children's Ward. After 8pm visitor access to the Children's Ward is a privilege and is only granted on a case by case basis. Visitors are required to leave the Unit when directed to do by Children's Ward staff without delay.*

A notional plan (not to scale) of the ward is included as Figure 1. The plan shows the relationship between the different key functions, and is indicative only. Once through the door there is again the impression is colour. The carpet in the corridors is red, with yellow patterns embedded into the carpet. The walls are yellow/cream with a silver handrail running the length of the wall, topped by a frieze of children's cartoon characters. Above the frieze are an assortment of pictures, life-sized cartoon cut-outs, notice boards with information for parents, some in English, others in the Māori language.

Figure 1: Ward Layout



Immediately after entry to the ward is the children's room, where parents/caregivers can take their children to play. There are many children's books on low shelves, a large lego statue, some ride-on toys, and a large TV. There are external doors leading to an outdoor play area. The play and education room also has posters lining the walls, mainly of interest to children, for example New Zealand insects, although there are also parenting education posters, such as a 'quitting smoking' poster. Across the corridor from the playroom is the Assessment Unit (AU). This room can be accessed by either corridor.

AU has space for four children at a time, but only two beds and two cots. There is a desk with space for two staff to work. The desk has an above-head level backing to provide privacy. There are numerous posters aimed at parents/caregivers on the walls, including motor development up to the age of one year, quit smoking help, infectious diseases information, advice to keep cell phones switched off, information about 'Toolbox parenting groups' and 'Parents Inc', both organisations offering parenting help. There are four low comfortable chairs, and higher chairs situated beside each bed.

Patients' rooms are all similar, the main difference being the number of beds in each room, and whether the room has its own bathroom. Some are single rooms, some double, and one room has four beds. All rooms except two have their own bathrooms for the child's use (labelled B in Figure 1).

Beds are a cot, a small bed or a large bed. All beds are electric. Beside each bed is a locker on wheels. Some rooms have a parent bed that can be pulled down from the wall, some have a La-Z-Boy chair which converts into a bed. Each room has oxygen and suction units. All rooms have a window with a view outside, offering plenty of natural light.

Utility rooms include the *dirty* where bedpans, urinals, and basins are stored, and the *clean* where medications are dispensed and equipment for dressings and procedures are stored. On the walls of both these rooms, which are out-of-bounds to non-staff, is educative material for staff such as information about medications.

The ward reception is visible through a sliding glass window in the nurses' station. The ward receptionist sits there in office hours, greeting visitors and responding to requests, amongst many other duties. Opposite the reception area on the wall in the corridor is a large poster, headed "Children's ward Team", with photos of staff. Paediatricians have photos, with their title and surname listed. One paediatrician is named with his first name; all other staff has their first names only, under their photo. Included in the staff are the ward clerk, hospital aides, and nurses, including nurses who work in Home Care (a service operated out of Outpatient clinics, staffed by nurses who also work in the clinics).

Just outside the reception is a white board with a photo of the Charge Nurse with full name and title. It also states the Nurse in charge of each shift; 7am - 3.30pm, 2.30pm -

11pm, and 10. 45pm - 7.15am. There is space for staff who are currently on duty to write their names on the board, and I observed that the information on the board was usually updated daily. Just past reception is one of the doors into the nurses' station which is the central area of the ward for staff. There are another three further patient rooms on the left. Double doors end this corridor, which need to be opened by pushing a knob which is high, out of reach of children. These doors lead to the parents' lounge and the parents' suite. The parents' lounge has a small kitchen where parents and staff can help themselves to hot drinks, and toast for breakfast. It has some comfortable armchairs, as well as a table and chairs. There is a television in the room. The walls are covered with posters for parents including this one from Children, Youth and Family, a service of the Ministry of Social Development in New Zealand,

The 10 things children need most:
The basics: food, clothing, warmth, shelter, and love
To feel safe and secure
Cuddles and good touching
Lots of smiles
Praise and encouragement
Talking
Listening
New experiences
Respect for their feelings
Your time and care.

Other posters in the parents' lounge offer advice on the *First 12 months of baby's life; No smacking; Quit smoking; Never shake a baby; Rights and responsibilities; Sexual violence.* The parents' lounge is used by nurses between 2.45pm and 3.30pm for their 'am' shift to 'pm' shift handover. There is a notice on the door informing parents the room will not be available then. The parents' suite has two single rooms available for parents wishing to use them. These rooms are allocated to parents at the *staff's discretion*. Both rooms are lockable from the inside as they open directly onto a public corridor. They have a bed and bedside table, and there is also a bathroom with shower. This is the shower facility for all parents staying in the ward.

To gain entry back into the ward, a doorbell must be rung and the person wishing to enter must then wait for someone to open the door using a release button in the nurses' station. On return to the ward, to the left are two single rooms. On the wall is a

large clock and a sign: *Children's ward rox* (rocks). The external wall of the nurses' station is mainly glass from the ceiling to desk height, then painted bright marine blue. On the walls are brightly coloured wall stick-ons. Looking through the windows into the nurses' station, large stuffed toys are visible sitting on top of shelves, also notice boards, folders and files. There is a notice facing outwards on one of the windows: "*We're against violence towards women".*

The emergency exit on the left has a large wooden cut-out of a waving, smiling children's cartoon character. There are a further six rooms 19, 20, 21, 22, 23 and 24, on the left, and on the right, the nurses' station, Charge Nurses office, clean utility room and bathroom. At the far end of the corridor on the left is the procedure room. This is the room where children are taken to for any procedure, for example insertion of an intravenous cannula, taking blood samples, insertion of a catheter, and lumbar puncture. This room is also decorated with many colourful posters, and stuffed toys. There are four bins with calico dolls, play dough, play cooking equipment. There is also a DVD player and speakers as well as numerous pieces of medical equipment.

The noise of the ward is usually a quiet hum of television in the background, staff talking in rooms or the nurses' station, occasionally punctuated by a child calling out or crying. There is an atmosphere of relaxed purpose, of staff knowing what they are doing and where they are heading.

The overall impression of the ward meets the expectations of a children's ward; colourful, child-focussed, and homely. The space is generally sufficient for the population who use it and the area functions well for its purpose. The lights are bright and the atmosphere is welcoming and friendly. Patient rooms are large enough to accommodate the child and a family member staying, or multiple visitors seated. Staff spaces, especially the nurses' station are cramped at times, especially in the morning when other health professional staff (doctors, social worker, physiotherapists, students) use the room, and at staff handover times, 7am, 2.30-3.30pm and 11pm.

Much of the literature on the walls is focused on parenting education, particularly parenting programmes/managing difficult behaviours, and parenting help; family violence; quit smoking; common childhood communicable diseases; immunisation; however there are also a number of signs informing parents on what to do/how to behave. Parent behaviour signs in the ward are particularly evident in the ward kitchen area: "*The food in this fridge is for patients only!!!!"* and *"PLEASE ASK STAFF*

BEFORE HELPING YOURSELF TO THIS FREEZER" and *"Milk fridge only!!! Breast milk must be kept in the fridge on the shelf not the door. Thank you!!"* A notice on the door of the children's room asks parents/caregivers: *"Please do not take toys out of this room".* Sometimes beds are stored in corridors, and all empty beds have this sign *"I AM A CLEAN BED WAITING FOR A PATIENT. PLEASE DO NOT SIT ON ME. THANK YOU".*

On the door leading into the nurses' station is a notice: *"PLEASE No patients or visitors in the office. We must protect patient confidentiality".* When a child is in isolation (for infection control), a sign is attached to the door, which is a child's drawing of stick figures, one of whom is washing their hands. The sign reads: "*KEEP YOUR HANDS CLEAN: wash your hands".* Other signs in the ward advising parents on behaviour include *"please don't bang door shut. Children are easily disturbed by this! Thank you"* and this one regarding food *"Information for parents: meals are not routinely supplied to living in parents. We are only able to supply meals to: breastfeeding mothers and some designated parents. Thank you".*

Outside the Charge Nurse's office is a big notice board covered with media clippings about the ward, mainly of children and families who have been in the ward. Further down that corridor is a display of photos with captions showing a child's journey through a surgical procedure: arriving in the ward, waiting in the children's room, waiting before theatre, funny pyjamas and a hat – checking into theatre, getting monitored on the computer, having a special sleep, after an operation – waking up in the recovery room, and getting ready to go home.

At the reception there is a large sign headed,

> *"Children's ward team norms"*
> *We will use our norms to ensure we have a healthy work environment*
> - *Each team member will be respected and valued for their contribution*
> - *Team members will work together in a positive manner to achieve a united goal working cooperatively and utilizing each other's strengths*
> - *We will maintain a friendly welcoming atmosphere for all staff*
> - *Good practice will be acknowledged and positive feedback given by all team members.*

The hub of the ward for staff is the nurses' station, where all staff movements originate and to where all staff return on a regular basis. The area is accessed from either corridor, and can be viewed from the corridors through large windows. Running the length of the wall looking out over two single rooms (17 & 18), is a desk with two computers, two telephones and three to four swivel chairs. This is where nurses sit, to talk to their colleagues and/or complete their documentation. Others, particularly medical, physiotherapy, and social work staff also use this seating. There is a security television screen high in one corner showing the entrance to the ward. Under this desk is the release button to the door leading to the parents' lounge.

On the opposite wall of the nurses' station is a large book case which houses patients' notes at hand level. On lower shelves are numerous folders such as *staff roster; incident reporting; pain sedation manual; infection control manual; gastrotomy care and enteral feeding; IV compendium; general guidelines/nursing skills; telephone consults; orthopaedics.* On the shelves are a book full of thank you letters to staff, all taped and well presented, and a Staff Communication Book last used two years previously.

There is a small bench with cupboards below next to the shelving unit. On the right of the shelves is the central core of the station for nurses, a narrow filing cabinet, on top of which is the *allocation book.* The allocation book is large, with the left page for the *'am'* shift, and the right page for *pm* and *night* shifts. The book is ruled in advance by staff, then the allocation of patients to staff is entered by the previous shift leader. Above the allocation book are thermometers (axilla), stethoscopes and pulse oximeters. This is the central point for this equipment.

Nursing staff starting their *shift* enter the station and firstly go to the allocation book to check their patients for the day, and then look at the white board on the left of the door. On the white board patients are listed next to their room number, alongside their age, consultant, primary nurse, duty nurse, diet and whether a parent is present. Also noted on this board are whether the child is in isolation, a *high dependency* (an acutely unwell patient who requires one-to-one care) patient (green dot by their name); or under the *homecare* team (orange dot). The medical registrar on call is noted, with the date, name and pager number, as is the medical consultant.

The walls of the nurses' station are covered with notice boards containing information on uniforms, parking, education opportunities, and special events such as International Nurses Day activities. There are 48 different patient information brochures displayed in

the corner of the room that have been developed by staff to give families about their child's condition.

The nurses' station is a scene of constant activity with coming and going. Very rarely is the station vacated and on several occasions as many as 16 staff could be present at any given time, including nurses, Charge Nurse, paediatricians, doctors, hospital aid, and ward clerk, engaging in up to six different group interactions simultaneously.

As well as the many signs around the ward, telling parents/caregivers where they can go and what they can and cannot do, parents are also given a coloured pamphlet on arrival to the ward, with a photo of the external play area and *"Welcome to the Children's Ward".* Inside the brochure is a place for the child's specialist to be noted, then information on doctors rounds *'please ask your nurse for times',* followed by *'Nursing'* noting that nursing is a 24 hour service, with the aim of continuity of staff to attend to child, and working with parent in partnership to meet the needs of the child. Subsequent to this is the following,

> ***You can expect the nurses to:***
> *Plan with you the nursing care to meet you and your child's needs*
> *Explain the plans to other nurses who will care for your child*
> *Tell you what to expect before tests or treatments*
> *Teach you about health care related to your child's illness*
> *Arrange follow-up and liaise with your health visitors/district nurses and social workers as appropriate. This will be done in conjunction with you and your family*
> ***We need you to:***
> *Tell us what you want*
> *Keep us informed about how you feel*
> *Tell us if you have an idea or preference about your child's nursing care.*

Included in the pamphlet is information about the television, meals, phone, social worker, then some general information about *staff only* rooms, what to do in an emergency, visiting, visitors, and brothers and sisters. The last page of the pamphlet gives parents/caregivers information about living in the ward, noting that only one parent can be accommodated overnight, where to sleep, Marae accommodation on hospital grounds, parent facilities, shower, toilet, ward kitchen, and car parking. Feedback is asked for and advice is given regarding how to provide feedback.

Information for parents is also provided as an A4 poster on the wall of each patient room. These posters include information about accommodation for parents, the parents' lounge, meals, visiting, and taking children out of the ward. A further poster describes nursing care, reiterating the pamphlet expectations about what parents/caregivers can expect of nurses. Additionally to the pamphlet the notice adds that parents need to,

> *Work in partnership with us*
> *Tell us about your child*
> *Help us meet his/her individual needs.*

Notably the request on the pamphlet to *tell us what you want* is omitted from the poster. In addition the poster advises parents to ask questions, and advises nursing care occurs over three shifts, reinforcing the importance of handover to ensure continuity of care. Finally the poster notes that the ward is a,

> *'Family Centred Environment'. The service and staff work within a philosophy of family-centred care. This means we aim to:*
> *Support family members as partners and decision-makers*
> *Respect each families values, beliefs and religious and cultural background*
> *Provide you with information so you can make choices*
> *Share information with you*
> *Respect your decisions*
> *Be flexible where possible*
> *Work together with you*
> *Empower you in the care of your child.*

In summary, the physical layout of the ward provides an indication of how things are done around here. The ward is similar to many other children's wards: calm, colourful, child-friendly, light-filled. Most activities between nurses and parents are completed in patient's rooms, so behind closed doors and invisible to others. Parent education is a focus, particularly regarding effective parenting, and family violence prevention. Parents have information from a range of sources regarding expectations of them during their stay in the ward, and what they can expect from staff. The expectation is that parents will do what is expected of them, by the signage and instructions given. Some rules of the ward are written, but there was also an unwritten rule, that parents

would do the right thing, namely take care of their child, concede to the advice of hospital staff and not create any fuss.

The ward population

The children's ward of this regional hospital is a public place, with people regularly coming and going. In addition to the children who are the patients, there is an adult population entering and staying in the ward for a period of time; four main groups of people dominated the ward: nurses, auxiliary staff including care assistants and cleaners, medical staff, and parents/caregivers of a child in the ward.

Nurses

At the time of field work there were 30 registered nurses employed in the ward. All nurses were female. A number of the nurses worked part-time, with some only working specific shifts such as afternoon or night duty. Initial impressions of the nurses were positive. Nurses wore colourful multi-coloured tops with black cargo pants which gave an impression that they were playful and fun. Each nurse had the words "registered nurse" embroidered on their shirt, and some also wore their New Zealand Registered Nurse badge. Some wore a name badge, usually first name only. Some had used tape to mask their surname on their name badge.

The nurse population had a low turnover. During four months of field work the only staff movements were two staff leaving for maternity leave, and one staff member commencing employment in the ward, from another nursing position in the hospital. There was a wide range of experience amongst the nurses, some had been working in the ward for longer than 10 years, and others were new graduates. Some nurses were engaged in post-graduate study.

Nursing students from a local tertiary education institution were sometimes placed in the ward for clinical experience for a period of up to six weeks. Usually only one to two students were in the ward at the same time. Students completed the same shifts as nurses, although rarely did a night shift. Students were *buddied* with a registered nurse and practised alongside the nurse, assisting with patient care. Occasionally the student's clinical supervisor visited the students in the ward.

Nurse Management

Overall nurse manager of the ward is the Clinical Nurse Specialist (CNS). As well as

being responsible for the ward, she is responsible for all children who enter the hospital, from the emergency department, neonatal unit and clinics. The CNS was frequently seen in the ward, talking with staff, and patients. Day-to-day management of the ward is the responsibility of the Charge Nurse (CN). This position was charge of the ward, the paediatric clinics and a nocturnal enuresis programme, managed out of the clinics. The CN has an office close to the nurses' station, and was highly visible. The third member of the nursing management team is the Clinical Nurse Educator (CNE). This role was a part time one, and included the Neonatal Unit and the ward. The CNE was present on the ward for any teaching or education. These sessions often occurred after the *am to pm handover* at about 3pm. All nursing management wore the same uniform as the nurses. The nurse managers usually were present in the ward in office hours, 8-5pm weekdays.

Medical staff

Seven paediatricians worked in the ward, all on a rostered basis. One paediatrician was the Clinical Director of the Unit (comprising the clinics, home care, neonatal unit and ward). Paediatric registrars provided 24 hour cover of the ward. At times, training medical students in their sixth year were also present in the ward. Sometimes other speciality medical staff came to the ward to see their surgical, orthopaedic, or ear nose and throat (ENT) patients. The busiest time for medical staff on the ward was between 8.30am and 11am when they would visit to do the *ward round* which involved reviewing the notes and then seeing the child for whom they were caring. Medical staff were also seen in the ward when a patient was admitted to either CAU or the ward, and when they were called to review a patient, usually by nursing staff.

Two medical staff wore a similar multi-coloured top as the nurses, otherwise they wore street clothes. Medical staff would mainly position themselves in the nurses' station, with forays into the child's bed space. They were often seen in groups, especially in the morning during the *ward round.* Later in the day, a paediatric registrar would arrive in the ward and would work at a desk either in the nurses' station, or in the Assessment Unit.

Auxiliary staff

Auxiliary staff comprised of one ward clerk, who worked office hours, and was based in the reception area of the nurses' station, and three hospital aides (HA) who usually worked during the day and evening. There were no hospital aides *on duty* (present and working in the ward) during the night shift. One HA worked mainly morning shift and the

other two worked mainly in the afternoon shift. Their duties included meal distribution, managing the kitchen areas, dirty utility, and assisting staff when required with bed-making and tidying the ward. They were not responsible for patient care. All auxiliary staff wore similar multi-coloured tops to the nursing staff.

Other health professionals

Other health professionals came and went into the ward, as required. A social worker worked for the Child Health Service and was a regular visitor to the ward. Physiotherapists, dieticians and other health professionals also visited the ward to see patients. Other health professionals wore street clothes and were only identifiable with their visible ID (identification) card. They mainly positioned themselves in the nurses' station where they had access to patient notes. Most of the visits by other health professionals were between 8 am and 4pm weekdays.

Child patients

Children patients were the least visible population out and about in the ward, as they were usually in their rooms, and the doors to rooms were often closed. During field work, the least number of child patients present on the ward was five, and the highest was 19, with an average of 11 patients per shift. Excluded from this number were patients present in AU which fluctuated and was not visible from the ward. Most children had a parent or primary caregiver with them consistently, but a small number did not.

Parents/caregivers

There were a range of avenues by which parents and their child were admitted to the ward. Some came via the referral from the AU. Some parents had open entry to the AU, especially if their child had a chronic illness (such as Cystic Fibrosis, or Type 1 Diabetes). Others had already spent time in emergency department (ED), their child having been assessed there by a medical doctor who then liaised with the on-call Paediatric Registrar who had offered entry to either the AU or directly to the ward. The remainder of the children were admitted to the ward from home, and were usually arranged admissions for a procedure (e.g., surgery, lumbar puncture, CT (computerized tomography) scan. Generally the parent's arrival was expected in the ward, especially if they had come from ED. In this case the ED nurse would give a phone handover to the ward nurse, who would usually ask if a parent was present with the child. Parents therefore often had a long period of waiting for assessment of their

child by medical staff in ED, AU or both, or may have entered the ward directly from home.

Those parents who had entered the ward via the ED/AU were generally with a child considered *acute*, meaning the child had an illness/injury with a sudden onset and thus was considered to require hospital level care. Previous to admission to hospital, the parent may have visited a primary health care provider, often several times, before the child was deemed to require hospital care. These decisions were invariably made by medical personnel, both in primary care and emergency care settings.

On arrival to the ED or AU further diagnostic tests may have been required, such as a blood test, a urine test, or an x-ray and often the care intervention was started, frequently with the insertion of an intravenous infusion. Finally, when the medical staff had made a medical diagnosis of the child's condition, and any required tests had been completed, the child was admitted to a room in the ward.

Parents/caregivers, either living-in or staying for short or long periods during the day, were highly noticeable in the ward, as they entered and exited the ward, went to the parents' lounge for food and drink or time-out, left the child's room to use the bathroom or phone, walked up and down the ward with a restless child, moved with a child to the children's room, or came out of their room to find staff. However parents/caregivers usual location was beside the child's bed/cot. The overwhelming majority of parents/caregivers were *living-in*, and took up residence beside their child.

Parents mainly engaged with nurses, with the nurses initiating the interaction during visits to the bed space, usually with the purpose of completing a nursing intervention on the child. Parent interactions with nurses depended on how often the child required nursing specific care; thus if a child was unwell the nurse would be present up to every 15 minutes or more frequently if required, but if the child was reasonably well and awaiting discharge, the parent could expect to see a nurse every two to three hours. Interactions with other health professionals including medical staff would be less frequent, daily or less often, usually in the morning.

Visitors/ family members/friends

Visitors were family and friends who came to visit the child and family members. Visitors were welcome between 10am and 12pm, and again between 2.30pm and 7.30pm. The parents' welcome pamphlet also specified no visiting between 1pm and

2.30pm which was a *rest period* for children. On most occasions visitors arrived in the ward, went to the reception window in the nurses' station, asked the ward receptionist for permission to see the patient and were then directed to the patient's room. Thereafter that visitor would freely walk into the ward and visit their friend/family member. The only enforcing of this rule was at about 8pm at night when a nurse would announce over a loud speaker system that visiting hours were over and visitors needed to leave the ward.

Summary: ward population

Key players in the ward were the staff, which was dominated by nurses. Staff were unified by their common colourful tops, and by their congregation in the nurses' station. Away from the nurses' station, most staff were alone, except medical staff who were usually in pairs or groups. Parents and other visitors were indistinguishable from each other, as they entered the ward and moved in and out of children's rooms. Child patients were least visible in the ward, staying mainly in their bed space. In public places such as the corridors, it is the nursing staff who were most visible. Parents were much less in evidence, with children rarely seen. Because of their visibility, nurses seem accessible, and also provide the ward with authority and calm. In the next section of this chapter, the nursing care delivery system, that is how the patient care was delivered by the nurses is discussed, to provide further understanding of the cultural context of the ward.

Nursing care delivery systems

In general, the way nurses are required to deliver care in a hospital situation is determined by hospital administrators, usually nursing leaders. However a children's ward requires different systems than adult wards, as nurses need to practise nursing alongside a family. The nurse managers in the ward, in consultation with nurses had derived the care delivery systems which will be described in this section.

Patient allocation

On each eight hour shift there was one *nurse in charge* and up to four other nurses. On a morning shift during week days, the CN was the *nurse in charge,* with usually four nurses being allocated a number of patients. On the pm shift, one nurse was *nurse in charge,* and this nurse would also be allocated patients. There would be two to three other nurses on the shift. On a night duty there were usually three nurses on *duty* (at work), one being in charge and also having allocated patients, and the others having

their own allocated patients. Patient allocations were completed by the nurse in charge of the previous shift, and written in pencil into the allocation book.

The nurses who made the allocations reported a number of factors that influenced their decisions about which nurses cared for which patients. Factors included the *skill mix* of the nurses, such as the length of experience of each nurse, and whether the nurse had looked after similarly complex patients. Another consideration was who had previously looked after that patient; and who was the *primary nurse*, a nurse with overall responsibility of the patient. Further factors were who was *clean*, caring for other children who were not infectious, and who was *dirty,* caring for children who were infectious; and where the patient was positioned in the ward, to prevent the nurse having patients spread geographically all over the ward, and the acuity of the patient. The CN noted that when she did the patient allocation she considered the *fit* between nurse and family, whether the nurse would *suit* the family and vice versa. The *fit* and the *suit* between family and nurse were determined by the CN, based on her knowledge of both nurse and family. If for example, the CN knew the family liked patient care completed at a certain time, she would allocate a nurse who would be amenable to being flexible. Thus she tried to match nurse and patient personality styles.

Allocation was generally accepted by the oncoming nurse, although on occasions the nurse would negotiate to change the allocation and this was generally agreed to between oncoming nurses. On one occasion nurses were unhappy with the allocation, perceiving that some nurses had a *lighter load*, patients who required less work, than they had.

Nursing care philosophy

All documentation in the ward noted that the guiding framework for staff in the ward was *family-centred care,* underpinned by the belief that *health-care providers and the family are partners, working together to best meet the needs of the child*. There was a hospital policy document on family-centred care, and this framework was also documented in the *Nursing Handbook, Child Health Services* which all nursing staff are given when commencing work in the ward. This document devoted two pages to the family-centred care policy, noting the principle concepts of the family-centred environment; *family strengths, respect, choices, information sharing, support, flexibility, collaboration, and empowerment*. The handbook informed that the *Family Focussed Partnership Model* is adapted from *Children's Nursing in Practice: The Nottingham*

Model (District Health Board (a), n.d.). The model has four aspects, all focused on the nurse: *Sharing of knowledge and information; enabling via teaching and education; facilitating via support and advice;* and finally *self-care and independence* (District Health Board (a), n.d.p.3.).

Nurses are also given an *orientation* book on arrival in the ward, which included six articles from nursing academic journals on family-centred care. The articles were relevant but dated, most being from the mid to late 1990's. The student orientation package observed that the ward philosophy involves *Primary Nursing* (District Health Board (b), n.d.).

During field work, a quality improvement project was undertaken on family-centred care (FCC). This project was led by the CN, but was driven by four nurses who volunteered for this project. The purpose of the project was to review the FCC guidelines, and to reflect on whether the guidelines provided each child with the best care in relation to FCC. The review involved a questionnaire of each nurse on their understandings of FCC, then on their definition and implementation of *Primary Nursing Care.* The project team reported back to staff on their findings, noting that eight staff had responded to the questionnaire, and also that *results seem to confirm the need for primary nursing but clarification of what this involves for the primary nurse and other duty nurses is needed.* The four nurses then made recommendations regarding allocation and requirements of each nurse. Of particular note in the *report back* document was the observation of the tension between providing continuity of care within primary nursing, and allocation of children in relation to patient need, knowledge and skills of staff, and staff development.

FCC as an overriding philosophy of care was rarely discussed amongst nurses; however the operational aspect of FCC, primary nursing and its ramifications were a frequent topic of conversation. Most nurses were of the view that primary nursing was not working in the ward as it should. The CN noted that primary nursing was *falling over,* mainly because of the number of nurses who worked part time, being unable to provide the continuity of care.

According to the documentation reviewed, the admitting nurse needed to assess if the child was likely to be in the ward for longer than 24 hours, and if so, a primary nurse needed to be allocated. There was a column on the white board in the office for the primary nurse's name, however it was rarely filled in. One RN noted that if she liked the

family, and had had a lot to do with the family, she would allocate herself as primary nurse.

In order to make primary nursing more visible, a review which occurred during field work was a three month trial of laminated cards (which it was anticipated would eventually be replaced by white boards) in each room, noting patient name, patient doctor, date admitted, primary nurse and duty nurse for each child. However most nurses found that the concept did not work: nurses did not have time to change the names each shift, sometimes it was difficult for nurses to access the board due to the furniture in the room, and nurses perceived that parents and patients did not understand primary nursing. The concept was not followed through. Just prior to the completion of field work, a ward meeting was held where the CN noted she would be *on the case,* ensuring that each patient who required a primary nurse was allocated one, that each nurse would have three primary patients and that all nurses would be allocated primary patients.

In summary, the espoused nursing care delivery system was family-centred care with its underlying premise that nurses and parents worked in partnership to care for the child. Primary nursing, where one nurse was allocated to a child and would provide the care to that child during the admission and on further admissions, was also used. Provision of primary nursing was under review and it was evident that there was a gap between this theoretical premise and the actual provision of nursing care. Some nurses did seek to work in partnership with families, some tried hard to preserve consistency of care, but maintaining the framework on a daily basis was problematic and difficult.

24 hours in the ward

In order to understand what was going on in the ward, during my first few weeks of field work, I visited the ward over a 24 hour period, over several days. In a hospital, care is provided, children and families are admitted, and life continues, over 24 hours. In the following section, how nurses and parents experienced 24 hours in the ward will be described to glean further recognition of the patterns of their lives in the ward.

Nurses

For nurses in the ward, 24 hours is divided into three blocks of time: 7am till 3.30pm *am shift*; 2.30pm till 11pm *pm shift*; and 10.45pm till 7.15am *night shift*. These blocks were the *shifts* or *duties* most nurses worked, although there were variations to this.

The nurse allocated to the AU started the shift at 12.30pm and finished at 9pm. Some nurses started at 6pm and finished at 11pm.

Morning shift started for most nurses at about 6.50am, even though nurses were not rostered to commence till 7am. Nurses went straight to the allocation book in the nurses' station, collected their *Ward Bed List* for the day, which listed patient bed number, name, patient number, doctor, and diagnosis. The list was printed for oncoming staff by the previous shift. Two oncoming nurses walked around the ward checking that patients on the list are in their beds and are safe (*breathing well and not requiring assistance*). All incoming nurses then went to AU and listened to the patient handover from the night shift, usually recorded by individual nurses on a tape recorder. All nurses listened to all patients' handovers. Handover was usually completed by 7.15am when staff returned to the nurses' station and may then receive another verbal update from the nurse going *off duty*.

Night staff then left the ward, and incoming nurses read the patients notes, making note of anything specific the patient may have due. Nurses then left the nurses' station and entered patient's rooms to meet or review patients and family. At 7.15am the hospital aide arrived on the ward. The CN usually arrived in the ward to commence work at about 8am, starting her day in the nurses' station, checking the allocation book and the white board, and greeting staff.

After meeting patients and family members, nurses gave out medication, often at 8am, then spent the rest of the morning completing tasks of patient care, including ensuring hygiene needs were met such as children were bathed or showered, beds made and linen changed, changing wound dressings, and recording vital signs. At some stage during the morning, usually before 10am, a medical team arrived in the ward to review the patient(s), the medical *ward round*. In attendance on the ward round were the medical consultant who has overall responsibility for the patient, a paediatric registrar, a paediatric house surgeon, and possibly a medical student. The medical team observed who was caring for the child that shift, by checking the whiteboard in the nurses' station, then found and asked the nurse to accompany them into the patient's room. The nurse is usually an observer in the ward round, however often the nurse was asked their opinion on an aspect of the child's health, or an assessment of the child.

Nurses had an allocated 20 minute morning tea break sometime between 9.30am and 10.30am. Breaks were always taken in the hospital cafeteria, about a three minute walk

from the ward, out into corridors, and up a flight of stairs. Morning tea was taken in turns, with one group of nurses and auxiliary staff leaving the ward, and another staying, then swapping over. Before the nurse left the ward, she *handed over* the patient to a nurse remaining in the ward. The handover comprised of information regarding what the patient is doing, or any medication due. There was a requirement that two nurses must remain in the ward at all times.

Nurses take their ½ hour lunch breaks between 1130am and 1230pm, with the same process of turn-taking and handover. Following lunch, nurses begin to complete their work for the day, updating *Trendcare,* a patient acuity computer programme, which notes how much nurses time each patient takes*,* on a computer in the nurses' station. Between lunch and 2.30pm nurses recorded their patient handover on the tape recorder which is kept in the CN's office. Nurses also completed their patient documentation, updating charts, and writing reports.

AU opens at 1pm, with the AU nurse starting the *shift* at 12.30pm. The AU nurse begins the day by checking all the oxygen and suction machines work in each room, in AU and the ward. AU nurses worked closely with medical staff, reviewing patients transferred from home or ED, then either discharging the patient, or admitting to the ward. Admissions to AU varied greatly from none to the ward record of eleven patients over an eight hour period.

Afternoon staff arrived in the ward at 2.30pm and then made their way to the parents' lounge where *am to pm* handover was held. If any parents were in the room at that time, they were asked to vacate the room for handover. The handover was mainly completed by listening to the previous shift nurses recorded messages, but if the nurse had not had time to make the recording, she would come into the room and give a verbal handover to oncoming staff. Ward meetings, and staff teaching also occurred between 2.30pm and 3.30pm, either in the parents' lounge or in the nurses' station. By 3.30pm the morning shift of nurses was due to leave the ward, and they left when they completed their work, usually by the required time.

The afternoon shift for nurses started similarly to the morning shift with nurses returning to the nurses' station to have a verbal patient handover from the outgoing nurse. Nurses then visited their allocated patients, introduced themselves to child and family, and completed patient observations. All medications were checked by two nurses in the clean utility room, and any specific patient care completed. When a new patient

was admitted to the ward, one nurse met the patient and family, orientated them and commenced the patient documentation, which included nursing assessment documentation and the child health nursing care plan.

Nurses started taking meal breaks at 5.30pm and during breaks nurses sat together talking about their work, or their personal lives. Staff remaining in the ward ensured that the patients' meals were handed out by the hospital aid. Most staff were back from meal break by 7.30pm and the rest of the evening was spent checking patients, taking observations, and completing any nursing care such as wound dressings, hygiene care (for example, bathing a child). Parents were often busy talking with other visitors until 8pm when general visiting was over. Nurses checked that parents/caregivers had what they needed for the night such as bed linen and fluids, and assisted with settling the child to sleep. The ward policy was that only one parent/caregiver is *allowed* to stay in the ward with a child. Nurses worked with families to ensure this occurred, although occasionally there was flexibility with this policy.

AU closed at 8.30pm, and the AU nurse went home by 9pm. During the pm and night shift a hospital coordinator visited the ward at least once, to check the staff were managing their workload, and to check bed availability (i.e. how many beds were available in the ward for incoming children) and status of *sick* children, those whose condition was considered unstable by medical and nursing staff (for example a baby with bronchiolitis needing oxygen, or a child with unstable diabetes).

End-of-day observations of the child were usually completed at 10pm, and then all documentation written. Three night staff arrived in the ward between 10.30pm and 10.45pm and handover this time took place in the CN's office. Again following handover, night and afternoon staff met in the nurses' station to discuss patients and ward management issues, such as bed availability. Most afternoon staff left the ward by 11.15pm. Night staff then completed a nursing *ward round*, checking children were *breathing,* equipment was working correctly, and parents/caregivers comfortable. Overnight, nurses left the nurses' station to provide patient care, and to sight their patients at least every hour. Staff reported that they tried to leave the ward for half an hour for a break, but it was more usual to stay on the ward. Staff frequently brought food to the ward, and left it in the nurses' station for all to share during the night. Patients' notes were written any time after 5am, documenting nursing care given during the night and any changes in the patient's medical status. Night staff completed the patient allocation book, wrote nurses names on the white board, updated the fireboard

(noting all people present in the ward in case of a fire), and sent menus to the kitchen. Morning staff arrived on duty before 7am.

For nurses in the ward, structure was important as they knew what to do at any particular time over 24 hours. As most nurses worked across the shifts, they appeared to be comfortable with the routine of each shift. Staff appeared to enjoy the regular structure of the ward, and commented if the ward got too *quiet* (few patients, or patients with little need for nursing care), or too *busy* (a large number of patients, or patients requiring significant nursing care; very sick patients). The best shifts for nurses were those when they had enough patients to be kept busy, but not too many that they felt they were not able to provide the care needed. Describing and understanding the patterns of social behaviour gives an insight into the ward culture, and the meanings given to organisation.

Nursing documentation

During field work, nursing documentation was considered and read as data, especially if it was apparent that a parent had been openly emotional. How and what the nurses noted about the parent's emotional state was observed, as was nurses' documented response to parents' emotional communication. Patient notes were integrated, with all disciplines who worked with the child writing consecutive notes. Nursing notes were divided into sections: general; observations; respiratory; input/output; social. In the *social* section, nurses included information such as family involvement/ contact/family/social issues that have arisen/ CYFS (Children, Young People and their Families Service), Social worker involvement, Mental Health services involvement. Documentation relevant to parents was sometimes documented in the social section of the nursing notes.

Another area of documentation where nurses had an opportunity to document emotional communication was the Child Health Nursing Care Plan. Some *problems* were pre-printed on this document, with one being: *Anxiety and discomfort related to child's hospitalization*. The pre-documented outcome for this problem was: *To minimise parent's stress and discomfort related to child's hospitalization.* Nursing interventions suggested were,

Living in yes/no;
Parents suite/beside;

parent meals yes/no;
keep caregiver well informed of child's progress and care;
ensure respect of cultural/spiritual needs.

If a nurse thought that *Anxiety and discomfort related to child's hospitalization* was a problem for the child and family, a nurse would date the problem, give a time frame for a 24 hourly review and the nurse caring for the child on each shift would sign beside the problem to indicate the care had been provided. At the bottom of the Child Health Nursing Care Plan page was a place for the parent to sign that *the goals for my child's care have been explained to me and I am in agreement with these.* Offering the parent an opportunity to view the goals for their child's care is consistent with a family-centred approach, however the Child Health Nursing Care plan was completed intermittently and irregularly, thus there was usually no documentation that the parent understood the goals of care.

Mum at bedside

The most frequently documented nursing note about the parent was the commonly used phrase *Mum at the bedside* in the *Social* section of the nursing notes. This would be the note if a parent (often a mother) was present with the child for the majority of the shift. Often this phrase would be the only documentation that the parent was present with the child.

Sometimes the nurse would document that the parent was at the bedside, and note that the parent was worried/concerned/anxious. This indicated that the nurse had acknowledged the parent's emotional communication, but there would be no discussion of the nurses' response to the parent,

Social: Mum at bedside throughout becoming more quite upset with xxx's condition.

Another nursing entry for a different child notes the mother's concerns, but again no nursing responses,

Social: Mum concerned that [child] *will be discharged prior to child drinking properly and will go back downhill again. Mum at bedside attending to cares, very tired so settled early when child settled.*

The following entry again notes the mother's overt emotional state, but no response from the nurse,

> *Social: Mum very tearful and did not really think she would end up here, and commented she* [the child] *looks worse than she really is.*

The next entry notes the mother is with the child, and her concerns,

> *Social: mum at bedside attending to cares, ATOR* [at time of report] *mum is not happy for dx* [discharge]. *Mum stated that she is worried they will just come straight back in.*

Sometimes the documentation would include parent's concerns, and the nurse's responses to the emotional communication. Most documentation was written in the third person. This nursing note is unusual in that it was written in the first person and gives more detail. Here the nursing response to emotional communication was to *acknowledge concerns* and *give support,*

> *Parents discussed their anxieties with me and I acknowledged their concerns and reaffirmed the care plan and that we need to work together to help* [name of child].
> *Social: support given as required.*

The following documentation is a series of nursing notes, over a month period about the same family. Nursing responses are reassurance, information and education. The final documentation notes that the mother is coping better with the situation,

> *2/5/11 am Social: mum very upset. Mum reassured +++, information given to mum and dad by Dr XXXX. Both parents attending to bedside cares*
> *2/5/11 2200 Social: mum and dad at bedside. Family at bedside. Mum staying overnight. Family upset and anxious. Education and reassurance given.*
> *3/6/11 1500 Social: at times mum has become very teary and anxious. Reassurance given to mum. Family have been present.*
> *04/06/11 nocte Social: mum attending to cares O/N. Mum appears to be coping ok.*

It was evident that at times nurses did acknowledge emotional communication, and sometimes they also noted their responses to parents in their documentation. However it was also apparent that documentation was inconsistent; parent's emotional concerns were frequently not documented, and nurse's responses to emotional communication were often not documented.

An example of the omission of the documentation of emotional communication was the notes of a four year old child with a life-threatening disease. The notes were reviewed from the time of first admission, two years previously. The first time any parental emotional concerns were noted was 18 months after the first admission. In those 18 months, the parents had had to face the child's diagnosis and poor prognosis and had numerous admissions to the ward as the child's condition deteriorated.

Nurses responded in a variety of ways when asked about the inconsistency of documentation. These included not knowing where to document information about emotional communication, and the way the notes were structured, whereby only variances, that is charting by exception, were to be reported in the nursing notes, with all other reporting about the parent in the care plan. Another concern was regarding legal issues, in that the notes were for the child so issues the parents had did not *fit* into the child's notes. While there was minimal written documentation about parents' emotion, nurses reported handing over the parent's situation verbally following handover.

In summary, nursing documentation, especially with regard to parents' emotional communication and nurses' responses, were found to be vague and inconsistent. Documentation of emotional communication was problematic for nurses.

24 hours in the ward – parents/caregivers

For parents/caregivers, their time in the ward had little structure in comparison to the staff. Parents' behaviour was governed by their child's needs, and the ward organisation. Corridor lights were switched on about 7.30am when the morning staff completed their handovers, read their notes and were ready to meet their patients. Parents were generally expected to be awake, and ready to talk to the nurse at this time. To prepare for this, some parents got up at about 7am to shower and dress. Children's breakfast was given out by the hospital aide between 7.30-8am, so the parent helped the child with their breakfast as required. Parents were able to help themselves to hot drinks and toast in the parents' lounge, however this required leaving

the child for at least five minutes. Parents were then encouraged to stay near their child, in order to be present during the medical *ward round.* On the *ward round* there may have been up to seven staff in the room/bed space, observing one doctor (usually the most senior) examining the patient (for example, listening to heart/lung sounds with a stethoscope, palpating abdomen, checking wounds or drainage bags). The parent was expected to assist the doctor examine the child, and then to respond to any questions. This was also an opportunity for the parent to ask any questions in relation to the child's care.

Following the *ward round* the parent was free to leave the ward if they needed to go home, or go out for provisions, or get some food/drink. If the parent did choose to leave the ward, they were asked to notify staff of their departure and anticipated return time. If the child was able, they could also leave the ward, but usually parents were encouraged to leave the child in the ward to be closely supervised by nurses. Children were offered a snack for morning tea, then lunch arrived at about 1230pm. After lunch there were no further requirements for parents until dinner at about 5.30pm. Parents thus spent their time trying to keep their child entertained; watching DVD's, talking to nurses when they come into the room, and perhaps talking with visitors who were welcome in the ward between 2pm - 8pm. During this time, parents needed to leave the ward to get their own meals. After 8pm parents settled their child for the night, then usually made up their own bed and tried to sleep. Corridor lights were usually out by 10pm, and it was less likely after this time that the parent and child would be disturbed.

Parents reported that time passed slowly for them in the ward. Apart from mealtimes, and the *ward round*, there was little for parents to do except to be with their child. For many parents staying with their child in hospital was a difficult experience, being so used to juggling family life, and/or work commitments. Parents reported feeling *trapped* and struggled with having difficult access to food and drink, showers and toilets. Occasionally parents would describe this situation as positive, having time to spend with their child one-to-one without the usual diversions of life.

This section of the chapter has described 24 hours in the ward from the perspective of the nurse, then of the parent. The ward is well organised and structured, and those who work there know the structure and appreciate its predictability and security. For parents however, the structure is new, time passes slowly, and their other lives are suspended while they exclusively attend to the needs of their sick child.

Chapter summary

This chapter has described and contextualised the research setting, the children's ward of a hospital in New Zealand. The physical layout has been examined, the population and organisational structures of the ward, and a summary of 24 hours in the ward from the perspective of both nurses and parents/caregivers, provides an overview of the ward. The ward is a calm, quiet environment, the hub of which is the nurses' station where most staff interaction occurs. Parents are moving in and out of patients' rooms and in the corridors. Nurses congregate in the station, meeting with parents mainly when they go to the child to provide nursing care. Nursing care most often performed is measuring and recording the child's vital signs (*observations*), which includes the axilla temperature, heart rate, respiration rate, and pulse oximetry. The next most frequent nursing intervention is giving medication, or checking patient's fluid status. Nurses rarely ventured into a patient's room without the pretext of an intervention on the child. Nursing documentation, especially that detailing emotional communication between nurses and parents, was found to be vague, inconsistent and problematic for nurses.

Nurses move freely around the ward, as they wish. They enter the ward for their eight hour *shift* and leave on completion of the *duty*. For many nurses the ward is like a second home, they know it so well, have been in the ward for a number of years, and feel very comfortable with most aspects of it.

Parents have a different view. Their movements are restricted, governed by many signs telling them what they can and cannot do, as well as signs advising them on their parenting styles, and their personal lives (smoking, family violence). The many signs in the ward give the indication that nurses are in charge and in control. Some parents feel confined, and restricted, which adds stress to an already stressful situation, having a sick child in hospital.

There is incongruence between the family-centred care model under which nursing care is structured and the reality of the ward which is that the parent is a visitor and is required to behave in a way prescribed by the hospital system. There is overt lip service to how nurses work collaboratively with patients, but the covert message is that: we will tell you what to do and when. Rules and regulations displayed in the ward are enforced in variable ways.

The environment of the ward is child friendly with the use of bright colours, toys visible, distractions in the form of posters, music, and televisions. For parents, however, there

is an unstated expectation to fit in, cooperate, and parent their child without fuss. They have to do this in an environment where their own basic needs are difficult to meet.

In the next chapter, the focus moves from the ward setting and culture to parent' understandings, culminating in parents' experience of emotional communication. Parents' experiences are pivotal in this study, as they contribute to a wider appreciation of nurse-parent communication.

Chapter 5: Parents' perspectives in the children's ward

Introduction

Parents' perspective of the ward culture enables further understandings of emotional communication. The chapter is divided into sections; the first chronicling the parent's journey in the ward, particularly their initial impressions and observations which have a marked effect on the rest of the hospitalisation. Parents' general expectations of nurses are then observed, concluding with the final focus on parents' experiences of emotional communication with nurses.

Parents' early experiences

Parents usually arrived in the ward with their sick child, presenting either acutely (with an unexpected illness), or the admission had been previously arranged for a procedure on the child. Sometimes one parent accompanied the child, with other family members often arriving later. Those parents who had been through the journey of their child becoming ill, going to primary health services, then to the hospital and ultimately the ward, were frequently exhausted by the time they finally arrived in the ward. One parent explained her experience,

> *because your child's sick and normally by the time you arrive at the hospital you - you've been dealing with quite a bit before it - the lead up - and so you're pretty exhausted by the time you get there*[2].

"Finding your bearings"

Most parents described those initial few hours in the ward as stressful. One parent suggested that this period of time was difficult,

> *I think because everything's new and you don't know the place - I suppose you've got to find your bearings to start with and then you're dealing with what's going on.*

This beginning stage of the hospital experience held many challenges for parents. Parents were focused on their child's needs, constantly checking their child, monitoring that the child's condition was not getting any worse, trying to find their way around the ward, and working out who were all the different people that they encountered. In addition, they had to find time to meet their own basic needs of food, sleep, warmth

[2] *Words in italics* are verbatim comments from participants

and comfort and these were often the least of their concerns. Parents experienced the ward differently; some finding the staff or ward friendly and welcoming, others struggled to cope with being away from their home and usual supports and networks.

"They made it comfortable"

Some parents perceived nursing staff had a warm welcome for them, even when staff were busy. Nurses would introduce themselves to the parents and child and then familiarise the parent to the ward. This orientation usually included a physical initiation, showing parents areas most pertinent for them including the parents' room, the central office, the kitchen, the children's room, and toilet and showering facilities. Also included in the orientation were the child's room space, the locker, the call bell, how to use the television/DVD player and what to do when the parent needed to find a nurse. Parents expected an orientation to the ward by nurses, although this expectation was not always met. Parents who received this orientation then described feeling comfortable in the ward, knowing where they could go, what was available for them and what was not, and what they identified as their *limits*. One parent described this,

> *They've made it very comfortable. Like we - because we're there with* [child's name] *...- you know we're allowed to help ourselves more or less - to things we need. So like things like that have "Staff Only" on the linen cupboards. ...Because we're in there all the time instead of ringing the buzzer we would go and just - you know they were - they were happy for us to help ourselves to things like that.*

Another parent described knowing the *limits,* because they had been informed by staff or read the notices,

> *You know we know the limits. So things like - go - you can help yourself in the linen cupboard to - you can't go into the medical room on your own. You're not allowed to do that. You know so we definitely know our boundaries*.

For this parent, there was also gratitude at not being made to feel a burden,

> *Like you certainly feel welcome and you certainly feel - you don't feel like you're being a burden or anything like that which is really good.*

This initial warmth of the nurses and orientation to the facilities set the scene for the remainder of the hospital experience, with parents continuing to feel as comfortable

and secure as they could be in a new environment. Appreciation for any kindness shown to them was apparent, for example, parents liked the way the chair converted into a bed and being given some freedom to make their room child friendly.

For some parents of children with chronic illnesses who had had multiple admissions to the ward, the environment was so relaxed it felt like a second home,

> *I learnt my way around and I know - you know what there is and stuff now 'cos I've been there for so many times. So it's like when I go back there now it's just like I - I feel like it's just another second home.*

And another parent also felt comfortable enough to help themselves to whatever they needed,

> *It's like I just - I help myself. You know if I want to make up my bed I'll go and get my sheets. I know where everything is. Yeah it's just - sometimes it feels like it's a second home.*

"Left to your own devices"

For another group of parents, the ward was not the warm and welcoming place. These parents did not feel welcome, felt like a hindrance, and struggled with the hospitalisation. One parent explained,

> *I don't think I got - really got shown around or shown - although - and I don't think they'd asked if I'd been there before either so they didn't know that I didn't know.*

These parents did not get an orientation to the ward, and consequently felt like an *intruder* or an *other*. They perceived themselves to be isolated and felt lonely in amongst the busyness of the ward routine. Not knowing what was required of them, nor their own boundaries in the ward, left these parents worried and insecure. Parents felt they were left on their own to *just get on with it*. Here a parent describes the experience,

> *there's not that feeling of friendliness or - or a family environment. It's like you're sort of in that room and you're left there on your - to your own devices.*

Parents who did get not get an orientation were left feeling inadequate and unsure. This parent describes feeling like an *idiot*,

> *They hadn't explained to me that he was in isolation so I tried to take him for a walk around the ward and got told off as well for that. So I felt really stupid. And really, really like it - I was just an idiot and I just thought "oh".*

In summary the first hours of a parent's time in the ward were experienced differently by parents. For some it was an affirming experience, they were orientated to the ward, felt welcomed, secure and thereafter regarded the ward positively. For others however, the ward was unwelcoming, leaving the parent feeling like an outsider. These parents were unsure of what to do and how to act, often feeling inadequate and insecure. Whether parents were orientated to the ward or not was random, some parents were and others were not. The impact on ward culture was that some parents felt disenfranchised, and started their hospital journey feeling alienated from the ward activities, which would then have an impact on their interactions with nurses.

Different experiences between parent of acutely unwell child and parent of chronically ill child

A number of parents described the difference between two types of ward admission, being either the parent of an acutely ill, or a chronically ill child. These parents had been in the ward with a chronically unwell child, who had had numerous admissions to the ward, and then had also been admitted to the ward with another of the family siblings who did not have a chronic condition, and presented with an acute condition to the ward. Unanimously this group of parents described the same thing; there was a marked difference between accompanying a chronically ill child and an acutely ill child.

Parents' ward experience with the chronically ill child was described as comfortable, with parents feeling that they knew quickly what was happening for the child, and what interventions needed to happen. Parents described knowing when the child needed admission and negotiating with staff, working in partnership with staff, especially medical consultants, and feeling empowered to challenge and question decisions made. They knew their way around the ward, and felt free to quickly make themselves at home in the ward. They described relationships with staff as familiar, friendly and supportive.

However, when the same parent accompanied another of their children, an acutely ill child, their experiences were quite different. Even though the parent knew the staff from previous admissions with their chronically ill child, they perceived staff to be less supportive, less friendly, and less available to them when they presented with another of their children. They did not feel welcomed in the ward, more of a *hindrance* and had much less control over the decisions made. One parent described what happened for them,

> *there was no communication or talking of where we're - where we're at you know. There was – you know from the ED - from the Emergency Department we go up there, they say you're going to get admitted but we sit in the assessment unit for - you know hour and a half or two hours and – and there's no communication. Just it's - they are finding out what's up with the child. Which is okay. You know which is good. But to the parents there's no communication of what they sort of – you know, want from you at that stage*.

And again,

> *you go in and you're not as - you're not treated like you're welcomed. You know. It's a different relationship that you have with the nurses when you come when you're not supposed - you know - when your kid's just fallen ill for the day*

Parents, who were accustomed to being in the ward with a chronically unwell child, and knowing what was going to be happening, were taken aback by the different response they experienced when they were with an acutely unwell child. Parents described a *different relationship* with nurses, depending on whether the child was chronically or acutely unwell. When nurses are familiar with the child, there is an easier rapport with the family. When the child is unfamiliar, the situation is more stressful for both parents and nurses, leading to a more strained relationship.

The hospitalisation journey

After an initial few hours, parents began to *find their bearings* in the ward, either because they had had an orientation from nurses or they had found their way around themselves. However, anxiety in the first 12 hours of the hospitalisation journey was high for a number of parents for a range of reasons. Worry about their child was a big issue for parents, and parents expected different things from nursing staff at this early time. Some wanted nurses to take over the care from them, and just let the parent

recover from the stress of getting to hospital safely. Others wanted to be acknowledged as the expert in the child's care and to be consulted regarding intervention and treatment. Some parents expressed concern that their expertise regarding their child's illness was not acknowledged, and others wanted nurses to respond quickly if they expressed concern about their child's health status. Many parents wanted the nurse's focus to be predominantly on the child until the child's condition was stabilised. Parents perceived that their child's physical health needs were much more important than any need the parent may have had.

One parent describes this experience,

> *sometimes even though we're really tired ... it's because we are not focusing about us. Yeah we are focusing on* [child's name].

Once treatment had begun and the parent knew the plan of care, they felt more relaxed and more ready to settle into the hospital stay. Parents described being informed of treatment options by medical staff and felt they were expected to concur with what was being offered. Parents became resigned to the hospital stay and went along with what they needed to do.

With the resignation came awareness that parents could not change anything about their situation; they felt out of control. One parent verbalises this,

> *Like having to deal with it the way it is as opposed - you - you can't really change it much, you can't. Yeah just you need your feet on the ground ...*

"I never heard of it before"

Parents described coping with the unknown. They were negotiating their way through the hospital journey, and for many this was a new life experience and a deeply disturbing one. They had had no preparation for it, and felt they were floundering and alone. Having to cope with the unknown and also translate that to their child was a challenging experience. One parent described feelings when realising that procedures were completed in the procedure room, and how this triggered a realisation that this was actually happening to them,

> *having needles is not very nice. And - and the Treatment Room sort of methodology of doing things I understand is a - is - well I - I've never heard of it*

before in terms of having a special room where you go to have procedures and things. Sort of highlighted the - the - what's the word - the realness of it.

As parents tried to help their child cope with the unknown, the parent often felt overwhelmed by the enormity of what was happening, for the child, for themselves and for their family unit. Another parent discusses her fear of the unknown,

And that was unknown yeah. So I think - yeah it was the unknown things that kind of got to me more than.....

And another parent discusses their fears,

Just the whole not knowing what was going on.

"Being in a fish bowl"

As well as dealing with the unknown, and coping with whatever was happening for their child, some parents expressed concern about their sudden lack of privacy. They had moved from being in their own home where they could shut the door and be totally private, to being in a room or a shared room with only a door or a curtain for privacy. That privacy was perceived to be illusory, as anyone could walk through the door or curtain without permission, at any time of the day or night. At no time did the parent feel they were in a private space. One parent described the experience as,

And I find that it's like being in fish bowl when I have to go up there.

And another,

those people were walking past all the time and ...You don't know other people - people just come in from behind the curtain.

Having to now live their lives, and parent in public was stressful and exhausting. Some parents felt on edge, always waiting for someone to enter their bed space. Living in this environment left parents feeling on edge and uneasy.

"You are away from your family"

Managing their split lives, with responsibilities in both the ward and at home, now became a reality for parents, especially those with other children at home. The ward would accommodate a parent bringing in a younger child, but usually only if the mother

was breast feeding. Otherwise the parent would have to make arrangements for any other children to be cared for by others. For some parents leaving their other children was very stressful and caused them anxiety and concern, sometimes even more so than their hospitalised child. One parent described how it was for her,

> *it is a strain because you're away from your family for three days and your other kids are missing you and crying on the end of the phone. And things like that. So it makes - you know makes it quite hard.*

Parents worked hard to juggle their lives, now split into two. For parents who were single, with no other adult support outside the hospital, there was always the concern that the children were not being supervised adequately, or that they were not able to attend usual activities.

"Your life is in their hands"

Parents described feeling out of control from the time they arrived in the ward. They believed that they had little say in the decisions were made about their child (and therefore affecting them) regarding interventions, treatments and discharge. For many this lack of consultation was a new and strange experience. They were used to being the adult who made decisions about their child, and now those choices were made by others, namely health professionals. Their own lives were no longer under their control, they had to shower when a shower was free, or when their child slept, or when staff were not expecting them to be in the room; they couldn't leave the ward without telling someone where they were going and how long they would be; they couldn't eat and drink as they needed; there were boundaries on their movements in the ward, and restrictions on their behaviour. To make a hot drink they had to leave the child's room, leave the ward, go to the parents' room, make the drink, wait for it to cool, drink it, wash their cup, then ring a bell to be able to get back into the ward. For many parents this involved too much time away from their child, so they neglected their own needs in preference to attending to their child. Parents had to sleep where staff told them to sleep, either a chair, which converted into a bed, or a bed by the child's bed, or a bed in the parent's suite, away from the child. They were unable to function as previously, not able to go to work, to take other children to school, to choose the food they wanted to eat. Very little remained of their previous independent free lives, and for many parents, this was a difficult adjustment,

> *Like you just feel like your child's - yeah life is in their hands really or health is in*

their hands.

And another parent,

all of a sudden it just feels so out of control. So it's - yeah frustrating.

"An emotional roller coaster"

It was evident that being in hospital with their child, took parents on an *emotional roller coaster*.

One parent describes the feeling,

You know you'll feel - you know like at the beginning you're - it's an emotional roller coaster type thing.

Being in hospital, away from their usual supports, worried about their unwell child, worried about other children/family members all added to the parents' emotional concerns. Parents described a range of reasons for their stress in hospital from lack of access to food, to poor communication with staff, to feeling guilty about child's illness, to being *stuck* in a room on their own. A number of parents felt some responsibility about the child's illness, then experienced guilt when the child's condition did not improve. One parent reflected on her feelings,

There's going to be spells where you're going to have your ups and downs and - I just felt quite lost with it all.

Parents oscillated from feeling they could cope, to feeling in the depths of despair, often influenced by the condition of their child.

In this section exploring parents' hospitalisation journey, the range of emotions identified by parents provide a picture of discomfort and vulnerability. In the next section, parents' general expectations of nurses are described.

Parents' general expectations of nurses

During the course of field work, I asked every parent I met to talk to me about their expectations of nurses. I asked such questions as "What do you want from the

nurses?" and "What do you expect nurses to do and to be like?" There were general expectations and those specifically focused on the topic of this study, emotional communication. General expectations included the nurses making a personal connection; seeing the same nurses; receiving explanations of plans and events; being involved in the child's care; and the nurse being competent, compassionate and caring.

"If they stop and chat to you"

Many parents discussed their desire to have a personal connection with a nurse or with more than one nurse. They believed that if they had a connection with someone on the ward, they would feel more comfortable and less isolated and alone, and would feel that they had someone on their side, supporting them. One parent noted that the nurses would come into the child's room, complete the intervention and,

> *you know it's almost like they do the rounds and everything's okay...There is no hanging out and getting to know you a bit more. Or asking the questions "How are you doing with all of this? How do you cope because crikey I can't imagine how you would" You know?...I think it would make a huge difference to a stay...The whole idea of staying over would be not quite so bad if Susan* [pseudonym] *was on or Mary* [pseudonym] *was on or you know 'cos then "Oh we'd be able to have a catch up"...And it would be like I wouldn't mind we needed to stay another night then because it wouldn't be so bad. Yeah.*

When the nurse was in the room, parents wanted the nurse to engage with them, as well as with the child. This parent describes wanting the nurse to chat to her,

> *I think it's just being available and chatting. If they stop and chat to you it gives an opportunity. ...If they build some kind of relationship with you.*

And this parent looked to nurses to be an ally for her,

> *Yeah it would make a difference because it would make - it would feel like you might have a –a friend or an ally or somebody...on the ward in amongst all the goings on and the patients and all the nurses and doctors backwards and forwards and to feel like you have an ally or a friend that - I don't know maybe that is taking just that little bit of extra attention for you.*

Seeing the same nurses

Parents discussed their wish for better continuity of nurses. Having the same nurse during the hospitalisation, and again on further hospitalisations, was something parents wanted. They anticipated that if they knew the nurse better, and if the nurse knew them, it would be more likely that a positive relationship would develop between parent and nurse. Parents explained that it was tiring to explain their situation to a number of different nurses and that seeing a familiar face, helped make the ward experience less intimidating. One parent explains,

> *I mean it's nice. Really nice if you can have someone familiar.*

Another parent described the stress of building a rapport with each nurse, and the work of having to find out what each nurse could do*,*

> *you've got to build - you've got to a build a rapport with each one of them and you've got to find out effectively what you think each one's good at and what - well what they're not good at, you know*?

Parents who had been in the ward previously looked for nurses they knew, to reduce the stress of the situation,

> *Like I was looking around for someone I knew you know...-- yeah there was no-one there so yeah. That was a bit stressful then.*

For another parent, there was an understanding that nurses needed time to build a relationship with the parent. Nurses were perceived to come into the child's room, complete the task and go quickly,

> *I think it probably takes time to build that up with somebody. In the ward they seem to be lot busier as well. Like sort of come in, do what needs to be done and go again.*

Having a connection with the nurse, and having the same nurse regularly care for the child was important for parents, as was sharing information about the child.

Sharing information about the child

Some parents specifically noted their main expectation was that the nurse would tell them what was going on. Parents wanted the nurses to keep them informed about their child's condition, about what they might expect in the way of intervention and on-going treatment. They wanted the nurses to tell them about any changes in the child's condition, and also to tell them what they were going to do about their concerns for the child. They wanted to be kept informed at every stage of the child's hospitalisation journey. Understanding the child's condition and progress was a primary concern for parents and one of their main expectations of nurses. If the nurse was unsure about something, parents expected the nurse to find out. Parents expected that the nurse would willingly share information about the child, rather than have to continuously ask nurses what was going on. Parents described feeling stressed and anxious if the nurse was not willing to share information openly. Parents disliked feeling that they had to,

> *sort of - you know poke and prod and ask questions and find out exactly how bad we were talking about. You know how bad things were before I could sort of feel like I felt control of the situation*.

Parents also wanted nurses to be open and friendly towards them and enjoyed it when nurses used humour to relax them and also when the nurse shared a small aspect of their personal lives. This made the nurse seem more *human*, and thus more approachable. In addition, the nurse being willing to share information about the child's care and condition was important for parents.

Another feature of explaining what was happening was the nurse being available to listen. This parent explains,

> *but I think a nurse needs to present as being available to you and available to answer any question that you - and no matter if they're rushed. You're their patient at that time - or your child is, therefore they need to present as being available to listen. And sometimes when they're "Oh I've just got to do this and this and this." And then they're off out the door you know.*

Parents wanted nurses to be available and approachable enough to ask questions of them, and to know their questions would be addressed in a timely manner. Parents wanted to be included in discussions about their child, including condition, interventions, treatment and discharge.

Sharing expectations of parents

For some parents it was important that the nurse discuss with them who would be doing what in relation to the child's medical and personal care. Parents were highly attuned to picking up cues from the nurses, regarding roles. When the nurse first met the parent at the beginning of the shift, the parent would wait and see what the nurse's plan for the day was, and if it did not include hygiene care for example, the parent would then assume that that was their responsibility. Parents wanted to be involved in the child's care and wanted to know the expectations of the nurse regarding the parent's care of the child.

This parent explains her frustrations,

> *Not knowing what my expectations were of what I was supposed to be doing to help. Was I supposed to help? Was I supposed to just support him?*

Parents were grateful when the nurse told them the plan of care for the shift, as they would then work around that. It was clear that the nurse was very much in control of the care, and how the care would be managed. When the nurse approached the child to complete a task, the parent wanted the nurse to explain to them and the child what was going to happen, before the nurse started the activity. This parent explains the confusion experienced in the early phase of the hospital stay,

> *Like they talk amongst themselves, like "I'll just do this because of this and that." And they use big fancy words that you have no idea about... So it gets quite confusing*

Being competent, compassionate and caring

Some parents specifically noted that a nurse's competence when working with the child was important to them. They wanted to trust the nurse to be working at their best ability and to be performing at the highest level. Perceiving the nurse to be competent was reassuring for parents and enabled them to relax, knowing nurses were responsive and taking responsibility for their child.

For the nurse to demonstrate compassion and caring was also central for some parents. They wanted the nurse to show compassion to their child, and also to them, and to be caring in the way the nurse interacted with the parent and child.

Parents' expectations of nurses: emotional communication

As well as general expectations of nurses, parents described their experiences of nurses when they were feeling emotional, including that the nurses would be aware that parents have multiple life stressors; asking parents how they are coping, and documenting/handing over parents' emotional concerns.

Being aware that parents have multiple life stressors

Parents expected that nurses would be aware and anticipate that parents would have a number of issues in their lives that were affecting them, not solely this hospital admission. Parents discussed the stress of hospitalisation, including being away from other children, being isolated from their close family and supports, especially if they lived in a different town/city or rurally. There was an expectation from parents that nurses would be prepared for parents to have multiple stressors, and be ready to offer emotional and other support as required. One parent explains,

> *whenever a parent is in hospital with their child it's a hard time no matter if they're really sick or if they're just there for a minor procedure it's still stressful because they've got stuff going on at home that that nurse has no idea about. And other stresses in their life at that time possibly. And that could just compound and just be - so they just need to be really aware.*

And again,

> *And I - I just think being aware of - that there's other aspects of that person's life. They're not–it's not just the here and now...And you have a whole other life outside of there with stuff going on. You know it's stressful as well. So this is - this is adding to the stress.*

How are you?

Anticipating, expecting, asking about and then acting on parents' emotional concerns were all expectations parents had of nurses. Many parents expected and wanted nurses to ask them how they were managing with their current situation, and to acknowledge and support their emotional concerns. Parents felt cheated if the nurses did not ask if how they were coping. This parent explains,

> *Yeah I don't recall any - many nurses actually ever asking me if I was okay. "How*

was I doing? Considering what was going on.... I don't really recall that.

Another parent waited for a different nurse to arrive in the hope that that nurse would have heard in *handover* that she was worried and would offer to help,

it would all start again because it would be a different nurse and I thought maybe this one might be able to tell me something. I don't - yeah. So no there was no "How are you getting on?" or –

Parents expected the nurse would be interested in what was happening for them and that their concerns would be important for the nurse. One parent explains,

it doesn't take much when you're standing doing someone's obs [observations/vital signs]*to say "How are you?"*

For some parents whose biggest concern was their child's condition, they needed to know that the nurse was interested in their concerns, and also would do something in response, such as consult other members of the health care team. One of parents' greatest worries was if the nurse brushed off their concerns about their child. This would leave the parent in a quandary; was the nurse trying to be reassuring and not showing how alarmed they were, but were going to take some action?; or were they not going to do anything about the situation? This parent explains,

Just for them to validate that I was concerned about his heart. And to say "yep that - oh I can understand it. I'd be concerned too" or "It's a - you know normal". To be - yeah just to explain why it wasn't a concern. Or find out why it wasn't a concern for me instead of saying "Oh I yeah I'd be concerned." But yeah just validation really that it's okay to be concerned and that you're not being neurotic and you're not stupid.

Parents explained that when they are stressed in hospital, their stress affects their child. If the nurse addressed their stress, asked them about what was going on for them, the parents believed they would be more effective parents. This parent explains,

they [nurses] *just need to not just take into consideration the child but the parents as well...it's not just the child that feels uncomfortable in hospital it's the parents as well. And I mean it's the children that look up to the parents for, you know, for*

comfort and things and if they're stressing out then they can't exactly give the child that comfort.

"I don't think anything was written"

Parents had expectations that if they had expressed emotional concerns to a staff member, those concerns would be either verbally handed over to other nurses or documented in the child's notes, so that all staff working with the family would be aware of the parent's worries. Parents reported feeling exhausted by retelling their story over and over again, or even worse, waiting for the nurse to raise concerns the parent had previously told another staff member, only to wait in vain. Parents were reluctant to be forthcoming with their emotional concerns, as they could not always *read* or tell when the right time might be for the nurse, and they were highly aware of nurses' workload and time constraints.

This parent expressed her disappointment when the nurse in the following shift did not raise issues previously discussed with other staff,

I don't think there was anything [written in the child's notes] *about "Can someone talk to Mum about it." Yeah. Or if there was no one did.*

In summary, parents had general expectations of nurses specifically focused on wanting nurses to be there for them, to be consistent, to share any information they had and to be compassionate and caring to parents at this time in their lives. When parents were emotional, they wanted nurses to be aware and acknowledge parents multiple stressors, to ask them how they were coping and to document parents' concerns so the parent did not have to keep retelling their story. Parents' expectations were focused on ensuring the parents' hospitalisation journey was manageable, and supporting the parent as they coped with being in the ward. In the next section, parents' perceptions of nurses will be outlined. Parents willingly shared their perceptions of nurses.

Parents' perceptions of nurses in the children's ward

Most parents were complimentary about nurses they had encountered in the ward, although some were not. This section is divided into particular positive behaviours, attitudes and communication. More critical perceptions of nurses follow.

Nurse behaviours and attitudes

Parents' frequently commented on nurses behaviours using complimentary words such as *lovely, good, great, brilliant and fantastic*. When asked in what way nurses were these things, parents would describe the way the nurse approached them, being friendly, smiling, and willing to go the extra mile, meaning that the nurse would go out of their way to help them. Nurses were perceived to be accommodating of parents' specific needs, and also good at working with children. Nurses were helpful and pleasant, thoughtful, anticipating physical needs of the parent and child. Being approachable and willing to help was also a common response from parents. Parents noted the responsive and attentive nature of the nurse, describing how quickly the nurse would answer a bell, or respond to a query.

Parents noted and appreciated that some nurses recognised that the parent was the *expert* in the child's care. For parents of chronically ill children, they enjoyed the nurse asking them how to manage the child's care, although one parent described feeling frustrated when she was in the ward with her chronically ill child and the nurses were reluctant to learn how to manage a technical aspect of the child's care. She wanted to share her knowledge with the nurses, and also to have some *time off*, when they were in the ward.

Nurses were perceived by parents as being particularly understanding and supportive of them. Parents liked the way nurses left them to get on with parenting their child without interference, and others appreciated the nurse being there for them when they needed support with their parenting. *Trustworthy* was frequently used to describe nurses' behaviour.

Nurses approachable and informative

Nurses were perceived by parents as being easy to talk to and much more approachable than other members of the health care team. Nurses were informative, telling the parent what was going on and what they could expect to happen. Parents perceived that nurses communicated well with them, keeping them involved in what was going on the child. This was particularly obvious when the parent was preparing for a significant event such as the insertion of an IV, or catheter, or preparing for theatre. Discharge planning was comprehensive and informative, with the nurse clearly discussing resources available to parents if they were concerned about their child.

Parents especially enjoyed nurses disclosing some aspect of their personal life, particularly if it related to an issue the parent was currently struggling with (i.e. managing a toddler, breastfeeding issues). Nurses seemed to be *open* in their communication and created opportunities for parents to talk to them.
Some parents noted appreciatively nurses anticipating their physical needs, such as their need for a break, some food, sleep, assistance with their child. One parent noted nurses' forethought in this way,

> *it's like they - they think ahead for me.*

The approachability of the nurses was epitomised by a parent of a chronically ill child who was a frequent patient on the ward. For this parent it was apparent that the nurses were friendly and interested in their welfare,

> *Even if they're not looking after us they'll pop their heads in to say "G'day, how are you going?"*

Critical perceptions of nurses

For some parents nurses' behaviours and attitudes did not always meet their expectations. Nurses were perceived to be focused completely on the child, performing interventions such as taking the child's vital signs, or monitoring their intravenous infusion, and not having the time or inclination to engage with the parent. One parent described nurses like this,

> *They're not - maybe they're not really focusing on us but they put their 100 percent focus on the patient.*

Parents felt they would be wasting nurses' time by asking them questions, so refrained from doing so. Sometimes parents felt that they had to work hard to get information from nurses, and they felt like a *pain in the ass* because of it.

Parents believed that nurses had an idea in their head of what makes a good patient, usually one who did not cause the nurse any difficulty. This parent explained,

> *I think a good patient for a nurse is one where there is no upheaval or issues. No problems from the parents to deal with. No questioning them. 'Cos if you start questioning them that doesn't actually go - that doesn't go down so well.*

Sometimes nurses were perceived as distant and remote. It was evident that if the nurse and the parent were of similar age, gender or ethnicity, it was more likely the nurse would engage with the parent. Fathers staying in the ward wondered why nurses seemed so reluctant to connect with them.

”We’re not fine”: Parents and emotional communication

> *We’re not fine. We’re not fine...I’m not blaming - blaming on the nurse because the nurse will just take as what we say.*

This comment was made by a parent, who was trying to explain how they felt when in hospital with their child. From their initial entry into the ward, until discharge, parents struggled to contain and restrain their emotions. Parents talked about trying to keep strong, maintaining control, and wanting to be perceived as coping. They were concerned that expressing their distressing emotions would be perceived by the nurses as being *weak*. Some parents wanted nurses to ask them how they were coping with their hospitalisation, and when they were not asked, assumed the nurses were not interested. Parents then turned to friends and family for emotional support. Parents noted that if the nurse seemed genuinely interested in them as a person, and made an effort to connect with them, they would feel more inclined to talk to the nurse about their worries. However most parents did not feel that connection, thus were not able to communicate on an emotional level with nurses.

A small minority of parents had another view. This group of parents were relieved that nurses did not ask them about their emotional concerns, noting that this was not the nurses’ role, and that the nurses’ primary focus should be on the child.

During field work observations, on only one occasion did I observe a nurse asking a parent about their emotional state, and later found that the reason the nurse had asked was because the nurse knew that the previous day the parent had been upset, and wanted to follow up. The only other times I noted parents addressing emotional concerns were when the parent was visibly emotionally distressed, such as crying or being angry or withdrawn.

Parents presented a wide range of reasons for why they did not discuss their emotional concerns with nurses. These included: perceiving that the nurse was busy; that the

nurse was oblivious to parents' emotions; that nurses needed to protect themselves from parents' emotions, or get burnt out; that nurses were afraid of what the parent might say or do if the nurse *lifted the lid* on parents' emotion; that nurses did not have the education/skills to manage parents' emotions; that nurses had too much paper work to do; perceiving that nurses were strangers, thus did not feel comfortable talking with them; believing that other parents had greater concerns (such as a dying child); worried they might break down if they started talking about concerns; feeling guilty about offloading on nurses; and not wanting to burden the nurse with their problems. One parent noted that she was afraid to tell nurses that she was feeling emotional as she was worried that their response may have been to take her child away from her (for respite care).

The overriding theme with regard to parents' emotional communication was that parents were *not fine* and they wanted to talk to someone about why they were not fine. When nurses did not ask them how they were doing, parents then excused the nurses for the myriad of reasons discussed. Parents waited for nurses to make that emotional connection with them.

Chapter summary

In this chapter, parents' perspectives of the children's ward, the parents' journey through the hospital experience has been documented; their expectations of nurses, and their perspectives on nurses. The orientation to the ward experienced by the parents had a strong impact on the rest of their stay; if the parent was warmly welcomed and oriented to the facilities, he or she felt secure and comfortable and began to find their bearings quickly. If the parent perceived the ward to be unwelcoming and unfriendly, the ward stay was more difficult, resulting in the parent feeling lost and alone.

Parents had a gamut of experiences from the time they entered the children's ward with their child, till the child's discharge. For most parents the effort for them was to work out what was going on in the ward, not only for themselves, but also to help their child through their journey. Parents were observed to be generally responsive and adherent to requests made of them. They worked hard to get on with all staff they came into contact with and for some parents, the experience was manageable. Other parents struggled however, especially those with a child with an acute condition. Many parents lamented their lack of privacy and comfort and felt they had lost control of a significant part of their lives.

Parents had a number of expectations of nurses, the primary one being that the nurse would engage and connect with the parent. When the nurse did not make an effort to engage, the parent was reluctant to share their emotional concerns. Parents believed that nurses expected them to be *fine* and were unwilling to acknowledge that parents were *not fine.*

In order to understand the nurse-parent dynamic, the following two chapters considers nurses' understandings, culminating in nurses' experiences of emotional communication. Nurses are central in the ward and their experiences are an integral part of this thesis.

Chapter 6: Nurses' perspectives in the children's ward

Introduction

The focus of this chapter is nurses' experience of their practice in the ward, based on an interpretation of how they perceived their nursing care of children and families. The chapter is divided into two main sections: nursing in the ward and nurses' relationships with parents. This chapter demonstrates that nurses mainly enjoyed their nursing practice in the ward, but had difficulty with their relationships with parents.

The experience of being a nurse in the ward is described and explained. In relation to nurses, reasons for working in the ward, the supportive nature of the team, and nurses' relationships with other staff are discussed.

Reasons for working in the ward

Nurses described a range of different reasons for choosing to work in the ward from being offered a job as a new graduate, to wanting to get out of the *comfort zone* of a previous work place. For some nurses however, arriving in the ward was like finding their place in the world.

Finding a niche

Some nurses described moving into the ward and finding that the work suited them and they felt comfortable,

> *I just knew. Found my niche. Yeah I was just smiling the whole time during my transitions* [pre-registration placement]. *I was like "Yeah this is the place"*[3].

Another nurse described how she felt when she arrived in the ward,

> *It just worked out. I just felt like it clicked and that was me sold for life*.

And another,

> *I think it suits me.*

[3] *Words in italics* are verbatim comments from participants

Fell in love with the setting

Some nurses described stronger feelings towards their work in the ward. One nurse described arriving in the ward and *I just absolutely fell in love*, another also *just fell in love with it*, and another nurse *got there and I loved it.* Nurses described feeling *drawn* to work with children and families. For some nurses, encouragement from their own family led them to the ward; for others, having had a sick child and observing the work that nurses did, from the perspective of a parent, led them to think they too could be a nurse in that clinical setting. Nurses' initial response to the ward was not diminished by the length of time they had worked there, which for some was many years. Nurses were still enjoying the ward, loving the work and feeling at home. Nurses described *looking forward* to going to work,

> *I never worry about coming to work. I look forward to it. I love it. Know I'm going to have a laugh but it's going to be - you know? Yeah it's a bit of everything.*

One nurse commented that nurses never left the ward *willingly*, rather they moved on because they were pregnant, or wanted to travel overseas. Another nurse described the work as being like a *hobby*, a break from her life at home with two pre-school children. For nurses, the ward *really worked*. One reason for this may have been the tight-knit team they experienced.

Supportive team

A key aspect of nurses' experience of working in the ward was the support they received, particularly from their colleagues and nurse managers. Nurses knew they could rely on their colleagues to help them if they needed assistance with any aspect of their work. Being helpful and supportive of each other was part of the ward culture, role modelled by nurse managers and nurses who had worked there for some time. Nurses knew that they could always ask another nurse for help, and also that other nurses would seek them out if they appeared to be having difficulty. The support was there for workload issues, such as when a patient became more unwell and the nurse needed to spend more time with the patient, or if the nurse had an admission. There was an underlying atmosphere of helpfulness and collegiality. For some nurses, this ambience was a contrast to experiences from previous clinical practice environments workplaces. As one nurse noted,

> *I think we work well as a team and I think - you know like if I get busy doing something there's always people there supporting you and helping out. And I think*

that's one of the main things that I think is really good which I haven't had in other places I've worked.

The support in the ward led some nurses to develop personal friendships with their colleagues. With nurses reporting,

it's the most amazing team I've ever worked with. That's why I keep coming back. Some of those girls are my closest friends you know and - you know it's an amazing place to work.

And,

I think also which is special to this ward is that all the nurses get on really well. We're all really good friends. We do stuff outside of work as well so it's a great work experience.

A new graduate nurse described the support she received from a nursing colleague when her patient became acutely unwell,

you just know if you call somebody that's it; they're at your bedside. I had one patient that went into a full blown asthma attack and within ten minutes I got my colleague and then she didn't leave his bedside.

Nurses were strengthened by the support they received from colleagues, which enabled them to debrief, have a break and return to the situation again. As one nurse recounted,

you know if you're working in a group with - with a good group of people which everyone pretty much is anyway, you'll get that "Oh, do you need a break" or "How about we sit down and you can debrief about things." You can kind of; you get that support back there too to go, you know, back in and deal with things again.

Nurses were observed supporting each other and checking-in with each other on a regular basis during the shift. This checking-in usually occurred when nurses met up with each other in the nurses' station or in the clean utility room, where medications are prepared. Nurses would ask each other how they were going; a nurse would tell other nurses about what had just happened (debrief), or would express concern/worry about

what might happen. The other nurses would listen and offer advice or support. Nurses described feeling *backed up* and *safe* in the working environment. This nurse described nurses supporting each other in challenging situations,

> *And we support each other if we're a bit - someone doesn't feel comfortable with something we help each other out and - you know. If situations have been a bit challenging we'll support each other through that.*

Support from the nurse managers, particularly the CN was also evident. The CN was a *hands-on* manager, who preferred working on the ward with staff, children and families, rather than being in the office doing paperwork. This was particularly apparent when a child became acutely unwell and needed to become a *high dependency* patient, which enabled the patient to receive one-to-one care from a nurse. The CN would work closely with the nurse working with the *high dependency* patient, ensuring the nurse was well supported and had the equipment/resources needed. The CN was frequently seen in public areas in the ward, meeting all the parents and children each morning, and then frequently being present in the nurses' station. The Clinical Nurse Educator was also readily available to support the nurses. This was evidenced by the nurses' comments,

> *if you need something or you need assistance, you need help, you need somebody to come down and show you something - if you're not too sure about your PCA* [patient-controlled analgesia, a system of administering pain medication]*, anything like that - so there's always someone you can phone. There was - you know they'll always come down and help.*

The CN had a strong awareness of what was going on in the ward, and quickly returned *to the floor* if there was a need to provide expertise and support. It was apparent that the CN was a supportive part of the nursing team, assisting and contributing regularly.

The CN described the efforts made to ensure the team was effective. On taking the CN role ten years previously, the CN had been concerned about the *horizontal violence* in the ward, the lack of team support and the poor dynamics between groups of nurses. The CN arranged for clinic nurses to staff the ward for a day and took all the nursing staff off the ward for a day of staff development, focused on working in teams. The day included developing *goals* and *norms* (ways of behaving) for the ward, and also

introducing a *safe* word that a staff member could say ('Bas', greek for stop) if colleagues were found to be breaking team *norms*. The *norms* were copied and laminated and posted in the nurses' station above the photocopier. An abbreviated version of the norms was also posted outside the nurses' station for others to read, as noted in Chapter Four, pp. 86. In addition to the public notice regarding the *Children's Ward Norms*, the notice in the nurses' station read,

> *We will provide support to/for each other in good times and bad*
> *All staff will assist with all ward activities*
> *We will behave in a professional manner at all times, remembering that individual actions reflect on the team*
> *Agreed consequences for not meeting the norms:*
> *Speak with colleagues promptly if you are having a problem with them. The only time the matter would be discussed with another person is when you need advice or help*
> *If you hear a colleague complaining about another colleague, ask them to stop and remind them to go and talk to that person.*
> *Use a safe word to stop colleagues breaking norms. This word is 'Bas'*

The CN described being *surprised* that the staff development day reduced the poor dynamics and issues that had previously affected staff. The effect of this day and the implementation and visibility of the ward *norms* was evident. It was rare to hear any nurse break the ward *norms*. The supportive nature of the ward and collegiality that nurses experienced were clearly apparent to staff and parents. Parents noted that the staff were a *happy bunch.* One nurse observed that people had natural roles, and worked well together,

> *people just seem to slot into the natural roles and it just seems - I don't know what particular thing makes it work well but it just - everyone has the ability to work very well together.*

A great place to work

Parallel to the supportive nature of the ward, most nurses described the ward as a great place to work. Nurses were unanimously agreed that they enjoyed the working environment and the ward. Nurses described the ward being *fun, awesome, cool,* and *great*. One nurse noted,

the majority of my time that I've been there it has been a really nice place. And I think that's probably one of the things that holds me there.

As well as the supportive nursing team, there were a number of different aspects of the ward work that made the work so enjoyable for nurses. These included: the unpredictable nature of the work, never knowing what lay ahead on that shift; the varied, diverse nature of the work, an *everything job,*

You get - everything - anything that walks through your door it's not just medical, it's not just surgical, it's everything. You can have mental health issues and it just is such an everything job that I don't think you can get anywhere else really.

Nurses particularly enjoyed the acute nature of the practice present in the ward, with some children presenting very unwell and requiring a lot of care. Other nurses liked the *high dependency* care (one-to-one care with an acutely unwell child) and the opportunity that gave them to extend their nursing skills. The diverse nature of nursing skills that was required to care for the patient population kept the nurses extended and *feeling fresh,*

it's so diverse. So you can pick up any skill that you - you want to and you concentrate on it. But you have to be diverse or you would not survive in the ward.

Nurses found some aspects of the work challenging and relished the opportunity to develop their skills in this environment,

Just being challenged on things I haven't done before and that I get put in to do and then I actually realise I can do them.

Other aspects of the work that made the ward a *great place to work*, were the patient population the nurses were working with, particularly the children. Nurses liked the way children got well quickly, and the rapid nature of their recovery. In particular one nurse noted,

Seeing how kids improve so quickly and how you can see a really unwell kid one day and then 24 hours, 48 hours later they're back to their normal selves according to the parents.

And the,

> *transition is very fast. Patients get admitted and two days - two or three days they can discharge. So you get to see the sick patient as well as them getting better and sending them home. So that's good... it's quite good to see how patients recover and go home.*

Having fun with children was described by some nurses as a key aspect of their enjoyment of their work. Nurses liked playing with children and getting on to the child's level,

> *I enjoy the interaction with the kids because I'm a kid at heart so I can easily get down on their level and play.*

Nurses enjoyed making a *fun atmosphere* for the child, in order to put the child at ease. Nurses were observed playing cards with children, providing children with activities to do, providing DVD's for the child to watch. Nurses took special interest in those children with no adult present. If an adult was with the child, it was rare for the nurse to socialise with the child. The exception to this was when the child had to undergo a procedure in the procedure room. In this circumstance, the nurse was the main provider of distractions, playing with the child, reading the child books, or encouraging the parent to do those things. Nurses appeared to enjoy the challenge of distracting a child from a possibly painful procedure and employed a variety of activities as strategies to distract the child. These included blowing bubbles, dressing in costume, speaking in funny voices, playing music and singing along, and pointing out features of interest in the room. Nurses liked being able to work with the family, to educate them about the child's condition and parenting issues.

Nurses' relationships with staff

Although nurses were the predominant health professional group in the ward, they worked alongside a number of other health professionals, particularly medical staff, a social worker, and auxiliary staff.

Nurses' relationships with each other

The primary relationship all nurses had in the ward was with other nurses. Nurses spent their working lives working alongside each other. The physical layout of the ward,

and central nurses' station led nurses to have close proximity to each other. Nurses described their relationships as being family-like, having fun together, and also being careful of *not stepping on others toes*.

Nurses knew each other well, felt comfortable with each other and often these relationships had moved into their personal lives. Nurses appeared to care for each other, demonstrated by asking each other about difficult life circumstances they knew about, and shared easily with each other. If other nurses were aware that one nurse was having personal difficulties, they would make an effort to assist that nurse with her workload. Nurses were observed to stay on after their shift was completed to support each other, knowing that other nurses would reciprocate.

It was apparent that the nurses generally enjoyed being with each other, and had fun together. Occasionally they played practical jokes on each other. One morning I observed the morning shift arrive in the nurses' station. The night staff handed over that there was a very sick child who had just been admitted into a side room opposite the nurses' station. The child had not yet been placed on *Trendcare* (computerised patient management system managing acuity) which was why the child was not yet on the Ward Bed List (an A4 list of patient's names, room numbers and diagnoses). The night nurse was very serious when telling the incoming nurses about this child and asked them to go and see the child for themselves. The nurses went into the child's room and emerged smiling. The 'child' was actually a large teddy bear in the bed. This episode took less than five minutes of the nurses' time, but demonstrated the easy, convivial relationship the staff had with each other.

Laughter between nurses was frequently heard in the ward. The clinical handovers were often happy occasions where nurses would not only report on the patients but also share their personal lives with their colleagues, often involving laughter.

All nurses were observed to be accepting and inclusive of each other. There was very little evidence of clique behaviour, or people choosing to work with some staff over others. New staff reported that they were warmly welcomed into the nursing team, and quickly felt comfortable and at home in the ward. Several nurses in the ward were immigrants to New Zealand, with one having just started employment in the ward. Both these nurses enjoyed the working environment, but particularly the warmth and collegiality they experienced from the nurses with whom they worked.

Occasionally however nurses did come into conflict with each other. Some nurses expressed concern about other nurses' advice to parents, believing that this advice may be confusing the parents. The nature of nursing work, with one nurse following the other each shift meant that parents sometimes talked about the previous nurse to the incoming nurse. This led to nurses feeling uncomfortable and as one nurse noted, she *did not want to step on other nurses toes,*

> *it's hard because mum has had a few issues with some of the nurses...Just with certain things that the nurses have said to the - the family and things like that and you know things they haven't done... 'cos I didn't want to step on the other nurse's toes.*

Nurses also felt uncomfortable when they observed another nurse's behaviour with which they did not agree. The general ethos was not report this behaviour *(tattle-tale)* to managers, however if the behaviour continued, nurses would confront their colleagues and ask them to stop. They reported,

> *'Cos I - I don't tattle tale. But if - if I felt bad in the past I have actually said to people "I don't think you should speak to the parents like that. There was no need for that." Yeah I've said it a couple of times but - I don't like that. That annoys me.*

Overall nurses had effective, professional relationships with other nurses, which often became personal relationships outside the ward. They shared their emotional concerns, giving and receiving emotional support from their colleagues. These personal relationships seemed to enhance the collegiality of nurses' work, strengthening the team approach, adding to nurses' satisfaction of working in the ward.

Nurses and medical staff

Nurses were observed to have a complicated relationship with medical staff. Nurses perceived they were valued by medical staff, that their opinion regarding the patient was sought and respected, and that medical staff were willing to take advice from nurses on patient issues. Nurses seemed grateful that medical staff *valued* them and asked for their opinion. As one nurse noted,

> *I feel very valued there. I think I like how we - we're part of - the doctors - the doctors ask us how the patients are. How - what we think. And vice versa*.

Another nurse noted that doctors were approachable and paediatricians would talk and work with nurses,

> *Even the doctors are very approachable and the paediatricians aren't afraid to come down and actually talk to you about things and work with you*.

Nurses wanted to work with doctors in a collaborative manner. In ward rounds, the doctors would look for the nurse responsible for the child, and ask the nurse to present the clinical case during the doctors' examination and visit. At times nurses were observed as active contributors to the ward rounds, volunteering information to the medical staff about patient issues and concerns. Other nurses, however, appeared reluctant to speak during the doctors' visit with the patient. Instead the nurse might pacify the child to keep the child quiet during the visit so that the doctor could talk to the parent, or stand quietly without contributing. It would be noticeable that when the medical staff left the room, the nurse would be more open with the parent, explaining the current plan for the child.

Some nurses noted that it was their role to educate medical staff about caring for children stating,

> *We're teaching doctors. And new doctors coming on how things work and we're teaching students what's happening.*

When nurses and doctors were in the nurses' station, the doctors were sometimes perceived as the keepers of knowledge and the authority. At other times, the nurses and doctors talked together collaboratively about the patient and patient issues. This mixed approach by nurses is exemplified in this comment by a nurse, who notes it is not *her or his place* to comment on a plan of care,

> *And at the same time I was careful not to offer any nursing opinion as to the doctor's planned care. Because it's not my place. And I see it's - I'm not a doctor. It's not my place to say if I agree or disagree with any particular doctor's plan of care.*

This approach was also noted when the nurse was having difficulty explaining a treatment to a parent, or getting a parent to comply with a particular treatment. The

nurse would call on the doctor to come to the ward and explain what was required to the parent,

> *It's the only time that I really say* [to the doctor] *"Mum's not really pushing fluids. Maybe - well maybe you could discuss this with her, and say that it's quite important*."

Another feature adding to the complicated nature of the nurse-doctor relationship was the observation of informal banter in which doctors and nurses engaged. This seemingly relaxed style of communication could also have an edge that was trying to get a message across, without being perceived as threatening. One nurse explained that nurses had given one doctor a *hard time,* as the doctor was not performing as nurses would like,

> *I know there's one doctor... that gets a hard time and he doesn't really come down and explain things like that. And I don't think 'cos he's getting that - he's getting more of a negative vibe as opposed to a positive one.*

There was a different relationship between nurses and medical staff they knew, such as the paediatric doctors, and those they did not know, such as the orthopaedic or surgical doctors. With the latter, nurses were more formal, less friendly and less relaxed. With the former, nurses were usually relaxed, chatty and friendlier. Sometimes nurses were observed to work closely with doctors, excluding family members, and at other times, nurses aligned themselves more closely to the parents, excluding doctors. Nurses described themselves as mediators between the medical staff and the parents. One nurse described a *battle of wills* between herself advocating for a parent and child to get some sleep, and a doctor who wanted to wake up the child to undertake an examination.

Some decisions about nursing practice were made by senior doctors on the ward. For example, nurses were not able to cannulate (insert a cannula into a vein for the purposes of an infusion or to take a blood test), take blood intravenously (with a needle) or via finger/heel pricks, nor catheterise (insert a flexible tube into the urethra for the purpose of emptying the bladder, or taking a urine test) children. These clinical interventions were subject to a medical decision, with the rationale that if nurses undertook these interventions the medical staff would not have enough exposure to practice their skills. For nurses who had come to the ward from other areas and already

had these skills, there was some frustration expressed at not being able to perform them on the ward. Nurses perceived they were being *deskilled* and worried about losing those skills they once had. Newly qualified nurses were concerned that they would not get a chance to develop these skills in the ward,

> *We also don't cannulate as well. Which sometimes I sort of miss because I think that's a skill that we're missing out on really. When I listen to other people it's like "we can do it too."... And we don't take bloods or anything like that.*

Nurses' relationships with other staff

Nurses had direct relationships with hospital aides who provided support to nurses with regard to meal delivery, bed-making, keeping the ward tidy, and a ward clerk who was based in the nurses' station. The relationship between these three groups was relaxed and informal. They frequently went on breaks together and shared their personal lives with each other. Each group appeared to have a good awareness of their role in relation to the other, and they worked well together.

There was one social worker who worked predominantly on the ward. This offered nurses an opportunity to promptly refer parents to the social worker whom they perceived to have expertise in managing parents' social and emotional issues,

> *and if the slightest problems we just let the social worker deal with all social and emotional stuff because Xxxx* [is an] *expert in that.*

The social worker also gave nurses an opportunity to debrief about situations with parents perceived as difficult. The social worker explained to me that social work involved dealing with parents' emotional communication and the nurse's role was more about managing the child's physical needs. The social worker also thought that nurses were frequently too busy to engage with parents, although when they had time they did a *good job.* There was a mismatch of expectations between nurses and the social worker, in that the social worker had expectations of nurses' roles, and the nurses had expectations of the social worker's role which were not always aligned.

In addition to interactions with nursing and allied health staff, the nurses on the ward frequently interacted and formed relationships with parents. In the next section, nurses' relationships with parents are elaborated.

Nurses' relationships with parents

In this section, nurses' relationships with parents will be described, including the nature of the interactions between nurses and parents; nurses' perspective of the parent in the ward; nurses' focus on the parents' physical needs; the rapport nurses have with some parents; and nurses' response to parents.

The relationship between the nurse and the parent was inconsistent. Some nurses perceived parents as patients alongside their child, who needed to be cared for collectively. Other nurses looked at parents more as a resource who would help the nurse in the caring role of the child.

Parent as patient

When care of a child was allocated as a patient to a particular nurse, nurses were aware that the parent would also be involved in the nurse-patient relationship, although the level of involvement the nurse expected of the parent was variable. For some nurses the *family* was the patient, yet for others the parent was an *add-on* to the nurse-patient relationship.

This nurse described enjoying nursing the child and family as the *whole package,*

> *You're also nursing the - the family. And that's what I enjoy too. It's not just the patient. It's the whole - the whole lot. You get the whole package.*

Nurses described their work as being *about families, working with the family as a whole,* and the *family-centred approach* (a model of care in which the family is seen as central).

And this nurse noted,

> *I think you just intuitively think the child and the parent are one.*

For another nurse,

> *caring for that child does mean that you have to care for the adults as well.*

When the nurse first met the parent, usually by the child's bedside, the nurse would explain who they were and what they were planning to do for the child during her shift,

> *Like in the beginning of the shift we tell them that this is what we're going to do.*

There was an expectation by the nurse that the parent would adhere to the nurses' suggested plan, and assist the nurse as needed. Roles were rarely negotiated; the nurse would take on the technical care of the child, and assumed the parent would continue to parent the child, which could include providing hygiene care, distraction, entertainment, and nutrition. Interaction with the parent was usually limited to discussion of the child's condition and treatment.

The parent in the nurse-child-parent triad

The nurse-parent relationship in the ward was consistently tempered by the reality that there was also a child involved in the interaction. Nurse-parent communication usually occurred in the presence of the child, and almost always revolved around the child. The focus of the nurse-parent interaction was the child.

This nurse explained,

> *I think we just tend to focus on the child and see the parent as a - off - you know a separate part of the child. Not as an - and individual that we need to be caring about as much as the child.*

When the nurse approached the child and parent, the child's physical condition was the most common topic of conversation. Attending to the child's physical needs gave the nurse an *excuse* to enter the child's bed space, and thus interact with the parent, and for most nurses the child was the priority as this nurse noted,

> *People are all different, they've all got different needs. And ultimately we are caring for the child, our first priority*

When working with the parent, nurses understood they had a variety of roles, from explaining the care offered to the parent, to assisting the parent meet the child's needs, and ensuring that the parent was physically able to provide care for the child. Nurses valued the input the parent was able to provide in supporting the child to get well, they recognised that the parent knew their child best, and they worked hard to listen to the

concerns of parents about their children. Nurses wanted to work alongside the parent, with the combined goal of improving the child's condition. This nurse discussed the value of working with the parent to meet the child's needs, consistent with a family-centred approach,

> *And she knows her daughter better than we ever will. So she knows - yeah as I said medication was not the easiest thing to get into her. And then we find things that work together. Like codeine and phenergan worked really well and so then in the end it was just like mum - mum would come and say it's time. So it was like "Yeah we know what it is." And yeah you just find little things that work and don't work together and as I said mum knows her best. So asking her is - was really important.*

Nature of nurse-parent interaction

In this section the nature of the nurse-patient interaction is discussed. Nurses focused on parent's physical well-being, were task orientated in their responses to parents, kept parents informed about what was happening with their child, and some nurses reported *clicking* with some parents. For some nurses, the level of rapport with the child and parent affected their emotional engagement with the parent.

"Are you okay?"

"Are you okay?" was a frequently asked question of nurses to parents. This question was most frequently posed when the nurse had completed tasks focused on the child's physical needs and was preparing to leave the child's bed space. Being *okay* for the nurse meant that the parent had enough sleep, food, and respite from the child, or that the parent was generally satisfied with their child's condition at that time. Parents usually replied that they were *okay* to this question, or they may comment that they were tired, or wanted the child to sleep, or that they were worried about an aspect of the child's condition. The question *"are you okay?"* did not focus on anything other than the parent's or child's physical wellbeing.

> *I think we are very responsive to physical needs which I think is really important.*

The above nurse's comment sums up the focus nurses had on parents' physical needs. If it became apparent that the parent was going to be staying in the ward, the nurses' gaze would move from the child's physical needs towards the parents' physical

requirements. Nurses would anticipate what the parent may need in the way of parking vouchers, food requirements, showering and toilet arrangements and offer these to the parent willingly. A nurse reported,

> *the other night I – they* [parents] *came in and they'd been in ED* [emergency department] *for seven hours or something like that. I said to them "Have you eaten?" "No, it's sweet* [colloquialism meaning satisfactory]*." "Alright I'll get a tray of food"*

Nurses were also persistent regarding parent's sleeping and rest. They were aware that if the parent was not well rested, the parent's hospital stay, and their support of their child would be compromised. Nurses also understood that if the parent was functioning well, the nurse's life would be *easier,*

> *Like if you're sending mum out for breaks you're giving her a bit of - your - your - it's actually easier for us because having the mother having a break makes her - or parent - dad, caregiver whatever is calming them down, putting them in a better - a peace - a mind space. And it helps us*.

Nurses were aware that having enough sleep and food helped parents cope emotionally with the situation the parent was in,

> *I think if you've had some sleep you can deal with anything better. If you've got some food in your tummy - especially those mums that are breastfeeding and stuff you know they need to make sure they look after themselves*.

And one nurse noted,

> *Because that helps emotionally. If you've got sleep you'll deal with things better emotionally...If you're eating.*

Nurses were responsive and proactive in ensuring that the parent's physical needs were met. Nurses interactions with parents were frequently related to parents' anticipated physical needs.

Like the "Are you okay?' question, when a nurse asked a parent about their needs, this referred to the parent's physical needs,

And then I always stick my head in later and say "Is there anything you need? Have you had something to eat?"

If a parent was observed to be *stressed*, nurses would usually suggest this was because of a lack of food, sleep or time away from the child. Nurses anticipated parents' physical needs, discussed them with parents and readily provided the time and space for the parent to meet their own physical needs. This nurse discussed her thinking when working with a parent,

Does that parent actually need me right now because - do they need to go out for a break? Are they getting overwhelmed and overtired and - you know just tell them to go. If you've got a good enough rapport tell them to get out the door sort of thing. It's hard. And I think they also need educating - just saying we are here. If you need a break, ring the bell and we'll come and look after your child.

Task orientated

Nursing interactions with the child and parent were usually initiated when the child needed a task completed, such as having their vital signs (temperature, pulse, respirations, oxygen saturation) measured and recorded, or medications administered, or their intravenous fluids checked, or a dressing checked, or post-operative assessment. When the nurse entered the patient's room, or bed space, the nurse would quickly move into the task, usually talking to the child and explaining what she or he was doing, and sometimes acknowledging the parent at the bedside by saying hello and stating what she was going to do. The nurse would then complete the task and gather equipment if used and prepare to leave the space. Often the nurse would ask the parent to *just ring the bell* [call bell] *if you need me,* then leave the room. Nurses usually called parents *Mum* or *Dad*, and usually did not appear to know or find out the parent's name. One nurse described getting *hung up on tasks,*

because on the ward you get - it's very task orientated. Like you can get hung up in tasks orientating - orientated nursing very quickly. 'Cos you think you've got this, this, this to do in an eight hour shift.

Other nurses would spend more time discussing the plan of care with the parent before moving into the task. For this nurse, establishing a relationship with the parents/family and child was important,

I don't normally go in and straight into the obs [observations] *for the kids. I normally go in and talk to both the parents but also to the child. "I'm going to do this. Hope this is good?"*

The plan of care was decided by the nurse and presented to the parent as a fait accompli. The parent was expected to go along with the nurse's presented plan. When the nurse had met the parent and child once before, the next interaction appeared to be more relaxed, and friendly, but usually focused on a task or intervention directed at the child,

I think we can be very task orientated sometimes. I think we go in to do the obs [observations such as vital signs] *and go in to do the basic tasks and it gets really busy, and you get really stressed and getting the basic tasks done is sometimes too much*.

And for this nurse, the focus was on the medical or surgical condition and the child, forgetting the need to also care for the parent,

you forget sometimes about that when you're so busy or so focused on the medical condition or the surgical condition or the child but when you're here you've always got to nurse the parent as well.

Nurses were anxious that parents contact them if needed and the parting phrase was usually,

"…find me or ring the bell."

This nurse noted that when leaving the patient's room, she or he would ask the parent to ring the bell if they needed anything,

You know always try and ask when I'm leaving the room if there's anything else I can do if you - don't hesitate to ring the bell - you know all those sort of things.

The nurses' focus was on the child, especially in the early meetings with the child. As the nurse came to know the child and parent more over the shift, the nurse became

more relaxed, and would be chatty and friendly with the parent, but still focusing on the child's physical needs.

Focusing on task when with the child and parent meant that the nurse spent little time interacting with the parent. Nurses were absorbed and attentive to the child's needs, to the point of excluding or not noticing the needs of the parent.

Tell parents what's happening

It was important for nurses that parents knew what the nurse's total workload was. Nurses would share their workload requirements with the parent during their shift. Nurses described feeling *guilty* if they felt they had *neglected* the parent and child,

> *I - I like to tell them what's happening. If at the start of the shift as well I always find that say I've got five kids - three are respiratory and two are really easy. I always like to go and visit my respiratory* [patients] *and then go and see my two other kids but say to mum "I'm X* [first name of nurse]*. I'm going to be your nurse today. Just so that you let you know I've got a couple of respiratory kids so I'll be in with them quite a bit. If you need anything ring the bell."*

Another nurse wanted the parent to be aware the nurse may not have enough time for the patient as the nurse would like,

> *I do tend to try and say to people if it's really busy "It is very busy today. I've got a lot of other patients I'm looking after so please don't hesitate to ring the bell if you need me or come and find somebody." All of that just to maybe give them a little bit of an up, as to how it is. So that they are aware that I'm not neglecting them I guess. I try and sort of - yeah I know it's not their problem that the ward's busy but I think also it's good for them to be aware that I'm aware that I might not have as much time for them as I'd like to.*

One particular nurse had difficulty on a shift when three of the four of the assigned patients were in the four bedded room, and the nurse felt that the parent and child would see the nurses with the other patients, and feel neglected,

> *I was really busy and I felt like I was neglecting my parent - and I said to them - you know 'cos I had all my - I had four kids and three were in the same room. And I - I was spending all my time with one because it was a blood transfusion. And*

when he'd gone home I said to them I'm so sorry if you feel like I've neglected you. And I said - you know - and I just told them.

Nurses were transparent with parents regarding their workload. They wanted the parents to know what was going on for them. They were concerned that parents did not feel *neglected*.

"Clicking" – establishing rapport

For some nurses, establishing a rapport with the parent was an important part of their work as a nurse. They wanted the parent to feel comfortable with them, mainly to tell them what was going on with the child,

different parents are easier to - to open up to...I find some parents a lot easier to relate to than others.

Nurses were however resigned to the reality that they would have a good rapport with some parents, but not all,

But sometimes we just are different nurses and sometimes a nurse - parents get used to one particular way of nursing and you come along and it's sort of like out of the water. Because we are different. And it's always going to be that way. We're not robots. And I think some people just clash. And we can't help that. You just - sometimes you just can't click with people.

Nurses *got on* with parents whom they perceived as similar to themselves, for example if the nurse and parent were of similar age, gender or ethnic group; or had had similar parenting experiences, there was a stronger rapport,

I've had the parents that I'm sort of like I can see that this is not going to be a great relationship from the beginning. But as I said it's - we're human. We don't get on with everybody.

Nurses knew when they had an effective rapport with the parent, because the parent would start talking with them about the child, or about their concerns. The conversations with parents would become easier, would flow better and the nurse perceived that the parent may share information exclusively,

They're comfortable to talk about things that they might not talk about with other nurses. Or bits like that...easy conversation...that you can just keep flowing.

Nurses were well aware that if they did not have a rapport with the parent, the parent was unlikely to talk to them about anything meaningful,

that's the one point of creating a rapport, if you don't have it then they're not going to tell you jack [anything].

Some nurses worked to establish a rapport with parents, realising that when the nurse and parent had an open relationship, the nurse would have a better understanding of the child's issues. Nurses mainly wanted an effective rapport with parents in order to care for the child more effectively. It was also apparent that nurses enjoyed the relationship more if they *got on* with the parent. The interaction would be more likely to be friendly and satisfying for the nurse.

When nurses did have a rapport with patient they anticipated parents' needs and *went the extra mile*. This sometimes entailed nurses bending rules and ward policy in order to meet those needs. Nurses would encourage the parent to eat the child's meal, if the child did not want it and the nurse knew the parent could not afford to buy a meal; they would contact the parking wardens regarding parking violations; let parents bring a hot drink into the ward; and ask medical staff to prescribe medication for the parent, rather than the parent leaving the ward for medical attention. Nurses were proud that they were willing to *go the extra mile* for parents, and received positive feedback from parents when they did this. This nurse rationalised this behaviour by acknowledging the parent was looking after their child and *wants to get through* the hospitalisation experience,

You know sometimes I don't care about the rules of parents not allowed to eat; it's just like buck - buck the trend. You know they're looking after their child. They want to get through.

Another nurse told me she did not mind getting *a slap on the hand* for giving a parent a meal voucher, as she or he recognised the parent needed food and could not afford to buy it.

However, the age and experience of the nurse also had the potential to prevent a nurse from engaging on an emotional level with a patient, as well as how well the parent and nurse have *clicked.* This nurse explained,

> *nursing experience. I guess different ages, stages of nursing. New grad. You know I mean it's all very different. They're - everything's new to them - you know - that's all new to a new person. So there's those differences. Personality. How you've clicked with that parent. How your personal relationship with them - or your professional relationship... Some parents - obviously you - you do click more with. Or some parents are more open with engaging emotionally.*

For this nurse, familiarity with the parent made a difference to the support offered. If the nurse did not *get on* with the parent, she or he *stepped back,*

> *I guess familiarity with the parent. If you - if you get on straight away with the family then you're going to be offering whatever you can. But if - if you don't then you - you probably step back a bit further than you should.*

The "difficult" parent

On report nurses' perceptions of parents were influenced by previous experiences of parents who were perceived as *difficult*. These parents might not have agreed with interventions and treatments offered, or may have challenged the hospital systems, or have been unhappy and unpleasant, and in the worst case scenario violent and abusive. Most nurses had worked with parents like this, and if they had not had personal experiences, had heard first-hand from colleagues who had, and therefore were prepared for this behaviour. A nurse reported that,

> *the parents can be quite scary. And some of the dads' - I've - I've been pushed up against a wall before by a dad and he had his fist like that. I thought he was going to punch me. And I've seen pregnant nurses on the ward being pushed about by dads and stuff...sometimes it's unsafe or it feels unsafe*.

Anticipating that any parent could be *difficult*, made establishing rapport, and working alongside parents a more stressful experience for nurses. Difficult parents *moaned* and as one nurse stated there are parents,

who don't think we're doing a good enough job and likes to - the occasional parent would like to moan about what other nurses have done on previous shifts and compare.

And this behaviour was reported as *challenging,*

we've had some very challenging [parents] *- as every area does - parents that push all the wrong buttons.*

Some nurses perceived that *difficult* family members impacted their nursing practice, and also prevented the child from getting better.

One nurse described a parent who was resistant to the nurse's exhortation to encourage the child to drink fluids,

One that says "My kid won't drink." And I say "Well can we try syringing a wee bit, maybe ten mls in." "No, he won't try that." "Can we try an iceblock?" "No." "Can we try a jelly? Is there anything that he will drink?" "Nah, he should have IV fluids."

Difficult parents were defined by nurses in a continuum, from moaning about other nurses, to resistant to a suggested treatment plan, to being violent and aggressive. Many nurses had had some experience with a *difficult* parent, and anticipated adverse parent responses to them and the care they were offering.

Experiences, either actual or second-hand, of *difficult* and *demanding* parents had a negative impact on nurses' abilities to form effective relationships with them. Nurses were noted to be wary of parents, to separate themselves from parents, and to avoid close contact with parents.

Nurses' responses to "difficult" parents

Nurses responses to difficult parents varied; from *biting their tongues* and ignoring parents, to disbelieving that parents would not take their advice, and frustration.

Bite their tongues and ignore

One nurse suggested that nurses had to actively stop themselves from verbally responding to parents, especially if the nurse did not agree with the observed parental

behaviour such as disciplining or feeding the child. Nurses had strong views about parenting issues and struggled when parents' behaviours conflicted with their views, as is evidenced by the following report,

> *nurses just have to bite their tongues. They don't believe that that's the right thing for that child but that's that mother caring for that child and that's - as long as they're not doing any harm then - and that's sometimes a - is a very difficult thing for a nurse to come – comprehend. Especially in paediatrics. Even like disciplining or feeding or - it's very different 'cos you've got your own ideas.*

Another nurse also worked to *bite her or his tongue* to stop responding inappropriately noting,

> *I might say something that I'm not meant to say. And it's sometimes it's like you've got to bite your tongue*

Along with keeping silent on parents' behaviours nurses also used the strategy of ignoring the parent, avoiding contact and interaction with the parent and child. As this nurse reported,

> *I mean you've got the tricky people on the ward and they ring their bell and everybody ignores it. There's you know tricky families that sort of - we've all got families that everybody wants to avoid*.

Ignoring was in part an action associated with some disbelief about parents' ideas as is further elaborated.

Disbelief and frustration

Nurses were disbelieving and incredulous when parents asserted their wishes about the child's care. Nurses did not anticipate that a parent may have a different view on the best treatment plan for the child, and expressed disbelief that some parents did not want the care being offered. For instance a nurse noted,

> *she's* [mother] *just obstructive to any suggestion at all... I can't understand why she - after all this time - after so many admissions last - so many this, I mean the*

child's ten - that's for ten years, she still doesn't listen and understand that - that we're trying to help.

Disbelief that parents would reject nurse's offers of help could lead to frustration and nurses had difficulty understanding why a parent could not or would not see the situation as the nurse perceived it. Parents' apparent lack of understanding regarding suggested treatment plans, and consequential lack of cooperation with health professionals led to frustration.

This nurse described wanting to keep *digging* and *pushing,* trying to understand what was going on for the parent.

It frustrates me. Yeah it really frustrates me. Which is probably why I keep digging you know trying to push and push. Because it does - it frustrates me.

Nurses had a range of immediate responses to *difficult* parents, with the long term response being a wariness of parents with whom they came into contact. Nurses reported refraining from responding verbally to parents, ignoring them, being incredulous that the parent would not take their advice, and feeling frustrated about the parents' responses.

Chapter summary

This chapter has described nurses' experiences of working in the ward, and their relationships with staff and parents. In contrast to nurses' relationships with other health care professionals in the ward, nurses' relationships with parents were clearly problematic at times. There were discrepancies in the way nurses perceive parents, either viewing the parent as a patient, or the parent as part of the nurse-child-parent triad, in a caring role.

Nurses' focus is either on the child, or the parent's physical needs, with a strong task orientation. Nurses do tell parents about their workload, and what they are doing, but are more likely to *click* with parents most like themselves. Nurses are wary of parents, and perceive them as *difficult*, which lends support to the challenging relationship between nurses and parents.

Practising as a nurse in the ward is generally a positive experience for nurses. The culture is supportive for nurses, especially with regards to managing their own

emotions. Whilst health professionals in the ward have a collegial relationship, nurses' interactions with parents can be problematic. There is confusion about the role of the parent, either patient, or collaborative care-giver working alongside the nurse. Nurses' approach to parents is usually focused on meeting the child's needs, with some consideration of parents' physical concerns. Some parents are considered *difficult* which has led nurses to be wary and distrustful of parents.

In the following chapter, nurses' practise of emotional communication with parents will be detailed.

Chapter 7: Nurses' practise of emotional communication with parents

Introduction

In this final results chapter, the central focus is nurses' experience of emotional communication with parents in hospital. Nurses' understanding of why parents may be emotional is outlined, nurses' responses to parents' emotional communication and finally nurses' perceptions of why they avoid emotional communication.

Communication between nurses and parents, which focused on parent's feelings and affective responses related to their child's hospitalisation, was rarely observed in the ward. As noted previously, the nurses' attention was mainly focused on the child. Parent's physical needs were anticipated by nurses, however parent's potential emotional concerns were not. Nevertheless, when nurses were asked about emotional communication, they demonstrated an understanding of possible reasons parents may feel emotional in the ward.

Nurses' understanding of why parents may be emotional in the ward

Nurses' responses to questions about reasons why parents may be emotional demonstrated nurses' empathy and understanding of parents' emotional concerns. Reasons included: concerns about their child or issues external to the ward.

Concerns about their child

Nurses were aware that concern about their child caused parents to feel distressed and affected their emotional state. Nurses thought that parents worried about their child, especially when the child was first admitted to the ward, when their child was undergoing a procedure, or if the child's condition was unstable. One nurse explained,

> *that is the main worry when they are in the hospital - about their child. Because they* [parents] *can be upset because they want to know about their child. I think that's the main reason that they are emotionally upset as well*[4].

Worries about their child were a key factor in parents' emotional state according to nurses. This nurse acknowledged that these concerns led parents to feeling *vulnerable*,

[4] *Words in italics* are verbatim comments from participants

parents feel quite vulnerable 'cos their little person's sick and lots of different people coming in and out and doing tests and things.

Nurses understood that worry about their child caused parents to react in an unpredictable way, including being abusive. One nurse explained,

we've had an oncology kid whose father's quite abusive. Which I'm sure just comes down to the stress of his illness and - like getting his poor [Intravenous] *access and stuff like that.*

According to some nurses there were an array of factors within the hospital experience that caused parents to feel emotional. Nurses reported that parents may feel upset or guilty about the child's illness or hospitalisation; they may not fully understand what is going on with the child, or the treatments suggested; they may be worried about the effect of their upset child on other parents in the room; or they may feel isolated from their sick child. One nurse discussed her understanding of a parent with whom she had worked,

It was difficult for her. She did voice that it was difficult for her to continue mothering the baby. She said she felt a bit cut off from baby at times because we were taking care of so many cares [for the child].

Another nurse described a mother who felt unhappy and guilty about the child's hospitalisation,

yep she was unhappy about hospitalisation. She was quite tearful that he was unwell and she was blaming herself that it was her fault that he - she didn't bring him in earlier. And that if they'd brought him in earlier he wouldn't be as unwell or - kind of round the normal guilt circles that parents do.

Another nurse described the stress of the child's sudden hospitalisation on the parent,

I guess coming in from the community into the hospital is quite an emotional upheaval for a parent. And especially if you're not expecting it. And you think your child's not that unwell or you come in just for advice and end up admitted with something like a pneumonia.

One nurse perceived that parents may feel emotional if they were unhappy about the care they had received,

> *sometimes it's the nurse that's talked to them previously that's made them emotional.*

And another nurse wondered if the parent was upset because she or he perceived the nurses were not doing *enough* for their child,

> *you know mum was past the point - she was also really upset. Probably tired from an early morning. Emotionally upset with him. Maybe thinking that we weren't doing enough.*

Nurses appreciated some of the issues that may have caused a parent to be emotional. Nurses understood the responses to be parental concerns about their child which included; being worried about their child; feeling vulnerable, upset and guilty; feeling isolated from their child; and being unhappy about care provision.

Issues outside the ward

As well as concern for their hospitalised child, nurses perceived that for some parents, it was issues outside the ward that affected parents' emotional wellbeing. Issues could include difficulties with their family relationships, stress about missing work or education, concerns about their other children/family members, and struggling to cope with their parenting at home. One nurse explained,

> *there can be all sorts of things going on in their life. They could be worried about the other kids at home. We've had a few who are having marital break-ups at the time.*

Another nurse noted that parents she worked with *struggled to cope* at home*,*

> *Very little support out in the community and it was obvious she wasn't coping. She was - she was struggling to cope*.

Nurses had an awareness and understanding of factors that could impact on parents in hospital, with the most common being concern about their hospitalised child. The response of the nurse to emotional communication is next considered.

Nurses' responses to emotional communication

Nurses had an array of responses to emotional communication. Overt displays of emotion by parents were usually responded to, and some nurses also described being able to detect parents' emotional state, noting verbal and non-verbal cues. My observation during field work however yielded very little nursing response to cues and concerns that the parent may be experiencing. When nurses did respond to emotional communication, the responses were observed to be either engaging or non-engaging.

Nurses' perception of parents' emotional state

Nurses confirmed that they knew of factors that may affect parents' emotional wellbeing. Some nurses also described an ability to detect parents' emotional state and described cues and signals that indicated to them that the parent was feeling emotional. Signals to nurses that parents were feeling emotional ranged from the parent being tearful and frustrated with their child as described by this nurse,

> *You know there's all those sort of things you've got to - lot of cues I think as nurses you need to pick up onto...I think - obviously if they're tearful. If they're getting a little bit frustrated with their child. You know if you can hear them going "C'mon." You know any sort of frustration.*

And to the way the parent presented as noted,

> *Either verbal cues or just how they're being in themselves I guess. How they're presenting. Yeah.*

One noted the parent's *demeanour,*

> *Just her demeanour. Just her - what she was talking about. Mum just wasn't as open as she had been previous times I'd seen her.*

And another nurse noted the parent was *on edge,* and *aggressive,*

> *She was also very - just on edge and I could just pick up that she was beating herself up about things and feeling quite angry and upset that she wasn't managing and not knowing what to do. So I just wanted to ask how she was*

feeling. So she has looked - she comes across a little bit aggressive almost but I think there's a lot of underlying - she's worried.

For this nurse, the parent's eyes and her *overbearing* nature toward her child confirmed her emotional state,

sort of bright eyes, a bit jittery, in your face, like asking lots of questions. And like very overbearing of the child. Like she wouldn't leave the child. Was always hugging the child. Was in bed with the child.

Another nurse noted the parent was *shaky* and *backing away,*

She just - she was a bit shaky. A couple of little tears leaking out the corner of her eyes. Her arms were shaking a little bit. She was just - and backing off. Just backing away.

For this nurse, the parent's *body language* gave a strong indication of the emotional state,

Body language, I mean you can tell when a parent's getting a bit stressed and they're getting a bit irritable with their kid or they look tired or they're getting tearful.

Another nurse observed that the parent's cues that they were emotional, gave the nurse an indication whether or not to *search deeper,*

I guess if you really think - like if you do see they are - they've got the twitching and the - you know - you're getting their cues you should go and - and whether you can get it out of asking and searching deeper.

One nurse noted other nurses read parent's cues that they were emotional,

usually they're pretty good at picking up cues from parents.

Some nurses described a level of sensitivity and awareness that detected if the parent was feeling emotional and described a range of cues that suggested the parent's state of being. Cues included the parent being tearful, on edge and aggressive, asking

frequent questions, being overbearing or irritable with their child, and shaking and backing away.

For those nurses who did detect the parent's emotional state, they would respond in some way. The more overt the parent's emotional communication, the more likely it was that the nurse would respond. These responses are outlined in two major areas: engaging responses and non-engaging responses.

Engaging responses

Nurses demonstrated an array of engaging responses which were clearly aimed at helping the parent through this difficult time in their lives. Engaging responses included trying to fix the wrong, encouraging the parent to take a break, offering information about the child's care and progress, attempting to give reassurance, having a joke and trying to work out what was going on.

Fixing what's wrong

When nurses were engaged in responding to parent's emotional communication, they felt a need to do something, to offer an intervention. Interventions were designed to fix the parent's presenting concern. Interventions ranged from encouraging the parent to have some food and offering to care for the child, to suggesting the parent had a shower and a *good cry,* to suggesting the parent talked to the ward social worker or a doctor, or encouraging the parent contact a family member. This nurse described being,

> *So caught up in the moment and in fixing what's wrong.*

One nurse described the interventions offered in order that *someone can make a difference,*

> *Try everything I can, like I am with referring to social work, which I did, social workers have seen her, referred dietician whatever's needed and just hope that someone can make a difference somewhere.*

For another nurse, a referral to the social worker was made at the slightest suggestion of an emotional concern,

we ask the social worker to come and help. Like that we - we do that. Even if the slightest doubt I've got that they [parents] *are not coping I'll just do a social worker referral.*

In nursing documentation, a night nurse noted the parent's concerns, and requests the day staff ask the parent if she would like to see the social worker,

Night duty notes: 0630: social: mum at bedside, became tearful stating she was on antidepressants and not managing well with [child] *vomiting. Please ask mum today if she would like to see a social worker.*

One nurse described moving the family to another room, or extending visiting hours so that the parent had more support from home,

bit more visiting hours you know if you know that a mum's a bit tearful we'll let the family come in later you know to - to support her needs and minimise the stress of the child.

Emotional communication from parents generated an intervention response in many nurses. Nurses wanted to reduce the parents stress and suggested or offered interventions they thought may *fix* the concern. Responses included referring to other health professionals such as dieticians and social workers, moving the family into another room, and encouraging parent to *have a good cry.* Closely associated with *fixing what's wrong* was encouraging the parent to *take a break.*

Encourage parent to "take a break"

Nurses believed that if parents were hungry or tired, they would feel more emotional, thus reasoned that if parents had frequent breaks from their child and the ward, they would be able to cope better with the situation they were in. A *break* could be physically leaving the ward, or getting a drink or food, and leaving their child in the care of the nurse.

This nurse knew the parent was a smoker and decided that the parent needed to take a break for a smoke, because the parent was crying,

and mum was just crying... as it was handed over, the nurse that was taking her over came in with me and we said "alright mum just go for a break. Just go. Just

leave the room. Right now." Because I could just tell that - because she was a smoker.

Nurses offered to *stand in* for the parent so that parents could leave the ward for a break, but the nurse would explain to the parent that her other patients also needed to be cared for,

and if I wasn't busy I'd say to them "Give me a wee shout, I'll come and sit with him. You can go and take some time away." But - but just make sure I - you know I'll say to them "But I'll do it round my - my other kids as well. So let me know and I'll come and sit."

Another nurse noted that *breaks are huge for parents; giving them some time out,* and also that instead of directly questioning parents about their emotions, nurses offered breaks,

And that is adhering to those emotional needs I guess it's just not done as a direct question but it's - you know "How about you go and have a break." "Would you like a break?"

A *break* could also entail the nurse offering to care for a baby and encouraging the parent to go and sleep. This nurse described hearing the baby cry from the office, and offering to take the child so that the parent could sleep,

the baby's crying a lot, we can hear that from the office. So we just take the baby if they're not in isolation. And we just take the baby and look after it and let the mum sleep. We feed the baby and we do - we just tell them "Don't worry." Because sometimes it's lack of sleep. And we just tell them "You go in the parent's suite and sleep. Don't care about the baby crying. We will feed the baby." We have done that and that's quite helpful.

Offering parents a break away from the child and the ward was a regular response by nurses to parents' emotional communication. Nurses believed that if parents had a break they would be more able to manage the situation. Nurses also felt that offering information was helpful.

Offering informational support

A frequent response by nurses to emotional communication was to give the parent information. The information could include what was going on for the child currently, discussing what may happen, or what the nurse was doing and why. The information would be given immediately the nurse detected parent's emotional communication. Nurses understood that parents were emotional because they did not understand what was happening for their child, or they were anxious for their child. This nurse described talking to the parent about what might happen if the child's condition did not improve,

> *From right when I came on I had casually mentioned to the mother in conversations "Well she's doing okay at the moment but the next step if she looks like she's getting too tired will be this thing called CPAP"* [continuous positive airway pressure, a type of breathing therapy]. *And I explained what it was and that baby would have prongs up her nose and she'd be sedated and allowed to rest.*

This nurse spent time explaining to the parent what was happening in lay terms, as it had appeared to the nurse that the parent did not understand,

> *You know I make sure I spend time to try to explain things in terms and things that they will understand because we will quite often find on a ward round the doctors will come in, talk, decide things, leave and the parents have no idea what the doctors have said.*

For another nurse, the information given during the doctors' round was also translated for the parent, adding more information if needed,

> *You know if they get a bit worried about what's been said on the doctors' round, we can reassure and offer that information*.

Nurses believed that giving parents' information helped to allay their concerns about their child. This nurse perceived that explaining what was happening would solve most of their emotional concerns,

> *Actually I think most of the thing is like you explain here in the ward - you explain to them what is happening and tell them really well and answer all their questions. So maybe most of that emotion is like solved by that.*

Another nurse described a situation where a parent was upset. The nurse explained what had previously happened from the nurse's perspective, and noted that the parent had gained a greater understanding and this helped them to calm,

> *And we just explained what's happening, what the plan for the day is, what happened overnight and he calmed down quite a bit.*

Again for this nurse, when the parent knew what was happening and why, their concerns were lessened,

> *I will generally ask "Did you understand what the doctors were saying?" "Are you - have you got any questions about that?" Informed consent you know you're always informing them. Which is - which is hopefully lessening the stress and the worry and the emotional stuff for them if they know what's happening.*

Nurses readily and frequently responded to parents' emotional communication by giving them information about their child's condition and planned treatment. Nurses *translated* medical orders and followed up with parents on their understanding; as well as attempting to reassure parents.

Attempting reassurance

Nurses described and were observed attempting to reassure parents who were emotional. Nurses would comfort the parent, and offer verbal reassurance that the situation will improve. Reassurance was also frequently cited in nursing documentation as a response to parents' emotional communication.

These excerpts from nursing notes demonstrated the emphasis on reassurance.

> "*Mum appeared at office at 0230 shaking and crying. She voiced her concerns about* [name of child] *and how* [child] *would react to this. Mum also reported she was awake worrying about* [child's] *heart "stopping" and her electrolytes being "unbalanced". Mum reassured about the above topics and encouraged to take a break out in the parents' lounge in which she did. Mum returned back to* [child's] *room after having a hot drink feeling "a lot better""*

In the following nursing note, the nurse responded to emotional communication by offering *reassurance* and offering an intervention, in this case asking a paediatrician to talk to the parents about the child's medical condition,

> *Social: mum went to go for breakfast at 1130 and burst into tears/hysterics about* [child] *and her fears for her daughter and her suddenly dying. Reassurance +++ given to Mum. Mum admitting she is exhausted/nearly falling over. Also realised they should have brought her in earlier! Paediatrician called to talk to mum and step dad about medical condition.*

A nurse noted that the parent wanted reassurance that everything is going to be alright,

> *And then they want to know is it going to be all right. And - but they want to know whether this is the treatment and it is - or she - the child is going to be all right. They just want some reassurance.*

In this documentation, the nurse notes giving *support* and reassurance, acknowledging that the mother finds the situation *overwhelming,*

> *Social: has been visited by family watching royal wedding. Mum to stay overnight. Mum needing support and reassurance and finding situation overwhelming.*

For other nurses, reassurance was offered to provide a common link between the nurses and the parent, in this case, having children with problems,

> *And the parents, because there are a lot of people out there who don't have a lot of experience parenting. It might be their first child. I've had* [children] *of my own so they might be having similar problems to what I've had with mine. And sometimes it's nice to offer some reassurance.*

When a nurse observed that a parent was emotional, they would sometimes write a brief note in their report on the child, and then would follow that up with a verbal discussion with the oncoming nurse, either in handover, or immediately following handover when talking with the oncoming nurse. As mentioned by this nurse,

> *I don't always put in the notes what - you know a big blurb about how da-da-day you know "just spoke to mum, she's this." But sometimes I put at the bottom "Mum*

very anxious," or "Mum very upset today please keep up to date with the plan." And that's all I put in. But then I'll handover and say "Mum's been a little bit tearful today."

And further reported,

we talk about it. We do talk about it amongst each other. Maybe we don't document it but we do talk...we do talk about how the parents are managing.

At other times nurses did not document parents emotional concerns, but did offer emotional support,

we do it [give parents emotional support], *we just don't document it or we don't tend to discuss it as much as the other parts.*

For this nurse, handing over verbally *worked* better than documenting parents' concerns in children's notes,

You hand it over to the next person who's going to look and say "You seem to have a great rapport. Could you - I've just got this concern. Can you do it?" And - and that works. And we do to say "Hey watch that mum. She's tired." They are - the trouble is they are - they - the child's notes.

Nurses reported handing over parent's emotional communication to the medical team, often just before or after the doctors round in the morning,

I've said to the doctors before - like I did with xxx I said to the doctor that was going down [to see the child] *"Look mum's a bit tearful. She's - she's feeling that we're not doing this or we need to do this or she'd like this done." I did let the doctors know that mum was concerned.*

Documentation of emotional communication occurred at times, but was inconsistent, and problematic for nurses. Sometimes nurses responded to emotional communication but did not document their response, in other situations; nurses only documented parents' emotional responses. Reassurance was a frequently documented as a description of a response to emotional distress. Another response was to have a joke

with the parent, in an attempt to make light of the situation or buoy the parents' demeanour.

Using humour

Some nurses responded to emotional communication by trying to lighten the atmosphere and using humour to interact with the parent,

> *the first thing you've got to do is try and have a joke with them and see how it goes.*

And another nurse noted that,

> *I actually crack a joke. Break the ice.*

For this nurse, *having a joke* helped the mother cope with her child's hospitalisation,

> *so we were joking with him but you know in the end - and I was just going in there - we were having a joke you know and mum was having a joke too*.

For these nurses, humour was used to engage with parents, and to defuse the emotion of the situation. Another response from nurses was to explore the issue, before suggesting specific solutions.

Exploring the problem

Some nurses endeavoured to assess what was going on for parents before stepping in with interventions or information. Exploring the problem includes actions that help the nurse to gauge the parents, as described by this nurse,

> *And then we tried to work out what was going on for the mum...So just trying to work through all those issues and trying to sort out for her more information.*

One nurse reported *trying to gauge* what was going on for the parents, especially if their child was seriously ill,

> *I do try to gauge what's happening with the parents. If it's a seriously unwell child I...take particular care. Otherwise if I think they just look - think they look a bit bewildered or something I do - I try to gauge what's happening with them.*

As well as gauging and working out what was going on with parents, nurses also stayed with parents.

Listening and being present

A further nursing response to emotional communication which was less commonly used was listening and being present with the parent. Nurses were observed and described a range of responses such as listening to parents' concerns and worries, rubbing the parent's back, hugging the parent and *being present.*

One nurse described not knowing what to say to the parent, but offering to sit with the parent and be with her,

> *I just held her hand and I said "I don't know what to say to make you feel better. So I'm just going to sit here with you."*

Discussing a parent who had difficulty in the ward, another nurse noted that*,*

> *listening to her has worked, listening to what she wants and what she needs.*

Offering physical comfort in the form of a hug was another nurse's response to emotional communication,

> *I - I always ask. But yeah if a parent looks like they need a hug - because there can be all sorts of things going on in their life. ..I - I'll just ask them "Do you want a hug? Do you need a hug?" And they'd say "Yes," or "No I'm okay."*

Sometimes offering physical comfort depended on how well the nurse knew the parent,

> *Maybe a touch on the shoulder or a rub on the back or - I don't know it depends on how well I knew the parent too. I mean if it's a long term child that had been in and out for a long time and something had gone wrong or they had got worse or anything like that then I would happily put my arm around them and talk to them. But if it was a parent I don't know very well I'll just sort of pat them on the arm.*

Nurses demonstrated a range of engaging responses to parents' emotional communication: most common responses were giving the parent information,

suggesting interventions, encouraging parents to take a break from the ward, and offering reassurance. Less used were humour, staying with the parent and trying to work out what was going on. In the next section, nurses' non-engaging responses to parents' emotional communication will be described.

Non-engaging responses

Nurses did not always engage with parents' emotional communication. It was apparent that nurses were wary of parents' emotional communication and as a result had difficulty engaging with parents. Nurses ideally wanted parents to feel comfortable in the ward, and to be able to cope with the demands of being a parent in the ward and then felt uncomfortable when there was an indication that parents were experiencing difficulty being in the ward. Nurses described not wanting the burden of knowing the parent was upset; feeling nervous and inadequate, and were taken aback when faced with emotional communication; or chose to ignore the emotional communication by *sweeping it under the carpet*.

Not wanting the burden

One nurse described her response to emotional communication, describing emotional communication as a *burden,* which made her feel *upset,*

> *sometimes I do* [feel comfortable with emotional communication] *and sometimes I don't. I think it just depends on what space of mind I am if I'm - yeah depends - yeah depends what's going on in your own life I think - if you want to take on that burden yourself...So it can be a burden and it can be quite upsetting to know that kind of thing can happen.*

Another nurse noted that a nurse's response to emotional communication was individual depending on *personal space* and how *secure* they felt, and that some nurses could respond effectively and others could not,

> *It is individual. Very much so of how everyone responds to it. Really depends on where their personal space is too and how secure they feel within themselves with their nursing and their personal life and like an example I can think of - specially when we've got a palliative patient. There are some nurses that can do it. And there's some that cannot.*

As well as not wanting the burden of knowing the parent was feeling emotional, nurses described feeling nervous and inadequate when confronted with parents' emotional communication.

Feeling overwhelmed

When confronted with parent's emotional communication, nurses felt overwhelmed, ill-prepared, and did not know what to say or do. One nurse described how she or he felt when faced with a parent's emotional communication,

> *it was hard because as I say I felt - I felt - I felt useless to the parents because I was like - I feel like I can't do anything...I don't know what I can do. I just felt useless to them... I was overwhelmed.*

And another nurse described feeling helpless,

> *I sometimes feel helpless that I don't know what to do.*

For this nurse, there was concern because the parent was upset about the prescribed treatment and the nurse could not think of any other treatment option for the child,

> *I didn't know what to do because this was really - I knew what was good for the child and there was no other option.*

Another nurse described being *scared* and wanting *support*,

> *I was nervous. And I was scared myself and yeah I just wanted that support.*

And another was nervous because she perceived the parents expected her to *do things,*

> *I was nervous because parents expect you to be able to do things.*

For this nurse, parents' emotional communication made her *upset* too,

> *the parents that are very stressed out but they show it to you by anger - being angry at you. And that's really hard as well because you get upset.*

Nurses felt inadequate, scared, overwhelmed and nervous when they realised that parents were emotional. Nurses needed their own support at this time.

Taken aback and worried

When parents were emotional, nurses described being taken aback and worried about what was going on. They felt out of control of the situation and were anxious about what may happen. This nurse described questioning her practice,

> *I was taken aback because I wasn't expecting anything like that* [parent being emotional]. *I was nervous and then I was real worried that maybe I had missed something or something had gone wrong so then I was worried about what my practice and what I'd done.*

And this nurse was worried the parent might shout,

> *She was getting really upset and crying. And then I felt guilty and I didn't know what to say to her 'cos I didn't want to make it worse. And I didn't want to get shouted at by her.*

Minimising the parents' emotional concerns was another reaction observed in nurses.

Minimising

Nurses described *sweeping* [emotional communication] *under the carpet*, or minimising it because it was difficult and uncomfortable. By this they meant neither acknowledging nor confronting the possibility that the parent may be feeling emotional in hospital.
One nurse described it like this,

> *I know the emotional thing is part of a holistic pattern, we tend to - sweep it - sweep it under the carpet or minimise it.*

Another nurse observed that nurses *don't approach the subject* (of emotional communication),

> *we don't approach that kind of subject.*

This nurse observed that nurses should care for parents holistically, but that engaging with parents about their emotions was not a *done thing* in the ward,

It's their business and it's - we're there to look after them rather than to - rather than to - I don't know what word I'm thinking of. Rather than to be there for them emotionally which we probably are meant to be there for them emotionally, but it's not a done thing.

Sweeping emotions under the carpet was demonstrated by this nurse who described a parent who was tearful and anxious. The nurses responded by giving her education about her child's situation but *didn't explore her side of things*, focusing only on the child's physical wellbeing,

a lot of the parents are tearful when they know they have to stay in hospital. And we had one anxious parent recently who - she wasn't prepared to stay. She didn't want her child on oxygen and I don't think she fully realised the child's condition and the importance. I just think the education had been missed so we spent a bit of time - yeah it was more education though it wasn't really emotional - yeah like we didn't explore her side of things. It was just the child's physical wellbeing.

While these strategies were evident in the field work, the reasons nurses used them as described in interview were to avoid emotional communication, discussed in the following section of this chapter. These include perceiving that parents did not want to share emotional communication with nurses and acknowledging that unless the parent was overtly emotional, nurses avoid emotional communication.

Why nurses avoid emotional communication

When a nurse was confronted with emotional communication from a parent, the nurse responded in some way. However, in their daily activities, nurses did not elicit emotional communication. When the parent was sitting with their child, the focus of the nurse was on the child's needs first, then the parent's physical needs. More often than not, nurses avoided emotional communication with the parent. Nurses were asked why they avoided emotional communication with parents and they had a wide selection of responses.

Parents don't want to share emotional communication with nurses

Nurses perceived that many parents did not want to talk with them about their emotions, for a range of reasons, from wanting the nurse to *do their job*, to looking to others for emotional support, to the lack of privacy in the ward.

They don't want to talk

Some nurses perceived that parents neither wanted nor expected the nurse to broach emotional communication. For this nurse, responding to emotional communication was not part of the *job*,

> *they don't want to talk - they just want you to do your job and get their child better so they can go home.*

Nurses believed that parents received their emotional support from other places, such as their family or friends, and did not look to nurses for emotional support,

> *They don't want to open up to you. They don't know you. And I mean you can't... those professional relationships going and it works and they do open up. Other people just don't want to do that. Their support is out of here. They just want you to do your job.*

This nurse also thought that emotions should be dealt with within the parent's family,

> *I guess emotion sometimes should be dealt with within a family. Like family to family.*

Another nurse thought that parents did not want nurses *asking questions,*

> *they don't want to ask any questions and even if you're asking questions they won't give you any answers. So in the* [ward] *rounds as well doctors, consultants are struggling to get some answers from them. They will just say yes or yes or - like that. So there are different parents.*

This nurse described parents putting up barriers and resisting nurses' involvement, and the nurse then retreating,

Sometimes you don't and they'll put - some parents will put the barrier up and just not go any further. And - and - and they're just like "Oh fine." So okay, "Leave me alone. I'm tired go away".

Nurses had a number of perceptions about parents that inhibited nurses from engaging with parents' emotional communication. These included perceiving that parents would not want to talk to parents, believing that parents just wanted nurses *to do their job,* believing that emotions should be managed by family members, and perceiving that parents did not like nurses asking questions. The latter leads into lack of privacy.

Lack of privacy

One nurse thought the physical environment, especially the four-bedded rooms, inhibited parents discussing their emotional concerns, and also nurses initiating emotional communication,

It's - it's all fine if they - it's - if they're in a side room. But if you're in a four bedded – two bedded room you struggle to do it. You've got another set of ears - sometimes four sets of ears listening. Parents are not going to share that with you. They are just not going to go there. So it is the environment, definitely the environment, which would hinder. You just can't - and you feel a little uncomfortable because you know you - it's not being a kept confidential conversation. So they're not going to share that with you.

And further reported,

if there's other families there soon they won't want to talk about that kind of private thing with other families just through the curtain, which is not very private. So that would inhibit them as well.

Another nurse perceived that the parent may not want to share emotional communication with a nurse in front of an older child, and that may inhibit the nurse initiating the communication,

I think depending on the age of the child is how you - you know if you've got a ten year old child and their mother's obviously upset they may not want to be upset in front of their child.

Lack of privacy to engage with parents on an emotional level was a prohibitive factor in nurses' lack of emotional communication. Fear of what the nurse may find was also an issue.

Fear of what we might find

Nurses described being afraid to ask parents about their emotional state, in case the parent told them something that may make the nurse uncomfortable. This nurse described being worried about what the parent may divulge, because that would lead to having to access services, and extra work,

> *I think it's like a fear of what we'd find out and do we want to find out what's going on? ...I think 'cos sometimes you're worried about what the answer might be.*

> *We might not actually want to hear that they're not coping because then we might have to access services and - so we might be hesitant to ask in case a whole different can of worms is opened and it can create a lot of extra work.*

> *I think it's easier not to lift the lid...because you don't know what's going to unravel... But you know like I think - yeah I think people think "what's going to pop out from under that lid?"*

Nurses also found emotional communication with a parent to be *emotionally draining,*

> *Like if it is a long and detailed story and it is emotionally draining yeah you do get exhausted.*

Anticipating that the conversation with a parent could be emotionally draining, led nurses to avoid the interaction, and thus not to initiate emotional communication.

Afraid of "harassing" parent, being invasive

For some nurses, there was a fear that initiating emotional communication might be perceived by the parent as harassment, or being invasive, which could potentially add to the parent's stress. This nurse was also worried about upsetting the parent even more by raising emotional communication,

they might feel a bit like we're harassing them. I mean especially if it's like - you know a case – like you do need to approach that subject but everyone's approaching that subject with them and we're just adding to their stress.

I guess people step back when it comes to emotions in parents and other people. You don't want to be jumping in and standing on toes or upsetting them even more by questioning how they're feeling.

Another nurse did not engage with parents about their emotions because she was not sure the parent would want to engage with the nurse, and also because the nurse was from a *different culture* and was unsure of what to ask, so *just kept quiet,*

I don't ask maybe because I don't know whether they want me to ask that question... it's like so much of privacy issues and that, isn't it? Like yeah so we asking some questions is not appropriate. Like I just feel - because I don't know which question to ask coming from a different culture. That's the main thing. So that's why I personally me - because I'm not sure about it so I just keep quiet.

One nurse noted that even with personal friends she was reluctant to discuss emotional issues, so with parents whom she did not know well, emotional communication was unlikely,

We always just do the physical stuff. And you're with friends you don't really explore that stuff unless it needs to be addressed. You know it's a personal thing. And I think that makes it deep if you're exploring someone's real personal life.

Nurses chose not to engage with parents on an emotional level because of concerns the parent may feel *harassed,* worries that emotional communication may make an already difficult situation worse, not knowing what questions to ask; and feeling uncomfortable with emotional communication. The busyness of the ward was also cited as a reason for nurses not to engage with parents.

Busyness of the ward

Nurses found that if they were busy with patients, they did not have time to spend with parents,

I guess sometimes people get caught up with the - with the - you know the prime needs in front of you... depends on acuity of the rest of the ward.

I think the only thing that can really hinder it is if you've got six admissions coming in the door and you just can't -you just can't do it.

Another nurse noted that emotional communication is *hard to see* when the nurse is busy,

But sometimes it's like - it's hard to see. 'Cos - especially if it's busy you're just sort of like "I've just got to get through all of this stuff and do."

And another said,

I think sometimes you're like "Oh my God what if this," I've - on a busy shift and you think "Shit, I've got - haven't got time for this."

Another nurse discussed not having time to sit because of her other patients,

Maybe workload. Maybe they don't have time to sit there 'cos they've got - or they've got really sick kids. So they're like too busy checking their other ones.

The busy nature of the ward, focusing on tasks to be completed and workload issues, meant that nurses did not have time to notice or respond to parents' emotional communication. For other nurses it was the emotionally draining aspect of emotional communication which led them to avoid parents.

Easier to "go with that flow", don't approach emotions unless they are "in our face"

Nurses observed that if the parent was quiet and did not appear concerned, it was easier not to ask about emotions and just *go with that flow* and assume the parent was coping with the hospitalisation,

It is easier to go with that flow... If the parents look in control, you know they're stoic and they look like they're coping and it's easier to just feed off the parent. Think, okay well they're coping, they're doing all right.

Nurses wanted parents to be coping and managing their child in hospital. They assumed that if the parent was quiet and appeared to be coping, that all was well. Avoiding emotional communication was the norm in the ward. Unless the parent was outwardly demonstrating their emotions, nurses would not ask the parent about their emotional state. This nurse explains,

> *we don't really approach the emotional stuff unless - yeah it's in our face or if it's a chronic child and you get to know them that well that they freely open up about that to you without - without us asking.*

And for this nurse the focus was on the child, unless the parent was showing cues that suggested emotional concern,

> *I think I'm probably one of those nurses that unless someone's crying or looks tired, or is getting a little bit agitated I probably would just - I'd focus on the child.*

And again another nurse noted that if the parent looks emotional, the nurse will initiate emotional communication.

> *if they look emotional we definitely go and ask.*

Nurses had a range of reasons for avoiding emotional communication, from fear of what they may find, being afraid of harassing the parent and making a difficult situation worse, the busyness of the ward, the emotionally draining nature of emotional communication, wanting to go with the flow and not disturb the parent, and not wanting to approach emotional communication unless the parent was overtly upset. All of these concerns, led to nurses avoiding emotional communication with parents.

Chapter summary

Nurses recognise and understand that parents have the potential to feel emotional when on the ward, however when parents are emotional nurses choose to either engage or non-engage with parents on an emotional level. Engaging responses include fixing what's wrong, encouraging parents to take a break, offering informational support, attempting reassurance, using humour, exploring the problem, and listening and being present, whereas non-engaging involved not wanting the burden of parents' emotions, feeling overwhelmed, feeling taken aback and worried, and minimising

parents' concerns. The burden of engaging with parents' emotions is cumbersome and emotionally draining, thus most often, nurses avoid emotional communication. Nurses believe that parents do not want to share emotional communication with nurses, believing that parents do not want to talk, lack privacy, are afraid of what they may find, and harassing the parent. The busyness of the ward is also a contributor to nurses avoiding emotional communication. Nurses did not approach parents' emotions unless they were openly expressed.

This chapter has completed discussing the study findings, leading into Chapter Eight, where the results are examined, alongside a discussion of relevant literature.

Chapter 8: Discussion

Introduction

The following discussion takes into consideration the key findings from the four results chapters namely, the ward, and parents' and nurses' experiences of emotional communication. With a continued focus on the study objectives the discussion highlights the significant study conclusions; parents want emotional communication with nurses; nurses struggle to acknowledge, confirm and respond to parents' emotions, and the context and culture of the ward influences nurse-parent engagement. This chapter draws on a synthesis of relevant and current knowledge as reflected in the literature. The discussion begins with an examination of parents' emotional experiences in hospital, as they settle into the ward. Personal control, emotional comfort (Williams & Irurita 2006), emotional labour (Hochschild 1979) and comfort theory (Kolcaba, Tilton & Druin 2006) are incorporated in order to elaborate and exemplify parents' experiences.

A review of emotional communication is followed by a discussion about interpersonal connectedness and the concept of nurses as cultural brokers (Chalanda 1995; Kinnaird 2007), gatekeepers to the ward. An exploration on how culture shapes practice is provided, and includes describing nurses' engagement or not with parents' emotions, and factors inhibiting that engagement. Also discussed is the nurses' perspectives of emotional communication focusing on nurses' sense of inadequacy, exploring the theoretical concepts of empathy (Davis 2009) and incorporating compassion. The chapter concludes with dialogue regarding family-centred care (Coyne et al. 2011), the task orientation of nursing practice, and nurses' self-protection and support for each other.

Parental emotional experiences in hospital

Most parents attending their child in hospital gave the outward impression that they were relaxed and calm. They were usually seated beside their child, spending their time focused on the child's needs such as playing or helping with bathing. Parents were generally friendly and welcoming to a visitor, interested in what was happening in the ward and willing to talk about their experiences. A deeper examination though, inquiring beneath the surface of that calm exterior, revealed a different picture; parents described feeling inadequate, insecure, isolated, lost, and exposed.

A parent feeling lost and vulnerable in hospital is not new. In the early 1970's when parents handed-over their child to hospital staff, they doubted their abilities as parents (Litchfield 1974). By 1981 mothers of a child in hospital described not knowing the rules, or what was expected of them, leaving them feeling overwhelmed with anxiety and distress (McKinlay 1981b). Darbyshire in 1994 (p.40) described parents feeling "uncertain, confused, unaware of how they were expected to function as live-in parents...and divested of some of the responsibility for their child". By 1997 Carr and Clarke found that family members experienced emotional upheaval when staying with family in hospital, and Kristensson-Hallström and Elander (1997) observed that parents needed security in the ward.

More recently, parents describe having multiple negative emotions (Melnyk 2000), and feeling helpless and inadequate when in hospital (Kristensson-Hallström 2000; Melnyk 2000), heightened by the disruption of their usual parenting role (Kristensson-Hallström 2000). Studies have continued to note parents feelings of isolation and fear (Aitkin et al 2004), and stress and vulnerability (Roden 2005; Ygge 2007).

Having a sick child in hospital is a major disruption in parent's lives. How parents cope with the disruption will be dependent on their previous life experiences, the severity of their child's illness, and their available support systems. These factors influence the degree of vulnerability and dependency and the level of connection they seek from nurses (Morse 1991; Ramos 1992; Williams & Irurita 2004). The more vulnerable and dependent they are, the more likely it is that they will seek an interpersonal connection with nurses who are caring for their child.

Settling into the ward

As previously described, when the parent realised that their child was to be admitted to the ward, they had to adjust to their new role, that of being the parent of a child in hospital. For parents who were new to this environment, this was a particularly unsettling and uncomfortable experience. The environment was foreign and strange; they had to learn new terminology and establish where they could go and what they were allowed to do. In addition they were worried and anxious, mainly about their sick child, but also about their life outside the ward, such as work and family obligations. Their lives were now in the public arena, and everything they did and said was open and visible to others. Away from their usual support systems, they were now dependent

on strangers, who made decisions about them and their child, all of which led to parents feeling as though they were on an *emotional roller coaster*[5].

Because of their perceived lack of control over their lives parents quickly assumed a passive role, waited to be told what to do, to be advised about what was going to happen. They understood that if they wanted to get on well in the ward, they must adhere to advice, follow the rules, not ask too many questions or be perceived as *demanding*.

Gaining a sense of control

One way that parents attempted to regain some control of their lives was through having information about what was going on, and how they could help improve their situation (Avis & Reardon 2008; Hallström et al. 2002a). As well as having information, Balling and McCubbin (2001) found that parents wanted control to manage their child's hospitalisation, such as staying with their child during procedures.

Personal control is a central feature of emotional comfort, a positive feeling of relaxation affecting the physical state of the body (Williams & Irurita 2006), and an ability to influence the situation or environment (Williams & Irurita 2005). Kolcaba's theory of comfort (Kolcaba et al. 2006; Kolcaba 2003) proposes that when patients and families are comfortable, they are more likely to engage in health-seeking behaviours. According to Oliveira (2013) emotional support is a comfort measure, triggered by the identification of unmet comfort needs, which include having a continuous presence, positive reinforcement, encouragement of expression of fears, active listening and empathy. The provision of comfort is so deeply embedded in nursing practice that comfort measures are often unrecognised and remain invisible (Oliveira 2013).

In Williams and Kristjanson's (2008) study, patients' levels of emotional comfort were influenced by the extent to which interpersonal interactions helped make the patient feel secure, informed, valued and connected. In the current study, some parents felt isolated and vulnerable, and their interpersonal interactions did not have the level of connection required to make them feel valued and supported, thus they felt emotionally uncomfortable.

[5] *Word in italics* are verbatim comments from participants.

Understanding the need for security, to be valued and connected, is a key to ensuring a personal sense of control over experiences, described by Rock (2008) as the SCARF model (Rock 2008). The acronym SCARF refers to the five domains of human social experience: status (relative importance to others), certainty (ability to predict the future), autonomy (sense of control over events), relatedness (sense of safety with others) and fairness (perception of fair exchanges between people). These five domains activate either the primary reward or primary threat connections in the brain, and allow people to either minimise threats or maximise rewards in their life experiences. According to Rock and Cox (2012) an understanding of the five domains improves a person's capacity to understand and modify behaviour in social situations, and therefore be more adaptive to changing circumstances. By labelling or reappraising the emotion, the threat response can be reduced (Rock 2008; Rock & Cox 2012).

The SCARF model (Rock 2008) has a strong association to parent's perceived reward or threat response when being a parent in hospital with a sick child. The parent's status is dramatically changed, from their usual role in life (for example, manager, teacher, unemployed, and parent) to being a parent in hospital. Parents' certainty in the future is now under threat, as they cope with their child's unpredictable illness and health professional's decisions about appropriate treatment. Parents' autonomy over their life has been lost; they feel either safe or unsafe as they cope with the new environment, and they are reliant on trust in others to be fair to them and their family. This model signposts why many parents may feel threatened in a hospital environment, and also provides health professionals with a window for understanding behavioural responses. Two domains of the SCARF model were particularly noticeable in the findings of this study: certainty and autonomy.

Lacking certainty and autonomy increased parents' sense of vulnerability and parents looked to nurses for help in providing certainty and to give them some autonomy over their lives. One way was to learn and follow the explicit and implicit rules of the ward.

Learning the rules

Parents became adept at functioning within the rules of the ward, learning the way things were done. For most parents this occurred unconsciously, being detected in the way the nurses and other staff talked to them, and the questions they were asked by staff. For some parents, this period of learning was alienating and difficult, but for others who were adequately orientated to the ward, it was safe and reassuring. Parents

would quickly socialise into their role, learning the ward routines and working out when it was acceptable to talk to staff and when it was not. Most parents moved into their role based on what they thought was expected of them (be a good parent, comply with the rules, trust ward staff to know what to do) and waited patiently to be discharged with their child. In doing so, they attempted to become what they perceived as the perfect parent, much like what has been documented as the ideal parent (Snowdon 2000).

Parents learnt how to navigate their way around the system, but in order to do so they needed someone to orient them. Weaving and navigating the network of relationships parents encountered was described by Dickinson, Smythe and Spence (2006), who found that parents were sometimes frustrated by a fragmented health service, practitioner behaviour and the lack of information. In the current study, those parents who were shown around by a nurse in the early hours of hospitalisation had a much warmer response to their hospital experience than those who were not fully oriented. Describing *making it comfortable, knowing the limits,* and *feeling welcome,* these parents quickly fitted into the ward, feeling accepted and welcome. However for other parents, *left to their own devices,* this beginning experience led to more and more feelings of being out of control and vulnerable.

Parents quickly learned their physical and cultural boundaries in the ward, where they could go, who they could approach for help, *how things worked around here*. These aspects of parents' experience were governed by nurses, as it was the nurse who orientated parents and spent the most time with them. Parents discovered that some spaces which were advertised as theirs, such as the parent's lounge, was out-of-bounds for them at certain times when nurses needed to use it, such as am-pm handover.

Nurses also developed the array of signage around the ward, advising visitors what they could and could not do. The ultimate power in the ward was held by the Medical Clinical Director, a paediatrician, with nurse managers, but it was the nurse providing direct care who was perceived by parents to be the voice of this authority and power.

There were definite rules about what parents and nurses did, some of which were written but most were not. One significant unwritten rule was that parents would stay in control of their emotions, and would cope with their situation. Nurses understood this

and parents who were in the ward long enough soon came to this realisation. However for those parents who remain vulnerable, a connection with a nurse is crucial.

Emotional connections between parents and nurses

Parents' degree of vulnerability and dependency determines the level of emotional connection that they need and want, as levels of involvement are a negotiated process. The level of involvement between the nurse and parent is also dependent on a number of situational and contextual factors, such as how long the child and parent had been in the ward, how sick the child was, how well the nurse knew the parent, the parent's experience with other nurses, and the time of day or night.

The greater the vulnerability, the more likely that interpersonal connections between nurses and parents will progress beyond a superficial connection to one in which each is seen as a person first and a parent or nurse second (Morse 1991; Ramos 1992). Staying, listening and being present is evidence of deep involvement in a relationship (Ramos 1992) whereby the nurse cognitively and emotionally identifies with the parent, and the nurse has understood the parent as a person first, then as the parent of the child (Morse 1991). This level of involvement includes connectedness between the nurse and parent whereby they come to know each other as people (Williams & Kristjanson 2008).

Patients and parents need to "be seen" as human beings, rather than as patients or parents (Blockley & Alterio 2008, p. 22), and this involves "sharing patients' space by sitting down and meeting them eye to eye" (Arman & Rehnsfeldt 2007, p. 380), and "understanding patients' desires and needs, going beyond a role and being a fellow human" (p. 383). Watson (2009) reiterates the need for nurses to see past the patient to the person who needs care, to "deepen the authentic caring-healing relationships between practitioner and patient to restore love and compassion as the ethical foundation of healthcare" (p. 477).

Connectedness is the extent to which a person perceives that they have a significant, shared and meaningful personal relationship with another (Haase, Britt, Coward, Leidy, & Penn 1992). Phillips-Salimi, Haase and Carter Kooken (2011) observe that connectedness between health provider and patient can improve patient outcomes, as the more connected the patient feels, the more likely they are to participate in decision-

making, adhere to treatment and reduce risk-taking behaviours. One attribute of connectedness is a sense of belonging (Phillips-Salimi et al. 2011).

Parents sought one or more nurses to be there for them, and to be consistent, meaning that the same nurses would look after their child during the admission and on subsequent admissions. Parents described wanting nurses to *hang out, stop and chat,* and *be an ally.* They wanted to know that preferably one or two at most nurses would understand and have their interests at heart, and would stand alongside them as they progressed through the hospital experience. Repeating their story over and over to a changing mix of nurses was stressful. Having consistent nurses, as espoused in the family-centred care model (Coyne et al. 2011), would enable the parent to ask questions and trust that the nurse would not only keep them informed but also be there to support them.

Parents reasoned that if they had a connection with one or two nurses, those nurses would know some of other stressors outside the ward the parent was experiencing, and would be able to support the parent as they managed those other aspects of their lives. Parents expected that the nurse would be interested in how they were coping and would want to know about the parent's concerns for their child and themselves. They believed that this would be possible if they had a connection with consistent nurses.

Parents want nurturing (Jones et al. 2007), and interactive relationships with nurses who sense parent's needs (Stratton 2004) and go the 'extra mile' (Fosbinder 1994). Families also want support, guidance and involvement, and for nurses to ask them how they are doing (Sarajärvi et al. 2006). The need to keep developing and trying to sustain trusting relationships with nurses was an ongoing stress for parents in Swallow and Jacoby's (2001) study, and Scott (2006) noted patients need to develop trust and emotional confidence, assessing staff continuously for cues that they can be trusted. Parents want emotional communication with nurses (Hopia et al. 2005; MacKean et al. 2005; Suominen et al. 1995), and the current study provides further evidence that parents are vulnerable in hospital, and want to make interpersonal connections with nurses. However parents are not in control of their own lives and know that they need to follow the rules of the ward. Nurses set the agenda, make the rules and ensure they are observed, so that parents' vulnerability and dependency are determined not only by their emotional state, but also by their need to fit into the ward culture. Nurses are seen by parents as cultural brokers of the ward (Chalanda 1995; Kinnaird 2007; Shomaker 1995).

Nurses as cultural brokers

Nurses' centrality in the ward was apparent; they were highly visible, there were a number of them at any given time (up to three managers, and five registered nurses on a morning shift), and they were seen constantly moving in and out of the nurses' station, patient rooms and other rooms in the ward. Fisher, Taylor and High (2012) observed that nurses are frequently the cultural broker because of their constant presence at the child's bedside. Cultural brokers bridge, link or mediate between groups of people to reduce conflict or produce change (Jezewski 1990).

The term 'cultural broker' was first described by anthropologists who noted that in some cultures, there were people who acted as "middlemen, negotiators or brokers" (National Centre for Cultural Competence 2004, p. 2). Shomaker (1995) observed that in any culture, there are shared symbolic forms for values, attitudes and beliefs, which lead to boundaries forming around the shared culture. The *way things are done around here* is thus shared by the group insiders, and assumptions regarding how to behave and act are taken as given. A cultural broker is a bridge between the insider culture and those outside (Shomaker 1995). Thus a cultural broker is a liaison between two different realms, the health system, ward and hospital, and the families who have entered this space, as well as a cultural guide, and mediator (National Centre for Cultural Competence 2004).

Hostetler (1993) and Hall (1976) describe societies as having either a high context culture or a low context culture. In a high context, people share many cultural lifeways, have intergenerational knowledge, use covert communication cues and can easily distinguish insiders from outsiders. In these cultures, boundaries are strongly maintained and change is slow to occur. In low context cultures change is more rapid, and people share fewer life experiences with each other, leading to more blurred cultural boundaries. Hall (1976) notes that all cultures have both high and low context features and those features influence patterns of behaviour.

In the current study, the strong cultural boundaries between the insiders (nurses) and outsiders (parents) were evident. Parents were aware they needed support from someone to help them cross the boundary in order to understand what was happening in the ward and how to manage the experience. They looked to nurses for that understanding and support, that is, to be their cultural brokers. Nurses on the other hand, were seemingly unaware of parent's need for support in this way, so that if brokerage occurred, it was ad hoc or unintentional.

The cultural boundaries were strongest when the parent entered the ward for the first time, as a stranger. For those parents of children with chronic illnesses, however, who had had multiple admissions, the boundaries became blurred. This permeable process (Huntington 1987, in Wenger 1995) occurs when one culture needs to learn from another. In this case, the parent who returns to the ward over and over again may eventually break through the boundary surrounding the ward culture.

Traditionally nurses and others who worked in a hospital considered the hospital was their place, maintaining a boundary between it and the outside world (Stacey et al. 1970). When visitors or patients entered the hospital there were certain procedures or ceremonies undertaken to cross the boundary, such as putting on hospital clothing, or getting into the hospital bed. When it was visiting time staff would withdraw from the patient's bedside, leaving the patients with strangers from outside, thus temporarily redrawing the boundary (Stacey et al. 1970). As the hospital environment has become more open to the public, nurses have withdrawn into spaces that are only theirs, such as the nurses' station and utility rooms. In these spaces nurses can be themselves, relaxed and comfortable. Pill (1970) suggests that this is the backstage of nurses' practice; opposite to the ward itself which is the front stage where the nurse puts on a performance, analogous to an actor on a stage. The backstage/front stage concept enables nurses a place to be themselves, as well as providing them some protection against visitors (who may be parents), who have the potential to be threatening.

The historical nursing perception of parents as visitors has been difficult to shift. Nurses have acted as gatekeepers to the parental role, exerting control over parents and being arbiters of the parental role (Brown & Ritchie 1990; Coyne 2007), and parents have described "parenting in public" as they moved into the public space of the ward and attempted to continue their parenting role, under the gaze of others (Darbyshire 1994, p.169).

It was evident from the first time I entered the ward that there was a clear distinction or boundary between the parents (them, the outsiders) and the nurses (us, the insiders). This separateness between these two groups was the norm, a cultural practice. Having this separation clearly worked well for nurses. The way the nurses spoke about parents, and the way they spoke to them, all suggested a wide gap between these two groups of adults. Conversations were held about child patients out of earshot of the parent (usually in the ward office which was out of bounds for parents), in which decisions would be made about the plan of care.

The physical spaces in the ward contributed to the metaphorical boundaries. The significance of the nurses' station to nursing practice and behaviour was evident; the station was where the nurse prepared and debriefed from patient and parent encounters, but also a place where parents were not allowed, thus establishing a physical boundary for parents. The station was the nurses' territory, where they were able to be themselves and relax. When nurses left that space and moved around the ward they were in a public space, which juxtaposed with the perceived private space of the station.

Parental behaviour toward nurses is governed by the cultural practices in the ward which included being a *good* parent. In this study parents had to adjust their lives to the ward routine; there was little adjustment to meet their needs. It has been reported that parents want to fit in, and often hide their anxieties and pretend to cope in order to be seen as being good, believing that nurses would be more likely to attend them if they were not perceived as being anxious; if they did become emotional, they felt they had to apologise to the nurses (Coyne & Cowley 2007; Hallström et al. 2002b). Trying to control their emotions led parents to protect nurses from a heavy caseload, and not want to *bother* them. Being afraid of *being in the way* is documented in early research into parents' experiences in hospital with their child (Pill 1970). Parents hoped that having the nurse alongside them, as their cultural broker, would enable them to cross that boundary, to fit in to the ward, thus prevent them being a nuisance, and giving them a reason for their presence.

Culture shaping practice

The organisation of nursing care is driven by the values and beliefs of those practicing the care, as well as the accepted taken-for-granted practices of the culture. The way nursing care is approached is fundamental to the delivery of care and to recipients' perception of care. The constraints affecting nursing care impacted on emotional communication, which was rarely observed in interactions between nurses and parents. This was particularly noticeable when a parent showed no outward signs of emotion. In these circumstances, nurses did not take the initiative to actively explore emotional concerns. On the other hand, there was emotional communication between the nurse and the parent when parents outwardly demonstrated their emotional state with noticeable signs of emotional distress, or concern, such as crying, sadness or anger

Attempting to engage

Sometimes nurses *tried to work out what was going on* for parents when the parent was openly emotional. Nurses were thus engaged in the nursing process; assessing the situation before planning and intervention. Nurses described and were observed standing back and thinking about what may be happening for the parent, in order to work out what was going on. This response suggests nurses were able to objectively focus on the parent's problem, thus avoiding engaging with parents' emotions (Hsu et al. 2012).

In other situations nurses were observed and reported *staying with, listening to and being present* for the parent. Of all the engaging responses observed, these were the most therapeutic and helpful to parents (Bolton 1987; Egan 2014). Presence is described by Fredriksson (1999) as having two parts: "being there" and "being with" (p.1167). Nurses were observed and described "being with" the parent, which is described by Fredriksson as a situation where nurses connect with the patient, listen to them, and makes themselves available to the patient. The patient can then accept the nurse to be alongside them as they manage their emotional concerns (Fredriksson 1999), or decline the nurses' offer. If the patient accepts the nurse's presence "the invitation is to come alongside and be allowed to see, to share, to touch, and to hear the brokenness, vulnerability, and suffering of another" (Pettigrew, 1990, p. 505).

Some nurses described being able to detect a parent's emotional state, and being perceptive to cues and signals of emotional arousal. As described by Kunyk and Olson (2001), perceiving clients emotions and situation is the first stage of empathy. Some nurses were also able to articulate an understanding of why the parent may be experiencing emotion, the second stage of empathy according to Kunyk and Olson. Heyn et al. (2013) found that cues and concerns are frequently missed by clinicians, as they are usually given without expression of emotion, and patients with higher language proficiency are more likely to express concerns than those with language problems (Kale et al. 2011). In the current study, although some nurses described their ability to pick up subtle cues and concerns, this activity was not observed in practice. Nurses were unable to move into Kunyk and Olson's (2001) third stage of empathy, demonstrating to the parent that they understood their emotions and situation.

Nurses were however highly attuned to meeting parents' instrumental and informational needs. Encouraging parents to take a break, perceiving that they were helping parents manage their physical needs was a common engaging response. Nurses thought that

parents would be more likely to be emotionally upset if they were hungry or tired, thus spent time ensuring that parents' physical needs were met, in an effort to prevent emotional *outbursts*. It was apparent that nurses continuously moved from meeting the child's physical needs, to meeting the parent's physical needs.

Informational support

When nurses did attempt to engage with parents in this study, their attempts often took the form of responses that did not achieve emotional connection, such as providing informational (Arora et al. 2007) and instrumental support (Tates et al. 2002), but not direct emotional support. Offering information to parents was a frequent response when parents expressed emotions directly. Informational support is one aspect of social support (Arora et al. 2007; Thoites 2011). Nurses do anticipate parents' need for informational support (Sarajärvi et al. 2006), and parents have consistently reiterated that they want informational support during their child's hospitalisation (Avis & Reardon 2008; Comp 2011; Hallström et al. 2002b; Hong et al. 2008; Terry 1987). In the current study, nurses assumed that the more information the parent had, the less likely they were to feel stressed and worried, and offered information to prevent parents becoming more emotional.

Consideration of the most appropriate time to give parents information is necessary, as it is evident that having information about their child's condition and understanding what is going on and why is important to parents. However responding to parents' emotional communication in a rational, factual manner by providing information demonstrates that nurses struggled to engage with the emotions parents were experiencing.

Bolton (1987) advises that responding to an emotional concern with information, or facts, in the first instance, shows a lack of awareness or sensitivity to the emotional concerns raised, and to the emotions being experienced by the parent. This is reiterated by McCabe (2004) and Morse (1991) who agree with Bolton (1987) that making assumptions about patients'/parents' needs can be a result of lack of awareness of actual needs/concerns, because nurses are not asking patients/parents about their potential issues. Loading parents with information can be overwhelming (Kruijver et al. 2001) and such a response keeps others at an emotional distance, thus avoiding involvement. Even when a care provider expresses empathy first, then gives information to a patient, any further discussion of emotion is stopped; and further disclosure is unlikely (Adams et al. 2012).

Instrumental support

Another response to parents' overt emotional communication was trying to fix the situation. This is an example of instrumental support, a further dimension of social support defined as "behaviour involving problem-solving skills such as asking questions" (Tates et al. 2002, p.282). It is common practice for health professionals to perceive that fixing a patient's problem will be helpful to the patient (Burnard & Morrison 1991; Coyne et al. 2011; Kruijver et al. 2001). Gibbons (1993) observes "the most difficult work for many of us is to hold back, to 'wait and see'. As nurses we tend to be action oriented and the first response to any problem is 'do something!' even if the outcome is ineffective or iatrogenic" (p 597).

Nursing is a helping profession (Somers, Finch & Birnbaum 2010), and nurses entering into the profession may imagine they are going to spend their careers helping and rescuing their patients from their many problems. While problem-solving for a patient may be well-meaning, and given with good intention, for some parents it may be disconcerting to have a nurse take over the situation and offer advice to fix the problem. Trying to fix the parents situation suggests a rescue, which can be disempowering for the parent. Problem-solving for, rather than with patients, results in health professionals missing opportunities to respond empathetically to patient's emotions (Hsu et al. 2012). Giving advice, or telling the parent what should be done negates the parent's own ability to manage their life, and also prevents nurses working in partnership with the parent to meet the parent's needs (Balzer Riley 2000). A further engaging response was false reassurance.

Attempting to reassure

False reassurance and clichéd responses were also used in an attempt to respond to parents' emotional concerns. Giving *reassurance* was a commonplace intervention documented by nurses in patient notes, meaning that the nurse responded to parent's emotion by trying to allay their concerns, and placating parents with false reassurance. Stein-Parbury (2014) highlights the difference between reassurance which is a planned nursing intervention, and false reassurance, the use of overused phrases such as "everything will be alright", and "don't worry", and "it will be okay". These phrases can be perceived as trite and meaningless, and may stop the parent disclosing any further concerns to the nurse. False reassurance glosses over and minimises the patient's concerns. When nurses described reassuring parents, it was false reassurance they were usually providing. Bolton (1987, p. 25) notes that "reassurance is a way of seeming to comfort while actually doing the opposite".

False reassurance can be an avoidance tactic, a message to the parent that the nurse is neither willing nor able to engage with emotions at that time. A study examining commonly used methods of reassurance found that when clinicians used reassurance (falsely) in an attempt to reduce anxiety, patients became even more worried about future pain or disability (Donovan & Blake 2000). Patients were much more likely to be reassured if their problems were acknowledged in the first instance. Offering false reassurance is an automatic response to someone who is experiencing stress; this response may make the nurse feel better, however it is neither always therapeutic nor helpful to the parent at a time of emotional distress.

Distancing

By and large however, there was little or no engagement with parents' emotional needs, because nurses kept parents at a distance. Faced with parents' emotion, or the potential for emotion, many nurses chose not to engage in emotional communication with parents. Numerous studies in the literature reiterate nurses emotional distancing from parents or patients (Allan 2006; Cimete 2002; McKinlay 1981b), and not making themselves emotionally available to parents (Bruce et al. 2002). Sometimes nurses were not aware of parents' emotional concerns (Simons & Roberson 2002), and when they were, nurses blocked those expressions of emotion to decrease their own anxieties (Sheldon et al. 2009; Uitterhoeve et al. 2008). Nurses were found to avoid emotional scenes with parents (Coyne 2007) and to focus instead on the physical tasks of caring for the child, such as taking vital signs and giving medicines, rather than being with the parent in an emotional sense (Coyne & Cowley 2007; Espezel & Canam 2003; Roden 2005).

Establishing clear boundaries regarding parents' and nurses' roles, distancing themselves and controlling contact have been strategies nurses have used historically to protect themselves from patients and parents. In a seminal study of health care culture, Menzies (1960) reported that defensive techniques were employed by nurses to reduce the anxiety of constantly dealing with others (staff and patients) psychological stress. Staff learned to professionally detach from others, to "refrain from excessive involvement, and avoid disturbing identifications..." (Menzies 1960, p.1020).

Distancing is an emotion-focused response to coping with stress, defined as changing the way a stressful event is interpreted by the individual, according to Lazarus (2006). A study of Australian and New Zealand nurses into workplace stress found that nurses who used emotion-focused coping, had reduced mental health (Chang et al. 2007).

Denial and distancing techniques help people control stress by removing the threat, or changing perception of it, however as demonstrated by Chang et al's study, distancing is unhealthy for nurses. Emotional distancing also has a detrimental effect on the nurse-parent relationship, ensuring that they cannot be partners-in-care, because the control of boundaries remains with nurses (Coyne & Cowley 2007).

Nurses' previous experiences, either actual or second-hand, of *difficult* parents made them wary and distrustful of parents. Parents were described as scary, challenging and difficult. Because of the potential for threat, nurses distanced themselves both physically and emotionally from parents. This finding lends support to other studies exploring nurse-parent interactions, which established that nurses regarded all parents with caution (Callery 1997) and viewed parents as an adjunct to care, distancing themselves from parents (Lewis et al. 2007). Distancing from the patient or parent, also led nurses to struggle to maintain control (Espezel & Canam 2003; Michaelsen 2012; Scott 2006). The struggle for control led nurses to set boundaries in relation to roles and tasks, assume control of decision-making, and to have a protective paternalistic demeanour which excluded parents (Paliadelis et al. 2005). Patients who threaten nurses' competence and control are also more likely to be labelled as difficult (Breeze & Repper 1998).

O'Neill (1998) asserts that when nurses distance themselves from patients in order to protect themselves, their care becomes depersonalised. Distancing is aligned to depersonalisation, where employees treat people as objects and present an uncaring attitude; depersonalisation is a dimension of burnout (Kapacu, Akkus, Akdeminr & Karacan 2009). Burnout is commonly seen in professional groups who have a heavy work burden, are not valued, work on a one-to-one basis and try to help others personally (Kapacu et al. 2009); all are features of nursing practice.

By maintaining an efficient business-like attitude and focusing on the physical acts of care nurses identify their own needs as separate from those of the family. This emotional detachment prevents nurses from recognising or attending to parent needs (Moran et al. 2009).

Ignoring

A further reaction to parents' emotional needs was minimising or ignoring emotional communication. Nurses in this study observed that emotional communication was *not the done thing* in the ward, thus a cultural norm. Nurses acknowledged that dealing

with emotions was *part of the holistic pattern* but they were not going to engage in parents' emotions, rather they were focused on other aspects of care, such as the child's physical wellbeing. When parents were observed to have the potential to be emotional, their emotions were unacknowledged and they were avoided. Coyne (2007) notes that when parents are perceived as a problem, nurses used an exclusion strategy, avoiding interactions with parents, or encouraging parents to take breaks from the ward.

Using humour

Another response to parents' emotional communication in this study was to make light of the situation through the use of humour. Parents appreciated nurses use of humour to relax them, and although joking was used by nurses to lighten the atmosphere and move the parents focus away from what may be concerning them, joking can also serve to distance the nurse from the parent's emotion. Jourard (1971) asserts that joking behaviour is an example of a controlling factor that influences people's interaction. Joking with another evokes a joking response from the recipient, thus limiting the behaviours of the recipient. "One of the latent functions of the bedside manner is to reduce the probability that patients will behave in ways that are likely to threaten the professional person" (Jourard 1971, p. 181).

Using humour and social conversation to respond to patients has been interpreted as a way of glossing over patients' anxieties (Lotzkar & Bottorff 2001), and softening negative messages to reduce the stress of uncomfortable situations, and help patients relax (Holmes & Major 2002-3). Humour has other uses as well. Humour can help nurses manage emotions as observed by Dean and Major (2008) who found that humour can mask the emotional tone of an interaction, requiring an experienced nurse to hear the hidden messages behind the humour. A further use of humour in the child health context is lightening the atmosphere, used to try to have some fun amongst the distress (Lundqvist & Nilstun 2007).

Humour therefore was used to distract and limit the likelihood of further emotional concerns being raised. Using humour can create distance between the nurse and patient, and keeps communication superficial (Dean & Major 2008), so even though the nurse appeared to be engaging with parent's emotions, in reality using humour was a distancing technique.

Nurses' experience of emotional communication

When considering emotional communication it was notable that interaction between the nurse and parents was more likely to occur when parents were overtly emotional and in obvious distress. Usually however there was little or no engagement on an emotional level between nurses and parents because nurses kept parents at a distance. They felt inadequate, poorly prepared, overwhelmed and unable to connect with parents. Emotional communication was found to be burdensome, making nurses feel overwhelmed, and, sometimes, leading to the minimising the importance of parents' emotions.

Sense of inadequacy

Nurses felt helpless and limited in their ability to relieve parents' emotional distress which led to non-engagement with parents (Papadatou et al. 2001; Turner et al. 2006). In the current study, nurses were overwhelmed by their own emotional response to parents' potential and actual emotions. Fear of what may happen if the nurse engaged with the parent was evident. Nurses described *feeling guilty* and *not wanting to make the situation any worse.* Nurses' concerns reflected a fear of the unknown, an unpredictability for which they felt unprepared, and nurses lacked confidence in their abilities to manage emotions. This lack of confidence may be attributed to nursing concerns that if they engaged with parents emotions, they would not have time for their other duties. Callery (1997) suggests that parents present a potential threat to nurses' control because of the unpredictability of their demands on nurses' time; however Coyne (2007) proposes that nurses avoid parents to limit, modify and control parents' behaviour, especially parents who are emotional or ask too many questions. A fear of making the situation worse has been noted (Gow 1982; Turner et al. 2006) while other researchers have highlighted nurses' fear and anxiety (Moran et al. 2009) when faced with communication nurses find uncomfortable.

Nurses felt nervous, scared and inadequate when confronted with parents' emotions. Not knowing what to do or say, or how to be when confronted with parents' emotional communication, led to nurses' inaction. In a longitudinal study between 1994 and 1998 in the UK, Bolton (2000) found that the most anxiety-producing situation for nurses was their emotional involvement in caring for their patients. While international findings suggest educational preparation for emotion-laden communication is an important factor for nurses (Sheldon et al. 2006), a recent study in New Zealand examining the characteristics of young nurses to identify potential recruitment and retention strategies, found that for 40% of these nurses, the realities of nursing differed from their

expectations. Nursing was an emotional challenge for many, and they felt ill-prepared to cope with a number of interpersonal issues, including emotional self-management (Kai Tiaki Nursing New Zealand 2011).

Emotions as burden

Some nurses shied away from parents' emotional concerns, considering them a *burden,* which made nurses feel *upset.* The burden of sadness and grief and managing the emotional demands of working with families was a critical theme in Turner et al's (2006) study of nurses' attitudes to providing psychosocial care for families with a parent with advanced cancer. The burden caused some nurses in the study to detach themselves from their patients. The term 'burden' refers to carrying a weight. Wros (2009) notes that for some nurses this weight is heavy, but for others it is gladly carried, a source of fulfilment. In the present study, nurses reported and were observed to experience the former; the weight or burden of managing parents' emotions was difficult, problematic and sometimes painful. Emotional pain was described as being a drain or creating a burden for nurses (Froggatt 1998), leading nurses to switching on and off, hardening or standing back, all of which imply distancing themselves from emotional concerns.

In a study exploring how nurses coped with difficult encounters, Sheldon et al. (2006) described how nurses struggled with their reactions to patient's emotions, and felt inadequate which made communication even more difficult. When nurses were faced with angry patients, they personalised the anger, feeling threatened, inadequate and inefficient (Smith & Hart 1994).

Lack of rapport

A lack of rapport between the nurse and parent was a further cause of little or no engagement between the nurse and parent. Engagement was more likely however when there was a common ground between them, such as similar age, gender or ethnicity. This became apparent during field work when a father noted that nurses mainly left him alone*,* and wondered aloud whether this was because he was a male amongst predominantly female nurses. Parents were less likely to establish rapport and engage with nurses with different ethnicity or socio-economic status than themselves. The majority of nurses were women, white, middle-class and employed; whereas parents were frequently Māori, Pacific or other ethnicity, male, or receiving a government benefit (such as the unemployment or sickness benefit).

An example of the rapport likely to develop if nurse and parent were similar was when a nurse of Pacific descent observed that she went out of her way to care for Pacific families, believing they enjoyed having her as their nurse as she was able to speak some of their language and had a better understanding than other nurses of their particular parenting styles. Parents who had different cultural backgrounds to nurses sometimes felt judged and were concerned that nurses may be disapproving of their behaviours, for example a teenage parent with three children who worried that nurses would make judgements about her parenting abilities.

When caring for families from a culture other than their own, nurses perceived those families as difficult and problematic (Coyne 2006-7) and were able to identify with, and more readily trust, those most like themselves in social situations (McKinlay 1981b). Rock and Cox (2012) reported that people feel more trust and empathy towards those who are similar to themselves and are more mistrustful and less empathetic to those they perceive as dissimilar, that is, members of other social groups. This phenomena, termed “in group preference and out of group bias” (p. 6) was evident in Gow’s (1982) work, finding that if nurses and patient had similar life experiences, they were more likely to be emotionally involved. This was also an issue with Fagerskiold (2006), who found that fathers were excluded from having a connection with nurses.

Similarity between the parent and the nurse was important in the establishment of rapport. If a nurse knew the family and was of a similar cultural group, it would be easier to establish a relationship. When managing the care, and interacting with parents from cultures other than one’s own, nurses in New Zealand are required by the Nursing Council of New Zealand to practice cultural safety, defined as “effective nursing practice of a person or family from another culture, determined by that person or family” (Nursing Council of New Zealand 2011b, p.7). Only the recipient of the nurse’s care can determine if the nurses practice was culturally safe. If, for example, the patient feels alienated from the health service being provided (Ramsden 2002), the nurse has a responsibility to provide more inclusive care. “Cultural safety is concerned with the safety of the person receiving care and the ability of the healthcare professional to develop trusting and effective relationships” (Richardson 2012, p. 6). A trusting and effective relationship between the nurse and parent would require a connection and a level of understanding of each other’s cultures.

Morse (1991) proposes that before nurses enter into a connected relationship, they evaluate the person’s needs and support system, and look for a personality click to

determine if they can work with this person. According to Morse, the nurse consciously chooses whether or not to make an emotional investment in the person (connected relationship) or just do their job (clinical relationship). The essence of the nurse-patient relationship is the engagement between them, whereby the nurse is able to identify with the patient (Morse et al. 1992).

Halpern (2001) extends the concept of identification further, suggesting that there is a trigger when clinicians are moved by the experiences of their patients, and it is this movement that is central to the development of empathy or clinical intimacy (Kirk 2007). It is Kirk's proposition that clinicians have a moral imperative to develop and implement empathy as part of the nurse-patient interaction. When there is no *click* between the nurse and the parent, it is therefore unlikely that the nurse will connect with the parent, thus rendering the parent vulnerable and isolated.

The development of empathy is an important consideration in emotional communication. Clinician empathy provides space for disclosure of patient emotions (Finset et al. 2013). Empathy encourages provider compassion toward the parent or patient, and enables the parent to feel less isolated and more comforted and understood (Davis 2009). In the current study, nurses sometimes lacked perception of parent' emotions, or knew about parents' emotions but were unable to move into the third stage of empathy, acknowledging to parents that they understood their emotions and situation (Kunyk & Olson 2001), thus were unable to empathise with parents' situation. As a result parents remained isolated and uncomforted. This lack of rapport and understanding were one of the factors leading into the difficulties encountered within the family-centred care philosophy, discussed in the following section.

Tensions with family-centred care

That parents felt the need to adapt to the ward culture is a stark contrast to the ward philosophy of family-centred care (Coyne et al. 2011) in which the culture should be adapted to the needs of both child and parent. The family-centred care model was the espoused guiding framework of the ward, indicating that nurses and family members are partners, *working together to best meet the needs of the child.* The underlying premise of family-centred care is to view the family holistically and to evaluate the physical and **emotional** [bold added for emphasis] support requirements of family members (Nethercott 1993), the family are supported in their hospitalisation (Kelly 2007) and involved in their child's care (Shields et al. 2007). Family-centred care or

FCC included meeting parents' emotional needs which nurses need to support and acknowledge. FCC is explicit that the family and nurse are considered equals, collaborating together and working alongside each other to best support the child (Espe-Sherwindt 2008), however when parents are kept at a distance from nurses as in this study, and nurses decide and control how much contact parents will have with nurses, FCC becomes problematic. Other recent studies exploring FCC have suggested that assumptions are made by nurses about parent's participation in their child's care without discussion with parents (Kelly 2007), and nurses have reservations about parents' abilities and are unwilling to relinquish control (Coyne et al. 2011; Espe-Sherwindt 2008; Shields 2010).

In the ward, FCC was underpinned by primary nursing, a model in which each child in the ward has one *primary* nurse who assumes responsibility for the care of the child during an admission, and who should also care for the child during future admissions. Primary nursing can enable nurses to consistently care for the same children and families, with the possibility of a stronger emotional connection between parent and nurse. Despite management efforts, primary nursing was not being implemented successfully because the part-time workforce did not allow for the level of consistency required, and its past failures meant that nurses had lost faith in the ability of primary nursing to improve the provision of health care. There were ongoing tensions regarding the use of primary nursing.

Thus, it is evident that in this study nurses were prevented from providing family-centred care (Coyne et al. 2011) because of the organisational and cultural constraints of the ward. A fundamental constraint was parents not being considered as a patient along with their child. Nurses continued to focus their attention on the child, as it was the child who is handed over to them, the child whose care was documented in notes, and the child who had the problem which caused the hospitalisation in the first place. Any information about the parent was shared from nurse to nurse obliquely during *handover*, for example *Mum at beside* or *Mum needs reassurance,* or handed over verbally after *handover* as a private interaction between nurses. The prescribed nursing diagnosis of the need to minimise the parent's stress and discomfort in hospital in the Child Nursing Care Plan documentation in all charts was rarely completed or acknowledged. As all written documentation was in the child's daily notes, there was nowhere appropriate for nurses to document their observations of parents' changing needs, so they were rarely documented.

A further constraint to the provision of FCC was nurses' inconsistent understanding of parents' role and place in the ward, with some nurses viewing parents as patients, an extension of the child, with an understanding that caring for the child meant also caring for the parent, whilst other nurses considered that the child was their first priority, with the parent separate. A premise of FCC is that care is provided to the whole family and the family are care recipients (Coyne et al. 2011; Shields et al. 2007), thus the former nursing view of parent as patient was consistent with FCC. The latter view that the child was the first priority was the prevailing belief in the ward, and was enforced especially in medical ward rounds.

Within the ward culture, from a medical viewpoint, the child was the patient with the *problem* which needed *fixing*, thus the child patient was the focus. This difficulty and confusion concerning who is the focus of care, and the espoused nursing model of FCC being diametrically opposed to the medical viewpoint in the ward, led to behaviours which separated nurses from parents.

The FCC philosophy was further hindered by the focus on task and adherence to set routine by nurses. Nurse-parent interactions were mainly initiated by the nurse entering a child's room to complete a task for the child, such as monitoring vital signs, preparing the child for a surgical procedure, assessing fluid intake and output, pain assessment and administering medications. The nurse would announce what they were going to do, and proceed to complete the task as quickly as possible. The overriding emphasis on task, and focus on the child's and parent's physical needs were pervasive, common and normal in this setting. Completing tasks was the driving feature of nursing practice. At the beginning of each shift, the nurse would note all the tasks to be completed, and as the nurse progressed through the shift the tasks would be ticked off.

Task orientation

Nurses have historically focused on task and physical needs above all else when caring for patients (Baggens 2001; Bond 1983; Gordon et al. 2009; Hewison 1995; Macleod Clark 1983; Menzies 1960; Suomeinen et al. 1995). When nurses actions are focused on clinical duties they refrain from being with the parent in an emotional sense (Coyne & Cowley 2007), and communication with parents is brief, technological and factual (Espezel & Canam 2003; Gordon et al. 2009). Vandekieft (2001) found that clinicians focused on relieving patients' pain, less often on their emotional distress and seldom on their suffering. Tay, Hegney and Ang (2011) described nurses who were task orientated shutting down communication, and being less effective with

psychosocial aspects of care in emotionally difficult situations. Managing patient's physical needs usually requires doing something active, thus looking busy. Responding to emotional concerns is much more difficult because nurses cannot do anything about emotions, they just are.

There are a number of reasons for nurses' ongoing focus on patients and parents physical needs, to the exclusion of any other actual or potential concern. The dominance of the organisational model of care is a key reason, first noted by Menzies in 1960. More recently Watson (2009) has reiterated that the dominance of a "medical-institutional foci... and system cultures and routines which inhibit the ability of nurses to practice their own profession", leading to underlying dissatisfaction with healthcare (p. 468).

Goffman (1959) suggested that nurses were busy and focused on task because that was the behaviour expected of them, observing that when front stage, and "in the presence of others, individuals infuse their activity with signs which dramatically highlight and portray confirmatory facts that might otherwise remain unapparent and obscure" (Goffman 1959, p. 26-27). Nurses then are like actors on a stage, who need to be seen to be performing their role, which is perceived to be busy and focused on physical needs. Once the nurse is in role, the behaviour patterns must be maintained, otherwise the system does not work, and any behaviour which is not in role needs to be stifled (Jourard 1971).

Nursing education traditionally also focused on the completion of tasks. In New Zealand nursing education was completed in hospital schools of nursing until the mid-1980's which led to a "narrow task oriented training" (Boyd 1967, p.14). The practice environment created by management also had an effect on nurses' communication which was found to be poor by Wilkinson in 1991, and by 1995 Hewison noted that institutional influences established that interaction between nurses and patients were largely routinised and task oriented. The culture of nursing developed a notion that "communication with patients is a luxury or extra bonus...[nurses are] seen as lazy or being idle if we spend time talking to patients" (Yam & Rossiter 2000, p.298).

Nurses in this study were questioned by other health professionals about the child patient's physical concerns such as temperature, fluids, physical wellness; thus nurses needed to be prepared and have an understanding of these physical aspects of the patients care. During observed ward rounds nurses were rarely asked about patients'

or parents' emotional concerns and so did not assess or engage with emotional issues unsolicited.

Despite the difficulties with continuity of care and primary nursing, nurses did want to collaborate with parents to meet the needs of their sick child. Their central focus was the child and they knew that the child needed their parent *on board* with staff in order to make a rapid recovery. The supportive nature of the nursing team and the espoused model of care, the FCC, supported the collaboration. These factors also, at times, hindered collaboration. The organisational and cultural aspects of the ward, such as the strength and cohesiveness of the nursing group, intensified the them and us dichotomy between nurses and parents; and the FCC model required nursing practices which were not able to be implemented, such as including parents as care recipients. Another factor, more hidden within the cultural norms, affecting nurses' engagement with parents' emotions was the strong need to self-protect

Self-protection

In this study, nurses were overwhelmed by parents' emotions which led nurses not only to not engage, but also to take action to protect themselves from parents' emotional concerns. While being with the person, fully engaged, can reduce patient vulnerability, this can lead the nurse to also become vulnerable, as Pettigrew (1990, p. 505) observes; "the healing power of vulnerability lies in nurse's willingness to be there in the midst of a helpless situation, rather than saying or doing the 'right thing'". Once the nurse is exposed to another's vulnerability, they have three choices: walk away, maintaining the usual barriers; shield themself under the guise of professionalism, using communication skills in rote, formulaic manner, therefore avoiding personal investment in the other person; or remain with the person, coping with feelings of discomfort and awkwardness (Pettigrew 1990).

Nursing has a history of emotional protection. In New Zealand, McKinlay (1981b, p. 222) observed that staff were on "no account to get emotionally involved". Nurses were expected to be cool and emotionally distant from the patient (McQueen 2004). Uitterhoeve et al. (2009) found that nurses responded to at least half of patient emotional cues by distancing themselves.

Distancing can be viewed by nurses as maintaining boundaries between nurse and patient as an important aspect of professionalism. Professional relationships involve

therapeutic relationships in which the needs of the patient are the focus (Nursing Council of New Zealand (NCNZ) 2012). Professional boundaries provide limits to the nurse-patient relationship, enabling a safe, therapeutic connection between nurse and patient (Australian Nursing and Midwifery Council (ANMC) 2010).

Professional boundaries have been identified as a continuum between under-involvement on one extreme, whereby the nurse is disinterested and neglectful of the patient, to over-involvement at the other end, which includes boundary violations (ANMC 2010; NCNZ 2012). The therapeutic relationship, the 'zone of helpfulness' (NCNZ 2012), lies between these extremes. Boundary violations themselves range from subtle boundary crossings, through to boundary violations such as sexual misconduct (NCNZ). Boundary crossings are defined as "brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a special therapeutic/care need" (ANMC 2010, p. 5). Subtle boundary crossings occur when nurses needs take precedence over the patients.

The boundaries with which nurses protect themselves are described as a "self-protective wall or shell" (Scott 2006, p. 141) which eventually leads to nurses' emotional and psychological withdrawal from the patient. When nurses self-protect in this way they are crossing boundaries as they are unconsciously meeting their own needs over the needs of the patient. Fisher et al. (2012) found nursing students' were anxious about showing emotion to parents, and voicing empathy for parents' concerns. Nurses are anxious to appear professional which can lead to appearing distant and emotionally withdrawn.

Another inadvertent boundary crossing observed in this study was nurses telling parents about their workload. Especially when they were busy, nurses wanted parents to know why they may not spend as much time with the child and family as expected. Sharing their workload issues with parents was understood by nurses to reduce parents' anxiety, but nurses' anxieties were also allayed by this action.

The difficulty in managing emotional labour (Hochschild 1979) is a further factor leading to nurses' self-protection. Strzyzewski (1992) observes that in the initial stages of any relationship people are usually polite, which leads to a control of dominant emotions, and tendency to either not impose on the other, or seek for approval. As relationships become closer, moving from clinical to a more connected relationship (Morse 1991), the expectations and rules about what emotions are acceptable to feel and display are

governed by the cultural context of the interaction (Burgoon 1993; James 1989; Mesquita & Delvaux 2013; Strzyzewski 1992).

In this ward culture, the accepted behaviour was to avoid and minimise emotional communication. Forsey, Salmon, Eden and Young (2013) found that exposure to parents' emotional needs left nurses vulnerable to emotional distress. Managing patient's emotions requires emotional labour. Nurses in this study reported inadequacy and concern about emotional communication, driven by their own emotional discomfort (Gibbons 1993) which diverted their concern away from the parent and towards themselves. Emotional labour can be harmful for the nurse, causing dissonance between themselves and others, requiring effort, and can lead to surface acting which seems fake to those around them (Mesquita & Delvaux 2013). Self-protection was one approach used by nurses to manage emotional labour.

Other techniques nurses used to self-protect included depersonalising the patient, detachment and denial of own feelings, and ritualising tasks (Menzies 1960). At that time tasks were given precise instructions including the way each task was to be completed, the order of the task and the time of performance. Thus in an attempt to reduce nurses' exposure to emotions, task orientation and professional detachment became the mainstay of nursing practice. Fifty years on, these behaviours continue to inhibit nurses from providing holistic care to their patients, which is now considered to be therapeutic. While nurses needed to protect themselves in relation to interactions with parents, a further aspect of the culture was that they provided emotional support to each other.

Support for each other

The supportive nature of the team of nurses was a feature of the ward culture. Nurses enjoyed their nursing experience in the ward as evidenced by the pleasant and cheerful tone of the ward and by the nurses' own reports. There was a low turnover of staff, they knew each other well and many socialised together.

Nurses considered themselves part of a strong team. Cohesiveness was a dominant feature of the nursing group, with few factions and little team dysfunction. Nurses were supportive of each other and this support was observed to move from physical, to psychological and emotional as necessary, depending on how well the nurses knew each other. A salient feature of the team support experienced by the nurses was the nursing leadership.

The Charge Nurse or CN was an active team member and was also highly visible in the ward. Early in her role she had successfully addressed poor team dynamics, which included nurses dividing into factions and complaining about each other openly. She encouraged nurses to talk to each other about issues of concern, and also led the development of children's ward norms, generated by the nurses themselves and prominently displayed in the nurses' station. By providing a sense of direction and encouraging self-determination, the CN epitomised a transformational leader, defined as "a caretaker who sets goals for employees, focuses on day-to-day operations, and uses management by exception" (Marriner-Tomey 2004, p. 175). Transformational leaders are more focused on commitment to a set of values than compliance to a set of rules. The CN had effectively enabled a process by which the values, beliefs and practices of the ward were articulated by the nurses themselves.

Transformational leaders encourage emotional intelligence, in particular self-awareness, self-regulation and motivation, and empathy and social skills (Goleman 1996). The CN achieved this and encouraged nurses to be aware of each other, to empathise and self-regulate. As members of the insider group, nurses frequently shared emotional communication, but the emotional support shared between members of the nursing team (the insiders) was not transferred over to those who visited the ward (the outsiders), the parents. Nurses demonstrated that they had the ability to communicate on an emotional level with others, however emotional communication with parents may have seemed to the nurse as a boundary crossing, thus they did not *go there*.

Nurses' support of each other establishes that there was a need for nurses to help each other, as being exposed to actual or potential emotional communication is difficult and hard work. Nurses own emotional responses and needs, such as fear, anxiety, stress, helplessness, guilt and feeling burdened, overwhelmed nurses and thus they looked to their colleagues for support and help.

Chapter summary

Nurses' responses to parents' emotional communication were ruled by the cultural norms of the ward, how things were done. The responses described in this study were those which were accepted, practiced, and taken-for-granted, thus reflecting the predominant values, beliefs and practices of nurses and to some extent of other health professionals in the ward. Reynolds, Scott and Austin (2000) remarked that nurses feel

anxious about spending time with patients one-to-one when this is not a clear expectation in the workplace. The culture of this ward, the expectation, was that nurses respond to overt emotional communication by helping, but fear of doing the wrong thing and of their own perceived inadequacies led nurses to not engage, and this behaviour was an accepted norm of the ward.

A constant thread throughout this study has been that the ward and nursing culture influences and shapes nurses' behaviour and affect with regard to emotional communication. Key features of emotional communication are empathetic understanding, comfort and connectedness, all of which were found to be wanting. Nurses have recognised and responded to parents' need for informational and instrumental support (Tates et al. 2002), however the recognition and acknowledgement that parents also need emotional support was largely absent from the data.

Another substantial finding of this study was the emotional burden experienced by nurses when confronted with parents' actual or potential emotional communication. Emotional labour (Hochschild 1979) is hidden, invisible and hard. The burdensome nature of emotional communication and managing emotional labour led nurses to detach from parents, keeping them at a distance, to self-protect. Although nurses' needs for emotional care are met within the ward by other staff, they self-protect against parents' emotional needs because of previous experiences with parents, their own emotional response, the inherent difficulty of emotional labour, and the organisational and cultural context of the ward.

Parents' lack of control and vulnerability resonated in the findings, yet parents anticipated that if nurses connected with them, these concerns would be lessened. Parents quickly learned to co-operate with ward activities and understood their boundaries in the ward. However parents were exhausted with always being on show, parenting in public. They anticipated that if one or two nurses had a connection with them they would be able to express their concerns, hopes and worries openly, and then relax knowing these concerns were heard. Waiting for acknowledgement from the nurse that they may have emotional concerns was an added strain on an already difficult experience. Parents craved for an empathetic response from nurses, confirmation of their stress and compassion for their current situation. The culture of the ward inhibited and restrained nurses' responses.

The rhetoric of family-centred care (Coyne et al. 2011) establishes that nurses need to physically and emotionally support family members. Parents and nurses have similar goals, to enable the child's needs to be met and to improve the child's condition. More than anything else, parents wanted to connect and engage with a nurse, who would be there for them as cultural broker, advisor and support. Nurses also want to collaborate with parents, to ensure the child's myriads of needs are met. However the cultural boundaries separating nurses from parents, and the under- or over-use of professional boundaries established by nurses inhibited effective nurse-parent interaction. A missing element of family-centred care was the provision of emotional support to parents.

The following chapter concludes this study, outlining the central thesis, and culminating in a conceptual model which arose from the results.

Chapter 9: Conclusion

Introduction

This final chapter draws together the threads of this study, incorporating the emergent major findings; parents want emotional communication with nurses, nurses struggle to acknowledge, confirm and respond to the emotions of parents, and culture shapes practice. Two models representing a diagrammatic depiction of the concept of culture shaping practice are presented. The use of the method, focused ethnography and limitations of the study, such as the ideal nature of the ward also are examined. Finally the implications of the study findings for research, education and practice are addressed, including extending knowledge of nurses as cultural brokers, evaluating the presented model for future practice (Figure Three), improving nurses' receptivity to patient cues in emotionally loaded situations, and practice change which encourages emotional communication between nurses and parents/patients.

Beginning with three specific research questions focused on nurses' and parents' experiences of emotional communication within the environmental and cultural context of an inpatient hospital ward, this study has exposed the effect of a ward culture on nurses' and parents' affect, behaviour and understanding.

In 1971 Joyce Travelbee (1971, p.40) wrote,

> *No human being can be repeatedly exposed to illness, suffering and death without being changed as a result of these encounters. So too, the nurse is changed because, in being confronted with the vulnerability of others, she comes face to face with the compelling force of her own vulnerability in a way that it cannot be disregarded* (Travelbee 1971, p. 40).

The findings of this study support the contention made by Travelbee by demonstrating that interpersonal engagement is indeed a vulnerable and challenging part of a nurses' experience. Parents of a child in hospital were found to be in a vulnerable position and requiring support. Nurses are ideally placed to provide parental support, however the provision of such support triggers emotional labour (Forsey et al. 2013; Mesquita & Delvaux 2013), which nurses found burdensome and difficult. The imperatives of this study's findings are that parents want emotional communication with nurses, and nurses struggle to acknowledge, confirm and respond to the emotions experienced by parents. The context and culture of a hospital ward

influence the nurse-parent engagement in such a way as to either impede or broker emotional support.

That parents experience vulnerability and isolation when accompanying their child to hospital is understandable (Hallström et al. 2002a; Roden 2005; Simons & Roberson 2002; Snowdon 2000; Stratton 2004); their child is sick, the environment is new, and the parent is trying to maintain their life in two worlds. This study has demonstrated a number of factors related to unsatisfactory communication between nurses and parents that include: nurses being receptive to parents' emotional cues, but respond by giving informational or instrumental support (Tates et al. 2002), rather than emotional support (Arora et al. 2007); when parents' emotion is overt and displayed, nurses do respond, by either engaging with the parent, or avoiding and minimising the parents' concerns; and nurses do not usually elicit emotional communication from parents.

Further, this study has demonstrated reasons why nurse-parent emotional communication is unsatisfactory for the nurse and the parent. A key finding was nurses' confusion about parents' role when caring for a child who is ill and in hospital. Parents are neither staff, visitors, nor are they patients, rather they are something in-between. Because nurses did not perceive the parent as their patient, parents' potential emotional concerns were not considered. Further, parents are not patients, there was little opportunity to formally document and discuss parents' concerns during change of shift handover, thus resulting in parents' needs not being at the forefront of nurses' anticipated care.

A further issue impeding nurses eliciting emotional communication identified in this study is their perception of parents as a threat, which causes nurses stress. Stress can lead nurses to emotional exhaustion and burnout, thus nurses were found to distance and protect themselves from the outset of the nurse-parent relationship. Nurses were unprepared for the emotional labour (Hochschild 1979) involved in managing their own and parents' emotions; they lacked the education and resources to manage this communication, the confidence and ability to respond to parents appropriately, and the support structures in the ward to engage with parents in this way.

The importance of the environmental and cultural context within which the parent-nurse interaction occurs was evident in this study. Although the setting might be considered ideal in the sense that there was ample opportunity for communication and the parents frequently had space and time to share their concerns with nurses, emotional

communication was rare. The distancing that occurred among nurses and parents led to a separation, creating a them and us scenario, with parents on the outer and nurses on the inside. Parents' and nurses' lives were controlled by ward activities, and nurses were perceived by parents as the gatekeepers of the ward. Parents lacked certainty and autonomy, and relied on nurses to give them a way in to the ward which would facilitate their hospital experience.

Parents looked to nurses to be a liaison between them and the hospital system, thus providing cultural brokerage (Chalanda 1995; Kinnaird 2007; Shomaker 1995). However the strong cultural boundaries in place in the ward created a barrier between the insiders and outsiders which was rarely penetrated. Nurses assumed that parents were comfortable with their situation when, in reality, parents reported feeling isolated and alienated from the ward culture.

Nurses are in an ultimate position to provide cultural brokerage for parents; they know the ward culture implicitly, and they have demonstrated in this study that they have understanding of some of the stresses and difficulties parents experience in hospital with their children. Nurses' knowledge and understanding of two cultures; the ward, and parents, through their own nursing lens creates an ideal position. Cultural brokers mediate, negotiate and intervene between two cultures (Chalanda 1995); nurses are ideally placed to provide this service.

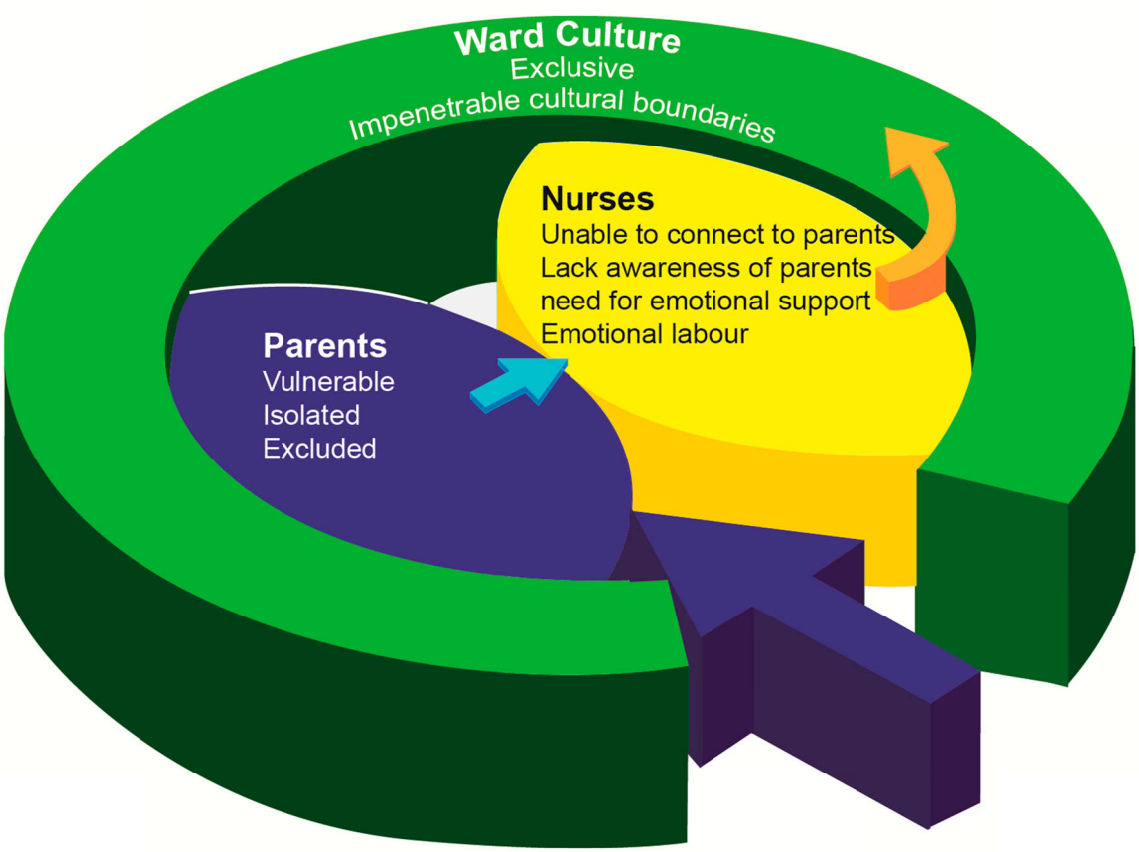
The failure in acknowledging or engaging with emotional communication has potential impact on both parent and nurse. For example, the presence of emotional support can promote physical health and psychological wellbeing (Arora et al. 2007; Cherry et al. 2013; Finset 2012a; Thoites 2011). For both parent and nurse in this study, there was a lost opportunity to connect and engage with each other. Parents felt isolated and vulnerable, and nurses were unable to satisfactorily implement family-centred care, as espoused by Kelly (2007), Shields et al. (2007), and Nethercott (1993). Family-centred care is where the whole family is involved in the provision of care to the child, working alongside staff as equals, with the needs of family members acknowledged and attended to and the family are care recipients.

Parents are ready for, and seek a connection with a nurse during their hospital stay. The potential for emotional distress and concern in a children's ward is high, and nurses are in a prime situation to provide support for parents. Nurses in this study wanted to collaborate with parents in order to improve the child's situation.

Culture shaping practice

Figure Two provides a diagrammatic representation of key findings of the study, the situation as described in this study. Parents enter the ward culture with their child, as shown by the large purple arrow. Although parents are physically present on the ward, the cultural boundaries established by those who share this common culture, dominated by nurses, are frequently impenetrable. Parents constantly look to nurses for a way in to the culture, using nurses as brokers, as demonstrated by the lighter arrows from parents to nurses. Parents look to nurses for orientation to the ward, guidance and help, and cultural brokerage. However the strong cultural boundaries enforced by nurses prove an obstacle for parents who then retreat, withdraw and wait for the experience to be over.

Figure 2 Present model



Factors impacting on the strength of the culture include nurses' lack of awareness and acknowledgement of parents' need for emotional support; nurses' taken-for-granted belief that parents will manage their experience with enough sleep, food and respite

from their child; ward organisation and documentation that prevents nurses from perceiving parents as requiring their care, in the same way as the child does; and finally the emotional labour (Hochschild 1979) required by nurses to manage and respond to parents' emotions. This combination of factors enables the separation between nurses and parents to continue, leading to dissatisfaction for both parents and nurses.

Figure 3 Future model

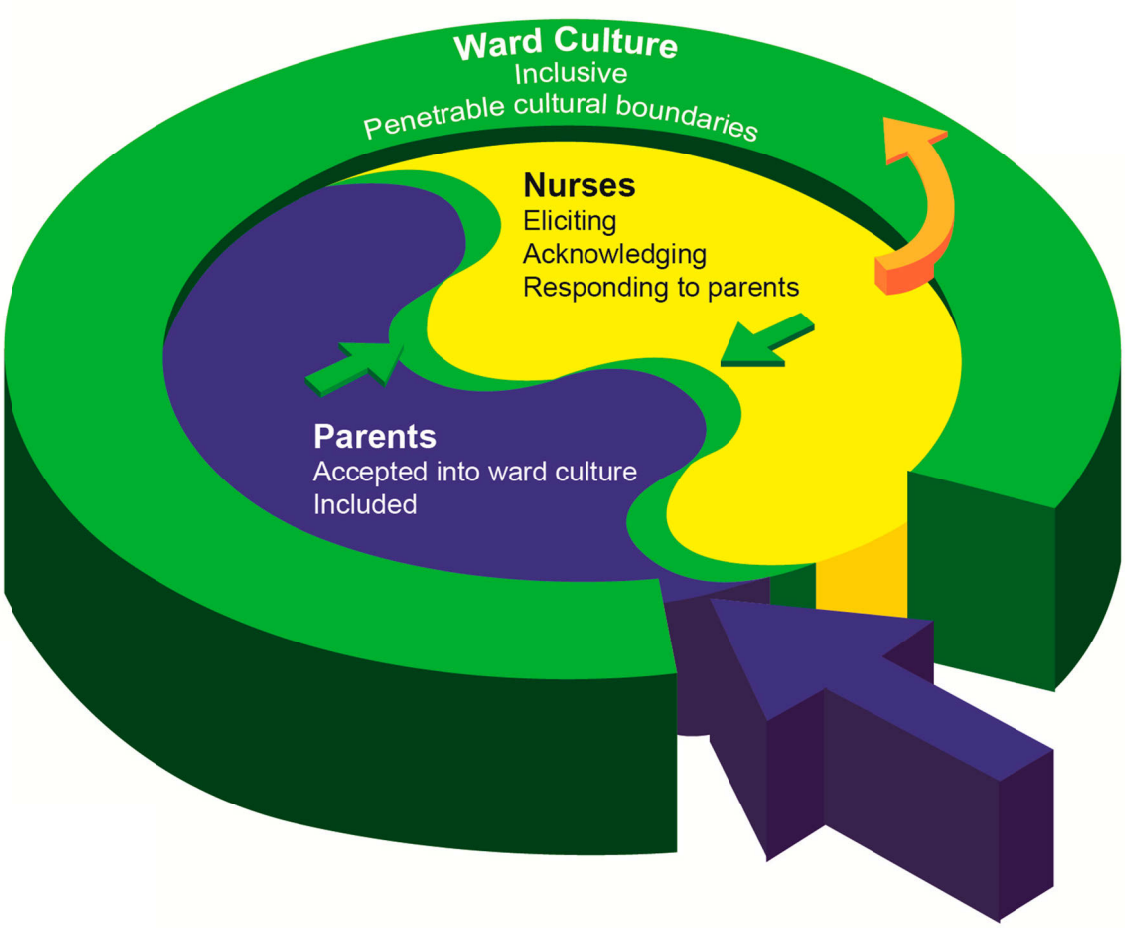


Figure Three, provides a pictorial future representation of the possibilities of culture shaping practice. This representation provides a model for practice. In this model, parents enter the ward and are rapidly accepted into and included in the ward culture, as demonstrated by the arrows indicating interaction between parents and nurses. Cultural boundaries are permeable, enabling parents and nurses to freely communicate about parents' emotional concerns, as well as their informational and instrumental needs. Nurses are supported within the culture in their management of emotional labour (Hochschild 1979), enabling them to elicit, acknowledge and respond to

emotional communication with parents, shown by the arrow between nurses and the ward culture. Nurses and parents collaborate and work together to meet the child's requirements. The inclusivity of the ward culture facilitates parents and nurses to fulfil their roles to their own and others satisfaction.

The development of these models provides an easily-understood depiction of the study findings and further introduces a model for practice which incorporates both parents' and nurses' needs. The Future model (Figure Three) enables collaboration between nurses and parents, which was found in this study to be an ideal goal by both groups. The development of these models has been facilitated by the on-going emic and etic perspectives, having a research approach which enabled me to mediate between two worlds (the audience for this study (etic) and the participants (emic) through a third (myself, as researcher) (Lambert et al. 2008).

Use of method

A focused ethnography with an interpretive approach was used as the design for this study. A review of the literature uncovered that the focus of previous research was on interpersonal dynamics alone, rather than the cultural/environmental context of the interaction. Studies were found to rely on what people said they did, which may have been different to what they actually did, so there was a strong case for observing what actually goes on in the real world of practice. Focused ethnography was chosen in order to gain entry into the world of the participants, specifically enabling understanding of the cultural context of the interaction.

The method was well suited to the research question in that I was able to directly observe nurse-parent interaction as it occurred, then follow-up with informal interviews with participants directly involved in the interaction. Participant observation enabled me to gain understanding of cultural rules, norms and values (Boyle 1994) of the ward, giving me awareness and understanding of the impact of the cultural context on nurse-parent interaction. Exploring the taken-for-granted nature of nurse-parent interaction and focusing on emotional communication was facilitated by the use of focused ethnography.

Limitations of the study

Hammersley (1992, p. 44) observes that the "goal of ethnographic research is to discover and represent faithfully the true nature of social phenomena". Nurses' and

parents' experiences of emotional communication within the context of a children's ward of a hospital were the social phenomena under investigation, and those experiences have been observed, and reported faithfully in this study. The findings are the report of a single unit in the field and the ward setting may have characteristics similar to other wards, and the nurses' and parents' experiences may also be comparable with others, however there is no claim that the findings of this study would be true for any other unit. It is for the reader to decide whether the findings fit their own experiences (Padgett 2013). However a theoretical understanding of the phenomenon does offer relevant information to others.

One limitation of this study identified early in the field work, was that the ward setting was almost too ideal. On entry into the ward, the ward was well staffed with nurses, nurses had effective relationships with each other, the ward was rarely busy so nurses had time to spend with patients and families, and the nursing management were supportive of staff. As an experienced registered nurse, I had never experienced a ward environment like this, with so many aspects functioning so well. In my experience a well-staffed ward, with supportive management and a cohesive team of nurses is a rarity in nursing practice, and I was concerned that this ideal setting for the participant observation would affect the study outcomes. However, due to the length of field work time, eventually the situation became more normalised (that is, like other wards I have experienced and others have described), in that the staffing was sometimes less than ideal, the ward was busier, there were some dynamics in the relationships with staff, and management-nurse relationships that were sometimes fractious. Thus, the length of time of field work contributed to seeing a more rounded picture, across a range of everyday ward environment experiences.

I was concerned that as a registered nurse who also has had previous experience of practising with children and families that it would be difficult to reduce the bias I may experience as I entered the field. However any bias I may have had dissipated when in the ward. A number of factors facilitated this process, including my unfamiliarity with the ward and that I was unknown, thus treated as an outsider; the willingness of staff and parents to allow me to observe their interactions, then talk to me openly about their experiences, thus enabling me to enter their world; taking copious field notes which gave me an opportunity to note what I observed but also my interpretations of my observations, which I then checked out with multiple participants to confirm whether my interpretations were their reality. Gradually any previous biases I may have had were overtaken by the reality of the participant's experience, and also by the culture of the

ward. The reflexive process undertaken during the study also permitted me to confront the impact I may have been making on the process and outcome of the research (Mulhall et al. 1999), my assumptions and biases and to continually challenge and question myself and my thoughts and interpretations.

Further consideration in the following section of the contribution of this work to the broad areas of research, practice and education illuminates the importance of the wider impact this work may have.

Implications for research

This study has added to the body of knowledge on this topic by providing a greater understanding of the impact of the cultural and environmental context of the ward on nurse-parent communication, and furthering knowledge of cultural brokerage in nursing practice, however with understanding comes more questions. Additional research is justified in a number of areas. Family-centred care (Coyne et al. 2011) as a model of practice was found to be problematic in this study, in that nurses kept parents at a distance and were the arbiters of the contact between nurses and parents. Research into the application of the family-centred care model into this hospital-based practice, specifically focusing on nurse-parent interactions, and their impact on the delivery of care is required. The use of cultural brokerage in facilitating emotional communication also requires examination and understanding.

A model for future practice (Figure Three) has been developed. This model needs to be evaluated in practice, thus applied research which allowed further development of this model is required.

Further research may provide nurses with the skills and attributes required to provide emotional support to parents, followed by an evaluation of parents' and nurses' experiences thus providing evidence of key skills required to implement emotional support for parents. A study exploring the impact of nurse-parent emotional support on patient outcome would also be valuable.

Exploring nurses' emotional labour (Hochschild 1979) is necessary, especially in the area of child health. The emotional labour of managing children and parents within the confines of a hospital ward needs further investigation.

Implications for education

This study reinforced earlier findings by Mesquita and Delvaux (2013) that emotional labour (Hochschild 1979) is connected to the cultural context of the interaction in which it occurs. This study uncovered that emotional labour is burdensome and difficult for nurses working alongside parents in a children's ward, thus nurses require formal and systematic education to learn how to manage their feelings, and the emotions of others. It was evident that nurses need more resources and skills to provide emotional support to parents in hospital.

Nurses need to be responsive to cues and to elicit emotional concerns. Questions such as: "How are you coping with the current situation with your child?" and "Have you got any concerns or worries you would like to discuss with me?" would provide an opportunity for parents to share their emotional concerns, and to receive emotional support from nurses. Questions such as these improve the rate of expression of cues that indicate emotional distress (Uitterhoeve et al. 2009). Educational courses which improve nurses' receptivity to patient cues in emotionally loaded situations would be beneficial. These skills can be fostered in undergraduate, post graduate and professional development education.

A further finding is nurses' lack of awareness of parents' potential emotional concerns, thus education raising nurses' awareness of parents' potential needs in hospital is warranted. Incorporating a holistic assessment of parents' needs and concerns into an overall assessment when a child is admitted to the ward would be beneficial, as would a brief assessment each time the nurse encountered the parent during a shift. Routinely asking patients about their fears and anxieties at regular intervals has been found to improve clinician collaboration (Beswick, Westell, Sweetman, Mothersill & Jeffs 2013). Transferring that knowledge into a children's ward and directly asking parents about their emotional concerns would add to parents' comfort.

Implications for practice

Nursing practice focused on task completion continues to be a barrier to effective communication. Practice needs to move from a task focus, to being proactive and responsive to patient and family individual needs. Added to this, a successfully implemented nursing service model which allows for greater consistency in care, thus enabling stronger connections between parents and nurses, is required, necessitating institutional change. Models for practice, which have already been proven to work,

need to be enmeshed in practice, such as the Family Partnership model which focuses on the interaction with families and increasing skills of staff to work with families (Braun et al. 2006; Wilson & Huntington 2009); and family-centred care (Kelly 2007; Shields et al. 2007). Ward organisations need to have embedded within them an acknowledgment that meeting all parents' needs, including emotional concerns, is vital, and will improve the experience and health outcomes (Thoites 2011) of parent and child. Parents' met and unmet concerns and requirements for social support need to be shared between oncoming staff, thus a change in documentation, ensuring that parents' informational, instrumental and emotional concerns, and nurses' response to those concerns, is required. Incorporating a brief assessment of the parents' needs is vital to ensuring these needs are met.

Both parents and nurses experienced difficulty with emotional communication, leaving parents feeling vulnerable and isolated, and nurses inadequate and stressed. These difficulties have been found to lead to a disconnection between nurse and parent, making practice change in this area warranted. Nurses need to recognise and acknowledge that parents have potential and actual emotional needs, and organisations must provide appropriate support and assistance to nurses managing the emotional labour of caring for children and their parents.

Chapter summary

The culture shaping practice concept (Figure Two) has identified the central thesis of this study: parents want emotional communication with nurses, nurses struggle to acknowledge, confirm and respond to the emotions of parents, and the context and culture of a hospital ward influences nurse-parent engagement. For both nurses and parents, emotional communication in the context of a hospital ward is fraught. The findings of this study are a reminder of the inherent difficulties faced by nurses practicing in hospitals as they bridge the unease between organisational/institutional demands, the needs of human beings they encounter daily and their own personal vulnerabilities. The current system as experienced by nurses in this study, requires nurses to focus on caring for the child, and puts an emphasis on physical aspects of client care. Although the family-centred care philosophy (Coyne et al. 2011) is espoused in practice, the dominant paradigm in this study favours caring for patients' physical needs above all else. Nurses in children's wards are well aware that children have emotional needs and that their parents are the people best able to meet those needs. Since the 1960s parents have been staying with their child in hospital, needing

nurses' support and concern. Nurses have responded by anticipating and caring for parents' physical concerns.

Parents look to nurses for support in the ward, and nurses have been providing this, to a limited extent, within the boundaries of their organisational requirements. In both nursing education and practice, it must be recognised and acknowledged that nurses are people with feelings impacted by the emotional labour (Hochschild 1979) of nursing practice. There is also an imperative to improve the connection between the two groups of adults who are caring for the sick child, their parents and the nurses, in order to improve their interpersonal experience, as well as improving the child's health outcome. Finally, the inclusion of meeting emotional needs of parents must be incorporated into the family-centred framework for practice. The future model as depicted in Figure Three provides a further realistic and accessible framework for practice in this environment, providing a cultural setting which is inclusive and enabling for parents and nurses.

Appendices

Appendix 1 Māori Health Approval

From: "Te Aira Henderson" <TeAira.Henderson@ dhb.govt.nz>
Date: Thursday, 15 March 2012 5:19 p.m.
To: "Ruth Crawford" <[redacted]@paradise.net.nz>
Subject: RE: PhD study at DHB - Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study

Hi Ruth,

Thank you for your email and alerting me to the fact that the approval was not in writing.
My apologies for being remiss and not sending an approval letter at the appropriate time.
I would have discussed this with the kaumatua group but am unable to recall their response.

I certainly recall meeting with you and the discussions around the approach you were taking, the possible impact on Maori (negative) and to support your research project. The support is without reservation.

Kind Regards TeAira

From: Ruth Crawford [mailto:[redacted]@paradise.net.nz]
Sent: Friday, 2 March 2012 5:37 pm
To: Te Aira Henderson
Subject: PhD study at DHB - Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study
Importance: High

Kia ora TeAira
It was good to catch up with you on the phone today, regarding my study which was undertaken in the Children's ward of DHB between March and November 2011. As I noted, we had several telephone email discussions (from 19 October 2010) regarding my proposed ethics applications and you were also going to consult on my behalf with the Māori Health Research Group and the Kaumatua group at
I also met with you in your office on Monday 7 March 2011, before I embarked on my study. At this meeting you gave me verbal approval of the study. I did appreciate your time and positive feedback at that time, but for my records I am required to have your approval in writing. Therefore I am further requesting, at your convenience, your documentation of approval for my study.
Please find below a brief summary of the study, including the relevance and responsiveness to Maori section of my Ethics application. The study was approved by the Regional Ethics Committee (CEC/10/12/063) and the UTS Human Research Ethics Committee 2011 027R.

Please let me know if there is any further documentation/clarification required.

Many thanks for your time TeAira.

Kind regards
Ruth Crawford

Appendix 2 Locality Assessment Approval

Locality Assessment by Locality Organisation

Refer to pages 13–15 of Guidelines for Completion of the National Application Form for Ethical Approval of a Research Project (NAFG-2009-v1).

Locality organisation sign off

Ethics committees review whether investigators have ensured their studies would meet established ethical standards if conducted at appropriate localities. Each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality.

Please note that the locality organisation may have additional requirements to be met before a study may commence at that locality.

Part One: General

To be completed by the principal investigator for this locality.

Full project title:	Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study
Short project title:	Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study
Locality to be assessed:	District Health Board
Brief outline of study:	This study will investigate the experiences of nurses who work in a children's ward, and parents of a child in hospital, focusing on nurses' responses to emotional concerns of the parents. Current literature indicates that nurses have difficulty communicating with parents when parents have emotional concerns. The setting for the research is a children's ward of a regional hospital. The researcher will observe nurse-parent interaction, talk to parents and nurses about their experiences and also observe the context of the nurse-parent interaction, the ward setting. Follow up interviews will be held with nurses and parents. This is original research, which it is anticipated, may provide nurses with insight into responses to parents' emotional concerns and a greater appreciation of the issues faced by parents of a child in hospital.
Principal investigator (for this locality):	Ruth Crawford
Contact details:	[redacted] [redacted] [redacted] New Zealand Phone Home: [redacted] Work: 06 974 8000 #5401 Cell: [redacted] Email: [redacted]@paradise.net.nz

Other local investigators (list all at this site):	nil
Contact details:	N/A

Part Two: Locality Issues

To be completed by the principal investigator for this locality and signed by the authorised locality representative. (See the Guidelines (NAFG-2009-v1) (pages 13–15) for more information and examples.) Identify any local issues and specify how these issues will be addressed.

1. **Suitability of local researcher**

   For example, are all roles for the investigator(s) at the local site appropriate (for example, has any conflict the investigator might have between her or his local roles in research and in patient care been adequately resolved)? [Y] Yes [ ] No

   Answer:

   The principal investigator has completed Masters Thesis research within another District Health Board. Research participants were registered nurses working within the DHB. Although this is the first research the investigator has conducted using this method, the investigator is supervised by Professor Jane Stein-Parbury, and Professor Denise Dignam, of the University of Technology Sydney, both experienced researchers. The principal investigator will be supported with clear guidance, mentorship and oversight of both supervisors. The investigator is a registered nurse, but is not employed by DHB and thus will not be providing patient care. Her role is as researcher.

2. **Suitability of the local research environment**

   a) Are all the resources (other than funding that is conditional on ethical approval) and/or facilities that the study requires appropriate and available (for example, is staffing adequate? Is this site accessible for mobility-impaired people where necessary)? [Y] Yes [ ] No

   Answer:

   This research is for a Doctoral thesis. Costs of stationary are covered by the principal investigator. No specific resources will be used from DHB. The researcher will seek guidance from managers at DHB to ensure that all processes and procedures for contacting and inviting employees of the DHB are followed.

   b) Have all potentially affected managers of resources such as patient records or laboratory managers been notified? [Y] Yes [ ] No

   Answer:

   Prior to commencing the planning for this study, the investigator contacted the Director of Nursing who liaised with the Charge Nurse of the Children's ward to gain permission to enter the ward to undertake this study. Consent for entry will be continually negotiated from managers during the data collection phase of the study.

3. **Have issues such as cultural issues specific to this locality or to** [Y] Yes [ ] No

people being recruited at this locality been addressed?

Answer:

All potential participants have an equal opportunity to participate in this study. There does not appear to be any specific cultural or other issues that this study highlights for this locality. Consultation is ongoing with Te Aira Henderson, Manager Māori Health Services, DHB. Te Aira is consulting on my behalf with the Māori Health Research Group and the Kaumatua group at (awaiting letter of support).

4. **Have the local investigator contact details and other important contact details been provided to the locality organisation for checking?** [Y] Yes [ ] No

Answer:

All contact details are provided on the Ethics application and this document.

Part Three: Declaration by locality organisation

I am authorised to complete locality approval on behalf of this locality organisation. I understand that I may withdraw locality approval if any significant local concerns arise. I agree to advise the principal investigator and then the relevant ethics committee should this occur.

(Questions 1–4 at Part Two above must be completed prior to signing.)

I confirm the organisation has sufficient indemnity insurance to compensate participants for harm that does not qualify for compensation under the Injury Prevention, Rehabilitation and Compensation Act 2001.

Signature:		Date:	3 | 12 | 2010
Name:		Position:	Director of Nursing
Contact details:	@ dhb.govt.nz		

Appendix 3 Regional Ethics Approval

Health
and
Disability
Ethics
Committees

Multi-region Ethics Committee
Ministry of Health
PO Box 5013
1 the Terrace
Wellington
Phone (04) 816 2655
Email: multiregion_ethicscommittee@moh.govt.nz

4 February 2011

Ms Ruth Crawford
[redacted]

Dear Ms Ruth Crawford

Re: Ethics ref: **CEN/10/12/063** (please quote in all correspondence)
Study title: Emotional Communication Between Nurses and Parent of a Child in Hospital : An Ethnographic Study
Investigators: Ms Ruth Crawford

This study was given ethical approval by the Regional Ethics Committee on 20 January 2011. A list of members of the Committee is attached.

Approved Documents

- Study Protocol, dated December 2010
- Information sheet Version 4 dated 14 January 2011
- Consent form Version 1 dated 17 November 2011

This approval is valid until 20 January 2015, provided that Annual Progress Reports are submitted (see below).

Access to ACC

For the purposes of section 32 of the Accident Compensation Act.2001, the Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out. Participants injured as a result of treatment received in this trial will therefore be eligible to be considered for compensation in respect of those injuries under the ACC scheme.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 19 January 2012. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

For the purposes of the individual reporting of SAEs occurring in this study, the Committee is satisfied that the study's monitoring arrangements are appropriate.

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

We wish you all the best with your study.

Yours sincerely

Production Note:
Signature removed prior to publication.

Claire Lindsay
Administrator
Regional Ethics Committee
Email: _ethicscommittee@moh.govt.nz

Appendix 4 UTS Human Research Ethics Committee Approval

FILE COPY

UNIVERSITY OF TECHNOLOGY SYDNEY

24 February 2011

Research and Innovation Office
City Campus
Building 1 Level 14 Room 14.31
PO Box 123 Broadway
NSW 2007 Australia
T +61 2 9514 9681
F +61 2 9514 1244
www.uts.edu.au
UTS CRICOS PROVIDER CODE 00099F

Professor Jane Stein-Parbury
Professor of Mental Health Nursing
KG05.02.06
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Jane,

UTS HREC 2011-0 STEIN-PARBURY, Professor Jane, DIGNAM, Professor Denise (for CRAWFORD, Ms Ruth Marion, PhD student) – "Emotional Communication between nurses' and parents' of a child in hospital" [*External Ratification: Regional Ethics Committee, New Zealand Human Research Ethics Committee HREC approval – Approval number: CEN/10/12/063 20/01/2011 to 20/01/2015]*

Thank you for your response to my email dated 14/02/11. Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that your external ethics clearance has been ratified.

Your UTS clearance number is UTS HREC REF NO. 2011-027R

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report. You must also provide evidence of continued approval from the Regional Ethics Committee, New Zealand.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,

Production Note:
Signature removed prior to publication.

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee

Appendix 5 Flier advertising research in the ward

Communication between nurses and parents in this ward

What is happening in the Children's ward?

There is a research study being conducted in this ward.

Nurse-parent communication is being observed.

How can you help?

If you are a parent (or primary caregiver) of a child in this ward **OR** a health professional working in this ward the researcher may ask you to be part of the study.

If you agree to take part your communication will be observed, the researcher will talk with you about these observations, and the researcher will make written notes.

Will it be confidential?

Yes, all notes are confidential and when the researcher analyses the notes, all identifying details are removed

Who is doing the study?

Ruth Crawford, PhD student at the University of Technology Sydney, Australia, under the supervision of Professors Jane Stein-Parbury and Denise Dignam.

Telephone: 06 974 8000 Ext 5401
Cell phone:
Email: @eit.ac.nz

The Director of Nursing (XXXX XXXX, Extension XXX) and Ward Manager have given permission for this study to be carried out. This study has received ethical approval from the XXX Regional Ethics Committee, ethics reference number CEN/10/12/063

Appendix 6 Participant Information Sheet for nurses

Participant Information Sheet for Nurses

Project Title: Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study

Principal Investigator: Ruth Crawford PhD student, UTS

Supervisors: Professor Jane Stein-Parbury, Professor Denise Dignam

An Invitation

You are invited to participate in a study investigating nurses' experiences, and parents' of a child in hospital experiences, of emotional communication in hospital.

What are the aims of this study?

The aims of this study are: to investigate nurses' experiences of emotional communication with parents of a child in hospital; parents' experience of emotional communication with nurses in hospital, and to examine the environmental and cultural context in which the nurse-parent interaction occurs.

How was I chosen for this invitation?

You are a health professional working in the Children's ward of the XXXX District Health Board. All health professionals working in this area and all parents with a child in this hospital are invited to participate in this study. Your participation is entirely voluntary (your choice) and if you choose not to take part this will not affect your employment.

Where will the study be held and for how long?

This study is being conducted in the inpatient Children's ward at the XXXX District Health Board, over a period of not more than 7 months. Interviews will take place following this period in a venue to be determined.

What will happen in this study?

The researcher is observing nurse-parent interaction in the ward and will be taking written notes following informal chats with parents and health professionals. The researcher will also be observing the general context of the ward setting, including nursing handovers, ward rounds, and accessing patient notes to observe written documentation related to nurse-parent interaction. The researcher may ask you some informal questions, and/or may observe your interactions. You do not have to answer

all the questions, and you may stop the discussion at any time. The observation and questions will take no more than ½ an hour of your time on each occasion. Following this field work period, 12 registered nurses and 12 parents will be invited to participate in interviews away from the ward setting. This interview will be no longer than 1 hour and will be recorded. All researcher notes from observations in the ward, and all recordings of interviews will be stored in a password protected computer or locked cabinet and destroyed after 10 years. No material that could personally identify you will be used in any reports on this study.

What are the benefits of participating in this study?

You may have a greater awareness and understanding of how nursing communication can meet parents' emotional concerns, and you may have more insight into the concerns of parents of a child in hospital. You will be participating in a project which will enrich the body of knowledge regarding nursing communication.

What are the risks/inconveniences of participating in this study?

There are no anticipated physical risks as no change to care will be undertaken. The researcher's role is research, not nursing care provider. Discussing your experiences may be uncomfortable for you initially. The researcher is obliged to discuss any unethical/unprofessional behaviour observed to the ward nursing manager.

How will these risks be alleviated?

You have had the study explained to you and can ask questions of the researcher (Ruth Crawford). The researcher has a background in counselling and experience which will allow for stressful situations to be handled sensitively and safely. Referral to appropriate counselling services will be made for anything other than minor distress. You have the right to withdraw from the study at any time without giving a reason, or withdraw data without affecting your employment. You may have a friend, family or whanau support to help you understand the risks and/or benefits of this study and any other explanation you may require. Nurses will be reassured that the researcher is not judging their nursing care. In the unlikely event that the researcher observes a practice that breaches professional or ethical boundaries and is required to report this, the researcher will inform the staff member in question prior to discussing the issue with managers.

What are the costs of participating in this research?

There will be no cost to you as a participant on the ward. If you agree to participate in interviews, transport to and from the venue will be a cost. There will be no payment or reimbursement of expenses incurred.

What will happen at the end of the study?

The study will end when the researcher leaves the ward, and completes the interviews with some nurses and parents. The researcher will write up the findings of the study, and document them in a thesis. As a participant you are welcome to view the findings of the study before publication. A summary of the findings will be written and sent to nurses and parents who are interviewed. The findings of the study will also be published in scholarly journals.

What do I do if I have concerns about this research?

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:
Free phone: 0800 555 050
Free Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Where can I get more information about the study?

You can contact either the researcher or the project supervisors. Contact details below. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation.

Researcher: Ruth Crawford, Registered Nurse,
Napier. Contact phone:

Supervisors: Professor Jane Stein-Parbury, Professor Mental Health Nursing,
Mobile phone: +61 , Faculty of Nursing, Midwifery & Health, UTS Kuring-gai, PO Box 222, Lindfield, NSW 2070, Australia, P +61 2 F +61 2
Professor Denise Dignam, Associate Dean, Teaching and Learning,
Faculty of Nursing, Midwifery & Health, UTS, PO Box 123, Broadway, NSW 2007, Australia,
P +61 29514 4790

This study has received ethical approval from the XXX Regional Ethics Committee, ethics reference number CEN/10/12/063 and UTS Human Research Ethics Committee 2011 027R.

The Director of Nursing and Ward Manager have given permission for this study to be carried out.

Contact details for Director of Nursing: XXXX XXXX, Extension XXX

Please feel free to contact the researcher if you have any concerns about this study

Appendix 7 Participant Information sheet for parents

Participant Information Sheet for Parents

Project Title: Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study

Principal Investigator: Ruth Crawford PhD student, UTS

Supervisors: Professor Jane Stein-Parbury, Professor Denise Dignam

An Invitation

You are invited to participate in a study investigating nurses' experiences, and parents' of a child in hospital experiences, of emotional communication in hospital.

What are the aims of this study?

The aims of this study are: to investigate nurses' experiences of emotional communication with parents of a child in hospital; parents' experience of emotional communication with nurses in hospital, and to examine the environmental and cultural context in which the nurse-parent interaction occurs.

How was I chosen for this invitation?

You are a parent with a child in hospital. All parents with a child in this hospital are invited to participate in this study. Your participation is entirely voluntary (your choice) and if you choose not to take part this will not affect the current care nor any future care your child may receive in hospital.

Where will the study be held and for how long?

This study is being conducted in the inpatient Children's ward at the XXXX District Health Board, over a period of not more than 7 months. Interviews will take place following this period in a venue to be determined.

What will happen in this study?

The researcher is observing nurse-parent interaction in the ward and will be taking written notes following informal chats with parents and health professionals. The researcher will also be observing the general context of the ward setting, including nursing handovers, ward rounds, and accessing patient notes to observe written

documentation related to nurse-parent interaction. The researcher may ask you some informal questions, and/or may observe your interactions. You do not have to answer all the questions, and you may stop the discussion at any time. The observation and questions will take no more than ½ an hour of your time on each occasion. Following this field work period, 12 registered nurses and 12 parents will be invited to participate in interviews away from the ward setting. This interview will be no longer than 1 hour and will be recorded. All researcher notes from observations in the ward, and all recordings of interviews will be stored in a password protected computer or locked cabinet and destroyed after 10 years. No material that could personally identify you will be used in any reports on this study.

What are the benefits of participating in this study?

There may be a greater understanding of how nurses respond to your emotional concerns. You will be participating in a project which will enrich the body of knowledge regarding nursing communication.

What are the risks/inconveniences of participating in this study?

There are no anticipated physical risks as no change to care will be undertaken. The researcher's role is research, not nursing care provider. Discussing your experiences may be uncomfortable for you initially. The researcher is obliged to discuss any unethical/unprofessional behaviour observed to the ward nursing manager.

How will these risks be alleviated?

You have had the study explained to you and can ask questions of the researcher (Ruth Crawford). The researcher has a background in counselling and experience which will allow for stressful situations to be handled sensitively and safely. Referral to appropriate counselling services will be made for anything other than minor distress. This study will have no direct impact on the care of your child, now or in the future. You have the right to withdraw from the study at any time without giving a reason, or withdraw data, without affecting your child's ongoing hospital care. You may have a friend, family or whanau support to help you understand the risks and/or benefits of this study and any other explanation you may require.

What are the costs of participating in this research?

There will be no cost to you as a participant on the ward. If you agree to participate in interviews, transport to and from the venue will be a cost. There will be no payment or reimbursement of expenses incurred. What will happen at the end of the study?

The study will end when the researcher leaves the ward, and completes the interviews with some nurses and parents. The researcher will write up the findings of the study, and document them in a thesis. As a participant you are welcome to view the findings of the study before publication. A summary of the findings will be written

and sent to nurses and parents who are interviewed. The findings of the study will also be published in scholarly journals.

What do I do if I have concerns about this research?

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:
Free phone: 0800 555 050
Free Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Where can I get more information about the study?

You can contact either the researcher or the project supervisors. Contact details below.

Researcher: Ruth Crawford, Registered Nurse,
Napier. Contact phone:

Supervisors: Professor Jane Stein-Parbury, Professor Mental Health Nursing,
Mobile phone: +61 , Faculty of Nursing, Midwifery & Health, UTS Kuring-gai, PO Box 222, Lindfield, NSW 2070, Australia, P +61 2 F +61 2
Professor Denise Dignam, Associate Dean, Teaching and Learning, Faculty of Nursing, Midwifery & Health, UTS, PO Box 123, Broadway, NSW 2007, Australia, P +61 2 9514 4790

This study has received ethical approval from the XXX Regional Ethics Committee, ethics reference number CEN/10/12/063 and UTS Human Research Ethics Committee 2011 027R.

The Director of Nursing and Ward Manager have given permission for this study to be carried out.

Contact details for Director of Nursing: XXXX XXXX, Extension XXX

Please feel free to contact the researcher if you have any concerns about this study

Appendix 8 Participant Information sheet for children

Participant Information Sheet for Children

Project Title: Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study

Principal Investigator: Ruth Crawford PhD student, UTS

Supervisors: Professor Jane Stein-Parbury, Professor Denise Dignam

An Invitation

You are invited to take part in a study about what happens when nurses talk to parents while their child is in hospital. I am a student at the University of Technology, Sydney and I am doing the study in order to get a doctoral degree.

What are the aims of this study?

I want to find out how nurses talk to parents who may be upset because their child is sick and in hospital. It is important that nurses know how to help parents feel better at this time, so I want to find out how they can do this. I also want to know how hospital routines and daily tasks affect how nurses talk to parents.

How was I chosen for this invitation?

You are in hospital and your parent(s) are with you. You don't have to be a part of the study; nothing will happen if you say no and you don't have to give a reason. The nurses and doctors will still take care of you.

Where will the study be held and for how long?

This study is taking place in the ward where you are a patient. I will be doing the study over a 7 month period, although you may not be here the whole time. I also want to talk to your parent(s) after you are discharged from hospital to ask them some questions about what happened when you were in hospital.

What will happen in this study?

I am going to be watching what happens on the ward and taking notes about what I see. I will also be talking to the nurses and parents so that I can understand what they are talking about with each other. Sometimes when the nurses are taking care of you and talking to you and your parent(s) I will be watching what happens. You or your

parent(s) can say whether or not you want me to be in your room and ask me to leave at any time. I won't ask you why and you need not give any reason.

What are the benefits of participating in this study?

It is important that nurses are able to talk to parent(s) in a way that helps them to feel better about having a child in hospital. I may be able to find out how nurses can help parent(s). This may help other children who are in hospital.

What are the risks/inconveniences of participating in this study?

You may feel nervous when I am watching you. I am not going to change any aspect of your nursing care: I only want to see what really happens.

How will these risks be alleviated?

If you feel nervous you can tell me or your nurses or your parents. We will try to help you to feel better about being watched. But remember, you can ask me to leave at any time. Nothing will happen to you if you do.

What are the costs of participating in this research?

You don't have to pay to be in the study.

What will happen at the end of the study?

I will write a thesis, like a book, about the study so that I can get my university degree. If you want I will show you and your parents what I have written. When I write about the study I will not name you or your parents so no one will know who you are.

What do I do if I have concerns about this research?

There are people you can talk to if you are worried about the study. They don't have anything to do with the study. The people you can contact are not your nurses and doctors and are independent advocates: They can be contacted by:
Free phone: 0800 555 050
Free Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

Where can I get more information about the study?

You can ask me or my university teachers about the study. We are:

Researcher: Ruth Crawford, Registered Nurse,
[redacted] Napier. Contact phone: [redacted]

Teachers/Supervisors: Professor Jane Stein-Parbury, Professor Mental Health Nursing, Mobile phone: +61 [redacted], Faculty of Nursing, Midwifery & Health, UTS Kuring-gai, PO Box 222, Lindfield, NSW 2070, Australia, P +61 2 [redacted] F +61 2 [redacted]
Professor Denise Dignam, Associate Dean, Teaching and Learning, Faculty of Nursing, Midwifery & Health, UTS, PO Box 123, Broadway, NSW 2007, Australia, P +61 29514 4790

This study has received ethical approval from the XXXX Regional Ethics Committee, ethics reference number CEN/10/12/063 and UTS Human Research Ethics Committee 2011 027R.

The Director of Nursing and Ward Manager have given permission for this study to be carried out.

Contact details for Director of Nursing: XXXX XXXX, Extension XXX.

Please feel free to contact the researcher if you have any concerns about this study

Appendix 9 Interview schedule

Notes for interviews

All
welcome
participant information sheet - review
sign consent
reminder about audiotaping

RN's

1. Age

2. gender

3. nursing experience

4. highest nursing degree/qualification

5. how long in this ward

6. reason for choosing to work in ward

7. please tell me about your experiences as a nurse in this ward

8. what is it about the ward setting that affects your role as a nurse?

9. When observing in the ward I noticed …

   that nurses were kind and responsive to child's and parents physical concerns

   that most nurses did not ask parents about their emotional concerns

   that most nurses rarely offered emotional support to parents (By 'emotional support' I mean, asking parents how they were coping with what was going on, listening to them, being 'present', being responsive)

10. How do you think that nurses could offer emotional support to parents?

11. How do you offer emotional support to parents?

12. What do you think affects whether nurses do offer emotional support to parents?

13. What helps and what hinders nurses offering emotional support to parents?

14. I also noticed that the ward environment (culture) did not support nurses responding effectively to parents emotional concerns (didn't value it, not role modelled by other staff). What is your experience regarding the culture of the ward affecting nurses emotional support to parents?
15. Why do you think nurses have difficulty acknowledging or addressing parents

emotional communication?

16. What enables…..what hinders…?

Parents

1. Age

2. Relationship to child

3. Age of child

4. length of stay of child; how many stays in this ward

5. Please tell me about your experiences as a parent in this ward

6. What is it about the ward setting that affected you in your role as a parent?

7. When observing in the ward I noticed.....

   that nurses were kind and responsive to child's and parents physical concerns

   that most nurses did not ask parents about their emotional concerns

8. What were your emotional concerns during your child's hospitalisation?

9. How did nurses find out about your emotional concerns?

10. What could the nurses have done to address your emotional concerns?

11. What would you have liked to see happen in relation to your emotional concerns?

12. I also noticed that most parents did not look to nurses for emotional support. (By 'emotional support' I mean asking parents how they were coping with what was going on, listening to them, being 'present', being responsive).

13. Please talk to me about whether you look to nurses for emotional support.

14. If the answer to 12 is yes, how and what was the nurses response?

15. If the answer to 12 is no, who did you look to for emotional support?

16. I also noticed that the ward environment did not support nurses responding effectively to parents emotional concerns (didn't value it, not role modelled by other staff). What is your experience regarding the culture of the ward affecting nurses emotional support to parents?

17. Why do you think nurses have difficulty acknowledging or addressing parents emotional communication?

18. What enables...what hinders...?

Appendix 10 Summary of findings

Emotional communication between nurses and parents of a child in hospital: An ethnographic study

This document provides a summary of preliminary findings of this PhD study. This study commenced in November 2010. Prior to the data collection in 2011 the study was approved by the Faculty of Nursing, Midwifery and Health, University of Technology Sydney; the XXXX Regional Ethics Committee CEN/10/12/063; and the UTS Human Research Ethics Committee 2011 027R.

These findings are presented to the participants in the study; the staff in the ward where the study took place, and nurses and parents who were interviewed individually, to ascertain if these findings are an accurate reflection of their experiences. I would like participants to contact me in order to validate, refute or elaborate these preliminary findings. This further feedback will add another layer/level to the data collected.

The overall aims of the study were to:

- investigate nurses' experiences of emotional communication with parents of a child in hospital;
- investigate the parents' experiences of emotional communication with nurses in hospital; and
- examine the environmental and cultural context within which the parent-nurse interaction occurs

The research questions which guided the study were:

How do nurses respond to parents in hospital who have emotional concerns?

What are parents who are in hospital with their child, experiences of nurses' responses to their emotional concerns?

How does the context of the hospital environment shape the nurse-parent interaction?

Data collection

Prior to the collection of data, I approached the Director of Nursing at a XXX XXX regional hospital in New Zealand. The Director of Nursing and the Ward Manager gave permission for me to gain access to the general paediatric ward in the hospital in order to conduct the study. Data collection began on 17 March 2011, and concluded on 22 November 2011. Data collection involved me visiting the ward 44 times, with each visit being between three and nine hours. In total, I spent 280 hours in the ward. In the ward, data were collected by observation of events and informal conversations with parents and nurses. Following the field work in the ward, I interviewed 10 registered nurses who worked on the ward, and 10 parents whom the researcher had met during field work. Interview times were between 30 minutes and one hour 20 minutes, with the average being an hour.

Preliminary findings

The findings are divided into two main areas; parents' experiences and the nurses' experiences. The environmental and cultural context of the parent-nurse interaction will complete this feedback. Direct quotes from either parents or nurses will be in *italics*.

Parents' experiences

Parents described their initial experiences of the ward as difficult, especially if their child had been ill for some time. Parents were often exhausted when they arrived in the ward and had to *find their bearings,*

> *I think because everything's new and you don't know the place - I suppose you've got to find your bearings to start with and then you're dealing with what's going on.*

This beginning stage of the hospital experience posed many challenges for parents, who were focused on their child's needs, constantly checking their child that their condition was not getting any worse, trying to find their way around the ward, and working out who were all the different people that they encountered. In addition, and often lastly, they had to find time to meet their own basic needs of food, sleep, warmth and comfort. Parents experienced the ward differently: some found the staff or ward friendly and welcoming, while others struggled to cope being away from their home, usual supports and networks.

Some parents perceived nursing staff had a warm welcome for them, even when staff were busy,

> *They've made it very comfortable. Like we - because we're there with* [child's name] *...- you know we're allowed to help ourselves more or less - to things we need. So like things like that have "Staff Only" in - out in the linen cupboards. ...Because we're in there all the time instead of ringing the buzzer we would go*

and just - you know they were - they were happy for us to help ourselves to things like that.

For those parents of children with chronic illnesses who had had multiple admissions to the ward, the environment was so relaxed it felt like a second home, and parents also felt comfortable enough to help themselves to whatever they needed,

You know we know the limits. So things like - go - you can help yourself in the linen cupboard.

For another group of parents, the ward was not the warm and welcoming place others had experienced. These parents did not feel welcome, felt like a hindrance, and struggled with the hospitalisation,

I don't think I got - really got shown around or shown - although - and I don't think they'd asked if I'd been there before either so they didn't know that I didn't know.

These parents did not get an orientation to the ward, and consequently felt like an 'intruder' or an outsider. They perceived themselves to be isolated and felt lonely in amongst the 'busyness' of the ward routine. Not knowing what was required of them, nor their own boundaries in the ward, left these parents worried and insecure. Parents felt they were left on their own to *'just get on with it'.*

After an initial few hours, parents began to find their bearings in the ward. However, anxiety in the first twelve hours of the hospitalisation journey was high for a number of parents for a range of reasons. Worry about their child was a big issue for parents, and parents expected different things from nursing staff at this early time. Some wanted nurses to take over the care from them, and just let the parent recover from the stress of getting the child to hospital safely. Others wanted to be acknowledged as the expert in the child's care and to be consulted regarding intervention and treatment. Some parents expressed concern that their expertise regarding their child's illness was not recognised, and others wanted nurses to respond quickly if the parent expressed concern about their child's health status. Many parents wanted the nurses' focus to be predominantly on the child until the child's condition was stabilised. They perceived that their child's physical health needs were much more important than any need the parent may have had.

Once treatment had begun and the parent knew the plan of care, they felt more relaxed and more ready to settle into the hospital stay. Parents described being informed of treatment options by medical staff and felt they were expected to go along with what was being offered. Parents became resigned to the hospital stay and went along with what they needed to do.

Parents described coping with the unknown. They were negotiating their way through the hospital journey, and for many this was a new life experience and a disturbing one. They had had no preparation for it, and felt they were floundering and alone. Having to cope with the unknown and also translate that to their child was a challenging experience for these parents. As the parents tried to help their child cope, the parent often felt overwhelmed by the enormity of what was happening, for the child, for themselves and for their family unit,

> *And that was unknown yeah. So I think - yeah it was the unknown things that kind of got to me more than....*
>
> *Just the whole not knowing what was going on.*

Parents also described concern about their sudden loss of privacy, *like being in a fish bowl.* As well as the lack of privacy, parents felt that their lives were in the hands of others. They believed that decisions were made about their child (and therefore affecting them) regarding interventions, treatments and discharge that they had little say in, and for many this was a new and strange experience. They were used to being the adult who made decisions about their child, and now those choices were made by others,

> *Like you just feel like your child's - yeah life is in their hands really or health is in their hands.*

Parents' perceptions of nurses

Parents frequently commented on nurses behaviours using superlative words such as *'lovely', 'good' 'great', 'brilliant' and 'fantastic'*. When asked in what way nurses were these things, parents would describe the way the nurse approached them, being friendly, smiling, and willing to go the extra mile, meaning that the nurse would go out of their way to help them. Nurses were perceived to be accommodating of parents' specific needs, and also good at working with children. Nurses were helpful and pleasant, thoughtful, and anticipated the physical needs of the parent and child. Being approachable and willing to help was also a common response from parents.

Nurses were perceived by parents as being easy to talk to and more approachable than other members of the health care team. Nurses were informative, telling the parent what was going on and what they could expect to happen. Parents perceived that nurses communicated well with them, keeping them involved in what was going on the child

However for some parents nurses' behaviours and attitudes did not always meet their expectations. Nurses were perceived to be focused completely on the child/patient, performing interventions such as taking the child's vital signs, or monitoring their intravenous infusion, and not having the time or inclination to engage with the parent. One parent described nurses like this,

> *They're not - maybe they're not really focusing on us but they put their 100 percent focus on the patient.*

Parents felt they would be wasting nurses' time by asking them questions, so refrained from doing so. Sometimes parents felt that they had to work hard to get information from nurses.

Parents' expectations of nurses

Parents had some general expectations of nurses, the most dominant one being a desire to have a personal connection with a nurse. They believed that if they had a connection with someone on the ward, they would feel more comfortable and would feel less isolated and alone, and would feel that they had someone on their side, supporting them,

> *I think it's just being available and chatting. If they stop and chat to you it gives an opportunity. ...If they build some kind of relationship with you.*

> *Yeah it would make a difference because it would make - it would feel like you might have a - a friend or an ally or somebody...on the ward in amongst all the goings on and the patients and all the nurses and doctors backwards and forwards and to feel like you have an ally or a friend that - I don't know maybe that is taking just that little bit of extra attention for you.*

Another expectation was that the nurse would tell them what was going on. They wanted nurses to keep them informed about their child's condition, about what to expect and to tell them about any changes in the child's condition, and also to share with them what the nurse was going to do about their concerns for the child. They did not want to have to,

> *sort of - you know poke and prod and ask questions and find out exactly how bad we were talking about. You know how bad things were before I could sort of feel like I felt control of the situation*.

Parents wanted nurses to be available and approachable enough to ask questions of, and to know their questions would be addressed in a timely manner. Parents talked about wanting to be *'in the loop'*, meaning that they wanted to be included in discussions about their child, including condition, interventions, treatment and

discharge.

Parents' specific expectations of nurses – emotional communication

Parents expected that nurses would be aware and anticipate that parents would have a number of issues in their lives that were affecting them, not solely this hospital admission. Parents discussed the stress of hospitalisation, including being away from other children, being isolated from their close family and supports, especially if they lived in a different town/city/rurally. There was an expectation from parents that nurses would be prepared for parents to have multiple stressors, and be ready to offer emotional and other support as required.

Anticipating, expecting, asking about and then acting on parents' emotional concerns were all expectations parents had of nurses. Many parents expected and wanted nurses to ask them how they were managing with their current situation, and to acknowledge and support their emotional concerns. Parents felt cheated if the nurses did not ask if how they were coping,

> *Yeah I don't recall any - many nurses actually ever asking me if I was okay. "How was I doing?" Considering what was going on.... I don't really recall that.*

Parents expected the nurse would be interested in what was happening for them and that their concerns would be important for the nurse,

> *it doesn't take much when you're standing doing someone's obs* [observations/vital signs]*to say "How are you?"*

Parents explained that when they were stressed in hospital, their stress affected their child. If the nurse addressed their stress, asked them about what was going on for them, the parents believed they would be more effective parents.

> *they* [nurses] *just need to not just take into consideration the child but the parents as well. ... it's not just the child that feel uncomfortable in hospital it's the parents as well. And I mean it's the children that look up to the parents for - you know for comfort and things and if they're stressing out then they can't exactly give the child that comfort.*

From their initial entry into the ward, until discharge, parents struggled to contain and restrain their emotions. Parents talked about trying to *keep strong*, to *not letting go*, wanting to be perceived as coping, and being worried that if they did express their emotions, they may be perceived as being *weak*. Some parents wanted nurses to ask them how they were coping with their hospitalisation, and when they were not asked, assumed the nurses were not interested. Parents then turned to friends and family for

emotional support. Parents noted that if the nurse seemed genuinely interested in them as a person, and made an effort to connect with them, they would feel more inclined to talk to the nurse about their worries. However many parents did not feel that connection, thus were not able to communicate on an emotional level with nurses,

> *We're not fine. We're not fine...I'm not blaming - blaming on the nurse because the nurse will just take as what we say.*

The overriding theme with regard to parents' emotional communication was that parents were *'not fine'* and they wanted to talk to someone about why they were not fine. Parents waited for nurses to take the first step in making that emotional connection with them.

Nurses' experiences

Nurses mainly enjoyed working in the ward describing having *found my niche* and *loving it.* A key element of nurses' experience of working in the ward was the support they received, particularly from their colleagues and nurse managers. Nurses knew they could rely on their colleagues to help them if they needed assistance with any aspect of their work. Being helpful and supportive of each other was part of the ward culture, role modelled by nurse managers and nurses who had worked there for some time.

> *I think we work well as a team and I think - you know like if I get busy doing something there's always people there supporting you and helping out. And I think that's one of the main things that I think is really good which I haven't had in other places I've worked.*

> *It's the most amazing team I've ever worked with. That's why I keep coming back. Some of those girls are my closest friends you know and - you know it's an amazing place to work*.

Nurses were observed supporting each other, checking-in with each other on a regular basis during the shift. This checking-in usually occurred when the nurses met up with each other in the nurses' station or in the clean utility room, where medications are prepared. Nurses would ask each other how they were going; a nurse would tell other nurses about what had just happened (debrief); or would express concern/worry about what might happen. The other nurses would listen and offer advice or support. Nurses described feeling *backed up* and *safe* in the working environment.

Support from the nurse managers, particularly the Charge Nurse was also evident. The Charge Nurse was a *hands-on* manager, who preferred working on the ward with staff,

children and families, rather than being in her office doing paperwork. The Charge Nurse was highly visible in the ward, meeting all the parents and children each morning, and then frequently being present in the nurses' station.

Parallel to the supportive nature of the ward, most nurses described the ward as a *great place to work*. Nurses were unanimously agreed that they enjoyed the working environment and the ward.

Nurses described the ward being *fun, awesome, cool,* and *great*.

The population the nurses were working with, particularly the children, increased nurses' enjoyment of their work. Nurses liked the way children got well quickly, and the rapid nature of their recovery,

> *Seeing how kids improve so quickly and how you can see a really unwell kid one day and then 24 hours, 48 hours later they're back to their normal selves according to the parents.*

Nurses also described enjoying having time with the child's immediate and extended family. Nurses liked being able to work with the family, to educate them about the child's condition and parenting issues. They also liked being able to *'reassure'* parents.

Nurses' relationships with parents

When the nurse was allocated the child for whom to care, there was awareness that the parent would also be involved in the nurse-patient relationship, although the level of involvement the nurse expected of the parent was variable. For some nurses the *family* was the patient, yet for others the parent was an add-on to the nurse-patient relationship, sometimes easy, but other times fraught. The nurse-parent relationship in the ward was consistently tempered by the reality that there was also a child involved in the interaction. Nurse-parent communication usually occurred in the presence of the child, and almost always revolved around the child. The focus of the nurse-parent interaction was the child,

> *I think we just tend to focus on the child and see the parent as a - off - you know a separate part of the child. Not as an - an individual that we need to be caring about as much as the child.*

When working with the parent, the nurse understood that she or he had a variety of roles, from explaining the care offered to the parent, to assisting the parent meet the child's needs, and ensuring that the parent was physically able to provide care for the child. Nurses valued the input the parent was able to provide in supporting the child to

get well, they recognised that the parent knew their child best, and they worked hard to listen to the concerns parents had about their children. Nurses wanted to work alongside the parent, with the combined goal of improving the child's condition.

A major focus for the nurses was on parents' physical needs. If it became apparent that the parent was going to be staying in the ward, the nurses' gaze would move from the child's physical needs towards the parent's physical requirements.

I think we are very responsive to physical needs which I think is really important.

Nurses were well aware that if the parent was not well rested, their hospital stay, and their support of their child would be compromised. Nurses also understood that if the parent was functioning well, the nurse's life would be *easier,*

Like if you're sending mum out for breaks you're giving her a bit of - your - your - it's actually easier for us because having the mother having a break makes her - or parent – dad, caregiver whatever is calming them down, putting them in a better - a peace - a mind space. And it helps us.

Nurses were aware that having enough sleep and food helped parents cope emotionally with the situation the parent was in.

For some nurses, establishing a rapport with the parent was an important part of their work as a nurse. They wanted the parent to feel comfortable with them, mainly to tell them what was going on with the child. They were however resigned to the reality that they would have a good rapport with some parents, but not all. Nurses seemed to get on with parents who they perceived as similar to themselves, for example if the nurse and parent were of similar age, gender or ethnic group; or had had similar parenting experiences, there was a stronger rapport,

I've had the parents that I'm sort of like I can see that this is not going to be a great relationship from the beginning. But as I said it's - we're human. We don't get on with everybody.

Some nurses worked to establish a rapport with parents, realising that when the nurse and parent had an open relationship, the nurse would have a better understanding of the child's issues. Nurses mainly wanted an effective rapport with parents in order to care more effectively with the child. It was also apparent that nurses enjoyed the relationship more if they '*got on'* with the parent. The interaction would be more likely to be friendly and satisfying for the nurse.

Nurses' perceptions of parents were haunted by previous experiences of parents who were perceived as '*difficult*'. These parents might not have agreed with interventions and treatments offered, or may have challenged the hospital systems, or have been unhappy and unpleasant, and in the worst case scenario were violent and abusive. All nurses had worked with parents like this, and if they had not had personal experiences of violent, abusive parents, had heard first-hand from colleagues who had, and therefore were prepared for this behaviour.

Nursing interactions with the child and parent were usually initiated when the child needed a task completed, such as having their vital signs (temperature, pulse, respirations, oxygen saturation) measured and recorded, or medications administered, or their intravenous fluids checked, or a dressing checked, or post-operative assessment. When the nurse entered the patient's room, or bed space, the nurse would quickly move into the task, usually talking to the child and explaining what she or he was doing, and sometimes acknowledging the parent at the bedside by saying hello and stating what she was going to do. The nurse would then complete the task and gather equipment if used and prepare to leave the space. Often the nurse would ask the parent to '*just ring the bell* [call bell] *if you need me',* then leave the room.

Focusing on the task when with the child and parent meant that the nurse spent little time interacting with the parent. Nurses were absorbed and attentive to the child's needs, to the point of excluding or not noticing the needs of the parent.

This focus on the child meant the parent was often the odd-one-out in the nurse-child-parent triad. The parent was an add-on, an extra in the relationship, mostly valuable but sometimes a hindrance. Nurses wanted to '*get on'* with the parents, they wanted parents to assist them by providing family care for the child, and they wanted parents to cooperate with the interventions offered and assist the nurse as required. The nurse wanted to see the child improve and return to their own lives as quickly as possible, and perceived that parents would want that too, and that the parent would actively work with the nurse to meet that goal.

Nurses' experience of emotional communication with parents

Communication between nurses and parents which focused on parent's feelings and affective responses related to their child's hospitalisation was rarely observed in the ward (but could have happened away from my view/observations). The nurses' gaze was mainly focused on the child. Parent's physical needs were anticipated by nurses;

however their potential emotional concerns were not. However nurses had some understanding of why a parent may be emotional in hospital. Reasons included: being concerned about their child; feeling guilty or upset about the child's illness and hospitalisation; feeling isolated from their child; concerns about other family members.

Some nurses also demonstrated an ability to detect parents' emotional state. Nurses described a range of cues and signals that indicated to them that the parent was feeling emotional. These included noting that the parent was tearful and frustrated; to the way the parent presented, their demeanour; to noticing the parent was on edge and aggressive.

When a nurse detected a parent was feeling emotional, she or he would usually respond in some way. The more overt the parent's emotional communication, the more likely it was that the nurse would respond. Positive response to emotional communication included trying everything the nurse could to 'fix' the parent's presenting concern; encouraging the parent to take a break, have some food and offering to care for the child; to suggesting the parent had a shower and a '*good cry';* to suggesting the parent talk to the ward social worker, or a doctor; or encouraging the parent to contact a family member.

A further frequent response by nurses to emotional communication was to give the parent information. The information could include what was going on for the child currently; what may happen (anticipatory guidance); or what the nurse was doing and why. The information would be given immediately the nurse detected parent's emotional communication. Nurses understood that parents were emotional because they did not understand what was happening for their child, or they were anxious for their child,

> *You know I make sure I spend time to try to explain things in terms and things tha they will understand because we will quite often find on a ward round the doctors will come in, talk, decide things, leave and the parents have no idea what the doctors have said.*

Nurses also described and were observed reassuring parents who were emotional. Nurses would comfort the parent, and offer reassurance that the situation will improve. Reassurance was also frequently cited in nursing documentation as a response to parents' emotional communication.

However nurses did not always respond positively to parents' emotional communication. It was apparent that nurses were wary of parents' emotional communication. Nurses ideally wanted parents to feel comfortable in the ward, and to

be able to cope with the demands of being a parent in the ward. Nurses felt uncomfortable when there was an indication that parents were experiencing difficulty being in the ward. Nurses described not wanting the parent to *'break down'.*

Nurses also described feeling inadequate and nervous when confronted with parent's emotional communication. They felt ill-prepared, overwhelmed, and did not know what to say or do,

> *it was hard because as I say I felt - I felt - I felt useless to the parents because I was like - I feel like I can't do anything...I don't know what I can do. I just felt useless to them... I was overwhelmed.*

> *I sometimes feel helpless that I don't know what to do.*

Some nurses described feeling taken aback and worried about what was going on. They felt out of control of the situation and were anxious about what may happen,

> *I was taken aback because I wasn't expecting anything like that. I was nervous and then I was real worried that maybe I had missed something or something had gone wrong so then I was worried about what my practice and what I'd done.*

Other nurses described *'sweeping emotional communication under the carpet'*, because it was '*difficult'* and *'uncomfortable'.*

It was obvious that when a nurse was confronted with emotional communication from a parent, the nurse responded in some way, as described. However in their daily activities, nurses did not generally anticipate nor initiate any communication with the parent that may involve finding out about the parent's emotional state. When the parent was sitting with their child, the focus of the nurse was on the child's needs first, then the parent's physical needs. Nurses avoided emotional communication with the parent. When nurses were asked why they avoided emotional communication they had a wide selection of responses: perceiving the parent did not want to talk to them; the physical layout of the ward inhibiting the discussion of emotional concerns; worry about *harassing parent, being invasive;* the busyness of the ward; the emotionally draining aspect of working with parents and fear of what the nurse may find,

> *I think it's easier not to lift the lid...because you don't know what's going to unravel... But you know like I think - yeah I think people think "what's going to pop out from under that lid?"*

Avoiding emotional communication was the norm in the ward. Unless the parent was outwardly demonstrating their emotions, nurses would not ask the parent about their emotional state,

we don't really approach the emotional stuff unless - yeah it's in our face or if it's a chronic child and you get to know them that well that they freely open up about that to you without - without us asking.

It was apparent that parents wanted to have a connection with a nurse, and expected that the nurse would be interested in how the parent was coping with their situation. Parents wanted nurses to make an effort to connect with them, on an emotional level. Nurses enjoyed working with parents and wanted to work alongside with the parent, with the combined goal of improving the child's condition. Nurses were aware of the difficulties parents experienced when in the ward with their child, and were able to pick up cues that suggested the parent was feeling emotional. When the emotion was overt, nurses responded positively in a variety of ways, including giving information and reassurance. However nurses were unwilling to approach the parent about their emotional state, and described feeling inadequate and uncomfortable.

The environmental and cultural context of parent-nurse interaction

A primary focus of this research was to ascertain what was going on in the children's ward, what was taken-for-granted, and to examine how the cultural environment shaped and influenced nurse-parent interaction, especially when the parent was emotional.

The ward is a calm, quiet environment, the hub of which is the nurses station where most staff interaction occurs. Parents are moving in and out of patients' rooms and in the corridors. Nurses congregate in the station, meeting with parents mainly when they go to the child to provide nursing care. Nursing care most often performed is measuring and recording the child's vital signs (*observations*), which includes the axilla temperature, heart rate, respiration rate, and pulse oximetry. The next most frequent nursing intervention is giving medication, or checking patient's fluid status. Nurses rarely ventured into a patient's room without the pretext of an intervention on the child.

Nurses are free to move freely around the ward, as they wish. They enter the ward for their eight hour shift and leave on completion of the duty. For many nurses the ward is like a second home, they know it so well, have been in the ward for a number of years, and feel very comfortable with most aspects of it.

Parents have a different view. Their movements are restricted; governed by many signs telling them what they can and cannot do; as well as signs advising them on their parenting styles, and their personal lives (smoking, family violence). The many signs in

the ward give the indication that nurses are in charge and in control. Some parents feel confined, and restricted; which add stress to an already stressful situation, having a sick child in hospital.

There is incongruence between the Family Centred Care model under which nursing care is structured and the reality of the ward which is that the parent is a visitor and is required to behave in a way prescribed by the hospital 'system'.

The environment of the ward is child friendly with the use of bright colours, toys visible, distractions in the form of posters, music, and televisions. For parents, however, there is an unstated expectation to 'fit in', cooperate, and parent their child without fuss. They have to do this in an environment where their own basic needs are difficult to meet.

It became apparent that nurses are the brokers of the ward, the keepers of the knowledge, those who 'allow' or 'disallow'. Parents are the outsiders, the 'other', forever trying to be 'in' and accepted, but destined to always stay on the 'other side'. A number of factors contribute to this state of being: the relative recency of parents being encouraged to stay with their child in hospital; the overriding medical influence and power still pervading the hospital; the ward space being a place where one group of adults work daily (nurses), and another group of adults only enter when required (parents); the difference in knowledge about the child's condition – nurses know more than parents about their child's medical condition, which leads to a power imbalance. All contribute to the vulnerability of parents and the permanency of nurses. Nurses know where they are going, what they are doing, and what they are expected to do. Parents do not have this knowledge: they feel lost, adrift, out of control and as though they are *treading water.*

Thank you
I would like to thank all the ward staff who welcomed and accepted me for 4+ months, listening, observing, following, and asking questions. You are an amazing team of people and I was privileged to spend time with you.

A thank you too, to the parents and caregivers in the ward who shared their experiences of being in the ward with me.

I would also like to thank the 10 nurses and 10 parents who gave up their time willingly to share their experiences with me.

I am truly grateful. I welcome your feedback on these preliminary findings.

Ruth Crawford

PhD student

September 2011

Contact details: [redacted]@paradise.net.nz or [redacted]

You can also contact my Supervisors:

Jane Stein-Parbury

+61 [redacted]

jane.stein-parbury@uts.edu.au

Denise Dignam

Denise.Dignam@uts.edu.au

Appendix 11 Flier advertising presentation of findings in ward

You are invited to a Presentation of preliminary findings of research study into Emotional communication between nurses' and parents' of a child in hospital

In 2011 a research study was conducted in this ward.

Nurse-parent communication was observed.

Preliminary findings will be presented to ward staff to check whether these findings are an accurate reflection of experiences.

When? Tuesday 25 September 2012

When? 3pm

Where? Nurses' station in ward

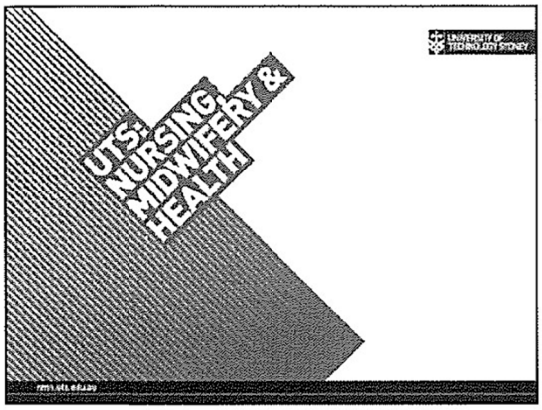
Please come along and give your feedback to the findings.

Ruth Crawford, PhD student at the University of Technology Sydney, Australia, under the supervision of Professors Jane Stein-Parbury and Denise Dignam
Telephone: 06 974 8000 Ext 5401
Cell phone:
Email: @eit.ac.nz

The Director of Nursing (XXXX XXXX, Extension XXX) and Ward Manager gave permission for this study to be carried out.

This study received ethical approval from the XXX Regional Ethics Committee, ethics reference number CEN/10/12/063

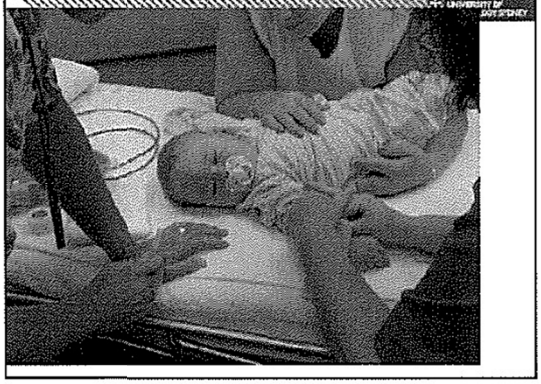
Appendix 12 Presentation of findings in ward



Emotional Communication between nurses' and parents' of a child in hospital

An Ethnographic Study

Ruth Crawford
Professor Jane Stein-Parbury
Professor Denise Dignam



Preliminary findings

- Presented to all participants in study
- Staff in the ward
- RN's and parents/caregivers who were interviewed
- Opportunity for you to validate, refute or elaborate on these findings
- Further feedback will add another layer/level to the data collected

Aims of study

- Investigate nurses' and parents' experiences of emotional communication in hospital
- Examine the environment and cultural context within which the parent-nurse interaction occurs

Parents' experiences

- Difficult, exhausting, had to *find their bearings*

  I think because everything's new and you don't know the place - I suppose you've got to find your bearings to start with and then you're dealing with what's going on

- Focused on child's needs; working out who all the people were; meeting their own needs (food, sleep, warmth, comfort)

Initial experiences

- Staff made it comfortable, warm welcome
- Knew the limits
- Felt like a second home, help themselves to what they needed (parents of children with chronic illnesses)
- Did not feel welcome
- Felt like a hindrance
- No orientation
- Felt like an intruder/isolated and lonely amongst busy ward
- "got on with it"

1st 12 hours

- High anxiety
- Worried about child
- Wanted nurses to take over care
- Be acknowledged as expert in child's care
- Expertise recognised
- Nurse to respond quickly to their concerns
- Nurse focus on child

Hospitalization

- Coping with the unknown
- Overwhelmed with enormity of situation
- Loss of privacy, *like being in a fish bowl*
- Others making decisions for them
- *Your life is in their hands*

Parents' perceptions of nurses

- *Lovely, good, great, brilliant, fantastic*
- Friendly, smiling, helpful, willing to go extra mile, go out of their way to help
- Accommodating, good at working with children
- Easy to talk to, approachable
- Informative, keep parent involved

Parents' perceptions of nurses

- Focussed on child
- No time or inclination to engage with parent
- Feel they are *wasting nurses time* asking questions

Parents' expectations of nurses

- Personal connection with a nurse to feel more comfortable and less isolated

  I think it's just being available and chatting. If they stop and chat to you it gives an opportunity. ...If they build some kind of relationship with you
- tell parent what is going on, be *in the loop*

Parents' expectations of emotional communication

- Anticipate , be aware and prepared for parents to have issues that affect them emotionally
- Ask parents about their emotional concerns, how they are managing their situation, acknowledge and support them

  it doesn't take much when you're standing doing someone's obs [observations/vital signs]*to say "How are you?"*

Parents experience of emotions

- Struggled to *keep strong*, not *letting go*, to be perceived as coping
- Worried that if they did express their emotions, may be perceived as *weak*
- If nurse was interested in them and tried to connect, they would feel more inclined to share emotional communication

  We're not fine. We're not fine...I'm not blaming - blaming on the nurse because the nurse will just take as what we say.

Nurses' experiences

- Love working in the ward, *found my niche*
- Team support, *backed up and safe*
- *Great place to work*
- *Fun, awesome, cool, great*
- Like seeing children improve quickly
- Enjoy working with parents, educating, reassuring

Nurses' relationship with parents

- Level of involvement of parent variable
- **Either** *family* was patient
- **Or** parent was an add-on in nurse-patient relationship
- Nurse-parent communication in presence of, and revolves around child

  I think we just tend to focus on the child and see the parent as a - off - you know a separate part of the child. Not as an - and individual that we need to be caring about as much as the child.

- Nurses want to work alongside parent, improving child's condition
- Focus is on parents' physical needs – rest, break, food
- Get on with some parents more than others
- If nurse and parent were similar, more likely to be a rapport

- Interactions with parents when child needed task completed
- Nurse absorbed with child's needs
- Aim was to get on with parent, for parents to assist in providing family care for child, parents to cooperate and help

Nurses' experience of emotional communication with parents

- Nurses had understanding of why parent may be emotional in hospital: concern about child; feel guilty or upset; isolated from child; concern about other family members
- Nurses can pick up cues parent is emotional: tearful and frustrated; presentation and demenour; on edge and aggressive

Nurses' response to emotional communication

- Try everything: take a break; food; respite care; have a shower; talk to ward social worker; contact a family member
- Give parent information
- Offer reassurance

Nurses' response to emotional communication

- Did not want parent to *breakdown*
- Felt *inadequate, nervous* and *overwhelmed*
- Felt *helpless*
- *Taken aback and worried*
- *Swept emotional communication under the carpet*
- *Difficult and uncomfortable*
- Avoided emotional communication

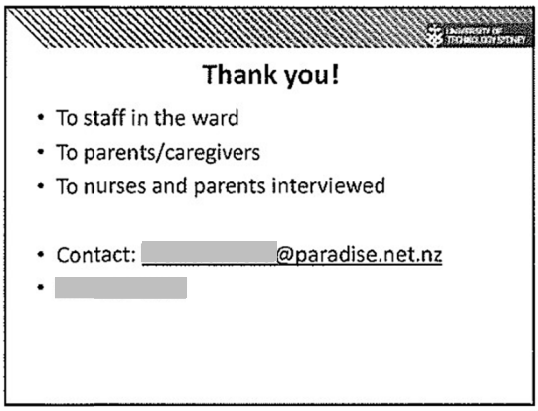
Why?

- Thought parents would not want to talk to nurse
- Physical layout of ward inhibited discussion
- Fear of what may find
- Worried about harassing parent, being invasive
- Busyness of ward
- Emotionally draining

I think it's easier not to lift the lid...because you don't know what's going to unravel... But you know like I think - yeah I think people think "what's going to pop out from under that lid?"

we don't really approach the emotional stuff unless - yeah it's in our face or if it's a chronic child and you get to know them that well that they freely open up about that to you without - without us asking

- Parents want a connection with a nurse
- Parents expect nurses to ask them about their emotional state
- Nurses enjoy working with parents and want to work with them for child's benefit
- Nurses aware of parents' stressors and can detect parents emotional state
- Nurses response when parents are overtly emotional – information and reassurance
- Nurses avoid engaging with parents on emotional level – feel inadequate and uncomfortable


Thank you!
• To staff in the ward
• To parents/caregivers
• To nurses and parents interviewed
• Contact: [redacted]@paradise.net.nz
•

Appendix 13 Consent form parents and nurses

Consent Form

Project title: Emotional communication between nurses' and parents' of a child in hospital: An Ethnographic study

Project Supervisors: Professor Jane Stein-Parbury
Professor Denise Dignam

Researcher: ***Ruth Crawford***

Request for interpreter

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakdewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Sāmoan	Out e mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania kin a gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

- ○ I have read and understood the information sheet dated 18 February 2011 for volunteers taking part in the study designed to investigate nurses' and parents' of a child in hospital experiences of emotional communication in hospital. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- ○ I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.
- ○ I understand that taking part in this study is voluntary (my choice), and that I may withdraw from this study at any time and this will in no way affect my employment/child(s) continuing health care.

- ○ I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
- ○ I have had time to consider whether to take part in the study.
- ○ I know who to contact if I have any questions about the study in general.
- ○ I would like the researcher to discuss the outcomes of the study with me

  Yes○ No○

I (full name) hereby consent to take part in this study.

Date _____

Signature _____

Full name of researcher Ruth Crawford

Contact phone number for researcher [redacted]

Project explained by: _____

Project role: _____

Signature: _____

Date: _____

Appendix 14 Non-disclosure form – transcriber

UNIVERSITY OF TECHNOLOGY SYDNEY

Non-disclosure form

Undertaking as to Non-Disclosure of Information

Whereas, I Jodie Patricia Cawtherne

currently residing at [redacted] Road, Albany

have agreed to transcribe the digital sound files made during informal and formal interviews by Ruth Crawford, for the purposes of a research project. As part of the transcription process, I will hear names, and other forms of identification of person/persons.

I agree that I will not, at any time, directly or indirectly share or divulge any information concerning the identification of the participants, and/or identifiable persons, and/or identifiable institutions to which I have been given access.

I agree that I will store the digital files in a password code locked file/disk, known only to myself, and the researcher Ruth Crawford.

I understand that only Ruth Crawford, the principal investigator, and Professor Jane Stein-Parbury, and Professor Denise Dignam, Research supervisors will be allowed access to the digital files, and subsequent transcriptions.

I also undertake that I will not at any time, either directly or indirectly, divulge to any department, agency or institution, information to which I have been given access.

Signed: Production Note: Signature removed prior to publication.

Witnessed by: Production Note: Signature removed prior to publication.

Designation of Witness: Neighbour

Date: 12-6-2011

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