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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.”

Signed_____

Julianne Hall.

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I am grateful for the opportunity of being involved with nursing the two children who were the beginning of this research project.

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Ethics committees

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Abstract

Grounded theory methodology has guided the grounded theory methods used to explore the acute care paediatric nurses' perspective of what they do when a child has had a severe accident. The research was initiated from the experience of nursing children in the context of a rehabilitation centre and wondering how acute care nurses promoted a child's recovery after a severe unintentional injury.

Many avenues were used to search international and New Zealand literature but the scarcity of literature related to what acute care paediatric nurses do was evident. Therefore this research has the potential of informing the speciality practice of acute care pediatric nursing.

Nursing children in the acute care ward after a severe accident is complex. It encompasses nursing the family when they are experiencing a crisis. It is critical that the acute care nurse monitors and ensures the child's physiological needs are met, and the nurse *"works with"* the child to maintain and advance medical stability. Nursing interactions are an important part of *"working with"*, communication is the essence of nursing. This research has focussed on the nurses' social processes whilst caring for the physical needs of the child and interacting with the family and multidisciplinary team when appropriate.

An effective working-relationship with a nurse and family is founded on trust. Trust is an accepted part of our day-to-day lives and how to develop a trusting working-relationship with the child and family has not been explored prior to this research. Grounded theory methods supported the process of exploring the social processes of *"building trust"* whilst *"working with"* families in a vulnerable position.

Nurses rely on rapport to be invited into a family's space to "*work with*" and support the re-establishment of the parenting role. The *"stepping in and out"* of an effective working-relationship with a family is reliant on trust. Nurses build trust by spending time to *"be with"*, using chat to get to know each other, involving and supporting the family to parent a "different" child and reassuring and giving realistic hope to help the child and parents cope with their changed future.

A substantive theory of the concept of "*building trust to work with*" has been developed using grounded theory methods. The theory has been conceptualized using the perspective of seven registered nurses working in paediatric acute care wards that admit children who have had a severe traumatic accident.

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CHAPTER ONE: The Background

> *"accidents will occur in the best-regulated families"*
> *said Mr McCawber in David Copperfield by Charles Dickens* (1850/1991, p. 413).

The background to this research is both personal and professional and is firmly embedded in the history of paediatric nursing in New Zealand. In this chapter I will begin with personal reflections on the development of my interest in exploring what acute care nurses do when they care for a child after a severe accident. I will include a brief case presentation of the children who influenced this research. I will then move from the personal to a wider review of the relevant statistics of unintentional accidents to children, the history of nursing children, and in particular those children admitted to hospital as a result of an unintentional injury. I will conclude by explaining the choice of methodology and by defining the way that I use the terms "traumatic accident" and "family" in this thesis.

Reflections

This research project began and was developed because of who I am as a researcher, nurse, teacher, and human being. When caring for children who had had debilitating accidents, I often questioned in my mind what could have been done earlier or what could be done now to benefit the rehabilitation and future of these children. My concern for the future development of the injured child influenced the way I coached student nurses when nursing a child after an accident that has severely impacted on the child's life.

I often questioned whether looking ahead and considering a child's future underpins all nursing practice. Common sense tells me that if nurses consider the

future abilities of the child in their care, those considerations would be demonstrated as nursing actions to promote the child's future health and independence. I do not know what acute care nurses do when they care for children who have had an accident; I can only assume from my own nursing experiences. The "wanting" to do something to give children the opportunity to have the best possible life following a severe traumatic accident has become an important issue for me. An issue I want to explore. The exact focus of this research, however, has taken several years to come to fruition.

The Beginning

Some years ago as an educator of nursing students, I was in a unit for children with disabilities. My thoughts and nursing interactions were guided by the need to make each child able to have a future where they would be as independent as they could possibly be. I had not previously experienced nursing in a service like this. This was a time of learning with the students and the impact of that experience will always be with me. It was a challenge to work with school-age children whose development was impaired by their inability to express their needs or to experience play. The students learned to work with the children using physical activities, play and social interactions to help them reach another milestone in life. The inescapable comparison with my own healthy children alerted me more to the devastating effect of a severe accident on the future of the child and the whole family.

Two particular children had the greatest influence on the beginnings of this research. They were unable to spread their life experiences beyond a limited context. They seemed aware that their bodies could not do what they wanted. I felt they were trapped, confined, restricted and unable to grow and develop further, atrophied like

the cramped roots of a growing plant in a flowerpot. I have called these children Bill and Ben, referring to the “flower-pot men” from children’s television.

> *Bill had left for school and it was like any other day, except this one ended differently as he was hit by a car when crossing the road, and this resulted in a serious head injury. I met Bill several weeks after his injury when he was transferred to a unit that provided long-term care and therapy to promote recovery. Bill was able to communicate through sounds and behaviours; he was able to transfer from bed to chair quite well. He could only stand on his tiptoes as his tendons had contracted so that his feet were always pointed like a ballerina’s. The time came when the therapists wanted to start to teach Bill to walk again. He could not do this without corrective surgery that delayed his recovery process for another two months. I knew this was detrimental and hindering his long-term recovery as the earlier the interventions are started with a child who has had a head injury, the better. I also knew that the muscle contractures could have been reduced, in fact prevented, with regular passive exercises in the acute phase of his care. Something needed to be done to promote the well-being of children like Bill in the acute phase of care.*

Bill’s health issues certainly made an impression on me and then I looked around at others in the unit. I had already met Ben but now took more notice of him. Apparently Ben had been in this unit for a long time. I had been teaching for several years and I recalled a young boy who was always alone at the end of a ward in the local hospital. I was never involved with his care. It was noticeable that nurses seldom went into his room. He was always peaceful in a clean tidy bed. Several months later he was no longer there, and I now recognized Ben as the same boy.

> *He was unable to share conversation, but certainly able to tell me what he liked and disliked and was obviously aware of his surroundings and of people. He seldom saw his Dad but when he did, he would have run into his arms if he was*

> *able. The excitement and delight were clearly apparent. His intelligent brain was locked into a body that wouldn't do what he wanted it to do. I felt that if Ben had had the appropriate nursing and therapeutic interventions in the acute phase of his care, his outcome would have been better. His response to therapy would have given him greater independence. The students and I were able to teach Ben to feed himself. This was five years after his accident; the results would have been quicker and long-lasting if Ben had been re-taught daily living skills earlier. We were able to stand transfer him from bed to chair easily; he trusted us and was willing to make the effort. Ben knew who he could trust and he would not help those caregivers whom he did not trust. Any progress that Ben made with the students and me would regress when we weren't there. This was frustrating to me. I don't know if it was frustrating to Ben but he was always pleased to see us. He never did improve; he was never given the time and the reasons behind this were probably related to the context of the nursing environment in both the acute and long-term care units, or was it because no one thought about his future?.*

Other children passed through this unit. It became evident that the children with a member of their family constantly involved with their therapy progressed and gained an independence that others did not. Their level of independence did not seem to result so much from the severity of the accident, as from the time the parent gave to work with their child. They wanted their child back and they worked their children very hard to prevent greater complications to their physical and developmental well-being. These parents had been an integral part of their children's care in the acute and long-term units. They questioned, they read and learned about their child's needs, and they were very strong advocates for their child in a system that did not always appreciate such power. Unfortunately all parents do not have the ability or resources to be able to be so involved.

Since this significant meeting with Bill and Ben, it has taken me several years to get to the stage of beginning this thesis. Originally I wanted to research the lived

experience of children and their families after the child had had a severe head injury. My own children were young adolescents and there was always someone in the family who was a new driver. The fear of them having an accident resulting in a head injury was my nightmare. I could not go there. I feared I was preparing myself for reality. From the nursing perspective, I had developed a passion to learn how nurses could be more influential on the outcomes for these children, so I left the lived experience of families behind and decided to discover what acute care nurses do when they care for children who have had an accident.

This research is the beginning. I was unable to find in the literature any research describing what nurses in the acute setting do when they care for children who have had an accident. Thus the researching of what nurses do in this particular setting was of interest to me. I have used grounded theory methodology to ensure that I discover what they do, not what I think they should do, or what I think they don't do.

Incidence of Unintentional Injuries to Children

The Ministry of Health acknowledges that "long-term disability and disfigurement are significant consequences of childhood injury" (1998b, p. 49). The advancement of medical intervention and technology has resulted in ways of preventing death from physical trauma but has led to greater consequences for the survivors of severe trauma and provision of nursing care (Melvin, Lacy & Swafford-TenEyck, 1998). Increased survival has required an increased focus on the development of paediatric acute care and rehabilitation services.

Childhood accidents have reached epidemic proportions in the industrialized world. The increased opportunities for children to have an unintentional injury have increased with the materialistic changes to our environment. There are taller buildings, more motor vehicles, and increased risk-taking activities such as trampolining and skateboarding. Children have less supervision now that many households require two incomes to meet the needs of their developing children. Children, unsupervised while parents work, may be significantly at risk of unintentional injury because their age and stage of development limit their awareness of the possible consequences of their actions.

There are no available statistics indicating the impact of accidents on the child's future growth and development. The increased survival from unintentional injury suggests that a higher number of children would be using or gaining access to clinical health care services. New Zealand's mortality rates from unintentional injuries are higher than other developed countries, twice as high as Australia and three times higher than England (Ministry of Health, 1998a; Safekids, retrieved, 2003). The statistics from 1990-1999 collated by the Injury Prevention Research Unit, Otago University, indicates that unintentional injury to children represents 34.4% of hospitalizations of children under 15 years in New Zealand. Of these, 45% resulted from falls, 7.6% from traffic accidents where the children were pedestrians or cyclists and 7.1% resulted from motor vehicle crashes (Injury Prevention Research Unit, retrieved October 12, 2003). Accidents are the second leading cause of children's hospitalization, with nearly 17000 children being admitted to hospital as a result of an accident in 1995 (Ministry of Health, 1998a).

The History of Children's Hospital Services

In 1959 the Platt report was published in the United Kingdom. It related to the needs of hospitalized children in England. In this section I will review the impact of the Platt report on the provision of health care services for sick children in New Zealand. The recommendations of the Platt report influenced a later review of children's hospital services in New Zealand. The review was reported by McKinlay in 1981. The recommendations of the Platt Report resulted in change from the extreme of very limited and regimented parent involvement with sick children to the expectation that a mother would stay with her child in hospital. Historically it was considered that a child's health would improve if nurses and doctors cared for them away from their families. Later, the recognition of fretting when parents left and the risk of infection were deemed detrimental to the child (Alsop-Shields & Mohey, 2001). Prior to the Platt Report, Doctors Cecily and H. P. Pickerill from Dunedin pioneered "rooming in" and encouraged parents to be involved in the care of their hospitalized child, but they were unable to influence change in the health care services beyond Dunedin (McKinlay, 1981). The Pickerills lacked the theoretical and scientific basis that enabled John Bowlby, in particular, to influence the provision of health care services for children.

Bowlby's theory of maternal deprivation was controversial and challenged by other scientists for its accuracy and lack of rigour. It had an influence on the recommendation of the Platt report that mothers were to be more involved with their children in hospital but the communities of the western world needed to understand Bowlby's theory. James Robertson, an Englishman, believed in Bowlby's theory. He

and his wife became the evangelists and went to the communities to share their beliefs (Alsop-Shields & Mohey, 2001; Darbyshire, 1993a).

McKinlay (1981) researched the background of New Zealand's hospital services for children. Her findings have been incorporated into this outline of the history supporting parents to be involved in caring for their sick child. The implementation of the Platt report in New Zealand was helped by a visit from James Roberstson. The New Zealand Parents Centres (NZPC) stimulated public pressure to influence the then Health Department to implement the Platt report. The NZPC supported the Robertsons to come to New Zealand in 1974. The Robertsons shared their views of John Bowlby's theory and the recommendations of the Platt report in a seminar on "Children in Separation". Their views and the films of deprived children affected the audiences who gave the support NZPC needed to continue to lobby for services where mothers could tend to children in hospital. Wider communities in New Zealand then backed the NZPC.

The investigation of services for sick children in New Zealand was publicized in the McKinlay report (1981). McKinlay's report has underpinned the structure of paediatric services in New Zealand in the last two decades. McKinlay completed "a descriptive survey of the public hospital paediatric facilities and services in New Zealand" (p.16). The Platt report had not been considered when planning the building boom of our hospitals in the 1960's and early 1970's. The hospitals lacked purpose-built children's wards in those modern ward blocks. The findings of McKinlay's survey of New Zealand hospitals and the subsequent report received in 1981 led to a more rapid implementation of hospital services that met recommendations within the Platt report.

The proposed development of an environment in the hospital and home favouring the ongoing recovery of the child initiated a change to the delivery of care to children in hospital. The findings from McKinlay's report guided future plans of the Health Department for children's health care services. This was timely and prior to the planning of a children's hospital that would provide national speciality services. The centralization of services influenced the development of the national children's hospital (Manchester, 1997). The hospital, completed in 1991, is situated in Auckland, New Zealand's largest city. Included in the central services is the Paediatric Intensive Care Unit (PICU) where a high proportion of New Zealand's children with severe trauma are initially admitted. Other city hospitals in New Zealand have smaller PICU units or children's beds within an adult intensive care unit.

The report also recommends that health care services for children need to be close to a child's home to reduce disruption to the family (McKinlay, 1981). This recommendation was not acknowledged with the centralization of complex health care children's services in New Zealand. The small population of New Zealand hinders replication of expensive services. The centralized services have considered some of the needs of families and provided comfortable accommodation for them when their child is hospitalized.

Children are not hospitalized for periods of time longer than is necessary for the best possible recovery. The admissions of children to hospital have been reduced with the recognition that children regain their health better in the environment of their home and family. Children are discharged from hospital earlier for the same reason. The development of specialist paediatric nurse services in the community support

families to care for their children at home. These services developed after preparatory education programmes for registered nurses practising as paediatric nurses in the hospitals. The education was provided by the then Auckland Institute of Technology during the mid-to-late1990s.

Increased resources in the community were required to implement the development of a more seamless transition between inpatient and outpatient services for families (McKinlay, 1981). However it is not possible to provide the expertise of all speciality services to all geographical areas for families; many families need to travel to centralized services. The difficulties involved with providing follow-up service to families who are not within a reasonable distance from the hospital need to be managed effectively by the service providers. Survivors of childhood accidents frequently require the involvement of multiple services after discharge. If these services cannot be provided in the child's home, a transition to a rehabilitation centre where there are appropriate services for the child's recovery is necessary.

The complex role of the nurse is fundamental to the management of effective paediatric services. Open visiting, the constant presence of a parent, play, education, negotiation and a team approach are now expectations of child health services. In the 1980s the possibility for children to be cared for by a parent was still considered a privilege by both parents and staff of the hospital ward (Coyne, 1995) whereas today "parents are expected to be involved in the hospitalized child's care" (Mulvay, 2001, p.12). Parents are not always confident or able to meet the expectation that they participate in the care of their child (Darbyshire, 1993b). This is particularly so when hospitalization is an unexpected outcome for their child (Gasquoine, 1996), therefore the nurse is required to assess continually the needs of the child and family in the

hospital setting. Nursing children is complex; the education for this specialist practice within nursing education is advancing in New Zealand. Postgraduate paediatric nursing programmes are now offered in a variety of universities in New Zealand.

Paediatric Nursing in New Zealand

My experience as a nurse and teacher of paediatric nursing practice has informed me of the current practices in health care and education. The discussion on paediatric nursing in New Zealand draws on my personal experiences and discussion with colleagues in the health care sector and education.

Paediatric nurses in New Zealand are registered as Comprehensive Nurses and in most cases the development of paediatric nursing skills occurs in practice by working with more experienced nursing colleagues. Postgraduate education to support developing expertise in paediatric nursing could still be considered embryonic in 2003.

Paediatric nursing education.

My experience in nursing education enables me to present this discussion based on personal knowledge. In nursing education the exploration of nursing practice to nurse families with a sick child effectively occurs at the postgraduate level of education. The undergraduate level is merely an introduction. Preparation to nurse in the paediatric setting is different within each of the seventeen undergraduate programmes in New Zealand. The Nursing Council of New Zealand monitors undergraduate education for nurses in New Zealand to ensure the scope of clinical learning experiences prepares the student for comprehensive registration. A person graduating from an undergraduate programme with a major in nursing is prepared for

the Nursing Council of New Zealand's State Examinations. Successful completion of this examination determines the applicant's registration as a Comprehensive Nurse. Once registered, a new graduate is able to enter the children's hospital services. Further experience, education, and the demonstration of nursing competencies advance the nurse's level of practice. Responsibility and remuneration for defined levels of practice is managed by the criterion set by the employer. The development of expertise of paediatric nurses is also supported by postgraduate education in the tertiary sector. The Advanced Diploma in Nursing in 1979 was the first post-basic education available for nurses caring for children. Today opportunities to complete Master's and Doctoral education focussing on nursing children enhance the advancement of nursing knowledge for nursing children in New Zealand.

Nursing a child after a traumatic accident

The context within which a child with unintentional injury is nursed in New Zealand depends on the severity of the injury. Initially a child may be transferred to PICU from the emergency department if the severity of injury requires one-to-one intensive nursing care to monitor and maintain physiological stability. If the child is more physically stable, they are admitted to an appropriate acute care admitting ward where the medical team has the specialist skills to meet the child's needs. The acute care admitting ward is the chosen context for this research. From the acute care ward the child moves on to be cared for by a team of rehabilitation therapists. This may be in a rehabilitation unit or the child's home.

Acute care nurses work differently with families depending on the individual family's journey to their area. The cause of the injury, their pathway to the ward, characteristics of the individual family, and the developmental age of the child all

impact on how a nurse works with that particular family. The family's stress as a result of the child's unintentional injury will inevitably begin to be worked through in the acute care setting, as the feelings of shock, guilt, blame and the "what ifs" are carried over from the accident to the Emergency Department or PICU and on to the acute care ward. Nurses need to acknowledge the family stresses related to an unplanned admission to an acute care ward. For example, forced separation may induce stress for the family or a fear of the unknown for the entire family, or the child may have old fears of being hospitalized (Burton, 1993). Any or all of these stresses affect how the nurse works with the family.

Acute care and rehabilitation nursing are practised in different settings; they are not usually considered the same, yet the promotion of the child's recovery underpins both. Pryor and Smith (2000) state "nurses can and should practice rehabilitation across all settings regardless of the patient's diagnosis or prognosis" (p. 3).

Rehabilitation processes are multifarious and do become part of acute care nursing in the effort to reconstruct an individual's life from the damage of injury. The Australian Rehabilitation Nurses' Association defines the goals of rehabilitation nursing as "the maximisation of self determination, the restoration of function and the optimisation of lifestyle choices for the client" (Pryor & Smith, 2000, p. 3). The reconstruction of life occurs from the moment a child enters the health care system (Edwards, 2001; Melvin et al.., 1998). Initially nurses are involved with monitoring the child's fluctuating signs of medical stability whilst preventing complications that may hinder the child's recovery. Nursing the severely injured child is made more complex because of the family's needs as well as the child's evolving growth and

developmental needs, with both being necessary components of planned nursing care (Beck & Higuchi, 2003; Pryor, 2002).

Nurses in the acute care setting provide care to restore the child's current physical, cognitive and psychosocial functioning to the levels present prior to the accident. To do this nurses collaborate with other health care professionals, referred to by the participants in this research as the multidisciplinary team (MDT). The team includes the family and appropriate health and education professionals. Specialist paediatricians, a physiotherapist, occupational therapist, play therapist, speech and language therapist, nurse, social worker, psychologist, and teacher may be the members of the team. Those health professionals whose speciality is required by the individual child or family become the team for that particular family.

The nurse's contribution to the team is 'knowing' the family and assisting with the reconstruction of the family's life. The nurse needs to create an environment to get that "snapshot" of the child and family prior to the accident. This snapshot of how the family was prior to the accident provides the goal for the interdisciplinary team when planning and working with the child and family (Pryor, 2002). The promotion of ongoing development of cognitive and psychosocial skills relies on the "inter-sectorial" approach to the management of the child's care. Educators and health care professionals work together to promote the recovery of the child.

Choice of Methodology

The nursing profession uses knowledge from the social sciences to inform nursing practice. Nursing is progressively developing a research-based foundation of knowledge embedded in the culture of the nursing profession. Nursing research has followed the tradition of the social sciences by using qualitative approaches when an

area of research is being mapped out for the first time (Creswell, 1994). Originally I had wanted to break the tradition and experience quantitative methodology, but the area I wanted to research did not have a sufficiently large, easily accessible population to complete quantitative research. The choice of qualitative methodology took time.

Having chosen to use data that gave the perspective of nurses working with children who had had a traumatic accident, I then needed to decide on a research setting. I knew I wanted to explore the impact nurses have on the outcome of the child after a traumatic accident. I began to focus on wanting to capture the reality of what acute care nurses do when nursing children who have had a traumatic accident. I did not want to research the perspectives of those nurses working with the children in an emergency department or intensive care because the management and maintenance of physiological stability is the primary focus when the injury has initially impacted on the child. I wanted to know what acute care nurses did once the child was physiologically stable. The acute care ward became the appropriate setting.

The time frame of a Master's thesis guided my decision to use the nurses' rather than the families' perspective. This research is a beginning of an exploration of the complex needs of children after a severe traumatic accident. I embarked on this project to learn a research process and my findings would be the outcome of that process. The question, "What do acute care nurses do when they look after a child who has had a traumatic accident?" guided the decision to use grounded theory methodology. This methodology allowed the exploration of my research question in present time, place and culture with the aim of developing a substantive theory.

I wanted to enjoy the process of learning. Often my colleagues just looked at me and indicated that the choice of grounded theory was a harder road towards a Master's degree. I knew a little about this qualitative method and felt that it was worth pursuing, initially because I was attracted to the systematic approach. The more I read and conversed with others, the more I believed the methodology suited both my question and me. I felt the inductive analytical process would lead me through my research process. The constant comparative method, which is the core to grounded theory analysis, would help to reduce the influence of my assumptions on the research findings.

Traumatic accident.

This research focused on the child who has had an unintentional traumatic accident resulting in a change in the child's appearance and function. Accidental trauma in childhood is a result of burns, head trauma, near drowning or multiple musculoskeletal injuries (orthopaedic). This research focuses on nursing children with head or orthopaedic trauma. The questions asked of the participating nurses were directed towards nursing the child with a "severe" trauma from an accident. A severe classification describes "injuries that may require longer term rehabilitation typically focused on developing independent living skills" (Accident Compensation Corporation & National Health Committee, 1998, p.12). An accident is "a sudden unexpected event or injury occurring without omen or forewarning" (Hensyl, 1990, p.9).

Defining use of "Family".

The paediatric nursing services in New Zealand support a family's involvement in it's child's care. The caregiver for the child in hospital is usually a parent. Therefore, in this thesis I have referred to all caregivers as parents. The term "family" relates to the child and parent/s. Reference to "extended family" incorporates more than the parent/s and child. The participants are interacting with the child and parent/s together unless indicated as separate interactions.

Summary

In this chapter I have shared my personal reflections which were the beginnings of my pursuing the research question: What do acute care nurses do when they care for a child who has had a traumatic accident? In view of the statistical evidence of childhood trauma in New Zealand, the exploration of how acute care nurses promote the future of a family following a traumatic accident to a child is important. The development of paediatric health care services and the involvement of parents in the care of their child relates to the context of what nurses do in the acute care ward. An outline was provided of the education and practice of paediatric nurses working with children who have had a severe traumatic accident during the acute care phase of their journey towards their recovery.

The next chapter (Chapter two) is a review of the literature that relates to aspects of what paediatric nurses do when they care for a child in the acute care ward following a traumatic injury.

CHAPTER TWO: Literature Review

Rehabilitation Nursing in the Acute Care Ward

Literature searches using multiple library catalogues, electronic indexes and resources including PubMed, Cinahl, Blackwell–Synergy, Ebsco mega file and Essential Nursing Collection revealed a scarcity of nursing literature related to what acute care nurses do when nursing a child injured from a severe traumatic accident. Research situated in the emergency or intensive care departments focused on the families' experience when their child was initially traumatized. My research focuses on the next stage of the child's nursing care in an acute care admitting ward and leads into care provided by rehabilitation services pertinent to individual children and family needs. Searches initially used key words "nursing" "children" and "accident". The search was then refined adding "family and/or recovery and/or rehabilitation" and "acute care". "Traumatic brain injury" and "musculoskeletal and/or orthopaedic injury" were also key words used to find literature pertinent to this research. Reference to literature from other health professions has been important to describe the needs of injured children and their families and to position those needs within nursing in the acute care paediatric setting. Literature from psychology and medicine supports nursing literature and describes the needs of the child in the given context to guide nursing praxis.

The intent of this literature review is to explore how the work of the acute cares nurse influences the future recovery of a child following admission to an acute care ward due to a severe traumatic accident. Most research focuses on children with traumatic brain injury or neurological disorders. Health disciplines involved in the

early intervention and rehabilitation processes have explored traumatic brain injury more extensively than orthopaedic and other injuries. The nurse's role is diverse; this review focuses on the psychosocial impact of the child's trauma rather than the physical impact. Literature referring to the monitoring and nursing interventions promoting physiological stability and the child's physical progress and recovery has not been the focus of this research. The child's long term future is *"being with"* their family therefore the literature reviewed focuses on the affect of the severe traumatic accident on the family. Literature that refers to the work of the acute care nurse has been used to lead into the findings of my research.

The Impact of Family Functioning on Children's Progress

The outcomes for a child with a traumatic brain injury (TBI) have been researched in retrospective longitudinal studies by groups of paediatric psychologists in North America. Rivara and colleagues (1992, 1993, 1996) and Wade and colleagues (1996, 1998) have regularly reported the progress of these studies. The findings emphasize the importance of a pre-injury assessment of the child and family's functioning prior to a traumatic accident. The acute care setting used in my research is the appropriate environment for the completion of the pre-accident nursing assessment of the family. The two frequently referred-to groups of paediatric psychologists, one led by Rivara, Fay, Jaffe, Polissar, Shurtleff and Martin (1992) and the other by Wade, Taylor, Drotar, Stancin and Yeates, (1996), used different populations of families with a school-age child who had a moderate-to-severe TBI. Wade et al. included a cohort of families where the child had orthopaedic trauma. There have not been any similar studies useful for the context of this research for families with younger children who have had a severe accident. The changing

developmental needs at the range of the different ages in childhood would change the findings of longitudinal studies; therefore, these studies have appropriately focused on a specific developmental stage. The review of the findings of both of the longitudinal studies over the three years are pertinent to the research question of my research because the nurse is the most constant health professional to work with families in the acute care admitting ward.

Each team of researchers, one led by Wade, and the other by Rivara, used a prospective design, quantitative methods, and included standardized assessment tools. The standardized assessment tools used for measuring family functioning and for measuring the severity of their child's head injury had been previously used and found to be consistent and reliable. The tools measuring family functioning included self-reporting questionnaires and guided interviews where responses were rated to provide a measurement to quantify the data.

Family Functioning and a child with an unintentional traumatic brain injury.

The research by Rivara and colleagues (1992, 1993; 1996) sought to determine the impact of family functioning on the recovery of a child following a moderate-to-severe TBI. Consenting families of children who sustained a closed head injury with some loss of consciousness were researched by Rivara, Fay, Jaffe, et al. (1992). A population of 81 was recruited from families who had a six to 15 year old who presented at the emergency department of either of two regional hospitals in Washington. Their research has measured family functioning from pre-injury by collecting retrospective data, and it then continued until three years after the child's injury. The severity of the child's head injury was used as a variable in the

longitudinal study. The classification of the severity of a child's head injury relied on the Glasgow Coma Scale score recorded during the acute care assessments.

The first report of the findings of Rivara et al. (1992) reflected the changes to family function over the first year post-injury. The hypothesis of this research was that good pre-injury child and family functioning and less severe injury predict better global child outcomes at one year. The outcomes of this research at one year after the child's injury revealed that family and child abilities, resources and cohesion were positively and significantly associated with competence and good global functioning.

Further analysis of the data and the inclusion of tests to measure the functioning of the child were included in a later paper by Rivara, Jaffe, Fay, et al. (1993). The purpose of their research was to measure the effect of the injury severity on the child's level of cognitive and behavioural performance one year after the injury and the influence of pre-injury family functioning on the child's academic skills post-injury. Significant associations between pre-injury family functioning and the academic and behavioural functioning of the child one year post-injury were found. There were stronger correlations with behavioural (74%) than with academic functions (40%) indicating that behavioural functions affected the family more. Parents reported that irritability, impatience, temper outbursts and arguing had decreased by one year in the mild and moderate TBI group, whereas those with a severe injury had increasing academic and behavioural problems.

Assessment of pre-injury family functioning by Rivara et al. (1993) found that children of those families who scored highly on pre-injury levels of control using family rules and hierarchal organization had lower social competence and lower adaptive functioning at one year post-injury. Lower levels of family control led to

better child academic functioning and fewer behavioural problems. Different ways families' function was found to be predictive of the child's behaviour post-injury. Improvement in the child's behavioural functioning was found to be relevant to family functioning. The findings of Rivara et al. (1993) have implications that inform the acute care nurse of important aspects of the nurse and family relationship in the acute care setting. Nurses can work with families to reduce the control the parents use over their child by role-modelling interactions to help the child regain some independence in functioning.

The need to get to know the family in the acute phase of care was confirmed in a further study by Rivara, Jaffe, Polissar, et al. (1996). In this research Rivara and colleagues reported that their research focused on the hypothesis that pre-injury functioning of both the child and family were the best predictors of the outcomes for the child three years post-injury. They found families who were more expressive, less controlling, more cohesive and better in general functioning were able to communicate, problem-solve and voice their concerns and needs. This kept families moving forward and adapting to changes related to their head-injured child. Family relationships deteriorated over one to three years but family stress decreased in this time.

The families with severely head-injured children fared worse than those with a moderate head injury in areas of relationships and coping. Families with a child with moderate to severe head injuries were more stressed at one to three years post-injury than those with a child whose head injury was less severe. Increases in stress were related to the child's independence, fatigue, argumentativeness, concentration and depression. Families of a child with moderate injuries were challenged by the child's

fatigue, slowness in word-finding, and difficulty in speaking. Family functioning and being with peers were highly significant to the child's outcome at three years post-trauma.

The significance of the findings of Rivara et al. (1992, 1993, 1996) for my research is its implications for the importance of how acute care nurses interact with families whose child has had a TBI. This knowledge informs nurses and makes them more aware of the future challenges for the parents of the head-injured child. Whilst working with a family, the nurse can inform them of future challenges that may arise. A limitation to the Rivara et al. studies is that the population only reflects the impact of TBI on families. Even though TBI is the most common result of severe unintentional injury in children, the findings cannot be generalized to understand the affect of different injuries on families.

Family Functioning and a child with orthopaedic injuries.

A control group of families whose child was recovering from severe orthopaedic injuries was used by Wade, Taylor et al. (1996) to explore more specifically the experiences of families with a child who had had a TBI. Wade et al. have found some difference in how different types of injury can affect a family. These findings are useful for nurses in the acute care setting to help inform families questioning about their future. The purpose of the research was to examine the changes in family functioning over time to determine factors to best predict family outcomes. The sample of consenting families from Cleveland, USA, included 53 with severe TBI, 56 with moderate TBI and 80 controls with orthopaedic injuries. All children's accidents were unintentional.

The first report of data analysis by Wade, Taylor et al. (1996) indicated that assessments of family dynamics when a child has had a TBI should continue for a minimum of a year. The findings identified that most stress for families related to concern for the injured child and the reaction of siblings and other family members. Interpersonal stresses with other family members, disruptions in routine, school and work schedules added to their stress. The initial family stresses and burdens after a severe TBI were found to be quantitatively and qualitatively different to the control group. Stresses and burdens were greater and more persistent for those families whose child had a TBI because of the changes to their child's cognition and behaviour. The families of a child with an orthopaedic injury do not have the same burden. For the families of a child with a TBI, the affect of the injury on family functioning declines less sharply.

A further study by Wade, Taylor et al. (1998) was designed to research family burden and stress, parental psychological symptoms and marital and family functioning when children had a moderate to severe TBI. They found that severe TBI in children results in greater and more persistent injury-related burden and stress for families than orthopaedic injuries. The severity of the child's orthopaedic injury had not been measured. The only criterion was that the child had to have had one night in hospital, whereas the classification of the head injury using the Glascow Coma Scale is more indicative, although not always a reliable measure, of the severity of the head injury. Not knowing the severity of the orthopaedic injuries to indicate the levels of stress for families may have skewed the differences found in this study. Wade et al. (1998) commented that most of the orthopaedic injuries were considered severe. Their work supported the findings of Rivara et al. (1992, 1993) that the cognitive and

behavioural problems that persisted with the children were the most stressful for the family. The peak of family dysfunction in this sample seemed to be six months post-injury.

The findings of both groups of psychologists inform nurses of the patterns of family functioning post-injury and are relevant to guiding nurses in the acute care setting when working with families and anticipating their future. Parents of severely injured children in the acute care setting ask for anticipatory guidance from nurses (Ramritu & Croft, 1999) therefore the contribution of the reviewed studies is that they inform nursing practice in the acute care setting.

The reviewed studies have not acknowledged the differences between the needs of children and those of adolescents in relation to the broad age range of six to 15 years used for the sample. The maturing of the child's cognitive and psychosocial development influences a child's response to a stressful or changed situation, as does their relationship with their parents. A six-year-old is dependent on parents for safety whereas a 15-year-old is striving for independence. Children less than six years old have not been part of the sample of the studies completed by Rivara et al. (1992, 1993, 1996) or Wade et al. (1996, 1998) even though unintentional injuries in one to six-year-olds are significant reasons for hospitalization of this age group. Whether the younger age of the severely injured child has a different affect on family functioning is not known.

The Need to Assess Family Functioning

Wade, Borawski, et al. (2001) claimed they completed the first study to examine specific coping strategies in determining the outcome for parents or

caregivers during the first year following their child's injury. Families with school-age children were recruited from four hospitals in Ohio, America. Mothers completed 96% of the returned questionnaires. A significant finding by Wade et al. was that the use of denial or disengagement by the mother during early hospitalization of their child post-injury resulted in higher levels of psychological disturbances and inability to cope post-injury. These findings influence the interactions of the acute care nurse working with families with severely injured children. Wade and colleagues found that those families who had higher levels of support-seeking shortly after the injury to their child had lower levels of family dysfunction and greater ability to promote the recovery of their child.

Stanton (1999) reviewed literature related to the impact of family functioning on the recovery of the child. She carried out the review to inform health professionals working in paediatric rehabilitation. She questioned whether family functioning affected the outcomes of children with neurological disorders including TBI. Rivara and colleagues were included amongst others in her review; others she reviewed were not pertinent to nursing. Wade and colleagues were not included. Stanton agreed with her findings that poor family functioning was associated with a poor outcome for the child who had a TBI and improved family functioning has the potential of moderating the impact of the head injury.

Rivara et al. (1992, 1993, 1996), Wade et al. (1996, 1998, 2001) and Stanton (1999) have carried out work that informs nursing of the importance of working with families to promote the recovery of the child. Their studies have indicated the need for pre-injury family assessment to promote family functioning and the outcome for the injured child post-injury. The acute care nurse is in the position to use assessment

and communication skills to identify the needs of families and ensure those children at greater risk have additional support, thereby promoting the recovery of the child.

Acute Care Paediatric Nursing

A recent book edited by Moloney-Harmon and Czerwinski (2003) focuses on the paediatric trauma patient. This book intends its audience to include nurses caring for children with physical trauma and informs them of the physical needs of the child in relation to their specific injury. Even though the importance of the psychosocial aspects of nursing is recognized when nursing a child and family, this is not considered until the final chapter. The authors do acknowledge the significance of family functioning and make the reader aware of the influence of parents' level of coping on the recovery of their child.

The significance of a family-centred approach to care to promote the ongoing recovery of the child emphasizes the importance of acute care nurses facilitating parental presence and participation in care. Moloney-Harmon and Czerwinski (2003) commented that subsequent reduction in parental anxiety by the promotion of participation in care is helpful in improving family cohesiveness and family functioning, thereby promoting the on-going recovery of the child. The accurate assessment of a family's functioning to identify functional and dysfunctional coping relies on the nurse's interactions and relationship with the family. Literature discussing the concepts underpinning how an acute care nurse works with a family will now be presented.

Working with Families

A question framing this part of the literature review is whether family-centred care is appropriate or possible in the acute care setting. The development of family-centred care has led to the expectation that this philosophy of care underpins all paediatric nursing. The tenets of family-centred care introduced by Shelton, Jeppson and Johnson (1987) were developed to encourage family and professional partnership with parents of disabled children in the community whilst promoting normalized patterns of living for the family. Shelton et al. have influenced the delivery of pediatrics health care services. Their tenets of philosophy of family-centred care are adopted by the Parent Liaison Group supporting the acute care wards where participants of my research worked with families.

There is no consensus about the meaning of family-centred care (Darbyshire, 1993b; Hutchfield, 1999; Nethercott, 1993) although the term seems to be connected with “partnership in care” with the parents being the leading partner. Nurses working with parents by “involving” them in care, encouraging their “participation” in care and working in “partnership” are all associated with family-centred care (Casey, 1993; Coyne, 1995; Darbyshire, 1994; Hutchfield, 1999). These processes do not necessarily all happen at once.

Casey (1993) developed a partnership model in care to try to clarify the meaning of family-centred care in the Hospital for Sick Children, London, where Casey was a ward sister. There was no consensus to the meaning of family-centred care by her nursing team. This was also at the time when the medical model of care was no longer thought to be adequate to promote the recovery of children; there was a call for a more holistic approach to care. Casey reviewed other models of care and

identified their meaning; she then developed her partnership model of care. Casey's model is underpinned by the philosophy that care for all children, well or sick, is best carried out by their family with help from health care professionals whenever necessary. Casey described the role of the paediatric nurse as "carrying out family and nursing care to promote the recovery or potential for the child's future." (p.184) The nurse supports the child and family by helping them to cope and function, he or she shares knowledge and coaches skills to promote their independence and finally refers the family on to other health professionals as appropriate.

Casey's (1993) exploration of the meaning of family resulted in her view that "the paediatric nurse was only concerned for the family as carers of their child" (p.185). In the hospital setting, nurses did not view the family as their client. This view would limit the nurses' practice as a potential assessor of each family. It would also restrict the nurses' ability to incorporate into their practice the findings of the studies longitudinal studies completed by Rivara et al. (1992, 1993, 1996) and Wade et al. (1996, 1998, 2001) concerning the significant influence of family functioning on a child's recovery from a traumatic accident. Casey acknowledges that the development of partnership in care is reliant on the consistency of the registered nurse working with the family. Consistency of the nurse and family relationship in New Zealand was facilitated by the introduction of primary nursing in the paediatric setting.

A pilot study completed by McKelvie (2001) described the application of Casey's partnership model of care in New Zealand. McKelvie used a focus group of paediatric nurses who had extensive practice experience during the years "partnership" was part of nursing language and literature. Set questions guided the

focus group of seven participants, the session was audio taped and field notes were written during the process to acknowledge the behaviours of the group. McKelvie's interpretation of the data focused on two categories: the "influences" of partnership on nursing practice and the "language and behaviours" of partnership (p.54). McKelvie acknowledges that there is no clear definition of the concept of partnership related to paediatric nursing practice.

McKelvie (2001) found that the main function of partnership was to promote understanding between the nurse and family whilst working together. Partnership was represented as togetherness between the nurse and child and their family with the intent of striving towards a mutually established goal to promote the outcome for the child. McKelvie describes a complex intradisciplinary partnership centred on the child and family. While it is questionable as to whether a partnership is this broad, she does refer to the term "connecting-relationships" which may be more accurate (p. 86).

Language and behaviour in partnerships emerged as themes in the data of the study completed by McKelvie (2001). Communicating and negotiating over a considerable period of time were found to be key strategies for partnership (McKelvie). These strategies were not only the key between the nurse and family but also supported intentional and meaningful involvement between the nurse and other health care professionals. McKelvie's findings related to children with chronic health conditions and considered partnership to be "working with" to find ways of managing the needs of the child and family and thereby promote their ongoing health.

Earlier New Zealand research by Gasquoine (1996) explored the lived experience of seven mothers who had a child who had been hospitalized in the acute

care setting within the year prior to the study. Gasquoine challenges the possibility of working in partnership in the acute care setting. The mothers in her research felt a need to be with their child in hospital whilst recognizing the hospital as the domain of those working within it. The family is in a strange environment; this puts a newly experienced distance between mother and child that is disempowering to the mother. Because mothers felt helpless, they expected nurses to negotiate their child's care on their behalf. Mothers enter an acute care setting to hand over their child to trusted strangers. Health professionals, particularly nurses, need to take over as the mother recognizes she can no longer help her child and the expertise of health professionals is required. Gasquoine found that the working-relationship between the health professionals and the mother is reliant on support from the nurse to continue to mother her child on her behalf whilst the mother is in an unknown environment.

Gasquoine (1996) also found mutual trust between the nurse and family needs to be developed. Trust is developed by the frequent interactions described by Gasquoine as the "little things" (p. 107) nurses do when working with the family. Trust can lead to partnership but Gasquoine challenges the notion that partnership occurs in the acute care setting. The development of partnership is hindered by lack of equality in the relationship because the mother is disempowered. Negotiation is important within partnership and this process is difficult when mothers are in a stressful, unknown situation and feel disempowered. Gasquoine's questioning concerning the reality of partnership in the acute care paediatric setting is supported by a later concept analysis completed by Gallant, Beaulieu and Carnevale (2002). These researchers used literature of disciplines that had studied partnerships including

nursing, medicine, the social sciences and psychology to support their view that partnership does not occur in the acute care setting.

In Australia Keatinge et al. (2002) completed an exploration of barriers to partnership. Keatinge et al. used 14 workshops in different areas of the country to focus on barriers to nurses and clients working in partnership. The participants of this study were those who attended the workshops. Registered nurses working in the field of acute care for older persons attended the first workshop. Family members of older adults receiving aged care services at the next workshop joined the registered nurses. The participants' discussion of what they perceived to be the barriers to partnership in care provided the data for this research. The much greater proportion of experienced registered nurses, 199 compared to 36 consumers, suggested that the consumers had less voice than the nurses.

The purpose of the initial workshop used by Keatinge et al. (2002) was to construct the nurses' perception of partnership in care. This workshop involved only the registered nurses and was planned to identify their meaning of partnership. The nurses perceived that "partnership in care" is reliant on relationships, gaining trust, being there, reassuring and working together involving the family. The result of partnership in care was found to be positive health outcomes.

The second workshop with the nurses and family members identified categories of barriers to the partnership between a nurse and family of persons receiving care. The data from both nurses and clients were used by Keatinge et al. (2002). Participants rated communication as the principle barrier to partnership in care. Perceived communication barriers included poor interpersonal skills especially listening, inability to understand each other, time, power imbalance, and confused

intra-professional communication. The workshop continued and data collected related to the nurses' and family members' collaborative work to determine strategies to address those barriers to partnership in care. Data used was where there was a consensus of both groups. The development of listening skills, improved intra-professional communication skills to prevent fragmented and conflicting information, and consistency in care were seen to improve opportunities for partnership in care. These skills were considered to be core to the development of any nurse client relationship in any setting. Time was also a barrier to developing partnership in care and the management of the environment with the high turnover of families in acute care wards may reduce consistency in care, thereby hindering the development of a working partnership. Children hospitalized with severe trauma are likely to have a longer stay in the acute care ward than most other children, therefore the opportunity to develop partnership in care is enhanced for them.

Cahill (1996) carried out a concept analysis of patient participation which did not focus on the paediatric setting but is, nevertheless, applicable to nurses working with families when their child is in hospital. Cahill identifies that "a relationship with another that is dynamic and waxes and wanes" (p. 565) is a significant attribute of parent participation but that the nature of this relationship depends on what is happening at the time. Cahill identifies a hierarchical relationship between the concepts of parent involvement, participation and development of partnership in care. Progress through this linear process is governed by the severity of the child's injury, the willingness or ability of the parents or child to become involved, and their participation in care.

Parent participation with the health professionals is important in the acute care setting to enable the family to learn new skills and to promote their ability to care for their child in the future, as well as promoting the family's ability to function. A relationship that begins with participation in care has the potential to develop into a partnership. The literature reviewed does not clarify whether a child and family have the time in the acute care setting to develop the mutual trust required in a partnership.

Rehabilitation in the Acute Care Ward.

Paediatric rehabilitation is recognized as a speciality practice by Beck and Higuchi (2003). The particular age and stage of a child's physical, cognitive and psychosocial development at the time of the injury guides the nurse's interventions with the child. The literature reviewed to this point emphasizes the importance of the family's role in caring for their child to promote the best possible recovery from an unintentional injury. There is also indirect suggestion of the importance of nursing interactions with families and their children in the acute care setting. The dearth of current research on the acute care nurse's role in the paediatric setting means that nurses rely on being informed by articles or texts which mainly focus on nursing adults.

I carried out a review of texts, including Edwards, (2001), Jackson (2002), and Melvin, et al. (1998) that all have the potential to inform acute care paediatric nurses of their role in promoting the rehabilitation of the child with unintentional injury from an accident. The review of these textbooks revealed that the acute care setting is not deemed to be part of the rehabilitation process. Edwards, Jackson, and Melvin et al. briefly mention the stimulation and physical needs of the child. Each

author refers to rehabilitation nurses working with children but whether this happens in the acute ward or a special rehabilitation unit where rehabilitation nurses prepare the child for discharge to the community is not clear. There is minimal reference to children who have had a traumatic accident even though traumatic accidents are the leading cause of admission to acute care hospital services for children. The chapters informing nurses about paediatric rehabilitation have a greater focus on the needs of children with disability from congenital anomaly or disease processes.

Klauber's (1993) chapter within a book focusing on the rehabilitation of the trauma patient provides a rare description of the acute care nurse's role in the physical rehabilitation of the adult trauma patient. The acute care nurse is part of the continuum of recovery and contributes to assisting the process of rehabilitation once the critical physiological dysfunctions have stabilized. Gradually the nurse is able to focus on the treatment of "basic functional deficits preventing an individual from living independently" (p. 711). Whiteneck (1994) agrees with Klauber that the acute care nurse's goal is to prevent secondary impairment caused by the development of complications from the impact of the initial injury and also that rehabilitation occurs in specialized centres or the community. Whiteneck does not view nursing as part of the rehabilitation process which is surprising when the nurse is the constant health care professional. Klauber has not considered the emotional and social needs of the traumatized person which have been seen to be significant in the studies completed by Rivara and Wade and their colleagues and supported by Stanton (1999).

Summary

Acute care nursing relies on the research of other health professionals to inform practice. This literature review had three focuses pertinent to nursing the child after a severe accident in the acute care setting. The importance of family functioning on the outcome for the child has been the most significant focus of the review. It was relevant to include acute care paediatric nursing and rehabilitation in the acute care setting in this literature review.

The importance of family functioning on the outcome of the child was evident in studies completed by two different groups of psychologists. The psychologists' longitudinal studies have identified the importance of "getting to know" the child and family prior to the accident. The relevance of "working with" the family to restore their ability to function as they did before their child's accident was found to have a significant impact on the recovery of the child.

Family-centred care, partnership in care, and participation in care have each been considered when reviewing nursing in the acute care setting. The explorative studies and literature describing the processes nurses use to nurse are useful and can be adapted to nursing children admitted to the acute care ward following a severe traumatic accident. The question as to whether a working partnership is developed in the acute care ward is not clarified in the literature; the reality of the notion of partnership in acute care was questioned by Gasquoine (1996) and is still questionable. The development of partnership is more likely when nursing children with a chronic health condition over a longer period of time.

The speciality focus of rehabilitation of children following a severe injury is most frequently discussed in literature related to children and adults with a TBI. There is a scarcity of literature to inform nursing of what nurses do in the acute care setting to promote the recovery of the child after a traumatic accident. The research and literature from the medical and psychology disciplines used in this literature review have been the most useful work found to help us gain insight into what acute care nurses can do to promote the recovery of the severely injured child. The two New Zealand unpublished studies by Gasquoine (1996) and McKelvie (2001) have focused on nursing children. Both have provided a view that is helpful to construct a description of what acute care nurses do when nursing children after a severe traumatic accident. The literature reviewed leads into the focus of my research.

The next chapter, chapter four, gives the theoretical background to grounded theory methodology. My research pathway is described using the stages of selecting my participants as the framework for the presentation

CHAPTER THREE: Research Methodology and Methods

Within this chapter the history and theoretical basis of grounded theory methodology will be described and linked to this research. Grounded theory techniques, including comparative analysis, theoretical sampling, and saturation will be explained before I guide the reader through the methodological pathway of my research process. My analytical process towards my grounded substantive theory has been illustrated by figures within this chapter. Detailed explanations of the model presented are included in the findings chapters. A glossary defining the terminology used in describing grounded theory methodology begins this chapter.

Grounded theory methodology has continued to evolve since its introduction in the 1960s by Glaser and Strauss, and there are therefore different approaches and many ways of completing the research process. The methodological choices made for this thesis are presented in this chapter. My research process is presented as having three phases of collecting and comparing the data, however the phases were not as linear as the presentation here indicates.

Glossary of Terminology

Substantive coding.

The empirical indicators in the data are conceptualized by the substantive code. There are two types of substantive codes, open and selective.

Open coding.

The essential aspect of transforming raw data into theoretical constructions of social processes is the generation of emerging categories and their properties (the social processes) that fit together, work together, and are relevant for integrating into a theory. The labels put on codes are either in vivo which is grounded in the data, or driven by concepts that have emerged from the data.

Selective coding.

The researcher selectively codes for a core category. This process may be referred to as theoretical coding. It is a process used to delimit the coding to those variables that relate to the core category.

Theoretical codes.

A family of codes that form connections between the data that have been fragmented into substantive codes

Category.

A category is the abstraction of phenomena from the open coding of the data. It contains a clustering of open codes (properties) that reflect the social processes or interactions fitting the label given to the category.

Core category.

The core category emerges after systematically relating the core category to other categories. The core category integrates and refines the categories, holding them together in a theoretical construction. A core category is the central theme of the data.

Substantive theory.

Substantive theory has a contextual influence as it evolves within the context of the focus of the research. Substantive theory is developed from an extensive enquiry reliant on the process of comparing categories that have emerged from the data.

Grounded Theory Methodology

Grounded theory is “an integrated set of conceptual hypotheses that are systematically generated from data” Glaser, (1998, p. 18). The method was developed from experiences of American sociologists, Glaser and Strauss, who were researchers from the opposing paradigms of quantitative and qualitative research. Glaser, experienced as a quantitative researcher, introduced comparative analysis to the process. Strauss, experienced as a qualitative researcher, used the theory of symbolic interactionism to underpin the methodological approach of grounded theory. The apparently opposing research paradigms have been blended to enable the development of grounded theory to facilitate the plausible explanation of people’s actions (Miller & Frederick, 1999). Others used grounded theory methodology after Glaser and Strauss (1967) recorded and then published their research process used in the research of the awareness of dying. Nursing researchers are increasingly using grounded theory methodology to explain phenomena that relate to nursing (Chamberlain, 1999; Miller & Fredericks, 1999). It provides a methodological framework within which the researcher can discover what is happening in those areas of nursing practice that have not been previously explored, by generating hypotheses that explain what is happening in a particular interactive environment (Glaser, 2001).

Grounded theory methods have continued to evolve since the beginning development by Glaser and Strauss (1967). Researchers have continued to use and modify the methodological processes using the theoretical perspective of symbolic interactionism to guide further developments (Annells, 1996). For example, Schatzman (1991) introduced a modification he called dimensional analysis. This innovative contribution to the methodological process refers to the researcher’s

interaction with the data promoting the ability to see the complexity of what is happening. The consideration of the attributes, context, process and meaning within the data (Kools & McCarthy, 1996) leads to “the identification of what is important and meaningful about the concept” (Schatzman, 1991, p. 310).

According to Glaser (1998) the criterion for doing and critiquing grounded theory relies on the fit, workability, relevance and modifiability of the methodology. The grounded theory has to fit the data to have validity. The discovered concept must adequately express the pattern in the data which it purports to conceptualize. The concepts and the way they work in relation to the hypothesis need to account sufficiently for how the main concern of the participants in a substantive area is continually constructed. The relevance of the grounded theory gives the research importance and needs to be constructed from a main concern of the participants involved. Grounded theory is not disproved by new data; instead it goes through an analytical change and is modified (Chamberlain, 1999).

The ability to explore social life patterns within an interactive environment has emerged from the symbolic interaction traditional to social psychology and sociology (Chenitz & Swanson, 1986). Appropriately the theoretical perspective of symbolic interactionism is the classic theory underpinning grounded theory methodology (Annells, 1996)

Symbolic Interactionism

Symbolic interactionism has developed as a theory about human behaviour (Chenitz & Swanson, 1986). Symbolic integrationists hold the view that life within society is a “dynamic process of ongoing activity and varied and reciprocating interactions” (Kendall, 1999, p. 745). The foundations of symbolic

interactionism were laid as early as the 1920s. A decade later George Herbert Mead unknowingly became an important contributor to the development of the theory of symbolic interactionism with his perspective that “the essential defining of self is through social roles, expectations and perspectives cast on self by society and those in society” (Annells, 1996, p. 380). In the 1960s Herbert Blumer, once a student of Mead, was critical of the positivistic methods that dominated social research and introduced the concept of symbolic interactionism and influenced its use as the theory, underpinning a special methodology for social science research that later evolved as grounded theory (Kendall, 1999).

Symbolic interactionism claims that meaning can only be recognized through one’s interaction with others. A key assumption of symbolic interactionism, identified by Blumer (1969) is that “human beings act towards things on the basis of the meaning that things have for them” (p. 2). Meaning is expressed through symbols such as language, gestures and dress and the person’s interpretation of these symbols is the basis of how they will act with another person or group. The meaning of a person’s interaction is determined by their unique experience in the context at the time. Therefore, an individual’s behaviour evolves from the social process of their interaction with others.

Symbolic interactionism guides the generation of grounded theory that explains and furthers the understanding of social and psychological phenomena (Chenitz & Swanson, 1986). The social processes involved when acute care nurses care for a child who has had a severe traumatic accident are being explored. What a nurse does when interacting with a child and family is explored from the nurse’s perspective, using individual interviews and a small focus group**.**

Grounded Theory Methods

Grounded theory methodology includes systematic approaches designed to maintain the 'groundedness' of grounded theory in the data analysis process (Chamberlain, 1999) and counter researchers' assumptions. This research has been guided by Glaserian methods, with modifications of using dimensional analysis described by Schatzman (1991). I set out to develop a substantive theory of the acute care nurses' perspective of what they do when they care for a child physically traumatized from an unintentional accident. The techniques that facilitated the 'groundedness' of the development of a theory were constant comparative analysis, theoretical sampling and questioning until saturation of the data was reached. Simultaneous analysis and data collection were deliberate, both being critical elements in grounded theory research (Chenitz & Swanson, 1986). The process was constant and data collection and analysis were interdependent.

Constant Comparative Analysis

The constant comparative method is the hallmark of the inductive process used in grounded theory research for the purpose of conceptualization (Glaser, 2001). Glaser simplifies the concept when stating "the constant comparative method involves simply inspecting and comparing all the data fragments that arise in a single case" (2001, p. 195). Language is compared line-by-line, incident-to-incident, and the researcher is constantly going back over the data and correcting and verifying the emerging patterns and concepts. These provide the base on which a substantive or formal theory is later built (Glaser, 1998). Patterns, which are indicators within the data, are compared to yield richer concepts and relationships rather than only

incorporating the sum of data expected in pure quantitative methodology. Constant comparative analysis is systematic when comparing similarities and differences at all levels of the data analysis; it occurs between the data codes, within and between interviews, and also between the contexts and the categories as they emerge (Chamberlain, 1999).

The constant comparative method guided my analytical process. Each interview was analysed by using open coding and then compared to the findings of the previous interviews. The categories and their properties were reviewed and adjusted, and the research findings represented all the data at that point. Selective coding then enabled me to focus on the categories that related to the emerging focus of the findings. The interviews then became more focused and provided rich data as the research progressed. Comparative analysis continued until no further properties emerged for a category and the core category to hold the substantive theory together was identified. The self-correcting nature of comparative analysis helped to inhibit the influence of my assumptions even though I was interacting with the data throughout the analytical process.

Theoretical Sampling

Theoretical sampling evolves whilst using grounded theory methodology (Glaser, 1992). It occurs when the researcher has become sensitive to the data and wants to pursue a question with a participant whose practice has the scope to provide depth to the question being pursued. The consent of a participant is sought because this participant is thought to be able to provide rich responses to the theoretical questions that have emerged during the development of categories in the comparative analysis of the data (Chenitz & Swanson, 1986; Glaser, 1998). The purpose of

theoretical sampling is to extend or contradict the category or relationships rather than merely replicating existing data (Chamberlain, 1999). Theoretical sampling enables the delimiting of theory while generating it and the development of a rich conceptual analysis using the inductive method. The proceeding analytical process then leads the researcher to actively seek clarity of what is going on, using deductive methods to collect data by theoretical sampling and questioning to clarify an emerging concept. Theoretical sampling is recognised as a powerful technique to clarify understanding, with the consequence of strengthening the credibility of the conclusions drawn from the research (Chamberlain, 1999; Glaser, 1999).

Theoretical sampling was used in my research process to foster better sources of data and a greater depth to the data arising from the interview process. The use of theoretical sampling is discussed in my research pathway further on in this chapter.

Saturation

Saturation means no new ideas are being found in the data. This is when the researcher is no longer developing properties of the category (Glaser & Strauss, 1967). Kendall (1999) claims conceptual saturation has been reached when no new categories emerge from the data and any remaining gaps in the developed conceptual idea are filled. It is not the frequency of the properties within the categories which is critical; rather saturation is reached when there are no new ideas. One can always accumulate evidence to support ideas so this clearly is not saturation. Comparative analysis continues until no further properties or relationships of note are being generated from the data. With no further ability to generate new ideas, saturation has therefore been reached.

My Presuppositions Interview

The presuppositions interview is a process used to uncover the researcher's thoughts, values and beliefs that could affect the validity of the research process. "Historical factors that impinge on the phenomena under study affect internal validity if they are not accounted for and if their impact is not assessed." (Chenitz & Swanson, 1986 p. 11) However a researcher's past can be capitalized upon. The past experience and knowledge of a researcher can provide a background that provides a sensitivity to the data and can lead to more in-depth exploration (Corbin, 1986).

The skill of the interviewer's questioning in my presuppositions interview to draw out my thoughts, values and beliefs was critical to the success of my research process. The opportunity to analyze the interview made me more aware of my "knowing". This helped to identify moments when my experience and knowledge were intruding on my research process. By completing the presupposition interview I have been alerted to my views and this has helped to ensure the data presented is from the participants' perspective. This has enhanced the validity of my findings.

Demographic Data of Participants

The recorded demographic data of the participants included their level of practice (as explained in chapter one) and the speciality focus of their practice. Four participants were level two nurses, one level three and two level four. The final interview with two level four participants was to continue to explore the practice of experienced practitioners. Their broader scope of practice and ability to reflect on their practice development whilst *"working with"* families enriched the depth of data collected for this research. The spread of the participants' level of practice reflects the

pattern of staffing in hospitals today as less experienced nurses are working in the profession.

Four participants worked with children admitted with head injuries and two participants worked in the orthopaedic setting. Children frequently have a head injury as a result of their accident therefore it was appropriate to sample more participants from this area. The sampling of two participants from the orthopaedic setting was useful to identify any differences in nursing practice between the two specialties. The participants included two males and five females, and two participants gained their paediatric nursing qualification in England. Gender difference altering nursing practice when "*working with*" families was not apparent in the analysis of the data, nor was the difference in education, therefore neither of these cultural differences have been relevant to the findings of this research.

My Research Methods Pathway

My research process is presented in the three phases identified by Chamberlain (1999) that relate to the stages of the sampling procedure. The associated styles of analyses used in each phase will be presented. The phases relate to the selection of participants, the first phase I used was purposive sampling, the second phase, theoretical sampling; and the third phase, theoretical sampling to clarify theoretical questions.

Ethical Considerations

Approval for this research was granted from the ethics committees of Auckland University of Technology, the Auckland Ethics Committees of the Ministry of Health, and the Auckland District Health Board. The committees considered the access to the nurses working with children in acute care admitting wards. Ethical approval was given to recruit registered nurses from two acute care units that were likely to provide care to children who had had a traumatic accident. The process approved by the ethics committees was to ensure that the participants were voluntary. It was important that there was no feeling of obligation because they knew me as a nurse lecturer.

The initial participants were recruited through the unit manager who then organised and attended meetings with me and interested nursing staff. An information sheet (Appendix One) was given to all interested nurses after the ward manager had introduced them to the proposed research. The approved inclusion criteria for the participants required them to be registered nurses who had at least six months experience to reflect on in the particular unit. Participants were asked to include their level of practice on the signed consent form for the purpose of theoretical sampling. The consent forms (Appendix Two) were to be returned in reply-paid envelopes.

The anonymity of the participants has been maintained by referring to them as Nurse A, B, C, D, E, F or G in the findings and discussion chapters. Limited service providers in New Zealand available to children after a severe traumatic accident resulted in a concern of maintaining anonymity in easily identifiable units because of the focus of my research. Maintaining anonymity is compounded by the ethical

approval to give each of the units used for this research a copy of the completed thesis. Those who read the thesis may recognize their colleagues from their expressions in the invivo quotations. Participants were aware of the thesis being given to the units prior to consenting and signing the appropriate consent form.

The process of theoretical sampling had altered my research methods. This is appropriate for grounded theory methodology. I submitted a further letter to the ethics committees to change my original consent which was only to interview participants individually, once, and maintain their confidentiality. Ethics committees granted the alteration to my research proposal.

The decision to ask participants to reflect on nursing children who had been admitted as a consequence of an unintentional accident was important. The nursing of a child in the context of their family is related to the individuality of the family; however, the dynamics of the family would be very different if the child had been admitted following a non-accidental injury. Therefore only children who had been admitted with an unintentional accidental injury were discussed in the interviews.

The First Phase

Purposive sampling and open coding are the two processes used in the first phase of my research process. All participants provided data through an audio taped verbatim transcribed interview. Purposive sampling was used. The nurses in this particular hospital setting were likely to have nursed children who had an injury from a traumatic accident. The first two interviews opened with the same question, even though the analyses of interview one had been completed before I began interview two. The opening question was "*Tell me what you do when you are nursing children who have had an accident."* I encouraged each participant just to talk rather than

interrupting their dialogue. I did not want to influence any of the participants' perspectives during this early phase of data collection. Data collection was then followed by open coding, the process used to break up the data to identify categories (Chamberlain, 1999).

Initially I lacked confidence in my analytical process. I completed repetitive analyses of interview one in particular, and became frustrated as I wanted to leap to the conceptual analysis rather than initially processing the emerging description of what was happening. An important and necessary part of the development of my analytical processes involved my wrangling with a potpourri of different methods presented in the literature. A potpourri is acceptable within the grounded theory process (Chamberlain, 1999) providing it is justified. I needed to and did, record my process.

My analytical process became more effective and insightful when I was introduced to Schatzman's (1991) methods by B. Bowers (personal communication August 13th 2002) to consider the dimensions of the data in relation to what was, or could be, happening in the line-by-line analysis of the first interview. This was to bring the view of the participant and the context together to construct meaning (Caron & Bowers, 2000) and develop further questions from the data. Dimensional analysis encouraged my questioning of the data and developed my analytical skills. I considered many different contexts and consequences within the data and documented these thoughts in a wide margin to the right of the line of the transcript. My tracking and coding had not begun at this stage.

"*We have to look for those cues.*" (Interview one; page 4, line 7).
Questions: Who is we? When do you have to? How often? What are the cues? How do you look? Can you only see them? Where do you find cues? Are those particular cues? Cues to what?

Figure 1: Example of questioning when using dimensional analysis

The development of a framework to record my thoughts while analysing the collected data to pursue my research question was necessary**.** I again needed to spend time to consider different suggestions of coding processes. Strauss (1987) and Strauss and Corbin (1990) initially helped me to record and track my thinking processes, but eventually I followed Glaserian methods, using two levels of coding throughout the analytical process.

I fully transcribed all interviews until my eighth interview with the small focus group. Glaser would probably have thought my method of transcribing and processing each interview to be time consuming and I possibly took the risk of drowning in the data. As a beginning researcher, I needed to know that I had not missed anything and the analysis of all the data in my transcribed interviews gave me the security I needed in my process. The development of a table provided a system for tracking substantive coding and thought processes. My memos helped to develop my theoretical codes. I put all the data that I found relevant during my analysis of the transcribed interview into the table presented as Figure 2.

From transcript	Context/interpretation	Code	Recode	Memos
1.14 Family often want reassurance that what the child is doing is normal That it's a normal thing that someone would do after having a head injury	*Reassuring by normalizing what's happening Knowing by being with and responding to the family Knowing about head-injured Children*	*Reassurance: Normalizing Knowing*	*Being with to reassure*	**More in-depth discussion on how to reassure families How do nurses know families want to think their child is normal when they are different to how they were? How do nurses know that this is a normal pattern /thing to do? Is there any reaction from family?**

Figure 2: An example of recording to track the analytical process.

I have interpreted the line, considered the context and consequence, and then coded and recoded the data. The substantive coding of the data changed many times during the comparative analysis, following the analysis of each interview. I now had a tracking system of my coding and thought processes, an important aspect of grounded theory methodology to ensure validity of the findings. I found the nurse's "doing" was linked to three different overlapping contexts and at this early stage there was a clear potential within the data for different studies or one broad study.

Figure 3 represents my development of categories and properties after my analysis of the first interview.

1.Being there Constant carer Initiates care Involves others in MDT Advocate for child/family	Working together Guided by MDT Follows thru and supports MDT Communicates with other	Nurses role lessens as rehab therapy increases Sharing of information Handing over
2. Being there 1.34 Getting to know child and family Looking for signs and cues Monitoring change for child and family Maintaining dignity and respect Striving for best 1.31 Reassuring: informing process and change Predicting and giving hope Stimulating child 1.13	Working together 1.36 – 1.39 Partnership with planning care Negotiating and supporting parenting role Advocating "voice" Informing 1.5 1.35 Updating Reorientating Child to change 1.14 Family to change 1.16 1.31	Handing over Re-establishing parenting role and family functioning

Figure 3: Analyses of interview one. The professional context is row one of the figure the child and family context is row two.

I was only able to superficially depict what nurses do with the child, the family and the multidisciplinary team. The participant was articulating the complexity of "doing" when trying to meet the needs of the child and other health care professionals in the multidisciplinary team (MDT). The participant described working with the professionals and working with the family.

The participants were aware that I was a nurse lecturer with an interest in nursing children. This first participant sometimes seemed to limit the sharing of detail, assuming that this was something I would know. Participant A would often say

"*You know*" during the interview. I therefore reminded the second and subsequent participants to try to suspend what they assumed I knew.

The social processes that underpin grounded theory methodology alerted me to the in vivo codes describing the participant's view of their social interactions with a family. The comparative analysis of the concepts and the use of in vivo codes led to the development of the social processes within the data of interview one and two. I began to identify the properties of emerging categories. The first two participants had referred to the rehabilitation process when discussing the handing over the child to the MDT and family. I was mindful of my original purpose of completing this research and conscious of ensuring the questions I asked participants were grounded in the data to date. My opening question to participant C was grounded in the data. *"Tell me what you do when you are nursing children who have had an accident and particularly tell me what you are doing when you are looking at their rehabilitation?"*

The comparative analytical process facilitated the discovery of categories with properties that defined the emerging concepts. The fit, the workability and the relevance of the properties to the categories were now being "played with" to provide an initial description of what nurses do when they care for a child and family after the child has had an accident. Figure 4 shows how I sorted the data at this first level of analysis.

"**Stepping in" "Holds all" 3.51** Being with Holding it together 3 Getting to know child and family 1.2 Looking for cues 3.46 Constant presence 3 Learning with families 2 Engaging interacting with child 2.21 3.42 Getting to know each other 3.46 3.29 – 3.31 Blends with family	**Advocate for child and family** Using nurses' knowing 3.24 Maintaining dignity and respect 1 Striving for best 1.31 2 Voice for child/family 1.3 Maintaining environment for recovery 2.21 Protecting child 3.45 Getting it together with MDT 3.45 **Supporting** Lowering family stress – responding to problems Creating space time out Encouraging broader family participation	**Monitoring change** Looking for signs cues 3.24 3.43 Adaptations of child 3 Adaptations of family 3 Routine/standard observations 1.34 2.10 Repetitive observations Looking for physical changes 2 Maintaining well-being, body function 2.5 2.13 3 Identified confusion in families 3.42 Comparing changes in observations
Working in together 1.36-1.39 Planning care 1 Learning about each other 1 2 3.46 Including family in care 2 Balancing – daily routines, environment, family presence 3.45 Taking time to know where child is at Gauging when and how to intervene	**Reassuring child and family** Informing process of change 1.5 1.35 3.24 Predicting giving hope 1 Updating 1 Discussing what's happening 2 Responding 2 I will be there all the time (crisis stage) Using nurses' knowing 3.24 Building a rapport	**Promoting recovery (Doing by not doing**) 3.9 Independence Stimulating child 1.13 2.21 3.15 Handing over to others 1 Supporting parenting role 1.16 Reorientating child to change 1.14 Re orientating family to change 1.16 1.37 3.23 Referring to and guided by MDT 2.23 3.20 3.22 Balancing stimulation and rest 2.21 Promoting parenting role 2 Promoting independence of child 2 Mobility 3.6 Ability 3.8 Encourage taking back control 3.10 3.43 Considering future 3 Promoting self care 3,54

Figure 4: Comparative analysis after interview three.

All three interviews included the participants' social processes "*to be with*"; "*stepping in*" to develop the ability to then "*work together*" to assist the child and family to

regain independence, and the nurse finally "handing over" the responsibility to the child and parents.

The context of the research at this point was limited to the nurse's social processes with the child and family. The process of comparative analysis had already and appropriately begun to determine the boundaries of my research. I decided not to pursue the interaction of participants with the MDT or their monitoring of the child's physical health. The data had a greater emphasis on the development of the relationship between the nurse and the family. I began trusting that the process would not let me "drown" in my data and I was entering the second phase of sampling and analysis. Glaser (1998) suggests using drawing to conceptualize how the categories interrelate. My initial drawing is presented as a diagram (Figure 5) and will be discussed in the findings chapters; five, six and seven.

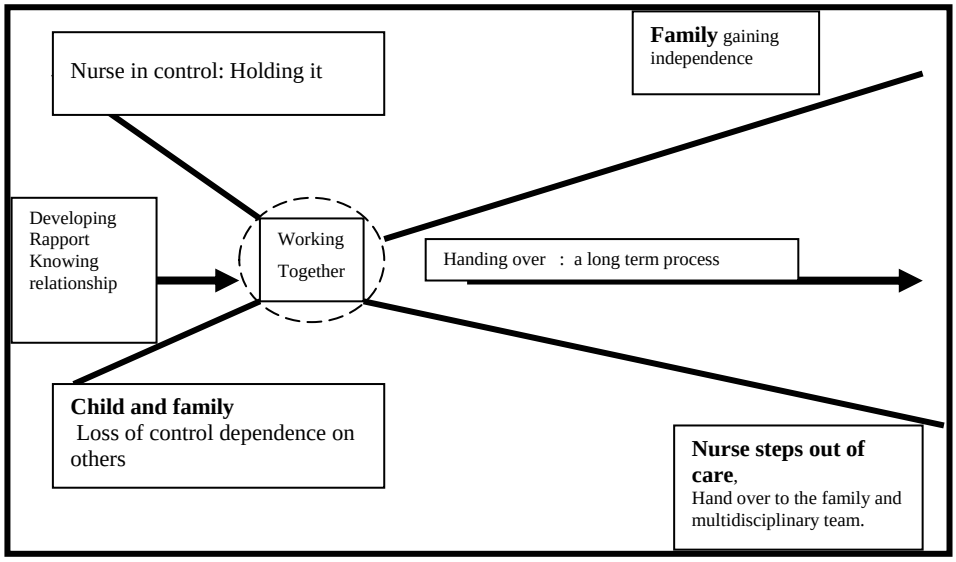

Figure 5: The social processes to work together and later hand over. A diagram depicting what happens in a nurse and family relationship when a child has had a traumatic accident.

The Second Phase

My sampling until this point remained purposive. The participants were nurses who cared for children in the acute care setting. I sensed the need to explore the same question with nurses in a different setting: they would be nursing children with different injuries from trauma, either head injury or bone injury. I interviewed two participants with the intent of confirming or altering the categories that had emerged from one setting (Chamberlain, 1999). This was theoretical sampling by using participants (two) from a different context to expand on properties within the emerging categories or new categories. My research now focused on the social processes the participants use to work with a family.

The fourth interview was more focused using questions that had arisen from my data analysis. I began pursuing how effective nursing interactions were in the recovery of the child. The following question was asked: *"Can you tell me about the times when you know as a nurse you have worked effectively with children who have had an accident?"* The response: *"It helps in nursing if you look after the same child a few times and you can gain their trust."* Consistency of the individual nurse and trust was seen to be helpful to the child's recovery by this participant but I wanted to explore this further with the question: *"Tell me what your role is and what you have done to promote the recovery of the child?"* This participant found this question difficult. The response required more thought than expected but led on to further questioning related to building relationships. The relevance of *"working with"* the family and developing a trusting relationship began to emerge in the first level coding of categories of interview four as the key to the child's rehabilitation.

Developing a relationship: Gaining trust 4.1 Being there 4.29 Working with/together Finding out 4.3 Responding to each other 4.6 Opening up important to be very open with families 4.7 Getting to know each other	**Reassuring** 4.4 Informing the family 4.11 Normalising the situation 4.12 Checking understanding 4.13 Anticipating future **Responding to Cues 4.33** Being there 4.9/10 Interpreting cues Following knowing Pick up signs Nurses' knowing 4.35	**Handing over 4.5** Involving MDT Doing for self Handing back care to family 4.30 Involving family 4.32 Promoting participation 4.23	**Promoting recovery** Promoting participation 4.23 Creating stimulating environment 4.27 Monitoring for improvement 4.19 change 4.22 Stimulating communication by questioning 4.20 Monitoring function/strength of limbs 4.21 Working with family Working the child Encouraging child to mobilize 4.26 Coaxing using rewards 4.27 Providing comfort and Hygiene 4.31

Figure 6: First level coding of interview four

Comparative analysis continued with the analysis of interview four being compared with all other data (Figure 7) and presented as a conceptual vision (Figure 8).

Developing a relationship "Stepping in" Being with / there 4.29 Getting to know child and family 1.2 Looking for cues 3.46 4.33 Learning with families 2 Getting to know each other 3.46 3.29 – 3.31 Blends with family Engaging interacting with child 2.21 3.42	**BUILDING TRUST 4.16. 4.29** Holding it all 3.51 Constant presence 3 Building a rapport	**Interacting with child/family** **Responding to cues 4.33** Looking for signs cues 3.24 3.43 Picking up signs 4 Identified confusion in families 3.42 Stimulating child 1.13 2.21 3.15 4.20 Reorientating child to change 1.14 Re orientating family to change 1.16 1.37 3.23 Responding to each other 4.6 Monitoring change/improvement Coaxing using rewards 4.27
Working in together 1.36-1.39 Partnership with planning care 1 Negotiating Learning about each other 1 2 3.46 Including family in care 2 4.32 Balancing – daily routines, environment, family presence 3.45 Taking time to know where child is at Gauging when and how to intervene Working with together 4.29 Promoting participation 4.23	**Reassuring child and family** Informing process of change 1.5 1.35 3.24 4.11 Predicting giving hope 1 4 Updating 1 Discussing what's happening 2 Responding 2 I will be there all the time (crisis stage) Using nurses knowing 3.24 Normalising the situation 4,12 Checking understanding 4.13 Handing care back to family 4.3	Voice for the child family 1.3 **Holding it together** 3 Using nurses knowing 3.24 4 Striving for best 1.31 2 Maintaining environment for recovery 2.21 Protecting child/ safe environment 3.45 Getting it together with MDT 3.45 4.5 **Supporting** Lowering family stress – responding to problems Creating space time out Encouraging broader family participation Maintaining dignity and respect 1 Maintaining comfort and hygiene 4.31
Promoting recovery / Independence *Probably not pursuing exploration of this aspect of what nurses do* (Doing by not doing) 3.9 Handing over to others 1 4 Supporting parenting role 1.16 Referring to and guided by MDT 2.23 3.20 3.22 Balancing stimulation and rest 2.21 Promoting parenting role 2 Promoting independence of child 2 Mobility 3.6 Ability 3.8 Encourage taking back control 3.10 3.43 Considering future 3 Promoting self care 3,54 Adaptations of child and family3 Routine/standard observations 1.34 2.10 Repetitive observations Looking for physical changes 2 Maintaining well-being, body function 2.5 2.13 3		

Figure 7: The comparative analysis after four interviews. The beginning evidence of the categories that are linked to building trust.

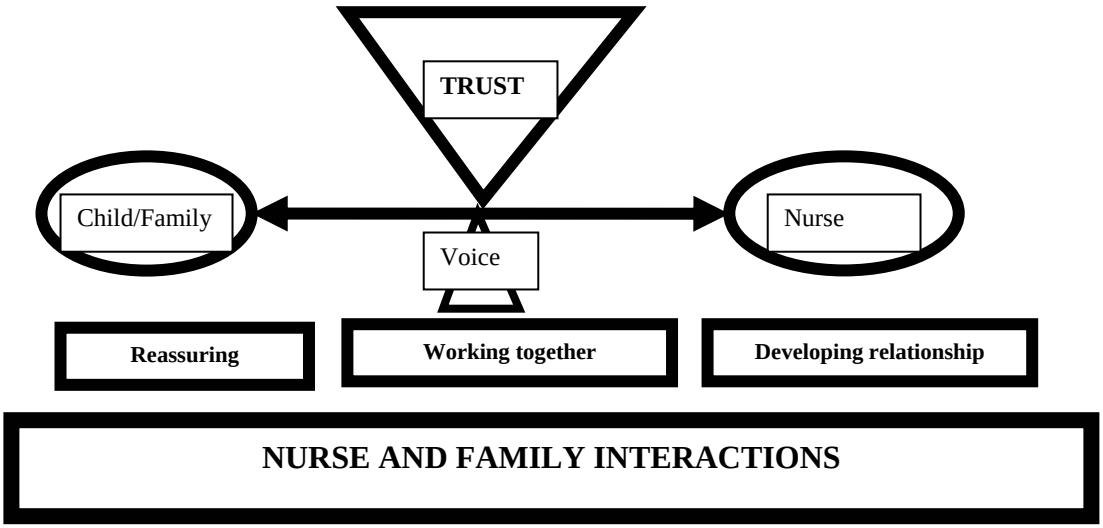

Figure 8: Balancing care: the nurse and family. The interactions between a child/family and a nurse help to balance the relationship. Trust is perceived to be important for the balance.

At this point, the participants' perspective supported the fit and relevance of "*gaining trust"* being the core category holding the other concepts together. I was aware of the warnings given by Glaser (1992) of the danger of early closure forcing the data.

The time seemed to be appropriate to begin to deliberate on finding the core variable of my research findings. The categories were gradually being refined, developed and related to one another, using comparative analyses and selective coding. The selective coding for a core variable meant that I was able to "delimit my coding to only those variables that relate to the core variable in sufficiently significant ways to be used in a parsimonious theory" (Glaser, 1978, p. 61). I entered the fifth interview to explore a question that arose from the data. "*What do nurses do to gain the trust of the child and family when the life of the child is threatened?"*

Theoretical sampling was used to seek a participant able to reflect on a longer term of nursing experience to enable a more useful exploration of this question. I also wanted to gain insight into the participant's experience from examples of their nursing practice because I still didn't seem to have the core concept of what nurses do to promote the health of the child and family when the child has been traumatized in an accident. I asked the fifth participant to *"think back to when you have been nursing a child who has had a traumatic accident and tell me about what you do as a nurse to help that child?"* I then waited for the reflections to be shared. I was able to promote greater depth by asking questions to discover why and how this participant nursed the child. I pursued questions to explore developing categories such as: *"What do you do to gain the trust of the child and family?"* and *"How do you know you have reassured the parents?"* This questioning enabled me to continue to search for properties that may fit the category *"building trust"*. My conceptualization of the data was continual and flexible; my research process remained open to further development. The comparative analysis after analysing interview five is presented as Figure 9 and conceptualised by the diagram of Figure 10.

	Stepping in	Pacing it together	Stepping out	
Monitoring	Being for	Being with	Moving on	Contexts
Parents knowing Childs knowing Own knowing Progress Positive impact Negative impact Predicting	Voice Giving hope Building trust Reassuring Informing Balancing Doing for	Sharing Trusting Presence Building confidence Coaching monitoring	Encouraging independence Handing over to Giving space	Environment Consistency of parties Experiences

Figure 9: The comparative analysis after interview five

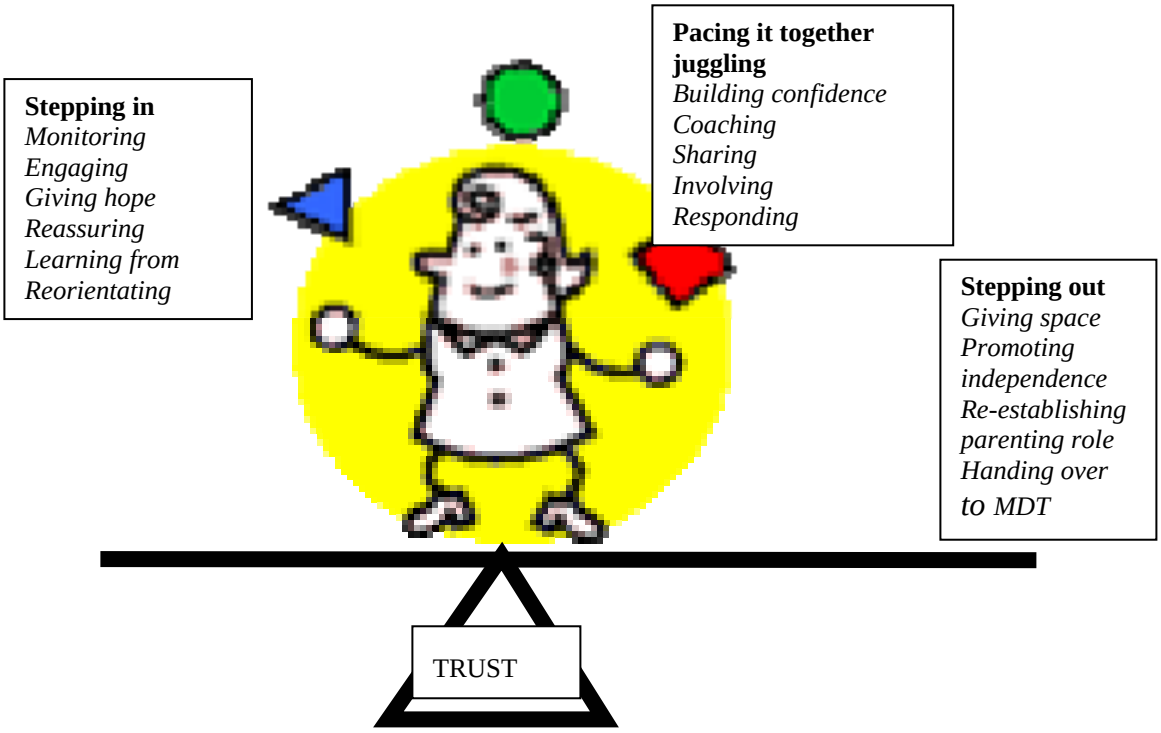

Figure 10: The social processes to "work with". The nurse juggles whilst working with the family to promote their recovery and independence.

The development of Figure 10 aided the conceptual process. Trust has become the base of the relationship rather than the overriding concept previously presented as Figure 8. The nurse's role is emerging as being complex and never static. A juggler seemed appropriate to depict the complexity of the nurse's role when working with the family of a severely traumatized child.

The sixth participant clearly identified the importance of the building of a trusting-relationship with the family and child to promote the child's recovery. The questions asked of this participant were in response to their comments and questions that had arisen from the data analysis to date. I began this interview with an open question: *"Tell me what you think are the most important things nurses do when they*

nurse a child who has had a severe accident?" Other questions prompted during this interview included:

> *You have mentioned coping. Is there a role for nurses in helping with that coping?*
>
> *What are the challenges of reassuring the family if they have caused the child's accident?*
>
> *Reassuring and trust, do they go together or are they different?*

The comparative analysis following the analysis of interview six is presented as Figure 11.

Contexual differences Experience of nurse • Lived • Professional • knowledge Individual child/family Environment • Time • Space	Checking in *Introducing self* *Planning day* *Being honest* *Beginning trust* *Chatting* **Earn respect to**	Stepping in *Information gathering* *Getting to know* *Chatting* *Approaching sensitively* *Being in another space* *Integrating into* *Having family's confidence* *Re-establishing parents role*	Being with *Being a partner* *Being positive* *Maximising potential* *Building trust* *Respond to cues* *Knowing other* *Climbing steps* *Raising hope* *Promoting independence* *Preparing for phases of recovery* *Using self*	Stepping out *Moving on* *Looking forward* *Re-establish parenting* *Preparing for phases of recovery* *Maximising potential* *(Had to have trust to move on)*
Getting to Know *Approaching sensitively* *Stepping in* *Chatting with and Being with*	Reassuring *Opening communication* *Explaining* *Educating'* *Predicting* *Informing*	Climbing steps →	Building Relationships *Child – voice* *Touch* *Cuddling* *Singing* *Honest*	

Figure 11: Comparative analysis after interview six.

I now thought "*reassuring*" could be the core category. The creation of a visual diagram of the analysis is presented as Figure 12

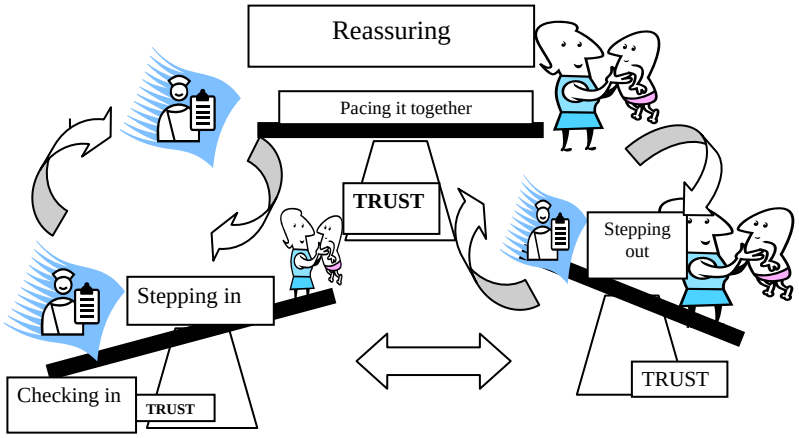

Figure 12: Reassurance as the core category, building trust as the foundation of nursing practice.

The arrows reflect the movement between the processes when a nurse works with a family with a child in the acute care setting following a severe traumatic accident. It was now time to become more selective in my questioning and theoretical sampling. Chamberlain (1999) suggests this is entering the third phase of the research process.

The Third Phase

Beginning the writing of the findings chapters facilitated the immersion in the data to find the core category and any other concepts that needed clarification. I continued to use theoretical sampling to pursue clarification and meaning. Selective coding involving the deliberate and directed selection of further data from participants guided this phase and lead to the confirmation of the core category

holding the theory together and ensured the theoretical account was saturated (Chamberlain, 1999).

I used theoretical sampling to select participant seven. The previous participant had the experience to answer the questions I was pursuing. I believed another senior participant working with children would benefit this research. I entered this interview with developed questions from my analytical process, although I continued to begin the interview with an open question*: "How do you work with a child to promote their health after a severe accident?"* Many of my pre-set questions were answered by the participant's response and during ongoing questioning that arose during the interview. I ensured all the questions I had begun with were clarified prior to closing the interview. The questions that had arisen from my data analyses and that I felt needed to be explored in this interview included:

> *What is the difference between trust and reassurance?*
>
> *How does gaining trust help the child's recovery?*
>
> *Tell me when it has been a challenge to step into the caregiver's role?*
>
> *How do you reassure a family when the family does not know what is ahead of them?*
>
> *Can you tell me about differences in how you work with a child, dependent on their age or cognitive ability?*
>
> *Is trust the overarching part of your practice or is it the base that your practice requires?*

The comparative analyses that continued after each individual interview had now provided a depth and saturation to the categories.

<table>
<tr><td colspan="2">Reassuring
Opening conversation
Checking in - introducing self Approaching sensitively
Planning the day
Giving hope
• Being honest
• Explaining
• .Educating
• Predicting
• Informing :Chatting with being with</td><td>Building relationships/trust

Child
• Voice
• Touch
• Cuddling
• Singing
• Honest
Family :Reassuring</td></tr>
<tr><td>Stepping in
Approaching sensitively
Information gathering
• Monitoring
• Engaging
Getting to know
• Learning from
Being in another space
• Re orientating
Developing partnership
Assisting with parenting</td><td>Pacing it together Being a partner
Coaching :Supporting parenting
Sharing
Involving : Promoting parenting
Responding
Updating
Maximising Potential
Climbing steps
Preparing for phases of recovery
Promoting independence/ hope
Each being self</td><td>Stepping out
Moving on
Looking forward
Re established parenting
Preparing for phases of recovery
Maximising potential</td></tr>
<tr><td colspan="3">Context :Experience of nurse Lived professional Knowledge Environment time space</td></tr>
</table>

Figure 13: Comparative analysis after seven interviews. A core category is no longer apparent at this stage.

Subtle but important changes occurred at the completion of the analytical process using the data from interview seven. I had reviewed categories and properties throughout the comparative analyses of my data after each interview but I had not physically "cut up" and "played with" the data, compelling me to re-read, re-think and re-define categories and properties. I needed to identify the core category in this process. The memos had been used to this point but they also were now resorted to, to weave the fragmented data together and formulate the theory to present to others (Glaser, 1978).

Glaser suggests that a family of theoretical codes helps the analyst to relate the codes that are grounded in the data and integrate them into a substantive theory. I did not consciously use a known "family," however Glaser's "interactive family

captures the interacting pattern of two or more variables when the analyst cannot say which comes first" (Glaser, 1978. p. 76) and this fitted my analysis. There is not a lineal process when *"working with"* a family: each interaction is different and there is no consistent sequence to the variables that are part of that interaction. The interactive family "fits" the findings of this research; the findings were not based on the interactive family.

The core category had now emerged from the analytical process. I had thought the core category was *"reassuring"* however the nursing action that holds all the categories together is *"working with"*. The core category emerged whilst beginning to write the "bones" of the findings chapters. The sorting and resorting of data and memos was an ongoing process until the theoretical order and core category emerged. The model that emerged from the analysis of the research data is presented as Figure 14.

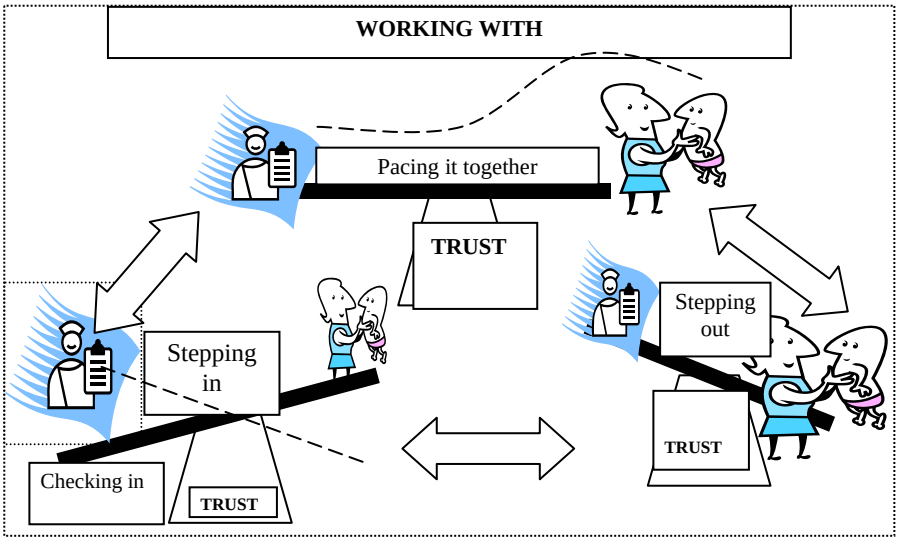

Figure 14: Model representing the social processes to build trust to "work with"

I sensed there may be a difference in the way a nurse *"works with"* children and families when the type of trauma is different. To clarify this I wanted to interview

two of my participants together. Each worked in a different ward, therefore the children had different injuries. This was theoretical sampling using a small focus group to explore theoretically sensitive questions. The appropriate ethics committees gave me permission to carry out this group meeting and the two participants consented to a further interview together to enable me to pose the theoretical questions that had evolved from the analytical process. I opened this interview with: *"I would like to know if there is a difference in building trust and reassuring a family when the trauma to the child is different. A discussion between you may clarify this."* I had other questions that had arisen from my analysis. These were either answered during the discussion or I asked the pair myself.

> *Is there a difference in the fear of parents?*
>
> *Does pain make a difference in the way we work to gain trust?*
>
> *How do you check in if you have not had a hand over or you have never introduced yourself to the family?*
>
> *Can you tell me the differences between trust, rapport, reassurance and support?*
>
> *Tell me about 'holding all' when a child is first admitted or in a very acute phase of recovery.*
>
> *Tell me how trust and reassurance interrelate in your practice.*
>
> *Is there a difference between reassuring and supporting?*

This two-hour interview had the definite purpose of seeking clarity to the concepts that had unfolded in the analytical process. I took Glaser's advice and listened to this interview transcribing only parts that were enriching to the data findings. The comparative analysis clarified and gave meaning to the concepts. For example; the further exploration of the *"stepping in"* process of nurses working with

a family was important to the research findings. The clarity of the finding through using a small focus group supported my choice of theoretical sampling and questioning to complete the data collection. I was mindful of checking the categories and properties that had developed to this stage to ensure saturation had previously been reached. This interview supported and verified my findings.

The Rigour of the Methodology

Rigour was ensured using several procedures from qualitative enquiry. The analysis of my presuppositions interview and the keeping of a journal throughout the research process identified my own assumptions. Therefore I was aware of these during the data collection and analytical processes. The strictness of the conducting of this research process is evident within the presentation of my research pathway. The tracking system of coding and recording of memos has been shown in the methodology chapter.

The constant comparative method used has ensured the categories and properties are grounded in the data. I chose to withhold the reading of literature during the data collection and analytical process enabling me to enter and proceed through the research process, free and with openness to the emerging concepts from the comparative analysis of the data. My questioning to participants remained synchronized with the research process.

Theoretical sampling contributed to a depth of analysis within the categories and properties that emerged from the data. The final small focus group repeated substantial research findings that I had already extracted from the data. The amount of “in vivo” interview data used in the construction of the findings chapters means the voices and accounts of the research participants have been well represented.

Summary

This chapter has provided the reader with a glossary of terms and discussion using the literature to describe the theoretical concepts underpinning grounded theory. The core processes of Glaserian grounded theory methodology; constant comparative analysis, theoretical sampling, and saturation have been explained. My research pathway has been presented as a progressive journey until data saturation was reached and a core category identified. The use of figures representing my research process has enabled the reader to track my conceptual analysis of the data from seven individual interviews and one small focus group.

The next three chapters present the research findings from my research methods. Chapter four focuses on the beginning working-relationship between a nurse and family when a child has had a severe traumatic accident. Chapter five reflects the times the nurse is interacting with and creating some balance in the working-relationship developed with the family to promote the recovery of the child. Chapter six reflects what the nurse does to promote the families' independence and enhance the child's recovery.

CHAPTER FOUR: Building a Working-Relationship

This chapter uses the research data to describe what acute care nurses do when they begin working with a family whose child has had a traumatic accident. The participants have reflected on their practice when nursing children whom they perceive have severe trauma as a result of the accident. This chapter presents the beginning social processes the participants used to build a relationship with a family whose child was admitted to the acute care admitting ward. The concepts of *"checking in," "stepping in," "building trust,"* and *"promoting a working-relationship"* are used to describe the nurses' interactions with a family following a child's admission to the acute ward from either the Accident and Emergency Department (ED) or the Paediatric Intensive Care Unit (PICU). The participants have clarified what the nurse caring for the family in the acute care setting does to initiate a trusting relationship. All the statements made in this chapter, and chapters five and six, are based on the data from this research. Most statements are accompanied by supporting quotations, but others are not, although they are all firmly grounded in the data.

Beginning a Relationship

The concept that nursing children who have had a traumatic accident involves nursing the "family" as a whole emerges throughout the data. The child and parent/s or caregiver/s will be referred to as "family" throughout the findings chapters. However when appropriate I will separate the child from the parents/caregivers. For ease of reading the parents /caregivers will be referred to as parents throughout.

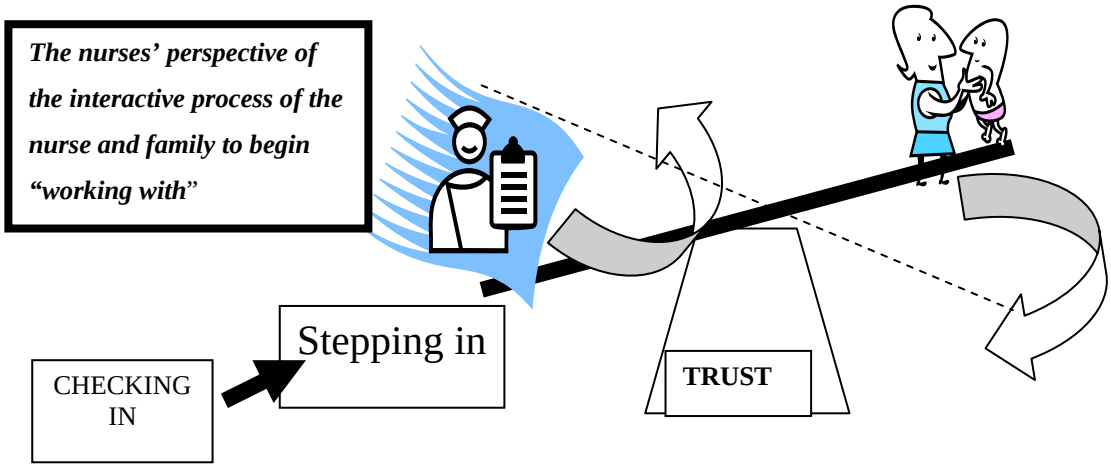

Figure 15: Stepping in to "work with".

The diagram showing the relationship working together on the seesaw has emerged as a valid representation of the social processes involved in nursing the family. The seesaw symbolises the movement of the "power of knowing" felt by the nurse when *"working with"* a family. The felt power is different in every situation, depending on the nurse and the individual family. The initial responsibility felt by the nurse may be *"holding it all"* or *"holding it together"* to hold up the fragile family at a time of crisis. The nurse *"checks in"* with the family to initiate the relationship but *"the family holds the key"*, giving the nurse permission to get on to their seesaw, into the family's space. The 'knowing" of each other begins at this point and the interrelationship develops as the nurse *"steps in"* to the family's space whilst *"nursing"* them. An effective working-relationship depends on beginning and then building trust between both parties. The sharing of the nurse's knowledge and the family's knowledge alters the balance of the seesaw. This is a volatile time when rapid changes occur in how a nurse works with a family (Figure 15).

The Beginning of "Working With"

The acute care paediatric nurse works with a family each rostered shift. The nurse who works with any particular family relies on the decision of the nurse leader on the shift. It may be that there is a *"small team who will care for the family in the acute phase"* (Nurse E) and they roster themselves to become the team *"working with"* the family. Each nurse is *"building on what other nurses have done"* and has a *"need to carry that on whilst bringing their own individuality"* to the relationship (Nurse G).

Introduction to the Family

Usually participants ensured the *"hand over"* process informed them so they could approach the family and proceed to *"check in"* with them. Participants were typically introduced to a family through the process of *"nursing hand over"*. The participants' experience of *"hand over"* was listening to either a taped report or a group process from nurses at the end of a rostered shift to those at the beginning of the next shift. Nurse C expressed the need for a more detailed hand over and said: *"I wait until they have done the allocation for the next shift and spot whoever has got who I had. I will go and chat to them again but that is not the routine. That is me."* Nurse C ensured that hand over provided everything that needed to be known to care for the family effectively. The nurse taking over the care would be informed of the patterns and changes of the child's physical and emotional status over the previous shift. Nurse C would share the family's current emotional and social needs with the oncoming nurse before they *"checked in"* with the family. Nurse C's diligence in

practice was evident when stating the need *"to make sure that I know that person knows what has been happening for the family"*.

A nurse does not always have the opportunity of being informed about a family at hand over. There are times they are called in to an emergency or the previous nurse may not have stayed back as Nurse C did. Nurses F and G emphasized the importance of *"straight away introducing myself so the family knows who I am"*, and *"asking the family to tell me what happened and saying I am here to help you"*.

Beginning a Trusting Relationship

The data revealed two stages in the beginning of a trusting relationship. The first when the nurse *"checks in"* with the family and the second when the nurse and family inform each other. The participants' view of the importance of trust as the basis of an effective working partnership with a family is illustrated by the metaphor "building blocks of trust" to provide an increasingly strong base for the nurse and family relationship. Prior to entering a relationship a *"nurse's role awards them a certain amount of trust from the family"* (Nurse F). The awarded trust provides the base on which the developing building blocks of further trust can be laid and this is shown in Figure 15 by the placing of building blocks of trust in the pedestal on which the seesaw is balanced.

Checking In

Participants used the term *"checking in"* to describe the process when the nurse first enters the family's environment after taking on the care of the family at *"hand over"*. This is the time spent with the family to begin to build trust in the

relationship so both parties can *"work with"* each other effectively. Trust is built in a relationship as all parties concerned *"get to know"* one another.

All participants acknowledged the importance of making themselves known to the family early after the *"hand over"*. Nurse G comments:

> *Over time and experience I now know that first impressions are really important… in the first five to ten minutes of the day I will introduce myself and if I am busy with my workload I will say that I will be back, I just need to meet my other patients.*

The building of trust begins *"in the first thirty seconds, it's how you come across to the family"* (Nurse F). Nurse F adds: *"This is how it happens when you don't know anything about the family, you are called in."* Nurse F experienced the importance of first impressions when his/her father was being nursed, Nurse F was on the other side of the health service as "family" and *"felt able to trust the nurses who came and introduced themselves at the beginning of the shift and explained what would happen that day"*. This experience clearly supported that the nurses who introduced themselves early in the shift were able to initiate a trusting relationship.

The beginning of a trusting relationship depends on how this first "building block" is laid. Individual participants began relationships with families using different patterns of interacting. Nurse A maintained professional boundaries and focused on the needs of the family. Nurse E opened interactions with the family by *"chatting about me"* but maintaining the focus of the nursing role. Similarly Nurse F *"often says what I am like as a person so they get to know me"*. Nurses C and G would *"just chat away"* but it's not always appropriate or easy to use *"chatting"* to get to know each other whilst *"checking in"*, particularly if the nurse is feeling unsure about what is happening at the time. *"I use a time of silence but I wonder if*

they think that I don't know, I usually chat but I can't if I am scared" (Nurse G). Participants consistently worked to gain the trust of the parent before focussing on the child.

The perceived and actual severity of the child's trauma influenced the initial interactions between the participants and the parents. For example Nurses B, E and F felt that the extent of "difference" in their child as a result of the trauma affected the parent's interactions with them. Another influence identified by Nurse G was how the degree of severity of the trauma to the child affects a nurse's initial interactions. Nurse G recognized that the first *"building block"* of trust is challenged when the nurse is unprepared and enters the space of a child whose severe injuries distort their appearance or when the prognosis for the child is poor.

> *I see a staff member go in with a smile and bright 'how are you'? Then they see the child and their whole language and body language changes. They need to be aware of that and learn how to do things differently. Once a nurse has learned these skills she has them. New nurses can come out and they say they don't know what to do and say. I find they are all diplomatic and polite. It's that next level they need to go to and by encouraging and saying they are doing well it helps.* (Nurse G)

Nurse G continues to comment that *"nurses may perceive their shock and distress has not impacted on their interaction with the family"*, but then observed how the altered interactions have affected the family. Nurse G's view of the art and confidence involved in being positive at times like this is discussed later in this chapter, in the section on reassuring the family.

Nurse F identifies the importance of the *"checking in"* process to develop a trusting working partnership to begin *"working with"* each other.

> *I think checking in first and stepping in after that. I say that because if I have stepped in first, families have said to me "We have been doing this, so why don't you just go and let us do it? Families also find it threatening if this person says "Why don't you do this?" and they are not ready to do that so I like to check in.* (Nurse F)

Getting to Know

The sharing of information and appropriate questioning explains what is happening "now" but all participants needed to know about the family prior to the accident to help to *"take them back to where they were"* (Nurse C). An important starting point of *"getting to know"* the family is facilitated by an open relationship. *"Taking time to chat with family and get to know the child's interests before the accident"* was often made easier by *"chatting about self"*. *"Chat encouraged families to be open about themselves"* and enabled them to see the nurse as an individual person (Nurses C, D & F). Nurse G explored *"what the accident means to them as a family"* to know how to *"work with"* the family during a crisis in their lives. The sharing with each other also helped to reduce the feeling of power, the weight a nurse carries when being in control of the care of the child. Nurse C comments: *"I have got all this kind of power in a way when I am assessing their child and they don't know who I am, so I just think it's very important to just have a normal chat with them, just find out what they do."*

Holding All

"Holding all" refers to who is holding what at the time during the nurse and family interactions. The responsibility of *"holding all"* the professional knowledge of what is happening was felt by some participants. All participants comment how

important it is to keep families informed when building trust and *"the sharing of their knowledge reduces the weight of 'holding all' "* (Nurses C & D). Nurse C introduced the concept of *"holding all"* when saying: *"I always think it's quite bizarre that you are suddenly looking after this child and they have no idea who you are, they have never met you before and you are looking after them and you hold all of this."*

The parents are not in a place they expected, their day began like any other day, *"their child went to school and the next thing their child is severely injured in hospital"* (Nurse B), they are in an unknown space and not in control of what is happening to their child. Nurse C went on to say *"I had all this kind of power when assessing their child"*. Participants' knowledge helped them to identify the needs of the child, *"some communicate well and others won't or can't say anything so we have to look for those cues other than verbal"* (Nurse A). The concept of *"holding all"* has been used to acknowledge the "knowing" the nurse has from nursing experience when the family is in a situation it has not previously experienced, and are unable at this early stage to hold part of that responsibility. Nurse G recognized the importance to *"take a deep breath and stop holding all"*. Nurse G clarifies this when stating: *"You have some of the jigsaw, some of the answers, but not all. You need to know what parts they hold but pick the right time."*

"The nurse is the constant health professional working with the family for twenty four hours seven days a week" (Nurses B & F). Nurse F acknowledges the importance of the expertise the nurse holds as well as the complexity of the nurses' role.

> *I think nurses have a triple role and interest in the acute care stage: that the child doesn't die, their condition does not deteriorate, and the physical needs of the child which then flicks over to the emotional needs are met.* (Nurse F)

All participants mentioned the responsibility they felt when monitoring the child's progress, their accuracy and findings were important for the child's future. This is only part of *"holding all"* as it is also the nurses' role to monitor and support the family that is in *"a situation they have not been in before and they find it daunting"* (Nurse A).

Some participants implied they were *"holding all"* when *"stepping in"*, enabling them as nurses to step onto the seesaw (Figure 15). Other participants felt the family invited the nurse onto the seesaw with them. Participants recognized that the nurse needs to *"step in"* to begin a working-relationship in any situation.

Stepping In

The view of the nurse's role when *"stepping in"* differed between participants. Nurse F described the *"stepping in"* as being *"a surrogate parent at times"* whereas Nurse D viewed *"stepping in"* as *"becoming very close to that particular family, you become a friend"*. *"Stepping in"* in the context of *"getting to know"* the family was perceived as being there, *"just sort of sitting with the family"* (Nurse B).

There can be barriers to nurses' ability to *"step in"* to a family's space. *"Building trust is a strategy to step in"* (Nurse G), but what is happening for the family can make the process of building trust more difficult. For example Nurse F describes *"having to chip away at a wall and have a clean slate to build trust with a family who feels the guilt of the accident."* Rather than chipping away at the wall, Nurse G *"would look through the windows to gain trust"*. The process of stepping in

takes longer when the family does not readily give the nurse the opportunity to *"be with"* them.

"Stepping in" is also considered *"stepping in"* to *"work with"* and this happens during the working-relationship, particularly in the beginning. Nurse G observed a family who wanted to do more but they were frozen; they couldn't do it. So Nurse G empathized with their concerns and fears, and reassured them that it was all right to feel like that and she/he would *"work with"* them to do what they wanted to do. This is an example of *"stepping in"* to enable *"working with"* a family to reassure them and begin to reinstate their independent role.

Reassuring the Family

Once trust was beginning, the nurses needed to do other important work that encompassed monitoring and caring for the family. Reassuring both the child and the parents emerged as a significant part of this work and an important component to continue to build a trusting relationship. The key concepts used to reassure the family early in the relationship included *"giving hope"* and *"being honest"*. These concepts continue throughout the nurse-family interactions. Reassuring is a "loose" word used easily by the participants. Nurse C acknowledged that *"reassure is such an easy word to say but it is difficult to do"*.

Reassuring the child and family is *"a building block of trust"* (Nurses F & G). Nurse G stated that *"reassurance is what we give but trust is something we need to build with the family"*. *"There is no linear structure to building trust"* (Nurse G), but the need for reassurance is evident in these participants' comments. Nurse F states: *"The ability to reassure a family relies on the trusting relationship that has been*

formed by 'getting to know' each other." Nurse G says: *"the development of trust is nurtured when the family feels reassured."*

All participants recognized that *"reassuring"* is an important social process not only while initiating a relationship with a family in the acute care setting but also throughout their time in the ward. It is a reciprocal process in respect that *"we give reassurance to families and families give reassurance to us"* (Nurse F). The interactions most often used by the participants to reassure families relate to sharing the knowledge that nurses have to guide their practice. Participants' interactions included orientating, informing, educating, explaining, and responding while *"working with"* or *"doing for"* to reassure the family by responding to their perceived needs. Nurse G comments that nurses need to *"explain what they are doing and why we are doing it"*. Illustrations of how participants use their knowledge to inform the family about what is happening to the child as a result of the trauma include *"what the monitoring of the child's physical health status means"* and *"interpreting the child's progress from the medical perspective"*.

Informing is related to the particular family and what is happening to them. Participants said that families were reassured by being informed of what was happening. However, Nurse F added *"reassurance is how you do it, not the content"*. Nurse A informed the family *"about the process that's going to happen and that it's a long term process",* whereas Nurse F would inform the family by including *"where we are at now, what we are looking for, identifying and informing them of small parts of recovery"*. Nurse F used this strategy when the future of the child was not easily predictable. When the outcome of trauma can be predicted Nurse G would *"anticipate what will happen"*. Nurse B says *"discussing with them what we are*

doing with their children and including them in the care" helps to reassure the parents. Nurses G and E orientated the family by explaining what they perceived as "*normal*" to be an important interaction leading to reassurance of the family. "*We know its okay to turn an alarm off but to them it's an alarm…we know… but just being in hospital, how normal is that for a family…just taking away scary things"* (Nurse G). Participants involved the family when tending to the child to *"help them to feel they are not a stranger in this environment"* (Nurse G).

Participants recognized that parents are often in an unknown place when the injury changes their child's behaviour, *"they are often aggressive or have a different personality"*. Nurses A and C responded to the parent's confusion by normalizing this behaviour and reassuring the parents it would get better. Nurses F and G deliberately refrained from using the term *"normal"* when reassuring families. Nurse F comments that experience helps, *"you learn how to read people, and you try other ways of talking with them"*. For example, instead of saying what an aggressive child is doing is normal Nurse F would say: *"this is what we expect, it is a phase they need to go through."*

Different situations create different hurdles and different strategies are needed to overcome those hurdles. Reassuring a family that blames itself for the accident is a challenge to nurses. Nurse D perceived that often *"the family thought the accident was their fault"* and *"going through what has happened with them"* helps them to be *"reassured that it is not their fault"*. Nurse F tells of the need to facilitate family meetings to give reassurance to those individuals. *"I have found from experience making them mention it to their family …getting them to open up…get the family to talk…say they do not see it as the person's fault."* When the impact of the trauma is

unknown to the family, sharing past experiences helps the nurse to respond and reassure those families with fears, especially those who don't know their future. Families seek reassurance about their child's physical health status. Nurse F recognizes that informing a family *"we are doing the best we can for their child"*, is needed to *"initially help families cope"* when the outcome for their child is not known.

Giving Hope

Giving hope is another strategy used by participants to give reassurance to families. Hope is initially given by interacting with the family and telling it how the nurse sees changes which reflect *"small steps as the child progresses"* (Nurse B). *"The families hang on to those small steps"* (Nurse F). The predictability of the future is difficult, particularly when the severity of the injury and possible outcome are unknown. Nurse F gave hope to families by sharing past experiences and reassuring parents that the changes they were seeing were progress for the child.

> *A young girl who had a severe head injury was going through the restless waking up phase. I guess with my experience that's where I got to bringing in the realistic phase as well. Mum was obviously exhausted, shattered, her posture was stooped, she was sighing a lot so I said "this is a tiring time, it's a positive time, and this is a stage of recovering from a head injury…this is progress, this is a really good sign.* (Nurse F)

Nurse E used positive interactions when a family was getting negative reports of the child's progress by reflecting on a previous experience. *"I told Mum about this boy I had looked after previously with the same sort of injury and he ended up walking."* Nurse F adds: *"There is the place for positiveness, but it is important not to blow it out of proportion."*

The giving of hope depends on the level of trust a nurse has with the family. Nurse E relies on the relationship with the parents to give hope to the child.

> *It's hard for us to get in there and get the kids hopes up because they don't know us and they may not talk to you. Just making the parents feel like he is improving so they can tell the kid [sic] they are improving.* (Nurse E)

Nurses E, F, & G acknowledged that *"the trust with the child is gained through the trust the nurse has with the parents."* To give hope safely when predicting the future, nurses inform families of what might happen in the future but also that predictions *"might not happen like that at all"* (Nurse E). *"It is easier to predict when there is a sequence to healing like in a fractured femur"* (Nurse G). Those participants who discussed giving hope as a strategy to reassure a family stated the importance of being honest and realistic when giving hope.

Being Honest

Being honest is another strategy used to reassure families effectively and build a trusting relationship. Nurses being open about their nursing practice with the families maintain honesty in the nurse-family relationship. Being open *"goes back to the education of families for what we are looking for, why we are looking, and what the changes mean so that could be positive or negative"* (Nurse F). There were times when participants knew they needed to be open with their feelings to reassure the family. Nurse G comments that *"sometimes it's just walking into the room and being honest and saying that it's tough and hard for me too"*. Nurse G was able to empathize in this situation by acknowledging the severity of the child's injury.

Children don't always survive traumatic accidents. Participants talked about the importance of *"working with"* the family by *"being with"* them in a time of crisis. Nurse F *"works with"* a family to promote an honest open relationship.

> *We need to support and help them to know what is going on. Give the truth knowing that they want their child to make it. We say that we will do all we can to help that and what we are doing is working towards that. I say to the parents, it is great that you are here and that you continue with your beliefs.* (Nurse F)

Nurse F is *"being with"* the family, acknowledging that giving support to families when the child is not progressing is a challenge. Nurse F believed *"all the experience in the world does not prepare the nurse for these situations. The ability to empathize and 'be with' is not easy for the nurse"*.

The nurse's ability to be trusted by a child relies on honesty at the beginning of their relationship. *"It is difficult to rebuild lost trust with a child"* (Nurse F). An everyday example of honesty is telling the child the medicine does not taste nice and *"having the lollipop in the pocket to give him afterwards"* (Nurse F). There are fine lines we cross frequently between honesty and dishonesty, nurses *"do it all the time with children"*, for example when nurses say something will feel like *"a wee sting there is no such thing"* (Nurse G). Nurse G questions *"how they may perceive this?"* Nurse F comments that an honest explanation helps to build trust with a child.

> *When explaining to them that something is going to be painful you have to be honest and let them know. I like to think I would have built some degree of a relationship that is trusting and once they are communicating continue on to be honest.* (Nurse F)

"Being honest with the family is reassuring" (Nurse F) and when nurses don't know what's happening they need to tell the family. *"We are doing this and this to find out what's happening and it's not unusual for us not to know."* (Nurse G)

Summary

This chapter has presented the participants' perceptions of how they begin to build a trusting relationship to *"work with"* a family whose child has been traumatized in an accident. Building trust by reassuring the family using the strategies of giving hope and being honest have been important social processes used whilst the nurse *"checks in"* and *"steps in"* to the nurse-family relationship. Participants professed that the building of trust with the family enabled them to *"step in"* to *"work with"* families.

Participants were aware of their responsibility for the future of the child and family when the families were in crisis from their child's accident. Participants used time *"get to know"* the family to *"work with"* them and promote the child's recovery. The development of a working-relationship requires reassurance and trust. These two concepts will continue to be discussed in the following two findings chapters, Chapter five and Chapter six.

CHAPTER FIVE: The Art of "Working With"

This chapter discusses the reciprocity and mutual interdependence of the participant and the family using the bases of trust to *"work with"* and promote the recovery of the child and family. From the participants' perspective, their role included the concepts of re-establishing parenting, supporting family functioning, and balancing by empowering the other. This process of *"working with"* is not linear and the participants clearly stepped in and out whilst 'pacing it together' although there is stability to the relationship whilst working together. The participants' goal is to develop a relationship between both parties where there is more independence, enabling the family to move on.

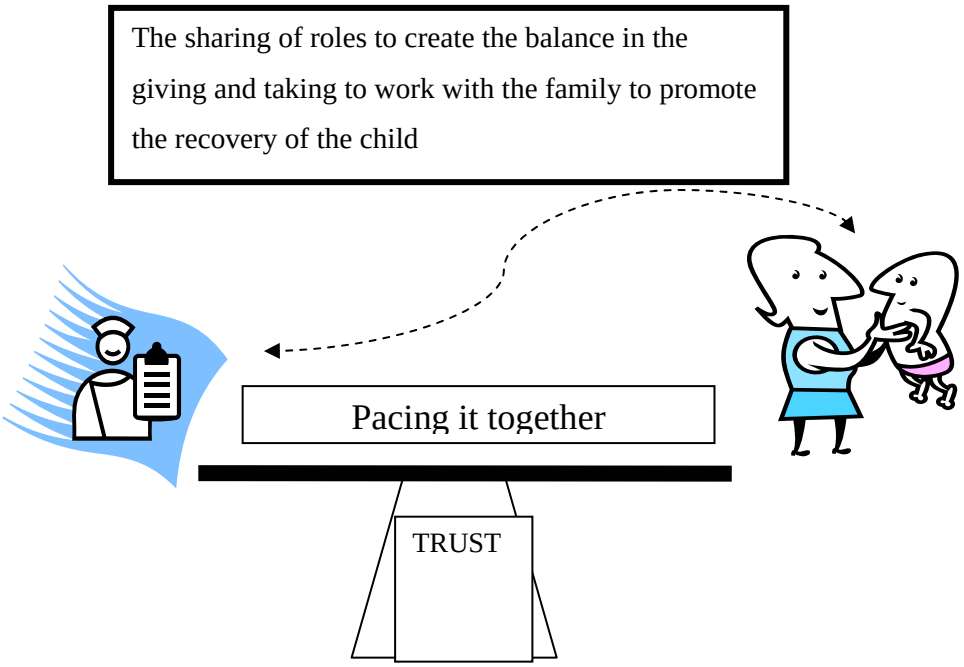

Figure 16: Pacing it together: the development of a working-relationship

The nurse has built the level of trust required to be a participant in care and *"work together"* to promote the independence of the family. The knowing of each other now reflects a working-relationship with a sharing of responsibilities to care for the family. There is a developed stability with the increasing trust built into the working-relationship, even though both the nurse and family remain in an area that still has aspects of ambiguity. There is an "art" to the balancing of the seesaw whilst nursing a family to support the re-establishment of parenting and facilitate rehabilitation processes, with the intent to promote the ongoing growth, development, and appropriate independence of the child. The seesaw is never completely still, reflecting that either the nurse or family attends to the child's needs. The shift of balance is affected by the way different situations call on the nurses or parents taking responsibility. Because of their particular knowing, either the nurse or the parent works more with the child and the balance of the seesaw alters. This phase of recovery continues to be interchanging interactions and the giving and taking of responsibility while nurses are *"working with"* the parents to help them to cope with the change in their child. Their increasing development of new and relevant parenting skills is ongoing (Figure 16).

Components of the Art of "Working With"

Communication processes used when *"checking in"* and *"stepping in"* have been identified by the participants as the prerequisites to being able to *"work with"* a family. The participants recognize the need to continue building the blocks of trust as a necessary component for maintaining the foundation for smooth interactions of explaining, involving educating, coaching, informing, reassuring, and supporting while *"working with"* both the child and parents. Participants were *"working with"* to

"try to get them back to the family they have come from" (Nurse C) by maximising the potential of the child's and family's recovery. A nurse *"gets to know"* a family more intimately whilst 'pacing it together'. By gaining trust and becoming *"very close to a particular family, you become a friend"* (Nurses D & E). Nurse E comments that the "*chatting"* by both parties means they "*get to know each other really well and they know about our family and everything"*. Nurse F seeks to "*know the family as a whole … Aunts and Uncles too"*.

The potential recovery of a child and family relies on more than one nurse developing a working-relationship with a family. Nurse F recognised that interactive processes are required outside the individual nurse and family relationship: *"I personally build up trust … coupled with the family being able to see that the nursing team is genuinely trying to do the best to help their child recover."* Nurse C adds "*that if you are working independently with a child you will not get anywhere*" and perceives the nurse to be the facilitator of *"gelling that team"*. Whilst 'pacing it together' Nurse F sees the individual nurse as the "*stepping stone to the rest of the team, including the therapists…the multidisciplinary team"*. Individuals from professions with different specialities work together and work with the child towards recovery by regaining the skills the child had prior to the accident. The art of *"getting the team together"* relies on the nurses' relationship with this team (Nurse A). Nurse A says the child's progress is *"reliant on a lot of different people to help at different stages of recovery"* whilst 'pacing it together'.

Re-establishing Parenting

Participants recognized the need to orientate parents to changed parenting activities resulting from the impact of the injury on the child. The participants

asserted that it is fundamental that a nurse is able to *"step in and out"* to coach parents in the parenting activities required when the context of their role has been altered by the environment, as well as by their child's changed needs from the trauma of the accident. New skills need to be learned and *"most families after accidents are out of their depth"* (Nurse G). Nurses support families through changed circumstances.

Moving to a different unit within the hospital is seen to be disorientating and confusing to parents. Participants mentioned that some children come to the ward from PICU. The confidence and trust parents had established with nurses is temporarily lost when the child is moved from one environment to another. Nurse F has a view of the parents perspective: *"It's new faces and the routines tend to change as well so they don't know where they fit in, what they can do for their child or how they can attend to their child."* It is important to "*see exactly what the family is comfortable with and what they would like to do"* (Nurse F) when they enter a new environment. Re-establishing parenting therefore relies on the nurse being guided by the family. Participants stated that they involved the family and worked with them while 'pacing it together' (Nurses C, E & F**)**.

Involving the Parents

All participants perceived the parents wanted to be involved with caring for their child and used their involvement as the first step towards re-establishing the child-parent relationship. Nurse E involved parents when two pairs of hands were needed and commented, "*they felt useful doing something and I think we do it to build their confidence"*. Gradually while 'pacing it together' the participants began handing over some of the parenting role by "*encouraging them to do the things that*

they can and they feel they want to do" (Nurse A). It was recognized that *"if distressed or traumatized they are not likely to be part of care-giving"*, therefore feelings of distress need to be resolved first (Nurse G). Participants explained to the parents what was happening to their child at the time to enhance their ability to *"work with"* parents and encourage parent's involvement in the care of their child. Nurse B acknowledged nurses need to know and respect when to involve parents in caring for their child. *"We can see those parents who want to be more involved, we also need to recognize the parents who are not comfortable at doing that and respect that as well."* Nurse B also gave the example of teaching a parent to feed their child when the child relied on feeding through a tube directly into the stomach. When parents became interested, Nurse B would *"educate the parents on setting up and safe practice"* with the feeding so they could do this for their child when they wanted.

The participants' comments indicated that the *"coaching"* and *"doing together"* to promote the recovery of the child requires the skill and knowledge of both the nurse and the parents. Nurse A comments that *"working together with the child and family"* helps make decisions. Nursing experience has informed Nurse G how to *"do with"* to ease the re-establishment of parenting. According to Nurse G, *"nurses start off doing for. Confidence helps us to do with"*, and emphasized that nurses *"need to do with rather than do for, and set up that basis from day one"* of *"working with"* a family.

Participants use *"doing for"* to develop the trust to initiate a working partnership. The moving of a child in pain, and the management of pain is an example where it is important nurses *"do for"* the parents. When a child is in pain it is difficult to maintain a trusting relationship and re-establish parenting. A parent's initial

concern is that their child is pain free and their first need is to *"get this pain sorted"* (Nurses F & G). Usually when the child is *"really distressed or traumatized, parents are not likely to volunteer to be part of care-giving"* (Nurse G). Nurses E and G talk of the importance of ensuring a child is free of pain; the child being comfortable is *"the greatest issue for parents. You cannot have their trust without the control of pain"* (Nurse G). Emotional pain is felt by the family when there is confusion or unknowing of what is happening and *"can't be the quick fix of most physical pain"* (Nurse F). Nurse G was aware that a serious injury meant more than physical pain to the child and encouraged parents to *"be with"* their child. Nurse G's hope was that *"working with"* their child would help both the physical and emotional pain felt by the child and family.

Nurse E needed to complete interventions that were noticeably stressful and painful to a particular child. The parent's involvement was thought to be better for the child, so Nurse E

> *just talked to Dad outside the room and explained that it was really important that he was there when we did his child's dressings because of the way it affected the child. I mean when Dad wasn't there the child was really traumatized, whereas when Dad was there I saw one hundred percent improvement and he was fine.* (Nurse E)

Involving the parents helps the recovery of the child but that can be difficult for parents when their child is "different" as a result of the accident.

Learning to parent a "different" child

Parenting is challenged when a child is recovering from a traumatic accident. Parents need to learn new skills to *"work with"* rather than *"do for"* their child so that their child *"can be helped to return to the child they were"* before the accident

(Nurse D). This was difficult for parents who wanted *"to protect their child, these parents don't understand they need to be pushed to get better"* (Nurse D). Participants also recognized that parents' skills were re-challenged when they were confused by the display of unknown behaviours and actions by their child. This was most noticeable when the child was beginning to regain consciousness (Nurses A, B, E, & F). Nurse B comments that unsure parents *"may withdraw from their child and not interact so much with their care"*. Nurse B recognizes the stress for families. *"Families become horrified at the violent swearing child thrashing around in their bed...An important aspect is to help them understand and stay and be with their child."* Importantly participants reassured families by saying that these are *"positive signs and it's good that this is happening"* (Nurses A, B, D, & F). Reducing the fear and confusion helps the parent to work with and "parent" their child although often the management of behaviour changes is passed over to the nurse. *"Often parents ask us to help with limit-setting as this is different to when they were at home so parents have often asked us to… step in to help with the caregiver's role"* (Nurse G).

Nurse G has been *"invited to step in"* and parent the child once the relationship of the nurse and family has the established working-relationship required to "pace it together". Nurse B commented that the parents *"who are very proactive and want to learn new skills to care for their child"* provide the opportunity for the nurse to educate them. For example, *"setting up and doing safe practices in feeding"* is a skill needed to parent a child. Nurse F comments that it is easier for parents to learn how to care for their child, and to initiate that *"when they know the nurse"*. It therefore helps parents to learn new skills if a nurse *"looks after the same child a few times and gains their trust"* (Nurse D). Nurse D comments that families with children

who have complex injuries from the accident are *"nursed by a small team"*. The whole team of this particular ward tried to organise a small group of nurses to be the consistent group that *"worked with"* and became known by the family.

Balancing by Empowering the Other

Empowering the other can occur by just *"being there"*, able to attend to the needs of the family that arise. The relationship between the nurse and the family in crisis after their child's traumatic accident is enveloped in trusting each other. *"Getting well and the rehabilitation of the family are based on trust. The most important thing is building trust with each other."* (Nurse G). Each party of the relationship is able to empower the other by the trust that is developed between the two while 'pacing it together'.

> *Trust is a two way thing…they can see you are willing to trust them when they know what we are going to do and then you step back and let them be their family and just be there in the background to work with them.* (Nurse G).

"The way a family trusts is very individualized" (Nurse F). Their background and previous experiences with nurses will influence the development of a trusting relationship. Nurse F empowers parents by *"fitting in and working with"* the individual parenting styles. As long as it was considered appropriate, Nurse F *"would use the family's philosophy when interacting with their child"*. If it was not considered appropriate, Nurse F would model examples of different ways to *"work with"* the child and demonstrate a different way of parenting.

Nurse F acknowledges the reliance on each others *"knowing"* as being integral to the success of *"working with"* and developing a mutual trust and working-relationship. The trust in each other empowers each other and takes away the barrier

between a nurse and family. Nurse C's goal when "*working with*" a family is to *"build up some sort of rapport with them and then you don't feel that you are always the nurse and they are always the parent."* By *"being with"* and *"chatting with"* the parents, participants listened to parents' thoughts, confusion and fears to help the nurse know how to work with the individual family (Nurses C, E, F & G), and thereby develop a mutual working-relationship and re-establishment of their parenting role.

Power is given to family by standing back and not *"stepping into"* the role of the parents, instead making a *"judgment call"*, waiting *"for family to do what needs to be done"*(Nurse G). Nurse G tells of being in an Intensive Care Unit (ICU) with a child seriously injured from an accident. Dad was dying as a result of the same accident. Nurse G spent a day in the adult ICU to monitor the child while the child lay in his bed next to his Dad's bed.

> *I wanted to go up and hold his hand to give him a cuddle and that for me would have been a natural thing to do, but I saw all the family there and it was a judgment call to wait for family to do that for him and they did. If I had done it, it would have been wrong. I am only part of a very short time of that child's life* (Nurse G).

Nurse G had to be patient and wait for the family to do what needed to be done.

"Working With" a Child

Having the trust of the parents is fundamental to the nurse's ability to *"work with"* a child. During the 'pacing it together' phase the child is often cared for by either the nurse and/or a parent. Both the parents and the nurse *"work with"* the child, sometimes together, sometimes independently, depending on whether the nurse has *"stepped in"* or *"stepped out"* of the interactive relationship. Participants agreed that

nurses need to have the trust of the parents to work with a child. *"If children see their parents trusting you there is an overflow of trust to them"* (Nurse F). The trust the nurse has with the family influences how the child reacts to them because *"children pick up the vibes from their parents"* (Nurse C). Nurse E voiced the importance of developing mutual trust with the family: *"I wouldn't want to look after a child unless I thought he trusted me. I think it would be impossible without the trust of the parents. It wouldn't be right."*

Building trust is reliant on the nurse *"being with"* the child and using touch, voice, and a stimulating age-appropriate environment to *"work with"* the child. According to participants, the time spent with a child develops the trust a child will have with a nurse and trust is imperative to enhance the recovery of the child (Nurses D, E, F & G). *"It helps in nursing if you look after the same child a few times and you gain their trust and then they start to talk to you about what's troubling them"* (Nurse G). Participants talked about gaining trust on the first meeting with a child by *"being with"* them and *"using time to just sit down and talk rather than just going and doing something to them"* (Nurse C). The frequent and intense interactions participants have to carry out to monitor the child's progress following a traumatic accident rapidly inform the participants of patterns in the child's behaviour (Nurses A, B, D, F & G). Those frequent interactions initiate further questions to guide how the nurse continues to interact with the child. For example: *"Are they able to understand what has actually happened and what injuries they have? How are they feeling? Are they in pain? Is there something major going on that they are frightened to deal with? Are they anxious?"* (Nurse G).

As previously discussed the pain a child is feeling affects the relationship the nurse has with the child as well as the parents. *"A child will not 'work with' or do things for you if they are in pain."* (Nurses C, D & F). The presence of physical pain affects the child's ability to develop trust with the nurse. Whether pain became a barrier to building trust depended on the child's injury. Those children with fractured bones or open wounds needed the nurse to relieve their pain prior to doing anything with them (Nurses F & G).

Nurses' interactions with children are guided by the child's age and cognitive ability (Nurses C, F & G). The ability of the older, competent child to share and "*chat"* enhanced the building of trust and the interactions to promote recovery (Nurse C). Participants' goals when *"working with"* the child are clearly stated by Nurses C and F as *"maximising what their potential is in the end"*. Every participant professed that this cannot happen if they do not have the trust of the child. Nurse G reflected on a child where the lack of trust was impeding his recovery:

> *As far as the recovery goes I have seen the child who doesn't trust and won't move which is a very important part of rehabilitation. He's not engaging in any of his cares, he's very frightened, everything is scary.* (Nurse G)

Being honest with the family and child is important when *"working with"* the child. The success of the nurse gaining the trust of the child relies on the nurse *"being honest with the child in the reality of their new world when they recognize temporary or a permanent change*" (Nurse G).

Supporting Family Functioning

"Supporting is when we do something for the family." (Nurse G). Giving support helps to develop the *"building blocks of trust"* (Nurses G & F). Support can be as easy as *"giving someone a cuddle or getting them a cup of coffee"* (Nurse G). However the supporting of family functioning is more complex than this and frequently occurs when the nurse or another family member *"work with the child to give the parents a break"* (Nurses A, D, E, F, & G). Participants perceived the need for families to be away from the child's bedside to restore a level of family functioning. The high dependency unit was not an environment where it was physically comfortable for family members to stay beside their child (Nurses B & C). Nurse C suggested families return to their own environment at times:

> *It was perhaps their fault you suddenly find they are there with them all the time and they won't go home, they won't leave them. They won't go home and have a night at home, that's the biggest thing… And that just completely suffocates the kid and can cause problems with other children, other siblings. You need to give them permission to ensure they can go home.* (Nurse C)

The family's ability to go home depends on their trust in the nursing team (Nurse F). The parents need confidence in the nurse before they can *"step out"* and give their responsibilities to the nurse. *"Parents like to know there is someone who will give their child their lunch"* (Nurse G). When this mother returned she commented to Nurse G, *"my son's concern is primarily in my mind and when I could not be there that was really helpful"*.

Nurse F has experienced the need to *"get into another's space"* to promote the relationship between the parents and promote family functioning.

> *Dad was very upset, withdrawn, sitting by the bed and just crying all the time. No one had dealt with it and they couldn't cope with it. He was not communicating with his wife, which I didn't think was a good thing at this time so I approached this…I talked with the wife and said that I noticed your husband is doing this. Is he usually like this?…We just chatted…and came up with strategies to break communication barriers that had come up…She went and had a coffee and the father came in and sat with his back turned so I went over and physically got into his space and just made it that he had to talk to me… Went straight to the fact that he wasn't talking and that broke down the barriers…we didn't have a fantastic conversation but the next day he was not himself, but he was talking.* (Nurse F)

Nurse F perceived the importance of *"checking out"* those observations with the wife before taking the risk of entering another's space without being invited. Nurse F has also used family members to promote family functioning, knowing a nurse is outside of the family and unable to do this.

> *There is no one good way to reassure the individual who feels blame for the accident because we are outside the family, we can try to reinforce that it was not their fault and they may start to think it was not their fault.* (Nurse F)

Nurse F used the mechanism of family meetings to create a supportive environment in which to restore family functioning. *"I encouraged the family to bring the feeling of blame out into the open by arranging and facilitating a family group meeting to promote dialogue of how each is feeling and what the child's accident means to each member."* In comparison to Nurse F, Nurses A and D were more inclined to use another health professional to facilitate the interaction within a stressed family.

Summary

This chapter has focused on the interchangeable role of the nurse and the parent whilst working with the child. 'pacing it together' is essential to maintain and continue to build a trusting relationship that has been initiated by the *"checking in"* and *"stepping in"* process. Supporting the family has been identified as an interactive process towards building trust and promoting family functioning.

The time the nurse and family *"work with"* each other is reliant on the child's and family's progress towards re-establishing their independent functioning. The frequency of *"stepping in"* lessens as the frequency of *"stepping out"* increases. Throughout the process, reassurance has been given by *"working with"* in a working-relationship whilst using the interactions of informing, educating, responding and coaching each other. Progress is determined by the child and/or parents having the confidence and skills to take over the responsibilities and care to enhance the child's recovery and independence.

Chapter six focuses on the processes nurses use to step out of a working-relationship and hand over the care of the child to the family and the MDT or community healthcare team.

CHAPTER SIX: Promoting Family Independence

This chapter presents the participants' perspective of what they do to *"step out"* of the working-relationship they have established with the family. The participants do this to advance the recovery of the family by supporting the involvement of other health care professionals and encouraging the independence of the child and parents. The interactive process of *"stepping in"* and *"stepping out"* to *"hand over"* to others is fundamental to acute care nursing practice. *"Stepping in"* to *"step out"* of the working-relationship is a process that takes time to complete. The length of time a family needs to take back their responsibilities is often determined by the severity of the trauma to the child and the re-establishment of family functioning whilst 'pacing it together'.

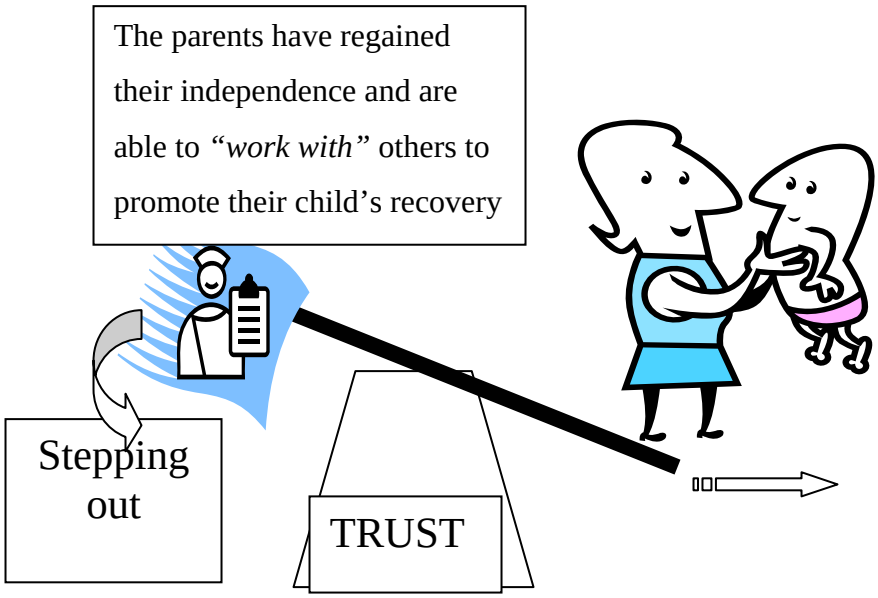

Figure17: Handing over. The family's progression towards independence and recovery

The movement on the seesaw fluctuates throughout the child's hospitalisation as the child recovers and the nurse *"steps in and out"* of the relationship in the process of *"handing over"* to other health professionals and the family. The position of the seesaw reflects the responsibility and knowledge the parents have to take with them into a changed parenting role. They either continue to *"work with"* to promote their child's recovery or care for their "different" child. The nurse moves out of the relationship, as the nursing role becomes less when the family interacts with either the multidisciplinary team and/or the community team. The trust built between the nurse and family provides the *"stepping stone"* for the family to build trust with other teams of health professionals. The nurse has *"handed over"* responsibility and therefore moves off the seesaw having enabled the family to move on to another environment. The nurse's presence is *"being there"* in a supportive role when required for the MDT and the family (Figure 17).

The Process of "Handing Over"

Participants say that other health professionals acknowledge that the nursing team provided the professional constant health care for the child. The MDT relies on nurses to *"coordinate the team"* (Nurse C). During the initial stages of "others" working with the family, participants experienced being a reference for those professionals seeking information or planning the time for others to *"work with"* the child and family (Nurses A, B, C & E). The empowering of the family during their working-relationship with the nurse, the necessity for the expertise of the MDT to promote the rehabilitation of the child and the nurse's perspective of the coping of the family facilitates the *"handing over"* to the family. Nurse G describes this process:

> *A nurse is often the positive person in the team within the realm of reality. The multidisciplinary team is part of a jigsaw and the nurse puts a few more pieces in and the family fills it up. The multidisciplinary team is a particular part of the jigsaw, they are physically minded and focused on what they are doing that is their role. The nurse's role is colouring in and putting other pieces in. The family's values and views of their reality when they are at home usually complete the jigsaw. I think often we put a few more pieces in. There is a fine line and a balance.*
> (Nurse G)

Stepping in and out of family

The moveability of *"the control of doing"* between the nurse and the family during hospitalization in the acute care setting is depicted as *"stepping in and out"* of interactive processes. The relationship between the two parties is the base to the success in *"handing over the doing"* completely to the parents. Participants describe how they use knowledge, experience, and intuition to guide their *"stepping in"* and *"stepping out"* of the working-relationship. The 'knowing' of the right time to do this is integral to nursing. *"It just seems to be as nurses we can see those parents who want to be more involved. We also need to recognise those parents who are not comfortable at doing that and respect that as well."* (Nurse B)

Nurses use their nursing knowledge and skills to respond to the needs of the family. *"Working with"* the family intermittently is part of the process of *"handing over"* the responsibilities they have held when promoting the recovery of the child. *"It's hard for parents to take the responsibility back for their child"* (Nurse C). The nurse *"steps in"* to reassure the parents and help them to make decisions to promote the child's progress with the intention of then *"stepping out"* again from the relationship.

> *Parents need to be reassured that it's okay for him to do this. It's okay for him to get up and walk around as long as you keep an eye on him. It's okay to go to the playroom to play with the kids. [sic]* (Nurse C)

Nurses *"have gained the family's respect to be able to step in, step out or interject"* (Nurse F). Nurse F considers gaining significant trust to be a *"surrogate parent is imperative to stepping in and out"* of caring for the child or reassuring the parents to make decisions.

There are various challenges for nurses when *"stepping in and out"* whilst caring for a child. Nurse F describes a family who was asked *"to do ABC but they would do EFG"*. Nurse F needed to *"step in"* more than *"step out"* because the family did not follow through with what they were asked to do, *"they were not capable"*. In this situation, the nursing team *"stepped in"* until it could be resolved. Nurse D perceived *"families do the things that you want them to because of the relationship you have with them"*. Nurse F comments that *"trust is a two way thing*". Mutual trust between both parties in a relationship enables the *"stepping in and stepping out"* process of nursing interactions. Nurse F also held another view of why nurses are not comfortable *"stepping out"*, acknowledging *"generalising"* but commenting:

> *Nurses as a whole are not very good at letting go their nursing roles and being able to step away and then being able to come in and work for or with… It is an important part of 'working with'. Those nurses that can relinquish their role, they are actually giving families a lot of trust.*
> (Nurse F).

All participants are aware that as the acute care phase moves on to the rehabilitation phase *"their role diminishes"*, they are no longer the constant health professional to care for the child. Being in the acute care setting *"they will not follow*

through with the complete rehabilitation process for the child. This may take two years" (Nurse C). The nurse may have been the *"constant"* health professional but now needs to *"relinquish the role"* to the true constant in a child's life, their family.

> *It's not me that is with them in the future. It's the family unit that helps the child get well. It's important to let people grow so they can fly. You can't keep clipping their wings by doing for them. That's always challenging as sometimes we think we could have done things better.* (Nurse G)

The parents are the constant in the child's life therefore the process of 'pacing it together' prepares the parents to regain their parenting role. Nurse C comments: *"You encourage the parents and child themselves to start taking back control over their rehabilitation. It's up to them how well they do."*

Handing Over to the Family

The preparation of handing over to the family occurs whilst 'pacing it together'. Participants have used different phrases to illuminate who initiates the process of *"hand over"* to re-establish parenting. Nurse C says the parents are *"encouraged to take back control"*, Nurse E suggests *"nurses are handing it back"*, and Nurse D states that *"it's letting them take some ownership back"*. All indicate that the nurse usually initiates the handing over of responsibilities to the family. Nurses B and D had experienced working with *"some parents who were very proactive at wanting to do for their child"* (Nurse D).

Re-establishing parenting in the context of the hospital has been the beginning of *"handing over"* the responsibility of the child to the family. Coaching parents how to work with their child who is "different" is important to support the *"handing over"* process. The family needs to be equipped to take their child home. *"This family is*

going home with this child; you are not going to be there so they need to understand fully what's going on to take over the care of the child." (Nurse D).

Handing Over to the Child

Nurse C commented that the *"child themselves also needs to take back the control"* during rehabilitation as they are an important catalyst as to how well they progress following a traumatic accident. All participants recognized that the child's age, cognitive skills, and severity of trauma affects the child's ability to care for self. Encouraging children who are able to make decisions gives the child some sense of control. A suggestion from Nurse C: *"Perhaps decide whether they want to go out in a chair, or give the older ones a video list, they can choose if they can point."*

An important step towards the child's recovery is *"having control handed back"*. The *"stepping out"* of both nurse and parents is a requirement for this to happen. Nurse C described *"stepping in"* to care for a child they did not know. It was breakfast time and this child had not fed herself since the accident.

> *She started feeding herself and was able to gauge when she wanted to start and wanted to finish and I sat there with her and just let her do it. She then did the same with her drink. That was handing it back."* (Nurse C)

Nurse C acknowledged that there are many times that this doesn't happen but recognised the importance of *"stepping back"* to give the child the opportunity *"to do it themselves"*. This is fundamental to the process of *"handing over"* to the child. Parents often need to be reassured before they can let go their parenting role of *"doing for"* their child. *"Those children whose parents continue to do for will not regain their independence."* (Nurse D).

Family Supporting Each Other

Participants were aware families have often required a mediator between family members to enhance the cohesiveness of family. Nurse F has frequently facilitated this to promote ongoing support for each other within the context of the family and preferred to do this rather than refer to a social worker. *"I know more about this family, the caseload of a social worker does not enable that person to have the trust and knowledge I have."* (Nurse F). Participants stressed the importance of parents being with the child in hospital as integral to the child's future progress. *"If they don't start the journey of recovery with their child they are unable to complete it"* (Nurse G). Parents living separate lives sometimes complicate this, Nurse C notices families came together at a time of crisis. *"Its very important parents are there, whether that be that the parents are split, the two sides come together, sometimes harmoniously, with the vision of how their child is going to be at home."* (Nurse C). Nurse G increases the support to the parents by *"bringing Grandma and other family members in to support the family"*.

Handing Over to the Multidisciplinary Team

"The process of rehabilitation is handing over to others." (Nurse B). All participants were aware the transition and *"handing over"* of the nurses' role is governed by the context of the acute care setting. At this stage of a child's recovery within the acute care setting, the nurse is responding to the needs of the MDT and is expected to *"coordinate the day"* and *"get it together"* to ensure the child attends the required rehabilitation activities (Nurses A & B). Nurse C comments that nurses are *"left to make sure it all runs smoothly"*. The process of *"handing over relies on mutual respect"* and *"knowing what members of the team are planning"* (Nurses B &

C). *"Guidelines and talking about the other health professions to the family helps them make the transition."* (Nurse G).

All participants were aware nursing in the context of the acute care setting limits the time they are able to continue the depth of the working-relationship they built with the family from *"stepping in"* to *"stepping out"*. As the child progresses from the acute stage and the MDT becomes more involved, the nurse *"may only interact with the family when doing observations every four hours"* (Nurse B). Nurses are required to *"move on to work more closely with another family"* (Nurses A, B &G) in a more acute phase of the child's injury.

Discharge Planning.

The severely injured child is transferred to a rehabilitation team where new relationships develop with the child, parents, nurses and specialists who can promote the individual child's recovery (Nurses B, C, F & G). *"A nurse representing nursing"* attends the *"weekly MDT meetings"* for families to *"map out future care and monitor their progress"* (Nurses B, F & G). MDT meetings are an important process used to monitor progress and organise complex discharge planning from the acute care services to another service provider. Frequently MDT meetings don't occur until near the point of discharge (Nurses B, F & G). Nurses' experience in being a voice in the MDT can be important for the family because they have *"often been told things that families don't share with others"* (Nurse D) due to the time the nurse spends "*chatting with"* the family (Nurse C). Interpersonal skills with the MDT are important for nurses to be able to be that voice. Nurses need to be given the opportunity to go to these meetings to strengthen their place and experience within the nursing team (Nurse F).

Discharge planning begins when the nurse *"stepped in"* to identify *"what the family was comfortable with and what they would like to do"* (Nurse G) and continues whilst 'pacing it together'. When the child is discharged home to family the participants considered the future abilities of this particular family to be able to meet the requirements of other health professionals. This can be *"more difficult for out of town families"* (Nurse C). *"Thinking about how they are going to get to the outpatient's appointments we need to make, do they have transport? How far away do they live? Is it better to go to Doctor or have District nurse?"* (Nurse G).

The acute care nurse does not have the opportunity of being with a family to the end, *"we only see the progress when the family revisits"*. Nurse C continues to comment: *"We are never part of the process of the completion to see the possible level of recovery for the child."* The discharge from the acute setting is the beginning of a new journey. Participants acknowledged: *"It has been an honour and a privilege to work with families and have the skills to assist their progress."* (Nurses F & G).

Summary

This chapter has discussed how the nurse supports the family to continue to promote the rehabilitation of the child by *"stepping out"* of the relationship more frequently than *"stepping in"*. The trusting relationship developed between the nurse and family has been the first *"stepping stone"* to enable the family to *"work with"* the greater team of health professionals whose interactions and skills assist the child's rehabilitation. The nurse has been the constant health care professional in the child's recovery process but now has a greater role to support the family to be the constant that coordinates the ongoing rehabilitation processes.

The nurse *"works with"* the family to put the jigsaw of rehabilitation processes together. By *"stepping out"* the nurse hands back the parenting role and the parents work with their child and the required professionals in the MDT to ensure the best possible recovery for their child. The acquired knowledge and skills the parents have developed enables them to *"take back the control"* and *"work with"* the "differences" the trauma has made to their child. The parents and others now work with the child to maximise their future independence.

The next chapter discusses the most significant finding within the findings chapters, i.e. the building of trust, this is the most important process found to facilitate the recovery of the child. The effect of the child's injury on how the nurse builds trust with the child and family is included in the discussion. The different levels of experience of a nurse are discussed in relation to how the nurse's experience enhances their ability to build trust.

CHAPTER SEVEN: Discussion

In this discussion, I am focusing on how acute care nurses work at the bedside with a family whose child has had a severe traumatic accident. The model I have developed represents the core social processes of *"working with"* the family in the acute care setting.

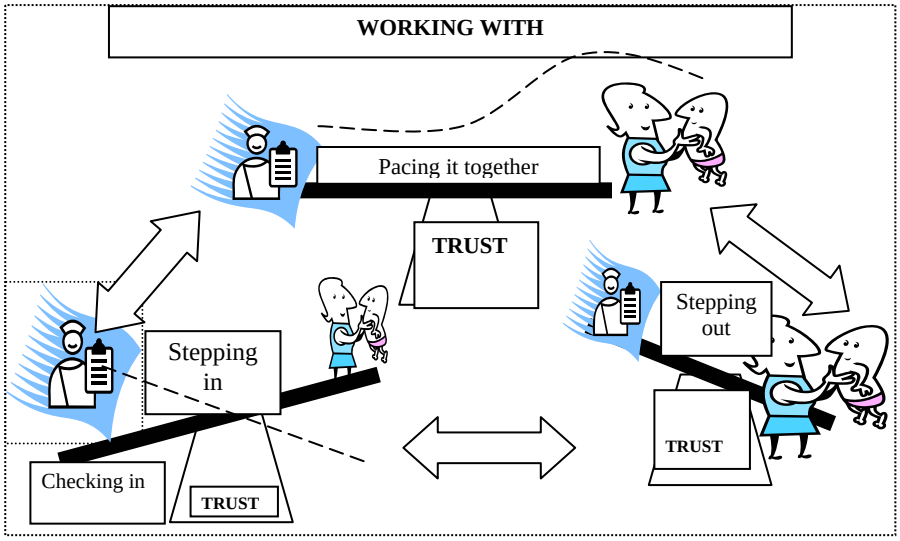

Figure 14: Model representing the social processes to build trust to work with. (Copied from Chapter three, p. 68).

Throughout the findings chapters, Figures 15, 16 and 17, represent those core social processes. Each process forms part of Figure 14 symbolizing the development of the relationship of the nurse and family to *"work with"* each other. Notably, trust is the foundation of the working-relationship and builds as the nurse and family learn how to *"work with"* each other. The foundation of *"working with*" is reliant on having trust with each other.

The purpose of this research was to find what acute care nurses do to promote the best outcome of a child who has had a severe unintentional traumatic accident. Grounded theory methodology was used to explore how the acute care nurse supported the rehabilitation of the child who had had a severe traumatic accident. The nurses described the process of *"working with"* families as multifaceted. Their work included monitoring the child and family, intervening to promote health, informing the medical team of change, coordinating the participation of the MDT and supporting the needs of the family. Chapters four, five and six have identified the social processes required to build trust.

The importance of the foundation of trust to enable nurses to *"work with"* families to promote the child's recovery from a severe traumatic accident was the most significant finding of this grounded theory research. The recovery of the child is enhanced by the social processes used to build a trusting relationship between the parents and nurses in the acute care setting. Ultimately, the parents are the constant who *"work with"* their child towards recovery. The parents learning is embodied in the trust they have built with the acute care nurses whilst working together at the beginning stage of what will be a slow recovery. Recovery continues after the child has been discharged from the acute care ward to either a rehabilitation centre or more frequently home, where the multidisciplinary team (MDT) works with the family.

This discussion chapter will focus on the social processes used to build trust. The participants of this research are referred to as nurses throughout the discussion. Within the context of this chapter nurse participants from other studies have been clearly identified as participant nurses in a particular research. The term nurse is also

used when including the findings of other studies to support the discussion of what nurses do to build trust.

The structure of this chapter.

This chapter is structured so that it begins with an exploration of the importance of trust in the nurse-family relationship, beginning with the importance of any working-relationship having the foundation of trust. The chapter then proceeds to discuss the social processes used by the nurses to build trust. Published research has been used within this chapter to support significant findings in this research. No literature to refute the findings has been found.

The contextual influences on the nurses' ability to build trust are discussed within this chapter. Discussion includes the relevance of two important factors affecting how a nurse interacts with a family. These factors are firstly, the context of the nursing practice and secondly, the level of nursing experience held by the individual nurse.

After discussing the barriers this research found to building trust the limitations and recommendations of the research lead to the conclusion of this chapter.

The Importance of the Foundation of Trust

Acute care nurses claim they have important work to do to build trust with families who have a severely injured child. A foundation of trust between the family and nurse facilitates the best possible level of recovery of the child because this foundation supports the child's co-operative response to care. The outcome for the child is dependent on the trust supporting the family and nurse's relationship to

"work with" each other. Therefore, from the nurses' perspective the family's ability to *"work with"* and trust all health professionals *"working with"* them is important to the recovery of the child. Initially trust is developed with the most constant health professional, the nurse. From the nurses' view the nurse and family work together towards the same goal, to prepare the family to care for their "different" child and thereby promote the ongoing development and long-term recovery after the accident.

Trust is critical to survival but taken for granted, probably because it is part of our everyday life. It is the foundation of all working and personal relationships. Caron & Bowers (2000) agree that trust is part of our day-to-day life and the scarcity of research in building trust may be due to the "difficulty to identify, describe and analyse what we take for granted" (p. 294).

The first three participants did not discuss the importance of trust although the third participant talked of the importance of rapport, meaning the development of understanding in the nurse-family relationship. Trust however means more than this. It has been suggested that to trust another person, one has to have confidence in the truth, worth and reliability of the other (McLeod & Hanks, 1982). A rapport does not require the time to build the confidence in another, a prerequisite for developing trust. Nurse D clearly identified the need to gain trust, describing it as the foundation of *"working with"* a child and family. Thereafter grounded theory methodology enabled me to question the later participants about how they developed a trusting relationship.

Literature related to nursing children often assumes trust, but the concept of how nurses build trust with children and families has not been well defined. Expert nurses don't always find it easy to coach a nurse to gain trust.

> *The most difficult skill to teach junior nurses is how to gain trust and I think the only way is to have new practitioners*

> *working alongside an experienced nurse and be given the chance to have a go. Shift coordinators allocating the patients need to think of the coaching junior nurses need.* (Nurse G)

This may well be because there is no clear theoretical guide to the process they are coaching. Trusting another person is not something that just happens. It is a complex process that is identified in this research to be the necessary foundation of *"working with"* a child and parents.

It is pertinent to go back to the beginning of this research and revisit Bill and Ben, each presented as a brief case research in Chapter one. When I wrote about Ben my assumed trust is evident, and it was not checked out. I assumed the presence of trust because Ben was less anxious and *"worked with"* the students and me. It seemed he would not *"work with"* all health care workers. It seemed likely that Ben could have regained a greater independence and recovery if he was always *"working with"* those he trusted. There is an inability of a child or family to *"work with"* unless trust is present. This is why trust has such a significant influence on the recovery of the child. The child and families' progress and ability to function well enough to take over the care of their child at home is reliant on the nurse-family relationships from admission to discharge being built on trust.

"Getting to know" each other is crucial to build shared trust between the two parties of a relationship. It takes time to *"be with"* and to *"get to know"*: Time needs to be planned into the day of the acute care nurse. The parents *"getting to know"* and trusting the nurse overflows to the child. Therefore, the child learns to trust the nurse through their parents' trust in the nurse, as well as through the nurse's use of time, language, play and touch appropriate to the child's developmental age. The parents and nurse coach each other in how to best care for and *"work with"* the child, each

using their own expertise and experience of how best to *"work with"* the individual child towards recovery. The interactions between the nurse and family enables the nurse to coach, trust and then *"hand over"* the coordination of care to the family, and the family to *"hand over"* the care of the child to the nurse when deemed appropriate. The handing over is reflected in *"stepping in"* and *"stepping out"* whilst *"working with"* the family.

"Handing over" is reliant on trust and is fundamental for the future of the family and the recovery of the child as the family is "the" constant in the child's life. The nurses in an acute care ward may well be the constant health professionals in this context but this is for only the short time a child stays in that environment. This is a small part of the time it may take for a child to recover from a severe traumatic accident. The time a family spends in an acute care environment is limited; the goal of acute care is to reach a level of medical stability to enable the child to move on to rehabilitation services that will continue to enhance their recovery. Rehabilitation or community health care services involving the MDT are essential to the child's long term recovery, working towards regaining a level of functioning as close as possible to that which they had prior to the accident.

The Affect of Trust on Family Functioning

The significance of the foundation of a trusting relationship to support family functioning when a child has had a severe accident has been an important outcome of this research. The acute care nurses identified the necessity to have a foundation of trust developed by the nurse taking time to *"be with"* the family to *"build trust"* as an essential component to support family functioning. Time to *"be with"* and *"work with"* families encourages their ability to support each other and help a family cope

with the crisis that has suddenly altered their everyday life. For example, Nurse F had taken the time to watch a father who was not interacting with his family and instead was just sitting, mourning at the bedside of his severely injured child. From Nurse F's perspective this was not right, but this nurse took the time to *"check out"* how the family functioned before the child's accident. Nurse F perceived the need to encourage a change in the father's behaviour; change to promote family functioning.

The nurses held the view that the final outcome of the child's recovery was reliant on the ability of the family to *"work with"* their child and with the health care professionals involved with the rehabilitation processes once the child was discharged from the acute care ward. Rivara, et al. and Wade, et al. (refer Chapter three) emphasized the importance of family functioning to the child's future. This research has identified how acute care nurses contribute to and promote family functioning when *"working with"* families in a trusting relationship. Nurses are in the position where families "*chat*" with them and share their stresses, concerns, and issues that could be detrimental to the ongoing recovery of their child. Nurses have the important position of being the constant health professional and need to use time to interact and *"get to know"* the family. "Knowing" the family is necessary to coordinate appropriate support meeting the needs of the individual family to help them cope and function in a way that promotes the optimum future for their child.

Building trust

The social processes identified to build trust are dependent on the awarded trust given to nurses as a professional group. This research has identified that nurses build trust by chatting, reassuring families using honesty and realism and involving and supporting families whilst using time *"working with"* them. Nurses work through

the parents to gain the trust of the child. The processes nurses use focus on the family, emphasizing that the amount of time the nurse spends with the family is fundamental to the building of trust with their child. Bricher (1999) completed a phenomenological research of what paediatric "nurses" do to develop trust with children, and also identified the importance of *"getting to know"* the child as a person and letting the child *"get to know"* a bit about the "nurses'" real self. Bricher acknowledges the difficulty of short stay acute care as a challenge to getting it right. She comments that three quarters of the nurses' time is spent with the parents yet the nurses who participated in her research felt the parents could be a barrier to gaining the child's trust. Bricher did not recognize the importance of the family's trust that has been identified in this research, she only considered the child. In agreement with the findings of my research Bricher viewed trust as a constant requirement for paediatric nurses to be effective when working with a child. Bricher also found that "trust requires a two-way relationship" (p. 456). A two-way working-relationship is depicted in my research when the nurse and family (including the child) are working together on the seesaw (Figure 14). This research found that nurses rely on building trust with the parents prior to gaining the trust of the child. Processes to build this essential trust can now be described from my findings.

Awarded trust is potentially the key given to the nurse to *"step in"* and *"work with"* the child and family, the beginning of a working-relationship. At this stage of the nurse's relationship with the family the foundation of trust is fragile. Awarded trust does not encompass the "knowing of each other" as the base for developing trust. The fragility of awarded trust needs to be protected and sustained and later built on by the togetherness of *"working with"*. Important work of a nurse in the acute care

setting is the facilitation of developing the ability to trust. It is not until then that trust can build and promote the advancement of the recovery of the child and family. *"Sometimes a nurse and family just click"* (Nurse G), and this helps the development of rapport and *"getting to know"* each other, but building a trusting relationship is not as easy as a *"click"*.

My research found that the nurses' ability to "*work with"* a family is governed by the parent holding the key and letting the nurse *"work with"* them. The nurse needs to be invited into a working-relationship and the ability to *"step into"* to *"work with"* is only facilitated by awarded trust and relies on *"getting to know"* each other. Nurses use social processes of chatting, reassuring, informing, involving and supporting to protect awarded trust and build trust whilst *"working with"* a family towards developing a working-relationship enveloped in mutual trust. The nurse has the responsibility of initiating building mutual trust with the family because the family is in an unknown place, having entered the nurse's world and being the more vulnerable in the relationship. What is happening or not happening for the concerned parties at the time influences the reciprocity of the trust within the relationship. It is the giving and taking, *"the stepping in and out"*, whilst working together that maintains the momentum for building trust. The giving and taking alters the balance of the seesaw (Figure 14).

When a child is admitted to an acute care ward the parents are vulnerable and powerless. Their child has had a traumatic accident and when the family enters the hospital service they "*hand over"* their child to those whom they assume know what to do. Nurses may feel vulnerable at this time as they are "*holding all*" because they think the family expects this of them. At this time using chat to "*get to know*" each

other and begin to build trust has not occurred, the nurses work with the base of awarded trust. Singleton (2000) supports the nurses' view of trust being awarded to the professional nurse. The concept of awarded trust remains unclear. Is the "*handing over"* of the injured child by parents due to the awarded trust given to professionals or is "*handing over*" necessary as the family needs a nurse (or medical professional) to take over and "*hold all*"? Is the parent's expectation that the nurse will care for their child the beginning of a working-relationship? Or is Mulvay (2001) more accurate in the assumption that nurses take control, take over on admission to hospital rather than beginning the building of a relationship with the family? The findings of my research suggests that the nurses prefer not to "*hold all"* and would rather "*work with"* the family bringing a balance on the seesaw (Figure 14, p. 68) as soon as possible.

A single nurse is limited in the contribution they can make to the recovery of the child but whether "nurses" are able to work together to begin to build a family's trust in "nurses" is debatable. My research found the building of trust is related to the development of a working-relationship between individual parties rather than trust being built for "nurses". There was no consensus in this research as to whether a nurse is capable of building trust for other nurses or the MDT, although one person's trust can be a *"stepping stone"* to trust developing between others. This can happen by informing the family and child of other health professionals' role in future care. Trust is developed within particular relationships. The management of the shift, day, or week to provide a family with some continuity in care by individual nurses is important to provide the opportunity of time for individual relationships to develop and build trust.

The management team of one of the wards used for this research facilitated building trust by having a small team rostered to work with a family over the twenty-four hours, seven days a week, particularly in the initial period after a child's admission following a severe traumatic accident. Continuity of care for a family often relied on nurses changing their shifts to *"be with"* the family more regularly at the beginning, when the family first entered the nurses' world. The management of the acute care setting will be discussed later in this chapter when discussing barriers to building trust.

Building a Rapport to Trust

Building a rapport is the next "building block" towards a working relationship supported by trust. A rapport is described as having sympathy and understanding of another (McLeod & Hanks, 1982) and is initiated by *"being with"* to participate in informal information sharing and *"just chatting*" when "*working with"*. This is an important part of nurses' work towards building trust. The *"just chatting"* enables the nurse to "*step into"* a relationship with the family (Figure 14) and begin learning how to "*work with"* each other. Informing the family of what was happening and what the nurse was doing at the time are social processes nurses used to enable the family to understand what the nurse was doing.

A person trusts who and what they know. The use of time to share one's own day-to-day life helps the family to share how they were prior to the accident and what it is like for them now. The informality of "*chatting"* reduced barriers and helped both parties of the working-relationship to *"get to know"* each other. When nurses used a few minutes at the beginning of the day to *"just chat"* they "*worked with"* the family more effectively than those who did not take this important time to *"get to*

know". *"Chatting to get to know"* about the "family as it was" prior to the child's accident assists the important exploration of the family's adjustment to being in an acute care ward.

"Chat" is an important social process enabling nurses to learn a family's values, beliefs and ways of doing. This "knowing" enables the nurse to become the guardian of individual family's patterns in life while they are in an unfamiliar place. At the beginning of *"working with"* trust is fragile and there is little stability. This lack of stability is reflected in the mobility of the seesaw (Figure 14). An effective relationship is poised on a foundation of trust supporting the balance of 'pacing it together'. *"Just chatting"* slows the momentum and facilitates *"getting to know"* and the building of trust.

My research has only considered the nurses' perspective; however, other published research that has used the parents' perspective supports the use of *"chat"* to *"get to know"*. Fenwick (2001) and Espezel and Canam (2003) both support my findings showing the value of *"chat"* as a medium to begin to build trust. Fenwick explored the experience of mothers of babies in a neonatal intensive care unit and found *"just chatting"* reduced mother's tensions enabling nurses to *"get to know"* the individual nature of each family. Mothers felt safe with the developing rapport facilitated by *"chat"* to enhance the building of trust. Espezel and Canam examined the experiences of parents who interacted with nurses caring for their child in hospital. They have not used *"chatting"* to describe the process of building rapport to *"get to know"*, but they found parents needed to have established rapport with the nurse to *"work with"*. These parents also felt it was important that the nurse knew

what their child was like prior to being hospitalized and valued knowing the nurse as an individual - more than just being the “nurse”.

Informing to Reassure

The nurses recognized the importance of keeping the family informed. The consistency of the nurse, and taking the time to update the family on their child’s progress were seen as important processes to reassure a family. Keeping the parents informed of the physiological stability of the child and ensuring their understanding of what was happening is a significant “building block” of trust. Reassurance from the other person in the working-relationship is a required component of building and maintaining trust. The family is in a vulnerable position and needs to be reassured by the nurse. Informing the family effectively relies on the nurse listening to a family’s perspective and needs.

Feeling reassured is important from the perspective of the nurse and family. A nurse also seeks reassurance that the parents are able to cope with the new skills required to care for their child. A nurse gains confidence in parent’s use of new skills by continuing to *“work with”* them to help the recovery of the child. Working together is reassuring for each other and leads to stability and trust in the working-relationship whilst ‘pacing it together’ (Figure 14).

Nurses reassured parents by alerting them to the small steps of progress. They also offered reassurance when they spoke of the child’s future when they saw patterns depicting recovery. Reassurance is given by signaling signs of progress and anticipating future progress. Experience enabled nurses to provide anticipated guidance and give hope to reassure the parents and child. It is important nurses are mindful of being realistic in their judgments of the future for the child because false

hope damages a trusting relationship. Benzein and Saveman (1998) agreed with the nurses' use of future orientation, positive expectation and the expectation to attain realistic goals as effective interactions to give hope.

Giving Hope

Hope is difficult to give when the future of the child is unknown; and realism and honesty are essential components of giving hope if the working-relationship is to continue to be built on trust. Nurses have the opportunity to reassure families by *"being with"* them, 'pacing it together' and listening, and responding to their needs whilst maintaining realism. When the future is not easily anticipated or the outcome for the child appears to be less positive, nurses used empathy to *"work with"* the family, maintain trust and give support. For example saying *"I know this is hard for you, it is hard for me too"* (Nurse G) helped the nurse and the family through this situation. Clarke (2003) supports the findings of this research when also emphasizing the importance of realism and genuineness in giving hope rather than falsely informing, indicating denial of the reality.

Involving and Supporting

The intensity of *"working with"* and involving and supporting the family whose child has a severe injury builds and maintains trust. A working-relationship founded on trust assists parents to re-establish their parenting role. Nurses used the social processes of involving and supporting the parents and child to learn new skills whilst 'pacing it together'. Nurses supported parents by *"working with"* them to gain confidence and use the new skills required to care for their "different" child. The intensity of nursing a child who has had a severe traumatic accident provides a great

opportunity for nurses and parents to work together and build trust in the acute care setting.

The process of the nurse *"stepping in and out"* of the working-relationship is important to the building and maintaining of trust. The more honest and real the relationship, the easier it is for the nurse or parents to *"step in"* and *"step out"* whilst *"working with"*. There are many reasons for *"stepping in and out"* of the working-relationship. Nurses used the process of *"stepping in and out"* to re-establish the parents' role and prepare the parents to take back the care of their child (Figure 14). Involving parents in caring for their child by coaching new skills gave parents the ability to become independent and promote the recovery of their child. Nurses offered to *"step in to take over"* when parents were seen to need a necessary break to rejuvenate their energy to continue to learn ways to function differently. Nurses *"stepped out*" to support parents who were "doing for" their child and developing independence, but would be mindful of the need to *"step in"* if the nurse felt the child's recovery would be enhanced if the child "did for self".

The use of "involving" making the child's experience of a painful procedure better was seen to be important to the process of building and maintaining trust with a child. Having a parent present reduced the trauma of painful procedures Nurses felt the development of shared trust by *"stepping in"* to *"work with"* contributed to the promotion of the child's recovery in the long and short term.

Building Trust in Different Contexts.

The wide range of different effects of trauma on children influences how a nurse builds trust with a family. The awarded trust is preserved by nurses' interactions when *"working with"* and promoting comfort and progress for the child

and family. “Differences” in the appearance of a child affected nurses’ initial interactions, a child may be lost amongst all the monitoring equipment or their body may be severely disfigured from the accident. Awarded trust is preserved by the ability of a nurse to disguise those feelings of uncertainty when first *“working with”* a family with a severely injured and different child. Experience in practice lessened the stress to the nurse but notably Nurse G commented that one is never fully prepared for such sensitive situations and the first thirty seconds with a family is important for preserving the fragility of awarded trust.

Different symptoms a child feels or displays alter how a nurse *“works with”* the child and parents. Building trust relies on the security a family experiences through the open relationship nurses created, enabling parents to voice their concerns or views about pain. Different ways of *“working with”* were obvious to Nurse F when nursing a child with a head injury and a fractured leg. The parents’ concern for the child’s pain was not a usual experience for Nurse F whose expertise is nursing head-injured children. Nurse F now recognized the need for nurses to ensure that effective pain management constantly relieved the child’s pain. Orthopaedic nurses were aware that a child is unable to *“work with”* a nurse if in pain and forcing that situation would undermine trust. They prioritized the management of a child’s pain to reduce parents’ concern and encourage the building of trust.

Attending to parents’ concerns about pain management for their child and *“working with”* families to promote comfort is important to build trust. Building trust relies on the nurse being mindful of the individual values and beliefs held by families in relation to managing pain, often a nurse’s perception of a child’s pain and management is different to the parents. Simons, Franck and Roberson (2001)

explored parents' and nurses' perspectives of pain management in a paediatric surgical ward. They found that there was a difference between the nurse participant's and parent's perception of pain and that a lack of effective pain management impacted on the parent's and child's ability to have a trusting relationship with a nurse.

Informing the family of the future, referred to as "anticipatory guidance", is a useful strategy to build trust. *"Working with"* the child and parents and having consistency in nurse and family relationships helps a nurse to identify progress in a child. Realistic anticipatory guidance has been discussed as a strategy to build trust, but warrants further discussion at this point because there is a difference in giving anticipatory guidance in the two areas of practice used for my research. Nurses *"working with"* children with an orthopaedic injury appreciated knowing the pattern of healing to help them predict the future. Predicting the future for a family whose child has a head injury was difficult for those *"working with"* head-injured children because the future is unknown. However, guidance can begin once progress is seen. Nurses *"working with"* families whose children have orthopaedic injuries often told the families stories of other children who had recovered and returned to the child they were. Stories of successful recovery helped to reassure the child and parents. Anticipating the future of the head-injured child relied on sharing the small steps of progress identified by parents or nurses whilst *"working with"* the child.

Nurses Experience and Building Trust

The nurses' initial response to the opening question of the interview, *"Tell me what you do when you are nursing children who have had a severe traumatic accident?"* highlights the relevance of the nurse's degree of experience on their initial

interactions with a family. Less experienced nurses were initially more focused on the monitoring of the child's physical state of health. For example: *"Observations are important. We need to make sure that they are …medically stable"* (Nurse B). More experienced nurses were able to interact with the family while monitoring the physical health of the child. Experienced nurses were more aware of the complexity of care. *"There are three different prongs and that is the physical and emotional health of the child and then there is the family and they are very much a big part."* (Nurse F). Nurse F has acknowledged the importance of physiological stability for the child but also recognizes the importance of supporting the parents during the initial interactions when *"working with"* the child. This is a key to work towards a working-relationship built on trust

One important difference between the nurses in my research lay in their ability to "begin" caring for the family when first *"working with"* the child. The nurses' recognition of the need to care for the family earlier was supported by Noyes' (1999) research of mothers of critically ill children. Those mothers wanted nurses to check out how they were feeling when being informed of their child's medical status. The *"checking in"* to *"be with"* to *"work with"* the family is essential to the building of trust and the experience of the nurse impacts on this.

The experience of the nurse affected how they *"work with"* a family and expertise *"only comes from experience"* (Nurse G). Nurses develop through practice the "knowing" which enables them to adjust their interactions to be appropriate for the individuality of each family. Expert nurses recalled when they were less experienced and lacked the intuitive skills or didn't take the time to *"get to know"* the family so they could learn how best to interact with them. Developed expertise using

the techniques to *"get to know"* the family are used by expert nurses in all situations (Tomlinson, Thomlinson, Peden-McAlpine & Kirschbaum, 2002). My research found the experienced nurse *"worked with"* families to *"get to know"* the impact of the accident on their day-to-day life, *"whether it was a child with a broken arm or broken body"* (Nurse G). *"Checking in, chatting, and working with"* were relevant to families' and to nurses' needs. The main difference between the experiences of nurses is their use of "time with".

"Time with" takes time therefore time is important to build trust. Taking time is illustrated in Figure 14 (p. 68) when the seesaw is balanced whilst 'pacing it together'. Trust relies on time to be built but short spells of time also contribute to building trust. The frequency of *"stepping in and out"* was often created by the nurse's workload or the ability of the family to cope with their child's injury. Frequent interactions by the nurses contributed to building trust. The needs of the child and parents dictated the time spent 'pacing it together' and the more time a nurse spent 'pacing it together' the more solid the foundation of trust.

Knowing when to *"step out"* is also reliant on the nurses' expertise and experience. More experienced nurses *"worked with"* and developed trust in the family to *"hand over"* their role. This is an important skill to promote the development of family independence.

Barriers to Building Trust

Barriers to building trust are imposed by the management of the ward, the level of staffing on units, and sometimes the situation for the family. It is pertinent for my personal knowledge of the impending change to the structure of nursing services within a ward to be part of this discussion. The intent to have a team approach to the

delivery of care may be detrimental to the development of a trusting working-relationship between nurses and family.

The building of trust to *"work with"* a family effectively takes time. It is acknowledged that it is preferred that children are moved on from the acute care setting as soon as they are medically stable to commence rehabilitation and promote long term recovery. Acute care is a higher cost to the health care system and not an appropriate environment for the working of the MDT (Neville, 2000).

It takes time and experience for nurses to learn the skills to build trust. The development of a nurse's experience in practice is reliant on opportunities to work beside an experienced nurse who can demonstrate the social processes used to build trust. The need to have experienced nurses to "mentor" and guide the developing practice of less experienced nurses is a significant finding to encourage the management of a ward to facilitate learning experiences for nurses. Opportunities in practice are lessening, with a reduced number of experienced nurses remaining in the workforce and controls of staffing levels imposed by budget restrictions.

"Leveling" (refer to Chapter one) was developed to support expertise in practice but the increased responsibilities are not as acceptable to the aging workforce. All nurses do not want to pursue further responsibility in the work place, and others choose not to study and progress through the levels of nursing practice. The casualization of employment by hospital management has also diminished the development or availability of expert nurses to "mentor" or coach less experienced nurses.

Trust is built between individuals, therefore the impact of rostering, twelve hour shifts and casualization reduces opportunities to have some consistency of

regular nurses *"working with"* a family with a severely injured child. Nurses commented on the time it takes to build trust and it is seldom that trust is developed in a day. Nurse G recalled a child who took two weeks to show his trust with a smile.

Impending change from individual nurses caring for a family, known as primary nursing, to a team approach has the possibility of reducing the nurse's ability to have the time to *" get to know"* and 'pace it together' to build trust. The level of trust necessary to promote the best possible outcome for the family relies on the nurse being able to have time to *"work with"* the child and their parents. Duty supervisors and ward managers need to be mindful of protecting continuity of care to foster the development of trust.

The parent's anxiety and feeling of guilt or blame is carried with the family to the acute care ward, and nurses recognized the need to *"work with"* the family, encouraging them to share how their child's accident had affected them and their day-to-day life. Noyes (1999) questioned parents about their experience when their child was admitted to a PICU and found they were anxious and needing nurses' time to enhance their coping with a sudden and significant change to their day-to-day life. A nurse working with a family whose child is admitted directly to the acute care ward needs to be able to give "time" so they have the opportunity to share and work through anxieties family's hold.

Nurses were aware of the challenge for families who move to another area within the hospital. The need to learn to *"work with"* a new team of nurses and build new trusting relationships can hinder the development of a working-relationship that will promote the recovery of the child. Nurses need to take time with such families and listen to their fears of the unknown in a different environment.

Limitations of research

This research reflects only the nurse's perspective although research completed in North America and England using the parent's perspective supports the findings. It is also limited to the relationships nurses have with families. There is no doubt that nurses interacting with families and building trust is a most important aspect of care. Communication with families is the essence of nursing, but undoubtedly there are other important skills that nurses use in practice. It is important to at least acknowledge the rest of what nurses do to promote the physical and emotional recovery of the child and family. For example, assessment skills, completion of tasks and interacting with the rest of the health care team.

The philosophy of the health care service may guide how a nurse works with a family rather than specifically working with a child. The philosophy of family-centred care underpins the practice of health care workers in the acute care wards used in this research. This may have influenced the predominance of *"working with"* the family rather than the emergence of more in-depth data related specifically to nursing the child. However this is appropriate and may also explain why responses to questions related to *"working with"* the child were answered in the context of *"working with"* the family.

The potential for the nurses participating in this research to assume that I knew or understood what they were going to say before they said it was a risk. This was a risk because participants knew me as either their past nurse lecturer or as the lecturer working with students in their area of practice. Even though I asked that they considered "I knew nothing" I still found I had to keep reminding them and myself of the potential of this issue. This was important to ensure that the findings of this

research was “grounded” and had sufficient depth to enhance the ongoing development of nursing practice.

The choice to use only two different areas of nursing practice has confined the research to children with specific injuries. Future research could include nurses working with children who had severe abdominal injury or burns from an accident to give a broader perspective. Children with only abdominal trauma don’t usually require the same level of input from rehabilitation services and the reason for the selected areas was governed by the original focus of this research project. Whether there is a difference in how nurses *“work with”* and build trust with families in other areas of acute care practice is not yet known. A broader view would have required multiple ethical approvals from different health care agencies. This was not impossible but daunting to a researcher at Master’s level.

The range of levels of experience of the nurses who participated in this research influenced the richness of the data. Even though I had reached saturation in the categories, I suspect I may have had more examples of practice if I had only used participants working as level three and four nurses in the selected areas of paediatric speciality. The extended experience of higher-level nurses provides a greater depth for reflection on practice. The more junior participants responded eagerly, and were keen to be part of the research process. The challenge of having at least seven experienced participants from two wards, especially when there are decreasing numbers of level three and four nurses, may have impacted on my ability to recruit participants successfully.

Recommendations from this Research

Recommendations from this research have the potential to influence clinical practice and future research.

The findings of this research suggest that the management of the acute care wards facilitate a consistency in the individual nurse and family relationship to support the building of trust. Hupcey, Penrod and Morse (2001) asked whether a trusting process relies on the individual attributes of the parties concerned and recommended this question needed further exploration. Their question is answered by the nurses in this research. The nurses perceived that a trusting process relies on individual attributes of both parties and they are only a "*stepping stone"* to another relationship. Importantly, this research holds the acute care nurses view and the findings are worthy of consideration by those managing a ward. Management of the nursing staff needs to assist building trust to enhance the child's recovery. This research has found that the key to working effectively with a family to promote long-term recovery is reliant on trust. There is an apparent need for nurse managers to acknowledge the time required and the importance of two parties "*getting to know"* each other to build a trusting working-relationship when allocating the workload to the nursing staff.

Consistency in care needs to be managed within the model of care the ward uses. The change from the model of primary nursing care to team nursing with supervision and delegation of nursing care is occurring within hospitals in New Zealand therefore consistency in care may need to be provided in another way.

It may be timely and appropriate to employ a nurse with the expertise in rehabilitation nursing of children to be the consistent person to work with the families

of children with severe trauma. The rehabilitation nurse in the acute care setting could 'pace it together' with families who have a severely injured child. Other responsibilities could include the liaison with the MDT, working together for the promotion of the child and family's independence. A specialist rehabilitation nurse could also support the acute care nurses, and the acute care nurses would "learn with" and support the work of the rehabilitation nurse.

Future research to continue to refine the processes of building trust will build on the concepts that have been discovered in this research. There is opportunity to develop a model of "building trust" to complement the model of *"working with"* developed in this research. It is now important to explore the perspective of the family, including the child; to ensure that the presented model of the nurses' perspective of "working with" founded on trust reflects the child and family's view. It is important nurses don't assume their perspective as being the 'right' one.

The development of a body of published knowledge of how nurses *"work with"* and build trust which is pertinent to the culture of nursing in New Zealand would be useful to influence nursing practice in New Zealand.

Conclusion

The use of grounded theory methods to explore what acute care nurses do when they care for a child who has had a severe traumatic accident led me to exploring an area of practice I did not expect, i.e. *"working with"* to build trust. The nurse participants' contributions in the eight audio taped interviews have described how they worked with families when a child has been admitted to the acute care ward with a severe injury resulting from an unintentional accident.

My research has explored speciality nursing practice where previous specific research could not be found. The use of grounded theory methods was appropriate to develop a body of knowledge to inform nursing of what acute care paediatric nurses do when caring for a child with complex needs after a severe traumatic accident. There were many avenues of nurses' work that could have been explored from the beginning findings of my research. The significance of the nurse needing to have a trusting working-relationship with the family to promote the parents' ability to care for their severely injured child in the long term, guided the continued focus of the questions asked of the nurses participating in this research.

My research has developed a substantive theory represented by the model (Figure 14) of the social processes to *"work with"* a child and family, when the child has had a severe unintentional traumatic accident. The findings contribute to nursing knowledge of how nurses *"work with"* families and gain trust.

This research has clarified the importance of social processes to *"work with"* being built on trust between the nurse and family. Trust is fundamental to the child's recovery; physically, emotionally and cognitively. The significance of having a trusting relationship in the acute care setting to *"work with"* and promote family functioning is important to enhance the child's long-term recovery.

Trust has been acknowledged as part of our everyday life and the suggestion made that this may well be the reason that there have not been previous significant studies to inform nurses (Caron & Bowers, 2000). A nurse participant also acknowledged that coaching a nurse to gain trust was very difficult without theory to support the coaching. The presented model of *"working with"* and the use of social processes have all been part of everyday nursing practice. Until now they have not

been brought together and "repackaged" with the focus of *"working with"* in an effective relationship, supported by built trust.

The literature used in the discussion within this chapter has supported my findings. It was important to include the perspective of the parents to compare or validate the nurses' perspective found from my research. The views of both nurses and clients in a working-relationship are required if the implementation of research to prompt change in nursing education and practice is considered.

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APPENDIX ONE

The Acute care Nursing of Children Who Have Had an Accident

Information Sheet for Nurse Participants

You are invited to take part in this research of what nurses do when they are caring for children who have had an accident. You have a month to decide whether to participate in this research, which is being completed for a thesis by Julianne Hall, a Masters in Health Science (Nursing) student At Auckland University of Technology.

You are under no obligation to participate in this research. Your right not to participate will be respected.

If you do agree to take part you are free to withdraw from the research at any time, without having to give a reason and this will in no way affect your future employment or progress

What is the reason for doing this research?

The aim of this research is to discover what acute care nurses do when they are nursing a child who has had an accident. The purpose of the research is to develop a practice based theory of nursing which explains how acute care nurses nurse children who have had an accident. In the future this can guide the development of this specialist nursing practice.

Can any nurse be a participant in this research?

As long as you have worked in this unit for 6 months and you are not in the new graduate program you are welcome to participate in this research.

Why the Orthopaedic and Neurology Units at Starship?

Both of these units admit children who have had accidents from the Emergency Department and the Paediatric Intensive Care Unit. The children are in the acute phase of their recovery.

How can I participate?

It is important that you do not feel pressured to participate in this research. You have received this information sheet from your unit manager with a consent form and a reply paid envelope for ease of giving consent if you so wish.

The details to contact me are on the consent form. Prior to deciding whether to give your consent I encourage you to contact me to discuss the research and clarify any further questions you have that are not answered in this information sheet. This will ensure that your unit manager will not know which nurses do not want to participate.

If I give consent to be part of this research how will I be involved?

Within this research there are two ways that I am collecting data to research acute care nursing practice.

The formal audio taped interviews will occur in your private time at an accessible place that is appropriate for you. It is important that this place is private and that we will not be disturbed for approximately one hour.

The participant observation and informal interview will occur on a particular day in your unit. Written data will be collected when we discuss your observed nursing of a child who has had an accident
You may or may not be involved this day, depending on whether this is one of your rostered shifts.

To explain your involvement better I need to outline the research design of this research.

A specific research methodology, grounded theory, has been used to design this research. The collecting of data will begin with an individual interview with any one of the participants followed by an interview with a second participant. At this stage I will begin analyzing the data looking for categories of findings that I want to pursue in further interviews. Therefore the selection of participants becomes purposeful. This is why you are asked about your level of practice and area of practice on the consent form.
For example the first two participants may have been level 2 nurses and the data that emerged may suggest the need to explore what level 4 nurses do when they nurse children who have had an accident.
The research design requires me to compare the findings as the data collection progresses and I continue interviewing participants formally until the findings become repetitive and no new data emerges. I would expect to be able to complete this process over a period of 6 months using about 8 participants.
It is important that the findings of the research is validated and one way of doing this is to observe the practice of acute care nurses caring for children who have had an accident. The nurses I will be observing are not necessarily the nurses I have interviewed. I will be in the unit for 6 –8 hours observing the practice of nurses

nursing children who have had an accident. These children and their families will have been provided with an information sheet when they were admitted to the ward. Their written consent will be given to the Unit manager or clinical educator after the family had had the opportunity to discuss the information they had been given.

What will I be asking in the interview?

The interview will begin with the question "Tell me what you do when you are nursing a child who has had an accident". I will then question you when you are sharing your nursing experiences with me. I want to explore how and why nurses do what they do when caring for these children and their families. Each interview will be different. As the analysis of the research progresses I will be pursuing the emerging information in more depth to provide greater meaning to my findings.

What will I be observing when I am in the unit?

I will be alongside the nurse while he/she is caring for a child who has had an accident. The length of time will depend on the time the nurse is providing care for the child, and will be intermittent during the 6 – 8 hours that I am in the unit. I will be listening to the nurse's communication with the child, family and other health care providers, for example the physiotherapist or Doctor. I will also be observing and assisting where appropriate with the nursing actions. For example, I may be required to help the nurse shift a patient in the bed or support a leg that required a dressing in an awkward place.

What will happen if the child and family seem uncomfortable with a researcher observing even though they did give consent?

I do not want to interfere with your relationship with your child and family at any time. I will stop observing you if either of us are aware that my presence is detrimental to your ability to provide the best possible nursing care for the child and family. You may notice me writing in a notebook, I will do this after I have been observing your practice and not within view of the child or their family. The notes are cues for the informal interviews that will occur during the day to find the meaning underpinning your practice. Written notes from the interview will provide me with the data to analyze at a later time.
If an unlikely situation arose when your professional conduct was in serious jeopardy (for example you were physically abusing a child) I would feel obliged to intervene by speaking to your unit manager.

During the research…

If you have consented to the formal interviews I will be the only person who will know your identity. Your name will be removed from the transcripts of the audiotapes. You will be given the opportunity to edit your transcript before the commencement of the research analyses.

If you have consented to your practice being observed and you are part of the team that day your colleagues may notice that you are a participant in this research

The tapes, transcripts and notes will be securely stored in my office unless I am working with them. Myself, my supervisor and yourself are the only people that have access to the data you have provided.

After the research…

The research findings will be presented as a Masters in Health Science thesis for marking. At a later date this will be used for publication and conference presentations. No material that could personally identify you will be used in any reports on this research.
The audiotapes and all hard copies of data will be destroyed once my thesis is successfully completed. The data will be secured at Auckland University of Technology for 10 years.
A copy of the completed thesis will be given to the unit for the staff to read.

Compensation…

In the unlikely event of a physical injury as a result of your participation in this research, you will be covered by the accident compensation legislation with its limitations. If you have any question about ACC please feel free to ask the researcher for more information before you agree to take part in this trial.

I would like more information.

You are welcome to contact me at work if you have any questions. My supervisor for this research, Jan Wilson, can also be contacted if you have any concerns as a participant in the research.
This research is approved by Auckland Ethics Committee.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz ,917 9999 ext 8044.

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Thank you for taking the time to read this information sheet

APPENDIX TWO

Consent Form – Nurse Participants

The acute care nursing of children who have had an accident.

English	I wish to have an interpreter.	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero.	Ae	Kao
Samoan	Oute mana'o ia iai se fa'amatala upu.	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea.	Io	Ikai
Cook Island	Ka inangaro au i tetai tangata uri reo.	Ae	Kare
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu.	E	Nakai
	Other languages to be added following consultation with relevant communities.		

I have read and I understand the information sheet dated 22nd June 2002 for volunteers taking part in the research designed to discover what acute care nurses do when they nurse children who have had an accident. I have had the opportunity to discuss this research by contacting the researcher. I am satisfied with the answers I have been given. I have had time to consider whether to take part in the data collection processes described in the information sheet.

I understand that taking part in this research is voluntary (my choice) and that I may withdraw from the research at any time and this will in no way affect *my employment in this unit.*

I understand that my participation in this research is confidential and that no material that could identify me will be used in any reports on this research.

Please delete what is NOT applicable

I consent to being interviewed by the researcher YES/NO

I consent to the interview being audio taped YES/NO

I wish to have a copy of the transcript YES/NO

I wish to have the opportunity to edit the transcript YES/NO

I consent to the researcher observing my practice YES/NO

I consent to the researcher taking notes when discussing

my practice with me YES/NO

I _____, a level ____ registered nurse

in Ward _____ hereby consent to take part in this research.

Date _____

Signature_____ Signature of witness _____

Name of witness _____

Researcher: Julianne Hall

Telephone contact: Day 9179999 Ext 7141