

PASSIONATE DEDICATION

**A qualitative descriptive study of nurses' and hospital play
specialists' experiences on a children's burn ward**

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in partial fulfilment of the degree of Master of Health Science

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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 (except where explicitly defined in the acknowledgements) nor material which to a substantial extent has been submitted for award of any other degree or diploma of a university or other institution of higher learning.

Signed _____

Dorothy Isaac

Date: _____

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ABSTRACT

A qualitative descriptive approach was undertaken to explore the experience of eight registered nurses and two hospital play specialists who care for children hospitalised with burn injuries. The research participants were recruited from a paediatric ward that offers centralised specialty care to children with burns. Collected through face-to-face interviews, the participants' stories were tape-recorded and transcribed verbatim using a process for analysis informed by van Manen, (1997b).

Emerging out of the data was the over-arching theme of 'passionate dedication' that shows the nurses and hospital play specialists genuine compassion and commitment to meet the needs of the children with burns. The findings of the study reveal that the participant's dedication is shaped and determined by a dynamic process that involves having professional integrity and in-depth knowledge of caring for children and burn management. The nurses and the hospital play specialists have a common understanding of what their role entails and the skills required to provide quality care and support to the children and the children's family. On a personal and professional level the participants encounter several challenges in this care context that are physically and emotionally overwhelming. Despite becoming overwhelmed the participants are revealed as being resourceful and resilient in their aptitude to find ways that enable them to cope and get through.

This study supports international literature that suggests that caring for children with burns is equally rewarding, as much as it is physically and emotionally

demanding. The implication in this study for the organisation is to seriously consider issues regarding productivity and efficiency of the workforce with acknowledgement that nurses and hospital play specialists cannot do this emotional work without effective systems of support in place. With the help of team leaders, managers and educators, the organisation will need to consider ways to monitor the job satisfaction of their staff. Furthermore, reinforce existing comprehensive measures, such as mentorship and clinical supervision programmes to encourage the retention and well-being of all staff, at all stages of their career on the children's burn ward.

CHAPTER ONE: INTRODUCTION

It takes two to speak the truth: one to speak, and another to hear.
Henry Thoreau, 1817-1862

A severe non-fatal burn injury is the most devastating injury a child can survive. This is because the young skin of a child tends to burn more quickly and deeply than adult skin, and at lower temperatures. Although more children now survive burn injuries than they previously did, for those who are seriously injured, the road to recovery is not easy. Moreover, the child has to also endure a number of painful surgical procedures over an extended period of time. Even though advances have been made in techniques to improve care management, expediting the child's physical recovery from deep partial and full-thickness burns, the emotional and physical scarring of the child last a lifetime. Indeed, the economic impact on the family and society as a whole is huge when a child is severely burned. The psychological and emotional devastation for the child and the child's family, though not on the same scale, is a culmination of the child's injury, extreme pain, hospitalisation and the consequence of the burn. Caring for a child who is burned demands specialised knowledge and skills to efficiently attend to all of the child's needs.

This study explores the experience of eight registered nurses and two hospital play specialists who work on a children's burn ward. It asks the question, "What do nurses' and hospital play specialist's experience when caring for children with burns?" The intention is to describe the nurses' and the hospital play specialists' experience of caring for children with burns using a qualitative descriptive methodology. Nurses and hospital play specialists, together with doctors,

dieticians, physiotherapists, occupational therapists, speech and language therapists, anaesthetists, social workers, and psychologists are among the varied health disciplines that make up the interdisciplinary burn team. However, nurses and hospital play specialists play a pivotal role in the delivery of care to the children with burns. On a continuing basis they have regular access to the children throughout their entire working day as opposed to the episodic presence of the doctor to make a diagnosis or perform surgery, or in the case of the physiotherapist who has allocated timeframes in which to work with each patient.

In their individual roles, nurses and hospital play specialist are continually exposed to a number of factors central to caring for children with burns. On a daily basis they deal with distress and pain, bodies altered by burn trauma, foul odour, bizarre behaviour, including the physiological instability of the child and the psychological impact of the injury on the child's family. Although nursing responsibilities encompass a holistic approach to care involving a range of skills, the fundamentals of care provided by the nurses include changing dressings, administering medications, assisting with feeding and elimination. The hospital play specialists have a more defined role, which is to support normal development, psychosocial wellbeing, and coping of infants, children and young people. They incorporate play as an integral aspect of their work, based on the understanding that play is fundamental to a child's learning, development, wellbeing and mastery. On the children's burn ward the responsibilities of the nurse and the hospital play specialist interrelate in complex ways. Nurses perform interventions that infringe on accepted boundaries of privacy and often inflict pain under the guise of care provision. The hospital play specialist's role is

complementary in providing the child with a focus that distracts the child's attention away from the nurse's involvement, while simultaneously providing support to the child's family.

Family care weighs heavily in importance in the trajectory of care to the child with a major burn injury. Health professionals often assess the family's ability to cope with the child's injury and the treatments. Hence, the complexity of care and, on a regular basis of being face to face with children who are afflicted makes it likely that nurses and hospital play specialists are affected by their patients' suffering (Morse, 2001; Nagy, 1998). Literature reveals that the impact of working with children with burns has considerable and far-reaching influence on the somatic and emotional wellbeing and the psyche of the health professionals, with stress and burnout being the outcome (Burnside, 1996; Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Steenkamp & van der Merwe, 1998). The role of nurses and hospital play specialists demand care responses that cater to the needs of children who are suffering the result of their burn injuries. Nurses and hospital play specialists perform a dominant role in easing and alleviating pain and distress by administering timely pain relief medication and by the provision of innovative play and distraction techniques. Therefore to ask the question, "What do nurses' and hospital play specialists' experience when caring for children with burns?" a qualitative descriptive methodology was the appropriate choice to discover their experiences from real life.

Through thoughtful processes of writing, reflection and re-writing a deeper understanding of the participant's unique reality is brought to light within story and text. The experiences of the participants in this study are not explored

individually. Owing to the fact that there are only two hospital play specialists as opposed to the eight registered nurses participating in this study, common themes will be looked for within their shared stories. However, in this introductory chapter the nursing role and the hospital play specialist role is explained separately in order to highlight the knowledge and practice that underlies their individual roles. The professional context in which New Zealand nursing and hospital play specialists programmes are developing is also explained, providing a background for a better understanding of the stories told by the participants in this study.

This qualitative descriptive study explores the experience of eight registered nurses and the two hospital play specialists who work on a children's ward in a New Zealand hospital designed to cater for children with burns. However, the ward also functions as an acute care surgical ward that caters to a client group with an age range from 0-15 years who are admitted with orthopaedic, plastic and reconstructive surgery, dental, ear, nose and throat diagnoses which may (or may not) require surgical intervention. Some nurses on this ward have received specialist training to care for children with burns and plastic reconstructive surgery and some are specifically trained to provide care for children with orthopaedic problems. Budgetary cuts and economic rationalisation are factors that lead to the establishment of mixed specialty surgical care wards like the present (Scully, 1995). This means that nurses are required to have a broad repertoire of knowledge and clinical expertise to care for children with varied and complex needs. However, this study is specifically directed towards the

experience of nurses and hospital play specialists who care for the children with burn injuries.

My personal interest in this topic arises from my own career in paediatric burn nursing, and more recently in the provision of professional development and support to nurses and allied health workers who work with children. In the course of my work I have personally and professionally experienced the impact of caring for children with burns. In my current role as a nurse educator I have witnessed and supported nurses and hospital play specialists during their delivery of care to the children with burns. Their experiences are situated within the context of their every day 'taken-for-granted' practices which might not always be made explicit when caring for children with burns. It is possible that the familiarity of their experience becomes so much a part of their day to day work that it is unnoticed and internalised. Thus, my curiosity led me to want to understand more about their practice.

The impetus to undertake this study

By turning to nurses and hospital play specialists and asking each to tell their own story will by no means show disregard to what other members of the burn team experience, or what is already known from literature and anecdotal evidence, including my personal familiarity within this care context. In fact, the participant's stories would be positioned alongside the existing knowledge to become a part of the landscape of what is already known about the experience of caring for children with burns.

My professional interest in understanding the experience of nurses and hospital play specialists was aroused a few years ago while in my current role as clinical nurse educator on a children's burn ward. My main responsibility in this role is to provide and facilitate ongoing professional development programmes for nurses. In this role I also have a close working relationship with allied health workers, including hospital play specialists who are a part of the burns multidisciplinary team. I have an open-door relationship with all of the nurses and hospital play specialists, who often seek my support or consultation on clinical issues and at times, matters of a personal nature.

Several years ago there was a significant upsurge in the number of children admitted with extensive and complex burn injuries to the ward. The events that followed had a marked impact on the physical and emotional well-being of the nurses and hospital play specialists who worked on the ward. The turning point occurred soon after the admission of a child with over sixty percent total body surface area burns. The balance between the number of available staff, skill mix, care organisation and high workload had major influence on safety and efficiency of care delivered to the children, as well as the staff who had to endure the situation. My role was to ensure that the nurses were clinically supported and that education was made available for them to provide effective, efficient and safe care to the children admitted with burns. The nurses spent long hours in the burns bathroom doing dressing changes on the children. Some nurses who were not clinically prepared to care for the children with burns had no alternative other than to help with the less complex burn dressings.

The months that followed the children's lengthy hospitalisation was challenging for many of the nurses and hospital play specialists who became emotionally and physically exhausted. Some nurses adamantly refused to take care of the children who had needs beyond the nurse's clinical capability and experience. Those nurses who did endure the complex caseload soon got exhausted. The nurse to patient ratio became particularly problematic in light of the high patient acuity. Despite the fact that bureau nursing help was regularly requested, in most instances the environment was new to the bureau nurse. This meant that the bureau nurse would need an investment of time for orientation. It takes time and energy to orientate new staff and the existing ward nurses had neither the time nor energy to do that. The situation became fraught with emotional outbursts from nurses who undoubtedly were stressed and overworked. The more experienced nurses lost confidence to competently care for the burn injured children: a behaviour contradictory to their usual efficiency. With the mounting symptoms of stress and exhaustion, the nurses were determined that action had to be taken. Senior nursing and medical management responded and a psychological review was arranged for the entire multidisciplinary burn team.

The help of a clinical psychologist was solicited to undertake a psychological review of the health professionals who were working with the children at the time. A crisis intervention programme was established with the expectation that the staff would have a facilitated process to assess their support systems, coping mechanisms and their understanding of their personal psychological response to the events at the time. Remarkably, participation in the programme was attended mainly by the nurses and the hospital play specialists.

At the time I mulled over the circumstances that surrounded the psychological review and the discussions that ensued. As I reflected on the stories that were told by nurses and hospital play specialists, a number of questions were raised in my mind. Their stories made me wonder about their experiences and the impact that it had on their care provision and support to the children. Moreover, I wondered what the leaders in healthcare would do if they had insight into the experiences of the nurses' and hospital play specialists' work realities. In response to those thoughts the study question arose, "What do nurses' and hospital play specialists' experience when caring for children with burns?"

The opportunity for this study came several years later as the result of my enrolment into a Masters in Health Science degree at Auckland University of Technology. From an education perspective the opportunity was timely to follow my interest to understand the experiences that shape the practice of nurses and hospital play specialists who care for children with burns. Nurses comprise the single largest number of health care professionals and represent one of the primary forces of clinical intervention. Besides, experiences that gives form to the clinical practice of health professionals who endure long hours with their patients, merits more research attention. For better understanding of the participants' stories this chapter will review the role and responsibilities of the nurses and hospital play specialists in this care context.

The nursing role

Nursing has long been acknowledged as a profession that is built on a body of scientific knowledge and therapeutic skills that moulds attitudes, intellectual

competencies and technical skills (Benner, 1984a). Using their considerable knowledge nurses save lives, they prevent health complications, alleviate suffering and help the sick and the well cope with their health needs. Nurses also protect their patients from risks and consequences of their illness, disability, injuries and treatment. As a service, nursing is more than the clinical tasks that nurses perform. Nurses provide care and support to the ill, the distressed and the vulnerable in ways that are fundamental to human survival (Leininger, 1981; Watson, 1990).

Understanding of nursing children in New Zealand made steady progress since the findings of McKinlay's survey of New Zealand hospitals (McKinlay, 1981). The survey findings influenced the country's Health Department future plans for healthcare services for children to be delivered in purpose built children's hospitals and wards. Due to the small population in New Zealand it was not possible to duplicate the whole spectrum of inpatient specialty services nationally for children. Thus, with imposed economic restraints, centralisation of health services for children dictated which hospitals children could be admitted to for specific specialities (McKinlay, 1981). The ward in which this study takes place is situated in a modern children's hospital in New Zealand.

Formal education for the registered nurse in New Zealand moved from hospital-based programmes to the tertiary education sector during the mid to late 1990s (Hardcastle, 2006). Currently, in New Zealand an undergraduate degree prepares a nurse for comprehensive registration. The Nursing Council of New Zealand, as a statutory body, sets and monitors the standard of education for the

undergraduate nurse to ensure that the scope of clinical learning prepares the nurse with the basic educational requirement for entry into clinical practice (Mockett, Horsfall, & O'Callaghan, 2006). This move is now entrenched and the majority of education programmes designed for registered nurses who are seeking to advance their level of practice in this country is aimed at postgraduate level. Postgraduate programmes in New Zealand are designed to enhance the basic nursing knowledge of the registered nurse who may wish to expand on his or her current knowledge of specialty areas, such as paediatric clinical practice. Registered nurses are now undertaking postgraduate education to support their professional development towards continued learning and advancement of competence in their clinical practice in this health provider setting. Another driving force towards education advancement for the registered nurses is the requirement to provide evidence of their continued professional development as a criterion within a managed programme governed by the employer and monitored by the New Zealand Nursing Council. The programme, which commenced ten years ago in the present organisation, has a set pathway for advancement in clinical practice that defines the nurses' responsibility and remuneration.

Following the Nursing Council of New Zealand's strategic review of undergraduate and postgraduate nursing education, education leaders in the healthcare provider settings took cognizance and challenged old practices (Mockett, Horsfall, & O'Callaghan, 2006). With the introduction of the New Zealand Health Strategy (2000) and the recent implementation of the Health Professionals Competency Assurance Act (HPCAA) (2003), all New Zealand

health professional governing bodies are required to review current practice (Mockett, Horsfall, & O'Callaghan, 2006).

The development of new frameworks for delivering post registration clinical education eventuated after a thorough analysis of the current clinical education delivery was undertaken at the hospital in which this study takes place (Mockett, Horsfall, & O'Callaghan, 2006). The change required clear management structures, strong leadership, perseverance and understanding of the organisation's culture to move away from in-house courses that had previously up-skilled registered nurses for improved techniques to care for patients. The change was complemented by the organisation's drive in encouraging registered nurses to undertake postgraduate education in order to work in specialty areas. Nursing children is considered to be a specialised field of nursing practice. In a specialised clinical area like the children's burns ward, nurses develop their clinical skills through a preceptorship model of learning by working alongside a more experienced nursing colleague.

The children admitted to this hospital with a burn injury follow a well researched clinical pathway of care designed to coordinate care from the moment the child arrives at the emergency department (K. O. Taylor, Goudie, & Muller, 2004). It is not uncommon for the nurses in the emergency department of the hospital that this study takes place to request the assistance of the ward nurses when a child with burns, requiring hospitalisation, arrives at the department. The reason for this practice is because of the high nursing turnover rate, mainly in the paediatric emergency department. Hence, it is not unusual for the emergency department to

be predominantly staffed by bureau nurses or nurses specifically trained in adult emergency care. The request for a ward nurses' assistance is based on the tenet that the ward nurses are clinically and academically more prepared to guide emergency management procedures for the children with burns. When the ward nurse is called to the emergency department it is at this time that she first meets the child and the parents and initiates the admission interview.

If at all possible, the parents are invited from the onset to be involved in their child's care. An informal contract that clearly defines the parents' role and the options for renegotiation of participation is agreed upon. During their first encounter with the parent, the nurse, as well as the hospital play specialist assesses the parents' ability to provide support during wound care procedures. Issues that are considered during this assessment include the parents' support of the child during the history taking, the appropriateness of the parents' responses to the questions, the parents' interest in seeing the injury, and the parents' own need for support relative to that of the child's injury.

Nurses who work with sick children and their families, particularly children with burns, are a part of a team or even several teams. It may be a ward team, a multidisciplinary team or a nursing team. On the children's burns ward that this study takes place the hospital play specialists work very closely alongside the nurses.

The role of the hospital play specialist

Hospital play specialists are a more recent addition to the health care team. They are licensed allied health workers who provide care and support to children, young people and their families who are in hospital. The overriding role of the hospital play specialist is to help reduce the stress and anxiety that children experience during their encounter when in hospital. This is achieved when care is individualised and based on assessment of the child's age, level of development, personality, coping skills and family situation (Heiney, 1991). Their focus is to provide a normal, reassuring experience; as well as increase each child's ability to regain confidence, independence and self-esteem. The hospital play specialist offers a wide range of creative, recreational and social activities which are entertaining and fun for the children in potentially stressful surroundings. In the context of this study the role of the nurse and that of the hospital play specialist is very closely interwoven. The hospital play specialist complements the nursing role by supporting the child and the child's family to adjust to the hospital environment. When working alongside the nurse during any procedure the hospital play specialist helps to distract the child using a variety of methods such as music, bubbles, toys, puppets, books and guided imagery to engage the child. Prior to a procedure, especially with a burn dressing the hospital play specialist will augment the information given by the nurse, telling the children when, where and how much pain they might experience and sensations they could anticipate. When the procedure is completed the opportunity for a period of debriefing is provided for the child and/or the family to ask questions or express their perceptions regarding the procedure.

In New Zealand the minimum qualification for a hospital play specialist is a diploma in Early Childhood Education (ECE) and a Diploma in Early Childhood Intervention, which focuses on special developmental needs of the child. A qualification in psychology and counselling are an added bonus. Some playrooms in certain organisations within New Zealand are licensed Ministry of Health early childhood centres, therefore experience in early childhood teaching and a recognised qualification in education is a requirement (Kayes, 2005). Kayes (2005) Masters thesis, at present the only study that focuses on the work of hospital play specialist in New Zealand, found hospital play specialists to be “resilient and committed” as they moved from their previous roles in early childhood education to their world of healthcare (p.143). Hospital play specialists have become an integral part of the paediatric multidisciplinary burn team in the ward that this study takes place.

In New Zealand and the United Kingdom the hospital play specialist role is said to be equivalent to the child life specialist role in the United States. Hospital play programmes in New Zealand have been greatly influenced by the development of similar programmes in the two above mentioned countries. As members of the healthcare team hospital play specialists work in children’s wards and other hospital departments where children are patients. Aside from a few public hospitals within New Zealand, hospital play programmes are existent in only half of the twenty-one district health boards (Kayes, 2005).

In the hospital in which this present study takes place the hospital play specialist service has been positioned on the children’s burn ward for about eight years.

They have become well established members of the burns multidisciplinary team with significant control over how procedures to children are timed in relation to the child's overall readiness. For example, if a child is distressed before commencement of a procedure the hospital play specialist will, in consultation and collaboration with the wider burn care team, review the treatment process and make considerations on behalf of the child until additional coping strategies, timing and pain management have been taken into account. Only then can a procedure be carried out on the child.

Viewed as a language, play becomes a communication tool that the hospital play specialist uses to build strategies of support and understanding between the child and the child's immediate hospital environment. Play, generally considered as an intrinsic childhood activity that supports a child's understanding of the world around, is a fundamental healthcare intervention used by hospital play specialist. When viewed as language, play becomes an important communication tool which children use to build support strategies between themselves and their professional carers (Kayes, 2005).

Play is by no means the exclusive domain of any single discipline. There is wide interdisciplinary interest and involvement of play when healthcare professionals interact with children. Even so, the hospital play specialists use play in hospital as a means to provide opportunities for children to understand aspects of healthcare experiences (Kayes, 2005). Hospital play specialists in New Zealand may use the terms "medical play", "therapeutic play" or "healthcare play" interchangeably in reference to play that they engage directly or indirectly with the children in

hospital to overcome the emotional impact of their illness, trauma or hospital experience (Kayes, 2005). Direct healthcare play may involve anything from finger painting to giving a doll an injection. The hospital play specialists provide opportunities for indirect healthcare play as a 'safe' option for children who are overwhelmed by their hospital experience. An environment is created with material that is expected to stimulate the child to play at their own pace and without coercion. The hospital play specialist attends sensitively to the child, observing their play and their expression of feelings (Kayes, 2005). During the course of these interactions the hospital play specialist is able to ascertain whether or not the child is developing emotionally to deal with hospitalisation. Through play children are able to master and cope with their injuries, hospitalisation and treatment. The hospital play specialist also provides support and advice to the child's family on appropriate play that will support the child through their trajectory of care. For the child with a lengthened stay in hospital as a result of being seriously burned, play and recreation has the potential to bridge the gap between hospital, home, early childhood centre or school.

In view of the fact that children are now surviving burns trauma means that seriously burned children can remain in hospital from several weeks to months. Kayes (2005) doubts whether hospital play specialist are ready for this change. Working so closely with each other, nurses and hospital play specialists are exposed to similar experiences on the children's burn ward. How each experiences their work environment is a matter that awaits discovery. The stories that the participants reveal of their work environment with the children with burns will be explored collectively to reveal a common understanding.

The structure of the thesis

Describing and interpreting the every day events of eight nurses and two hospital play specialists when caring for children with burns is the primary concern of this qualitative descriptive study. As the researcher I am seeking an account of the participant's experiences in everyday terms of the event. This chapter introduces the context of the study which traces my historical footsteps that led to my interest to undertake this research study.

Chapter Two reviews literature relevant to this study. Many of the studies claim that caring for children with burns is emotionally stressful because of the demanding nature of the care.

Chapter Three describes the research approach and the methodology that underpin this study. The design of the study is described, which includes information on the participants, the interviews and the process used for analysing the data. Chapter Three concludes with the ethical approval process and the way in which trustworthiness of the study is established.

Chapters Four, Five and Six presents the findings of the study. And, finally Chapter Seven discusses the findings in relation to literature and their meaning for practice. Included in Chapter Seven is a discussion of the study's limitation and areas for further research.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The purpose of a literature review is to inform the researcher and the reader of the topic being researched, and to identify gaps in the research that new research can address (Cormack, 2000). This study involved literature searches using multiple electronic databases. The initial search strategy used a combination of the following key words that were relevant to the research topic: nursing children, burns, burn care, paediatric, acute care, high-dependency and trauma. The search was then refined adding new key words: family, stress, suffering and emotional impact as subject matter pertinent to this research became obvious. Reference to literature from other professions was important to compare against the experiences of health professionals, and to position those findings in the context of caring for children with burns. Literature related to nurses who work in burn units, particularly those who work with children was used to lead the findings of this research.

Caring for children with burn injuries

Caring for children, who are sick, injured, abused or in pain can be very demanding of physical and mental energy. To be burned is one the most devastating and catastrophic traumatic event any person can experience. Even a small burn, strategically placed, has the potential to cause significant physical and psychological impact on a person. Burn injuries is one of the most complex and comprehensive injury a person can suffer and they are perhaps the only injury

that requires specialist treatment by a team of medical and nursing personnel possessing a specific specialization, in this case in the treatment of burns. When a burn injury is serious enough to require admission into hospital both medical and nursing interventions immediately focus on life-sustaining measures, followed by restoration and repair of tissues. The unexpectedness of the trauma, acute pain, ongoing painful manipulations, separation from home and loved ones, alongside prolonged convalescence, disfigurement, chronic pain, depression, alienation and contractures induce permanent disability with life-long adverse effects on the child's emotional and physical wellbeing (Burnside, 1996). Such a situation forces the child to regress emotionally, psychologically and physically (Bowlby, 1988; Wong, 1995).

Regression is a well documented process that affects different aspects of the child's development, mainly muscle control and speech (Bowlby, 1988; Palmer, 1993; Wong, 1995). A very obvious sign of regression often observed by paediatric nurses is the child's loss of bladder and bowel control. To care for a child who is physically and emotionally imbalanced as a result of being burned requires care from health professionals that are knowledgeable and understands the physical, emotional and psycho-social needs of the child.

Children with serious burn injuries may become anxious and confused due to the sudden change of circumstances and the effects of their physical status, such as pain and acid-base disturbances (Oh, 1990; Ray, 1995). The child's anxiety may further perpetuate the release of body chemicals which trigger change in the child's cardiovascular, metabolic and renal functions (Tortora & Anagnostakos,

1990). This adds to the child's distress making it even more difficult for them to cope with their situation. Thus, care provision by health professionals becomes more intensive and demanding.

The optimal management of the severely burned child is intensive (Mills, 2005; Ray, 1995) and even after survival is ensured, for years the child will require protracted surgical, medical, psychological and rehabilitation input (Sheridan et al., 2000). Caring for children with high needs necessitates an expansive repertoire of knowledge and skills in order to meet the individual needs of the child and the child's family. Requirements also have to include constant vigilance, astute observational skills, expertise in recognising changes and appropriate responses to the problems caused by the child's increased vulnerability and developmental immaturity (Doman, Prowse, & Webb, 2004).

The burn is not a superficial and localized injury affecting only the skin; it involves all systems of the body which requires intense systemic management (Siamanga, 2002). Accurate evaluation of the extent of a burn is important; because skin destroyed through burns is unable to retain body fluids and electrolytes essential for optimal body functioning. When large quantities of body fluid and electrolytes are lost or misplaced the need for immediate intravenous fluid replacement is crucial. If not, shock becomes inevitable and this may be fatal.

Classification of burns

To estimate for burned body surface area in older children and adults alike the rule of nine has been found to be the most accurate. According to this rule, various parts of the body are divided into surfaces corresponding to 9% total body surface area or its multiples, with the exception of the perineum, which is calculated as 1% total body surface area (Ray, 1995; Siamanga, 2002; K. O. Taylor, Goudie, & Muller, 2004). For children eight years and younger the percentages allocated to calculate body surface area varies according to the age of the child. This is because of the marked variation in the anatomy and physiology of children eight years and younger (Siamanga, 2002; J. Taylor, Muller, Wattley, & Harris, 1999; K. O. Taylor, Goudie, & Muller, 2004; Wong, 1995).

The division of a burn injury is rated in degrees which correspond to the skin depth that is damaged. A superficial or first-degree burn affect only the epidermis, causing reddening of the skin, pain, and oedema. If uncomplicated by poor circulation or infection the burn heals without medical treatment in 12-15 days and does not require specialist care. Partial-thickness or second-degree burns affect not only the epidermis but also some of the dermis, causing reddening of the skin, acute pain and the formation of blisters and oedema in and around the affected area. This type of burn usually heals in 21-30 days. Third degree or a full-thickness burn destroys the full thickness of the skin (epidermis, dermis, subcutaneous fat, muscle, and bones). The burned area is white and dry. Owing to the destruction of the nerve endings, pain is minor or non-existent. Deep-partial thickness to full thickness burns takes much longer to heal and is

associated with the risk of scarring and contracture formation (Siamanga, 2002). Skin grafting is a requirement for deep-partial thickness and full thickness burns.

Characteristics of burn injuries in children

Even in light of increasing survival rates owing to technological advances such as early excision and grafting, increased ability to prevent infection and the application of 'artificial skin'(Mills, 2005), burned children remain a national tragedy. Contact burns and scalds are a leading cause of injury to children in New Zealand (Chalmers & Langley, 1999). The Injury Prevention Research Unit-IPRU (2001) has on record an average of nearly five hundred children under the age of fifteen years of age being admitted to hospital each year with burns (Chalmers & Langley, 1999). Although children with severe burns tend to survive more readily than they previously did, their recovery is long and intense.

From the moment that the child with burns arrives at the hospital a wide range of medical and nursing procedures are commenced and it continues on until after the child is discharged. Paradoxically, the length of hospital stay for children with more than forty percent burns is therefore increased owing to their improved chances of survival. For example, with early intervention and administration of specific antibodies to produce a state of passive immunity in the recipient, death from toxic shock in children with burns is becoming rare and is potentially preventable in New Zealand (Edwards-Jones, Dawson, & Childs, 2000).

The comprehensiveness of caring for children with burns extends from the acute phase, which is from the time the burn trauma has occurred, through to

rehabilitation. The overall care provided to the children with burn injuries from a nursing perspective encompasses fluid and electrolyte management, the threat of potential wound infection, nutritional deficiency, the child's pain and the sequelae of immobility and functional losses that may follow. The ambience on a burn ward conjures up images of extreme pain, disfigurement, loss of function, long stay in hospital and intense busyness (Cronin, 2001; Goodstein, 1985; Lewis, Poppe, Twomey, & Peltier, 1990). Thus, it could well be argued that health professionals who work on a children's burn ward over an extended period of time and for greater periods of their working day may themselves experience psychological reactions to the traumatic event, similar to the survivors of war, natural disasters and holocaust (Davidson & Jackson, 1985). Since issues relating to the child's injuries, their pain, hospitalisation, treatments, and separation from familiar surroundings and family interrelate, they need be considered collectively and comprehensively when caring for the child with burns. These are complex factors that are to be considered and discussed with the child's family. Considerations of equal importance are the child's personality, their family background and the circumstances in which the burn trauma has occurred.

Burn trauma -the impact on the family

A parent's presence and participation in all aspects of their child's care following admission for burn injuries enables them to maintain their usual parent role. That which includes comforting the child who is scared and in pain and making decisions about the child's daily cares (Trofino, 1991; Wong, 1995). The visibility of a burn especially on the hands and face of the child may be a constant reminder of the accident for the parent and/or family (Kent, King, &

Ray, 2000). Therefore, the child's family is more likely to experience feelings of guilt and helplessness about the child's injury and pain. Additionally, feelings of helplessness may also arise from lack of information given about their child's condition, prognosis and understanding of hospital routines (Gordon, 1993). Nurses and hospital play specialists are in an ideal position to be involved in the family's psychological response and adjustment to the experience, which could potentially influence the family's psychological adjustment following the child's discharge from hospital (Kent, King, & Ray, 2000; Sutton, 1993).

Previously, nurses were directly involved in all aspects of care for the child undergoing treatment as a result of being burned. With the introduction of parental participation in the treatment schedules, nurses are beginning to relinquish their role of providing direct emotional support for the child to the parent. How nurses and other health professionals view the impact of parental participation on their role in treatment procedures significantly affects their acceptance of a parental participation programme (Darbyshire, 1994). Children with burn injuries undergo significant physical and emotional trauma, initially from their injury, and subsequently from the dressing changes and related treatment that they endure throughout the healing phase. Pain that the child experiences during dressing changes and related treatment is often distressing for the parents and the health professionals.

When a child is burned, the situation inflicts a unique crisis in the lives of the child's family. Unfortunately, from the health professional's perspective the impact is often a hidden dimension. The child who is burned and the family who

suffers as the result of the child's injury becomes the focus of attention in this crisis; but, if the focus is shifted and the health professionals are asked what the experience is like for them, a different story unfolds.

Inherent work demands related to caring for the burned child

While there is no intent to render extraneous or negate the child's burn experience, understanding of the child's course for recovery has been made relatively predictable through an expanse of literature and research (Davey, 1999; Edwards-Jones, Dawson, & Childs, 2000; Mannon, 1985; Marvin, Carrougher, & Bayley, 1991; Oh, 1990; Ray, 1995; Wong, 1995). Techniques to facilitate the physical healing of burn wounds and the psychological rehabilitation of children with burns, have made recovery possible for many critically burned children (Meyers-Paal et al., 2000). Thus far, literature highlighting the care that nurses provide in children's burn units is abundant in providing comprehensive information about techniques to facilitate the physical healing of burn injuries. Many of the studies that focus on the experiences of paediatric burn nurses who care for the child with burns are mainly quantitative designs that focus on the nurses' response to work-related stress and subsequent coping behaviours (Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Steenkamp & van der Merwe, 1998).

Stress – as a work-related issue

Working in a burn unit is claimed to be a stressful occupation, and when left unresolved, the continued exposure could become detrimental to the health professional, simultaneously to the patient and to the families (Lewis, Poppe,

Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998). Work-related stress is a widespread problem across industries, but is endemic in the human services where nurses form the largest workforce (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000; Ernst, Franco, Messmer, & Gonzales, 2004; Olofsson, Bengtsson, & Brink, 2003). The topic of stress in nursing has been documented for several decades (Badger, 2001; Benner & Wrubel, 1989; Davidson & Jackson, 1985; Davitz & Davitz, 1975; Davitz, Davitz, & Rubin, 1980; Perkin, Young, Freier, Allen, & Orr, 1997; Rafii, Oskouie, & Nikravesh, 2004). In the studies undertaken by Lewis, Poppe, Twomey and Peltier (1990), Nagy (1998) and Steenkamp and van der Merwe (1998) stress is inferred to as an objectified state, almost separated from the person: like a remote variable to be managed or changed.

Stress is said to be a non-specific response of the body to stimuli or stressors which can have both positive and negative effects on the individual (Neuman, 1982; Olofsson, Bengtsson, & Brink, 2003). Interpretation of a stimulus as being pleasant or threatening is dependent on the individual's prior experience of the situation. Some stimuli would be unanimously regarded as negative, while other stimuli are perceived as positive by some individuals and as negative by others. An individual's perception of the stimuli may be related to the individual's emotional state, traits, prior experience and objective external threats, such as limited time frames in which to effectively complete a task. Olofsson, Bengtsson and Brink, (2003) believe that on an individual level a person may become stressed due to the inadequacies in the persons "character, behaviour or productivity" (p 352). Contrarily, Maslach and Leiter (1997) claim that stress

which leads to burnout may not be related to the incapability of the individual. Rather that it relates to the social environment in which the individual is situated, such as in their workplace. The results of a survey undertaken by Ernst, Franco, Messmer and Gonzalez (2004) that involved two hundred and forty nine nurses employed at a children's hospital showed that nurses with more years of professional experience, longevity on the unit and the hospital, had more confidence and were less likely to become stressed even though greater work demands were placed on them than those with less. In addition, the older nurses in Ernst, Franco, Messmer and Gonzales' (2004) study showed less concern about task allocation than the younger nurses. However, Garrett and McDaniel (2001) argued that a nurse's perception of the environment is more a function of personality than education or experience. The suggestion being that conscience and commitment were prominent characteristics that modified nurses' response to burnout (Garrett & McDaniel, 2001).

Williamson and Dodd (1999) consider nursing to be a stressful occupation because the focus is on the client rather than on the professional carer. Stress measurement and rating tools traditionally used in nursing research was considered by Williamson and Dodd (1999) to be deficient in taking into account that stress occurs when a situation raises the demand placed on the worker, especially if the worker is unable to meet the demand placed on them. There is some credence that stress generated from the private lives of a person encroaches into the workplace, as the two realms cannot be separated. A point that has to be considered to make research on stress in the workplace more meaningful

(Williamson & Dodds, 1999). In a study to establish how nurses dealt with their emotions on a burn unit Cronin (2001) concluded that:

Stress was linked with how nurses deal with emotions. By the very nature of the burn unit and its work, nurses who are involved with care of the burn victims know that stress is part of this type of nursing (p 344).

Common contributory factors that lead to stress for health professionals who on a daily basis care for children with burns include being witness to or participating in painful procedures, failing to manage the child's pain, exposure to inter-staff conflict and high workload (Cronin, 2001; Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1999; Steenkamp & van der Merwe, 1998). Working with uncooperative patients and patient's families, as well as other health disciplines (mainly doctors), or having to act as a proxy parent to the children left on their own in hospital following a burn injury, are other notable factors that contribute to high levels of stress among nurses (Davidson & Jackson, 1985; Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998). Caring for children with mental health problems or social problems scored higher stress levels among nurses, suggesting that caring for children with less than straightforward conditions is clinically more demanding (Doman, 1997). In critical care environments where the workload is demanding and the emotional expenditure is high, stress among the workers was found to be equally high (Boyle, 1991; Cudmore, 1996; Lally & Pearce, 1996; Sheward, Hunt, Hagen, Macleod, & Ball, 2005). When faced with the constant barrage of stressful events, health professionals were found to feel emotionally powerless and depleted (Dunn, Wilson, & Esterman, 2005; Nagy, 1998, , 1999; Sheward, Hunt, Hagen, Macleod, & Ball, 2005). McCann and Pearlman (1990) suggest that exposure to stressful and traumatic experiences of

victims could become hazardous to the mental health of the health professional involved in the patient's healing process, more so if recovery is less than ideal (McCann & Pearlman, 1990; Tyler & Ellison, 1994). Likewise, health professionals who work in sole positions, like occupational therapists could easily find themselves in an isolated spot because there is no like-professional to consult with, to delegate to or to seek assistance from (Sutton, 1993).

Enthusiasm, optimism and a display of extreme perseverance to accomplish may become a source of stress for new health professionals who lack insight into their job limitations (Sutton, 1993). Studies suggest that stress at work plays an important role in the development of negative individual and organisational factors which forms a common element in linking working conditions, substance abuse and team disharmony (Lewis, Poppe, Twomey, & Peltier, 1990; Sheward, Hunt, Hagen, Macleod, & Ball, 2005; Steenkamp & van der Merwe, 1998; Sutton, 1993).

A significant correlation exists between the difficulty to relax at work and negative emotions such as feelings of inadequacy, depression, somatic complaints, sleep disturbances and burnout (Tyler & Ellison, 1994). Furthermore, studies show that powerlessness, feelings of guilt, conflict and maladaptive forms of coping are also not unusual (Davidson & Jackson, 1985; Dunn, Wilson, & Esterman, 2005; Goodstein, 1985; Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Sheward, Hunt, Hagen, Macleod, & Ball, 2005).

Cronin's (2001) study on nurses who worked on the burn unit found that the effect of stress is not always negative. The nurses in Cronin's (2001) study recognised the need to deal with their emotions when faced with the inherent stressors of their work. However, there are some who argue that nurses suppressed their emotions in order to care, irrespective of their personal attitude to self, the patient and the circumstance (Smith, 1992). Stress has the potential to instigate alertness and a response to pressure (Cronin, 2001), though in some instances the intensity of the stress may be beyond the level for adaptation (Tyler & Ellison, 1994). Tyler and Ellison (1994) infer that nurses who have stress-related emotional symptoms could benefit from acquiring coping skills gained in stress- management and assertiveness training courses.

Tyler and Ellison (1994) examined occupational stress in four high-dependency areas: theatre, liver, renal, oncology and elective surgery and found that the overall stress levels did not differ between the areas. However, there were differences noted in the source of stress between the areas (Tyler & Ellison, 1994). On the other hand, Omdahl and O'Donnell (1999) in a study that examined the extent to which empathy variables contributed to nursing stress found that no significant differences emerged based on the types of nursing, even though the areas included places such as oncology. Doctor-nurse conflict and giving psychological support to the patient's family when workload increased, was seen as a significant source of stress for the nurses on the liver and elective surgery wards (Tyler & Ellison, 1994). The nurses working in theatre and haematology attributed large workload and the risk of falling behind in their administrative work as being the source of their stress (Tyler & Ellison, 1994).

Tyler and Ellison's (1994) study also described situations such as when patients became physically and psychologically dependent on the nurse as being stressful and demanding. Nurses dealing with critically ill children who suffer major morbidity outcomes as the result of their condition may find the experience stressful and psychologically demanding owing to the nurses' restricted decision latitude regarding care outcomes for children (Omdahl & O'Donnell, 1999; Tyler & Ellison, 1994).

Witnessing suffering

Thirty years ago Davitz and Davitz (1975) concluded that nurses in general displayed a strong urge to distance themselves from the individual who was suffering. While suffering and pain may appear synonymous, they are not. There are many sources and causes of suffering, and pain may be one of them. However, the intensity of suffering does not always correspond directly to the intensity of one's pain (Cassell, 1992; Kahn & Steeves, 1994; Morse, 2001). A wealth of literature has been written about the predicament in which those who suffer find themselves (Morse, 2001; Starck & McGovern, 1992). Morse (2001) suggests that nurses are the "caretakers" of those who suffer, therefore understanding suffering and responding to the needs of those who suffer becomes an onerous responsibility for the nurse (p.47). Patients' stories of their suffering is made known, yet there is no connection between the patients' stories of suffering and the responses of the caregiver (Morse, 2001).

Suffering is subjective, in that no two persons can undergo the experience identically. As an interiorised and personal experience, suffering varies in

intensity and duration, affecting not just a single part; instead it pervades and threatens the cohesiveness of the physical, emotional, spiritual, mental and social being of the person (Cassell, 1992; Starck & McGovern, 1992). The nurses' necessity to care puts him/her at risk of suffering as a response to viewing or assisting those who suffer (Morse, 2001). In a qualitative study examining nurse-patient relationship Morse and Mitcham (1997) referred to the contagion of physical distress as "compathy", which is described as being a physical equivalent to empathy. The way in which compathy differs from empathy is that compathy is experienced within one's physical body which may be similar to or related in some ways to the witnessed suffering (Morse & Mitcham, 1997). With experience nurses learn to suppress their compathetic response by hiding their true feelings from the patient. For example, when viewing the grossly disfigured and scarred body of a seriously burned patient (Morse & Mitcham, 1997).

There are many who candidly claim that suffering forms part of the tapestry of life events closely related to concepts such as, grief, loss, poverty, pain and loneliness (Daly, 1995a, , 1995b; Starck & McGovern, 1992). Extant literature on the theoretical views of suffering is considerable, with the meaning and nature of suffering being ambiguously described or explored (Daly, 1995a). The word suffering is rich in meanings and heavily value-laden. The meaning of suffering has a wide range in that it can mean, allowing or tolerating, enduring or undergoing, sustaining injury or, feeling pain and distress. When used in the context of a child following a burn trauma, suffering could mean feeling pain, fear and distress. However, a mere definition of suffering is not capable of describing the effects of the suffering when perceived from the perspective of a

child who is distressed and in pain following a major burn trauma. Therefore, suffering from the perspective of a child who is 'robbed' of the joys of childhood due to his or her devastating injuries and severe pain is an undeserved adversity that has major impact on those who are closely involved with the child (Burnside, 1996; Trofino, 1991; Wong, 1995).

While health professionals are frequently witnessing suffering across diverse areas of their practice, the crux of the phenomenon, namely suffering, and the repercussions that suffering could have on the health professional has not gained much curiosity by nurse researchers either by inquiry or discussion (Daly, 1995b; Kahn & Steeves, 1994). Kahn and Steeves (1994) concluded from their phenomenological study that nurses knew and understood a great deal about the suffering and were not prepared to be silent about the suffering they had witnessed. In witnessing the suffering of others the nurses in that study readily described suffering experiences without a need to conceal what they saw or felt. Neither was there any inclination to diminish the quality of their experience. The findings of Kahn and Steeves (1994) study is in contrast with Davitz and Davitz (1975) who implied that nurses distance themselves from suffering. According to Morse (2001) distancing is attained at the cost of depersonalising and dehumanising ones self and the person who is suffering. Thus, from whatever the cause that suffering is generated, my confidence informs me that this present study is timely to understand and make known what it is that nurses and hospital play specialists experience when caring for children with burns.

In a study asking undergraduate student nurses to describe their experience of caring for individuals who were suffering found that uncovered feelings of powerlessness were experienced when the students were unable to alleviate their patient's suffering (Eifried, 2003). Nurses who are in the process of building their repertoire of knowledge and experience to care for suffering patients find it a challenge to balance compassionate care towards others while simultaneously engaging in self-care (Eifried, 2003; Morse, 2001). The students in Eifried's (2003) study distanced themselves from the suffering individual as soon as they became emotionally depleted. Eifried (2003) believes that learning about suffering and being compassionate to those who are suffering occurs when nurses are offered the opportunity to discuss and reflect on their experience of being witness to suffering.

Compassion is one way of allowing some distance to be maintained between the person who cares and the person who suffers (Bloom, 1997). Empathy on the other hand requires that one inadvertently experiences some of the pain that the other suffers (Bloom, 1997; Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). Bloom (1997) suggests that people who have close contact with traumatised victims may become emotionally overwhelmed and gradually become indirect victims of the insidious trauma themselves. This phenomenon has been well documented under several terms: vicarious traumatisation, compassion fatigue, secondary traumatic stress and burnout (McCann & Pearlman, 1990).

Burnout- an overwhelming fact

Burnout, secondary traumatic stress, vicarious traumatisation, occupational stress and compassion fatigue are terms that are used interchangeably to address the effects of working over a lengthened period with traumatised individuals, mainly in relation to doctors, nurses and therapists (Badger, 2001; Cudmore, 1996; Davidson & Jackson, 1985; McCann & Pearlman, 1990; McVicar, 2003). Burnout is related to stress and is most frequently related to emotional exhaustion, depersonalisation in relation to work and a sense of waning in regards to personal accomplishments (Khowaja, Merchant, & Hirani, 2005; Kreisher, 2002). Burnout has its origin in physical, emotional or psychological demands, as well as institutional demands. Grounded in vast literature, there is the assumption that nurses because of their long contact hours with their patients at an extremely personal level and in environments that are not always conducive to positive outcomes, are prone to stress and burnout.

Nurses have been found to change their caring behaviour according to the characteristics of their patients' needs as well as their patients' response to the nurses (Rafii, Oskouie, & Nikraves, 2004). The nurses in Rafii, Oskouie and Nikraves's (2004) study showed a decline in physical and emotional energy, as well as motivation when positive affirmation was not received from patients to whom they provided care. When positive appraisal of work is not received burnout is likely to eventuate among nurses (Rafii, Oskouie, & Nikraves, 2004). In congruence with that view it is believed that there is little evidence to show that caring is a uniform state (Maslach & Leiter, 1997). It is not so much that the caring becomes depleted, rather it is the nurses' personal need for emotional

protection which also is a symptom of physical and emotional exhaustion (Benner & Wrubel, 1989). It is thought that the symptoms of burnout or secondary trauma, in whatever labels it may be packaged, is often compounded by the increased risk of emotional distress and physical exhaustion (Davidson & Jackson, 1985; Kreisher, 2002; Olofsson, Bengtsson, & Brink, 2003).

Although nursing is spoken of as being a caring service (Benner & Wrubel, 1989; Watson, 1988), Cronin (2001) believes that some organisations may be still in the dark about what nurses feel and experience when they are faced with work challenges that are deemed intense and difficult. There are several arguments in the extremely vast publication that exists on the well recognised topic of burnout among people-centred occupations, mainly healthcare (Kreisher, 2002). Basically, the cause of burnout lies within the disruptive emotional aspects of patient care that includes overly demanding patients, unreasonable patient behaviour, patients who are in extreme pain and/or the certainty of death, or when treatment options for the patient is difficult or factors that root strong emotional responses from the nurses (Kreisher, 2002). The reason for the high incidence of burnout in nursing relates to the very nature of nursing being related to empathy, compassion and humanisation of care (Olofsson, Bengtsson, & Brink, 2003). Nurses and other health professionals are involved with people on an exceedingly personal level in an environment that is not always conducive to positive consequences (Ernst, Franco, Messmer, & Gonzales, 2004; Olofsson, Bengtsson, & Brink, 2003).

Sherward, Hunt, Hagen, McLeod and Ball (2005) inspired by the nursing shortage in England and Scotland undertook a study to explore the relationship between nurse staffing, emotional exhaustion and job dissatisfaction in 29 acute hospitals across the two countries. The study significantly confirmed that a high patient ratio was associated with increased job dissatisfaction and emotional exhaustion reported by nurses. When nurses are unable to provide appropriate care to their patients because of the high demands being placed on them, feelings of self-doubt, frustration, hopelessness, irritability and lowered self-esteem prevails (Sheward, Hunt, Hagen, Macleod, & Ball, 2005). All of these factors lead to depression and burnout (Dunn, Wilson, & Esterman, 2005; Olofsson, Bengtsson, & Brink, 2003; Sheward, Hunt, Hagen, Macleod, & Ball, 2005).

In a climate of care

The role and responsibilities of nurses and hospital play specialists are distinctly different. Inherent in both their roles however, is one common factor: caring. Caring has been described by many theorists to be the defining, as much as the core characteristic of nursing (Benner & Wrubel, 1989; Watson, 1990). However, there are many implications associated with caring that are equally applicable to other occupations, not just health professionals. Caring is attained when a person assists another to achieve an elevated level of physical and psychological comfort and well-being. When defined as feeling cared for, or showing care or compassion, caring denotes an attitude. Yet, when related to professional care, caring is commonly spoken of as being central to practice (Woodward, 1997). Beyond question, nurses and hospital play specialists would agree that caring is fundamental to their roles (Henderson, 2001; Webster, 2000; Woodward, 1997).

Some nurses may accede that nursing is an altruistic vocation, with caring being an imperative (Henderson, 2001). Aspects of the hospital play specialists role distinguishes them from other health professionals in that their focus of care is directed solely on the emotional world of the child, rather than on clinical tasks (Webster, 2000). While they may be involved in helping the children to manage their painful or invasive procedures, the hospital play specialist has little control over how the procedures are arranged or performed.

The educational, professional and organisational goals of any caring practice endorses the instrumental component of caring. Instrumental caring is the predetermined action that the professional carer provides and which is based on the carer's knowledge and skills (Henderson, 2001). Care, whether in its altruistic or instrumental form is provided and sustained until such time that it is no longer required by the person for whom the care is given (Woodward, 1997). Leininger (1981) claims that reciprocity is a vital element within caring relationships, suggesting that mutual benefit is gained by both the carer and the cared-for.

The caring behaviour of a caring professional may be described as attentive listening, comforting, honesty, patience, responsibility, touch, sensitivity, respect, calling the patient by name or providing information so the patient can make an informed decision (Woodward, 1997). Caring is the core concept of any person who is in a caring role, not just in nursing. For example, the hospital play specialist provides care that focuses on nurturing the emotional needs of children by facilitating them to achieve mastery of their situation while in hospital (Kayes, 2005).

The work of any health professional who cares for patients that are physically and emotionally traumatised is often characterised by tension and heightened emotions (Cronin, 2001). Thus, the act of caring has the potential to be emotionally laden. Caring involves feeling, and feeling involves personal vulnerability. Indeed, the personal investment of the professional carer can to some extent go virtually unrecognized and unacknowledged (Benner & Wrubel, 1989). As a result, the health professional is left exposed to both personal, as well as professional costs and benefits (Benner & Wrubel, 1989; Henderson, 2001). Conversely, the emotional element of caring can be equally motivating and emancipating (Woodward, 1997). Caring is generally viewed by nursing as an essential component of cure, a hallmark of the professions' distinctiveness (Millward, 1995). However, the extent to which professional caring is invested may to some extent be a matter of choice, contemplated by the degree of emotional engagement or detachment that the individual chooses (Henderson, 2001).

Caring for hospitalised children presents a double challenge for the health professional. Professionally, the healthcare worker is expected to help the child and the parent through the process of hospitalisation. When undertaking a procedure such as a burn dressing, nurses are expected to ensure that the task is done as efficiently as possible. The primary fear of children who are hospitalised has been consistently reported as being fear of pain and mutilation (Brennan, 1994). Literature is replete with helpful suggestions to make the hospitalisation and the procedures less stressful for the child and their parents. Heiney (1991) maintained that coping with painful procedures for the child requires three

distinct phases of the procedure: the anticipation of and the preparation for the event, the actual procedure, and the aftermath. The procedure itself is often the worst for the child because it involves pain, restriction of movement, anxiety and the lingering emotional trauma of the event (Heiney, 1991). The task for the health professional involved is therefore further complicated, in that strategies have to be implemented to help the child and the parent through all the phases.

The child's and the parent's attempt to deal with the event or procedure are considered to be coping mechanisms. Coping is an individual response that changes as the child and/or the parent perceives the situation and their ability to manage it. A successful event may well increase a child's repertoire and confidence to cope when the procedure is repeated. There is also the potential for increased upset or a more spirited reaction displayed by children when they are repeatedly trying to manage their thoughts and feelings (Brennan, 1994). The need for health professionals and parents to negotiate roles is not only peculiar to caring for children with complex and high needs, it is an integral part of family centred care in hospital environments (Darbyshire, 1994).

Challenges for health professionals may come in any shape or form. In hospitals, the power relationship between the parent and the staff is often tipped in favour of the healthcare professional, with the parent becoming the visitors in an unfamiliar environment (Brown & Ritchie, 1990). When the contact with children who are burned is close and extends over a long period of time it is easy for the health professional to share the tenor of the child's world (Zengerle-Levy, 2004). For example, Zengerle-Levy (2004) found that the nurses in her study became more parent-minded towards the children with burns who were left on

their own in hospital. This being because the child's parent was either injured or had died in the accident related to the child's injuries, or were living a great distance away from the hospital or were unable to participate in their child's care for reasons personal to them (Zengerle-Levy, 2004).

Engaging families in the care

The family of the hospitalised child have twenty-four hour visiting access to the child each day where in the past hospital restrictions denied them the right of choice. Parents or other members of the family are also free to participate in the child's care. Although family-centred care, parental participation and partnership approach between health professionals and the family is fast becoming the ethos in a number of children's hospitals (Darbyshire, 1994), a consensual agreement by paediatric nurses is not always evident (Coyne, 1995; Darbyshire, 1993). This philosophy of care is incorporated into all child health nursing education programmes. There are several factors that could inhibit the child's family from fully participating in the child's care. Problems may arise when the role of the family and the role of nurses are not clearly defined or when the family does not meet the nurses' expectation (Brown & Ritchie, 1990; Darbyshire, 1994). Other factors include nurses not taking heed of the family's need or not giving the family the information that is required to negotiate their role within the care trajectory of the child (Coyne, 1995).

Brown and Richie (1990) found that nurses who took care of children were accepting of the interrelated role that they shared with the parents, even though the margins between their roles got somewhat blurred at times. Nurses

acknowledged that parents needed as much emotional support during the hospitalisation of their sick child (Brown & Ritchie, 1990). However, when care provision for the parent supersedes the care given to the child and the parent becomes the principal client, the situation creates a breeding ground for interpersonal conflict (Brown & Ritchie, 1990). Hence, care negotiation between nurses and the child's family can in some instances become problematic.

In a quest to develop a collaborative model of care for the provision of a more supportive hospital environment for children and families, Johnson and Lindschau (1996) undertook a study to assess the personal and professional attitude of various healthcare professionals towards parental participation in child's care during hospitalisation. The study reported that the personal characteristics of the sixty two participants such as being a registered nurse, married or being a parent, resulted in a more accepting attitude towards family participation in the care of the hospitalised child (Johnson & Lindschau, 1996). Of relevance to this study Johnson and Lindschau (1996) found that the health professionals employed on the children's burn ward had a more accepting attitude towards family participation as apposed to the nurses employed in other acute clinical areas.

Rewarding experiences

Single-mindedness prevails in the literature regarding caring for children with burns. The focus is mainly on the arduous aspects of burn care. Thus far, literature is somewhat limited on the positive rewards that nurses or other health professional experience when giving care to the children with burns. Steenkamp

and van der Merwe (1998) compared the psychosocial functioning of nurses who worked in the burn unit against a control group of equal numbers from the plastic surgery and obstetric wards. Using a basic questionnaire listed with pre-identified stressors, coping strategies and types of support activities, Steenkamp and van der Merwe (1998) qualitatively analysed the data. Their findings concluded that team work and peer support rated highly as an enabling factor for the nurses on the burn unit. When weighed against the negative forces of frustration, stress and helplessness, the nurse's positive feelings of satisfaction, achievement, and expectations were found to be stronger (Steenkamp & van der Merwe, 1998). The outcome of their study supports the results of Lewis, Poppe, Twomey and Peltier's (1990) survey of perceived stressor and coping strategies among burn unit nurses. Both studies conclude that talking with co-workers and maintaining a sense of humour at work, and engaging in physical activity or talking with family and friends after work were helpful coping strategies (Lewis, Poppe, Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998).

Zengerle- Levy (2004) explored the experiences of sixteen nurses who worked on a paediatric burn intensive care unit with the exclusive purpose of understanding the practices that nurses engaged in to facilitate the holistic healing of the burn injured child. The findings of that study revealed that there was a sense of emotional connection that developed between the nurses and the children in the unit. The nurses became more parent-minded to the children who were left on their own in hospital (Zengerle-Levy, 2004). Restoring the general well-being of the child was seen as being equally important to the nurses as attending to the children's physical needs. The nurses in that study showed that they were able to

transcend the everyday realities of the ward. They connected empathically with the children under their care, nurturing their emotional needs and showing tenderness to the physically abused. They had fun by playing music, talking and reading to the children. All of these actions were said to have been interwoven into their contemporary protocols of nursing practice and care (Zengerle-Levy, 2004). The nurses communicated and interacted with the children in ways that showed that they understood the children's pain and suffering and recognised their fears and loneliness when left alone in hospital without a parent (Zengerle-Levy, 2004). These were practices that Zengerle- Levy, (2004) interpreted as being built on the notion of sustained connectedness with the children which could be argued as being standard nursing practice for all patients. Zengerle-Levy, (2004) implores nurses who work with children with burns to transcend the technical aspects of care by shifting concern and involvement towards nurturing the "emotional, spiritual and physical well-being" of the child (p. 1272).

Strategies that facilitate coping

Nurses perform many tasks that are sometimes mundane and unrewarding or by normal standards disgusting, distasteful and degrading (Hingey, 1984). However, nurses have been known to learn very quickly how to accept their daily confrontation of suffering, pain, grief and death and find ways in which to cope. In order to care effectively some nurses attempt to suppress their emotions, irrespective of their feelings in relation to contextual circumstances (Benner & Wrubel, 1989; Morse & Mitcham, 1997; Smith, 1992). Nurses employ two very distinct self-protective strategies to reduce sensitivity to unpleasant experiences.

One is to distance themselves from the event that causes them heightened emotions and the other is to consciously engage with the event (Nagy, 1999).

Distancing as a coping strategy is not an attempt to deny the existence of an unpleasant experience. Rather, the attempt is made to maintain a safe distance between the emotional and physical impact of the experience between the carer and the cared-for (Benner & Wrubel, 1989; Gunby, 1996; Nagy, 1999).

In contrast, engagement is a strategy used by nurses to focus on the positive outcomes of the task at hand even though the event or procedure is painful for the patient (Benner & Wrubel, 1989; Nagy, 1999). The use of this strategy has been found to generate increased job satisfaction among paediatric nurses (Ernst, Franco, Messmer, & Gonzales, 2004; Nagy, 1999).

On a positive level nurses have been known to seek social support and reassurance from their colleagues to help them get through work related issues (Begat, Ellefsen, & Severinsson, 2005; Nagy, 1999). Studies show that feelings of satisfaction are gained when nurses make a conscious effort to prepare the patient for painful experiences by giving adequate pain relief, providing physical and emotional comfort to the patient or spending time with their patient (Nagy, 1999; Steenkamp & van der Merwe, 1998; Zengerle-Levy, 2004).

After undertaking a two year participant - observational study at a burn centre, Mannon, (1985) found that as a support during times of stress nurses looked to each other to improve their morale and solidarity on the unit, maintaining a sense

of togetherness and team centeredness (Mannon, 1985). Mirrored findings were later concluded by Lewis, Poppe, Toomey and Peltier (1990), Nagy, (1999) and Steenkamp and van der Merwe (1998) in their respective studies of burn unit nurses.

As already noted, nurses with more years of experience in a work setting experience less stress than the less experienced nurses (Ernst, Franco, Messmer, & Gonzales, 2004; Hegney, Plank, & Parker, 2003; Olofsson, Bengtsson, & Brink, 2003; Steenkamp & van der Merwe, 1998). Nurses with several years of experience engage in active coping strategies rather than use avoidance mechanisms (Ernst, Franco, Messmer, & Gonzales, 2004). Years of experience can overcome the stress caused by having inadequate technical knowledge of burn care. Conversely, years of experience can also cause nurses to become more liable to conflict encounters with nursing colleagues and medical staff because of the subsequent expansion in their skills and knowledge acquired over time (Ernst, Franco, Messmer, & Gonzales, 2004; Lewis, Poppe, Twomey, & Peltier, 1990).

Cronin (2001) found that nurses who worked in burn units for a number of years develop informal support systems and networks among themselves. When friendship is developed amongst each other a more established network is created. Novice nurses on the other hand, go through periods of adjustment and may feel unsupported. For support novice nurses tend to turn to their own family and friends to support them when life in the workplace gets tough (Cronin, 2001; Gunby, 1996). Although burns units are generally remarked as having high levels of staff support (Mannon, 1985), it is not significantly higher than that of other

areas (Lewis, Poppe, Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998).

As a consequence of their stressful work environment nurses were found to engage in strategies that helped them cope with their stressors when working with the burned (Cronin, 2001; Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Steenkamp & van der Merwe, 1998). Studies have shown that talking to someone with whom feelings can be shared, teamwork, social support, physical exercise and connecting meaningfully with the children in order to preserve the wholeness of the child are other positive ways to overcome the emotional impact of caring for children who have been burned (Lewis, Poppe, Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998; Tyler & Ellison, 1994; Zengerle-Levy, 2004). In a study exploring stress among children's nurses Doman (1997) found that nurses who had a nursing qualification to care for sick children experienced less stress than the nurses who had not. Tyler and Ellison (1994) highlighted several sources in literature that claims social support to be instrumental as a coping style, with one's family being the main resource for support in times of stress and distress. Also of significance in Tyler and Ellison's (1994) study is the strong evidence that people without the facility to express their feelings to others, be it spouse, family, friend or colleague, may exhibit greater psychosomatic symptoms and resort to maladaptive or avoidance coping strategies. Since little is known of the intricacies that make the experience of caring for the children with burn injuries a stressful or a joyful experience, this study is timely. Benner (1984) sets in motion the understanding that physical, psychological and emotional experience of caring becomes embedded in practice without being fully

understood. Hence, my research question asks, “What do nurses and hospital play specialist experience when caring for the child with burn?” By permitting nurses and hospital play specialists to tell their story, a deeper understanding of their unique experience will be made known in the hope that ideas will be generated to improve the support and education given to nurses and hospital play specialists, and in so doing enhance the care that they give to the children with burns.

Cronin (2001) suggests that the decision for formal support is the responsibility of each person. Different ways of gaining support could be acquired or strengthened by the provision of informative teaching sessions that provides the health professional with processes to alleviate their emotional burden (Cronin, 2001). Taking time out of the unit to discuss demanding work-related issues or attending regular debriefing sessions to review clinical incidents were other forms of support that Cronin (2001) suggests. She proposes for a well constructed formal plan of support to be incorporated into the burn unit’s protocol to improve staff morale, reduce attrition, stress and burnout (Cronin, 2001).

Over two decades ago von Baeyer and Krause (1983) advocated for regular stress management training as a way forward for burn unit nurses. The recommendation was based fundamentally on the notion that nurses require professional support as burned patients stayed longer in hospital, resulting in the nurses becoming more emotionally involved with the patient and the patient’s family (von Baeyer & Krause, 1983). In contrast, nearly sixty percent of the nurses in Lewis, Poppe, Twomey and Peltier’s (1990) study wanted input from the psychologist only on request, rather than routinely.

Spending a great deal of time in intense interaction with severely distressed patients, such as children with burns, and their families can be stressful for the carer (Doman, 1997). Although research has found high burnout levels among nurses who have little support (Lewis, Poppe, Twomey, & Peltier, 1990; Steeves, Kahn, Wise, Baldwin, & Edlich, 1993; Tyler & Ellison, 1994; von Baeyer & Krause, 1983), to date there is no formal professional support system built into the framework of care for nurses or any other health professional to access on a regular basis in this centralised burn ward that this study takes place. Formal professional support is done 'ad hoc' via a referral made to the occupational health services by a concerned charge nurse or by self referral. Arising from personal discussions with colleagues, hospital play specialists in this study are known to have ongoing peer supervision and professional psychological support available to them on a regular basis. They also have regular meetings with their team leaders or more experienced hospital play specialist colleagues. Kayes (2005) study revealed that hospital play specialists were indeed appreciative of the support received from their nursing colleagues especially after distressing experiences on the ward.

Summary

In this chapter I have explored the literature relating to contextual factors that are linked to caring for children with burns. Attention is drawn to studies as a stratagem to highlight the gaps that exist in clinical practice regarding caring for children with burns in relation to other acute high-dependency areas. Burn injuries pose a major threat to the health of children, and a severe non-fatal burn injury remains the most devastating injury any child can survive, because of the

excruciating pain that accompanies the injury and the complex treatment procedures that follows. Working with children who have been burned is described as being a stressful occupation that evokes a considerable amount of emotions among the health professionals who spend a great deal of time with the children and the children's families. Health professionals who work on a children's burn ward encounter events that include daily dressing changes, being witness to pain and suffering and often heavy workloads. There is much anecdotal and empirical evidence that provides insight into the experience of caring for children with burns. However, paucity remains in research on the experience of nurses and hospital play specialists who care for the children with burns. The next chapter describes and justifies the methodology and methods used to undertake this study.

CHAPTER THREE: METHODOLOGY

The craft of thinking, describing, reflecting and writing

All inquiry entails description, and all description entails interpretation. Knowing any phenomenon (or event or experience) requires at least knowing the “facts” about that phenomenon. Yet there are no “facts” outside the particular context that gives those facts meaning (Sandelowski, 2000, p. 335).

Introduction

Research is a systematic inquiry that uses disciplined methods to answer questions or solve problems. This chapter discusses and justifies qualitative descriptive research as the methodology selected to undertake this study and the process for data analysis as informed by van Manen (1997b). Outlined in this chapter are the qualitative research methods used in the study. Included are: gaining ethical approval, issues of consent, participant selection, data collection and the data analysis. Finally, the strategies used to ensure trustworthiness throughout the process is discussed using the method outlined by Lincoln and Guba (1985).

Why qualitative descriptive methodology?

My initial intention was to undertake an interpretive study as I wished to understand the essence of the nurses’ lived experience when caring for children with burn injuries. I also wanted the study to be descriptive as I proposed to seek from the nurses’ descriptions rich details that would express the nature of their experiences if a phenomenological interpretive approach was undertaken. However, after beginning the data collection it became evident that the data

obtained during the interviews with the participants was not rich enough to accommodate the originally selected methodology. After much thought I followed the advice of my research supervisors to use a qualitative descriptive methodology assisted by the process informed by van Manen (1997b) to analyse the data in this study. I believe that heedlessness and lack of rigour in my approach to the purpose of the research was an indication of my embryonic thinking in relation to qualitative and interpretive methods. My subsequent choice for a qualitative descriptive methodology was based on Sandelowski's (2000) line of reasoning of the methodology being a unique and valuable way to explore human existence as it occurs in everyday life. In addition, the methodology is more descriptive than it is interpretive (Sandelowski, 2000). Accordingly, Sandelowski's interpretation of qualitative descriptive methodology will guide my discussion on the methodology and the methods undertaken in this study.

Although qualitative content analysis is the analysis strategy of choice in qualitative descriptive studies (Sandelowski, 2000), the data arising from this study will be analysed, as already mentioned, using the approach advised by van Manen (1997b) to recognise significant emergent themes. The rationale for selecting van Manen's (1997b) method for data analysis will be explained following the discussion that makes a case for a qualitative descriptive methodology. Also incorporated in this chapter are the views of other authors that are of relevance to qualitative descriptive methodology and methods.

Characteristics of qualitative descriptive research

Qualitative descriptive studies support the viewpoint of constructionism on the tenet that the researcher interacts with the participants in order to access the multiple views of reality that may exist (Appleton & King, 1997). Constructionism as an approach supports a relativist ontology in that the views, beliefs and principles discovered through the process of investigation, relate only to the time and the persons involved in the study (Appleton & King, 1997). Qualitative descriptive studies support the constructionist epistemology in that it is unencumbered by pre-existing theoretical and philosophical obligations (Sandelowski, 2000). The findings from a constructivist perspective are usually presented in terms of credibility, transferability, dependability and conformability, which replaces the positivist criteria of internal and external validity (Lincoln & Guba, 1985) as will be considered in this study.

According to Denzin and Lincoln (2005), qualitative research is simultaneously referred to as a natural inquiry, as well as interpretive research. Indeed, the goal of research is to describe, explain and predict (Denzin & Lincoln, 2005). Human beings are in constant reciprocal states with their environment. Moreover, life processes evolve irreversibly and is unidirectional along a continuum of time and space. Health care professionals are concerned with human beings. Because human experience is the focus of concern in healthcare practices, a means of describing the experiences in practice settings is of paramount importance for healthcare research. Denzin and Lincoln (2005) uphold qualitative methodologies as being well suited to address fundamental theoretical and substantive issues,

including clinical, organisational and policy decisions on the bases that knowledge and new information improves practice in the health industry.

The foundation of qualitative descriptive studies is based on the assumption that there is no one universal truth (Ashworth, 1997; Denzin & Lincoln, 1998; Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003)). Therefore, the experiences of nurses and hospital play specialists in this study does not necessarily await discovery, rather it awaits construction of their experiences through the process of inquiry. Such an inquiry necessitates an interactive process in which construction of the participants retrospective reflection on their experience becomes the object of inquiry through interview between the researcher and the participants.

Quantitative descriptive studies involve collecting large amounts of data from subjects that are closely similar and analysed by numeric analysis. Hence, the human aspect of understanding the experiences of people is not always taken into account (Thorne, Kirkham, & MacDonald-Emes, 1997). Qualitative descriptive studies focus on human phenomena and therefore, on the life and culture of people (Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003).

Viewed from a hierarchical perspective, quantitative studies are generally awarded the mark of distinction for the aim to predict and control, in contrast to non-experimental designs (Talbot, 1995). Thus, when compared against quantitative descriptive research, the positivist paradigm, qualitative descriptive studies are regarded somewhat negatively. Indeed, scientific methods are useful

to prove or validate an argument or a hypothesis, concluding with statistically generalised findings (Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003). However, the way in which nurses and hospital play specialists experience their practice involves intention and meaning which cannot be explained objectively by measurement, categorisation or statistical indices using quantitative methods as a research inquiry (Benner, 1985; Oiler, 1982; J. M. Swanson & Chenitz, 1982). Hence, in search for insightful understanding and description, researchers look more favourably towards qualitative descriptive methods to understand the reality and experience that acknowledges and values the individual in a health professional-patient relationship (Benner, 1985; Oiler, 1982). Therefore, the qualitative researcher has to stay as close to the data to make the understanding known.

Indeed, qualitative descriptive studies may be less interpretive than phenomenological or grounded theory as the researcher attempts to present the study in everyday language rather than in deep and meaningful philosophical terms or abstract frameworks (Lincoln & Guba, 1985; Sandelowski, 2000). This is not to say that qualitative descriptive inquiry has no scope for revealing the variety of meanings that participants attach to particular events or issues that may arise from their personal or professional background and experiences. Ashworth (1997) highlights that the overall purpose of qualitative research is to present a description, which creates an understanding greater than the individual could have provided unassisted.

Regardless of the different approaches and methods, the researcher's role in a qualitative study is to interpret subjective meaning from the point of view of those who are experiencing that world (Bailey, 1997; Sandelowski, 2000). The researcher adopts both a flexible and reflexive approach to enquiry, encouraging the exploration of new leads in order to gain understanding from the participants' perspective. Sandelowski (2000) stresses that the researcher is the vital tool to enable the participant's experiences to be made public. Cutcliffe and Goward (2000) concur with Sandelowski (2000) that the researcher approaches the study with a view shaded by his or her own values and experiences. In this way the qualitative researcher cannot be separated from the topic being researched (Cutcliffe & Goward, 2000). Thus, it is well recognised that the researcher's subjectivity is a valuable aspect of qualitative research which is regarded as being a strength in qualitative studies (Clark, 1998; Schutz, 1994).

Questions of a compelling, complex and contextual nature in nursing science borrow epistemological perspectives and approaches from diverse disciplines such as psychology, philosophy, history, literacy, cultural, sociology, anthropology, and philosophy to find their answers (Emden, 1997; Koch & Harrington, 1998; Thorne, Kirkham, & O'Flynn-Magee, 2004). The move created an impressive display of qualitative designs such as phenomenology, grounded theory and ethnography which instigated several deviations of thought that stimulated lively debate about approaches within traditions (Emden, 1997; Koch & Harrington, 1998; Thorne, Kirkham, & O'Flynn-Magee, 2004). One of the main points of concern that arose out of the move was the inability to reach common agreement on methodological integrity of research procedures for

qualitative research designs (Emden & Sandelowski, 1998; Koch & Harrington, 1998). However, change reoccurred when the dictates of the disciplinary perspectives became too constrained for some nurse researchers. Consequently, current qualitative designs were surpassed for nursing theories and practices to underpin nursing research (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Kirkham, & O'Flynn-Magee, 2004). The diversity that was created resulted in many legitimate qualitative studies within nursing being criticised for “methodological slurring” (Baker, Wuest, & Stern, 1992). Thus, Sandelowski cautions the qualitative researcher against the risk of ‘method abuse’ which she labels “methodological anarchy”, in reference to researchers who lose track of the required methodological processes: a situation not uncommon to a research neophyte like me (Emden, 1997, p. 139). This is another reason why this unencumbered methodology (Sandelowski, 2000) was considered as a method to understand and make visible the meaning of the participants’ everyday encounter with the children with burns.

Qualitative descriptive methodology forms the bases of the more revised variations of qualitative studies (Sandelowski, 2000). In qualitative descriptive studies the researcher encourages the exploration of new leads in order to gain understanding to make the event visible (Cormack, 2000). It is also an expectation that the qualitative descriptive researcher controls any impulse that would likely interfere with the process that allows the participants to give voice to the study (Sandelowski, 2000). Therefore, the researcher assumes a noncommittal active listening stance and follows the participant’s story carefully without unnecessary interruptions yet, encouraging the speaker with occasional

head nods and monosyllabic affirmations that encourage the participants to expand their story (Morse & Field, 1995). By engaging in a sustained act of construction, the researcher is able to report the events in terms that help others to understand the relationships and meanings in the participants' experiences (Holloway & Wheeler, 1996).

There are several sampling techniques that could apply to qualitative descriptive studies and in this study purposeful sampling was the choice. The strength of purposeful sampling is in the selection of 'information-rich' informants who can be studied (Morse, 1991; Patton, 2002). Such an approach enables the researcher to learn a great deal about the issues that affect the participants and those that are central to the purpose of the research. Purposeful sampling results in data that is rich in the participant's experiences and viewpoints on the subject being investigated (Morse, 1991; Patton, 2002).

Oral narration more often forms the basis of qualitative research data collection which is usually gained through the direct encounter between the researcher and the participants, either through in-depth interview or focus groups (Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003). In-depth interviews, also referred to as qualitative conversations, used in qualitative descriptive studies tend to be unstructured or semi-structured. The skilled interviewer is sensitive to non-verbal messages, effects of the setting on the interview, and nuances of the relationship between the interviewer and the interviewee. These subjective factors could be viewed as a threat to the credibility of the data. However, they can also be strengths because the skilled interviewer uses flexibility and insight to

ensure an in-depth, detailed understanding of the participants' experience. The interviewer's response may entail a probe into the experience that takes the representation of the experience far beyond what is possible through a structured interview (Fontana & Frey, 1998). Hence, questions and answers within a conversation expose the strength of what is being said. The advantage of drawing up a list of prepared questions as a framework, which I undertook to do in this study to guide the conversation served as helpful prompts. Questions assist the participant and the researcher to think more deeply about the meaning of the experience when it is done in a climate of mutual trust, listening and respect for the experience as it is described by the participant (Ely, Vinz, Downing, & Anzul, 1997; Fontana & Frey, 1998).

In qualitative descriptive studies interpretation of the data relies on summarising the data and presenting the findings as accurate accounts of the events. However, description of events in the 'real world' cannot avoid aspects of interpretation (Ashworth, 1997). Both van Manen (1997b) and Ashworth (1997) claim that the researcher highlights matters of relevance to the research and discards links with other aspects of the individual's experience that might seem important to them.

According to Sandelowski (2000) there is no mandate in qualitative descriptive studies to reproduce data beyond being purely descriptive. A qualitative descriptive, does not merit significance according to the depth or surface of the analysis (Sandelowski, 2000), as one would when classifying the extent of a burn injury (Ray, 1995). When a description rings true it is validated by mutual recognition when given the nod of acceptance which says, 'Aha. That is an

experience I could have had' (van Manen, 1997b). A study is considered credible when the reader of the research can recognize the experience when confronted with it after having only read about it (Sandelowski, 1986). Through a process of thoughtful writing, reflection and re-writing the everyday experience of the nurses and the hospital play specialists in this study will be brought to awareness through their stories (Koch & Harrington, 1998; van Manen, 1997b).

Studies seeking to establish association or predict develop theories that have either been modified or changed (Seaman, 1987). Nonetheless, a sound descriptive methodology is able to capture descriptions in nursing that will not date, but reflect the context at the time. It will show the changes that have occurred (or not occurred) when balanced against a review of literature on the subject (Seaman, 1987). Such an approach is congruent with the practice world of any health practitioner who is constantly evaluating the experiences of their patients under their care.

Rationale for the research methodology

International researchers have utilised the methodology in nursing disciplines which focus on nursing roles. However, in my review of literature published studies that utilised qualitative descriptive as a method of research to understand the experience of caring for children with burns or children in related nursing care context was found to be minuscule. This is not to say that qualitative descriptive study in nursing and other practice healthcare disciplines is not undertaken. Rather, it is relatively limited when viewed against the more favoured descriptive studies, namely phenomenology. Qualitative descriptive

methodology is not unlike the practice world of nurses and hospital play specialists who base their clinical practice on understanding as much as possible about their patients, detecting commonalities and variations among them in order to provide individualised care (Thorne, Kirkham, & O'Flynn-Magee, 2004).

The researcher's role - assumptions and expectations

I experienced a sense of disquiet at the onset of this study wondering if my role as researcher and my role as nurse educator within the research setting would come into conflict during the interview process. Schutz (1994) highlights 'role conflict' as a term commonly used for researchers who conduct research in familiar settings, suggesting that problems may arise when the researcher is known in another role. It is therefore important for the researcher to establish a relationship with the participants before the study is undertaken (Schutz, 1994). My fear was that the participants might perceive the study as an evaluation of their practice and be threatened by the interview process. Thus, a reflective journal was maintained throughout the research process to ensure that the monitoring of my "what is going on here" thoughts could be reflected on and worked through.

After approval was attained from the hospital Clinical Board, I spent a great deal of time formally and informally meeting with the staff on the children's burn ward explaining the purpose and method of the study, leaving open the invitation for them to participate or not participate. I arranged to meet the staff at the weekly ward meetings so that questions could be answered and doubts clarified in relation to the study.

Ethical Approval

Ethical approval for this study was granted by Auckland University of Technology Ethics Committee (AUTEK) (Appendix Five) on 14th June 2004. An extension of time as a result of personal circumstances was requested and granted on 5th July 2004 (Appendix Six). A subsequent successful application was made to invite hospital play specialists to participate in this study. The Auckland University of Technology Ethics Committee granted the amendment on 18th May 2005 (Appendix Seven).

Since I had a professional relationship with the potential participants I consulted the manager of the service and the charge nurse of the unit to inform them of the project and advise them that their staff were invited to participate in the study. However, the charge nurse and the manager were not told who the staff were that volunteered to be participants on the study.

The study participants

I decided to involve only nurses and hospital play specialists because it is well documented that health professionals who have continuous daily contact with children who are traumatised and in pain are influenced by the experience (Nagy, 1998; Quinby & Bernstein, 1971; Trofino, 1991). I also wanted to keep the scope of the research within manageable limits. Nurses and hospital play specialists provide most of the care to the children; their contact is closer and more continuous than that of other health professionals. Furthermore, they generally act as intermediaries between the child and the child's environment. All ten participants, eight registered nurses and two hospital play specialists had

experience in this care setting that ranged from eighteen months to thirty years and were currently employed at the organisation in which this study took place. The reason for the small sample size was because only eight registered nurses volunteered to participate. Besides, the criteria for this study required participants with greater than twelve months experience of working with children with burns. Not all of the nurses who work on this ward take care of patients with burn injuries. It is a general expectation that nurses who have undertaken the Burns and Plastic Reconstructive Surgery course, including those who are keenly interested in developing their knowledge and experience to care for patients with burns are allocated to look after a child with burns.

There are only two hospital play specialists who work on the children's burn ward and both willingly consented to participate. According to Bowling (1997), to obtain data for better understanding of the experience under investigation a small sample size increases the possibility of intensive exploration of the human experience. Even though a small number of participants are sometimes used in qualitative studies, the information produced is rich in the participant's experiences and viewpoints on the subject under investigation (Bowling, 1997; Patton, 2002; Sandelowski, 2000).

Therefore a purposive sampling approach was used to include participants who were most able to contribute to the purpose of this study. By using purposeful sampling the researcher learns a great deal more about the issues that affect the participants, including that which is central to the purpose of this research. The strength of purposeful sampling is in the selection of informants who are true

representatives of their world (Patton, 2002; Sandelowski, 1986). Therefore, the only criteria for this study required registered nurses and hospital play specialists with no less than one year experience of working with children with burns at the time of the study.

Given that interviewing is the data collection method, Sandelowski (2000) views this as being potentially problematic. Her concern is that purposeful sampling could attract respondents who are generally more outspoken and assertive, creating what has been labelled “elite bias” (Sandelowski, 1986, p. 32). However, in this study the nurses who volunteered to participate made up the majority of potential informants who met the criteria and my hope was that it would minimise the potential for elite bias.

All of the participants were women, aged between 21 and 57 years. Most of the participants had a wide range of experience working with the children who were burned. Some participants had experience in this field of care from countries other than New Zealand but had been employed in this children’s ward for greater than eighteen months. There was a range in ethnicity and cultural affiliation among the participants, with majority claiming to be of European or New Zealand European/Pakeha descent. None of the participants identified themselves as Maori.

Selection and recruitment of participants

The decision to include hospital play specialists in this study is because like nurses they spend long hours of their working day with the children with burn

injuries. I believed that the inclusion of hospital play specialists improves the objectivity of the data, which in turn increases the credibility of the study findings. According to Benner (2000) objectivity is achieved when multiple perspectives of a reality is gathered from a community of participants and made public for interpretation. Without the many voices the researcher's report could be viewed as being egotistical (Benner, 2000).

Potential participants were easily recruited following the placement of information sheets (Appendix One) inviting their participation which I placed on the notice board in the ward. I also handed out the information sheet (Appendix One) to the nurses when I met with them at the weekly staff meeting to explain the study. Most of the participants responded quickly and freely consented to participate by giving written consent (Appendix Two) that was based on adequate available information explaining what their participation would involve, why the study was being undertaken, how the information would be used and disseminated and how their confidentiality would be respected and protected.

Participant's Rights

Prior to data collection I spent a great deal of time with the potential participants explaining the purpose of the study. While the goal is to advance knowledge it is imperative that the rights of study participants are protected ethically. The participants consented without coercion to participate.

I was constantly aware of the importance of ensuring that the participants were not pressurised to participate. Therefore at the start of each interview, the

participants were again assured that my role as researcher and my role as the clinical nurse educator were separate. In addition, the participants were assured that the content of their interview would not be used outside the research. The participants were also offered the opportunity to discuss any concerns they might have had about the research process, mainly privacy issues.

The information sheet (Appendix one) that I had initially given to the participants was reiterated and the participants were assured of data confidentiality and the maintenance of their confidentiality in the reporting of the research. Confidentiality requires that the individual identities of participants are not linked to the information that they provide for the study (LoBiondo-Wood & Haber, 1994). I reiterated to the participants that their interviews would form the basis of my Masters thesis and that the final report will be made available to them. The participants in general, conveyed that they viewed their involvement in this study as being important to inform the organisation and other services of the complex roles that they performed when caring for children with burns.

The participants were invited to choose any place of personal preference, deemed private and free of interruptions in which to be interviewed. I gave my assurance that it would be up to the participant to decide on the time in which the interview took place and that they were free to withdraw anytime from the study if they so wished. All ten participants chose to be interviewed in my office which is situated in a quieter corridor away from the ward. There were no concerns that being interviewed in my office might make their participation obvious to others because visiting my office is an acceptable practice for them. I made sure that the

'Busy' sign was in place on my door during interviews in case anyone did want to see me. Originally one participant requested to be interviewed at her home but later changed her mind and requested for my office to be used. I was pleased that the interviews did take place within the hospital. In anticipation, I had hoped that by being close to their work area a sense of context would be maintained so that salient aspects of their stories could be brought to the fore.

Any identifying detail in the writing up of the study that might potentially link the experience to the participant or the patient was changed or disguised. Pseudonyms were assigned in the transcripts and the thesis report to obscure the participants' identities. The participants were also assured that a confidentiality agreement was signed by the typist (Appendix Three) who transcribed the data, and that the tapes would be stored in a locked cabinet in my home and a copy of the transcripts would remain in a locked cabinet. The participants were given consent forms individually at regular ward meeting where I outlined the appended research information sheet (Appendix One) and consent forms (Appendix Two). Smith (1992) concludes that care must be taken to balance the need of the researcher and confidentiality promised to the participants through informed consent. Furthermore, research studies are not expected to expose participants to situations for which they are not explicitly prepared (Polit & Hungler, 1997).

The right to protection from discomfort and harm is based on the ethical principle of beneficence. According to this principle researchers should conduct their studies in such a manner so as to protect their informants from discomfort and harm and to try and bring about the greatest possible balance of benefits in

comparison to harm (N. Burns & Grove, 2001). Professional support through the organisation's Employment Assistance Programme was made available to the participants at no cost to them in anticipation of any emotional or physical discomfort or stress that could arise during or as the result of their participation in the study. Most of the participants found the interview experience to be beneficial as it enabled them to 'let go' some of their frustrations related to their practice. It also enabled them to reflect on the positive aspects of their practice, as well.

Data collection: the interview process

Interviewing appointments were arranged on receipt of the signed consent forms (Appendix Two). Interviewing involves interaction between at least two people who enter a situation with their own life histories. The purpose is to provide narrated information that becomes the source material from which a deeper understanding of the experience is obtained through analysis. I was cautioned from my initial reading on the subject of qualitative research that qualitative interviewing was a unique experience (Fontana & Frey, 1998) and quite unlike the interviews with which, as a nurse and educator, I have been used to. Therefore two 'practice run' interviews were carried out prior to my interviews with the potential participants. One was with a senior colleague who had previous experience working with children with burns and was currently in a management position. The other was with a colleague from another local hospital. Undertaking the 'practice runs' first was advantageous in that I gained insight into my shortcomings to expand the conversations for rich data to be captured. The other benefit gained from the practice session was that it gave me some experience in creating an interview that was as close as possible to everyday conversation.

Lincoln and Guba (1985) support the view of ‘practice makes perfect’ with the researcher having a trial run “with an appropriate role ‘stand-in’” prior to undertaking the interview process (p. 270).

Using semi-structured face-to-face technique was useful because it enabled constant evaluation of the situation so that on the spot decisions could be made concerning the next question or the re-phrasing of the question (Morse, 1991). A semi-structured interview format was selected as it was helpful to have guideline questions (Appendix Four) to prompt conversation flow and cover the same areas with each participant. Oral narration of the participant’s experiences through a qualitatively in-depth interview process makes a case for good qualitative data gathering (Sandelowski, 2000; Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003; van Manen, 1997b).

Unstructured or semi-structured (used in this study) interviewing serves a naturalistic study well “for exploring and gathering experiential narratives” to develop a richer understanding of the experience (van Manen, 1997b, p. 66).

According to van Manen (1997b) research means:

To question something by going back again and again to the things themselves until that which is put to the question begins to reveal something of its essential nature (p.43).

Therefore questions like “what was that like for you?” or “how did that feel?” or “tell me more about that” helped to probe for deeper understanding. The advantage of a face-to-face engagement with the participants during interviewing is that the researcher can use body language, like head nodding and facial expressions to encourage and spur the participant to expand on their story. It also

allows for words of encouragement to be offered or rewording of a question that might have been vague. During the interview I took note of my own personal feelings and reactions. I also made notes of the participant's obvious physical and emotional feelings through their use of body language, such as gestures, accentuations and facial expressions.

Each interview was recorded by two tape-recorders as a backup should one have malfunctioned. Initially, the participants were conscious of the tape recorders but not long into the interview they soon relaxed and the interview continued on in a conversational manner, which for a qualitative study is applicable "for exploring and gathering experiential narratives" (van Manen, 1997b, p. 66).

I focussed on listening carefully without leading the interview into a particular direction or prematurely interpreting meaning which could easily distract my listening. I concentrated on being steadfastly orientated by asking the "what was that like" question. The emphasis was on repeatedly going back to the original question until I felt that the story had something to reveal about the experience (van Manen, 1997b). After the first couple of interviews I began to relax and soon became more confident in the process. I noticed that my process for exploring the participants' experiences 'kicked-off' with more spontaneity when using open – ended statements like: "What was that like for you when...." or, open-ended questions: "How did you feel when...?" I eventually became more concrete in my questioning by asking the participants to think of a specific situation then explored it further. At times the participants gave fleeting descriptions of their stories which I had assumed was because they might have

felt I had shared understanding of their situation. By remaining silent or saying, “tell me more” prompted the story to unfold.

As a novice researcher I recognised that my skill in interviewing was not as astute in the first two interviews. I did not capture the depth of the two participant’s accounts that I was hoping because I allowed my apprehension to overwhelm me in spite of my ‘practice runs’. I noted my anxieties and unease in my journal following the interviews. After reading the first two scripts I discussed and shared my experience with an experienced colleague. The feedback I got was helpful. Hence, subsequent interviews found me more relaxed and confident, rewarding me with text that reflected richer data.

As anticipated, some of their stories brought back memories and a range of feelings that were clearly distressing. When this occurred the participants were given the choice about whether to continue with that story as part of the interview. None of the participants took up the choice, and no one requested any information to be left out. When opportunity is given for the experience to be described the not-so-obvious becomes obvious (Sandelowski, 1986; van Manen, 1997b). Attempts to search for meaning and understanding of the experience is essentially through the carriage of language as described by those who experience the reality (van Manen, 1997b). Accordingly, the spoken words that form the text holds the lived thoroughness, evocation, intensification, tone and epiphany of the participant’s experience (van Manen, 1997a). By staying as close as possible to the actual experience being described by the participant I was able to keep focused with an open mind on the stories being related. As will become evident

in the findings, I anchored onto words that the participants used repeatedly and took note of the pauses between the words and phrases which were charged with special meaning as a result of intensification. Hence, interpretation of the data began as I collected the data. At times when the participants moved away in their response from the actual experience I redirected them back to the specific by asking them to tell me more about the experience. I found it helpful to ask the participants to give an example of a situation that was particularly meaningful. It seemed that some of the participants found the interview process helpful to unburden feelings that had stayed with them for many months.

By asking the question with a particular tone and pitch I was able to capture the concreteness of their stories. Concreteness and vividness of the text places the reader/s in the midst of the lived reality where the experience can be felt. The meaning inherent in the experience has the ability to evoke particular images that brings into the present aspects of the experience that the reader might be interested in (van Manen, 1997a).

Transcription of the data

Out of the ten interviews undertaken, a typist transcribed nine and I one because the typist was unable to understand the participant's accent. Although time consuming I found that by transcribing the data myself I had become familiar with the story much quicker than I did the others. Once the transcriptions were completed the printed data was sent back to the participants to ensure that the transcription reflected the intended meaning of what was said during the interview. No one withdrew any information from the transcripts, instead in

instances where the participant's voice was lowered and not captured on tape the gaps were filled in by the participants. Some participants chose to explain their story further which they felt was not made explicit after reading the transcript. Their complementary notes in no way altered their story but enriched and provided depth to their story. On receipt of the transcripts the participants took the opportunity to talk about the interview process and the stories that they had told. According to Lincoln and Guba (1985) debriefing can be carried out informally or formally after the data is collected and analysed. This informal process occurred naturally in this study.

Analysing the data

The purpose of data collection, regardless of the type of data or the underlying research tradition, is to organise, structure and elicit meaning from the data provided by the participants (Polit, Beck, & Hungler, 2001). In view of qualitative research being characterised by the simultaneous collection and analysis of data whereby each reciprocally shapes the other, thematic analysis was the choice for my study because of it being reflexive and interactive (van Manen, 1997b). Emerging themes from the data influenced the description of my findings in the study as van Manen (1997b) explained it would when thematic analysis is utilised. The process for data analysis is difficult to describe in an orderly fashion. This is because the activities and the transformations that are involved do not always occur in a chronological sequence.

There is a proliferation of analytic techniques that fall under the analysis umbrella, such as thematic analysis, semantic analysis, and content analysis.

Content analysis as previously noted is the method of choice for qualitative research (Thorne, Kirkham, & O'Flynn-Magee, 2004). Sandelowski's (2000) trust in thematic analysis being the choice for qualitative descriptive studies to analyse data supports my choice for van Manen's (1997b) method to analyse the data in this study. Thematic analysis is claimed to be capable of providing a summary that is both informative and as well as being interpretive (Sandelowski, 2000; van Manen, 1997b).

The rationale for a selected method to data analysis

I believe that data analysis is the most complex of all the steps in qualitative research, yet receives the least thoughtful discussion in literature. In order to generate findings that transform the data into new knowledge, van Manen (1997b) suggests that the researcher must engage in an active process of analytical thinking throughout all phases of the research, which is no different to data analysis in other qualitative descriptive studies. To begin with I had to understand the process of analysis, as van Manen (1997b) conceives the process as being the most important aspect of doing qualitative research alongside reading, understanding, and interpreting.

To aid in the analysis of the data I found it useful from the onset of the study to record my insights, work progress and my thoughts and observations made during data collection (van Manen, 1997b). As I came to terms with the layers of truth and the meaning of the text, I believed that it would be best to understand the participants' experience in terms of themes. I preferred Van Manen's (1997b) mechanical steps to data analysis which I will explain later in more detail. A

further interpretive strategy that van Manen (1997b) suggests is to be constantly reflexive, which involves a sustained, reflective dialogue with the data. Writing memos proved to be helpful in that the technique enabled me to ‘think aloud on paper’ as thoughts were recorded regarding the various themes and issues that were developing (van Manen, 1997b). Van Manen (1997b) has faith in themes giving structure and order to research and writing, as well as enables better understanding of the participants’ experience (van Manen, 1997b).

The process of identifying themes in a qualitative study is not precise. It requires sensitivity, strong listening skills, and openness for appreciating what might be revealed. As van Manen (1997b) writes:

Making something of a text or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure – grasping and formulating a thematic understanding is not a rule-bound process but a free act of “seeing” meaning (p.79).

To assist in thematic formation, van Manen (1997b) proposes three approaches that can be used to recognise significant themes. In the wholistic approach, the researcher attends to the task as a whole by questioning whether there is a sententious phrase within the data that captures the fundamental meaning of the main significance of the text in its entirety. In the selective reading approach, the researcher listens and reads the texts several times, questioning and searching for statements and phrases that seem particularly essential or revealing about the experience being described. Finally, in the detailed reading approach, the researcher looks at every sentence or sentence cluster and enquires whether the sentence or the sentence cluster reveal anything about the experience being

described (van Manen, 1997b). Since themes are dynamic and multi-layered, van Manen (1997b) advises the use of all three approaches to reveal essential themes.

Steps in the analytic process

Van Manen (1997b) suggests using personal experience as a starting point for investigating an experience. By bringing my experiences out in the open I am acknowledging that they might be possible experiences of others. Accordingly, van Manen (1997b) states:

To be aware of the structure of one's own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all other stages of the phenomenological research (p.57).

The reflective element in qualitative nursing research recognises the use of the researchers own perception and experience. There is a valid place for the researcher's records and reflections of personal experience, which in itself contributes to the collection of the data and the researcher's interpretation of the data (van Manen, 1997b).

The first stage in the analytic process was for me to ensure accuracy of the transcription of the narratives from the audio-tape recordings. One of my goals at this stage was to make sure that essential information such as body language, emphases on words, silences and abbreviations were in text. The other goal was to become familiar with the data.

The second stage followed as a reflective activity of attentive listening and reading which meant going back and forth and at the same time writing to make

sense of the participant's descriptions. By listening to the tapes and reading the transcripts at the same time I was able to clarify what the participants might have been revealing or confirming through tone of voice, emphases, silences, hesitations and other paralinguistic that would not be made known by reading the written transcripts alone. Some participants moved in and out of their stories throughout the interview which after the first few reads did not yield meaning easily. In order to make up a whole picture of their experience I found it helpful to reconstruct parts of their story and bring it into its entirety (van Manen, 1997b). This process did not happen immediately, instead it took me a long while to realise that fragments of a story were 'hidden in between the lines'. Meaning is only made visible by moving in and out of the details in the text in an iterated manner (Thorne, Kirkham, & O'Flynn-Magee, 2004; van Manen, 1997b). Commonalities and similarities though varied in response, reaction, savour and zest soon became obvious in some of their stories. Talking to others who had completed an interpretive thesis or were in the process of writing their thesis was helpful at this stage. With the combined assistance of persons experienced in this field of research, which included my thesis supervisors, I found a balance and subsequently began to make sense of the data. By reflective processing of personal thoughts, values and beliefs I was enabled to decrease my personal interpretive bias, thus supporting the credibility of the study and the study findings.

The third stage was to search for emerging themes. At this stage I used all three approaches that van Manen (1997b) suggests. That is, the wholistic approach, where I read the whole text looking for sententious phrases that captured the

meaning of the text as a whole. With the wholistic approach I discovered that the participants' world, though complex and challenging, is a space where self-growth and self-actualisation is enabled within a climate of mutual trust and respect. In the selective reading approach, I listened and read the text several times over looking for statement(s) or phrase(s) that indicated something essential about the event or the experience described. When identified as belonging to a theme the statement or phrase was selected and highlighted. Thus, when Lizzie said, "I think if you are passionate about those two things [children and burn care]", the statement began my interpretation of a theme, *Passionate dedication*. The theme *Passionate dedication* became the overarching theme because there was something in all the data that spoke of the participants' passion and dedication to care for the children with burns. Finally, in the detailed reading approach I looked at each sentence or sentence cluster and searched for the experience that was described. With this approach I uncovered that the nurses and hospital play specialists made a difference in the lives of the children with burns. Lizzie's words again, "You can really make a difference". Since themes are dynamic and multi-layered I found it useful to use all three approaches to reveal essential themes regarding the experiences of nurses and hospital play specialists.

The number of hospital play specialist participating in this study did not correspond equally to the number of participating nurses. Taking that into account I became more convinced that the participants' experiences should be analysed collectively, rather than separating them out. Hence, I mostly use the term 'participant' throughout the next few chapters as it conveys more of the

common spirit in which hospital play specialists and nurses shared of themselves. In this way I also avoid separating out their experiences to show differences. However, when I deliberately state the experience as belonging to one or the other I do so with the intent to emphasise the commonality in their practice.

To help me determine whether a theme is incidental or essential I had to as van Manen (1997b) suggests, question whether there were aspects and qualities that made the experience what it is and if it were not there would the experience be what it is. Since many of the participants shared stories of their dedication to work with the children with burns I wondered whether the theme *Passionate dedication* that I determined to be an essential theme emerging out of their stories was what it is. It took thoughtful consideration before I finally acknowledged that the theme maintained an accurate picture of the participants' experience. Identifying the essential theme lent direction to the creation of the final report text by providing a framework within which to discuss the most substantial findings (van Manen, 1997b).

As the sub-themes began to emerge from the data, I was guided by van Manen's (1997b) advice to allow thematic meaning to become expressive meaning. Printing each of the participants' stories on different coloured paper was helpful in making them readily distinguishable. It also made it easier to piece together commonalities in a story that were told by more than one participant. Throughout this process, I constantly asked myself: What is going on here? What is the participant saying? What is the meaning of the story? Analysis of the text revealed many recurring ideas in statements and phrases. From the description of

their experiences the theme '*passionate dedication*' became the overarching theme that captured the participants' experience.

My search continued until I was finally satisfied that the thematic structure formed out of the data was representative of all the narratives. As such, the three sub-themes, *Building relationships*, *Becoming overwhelmed* and, *Getting through* were aggregated into the theme *Passionate dedication* that best described the participants overall experience on the children's burn ward. Throughout the process of interpretation writing and re-writing became the 'central' activity in the construction of this thesis (van Manen, 1997b).

My orientation with this research study came in waves of highs and lows with an array of different feelings: excitement, hope, anxiety, despair and self doubt. I became attentive to related studies and began to apply meaning to actions and behaviours that I or others exhibited. I was imbued by a constant pre-occupation with this research.

Writing and re-writing

A text is only successful when it lets the truth shine through (van Manen, 1997b). I actively crossed the threshold and engaged in the world of the research participants through dialogue and brought knowledge into view by moving from the data, to writing, to reflection and then rewriting, backward and forward until an understanding was generated (van Manen, 1997b). I hoped that through writing I would bring understanding and interpretation together in a common language that allows things or incidents to speak for themselves. To write is to be

able to describe something and to feel what one is writing about. Following van Manen's (1997b) argument that writing and rewriting is the most important step in the process, I wrote and re-wrote until interpretation of the participant's experience began to be revealed which resulted in a felt sense of personal pride. When understanding is attained it is said to bring joy and accomplishment for both the researcher and the reader (van Manen, 1997b).

Trustworthiness of the study

Over the last three decades there has been much debate on how best to judge the quality of qualitative research. To date consensus has not yet been finalised. There are many research critics who favour the appraisal of qualitative research using the same validity criteria as for quantitative studies (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Nolan & Behi, 1995). The inferences are that the hallmarks of the positivist approach are the 'gold standard' criteria. While there are issues that appear to be the same in both qualitative and quantitative research, the routes to achieving robustness in qualitative studies are modified (L. Clarke, 1995; Sandelowski, 1993). There are many qualitative researchers who hold strong opposition to the inappropriateness of quantitative evaluation criteria to appraise qualitative research (Denzin & Lincoln, 1998; Emden, Hancock, Schubert, & Darbyshire, 2001; Emden & Sandelowski, 1998; Koch & Harrington, 1998; Nolan & Behi, 1995; Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003).

The researcher's goal in all qualitative studies, regardless of the differing approaches and methodologies, is to interpret and/or reconstruct subjective

meaning from the data (Denzin & Lincoln, 1998). Therefore, credibility criteria of validity and reliability from a positivist paradigm cannot automatically be transferred to studies that are interpretive in nature. Sandelowski argues for issues of validity not to be linked as 'value' or 'truth' in qualitative studies, but rather to 'trustworthiness' (Sandelowski, 1993).

Criteria that constitutes 'goodness' or 'trustworthiness' of a qualitative study is another strongly contested issue that left wide open many viable options that I personally considered to rate my qualitative study 'good' or worthy of standard (Lincoln & Guba, 1985). Though there are many differing arguments of persuasion, there is no single paradigm that can accommodate all of the so-called qualitative criteria into a unified guideline for judging the quality of qualitative studies (Beck, 1994; Koch & Harrington, 1998; Sandelowski, 2000).

I have presented an array of viewpoints given by several qualitative researchers which for me suggests that qualitative research has a certain amount of flexibility to its approach. However, to expose the trustworthiness of this study I will utilise the criteria as outlined by Lincoln and Guba (1985). Lincoln and Guba (1985) developed four criteria to evaluate trustworthiness in qualitative studies as an evaluative procedure: credibility, dependability, transferability and confirmability. By making explicit my actions throughout the process of this research, beginning in chapter one when I stated my interest in this study, I hoped to have opened an aperture for intrigue to the reader/s. My intent is that the reader/s would give the validating 'nod' to experiences that are described.

Credibility

Credibility involves reflexivity, triangulation, member checking, peer examination and interview technique. According to Lincoln and Guba (1985) a qualitative descriptive study is credible if all the steps in the process are easily traced and the findings represent the experience of the participants. Reflexivity was maintained throughout the process of this study by recording my thoughts, ideas and reflections in a journal as a constant point of reference to guide my thoughts and actions. Reflexivity is said to help minimise the researcher's a priori values and beliefs that could potentially influence the study findings (Lincoln & Guba, 1985). My professional and personal relationship with the study participants ran the risk of impeding openness and discovery of salient findings in the data. According to Lincoln and Guba (1985) there are no techniques that will provide a guarantee against coming into focus too soon, either consciously or unconsciously. Being cognizant of my role as an insider was a great step towards prevention as inferred by Lincoln and Guba (1985).

The relaxed and conversational manner in which the interviews were conducted with the participants was suitable for a qualitative inquiry. There was no sense of rush to complete the interview within a restricted timeframe. In fact, the interviews came to its natural halt, which for most lasted at least hour. Additional time was offered to the participants at the end of the interview for further thoughts and comments which seemed to have been appreciated as a time to debrief. This function was not explicitly stated, but for some it seemed that being able to speak of their intimate feelings was a way to unburden emotions that had

been with them for a long while. In addition, the informal 'debrief' that took place when the participants returned their transcripts took approximately half an hour.

Credibility of data collection also involves observation. This refers to the researcher's focus on aspects that are of relevance to the experience under investigation. As implied by Lincoln and Guba (1985) observation of the participants' body language and paralinguistic supported the study findings.

Credibility of the study is strengthened through peer debriefing which according to Lincoln and Guba (1985) exposes the researcher to intense inquiry by experts and students in interpretive research. Exposure to searching questions from colleagues and research supervisors raised my awareness of salient aspects regarding my researcher role. It also helped me to see the limits of my interpretations. Returning the transcripts to the participants to verify accuracy of their recorded conversation is another action that confirms credibility of the data. Consulting with the nurses and hospital play specialists and asking them to verify the constructs of the data analysis established credibility of the study findings (Koch, 1994). Guba and Lincoln (1998) argue earnestly for member check, which is returning the text to the participants following analysis as being a crucial technique to establish credibility in the findings.

Dependability

Dependability includes audit, dense description of the research methods, and peer examination. Audit trails make transparent the dependability of a research project so that others can ascertain how conclusions are reached, which includes judgements on the adequacy of how sections of the study link together from the

research question, analysis and interpretations of findings (Schneider, Elliot, LoBiondo-Wood, Beanland, & Haber, 2003). Auditability was achieved by making explicit all the processes involved in this qualitative descriptive research study so that the reader is able to examine and understand the methodology, methods, documentation of the data, the positioning of myself as the researcher and the outcome of the findings. This study shows a trail from the conception and reason for undertaking this study, to the research question, the choice for this methodology, the data gathering and the data analysis. Throughout the process I maintained a record of the steps followed to complete this research.

Supervision guides a rigorous research process with academic standards that ensures an audit trail consistent with the methodology. My research supervisors provided ongoing valuable direction throughout the study by prodding my thoughts when broader choices could have been made or giving reasons why one line of enquiry should be chosen and not another. Prompts and encouragement with concerned fervour heightened when my research journey for personal reasons came to a staggering halt several times along the way. Through dedicated supervision I was challenged in all aspects of this research process. Alongside this I was assisted by discussions with learned colleagues.

The feedback I received from my participation in a qualitative interpretive thesis workshop provided for Master's students at Auckland University of Technology challenged and provided the guidance that made my research journey easier. A study and its findings is considered dependable when the researcher provides an explicit discussion of his or her decisions throughout the study (Koch, 1994).

This has been made clear through the discussion on methods and analysis processes.

Transferability

Transferability is established through the production of dense description of study findings, dissemination of the study following completion and when the nod of recognition to the study findings is given by the readers. Elliot, LoBiondo-Wood and Haber (2003) assert that qualitative studies ought to reflect the everyday reality of the participants that others in the discipline could relate to or evaluate the worthiness of the study to their own practice. Data collection and analysis was undertaken concurrently. I continued to evaluate the data through careful reading and rewriting to ensure that the developing themes were grounded in the data. In the findings I show how themes were supported by excerpts from the raw data by linking the data interpretations to the words of the participants. The participants' reflections conveyed in their own words strengthens the trustworthiness of the research (Patton, 2002).

Confirmability

Confirmability includes reflexivity as well as triangulation. Confirmability is assured when the other criteria, that is credibility, transferability and dependability are achieved (Guba & Lincoln, 1998; Sandelowski, 1993). Having discussed the various criteria for assessing the trustworthiness of this qualitative descriptive study I present my personal reflexivity for this study.

Reflexivity

Reflexivity refers to the active acknowledgement by the researcher that his or her own actions and decision inevitably impacts on the meaning and context of the experience under investigation (Horsburgh, 2003). Ongoing reflection meant recording my thoughts and concerns in a reflective journal noting key thoughts, hunches and line of enquiry during data collection as a form of audit trail. Recognising personal perceptions and knowledge, then recording and reflecting on them, lent itself as a valuable source of understanding. This brought a personal perspective to the research, which was advantageous in generating knowledge and opening up understanding of the experience. Another reason for using a reflective diary was to record the conversations I had with the participants outside of their interviews. The usefulness of this activity was to keep separate those conversations so that it did not influence the interpretation of the interviewed data.

Reflexivity also offered the opportunity for voices other than my own to contribute to the text, thus deepening my own understanding and insights. Indeed, maintaining a reflective journal was helpful in that it helped me reflect on processes and procedures adopted, that is the methodology and method of analysis, ways to meet the requirements of the ethics committee and the clinical context in which this research was undertaken. Exploration of issues discussed during supervision was also made easier through this reflective process.

Summary

In this chapter I have argued the case for selecting a qualitative descriptive research methodology as an appropriate choice to answer the study question. Matched with the research method of using semi-structured interviewing, the participant's experiences were analysed and themes were generated utilising a process informed by van Manen (1997b) to describe the findings. Along with ethical approval and issues surrounding participant selection and informed consent this chapter has shown the connection between the research question, and the methods used for data collection, analysis and interpretation. This chapter concludes with a framework for evaluating trustworthiness of the study. Distinct themes that emerged from the data analysis that reflects the participant's experience on the children's burn ward will be discussed in the next three chapters.

CHAPTER FOUR: STORIES OF PASSIONATE DEDICATION

This chapter presents the findings of this qualitative descriptive study which shows what nurses and hospital play specialists experience when caring for children with burns. The stories that the participants told began for some from when they first started work on the children's burn ward. Their recollections created a landscape of their unique experiences of caring for children with burns. The overarching theme, *Passionate dedication* culminated the three sub-themes, *Building relationships*, *Becoming overwhelmed* and, *Getting through*. The themes captured the participant's experiences that shaped the reality of their care to the children.

To determine which themes were appropriate and to maintain true meaning of the experience was not an easy task. The reviewing and re-writing helped in deciding whether a theme was applicable to just one participant, one group of health professionals or to all of them equally. Even though the roles and the responsibilities of nurses and hospital play specialist are markedly different, what I discovered from the data was their common reference to each other as "we", implying a common bond and a merging of responsibilities in terms of specific care in relation to the children. The nurses and the hospital play specialists worked very closely with each other and over time developed a common language communicated by the use of body language, gestures and hints. This suggested to me that their relationship, as the result of their working side by side over a long period of time has a quality of confidence that senses the others understanding especially when on the spot clinical judgements have to be made.

For example, when a child needs more pain relief during a dressing change the nurse takes on board the subtle hint conveyed by the hospital play specialist's hand movement indicating that a 'top up' of pain relief is timely. Alternatively, when a nurse and a hospital play specialist described an encounter in which both were involved, each described the impact of that same experience using the metaphor of the 'crushed body' which demonstrated that the impact of their experience was more common than different.

All of the participants showed how natural it was to provide care that contained specific knowledge and skills in this particular life-world. Care and caring in their world on the children's burn ward allowed them self-growth and self-actualisation of the other: a process that involved development, in the same way that friendship emerges through mutual trust and a deepening qualitative transformation of relationships.

The themes were derived from the participants' descriptions of their experiences on the children's burn ward. On the burns ward their lives were balanced against the reality of their work with the children, the children's family and the wider healthcare team. Their memoirs were complex. In general it resounded with a multiplicity of close human interactions that situated them within a relationship with the children, the children's family, each other, the wider health team, as well as their own family and friends. What they saw, felt, heard and smelt in their various clinical encounters on the burns ward was a testimony of their *Passionate dedication* and devotion to the children with burns. Like parts of a whole, the following sub-themes, *Building relationships*, *Becoming overwhelmed* and

Getting through captured their acquiescent experiences in this caring environment (Figure 1).

Findings from the data will be described in this, and the two subsequent chapters. Each chapter will consecutively focus on the three sub-themes: *Building relationships* in this chapter, *Becoming overwhelmed*, in Chapter Five and the sub-theme '*Getting through*' in Chapter Six. In these chapters I will illustrate how events, experiences and ideas support the sub-themes. Finally, in Chapter Seven the whole will be brought together by showing how all the sub-themes link to capture the overarching theme *Passionate dedication*. Most of the descriptions are accompanied by participants' verbatim; when they are not, the interpretations are based firmly from the data.

The diagram (Figure 1) shows how the three sub-themes *Building relationships*, *Becoming overwhelmed* and *Getting through* supported the overarching theme *Passionate dedication*. *Building relationships* are social processes that the participants engaged in or relied upon to build relationships with the child, the families and the wider interdisciplinary burn team. Establishing a well grounded relationship with the child and the family at the onset of their admission to hospital was well recognised by all of the participants as being of central importance to their practice. *Becoming overwhelmed* shows how volatile situations bounced its way in and out of the participants' professional lives leaving them feeling overwhelmed and vulnerable. The vulnerability that they experienced in the presence of suffering was often compounded by feelings of uncertainty, helplessness and powerlessness. *Getting through* shows how they found their sources of strength to help them come to grips with their experiences

and the many feeling that were evoked. The diagram symbolises their determination to bounce back and face each day with renewed strength to care with passion and dedication. Their passionate dedication to care for the children with burns was the nucleus of their humanness to care unconditionally for the children with burns.

Capturing the whole

- Giving shape to disclosure
- Caring with whole-hearted devotion
- Complexities of caring practice
- Shielding from suffering
- Compassion and commitment
- Building foundations
- An overwhelming passion
 - A vicarious fact
 - A breeding ground for stress
 - Burnout
 - Valued support
 - Clinical supervision

Building Relationships

- Making a difference
- Knowing when a job is well done
- Showing human kindness
- Giving hope
- The healing touch
- Having fun with
- Developing trust
- Engaging the family
- Challenging the task
- Finding the balance



Getting Through

- Giving and receiving support
- Coping strategies

Becoming Overwhelmed

- Overcome by uncertainty
- Helplessness and vulnerability
- Powerlessness and hopelessness
- What's the point?
- Bodily remembering
- Overpowering the senses

Figure 1: Illustration of thematic analysis

Building relationships

Building relationships with the child and the child's family was a primary caring practice for all of the participants. The participants' stories of building relationships with others were reflected in their desire to value others. Gathering information called for a delicate social balancing which the participants had to accomplish if they were to establish themselves as involved partners in the relationship with the child and the families.

Beginning a relationship

Connie was fastidious about organisation, processes and expectations for the children and the children's family. Getting to know her patient well was paramount to good preparation. It was also essential to establish how the day was going to evolve for her. Recognising the child's ability to understand, and the child's right to know what was going to happen to him was for Connie of utmost importance. The first meeting with the child and family was crucial for relationship building, making assessments and giving explanations. Connie's words reflect this:

... you need to, like, prepare them for the bath and the change of dressing. I usually explain, it depends on their [the child] age as well, but, I usually explain to the family what I am planning to do for the day, and that the doctors need to see them. And I explain to them about what medication we give for the burns baths and dressings. And, you know, what they [the child] will do and how the child will probably feel sleepy afterwards. Or that they [the child] might act a little bit differently and stuff [sic]. With the older children if you go and do it all at once it will kind of freak them out [sic]. So, I find it is usually better to go through everything with them first, explain the scenario and you know, like prepare them for what's going to happen. Because, they just have no idea and, it is hard for them to comprehend what it [the dressing change] means. And I also try to use normal language because sometimes we

automatically just say things and they have no idea what we are talking about. And most kids will ask lots of questions, so it is quite cool [sic] to just answer them.

For Connie getting to know her patient was fundamental as a basis for an effective working partnership. As a moral concern building sound relationships created possibilities for advocacy in its most basic sense. It decreased the vulnerability for the child and the child's family. Simultaneously, preserving the dignity and integrity of all concerned within the relationship; that is the child, the child's family and the participants included.

With nurses working on a roster, building relationships began at handover from the beginning of each eight hour shift. The morning shift, which started at seven o'clock, was their busiest. The shift usually started with all of the participants' receiving a "handover" informing them of the child's physical and emotional status over the previous eight hours. At the handover they were informed of the circumstances that led to the child's injury, the family's ability to cope with the tragedy and how if the family were able to, participate in the child's care. Each nurse was generally assigned to the care of four children on a given shift.

Generally the participants' believed that their knowledge of this particular patient population added to their understanding of the common issues, common expectations and common timetables. Their voices exuberated with pride when they spoke of their clinical knowledge being made complete when caring for the children was personalized. Their actions showed that they were steadfast and vigilant in ensuring that no information was to be left out when preparing the

child and the child's family for yet another intense and protracted assault: the burn dressing.

The nurses and the hospital play specialists spoke in one atone of their roles being complementary. Lena, a play specialist described with preciseness how she engaged the child and the parents to understand what was to happen during hospitalization. Building relationships was for Lena the first and foremost goal that had to be achieved before anything else. Lena explained what she normally did once she received a handover:

From then I will either find the child's nurse or I will go back and read the clinical notes to gather information. Once I have done both of those things in either order I have the opportunity to prioritise which way my day is going to go. And which children I need to support. Once that is organized then I will, if I have time, I will go and meet the children again that day or I will go straight into dressing changes...So, the first part of the morning is more about processing and how to make the day go right. And from then it's just a roll through with dressing changes. That's the first clinical priority that I have.

Lena recognised when the child was scared or in pain. She worked patiently taking time to establish whatever coping strategies the children might need to be able to manage all their cares. To make the process as supportive as possible, she talked to children and parents about any previous experience they might have had. Lena moved in gradually so that the child or the parent did not become overwhelmed. Lena explained:

I want to know, how do families interact? How does medication support the process of the dressing change? and the thing I want to know is, what's going to happen after a dressing change? Because, I don't believe that dressing changes are the only thing that ever happened in this [child's] life.

Lena's conversation with the child and the family was comprehensive. It was important that no stone was to be left unturned. Her conversation was an example of how the other participants likewise recognised the importance of establishing a connection with the children. Taking their time was worth the effort "to make it go right for them [the children] from the start" (Lena). Lena explained:

Once I have explained that, and in the conversation they have returned some sort of indication that they understand where I am coming from, then I would proceed and maybe say to them, "I know that you have had a dressing change before. "Tell me what it was like." And it has to be open-ended. And then I wait for the information to come back, and then clarify it, so I reflect back on it and clarify it, "So that was easy, that was difficult." "What were the feelings and the sensations that you experienced?" "What was important for you to be able to manage?" "What sort of things do you think that I can assist with?" Often for older children, so that's another privacy issue. With the younger children, what is mum's ability to support the child in doing that [dressing changes]. Because so often that's a close physical security support thing and if you don't have...[silence] If mum isn't strong enough to be able to stay calm inside during a dressing change then we actually need to figure out where to position everybody to make that go right.

And I will do anything that I can to make this go right for the child. So I will be guided by them [the parent]. What they [the parent] often don't acknowledge is they have so much information about their children that unless we elicit that information, it is not a partnership. And they [the parents] don't expect to work in partnership. They expect to be told what to do and so I quite often come in and put the scenario out there that they haven't expected to be part of. They wanted to be but they hadn't expected to be.

I then have a talk to [the nurse] about how we are going to manage this situation. Often the thing that we talk about a lot is what each of us needs to focus on. If we are going to make this go right for a family I have to be clear about what [the nurse] needs to focus on to make that go right. And what part I can focus on to support that. And if we put that together in partnership with the family then it's got to go as best as it can for the child.

Ordinarily this may sound like Lena was performing a routine exercise of assessment, evaluation and care planning. However, when Lena brought to the present her past practice reality, I noted that the tone of her voice resonated with

serene gentleness. As a listener I could sense that the children's experience did matter to her. Enquiries about the child's or the family's experience was not gathered on a need-to-know basis. It was done with the intent to create an environment of support, partnership, community and hope. All of which was depicted in Lena's story as one of determination to develop a strong social bond with the children: a common tone that was noted in all of the participants' stories. Learning more about the child and the family's dynamics set the foundation on which to build structures of care. Lena's heightened awareness of the inescapable realities of burn trauma to produce a considerable degree of forced dependency led her to place "boundaries" (Lena) that made the environment safe for the children.

Giving information to the children and the families created an environment that affirmed both the nurses and the hospital play specialist's belief that a more informed and less stressed family enabled better engagement with the child. This reflects the suggestion made by Coyne (1995) that a partnership cannot exist without honest and deliberate assessment of attitudes and expectations relating to the nurse and the parent in a joint commitment to the relationship, with the child being the focus of care.

The participants stated that preparing the child was important. If not done well, the little control the child might still have had could be taken away. The participants spoke of approaching partnership building with heightened awareness and caution. Sandy explains in her story how she strived to give control back to the child who had had a bad experience during dressing changes on the previous day:

And what I did was allow her to take the dressing off herself and then we walked her to the bath, put her in the bath and let her remove the dressing herself, because yesterday the dressing stuck, and that of course is another problem. And today the dressing came off really easily and then of course the cleaning was the hardest part so we did a bit of counting and breathing and she seemed to..[silence] She really worked well with that.

This story shows that Sandy has an awareness of how hospitalisation takes away the child's control in the name of 'efficiency' (Brennan, 1994). She crafted ways that gave the child back some control, however limited, over her painful experience. The situation illustrates a practice common to nurses and hospital play specialists alike; that is giving the child control to make choices in order to reduce the child's sense of helplessness and increase cooperation during procedures.

How the participants were perceived by the children and the families was of concern to them. The participants explained that they made it their priority to make the experience for the child and their family the best possible under the circumstances. They showed that when building relationships with the children and the families it was done professionally with generosity and thoughtfulness. The participants wanted the children and their family to know that they could be trusted and spoke of building strong foundations with the children and the children's family as being the groundwork for an ongoing partnership. Their stories demonstrated a sense of resourcefulness to engage, earn trust and harness coping mechanisms especially during wound care and dressing changes. Dressing changes was spoken of as being their constant focus as the task had the tendency to become overwhelming for everyone, including themselves. However, the

overwhelming focus on the task had the potential to be shifted with specific interventions such as play and distraction.

Play was described as integral to relationship building. The participants said that play was initiated on the premise that it was an avenue for children to communicate, cope, learn and adapt to hospitalization and the events of hospitalization. They revealed how role-playing wound care and dressing changes before and after the procedure helped to minimise the impact of the task on the children. Play, as a basic activity of childhood, was also facilitated on the basis that it was fundamental to child development, psychosocial wellbeing, learning and mastery. They showed that by initiating play as a distracter, hope could be reinstalled into the young lives. Verna explained:

There was this time I was helping a three year old with painting. Her hands were burned and she wouldn't move her fingers, so the play specialist used to give her painting to do. Well she refused to hold the brush. She wouldn't hold the brush so I started painting first. So cute, only pointing to the colours that I had to use. She laughed when I got the paint smudges on my face. And next thing what she did was she put her bandaged hand into the paint and whacked me on the face. It became a fun game. I painted her face and she painted mine with her bandages first then next she grabs the brush and starts to paint my face with it.

The participants showed that they understood that interventions are recommended to increase the child's coping repertoire, to enhance the child's own choices, and ultimately facilitate the child's management of hospitalisation. They believed that some knowledge was necessary to enable the children to understand why they were in hospital and what was going to happen to them. Children need to have a basic understanding of the body and its functions to enable them to make rationale decisions regarding lifestyle and health (Lansdown, 1996). The participants spoke of play as a tool to teach the children how to deal with their

situation. Lansdown (1996) describes five functions of therapeutic play: aiding normality, reducing anxiety, hastening recovery, facilitating communication and as a preparation for hospital and clinical procedures.

The participants generally understood when a family member was unable to support their child during the wound care. One participant described how she often took over and supported the child until the parent was ready to step in from a passive role to a more active role in the burn bathroom. As the parent gradually got more confident this participant was then able to redirect her attention by “supporting the parent to support the child” (Grace) with the distraction play. Grace explained that a well established reciprocal support system in the burn bathroom was helpful in getting everyone through the task.

The participants described how they performed a number of supererogatory tasks over and above their expected clinical role with the children on the ward. Sensing the children’s loneliness, the participants explained how they spent long hours above their normal work time with the children who were on their own without a parent or caregiver. They knew experientially that reading, listening to music and watching videos were normalising experiences for the children. Spending extended time with the children was a source of personal gratification for the participant and the child. However, it also has the tendency to create a breeding ground for the development of co-dependency between the participant and the child.

Respect for autonomy and reality of others captured the nature of the participants’ passionate dedication to build relationships. When confronted with

difficult situations the participants' own interests and concerns were put aside. They found real satisfaction in making the wellbeing of the children their foremost concern. Their stories revealed professionalism, insight, understanding and compassion which interpreted as genuine dedication to make a difference in the lives of the children with burns.

Making a difference

Building relationships was demonstrated by the participants in ways that took candour, courage, commitment and compassion to make a difference in the lives of the children. When faced with difficulties, both personal and professional, the participants showed that they could remain loyal to their profession. Lizzie explained:

I think that if you have that commitment and that focus to those two specialties [paediatrics and caring for the burned] I think that makes it slightly easier. I mean, you talk to other people and they are like, you know, "It's a hard job to do, why do you do it?" But I think if you are passionate about those two things then you can really make a difference. I think that I do, I think that I really do. I think it is a very 'satisfying' job.

Several participants reported similar reactions from friends and relatives. Well meaning others on the one hand valorised the work that the participants did, while simultaneously expressing abhorrence of their work. In spite of what others said they were not deterred. For Roxanne however, it felt isolating when friends and family treated her work with disdain and refused to listen to details of her work. She said:

Um, yes, isolated and lonely. I don't want to talk too much about it [work] because my kids can't stand anything hospital; anything about blood. So I don't talk about it with them. If I mention it briefly they say, "O'h mom please don't talk about it". So you don't.

I can't talk about it [work] with friends as well. Because nobody is nursing so they don't understand it anyway. I did in the past. Well we don't talk about patients as such, but in general. They say, "Oohh! Yuk! [sic] Don't talk about it". So I don't.

It was rare for a participant to turn to and get support and comfort from an understanding spouse, partner, their children or friends who had no affiliation to the health care industry "because none of them understood" (Donna). Along with this there was always the confidentiality issue that prevented disclosure. Though it was a lonely existence to keep work life separate from their personal lives, the participants were loyal and committed to their work on this children's ward. Some had dedicated many years of their professional lives to care for the children with burns.

Being committed to the type of work that demands intense human caring was not a light-hearted pledge for the participants. They expressed that they did so knowingly of all the added responsibilities and strong oppositions that made working on a children's burn ward "a hard job". They spoke of being driven by desire and dedication to "make a difference" (Lizzie) in the lives of the children, even when their confidence in self contrasted with opinions and reactions of others, who did not understand their love and dedication to their work. A child who went home after a protracted hospitalisation with minimal or no complications gave this participant a sense of pride. Sandy explained:

Ooh! It's when they heal. You know, when you are doing a dressing and you see how they are improving because they seem to heal so quickly you know. They seem to get well so quickly or the burn gets better so quickly. It's just amazing, especially when they take a bath. When they have been here a long time, that is a bit heart wrenching. It's sad to see them go but it's happy to see them go. You know what I mean. Well I am happy when I see them go, I think "O'h we have done a great job!" They are looking well. It's wonderful and I hope that the parents carry on with this great work,

you know. The after care, pressure garments, whatever they need, moisturizer, keep them out of the sun, things like that.

For Grace it was a “wonderful achievement” to see a child get back on his feet again. Grace explained:

I won't say I enjoy it [seeing a child burned] because it sounds like I am enjoying working with burn's patients. I think I enjoy seeing the difference that we can make from the time the child arrives to the time he leaves. We had a little boy today who came back for his last appointment, his last [dressing] change. He was running down the hallway. You know, three weeks ago he had come and, you know, screaming in pain for every dressing change. He couldn't move; wouldn't do anything. And I think it's that progression and seeing the kids from when they first get here to when they leave. And I think also the progression in the parents as well. The parent's actually getting through that process where they do learn to cope, when they have made it to the end. It was such a wonderful achievement for him. That's the part that I enjoy!

Lizzie derived enormous satisfaction from her work when she could make a difference for a child and the family. She said:

I think for me personally, I find it really satisfying because I know that I can make a difference. I think it is a really hard job because you are dealing with kids that have been through such a traumatic experience with that initial injury, and the families are really traumatized. But I think for me knowing that I can make a difference. And that I can make a significant difference, and that's satisfying. I think that's why a lot of people do the job. Because you actually do!

You have to do a lot of decision making and management of day to day things. With a burn patient there are so many different variables and I think with the wound management side of things you have to and you can work fairly autonomously as a nurse. And you are the one that often knows more. Like with the burn assessment kind of thing [sic], you actually know a lot more than the registrars. And so I think you can make a significant contribution. Whereas I personally find with other specialties it is doctor driven. There's a certain pathway of treatment with burns and there are so many different variables. And there probably is with others, other conditions I mean. But I guess it's because I am so focused on burns and have been doing this for such a long time I know that I make a significant difference.

Each of these excerpts resonate the participants' passion, determination and devotion which figuratively became the 'master key' which activated their desire to care for children with burns. In giving they received personal satisfaction and professional pride. Having faith in their clinical expertise, knowledge and self was the spark that kept them fired-up to do their job well.

Knowing when a job is done well

In building relationships, passion and dedication was exhibited as being intuitive and knowledgeable and knowing when a job is done well. Being knowledgeable and intuitive to make an informed decision to omit administering a medication which she believed was contributory to an eight year old girl's altered behaviour during a dressing change, was for Sandy a "great relief". Sandy's quick thinking and informed action helped this child get through her dressing change with minimal pain or suffering. For Sandy it also meant that she could get through the task unscathed from potential abjection. Sandy said:

Now today we gave no Madazalam, only gave her Morphine and it was different, she was so different, so she met me yesterday and she knows me. She does remember some of what happened in the dressing change yesterday and today she was more co-operative.

A healed wound for the participants' meant a job done well. For Lena it was "the most magic feeling" knowing that she had "done the best job possible" on a child who was about ready for discharge. Doing her best for the child signalled pleasure that was derived from her influence to induce healing. The nurses and the hospital play specialists spoke of 'healing' that did not only pertain to the child's physical injuries. According to them the concept of healing was nebulous and not easily quantifiable. They accorded even value to healing the child

physically, emotionally and spiritually. One participant explained her beliefs on the spiritual dimension of healing. Verna explained:

I think, it is just part of our job, you know. Something that I believe I have been called to do.

For Verna caring for the children with burns had a spiritual mandate. Verna believed that she was capable of fostering hope at a time when stress and turmoil was significant in the lives of the children. Verna's devotion to her work went beyond her call of duty. It was centred on the good that she could do in her relationship with the children.

In general the participants' showed that even talking to their clients required specialist skills. Their stories validated that by active listening, attentiveness, genuineness and an understanding of their patient's situation they were initiating healing. Their stories revealed that these affirming interactions were ways in which they could connect with the children and the children's families in deep dialogue, and this was how healing took place. In respecting life, in seeing the joy of recovery and in experiencing suffering with the children and the children's family their actions were made more meaningful and worthwhile.

This participant explains her overt passion and dedication to her work with the children and the children's family. Connie explained:

I enjoy the history taking, the assessment, talking to the families, the children, educating them. I do enjoy those kind of things. But at the same time it is also challenging because there is so much to do and think about. And I enjoy the challenge. I enjoy debriding the wounds, assessing the wounds. With children, especially the little babies, even though you may not have time to always assess, because they are wriggling around ... you kind of need to get the dressings on as quickly as you can. It's harder to debride, but I still enjoy that.

With a cheerful state of mind Connie was observed in her revelation as being capable of making a virtue of the necessary, by doing the unpleasant with grace. Her overall satisfaction with her work was rated by the degree to which the experience of caring satisfied her own wants and needs. Her story was told with joy and excitement [researcher's observation of facial expression] of one who devotes self to a righteous cause or dedicates their life to the service and well-being of others. While self-interest might not be a legitimate consideration for Connie, caring none-the-less provides mutual benefit to both the carer and the cared-for. Reciprocity is a vital element within a caring relationship (Leininger, 1981; Woodward, 1997). People who experience stressful events in life and come into contact with people who care, derive benefit from the comfort and support that the caring provides.

Showing human kindness

Another way that the participants' built relationships was noted in the value they placed on showing human kindness to others, especially the children. Showing human kindness was explained as being available to comfort and nurture the children's needs even though the participant was tired following an exhausting day and being "emotionally drained" (Donna). After several hours in the burns bathroom supporting the child, the family and the nurse to complete five consecutive dressing changes with only minimal breaks between each, Grace follows up by ensuring that the child who had a difficult experience coping with the dressing changes was comfortable. Grace said:

I was involved with all those patients in their dressing changes to varying levels. I mean one was an hour and a half...probably from start to finish. When we were all done I had to pop in and quickly say, 'Hi.' Just to make sure that he was settled and fine.

Grace's compassion, connection and consideration for the children's wellbeing combined as a call of duty and genuine human response. Compassionate acts are those which take into account the suffering of others with attempts to alleviate that suffering by being humane.

The participants also had a keen eye for the parent who blamed themselves for their child's injury even when "it had purely been an accident" (Verna). Verna explained:

I think that when any child gets burned a lot of the times the parents blame themselves and I think when you come in sometimes you get that sort of feeling from the parents that they do blame themselves and that is kind of difficult to work with because mums and dads want to be there for their children and want to protect them from everything and sometimes accidents do happen. It is just a part of life. And I think that it is hard to see parents very distressed when it has purely been an accident...

In caring for the children and their families in ways that show human kindness was not something that the nurses and the hospital play specialists were taught; rather, it was a part of their human nature, a personal characteristic trait. The participants generated a meaningful connection with the child's family in the hope that the family would understand the treatment procedures and the child's response to the treatment. By working in partnership with the families the participants were able to engender possible the restoration of hope where hope was diminishing.

Giving hope

The participants' stories showed that by engaging the child and the family in a relationship that was therapeutic it stimulated more hope into their lives. Inspiring hope was a taken-for granted activity that underscored many of the

participants' actions and practices. They spoke of hope as being developed through fun and play which was an important consideration made by all of the participants as they helped the children adjust to their circumstances. The participants recognised when hope was needed then gave it freely to the children and the families.

Both the nurses and the hospital play specialists believed that it was also necessary to safeguard the child's welfare in any shape or form. Lena described how she became vigilant by placing protective boundaries to preserve one child's wellbeing, who by the nature and circumstances of his very severe injuries became a spectacle for the curious onlooker and a learning example for the doctors:

I was very strict on his routine. I was very strict on who went in and out of his room, probably stricter than I have been with a lot of other children. He was not for popping into. Not when he was first sick, because that was intrusive. It was over stimulating. He was made to feel that he had to be on show and there were times when it was too much. So probably we did go into an over protectiveness of how we managed him and then letting him branch out.

A common thread of protectiveness was revealed in the participant's stories that showed their heightened awareness of the potential for abusive practices. The participants' confirmed their readiness to shield the children from further insults to their already precarious emotional state. They revealed that by standing firm they could advocate on behalf of the children who were not able to defend themselves from society's shallow values of the 'perfect' body.

By striving for health and well-being Lena's intention was to encourage this child's integration back into society with renewed hope to face the world again.

Lena said:

When we would move between his bedroom and the bathroom I remained quiet and let him answer when people asked him how he was. I had to let 'my baby' go and let that happen for him. And of course he was a social child, he was part of a large family and we needed to re-establish a larger community for him. My second tactic was being very brave in taking him to the play room. I relied on his resilience to be able to be brave. And to grow on peers that he didn't know and let him take the initiative. I was again letting go of my protectiveness of him. Also giving him some skills to be able to manage the situation and just knowing that he needed to have those skills first.

This story reveals apprehension. Yet the necessity of letting go was seen as being responsible in that it permitted the child to become independent to socialise and become self sufficient again. By giving the children hope in small doses, such as dressing themselves, ordering their meals and socialising with peers, life for the children became less overwhelming and manageable. It decreased the child's dependency on the nurses and hospital play specialists. Genuine hope has the ability to lead a person to confront and overcome obstacles with vigour and confidence and achieve that which might have been thought impossible (D. Clarke, 2003). Hope is therefore an important consideration in a person's ability to adjust to any serious life altering situation. Particular hopes, for example, a perfect (or near perfect) appearance might be quelled. But a generalised hope and an optimistic disposition, which the participants strived to achieve for the children and their families was expectant of sustaining them through the necessary psychological adjustment.

The healing touch

Building relationships was also achieved through touch and being touched by the children. Touch was also spoken of as giving “cuddles” (Sandy) to a crying child.

Barbie showed how she used her own hand to gently rub the open wounds of a child who was overly distressed with severe, persistent itching. Barbie said:

I took him to C Pod [an empty area on the ward] where it was quiet and turned the TV on and the fan on and started rubbing his arms. Then he gave me a big hug. Because I think he was so itchy and the rubbing was not making much difference to relieve his itch. He knew me and I think he just wanted comfort.

Since all other measures failed the only action for Barbie was to do what came naturally to minimise the child’s distress. Being so close to the children was hard for the participants not to be ‘touched’ by their plight. Sandy explained her concerns:

I want to take them home. I love the children, I would have had a houseful of children (laughter) by now. But there is nothing you can do, you can’t get those children. I have also done some home visits and it’s so sad sometimes you see the way they look, you know what I mean. You can see they have been in the same nappy all day, with terrible nappy rash, all day. It’s freezing outside and they are only in a little T-shirt. All of them have got runny noses, it’s just terrible, and I think you can only do so much, I think you would tear yourself apart if you, you know, worry over every single child.

Touching and being touched was central to all of the participants: it gave joy, it comforted, it healed; and it caused pain. As a two-way process touch forms a bond between the people involved. Apart from touch causing pain especially during wound care; touch was also seen as a positive demonstration that was not to be hurried.

Having fun with

The participants' spoke of doing "fun things" (Verna) with the children. Verna explained that when she cared for a child who had been on the ward for many months, much of her care in his recuperating phase focussed on 'normalising' life for him again. Verna said:

When he was on the ward we tried to get him along to all the activities. You know we took a group of kids to a rugby game one evening and we got his uncle to come as well. He would just about always have his room, the same room every time. And that was quite important to him because that's his room in hospital. That is how he associated room [number]. That was his room. He was pretty much in [hospital] all the time, so we tried to make that [room] available for him. And just spending time with him, you know. If I was on an afternoon [shift] just sitting down and watching a movie with him or having a drink with him. After his dressing you know the thing he would always ask for would be a can of coke. So you know, I did things like that which were special to him and that would be one of the ways he would get through dressings, even some of the smaller dressings.

The participants knew from experience that creating a relaxed and near normal environment enhances the child's ability to cope. The participants revealed that in their everyday practice talking, touching, playing and having fun with the children was enmeshed into their daily cares for the children. The way that they cared for the children flowed from their belief in compassion for fellow human beings. Their compassion and empathy for the children stimulated practices that brought out their humanness to bond, love and nurture. They understood the children's fear of becoming marginalised because of severe scarring and disfiguration. Such understanding drew attention to the participants' practices to provide companionship and security in fun ways that earned them greater trust.

Developing trust

The participants' spoke of their determination to develop a trusting relationship with the children which was necessary when building relationships or carrying out painful treatment procedures. Sandy explained:

If you have looked after the patient for a while, it is okay. But if you just come in for the first time you need to earn their trust. It takes a little while, especially if you have told them [the children] you are going to do something and you don't follow it through. Say the previous nurse, said they were going to do something and they didn't do it then the patient becomes distrustful and they don't co-operate.

Developing trust with the children was disclosed as a process that could not be hurried. It took dedication and time to develop but once established trust was to be honoured. Trust was believed to be the key to co-operation. There were many variables that both helped or hindered the process of gaining the child's trust.

Lena said:

I don't get upset with children protesting. Why would you let total strangers in your body space and your perception of these strangers is that they will hurt you even if their intentions are helping you get better. Why would you naturally do that if you hadn't built up a trusting relationship? And so I don't actually object to crying. For me it's a good indicator of how a child is managing.

Lena accepted that earning trust was not to be taken lightly. She questioned why any child would "naturally" allow a stranger to get close to their already hurting body. Lena explained that it was a great ask to be 'permitted' access into the child's "body space" if the child's perception was that a stranger was not to be trusted; even if the stranger said that they were going to help make it better. This false dichotomy of narrow opposites, that is when hurting is supposedly making one well, led Lena to accept that crying was a good indicator for her to know how a child was managing during a dressing change.

Sandy explained that she found it unacceptable and got furious when trust between her, the child, including the parents, was hindered because the doctors turned up late to view the progress of the child's wound. When word was given to the child and the parents that the dressing would be done within a specific timeframe it had to be respected. Sandy explained her feelings:

Well I get angry, you know. I get angry with the doctors because they are not here. Especially if they said they want a dressing down by a certain time and they don't pitch up.

Connie recalled how she felt in a similar situation. Connie said:

You know, it's hard when the doctors say to get the dressing down by 7.30. And you work hard to get the dressings down by that time because you have to really manage your time, give the pain relief on time and then waiting to see when it takes effect. Getting in there [the burns bathroom] and getting the dressings off and then a lot of the time the doctors might turn up for an hour or so.....

It is so annoying! I get so annoyed especially if it's a child that, you know, you've got the dressing down and you are just waiting. The pain relief is wearing off. And the children get sick of it and want to get out of there. So by the time the doctors come and you're ready to do your dressings the child is totally over it [sic] and that makes it so much harder to get the actual good wound care and doing good dressings. So yes, it's annoying.

Connie spoke of her many fruitless efforts made to get the doctors to honour their word. She said:

You know, you can ring the doctors and pester them to come and tell them that. But usually they are on the other side of the hospital or whatever. So you just got to wait for them and just try and keep the child occupied and keep informing the family that we have got to wait for them and just try to keep them as least stressed as possible. And I feel, a lot of the time like I am letting the family down. Because I have said we have got to get in and we have got to do this. Then we get there and they go along with everything and then we just kind of sit there and wait. And it is hard for them because they are the ones that have to try and occupy their child who is crying and not wanting to be there. So I do feel like I am letting the family down and, yes, it'syou know, it's hard. They [parents] are usually pretty understanding.

The participants found it unacceptable when other members of the team broke trust that was especially essential for them to get through the task of wound care. There was a general indication that the doctors relegated the children to the end-of-the-line status by arriving late to see the children who had their wounds exposed for the doctor's assessment. The participants declared their intolerance of such behaviour especially when consistency, predictability, successful time management and effective performance were for them a number one priority. Trust was challenged or lost when the participants word could not be kept or when the child was frightened or in pain. Connie's story highlights the importance that the participants' placed on keeping their word to the children and the families.

There was a general agreement among the participants that they were "not only looking after the child but also looking after the parent" (Lizzie). Offering the parent a break from the ward, providing education, counselling, explaining comments made by the doctors and counselling them when distressed earned the participants the parents' valued trust and respect. The participants believed that if the situation went well for the child then the parent was reassured and had confidence in their "clinical judgment" and "clinical skills to care for their child" (Lizzie). Some participants regarded care of the parent as an important part of their role while a few spoke of it as being less of a commitment. This participant felt strongly about gaining the parents' trust when attending to the child's needs.

Lizzie explained:

I can tell by their [parent's] body language and by the way they [parents] ask questions and they ask a lot of questions. Not the same old questions. But, when they do, then I start to think maybe I am not explaining well enough. I know when they are really listening to

me. I recognise the confidence in their eyes. Then I explain, “You know this is what we do to make the dressing go well and to help your child better quicker”. And if things do go well and if things... and the parents see that steady progress in the wound then they can be confident in my job. And when things turn out in the way I said that it would then you can see the parents are pleased and they do feel comfortable asking questions where at other times they might not ask. And I think that I get a great deal of satisfaction out of knowing that a parent is satisfied with the care that I have provided for their child. It becomes a whole different ball game when you have children of your own.

In this story sensing and ‘seeing’ the parents’ pain and fragility as they fix their eyes on the extent of their child’s injuries stirred Lizzie to ‘will’ her own strength through her personal understanding of being a parent. Similar practices were recalled by other participants who assumed a ‘parent’ role when the child was frightened or on their own. The participants cared for the children in a ‘parent-minded’ way that they would have wanted their own child to be cared for, whether or not they had children of their own. Some participants’ who were not parents disclosed that their empathetic understanding gave them a glimpse into the private world of being a parent. Verna who is not a parent explained her perspective:

When you have got a newly burned child there is a lot of emotion going on. Usually the parents, especially if it’s a first change of dressing there is a lot of new things to explain to mum and dad. Often when it is a very superficial burn when you put them in the bath there is a lot of blood and that’s quite a hard thing for the parents to see, you know, for the first time. And it’s a lot of support for not only the child with pain management and things like that but also for the parents to get through the dressings and be able to be there for the children but also that they are okay with how things go.

In her story Verna shows empathy for the parents who were likely to become distressed by the painful procedure being performed on their child, as well as the child’s behavioural and emotional reaction to hospitalisation and related

treatments. Verna's genuine interest in the parent and the child is expressed in a way that shows warmth and an unhurried relationship.

Engaging the family

There were both general and particular aspects to the participants' justification towards frequent assessment of the parents' readiness to participate, which had elements of a temporal, corporeal and relational nature. The participants' accounts of their relationship with the parents suggest that the quality of the development was largely dependent on the parents themselves, with the parents' personality being an essential factor to rapport formation. For the relationship to develop some participants felt that it was important for the parents to 'come on board' with the clinical decisions that were being made for the wellbeing of their child. Lizzie's story shows that it takes candour and courage to admit that she was wrong and the parent was right. Lizzie explained:

We had a patient recently who challenged us a lot. She was a little girl with a burn on her arm who should have really had a skin graft but the family decided that they didn't want her to have surgery. Basically they just did not want her to go through an operation. I guess we tried to explain that just because a child is needing surgery it is not necessarily a bad thing, that the long-term results could be better.

She did challenge me personally, and the team as well. I guess it made us look at things from a different perspective. We tend to get so engrossed in what we think is right, but families have other factors that involve different priorities and different obligations. I think sometimes I do get a bit judgemental with families because I keep thinking well this is what's best for the child, from my perspective without taking into account the whole family. I think I am getting better at this now that my personal life has changed... with having my own children. I think now in hindsight that it was not a bad result for that child. And looking back the parents are probably right.

Lizzie acknowledges that a parent's lack of readiness is not synonymous with lack of capability. The importance of situating themselves in the parents' world is a move that counteracts potential resistance from the family to participate. Managing and negotiating care and procedures with the families involves collaboration with interdisciplinary teams, advocating for the children and the parents' needs, and very often coming to terms with conflicting protocols regarding informed consent issues. In the uniqueness of this clinical dilemma Lizzie gains a newfound openness and tolerance. Her flexibility and attention to various possibilities and challenges in the clinical situation was enhanced by her knowledge and clinical experience. Advocating for the child's needs from a professional's perspective, and coming to terms with conflicting prejudices requires self reflection and a willingness to accept that one is not always right.

The stories told highlighted the participants' skills to predict a parent's readiness to participate in their child's cares. Often when there is no parental support, more often during the dressing changes, the participants made their anxieties and despair very evident as will be made clearer in the next chapter. They spoke of thoughtful actions and intuitive decisions made on what they thought might be the best pathway of care for the child. This is what van Manen calls non-cognitive knowing, the sort of knowing that may seem invisible when one is momentarily apprehended by crises, yet resides in the lived action, and is embedded in practices and in relationships (van Manen, 1997b).

Challenging the task

In their determination to hasten physical healing of the child's injuries the participants became totally absorbed by the one task: wound care and dressing changes. Although wound care and dressing changes are only a part of the many nursing tasks involved in nursing the children with burns, the participants commonly referred to it as the "central" (Roxanne) event; "the biggest part" (Lizzie) of their overall tasks. They claimed that procedure could take anything from forty five minutes to a couple of hours. Thus, the task was viewed as being "time consuming" (Sandy) because it absorbed a great part of their morning shift, as well as their physical and emotional energy. Another participant described it as being "exhausting for the patient, exhausting for the parents and exhausting for the nurse; for everyone" (Lizzie).

To the participants all other clinical tasks faded in comparison to the intensity of this all encompassing task that was commonly described as being "challenging" (Lizzie). The challenge for the participants originated from the fact that they could not always predict how the event was going to unfold. The options underlying the success of this procedure included building rapport with the child and the family and gaining their confidence. Success for them weighed heavily towards succeeding with minimum distress and getting through the procedure in the least amount of time. Even though distraction play was essentially the responsibility of the hospital play specialist during dressing changes this activity was also 'played' out by the nurse. Roxanne explained:

It's not always easy to dress some parts of the body. What I did was to get him to hold this toy as high as he could so that I could clean under his arms. Those are the difficult parts, the arms and the groin.

The participants used distraction play, gave “big cuddles” (Sandy) and medication to desensitise the pain that the children experienced. In some instances protracted negotiation was necessary to get through the task. Their real challenge however, was in knowing when to try which approach.

Wound care took place routinely each morning in the burn bathroom amidst much protest and “lots of screaming” (Lena) from the children who were generally scared and in pain. The participants described how they gowned and gloved in preparation to carry out wound care in the “heated” (Donna) burn’s bathroom. Wound care being both a tedious and tenuous procedure required experience and knowledge to know how much or how little debriding (removing loose dead skin) was necessary, as well being able to recognise the changes in tissue structure that was taking place. The nurses spoke of having the confidence to make a decisive choice of wound care treatment based on the condition of the wound and the stage of healing. Lizzie gives her enlightened view:

I think if you have a really good rationale for what you’re doing, and once again it comes down to experience and good clinical judgement. Because some people are quite aggressive in their debriding and some people are not. I think you’ve got to know when to draw the line. And I think that comes with experience as well. You’ve got different ends of the spectrum where new people are too scared to do anything, and that’s detrimental because some skin has to come away and some doesn’t. And then you have other people at the other end of the spectrum who are of the belief that any loose skin has to be completely debrided. But I think there has to be a happy medium.

According to the participants being able to juggle their activities in the burn bathroom underscored their insight, clinical expertise and determination to get the “best possible” (Lena) job done. It was only when they were completely satisfied that the wound was thoroughly cleaned did they put on the fresh dressings.

According to several nurses in this study the ideology was that if the wound was clean the quicker it healed. A wound that healed without becoming infected was said to have given them a “most satisfying” feeling which was proudly orchestrated by all the participants. Lizzie implied that the ideal outcome to wound care could be achieved through having sound knowledge and constant practice. Lizzie’s story infers that having sound knowledge on wound care was to display a certain level of expertise; whereas not knowing, and not making the effort to know could hinder perfect healing.

The other ideal that was commonly inferred was for completion of the procedure with the minimum of distress. It was well recognised by the more experienced nurses that the ideal was not always possible because disparity existed within the clinical practice and the level of knowledge of the nurses. While it might have been the expectations for most participants to achieve minimum distress it only added to their dilemma of ‘doing it for the child’s own good’. Some of their stories showed that the participants had no choice but to persist with certain practices during wound care because the long-term consequences of scar reduction and an infection free wound were far more important. Lena spoke of her encouragement given to a young boy who refused to weight-bear after a full depth burn injury to his legs. Lena explained how she gradually got the child to get back on his feet and weight bear following a lengthy time in hospital. Lena said:

It’s about being able to have that gentle touch that goes with getting those muscles working again and massage is a beautiful way for that.

He has one leg that is almost ready to support him but unless you put the sensory information back into that leg it would never support him. Because as soon as he first put weight on it the whole muscle

area started shuddering and he was going, “No!” Because developmentally five year olds they can’t do it the first time. They want to do it. So the gym was not an option. And so in talking to the parents we started talking about being able to touch and we started actually rubbing cream on his knee. It was well healed, it was an easy thing. When we asked them to do it we explained from our position that our end goal was walking. But before you can do that there were lots of steps we believed had to happen. And that was a three way conversation because nursing staff, myself and physios had that conversation. It was reinforced, it wasn’t overly done but it was reinforced between the three of us.

The most magic thing was that they [parents] started sitting him on the floor which is the first thing. Because they thought that was achievable as parents. We went from rubbing cream on his knee and a dressing change and then sliding a finger up and down his leg. And then the nurse in a dressing change said to him “I need to be able to hold...I need to be able to bandage your toes and to be able to do that I need to hold the bottom of your foot. That’s what I am going to do”. And she was the first person that could put her whole hand around his foot. And while she was doing that and putting the dressing on with her other hand she could put a smidgen of pressure on it because she was the only one that was allowed to touch his foot. So this child had us all worked out. His Dad reported a couple of days later that he had sneakily got up and started to crawl.

And one of the conversations we had that was right one for the child was, “We think it’s time to be able to do this. We know that leg has healed well enough to be able to do that. We just have to let that leg know that that can happen, and I wonder if that leg will just let us do that and just take it gently from there”. And I think it is always the stuff that you can put your finger on and identify.

When Lena told her story I noted the modulation of her vocal tone which reflected a gentleness that she would normally use when conversing with children. Lena’s story illustrates how persistence, increasing in quality and quantity becomes the stimulant for healing. Lena’s soothing act of rubbing cream onto this child’s healed knee stimulated the child’s confidence to weight bear.

The participants explained how they were constantly worrying about the outcome of this “emotionally draining” (Verna) and “hard” (Connie) task. Verna explained:

I enjoy working with the families. I enjoy having that interaction with the parents. And generally when you have got a younger child you have got more involvement from the mum and the dad and I really enjoy that. That feels really good. But it is also very worrying. I worry about if I have done a good job or not. But there is always someone that you can ask.

Van Manen's (2000) asserts that caring-worrying is a human response to vulnerability in others which is a moral view of human existence. To respond to a care encounter is to experience the call of the other (van Manen, 2000). Caring for the children and worrying about their outcome was seen as a complex emotional relationship of responsibility. Van Manen (2000) contends that the more one cares for a person the more one worries, and the more one worries their desires to care becomes even stronger. The genuine caring relationships that existed between the participants and the children illustrated an understanding of the practical caring responsibilities explicated by the participants in their unique situations.

The participants revealed that it was important for them that the child and the family member who was going to be present during the dressing changes had the skills to cope through the ordeal of wound care. The nurses and the hospital play specialists valued the parents' participation during the child's dressing changes and were constantly on the lookout to ascertain whether the parent was not becoming over anxious about their child's condition. The stories revealed that the participants gave care to the parents as they did the children. They felt that it was essential to work alongside the child's family supporting them through their tragedy. The participants' stories showed that care given to others is not a measurable act. When given with generosity and genuine devotion it was rendered invaluable.

Joy revealed her pleasure and appreciation of wound care and dressing changes:

I enjoy the challenge of doing a big burn dressing because at the end of it you are going to get a result. It may take a while but eventually they will heal and walk out of hospital. I am quite confident in doing these dressings.

I definitely feel most comfortable doing burns dressings because that is what I like and I know that what I do is right.

“Getting it right” was not an overnight process for Joy. It took her several years to develop her expertise with the task that was “not learnt from a book” (Joy). With determination and help gained from colleagues Joy was able to master the task by “putting my self in a position where I had to cope” (Joy).

The participants explained that it was much easier to organise their minor tasks before they could put all their focus on the child in the burns bathroom. In general they talked of being happy to move at a pace that made it easier for the child, “taking small breaks when it was needed” (Grace) during the dressing changes. They showed that by allowing the children to play and take short breaks during the dressing changes afforded them the time to assess and reassess the situation because maintaining rapport and the child’s trust was considered important. Timing of the task was equally as important because it had to suit all those involved in the wound care procedure. Team work during dressing changes included the orchestrated effort of the nurse, hospital play specialist, physiotherapist, occupational therapist, doctor, parent/s and the child. For this team to be cohesive and functional, the links had to be strong. Therefore, relationship building is an important factor for the participants to consider in relation to the team of health professionals, as well as the child and the family.

Finding a balance

Every social setting has its own balance of tempo and rhythm in which events occur and actions unfold. For the participants in this study their daily lives were spoken of as being punctuated by the rhythm of their actions and bounded by the space, mainly the burns bathroom. There was common reference to finding ways that buffered and balanced their own physical and emotional distress which was achieved by “doing fun things” with the children. In accordance, it helped the children to recognise them not just as ‘the inflictor of pain’, but as persons who were kind, fun and safe to be with. Their stories reflected their belief in sustaining life, comforting always and maximising physical and emotional healing for every child. In a beauty revering society, the participants showed that they recognised their role as being ambassadors for the disfigured by virtuously challenging the stigmatisation of scarring and disfigurement. For some of the participants the ever-changing nature of the ward environment influenced their sense of balance. On the one hand their work could be physically and emotionally draining, but on the other it could be equally, if not more rewarding. Connie explained her dilemma:

At times it is stressful. When you know what you have to get done. A lot of times you are out of time because of doctors coming in [the burns bathroom] or a physiotherapist coming in and that’s hard. It makes it harder and some children don’t co-operate with what you are doing which is totally normal.

I find that being able to have a relationship with the children and like having fun with them, you know, and interacting with them outside of the bathroom and their dressing changes. It really lets you appreciate why you are doing it. If you see the child in a near normal atmosphere and you know how they normally act [silence]. Yeah, that is what distresses me and that what sorts of gives me the reason to keep on doing it.

I think, like when you’re doing procedures and things like that with children that’s their, you know, their kind of defensive mode. It’s when you are away from things like that and they are in the

playroom or with their family in their room playing or whatever. That is usually the time when they know you are not threatening them with something. They are not feeling threatened. I think that is when they are sort of the most normal that they will probably be in hospital anyway. I think that's probably a most rewarding thing from my job.

Connie's account highlights her inability to create some system of priority in an environment that was constantly changing. Some participants found that the interdisciplinary team approach to care had moments when it became problematic for them. As members of a larger team their work activities became inextricably linked with or dependent on the work of the other team members. The challenge arose for the participants when others showed disregard for their particularised plans in preparation for a burn dressing procedure. They said that this mostly happened when other members of the team failed to keep their end of the bargain, which then put the wellbeing of the children at risk. At times like these the participants were left divided in their choice of options to deal with such situation.

The participants repeatedly talked about problems experienced when staff numbers on each shift were inadequate. In such instances problems were exacerbated especially when a child requiring intense care was admitted to the ward. Verna explains the extent and level to which she would go to find the right balance. Verna explained:

Usually I do burns because we seem to get runs of them and when you are on a morning there are not many nurses that can do burns. So normally I have to do them just because of the skill mix. But I think an advantage of doing smaller burns is that you know you don't just have to take one, you can take a few others and do your burns [dressing] and have that sorted in the morning but then have other patients as well. I do prefer that, you know, as much as sometimes you just do one burn and that's it, I quite like having a bit of variety, but then in saying that it is draining doing them all the

time and I think it is important to, you know if you can have a break yourself sometimes. If you have a bad stretch and on day four you're tired then I have got no problem saying to [names the charge nurse]"Look, I need a break". Because sometimes it just gets a bit much.

Yeah, physically, and it can be very tiring in the bathroom, very hot, and emotional. It is a lot more stressful than looking after a child with a broken arm so I think you know, you know you just kind of learn and recognize your boundaries and your limits and when it is appropriate to hand that patient on.

Sometimes, you know, there have been situations like in the middle of winter where you want to carry on because you want to follow the family through and continuity is really important with these families. I will try and sometimes negotiate times in the bathroom when nurses can come and help me if it's appropriate. Having two pairs of hands it's a lot quicker. Sometimes you know if you have got someone that can help you, you have got that support in there and it's a lot quicker and I am just learning. I have come to, you know just to learn that I can always say something to [the charge nurse]. You know I think that's also healthy for the patient as well.

Understanding one's limit takes courage especially as Verna is still 'learning the ropes'. Her willingness to take the risk and trust others to support her learning and development shows courage, determination and will. Verna acknowledges that working with children with burns is personally rewarding. She also recognises the danger of overly complex, high demanding situations with staff shortage and poor skill mix to be a major determinant to declining care provision to the child and personal emotional exhaustion.

Summary

Building relationships was seen as being important in each of the participants' stories and was an integral part of their dedication to both the child and the child's family. In their interaction with the children and their families the participants acknowledged and valued their felt satisfaction on seeing the physical and emotional healing taking place in the child. Their stories revealed

that it took commitment and time to know the child and the family as persons rather than clients, along with the challenges of finding a balance in care situations. Building rapport early with the child and the family provided a starting point for communication to occur, trust to develop and involvement of the family in the care of their child. By developing a partnership with the children and the families they revealed that they were able to provide the best possible experience for the children to cope in normal and extreme situations. Through their stories the participants showed how they tempered the insults inflicted on the children's existing pain during wound care by crafting ways that diverted the child's attention away from their pain and fear.

Their stories also revealed how they were placed in untenable situations when doctors relegated the children to the end-of-the-line status by arriving late. Being able to tell their story provided an avenue for the participants to understand the challenging nature of the care they provided and learn about their feelings, as well as their response to their feelings that arose from the work that they did. Their stories also echoed their uncertainty and struggle to gain a foothold, when expectation and understanding of their role came face to face with realities that were beyond their control: exposing a raw vulnerability. Their experience of coming face to face with difficulties and challenges shapes the landscape of the next chapter. The chapter that follows will describe these events and ideas to show how the participants overcame their difficulties and got through.

CHAPTER FIVE: BECOMING OVERWHELMED

The participants' stories echoed uncertainty and struggle to provide the best possible care that with dedication became an essential part of their everyday practice with the children with burns. Their stories also revealed the number of occasions in which their world on the children's burn ward became overwhelming. The participants described how their emotions took them on a roller coaster ride - with highs and lows - that went around and around in circles, revealing the 'bitter sweet' experience of caring for children with burn injuries.

Their stories echoed an ongoing busyness of their work and the constant need to please, "the patient, the family and the doctors" (Lizzie). They also showed that keeping abreast of their feelings or keeping their feelings under control was not altogether straightforward. When their actions on the ward promoted benefits for child and/or themselves, the care that they gave to the children was done with effortless control and gratified goodwill. Yet, when the unforeseeable occurred or the intensity of events escalated, alongside being witness to the pain and the suffering of the children, they became acutely overwhelmed and struggled to keep their emotions under wraps. What emerged from their stories were their battles to overcome the deluge of emotions which occasionally made the spontaneity of their caring, joyless. They disclosed capricious situations in which their resilience wavered, making unstable their ability to bounce back on firm footing. As a consequence many of them simply got overwhelmed and it is to these experiences of being overwhelmed that are now discussed.

To become overwhelmed means to be surged over or engulfed; defeated completely and decisively; affected deeply, presented with excessive amounts of, turned over or upset (The New Collins Dictionary and Thesaurus, 1992). The participants related a number of clinical incidents in which they had become physically, mentally and emotionally overwhelmed. Within this study becoming overwhelmed (Figure 1) included being overcome by uncertainty, feelings of helplessness and vulnerability that caused them to feel powerless and question the point in continuing with such care.

Overcome by uncertainty

Becoming overwhelmed was graphically described by two participants who recalled their feelings of uncertainty and bewilderment. They showed how they searched desperately for ways to steady themselves, lest they fell. Sandy and Grace both recalled an event in which an eight year old girl who was to have her dressings changed for the second time reacted adversely to a commonly prescribed sedation. Instead of the sedation having a calming effect on the child, it had the opposite, sending the child into a frenzy. At the risk of not achieving the desired wound care Sandy and Grace were forced to move in fast and get the dressings done as quickly as possible. This was Sandy's experience:

Now this child that I just did yesterday, I mean, I met her for the first time. She is a lovely child. She is eight years old. [It was] the first time she has had Medazolam [a sedative], and she reacted. She was kicking, screaming. O'h it was terrible... because, you can't [helpless silence]... You are trying to calm her down and she doesn't want to calm down, and you are trying.

I just felt I needed to get the dressing done and the patient out of the room...to get her out of the situation. Because once the dressing is finished and over they are fine, they calm down. So I just felt I had to do this as quickly as possible. But the down side is you couldn't do it [the dressing] properly, you know. I couldn't clean the wound properly or anything, I just had to do the bare minimum, otherwise

she would never have allowed me to do it. We [Sandy and Grace] tried to get her to do deep breathing. You feel helpless, really.

Grace recalls the experience from her perspective:

My instant reaction was, “Oh my God! How are we going to cope with this child”? I was trying to figure out a way to engage with the child. Do we need to stop now and give her more drugs, or reassess the situation or do we get it over and done with so we can get out as soon as possible? And what I tried to do was have a brief discussion with the nurse ...to kind of gauge how she [the nurse] was feeling because I know it’s just as uncomfortable for them [the child] as it is for us. I think we had a very brief discussion and she [the nurse] said, “Well we have to do this and we have to get it over and done with”. And, I mean it’s horrible, you kind of walk out at the end feeling like you are hit by a bus. Because it is just like an emotional ball of energy that you use up in there [the bathroom].

Faced with the suddenness of a situation that went against normal expectations in the burn bathroom two people were sent into a state of being overwhelmed. The account related by both the participants resonate their trepidation, helplessness and despair. Their main concern was not to disintegrate mentally and emotionally lest they failed the child. This story illustrates how situations of a complex and uncertain nature can strike both the mind and the body in an unexpected way. Both Grace and Sandy were profoundly overcome by the unexpected turn of events. It was a situation that van Manen (1997b) describes as a place of wonder.

Wonder is that moment of being when one is overcome by awe or perplexity – such as when something familiar has turned profoundly unfamiliar, when our gaze has been drawn by the gaze of something that stares back at us (van Manen, 1997b, p. 5).

As they returned to the ‘moment-that-was’ to make sense of what had happened in the now both Sandy and Grace reported that their alert thinking at the time of the event was active, intentional and purposeful. Perhaps at the time when they were both completely immersed in their reality their description of it might have been different. They spoke of the effort it took to bring their ordeal to a close.

Losing their “energy” reserves meant that a less than perfect job had to be done in order to get through. Choice in the light of uncertainty calls one to leap into the unknown and grasp the controls.

In desperation to maintain composure both Sandy and Grace hasten their pace to dress the wounds ‘as quickly as possible. Getting the child out of the bathroom sooner meant that their struggle, including the child’s, would be quickly contained; like a temporary ‘band-aid’ put into place only to be opened up again the following day.

Reflecting on the aftermath of the event Sandy described the impact of her experience as being in “a train wreck”. The metaphor of ‘the crushed body’ which was used by both participants to describe the physical impact of their experience, were powerful words that spoke for themselves. According to Van Manen (1997b):

By way of metaphor, language can take us beyond the content of the metaphor towards the original region where language speaks through silence (p. 49).

The surrealism of Sandy’s and Grace’s experience described as being “so unbelievable” and “really sad” (Sandy) also resonated a sense of disdain because the child’s grandmother “couldn’t cope being in the bathroom because it was too hot” (Sandy). Their additional responsibility to support the child through her painful wound care, more especially as it turned out to be so catastrophic was “upsetting” (Grace) for Grace. Even though the participants’ generally accepted that some families were not able to cope with what they witnessed in the burn bathroom, on this occasion their empathy wore noticeably thin. Grace spoke of

her frustration at parents who had no understanding of “how traumatic it was for the child” (Grace). It was obvious that the psychological and physiological discomfort that these two participants’ experienced demanded and exceeded their normal ability to cope.

What is the right thing to do in a particular situation is not found in certainty of theory, principles or rules, but is found in listening and attentiveness to the needs of the situation. The attitude of the question ‘is this right?’ is not one of confusion or not knowing, but one of validation to what is needed for ethical action in a particular situation. Sharing knowledge for ethical action was found in the closeness of the participants’ relationship with each other which had much to do with mutual respect, mutual thinking, engagement, respect, uncertainty, vulnerability and freedom.

Helplessness and vulnerability

Some participants spoke of not being prepared for the assault to their personal and professional character that occurred within the first few months of starting work on the children’s burn ward. Despite all of their effort to reduce pain or avoid causing more pain to the children they were not always successful in eliminating the child’s pain. Their stories of children who openly expressed distress by screaming and resisting treatment portrayed the participants’ sense of helplessness to comfort the child. Connie describes her feeling of vulnerability and helplessness when left to cope with a crying toddler during a dressing change. Connie explained:

It’s hard. I find it’s harder with the really young ones that just cry, because it is hard, there is nothing you can do, you know, it’s

usually just... [long silence] [Observation note: she shrugs her shoulders and holds out her hands in a helpless gesture].

If you have good family input with them [the children], if the parents are coping really well and, I find that the coping of the parents makes a big difference as well. If the parents are freaked out [sic] and sort of not coping as well, their children can sense that and everything, it usually freaks them [the children], too.

Connie was a novice at caring for children, let alone the children with burns. Her story exhibits anxiety and anguish at being left on her own without a parent to support the inconsolable child. The parents' 'abandonment' of their child at a time of need - both the child's need and Connie's need - 'freaked' not only the child, but Connie as well. Being incapable of consoling the crying child rendered Connie helpless.

When novice nurses enter this environment on the children's burn ward they very quickly develop new skills and knowledge to equip them in their new role with the help of a preceptor. The need for support from peers is great when work situations become overwhelming. However, it is not always possible to have a support person alongside to assist when staff numbers are limited. Thus, when influence over work situations gets beyond one's reach it leads to feelings of hopelessness (Olofsson, Bengtsson, & Brink, 2003).

Powerlessness and hopelessness

As his primary nurse, Roxanne's story reveals how she became overwhelmed by utter hopelessness as she entered the world of a young boy with extensive burn injuries. Her account is an example of how easy it is even for a person with decades of experience to sink to a state of powerlessness and hopelessness.

Roxanne related:

I was his primary nurse for five or six days a week. Normally, I [worked] four days, but in those three months I worked five to six days a week simply because there was nobody to take over, the morning shift anyway. Then I suppose I became his mother as well. Especially,...well... because I was with him most of the time. So he told me all sorts of things... like, “Why don’t you let me die and”... [Roxanne cries] [long silence]...And for a long time he could only lie flat and he liked stories. So I used to lie next to him and hold the book so that he could see it and things like that...I was constantly with him in the bathroom most of the time. Four or five hours [a day] was normal in a bathroom.

I was so grateful for the play specialist because she...[Observation: a moment of hesitation]...at least I knew he was safe in that area, you know. She looked after his emotional side of things, so I could do the dressing. Otherwise it [the dressings] will take twice as long...[long silence]

Yes, you can’t keep crying. Yes, I cried many times under my mask, behind the curtains doing his dressings. Especially when he looked in the mirror. He said, “I look like a monster, I look like a monster”....[cries] [long silence].

And another thing is, his skin will not be as nice, you know. Most kids have beautiful skin but his is not, absolutely not. So that’s another thing, his face and body, everywhere... it is not a nice scarring. I just hold my breath, you know, when he is 17, 18 [years old], Yeh...[Observation note: Roxanne lifts her shoulders in a shrug and sighs deeply.]

The fragmentation in which this story is related reflects Roxanne’s equally fragile and fragmented emotional state. When Roxanne was ‘forced’ to take this child ‘under her wings’, time stood still. She spoke of the long hours spent each day in the hot burn bathroom caring for his extensive injuries. Roxanne strived to get the child to be as near perfect as she could possibly achieve. She was alone in her struggle because the other nurses were “not really experienced to look after a child with this type of extensive burns” (Roxanne). Roxanne felt powerless in the hopelessness of the situation where normalcy was irretrievable for the child. Thus, with ambiguous hope and expectation for a child with a dismal future Roxanne laboured on to create a relationship of interdependency between herself and the child. She ‘looked’ on him with a motherly gaze that prompted her to do

more than was expected of a nurse. She spoke of how she went “shopping for things he liked and bringing stuff from home for him” (Roxanne). Roxanne acknowledged that her professional and clinical experience did not have the capacity to protect her from becoming overwhelmed by emotions that crept in surreptitiously, binding her to the child’s plight and suffering. Only after Roxanne had become totally engulfed did she realise that she was indeed “drowning” (Roxanne).

Roxanne returned to her story:

You know, I was really, really angry, because I felt that I was drowning. I called for help, because you know, people can say “Oh, you didn’t tell. You didn’t call”. But I asked for [help] so many times already...and because I literally felt that I was drowning in emotion, in tiredness, in everything. But everybody just passed. I just felt that, that the patient and I were guests in the ward. That we would love to use the room, the corridor and the bathroom and everybody just left us alone.

I was quite sad and angry because when I asked for help it was already... I had already crossed the boundary. Yes. Yes, with that particular patient I knew that I crossed the boundary, the professional boundary as a nurse, not a person. But when I realized it, then it was already too late. And that’s when I asked for help... [sobs]

I really couldn’t cope. I had nightmares. In my nightmare I was driving to [the hospital] and the road became longer instead of shorter. I just didn’t arrive at [the hospital].

Roxanne’s story resounds with feelings of emptiness and isolation. When the call for help is too late and one is left alone a sense of helplessness prevails. Encapsulated by a multiplicity of emotions that were closing in on her, Roxanne was carried away by a stream of despair, screaming silently in terror and fear of going under. Time seemed to have slowed down for Roxanne as she held her breath for help to come. Roxanne’s reflection highlights how easily ‘caring’

colleagues can unknowingly let a fellow colleague sink into a state of total despair. The irony in this situation is that Roxanne was indeed 'alone'. She acknowledges that her clinical expertise sets her apart from the other nurses, but this unintentional action threatened her equilibrium.

Roxanne's description of being 'pulled down' into the murky depths of powerlessness and hopelessness captured the concept of 'agonising heaviness' which Daly (1995b) suggests represents a painful, weighty anguish which unfolds when mutual interrelationship with another or with situations reach a stage of interdependency. Seeing herself as "drowning in emotions" (Roxanne) in context reflects a language of imaged values (Daly, 1995b). Roxanne struggled to move on with the shifting images of self in the light of what was, is and is to be valued.

Roxanne's story also expresses the deep anguish and fear of moving into dangerous territory when she "crossed the boundary" (Roxanne), casting aside all professional beliefs and values. On the other side she flounders for a handhold to regain her stability. Roxanne's story was a classic example of how health professionals who spend long hours with their patients can become vulnerable when overwhelmed by the length of time spent with them.

When Roxanne was praised for her wound care skills by a senior medical colleague she recalled becoming angry and replying with a curt response.

Roxanne said:

Yes, I noticed that for instance that our burns director was praising me and but instead of saying 'O'h thank you'. I was mad at him. He said, "You've done a really good job Roxanne ...this and that, you know. And I, I don't know well, there was a ... well, yes, I can't remember exactly what I said but it was not very friendly. Instead of

saying, “Yes thank you for your compliment”, it was something like I was rejecting it. Something like you know wow, wow, wow, big deal! You know, who cares whether I did a good job or not, this child is suffering plus nobody is willing to take over.

So what is the point of praising me and in the meantime you just let me drown. Because that’s what I felt like after three months, that I was drowning in the ward and I was isolated ...

This story describes how a compliment can be denied when given at a time when hopelessness and vulnerability is at its peak. Entanglement with anguish brought to the surface feelings of conflict, hurt, paranoia and disharmony in Roxanne’s relationships with others. She questioned the futility of her efforts to achieve a near perfect healing if severe scarring was to be the consequence. In a state of disillusion and despair Roxanne ‘shrugs off’ any suggestion of hope for herself or the child, who believed himself as being grotesque. Van Manen (1997b) reminds us that:

the nihilistic “what’s the use” is less a question than a sigh, a shrugging-off of any suggestion that there might be a cause for hope (p. 123).

Van Manen (1997b) explains that “nihilistic forgetfulness” which comes from the very nature of one’s being, can turn loose certain self-destructiveness (p. 123). Roxanne’s willingness to participate and give herself fully to caring for the child cultivated her own vulnerability. It also increased her susceptibility to the suffering of another human being. Benner (2000) explains that people sometimes respond immediately with mercy to another who is suffering with no additional thought or calculation. The hopelessness that Roxanne felt about her patient’s future haunted her thoughts both day and by night. At the time there was no foreseeable end to her despair or the child’s. Without a light at the end of her proverbial tunnel the familiar road in which she travelled daily to work “became longer instead of shorter” (Roxanne). A road without an end is much like one’s

professional life and one's life at large; impossible to separate (Denzin & Lincoln, 2003).

When people meet they each experience the other reciprocally through a certain physicality that is within each others "landscape or world" (van Manen, 1997b, p.103). Within that encounter the individuals reveal or conceal aspects of themselves, consciously and unconsciously, through their physical responses. It takes subjective time for interpersonal relationships to develop. Subjective or temporal time referred to as "lived time" coloured the landscape of Roxanne's experience with a child who had a profound impact on her past, present and her future as a nurse, a mother, a colleague and a person. When entering new possibilities we learn to dwell in that new life-world which becomes part of our reality. Roxanne found it hard to accept the realities of her experience that had a profound "impact" (Roxanne) on her. It was one that would influence the rest of her life, because it was "not to be forgotten" (Roxanne).

Increased workload, demanding work tasks and staff shortages had a negative affect on the participants. They described how their request for extra staff cover, especially at night, was not always a possibility. Donna commented:

I just don't feel there is enough support in place to make us want to be burn nurses.

Managerial issues for increased productivity with limited resources had a direct effect on the nurses and the hospital play specialists who felt as though they were forgotten and often overlooked. Barbie explains her experience:

It is not just the number of burn patients you have on the ward. It depends on the combination of nurses you are working with. For example like today, we have two registered nurses and two enrolled

nurses and if you have a child come in with over 10% burns this will mean that the child will need to have a one on one nursing. And you cannot allocate that patient to an enrolled nurse. And if you are doing charge as well, it is difficult to manage the rest of the ward. And if you are the only burn nurse there you cannot manage.

There was a night that I came on there was a nine month old child admitted with 12% burns. This patient was sent to the ward straight away instead of all the immediate care being done in EC [emergency care]. When I came on there was the plastic registrar here, medical registrar and the ICU registrar. This is before I even took a handover. They had started the fluids and then I looked at the staffing. There was one other registered nurse with me and an enrolled nurse. I thought, 'What am I going to do?' There were two more admissions to come in. I thought, 'How am I going to manage this patient?' He will need special care to keep an eye on his fluid and urine output. Why did the previous shift not think to order more nurses. Did they think that because I am on I will manage? But they don't think that I still have to manage the rest of the ward. It is those types of situations that you really struggle. By the morning your body is burnt out. This is what I mean by the high acuity and intensity of the work.

Partly as a result of poor staffing levels the nurses in particular had concerns regarding the care allocation of patients with higher need requirements. In general the responsibility ultimately fell on the nurse with greater clinical experience, who along with caring for the burned patients had the added responsibility of managing the shift. The combination of being a shift coordinator and providing inclusive care to children with higher need requirements was viewed as being a recipe for role conflict. Role conflict has the potential to harm the well-being of the nurse, the quality of care delivered to the child and the management of the shift (Doman, Prowse, & Webb, 2004).

When the wellbeing of the staff and the patients became overtly critical it took a caring spouse to correspond formally with the organisation to initiate some action. The action prompted the services of a clinical psychologist to be initiated facilitating debriefing sessions with the ward staff. While many spoke positively

about the counselling sessions that helped them to talk about their personal and work issues, inadequate staffing was reported to have continued. This participant explains what had happened:

It was him actually that sent a letter to the director and said this had to stop. And then the ball started rolling. That is when they called in a counsellor and that is when we had meetings and so on.

Such a personal testimony enables one who is emotionally overwhelmed and powerless to put her story into the larger historical context, and to engage in a system of support for personal healing to occur. Testimonies are a way of informing the world not to forget (Eifried, 2003).

Donna reported that the extent of her physical and mental exhaustion which arose from work situations encroached into her personal life causing her to become “tired” and “grumpy” (Donna). Exhaustion caused Donna to become depleted of energy and with no inclination to spend time with her family and friends or attend to her physical appearance. Donna explained:

It took me a long time to realise it, but I think sometimes I would go home and I would actually take a little bit of that guilt, sometimes that extra energy which comes out as anger, on my partner.

I was grumpy, overtired, just don't want to talk to anybody. 'leave me alone', I just want a shower and sleep my life away. No I am not hungry. It took me a while to pick up that my own life did not, well actually my work life. That I needed to help myself to get to grips better with my work situation. I needed to be involved more in external activities outside work because all I was doing was work. Work, work work, work, work. Come home, sleep, sleep, sleep, sleep, sleep. Wake up eat, go back to work, it was just a cycle and I didn't like myself, I didn't like what I saw. I saw someone that I didn't like. Grumpy, tired, sometimes I didn't have time to get my hair done properly at the hairdresser.

I saw someone that didn't have time for themselves. I saw someone that was giving so much of themselves at work that when I came home I had no energy, I had no time for my personal life, I had no time for my family, I had no time for my friends. I saw someone

that was tired and worn out and just a little bit angry about how life was going.

Inescapable work situations had consequences on those whom the participants held dear, including their individual wellbeing. Several participants reported how difficult it was to recover after a busy day on the ward.

Verna explained how she felt when she first started work on the ward:

I think that it's certainly been a process. I think I used to take a lot home with me you know when I first started when it was all new. But I think that a lot of it is experience, just learning to leave it at work and go home. But certainly when I started it was hard, you know.

Barbie explained how difficult it was for her to forget work experiences during her rest time:

When I went home ...normally when I go home I lay down with my husband. But that day I could not sleep. I kept thinking of this child and the trauma he was going through. I wished that there was something I could have done for him. According to my knowledge I knew that I had done my best. It was like being tortured.

Professional responsibilities put the participants in a more intimate contact with their patients, placing them at risk of becoming overwhelmed. On the surface they might have appeared to cope adequately, yet their susceptibility to the traumatic experience forced many to deal with their experiences through maladaptive means (Davidson & Jackson, 1985).

Barbie and Joy described their feelings of powerlessness when a teenage boy got into an agitated state and ripped off all his dressings. They described feelings of hopelessness and helplessness at not being able to relieve the patient of his agony while he screamed and rolled on the floor tearing away his newly grafted

wounds. Joy explained how the boy was “beside himself” (Joy) in spite of being given several different sedations to relieve the acute itch that he was experiencing. Barbie and Joy were baffled by what they saw. They recalled how assistance was required to hold the boy down and stop him from causing further damage to his wounds. Barbie explained her encounter of the incident when she came on the evening shift:

It was like a nightmare. This was totally unpredictable. You cannot predict that this kind of thing will happen. This child was screaming and screaming. He was rolling around on the floor and no one knew why. And there was a language barrier because he spoke only French. He [patient] knew us and he just wanted to hug us so that we could scratch his body. And he kept making excuses to go to the toilet so that he could rub himself against the toilet seat. I cried...[long silence] I cried when I saw the boy doing that, because he had all his grafts taken off by then.

Though overcome by the bizarreness of the situation Barbie drew strength from within and removed the child away from curious eyes to a place that was private and quiet. ‘Being there’ for her patient involved touch and proximity, which simultaneously guaranteed respect for his privacy. Her sensitive, non-judgemental reaction took on a nurturing presence that sensed the child’s fear of being alone and being unable to communicate feelings. Barbie’s presence was felt through the sincerity of her spoken words and the quality of her care. Her tears expressed her emotional vulnerability. For many of the participant’s vulnerability involved an extension of self to the point of becoming stretched to the limit and reduced to tears. Their ‘presence’ was felt in their willingness to touch, to care, to share feelings and acknowledge the personal impact that their patient’s life had on them. Some experiences are mystifying when encountered for the first time and alteration in the frame of reference has the potential to be distressing.

Joy related her feelings of powerlessness and helplessness when learned colleagues were unable to give her a “definitive answer”:

He had people holding him down because he was scratching and described it as bugs crawling under his skin and that was a horrible experience to go through... It was just horrible having to watch. He was beside himself. And we were not able to do anything about it. No one had been able to explain why he did that and even some of the consultants had looked in research and not been able to find anything definitive. It was just a new experience for everyone. None of the staff, none of the consultants, none of the anaesthetists had ever had to deal with it.

Joy was faced with a situation in which essential information on how to proceed was missing and no one amongst colleagues on whom she usually could rely could provide the answers or prescribe a remedy. This unexpected event was talked of as being something beyond describable words. In this situation one participant is left searching for answers to bring relief. When remedy or relief is not found and answers not provided to a mystifying situation, people become vulnerable and feel unsupported.

Being able to talk about this experience meant for the participants a way of giving the experience an introduction to become part of their repertoire of experiences. Once an experience becomes a part of the lived language of a culture, it is as if the experience is put on a map. It pushes that experience from the inexpressible to the describable, from the hidden to the fully exposed (van Manen, 1997b).

What’s the point?

Becoming overwhelmed is a place that is reached when the question “What’s the point?” may often be asked. If the end result is to be a damaged product, the

worth of all one's effort and struggle to ensure 'perfect healing' was undermined. The importance of appearances and the limitations imposed upon the life of a disfigured child caused intense and prolonged emotional anguish for many of the participants in this study. Their stories reflected a sense of futility when they spoke of the dismal future that a child with severe scarring might have. When Sandy recalled her experience of the same child that Roxanne anguished over, she said:

...with such a big burn you think, "O'h what is his life going to be like? And I sometimes think we have done too much for him. I've cried behind my mask so many times for him. I think sometimes he should have just gone [died]. You know what I mean. Because he is now older and he looks like a little monster, he does.

He is a lovely child, he is beautiful but, he looks like a little monster and children are cruel. And he has a hard life, as well. And you think, "Oh, maybe we should have just let him go". I mean now, he has had suicidal tendencies.

Most of the participants questioned their role as alleviator of suffering and one who prolongs and sustains life, because life for the disfigured child ready for discharge into the big cruel world had the potential for more suffering. They described their anguish over the kind of life that awaited the children with severe disfigurement, which was spoken of in language that was void of hope. In this excerpt Sandy struggled with the ineffable, that is the 'unspeakable', the 'not to be uttered' in the hope that she was understood when she used the word "gone" (Sandy). It was observably difficult for Sandy to admit that it would have been best for the child to have died. Being so close to suffering causes one to question the point of living when life after a major burn injury for some children was obviously going to be very tough for them. The plight of children with severe burn injuries calls Sandy to question her moral beliefs.

Both Roxanne and Sandy spoke of having to hide their own pain behind their masks. Hiding behind their professional image was their way of separating themselves from the risk of becoming overwhelmed. However, maintaining a 'professional image' was not unhealthy, for it did indeed bring reassurance to the child and the parent. To be overwhelmed by feelings of pointlessness lacks the possibility for uncovering and exposing the covered over meaning that one takes for granted of everyday life. To have hope is to believe in the possibilities that hope will build and strengthen the mind and the body (van Manen, 1997b).

Bodily remembering

Becoming overwhelmed was experienced through bodily sensations. Our bodies carry messages of our engagement with the world. When we hear a particular song being played it reminds us of a time or a situation or an event. The sound can bring on a particular bodily sensation. Being in a certain space can also produce similar sensations; sometimes pleasant and sometimes overwhelming sensations. Some participants spoke of situations when they became physically and emotionally overwhelmed in the physical space of the burn bathroom. As Donna recounted her experiences in the burns bathroom, I observed her bodily response to her experience being recalled in the present. Telling her story made Donna literally "sweat". The physical space of the burns bathroom was described by Donna as though the 'space' was closing in on her. Donna explained:

I am being honest here now, [researchers name], even though I am going on to my second year I am not comfortable with burn stuff...And yes, I do avoid them, I do. But if it's given to me I will just say, "Okay, well, Lizzie is on [duty], she's the burns nurse otherwise, Roxanne, she is one of the senior nurses. I basically run out [of the bathroom] and say, "Can you help me with this. I am not too sure about this", and bring them [the nurses] in. But it's still stressful because you avoid it so much [and] your experience is not

up to par and you find you can't [Observation note: Donna shrugs her shoulders]. It's not something I look forward to.

There is nothing much you can do[in the bathroom] because the heaters are going, the child is screaming and sometimes you have got those silly plastic gowns, not the cotton ones, so you are sweating [Accentuating the word 'sweating'] and there is nothing much you can do just except have a mental conversation with yourself and just say, "Right, Donna, you know, you know what you are doing, just get through it ASAP [as soon as possible], the faster you go the quicker this will be". And that is pretty much all you can do, in there. You are Johnny on the spot [sic] you have just got to do it.

It is mainly fear, because I feel that pressure when I go in there [burn bathroom] as a nurse; not as a person, as a professional person. That's what I feel, and nobody is putting that pressure on me, but I feel that's my expectation of myself, that I should be at that level [on par with clinical skills]. Yes. I shut down emotionally, I switch off. I notice myself doing it. But for me it's a survival mechanism and if I don't shut down I go into overload. I just tell myself, this is it, this is the here and now and I have got to make it through this situation. So I try really, really hard to fight down my most surface emotions and I just swallow it. I just, in a way, I just shut down and I just do what needs to be done at that point in time. Not only to make it go quicker but, to get myself through it and then when I come out at the end of it and that door is closed I can, you know, breath a sigh of relief .

Donna did not believe that she was moulded to fit into this landscape of care as did her colleagues. Her story shows how she grappled with her inability to adapt to the demands of this clinical area. It was clear from Donna's story that she was genuinely concerned for her patient. It was not so much her clinical skills or her moral sense of care that was in question. Basically, Donna could not cope with the emotional upheaval she found her self getting into every time she carried out a burn dressing. Just talking about her experience brought on a cold sweat. Donna struggled to engage with the children and their suffering. Becoming overwhelmed by the magnitude of the event can put one into a state of despair and utter hopelessness (Morse & Penrod, 1999). Dass and Gorman (1993) describe the experience of being face to face with suffering of others as a call to woundedness,

which creates feelings of vulnerability. Discomfort in the presence of suffering becomes less destructive when it is no longer denied (Dass & Gorman, 1993).

Almost two years had passed, yet time had made no difference to Donna's discomfort. Dressing changes was the one task she disliked doing the most. When the pressure in the heated bathroom closed in on her, Donna became overwhelmed by feelings of panic. Her silent screams were far more deafening than that of the child she was attending. While telling her story I could sense Donna's feelings of being trapped. The only escapable route was to engage the help of others who could reduce her feelings of inadequacy. Gaining the assistance of her more experienced colleagues provided Donna with a buffer against becoming emotionally involved with the task at hand. Her experienced colleagues helped minimise her involvement by becoming the 'wedge' between Donna and the child in the bathroom. Supportive peers cushioned Donna against impending negative outcomes.

By its physical dimensions the burn bathroom was, both a "mathematical space", as well as a "felt space" (van Manen, 1997b, p. 102). Van Manen (1997b) postulates that a space in which a person finds him or her self affects the way they feel. The space may make an individual feel vulnerable, trapped, alone, small, free, safe, helpless, or comfortable (van Manen, 1997b). Stories have shown that the participants were affected differently at different times when doing dressing changes in the burns bathroom. Donna's story revealed that the bathroom was not her favourite spot on the ward. Being in the burns bathroom brought on for Donna intense emotions and overwhelming bodily sensations. Her ongoing battle to keep her emotions under control was made even more difficult

in the presence of “anxious and guilt ridden” parents and “screaming” children (Donna). In the ‘space’ Donna avoided any attempt to influence or develop a significant relationship with anyone, including the child. With the pressure on her to get the task done, Donna could only survive by switching her focus into ‘auto pilot’ mode and hope for everything to go right.

Anticipation of the dreaded procedure and the ‘closing in’ space became all consuming, leaving Donna overwhelmed with feelings of powerlessness and vulnerability. As her vulnerable body filled with fear and dread of unpleasant experiences, Donna became ever watchful and hypersensitive to ominous signs of impending discomfort. Constant vigilance became a way of life. Although the effort to protect her self took precedence, Donna realised that she had no choice but to complete the task. Treatment that causes pain and discomfort is an essential part of the participants’ job. There is no escape.

To “switch off” meant that Donna was “deliberately trying not to think of the patient as a person” (Nagy, 1999, p.1431). Nagy (1999) contends that ‘distancing’ was not used as a strategy to deny the existence of the patient’s pain and suffering. Instead, it is one of the many coping strategies prevalently used by health professionals to deal with their feelings when carrying out procedures that cause pain to patients. Nagy (1999) states that by becoming emotionally detached a safety net is created between the professional and the patient that helps diminish the impact of the patient’s pain on the professional.

Overpowering the senses

Every participant was able to recall a particular story that disclosed their personal struggle to cope emotionally with the realities of caring for the children with burns. Their language reverberated with tones of uneasiness and discomfort as they talked of their encounter with situations that were either disturbing to see, hear, touch or smell. For Connie seeing a child's wound for the first time was described as "a wee bit overwhelming"; while for Donna it was "the screaming, especially the younger babies" that she found to be "really emotionally draining". Grace felt that wound care was a "whole different category" because no other procedure on a child came "close to it". Grace suspected that the shock of seeing the dressings being taken off for the first time on a child who had lost several fingers and toes was "clearly seen" on her face. Grace reported how she was forced to maintain a balanced composure when she got "kind of freaked out" by the "very distinctive smell associated with these patients" (Grace). Grace explained:

I don't think anything else would come close to it [dressing changes]. If I spent the amount of energy that I put in to do a burns dressing, even if that's an hour long, or maybe it is three hours long, whatever. If you are asking if there is any other procedure that I would do with a child, if anything would match that intensity. No, that's in a whole different category I would say. It's probably..I think it's a combination of the burns bathroom with...you know, the intensity of it; it's the heat, it's the smell. It's the emotional impact on the parents, all those things tied up I think makes it an experience that doesn't compare to any other procedure. That's the other thing; the smell of the dressings. I get home and I can still smell the dressings and I don't even know what it is that creates that smell. But, it's just like a reminder every time I go home that I have been doing burns all day. It's an absolutely overpowering smell.

It was clear that it took an enormous amount of physical and emotional energy to support the child and the families through the process of wound care. Claims are

made that the conditions surrounding dressing changes are significantly more stressful than those surrounding most other procedures for everyone concerned (Foertsch, O'Hara, Stoddard, & Kealey, 1998). The participants expected to be constantly presented with situations which required greater expenditure of physical and emotional power through transference. No matter how considerable the temptations were, the participants were generally conscious of their weaknesses, which some found easier to resist and while others became overwhelmed.

Donna described how her escalating anxiety was brought on by the smell of the child's wounds:

Basically I try not to breathe sometimes, especially when I am really close. I sort of take a deep breath and I don't breathe; and I just do what I have to do quickly and then just turn around and grab a new swab and take a new breath and start again. Yes, I've gotten used to it slightly, but boy, it's overpowering. At the beginning especially when you haven't dealt with stuff like that before and you take the dressing down and that protein stench just hits you right in the face. Ooh, I think I want to gag right about now [facial expressions noted: gagging] Yes, like I said, you hold your breath, you turn away; you pretend to look at something, take a deep breath, come back and start again.

When Donna told her story in reference to the inherent "smell" of a burn ward I observed her literally "gagging" as she recalled with repulse the "smell of dead flesh" (Donna). Donna admitted that the smell was a "huge factor" (Donna) for her which often made her question her desire to remain working on the ward. Being wary of the parent's questionable gaze on her, Donna was careful like Sandy and Roxanne to "hide" (Donna) her true feelings behind the protective mask she wore. Donna felt that the best solution for her was to simply "avoid doing the burns [dressings]" (Donna) and "not to do it" (Donna). Although the

techniques of wound care might have been mastered, for Donna it was not always accompanied by gratifying feelings of accomplishment. Management of hostile impulses and guilt over producing pain continued to be pervasive but were approached by the participants in different ways.

Summary

The struggles depicted by the participants in their stories encapsulated visions of physical sensations, states of mind and emotion that sketched their actions and interactions with the children and the people around them. Their stories revealed experiences of becoming overwhelmed in an environment and culture that demanded physical and emotional expenditure. Each day on the ward brought on feelings of uncertainty, helplessness and vulnerability, powerlessness and hopelessness. These feelings brought forth emotions that overpowered their senses, and at times the participants questioned what the point of it all was. Nonetheless, the participants endeavoured to establish an environment that was conducive to healing. They recognised that collectively their efforts could make a difference to the children and the families that was satisfying for everyone in this care trajectory. To get through their difficult times the participants found that they got the best support from each other. It is to the theme '*Getting through*' that the next chapter will discuss.

CHAPTER SIX: GETTING THROUGH

The participants' described how investment in their work was done with determination and dedication to get them through the caring that made a difference in the lives of the children. They revealed that investment was made by taking on additional responsibility, working long hours, increased workload and delivering care at an exceptional level of commitment. The challenge however, was that their investment came at the expense of not achieving a work-life balance. The previous chapter highlighted some of the challenges that the participants frequently encountered on the children's burns ward. This chapter reveals what the participants did to care for themselves and each other which enabled them to get through. Roller-coaster careers might be a bit too much for some, yet in this study all of the participants, claimed that their job was engaging and satisfying. Getting through this special type of care requires the carers to acquire ways of coping. The participants recognised that giving and receiving support from each other was indeed very important.

Giving and receiving support

There were many different ways in which the participants got through events that were overwhelming and which brought forth negative feelings such as helplessness, hopelessness, sadness, anger and frustration. Self-awareness played a critical role in how they dealt with their many challenges. What they valued most was the support that they got from their peers. Most of the participants spoke favourably about their working relationships with each other. Donna's story shows commiseration being received from an understanding colleague:

Sometimes the play specialist... it is amazing because I never thought they would understand because they are not really nurses but they are in there [in the burn bathroom] all the time and they just say to me, "Your feelings are quite normal, you are not the first one to express that". And suddenly I think 'Oh God! Perhaps I am not going barmy after all'. This is normal and the fact that I don't have children so maybe the consequence of screaming is quite normal.

In essence commiseration involves reflecting on the mutual response to a common experience. Donna's story recalls Lena's attempt to 'balance' her feelings and calm her anxiety by using verbal reassurance in a tone that is not unlike that of a 'parent'. A tone Lena uses when talking to the children. The participants commonly reported that their primary source of support came from fellow colleagues who underwent the same experience and who 'intuitively' knew and understood how the other was feeling. Being supported meant being valued, listened to, heard, shown genuine concern, diluting problems and receiving approval. Having the presence of a supporting peer both inside and outside of their work environment was claimed to be valuable for their well-being. After a long and exhausting day Lena was assured of support being at hand from a colleague she could "trust, to make it go right".

Sandy explained how she was orientated to the ward by working alongside an experienced nurse. Sandy explained:

When I did a dressing there was always somebody with me. I just didn't go in [burn bathroom] and do it [the dressing] on my own. I had one of the senior nurses. Roxanne, who was my mentor, when it came to burns [dressings] she was just so good, you know. And just from watching her, just assisting initially and then having to do it [the dressing] yourself, you learn so much.

Sandy's first experience in the burn bathroom was startling, but with the help of an experienced and caring colleague she was guided step by step through the

dressing changes. Newcomers to the ward are not left on their own to discover the realities of nursing children with burns.

On entering a new area for the first time some participants' had high expectations of 'attending to', not anticipating that in doing so they themselves might need attendance. Connie recalls her first day in the burns bathroom as one of apprehension, mingled with overwhelming awe. She was guided and coached by an experienced colleague to remove a toddler's first dressings following skin grafts. Connie told her story:

I guess it was a wee bit overwhelming seeing the wounds because it was quite a bad burn the first one that I saw. But it helped that I had a really good preceptor and she was really helpful with just explaining things to me and getting me involved in, you know, saying why we do this and, yes this [the dressing] is only part of the care. That was really helpful having that sort of person.

Connie received unconditional support from a knowledgeable peer who helped her to overcome her anxieties and instil hope. With the support of a "helpful preceptor", Connie comes through understanding that the burn dressing was only a part of the child's overall care on the burn ward.

Donna gave an example of how as newcomers she was guided through her first experience in the burn bathroom. Donna said:

She [the charge nurse] said, "You know when I was in your shoes" and she took me by the hand and put me in there [the burn bathroom] and we did the debriding together.

On her first day Donna was led "by the hand" (Donna) of a caring charge nurse who guided her through her first and biggest challenge. Being supported through their initial experience on the ward was claimed by most of the nurses to be

valuable. They were gently introduced to the task that was often found to be emotionally challenging. However, Donna did accept, as was seen in an earlier excerpt (page 146) that she was “not cut out to be a burns nurse” (Donna). In spite of all the help she got Donna still struggled to ‘shape’ herself into the climate and culture of the burn ward. This story highlights the fact that not all health professional can work and gain job satisfaction when working with children with burns.

There was indeed a cohesive network among the participants who placed value on the informal debriefing sessions that they had with each other after a dressing change. Verna explained:

You do have to unwind after a burn’s dressing and just take some time out and we often just talk. The play specialist and I will talk over the dressing afterwards and then have a chat with the parents and see how it all went, just a sort of de-briefer, but at the end.

Another example of their supportive network was explained by Lena:

To me what makes my job go, what supports me in my job is the people and the relationships I have with these people. I find that’s the biggest thing that I get. That it’s very much the people!

Grace added her slant to the picture by illustrating what support and teamwork meant for her. Grace tells her story:

...the team being the child, the parent, the nurse and the play specialist, the physio ...definitely, that to me feels like a team. Often with the burns dressing the parents aren’t able to support the child, so it’s sometimes me that will go in and support the child myself. And then also supporting the nurses, supporting the team [the nurse, child and parent] and taking care of the child so that that dressing change is the best experience it can be. It just takes a lot of energy, for me, anyway. I think I have got so much [energy] because you are constantly trying to get a child’s attention or distract them or distract their parent. And I feel like I’m constantly being in their face talking, distracting, using a book, if that’s not working, getting another toy, if that’s not working, getting another toy. At the same

time, I want to help the nurse if they have got a huge amount of dressing to take off, you know. If I can help the parent do the distracting and the talking, then I can actually help take off the dressings which means in the long run that the child is done quicker and out of the bathroom quicker.

A hospital play specialist is generally present during every dressing change undertaken during the day shifts. During dressing changes Grace's role and responsibilities are huge. She focuses on 'holding' her team together: the child, the parent and the nurse. In the "intimacy" (Grace and Lizzie) of the burn bathroom the parent is closely monitored on the premise that they have to absorb the sudden disruption that has occurred in their lives. Grace becomes attentive of the nurse doing the dressing who she perceives might need a helping hand. But all the while her main attention is centred on the child. She makes use of a number of distraction techniques to draw the child's attention away from the traumatizing dressing change. Grace's story reveals a climate of collaborative, cooperative teamwork and support that combats the threat of helplessness in the face of trauma and pain. According to most of the participants teamwork was experienced as a resource that sketched a climate of possibility. Grace felt energised to lift, strengthen, encourage and comfort everyone in the bathroom. A person depleted of energy is not able to usher the support needed to 'hold' a team together.

Working alongside each other in the confined space of the burn bathroom the nurses and hospital play specialists very quickly developed unique ways of communication. Lizzie explained the scenario from her perspective:

I always have a play specialist with me [in the bathroom]. When you work with someone for a while you learn to communicate nonverbally and there will be looks that they give me or whatever. We are very good at that, keeping those lines of communication

open. And sometimes there are things that I need to do that are not nice and they [play specialist] immediately knows that, and so they respect my clinical judgment and I respect their judgment. We need to be friends as well. It is a very stressful and tense situation. If you can have a relationship where you can debrief afterwards and you can support each other a little. So you can reflect on each others practice and make suggestions to what each other can do better or do differently. I think that's important as well. We are happy to give feedback, good or bad, I think that's important.

Grace was quick to notice when the child was getting distressed. She explained how she gave the nurse "little cues" suggesting when to speed up the dressing changes. She spoke indirectly to the nurse while directing her conversation to the child, "Count to five and the nurse will then stop" (Grace) which allowed the nurse time to pace her progress when undertaking a complex dressing change.

People from all walks of life use gestures to communicate - traffic wardens, street vendors, drivers on the motorways, teachers, children in the playground, and sports people with their exuberant hugging, clenched fists and "high fives." People use their hands, heads, and bodies to communicate expressively. Without gestures, the world would be static and pallid. Gestures and body language communicate as effectively as words (at times more effectively). Gestures are used daily, almost instinctively, from outstretched the hands that invites a child's response to be picked up, the beckoning to a waiter, or a parent using a whole dictionary of gestures to teach (or preach to) a child. Gestures are inextricably woven into the participants' daily lives: a "vocabulary" that is both informative and engaging (van Manen, 1997b).

The participants offered rewards to the children as a gesture to acknowledge their 'bravery' after their dressing changes. Grace explained what she did:

I think also it's not only the actual dressing it's the after bits that's, ...[pause] I was going to say the warm fuzzy bits [sic] at the end. But, it's giving them the stickers, the rewards and things... and then also encouraging them to go to the playroom or transitioning them out of the burns bathroom into something final, something fun that they could look forward to.

The participants likewise felt rewarded when a child left the bathroom happy and content after their dressing change. Giving away tokens for 'bravery' to the children was a way of reaching a satisfying end to a painfully "hard" task. It was as though Grace was rewarding herself for getting through yet another dressing change.

Being busy was an everyday occurrence inherent in the participants' role. When Grace was asked to describe what a typical day was like, she said, "Can I talk about today, because it is a relatively typical day." Grace had just completed a marathon stretch of five dressing changes with the nurse in the burns bathroom. Apart from one child, who needed a minor dressings change and took less than an hour to complete, Grace explained that together she and her colleague had spent "an hour and a half, from start to finish" with each child in the burn bathroom. Gathered from Grace's temperament at the time of her sharing this information it seemed as though her heavy workload made for a long day, yet it did not diminish her enthusiasm. Grace's demeanour confirmed that hard work can become bearable if caring colleagues are available to lift one's spirits.

Coping strategies

When the participant's were asked what it was that got them through a stressful day, they mentioned an array of resources that they felt worked for them. For example, Donna used 'distancing' as a strategy to keep her safe from becoming

overwhelmed by aspects of her work. By “switching off” and “running out” (Donna) several times from the bathroom during dressing changes Donna was able to physically and emotionally detached herself from the child’s pain and their injuries. Some participants spoke of how they focussed their attention on the task at hand during dressing changes rather on the child and the child’s pain.

When Sandy referred to the patient she described on page 145, she said:

I just felt that it [dressing changes] needed to be done. So I just did it and that was it, you know, and I think, I kind of,..how I dealt with it then I probably switched off, you know. You just do it mechanically and I just did it, you know. Because I think if you thought more about him [the patient] you would probably go a bit crazy. You know what I mean? You would not cope with it, you wouldn’t be able to do the dressings. So that’s how I did it. I just went in, I knew he needed it done so I just did it, and there was only a few of us doing his dressings because there were only that many people experienced to do it or wanted to do it[dressing changes].

Reading books, watching a movie and playing with the children was another way of coping with the stressful nature of the job. Verna explained on page 112 how having fun with the patient helped her cope. Another participant spoke of taking long walks around the hospital during her meal break. Lena looked for quiet places to escape, where she knew for certain she would not be disturbed. Lena explained:

I now know where there are spaces in the building where there is nobody else so I might go and have a cup of coffee there. I have been known to go and have a shower, ... because water is quite relaxing and if I have done a series of long hard dressing changes, and I am talking about three or four in a row, or if I have done one that has maybe lasted three hours, then as a release I know that works for me. When I go home there must be release physically. I am an outside person, so I can go and potter in the garden or I could go for a walk. I used to go swimming, but the interesting thing was the noise level was raised with the indoor pool and when I am not at work I can’t cope with that raised level of noise. And the other thing is finding something that I wanted to learn, I have always believed that you should learn something new each year and so this

year its patchwork, and that gives me the time out for me as a person...

Caring was referred to as investment of self, but such expenditure meant that the participant would need a period of respite from the care. There was a need for some kind of 'replenishing' at the end of one encounter before another could be entered into, or "time out" (Lena) when the demand became too great. Lena was always on the lookout for places that were quiet enough to re-energise her body and her thoughts before returning to the ward. The participants appreciated the reciprocal nature of their relationships with each other and found it to be personally rewarding. They believed that it was important for them to 'share the load'. Their stories contained similarities that revealed a shared life, as apposed to a formalized system which might have exhausted all the ways in which their clinical and caring knowledge was received, transmitted or created (van Manen, 1997b). The ward environment was spoken of as having a social-emotional climate of camaraderie, mood, and a sense of possibility, which each participant experienced at some time or the other.

With an enhanced sense of being valued by others Lena explained how recognition of her role was appreciated by her colleagues. She felt that it was a "special" feeling to be included as a member of the team. In remembering how easy it was to feel isolated, Lena said:

I am always welcome...I always felt that they respect what I have to say and that there is always an open discussion...If you are included you are part of the group. You have to actively work to be part of that group and they allow me to do that and that says to me that they actually value what I bring to the team. That's special! I think it's a privilege, it a real privilege.

Having the opportunity to work collaboratively as an interdisciplinary team member was seen as marking a point of change from what used to be. From feeling that there was a time when others were indifferent to her, Lena is now overwhelmed by the progress that has been made; what's more, her contributions are acknowledged. In working together each participant is valued as a team member.

Sandy recollects the time when they had an anaesthetist to work alongside them during complex dressing changes. She questions why practices that were supportive were taken away without consultation. She pleads for the recommencement of the practice which worked well for the children who were older and who coped better with their dressing changes when inhaled gases were administered as sedation. Sandy explained:

... and for a long time we did a lot of the dressings on the ward with an anaesthetist and that worked really well. But for some reason it's just faded out. Now, the older children could benefit with having an anaesthetist on the ward. Because some of them just do not cope, you know.

Summary

Understanding a person's world or their experiences or their profession requires asking about the "nature of the lived space that renders that particular experience its quality of meaning" (van Manen, 1997b, p 103). By entering the world of the nurses and the hospital play specialists in this study it became clear that maintaining a perfect balance was like a juggling act. The previous chapter showed the struggles that the participants went through as they attempted to achieve the best health outcome for the children. It revealed their vulnerabilities

and anxieties in the face of difficult and overwhelming situations. It also showed that their world on the children's burns ward was not always predictable and that the unexpected can unfold in surprising ways. This chapter unfolded stories of giving and receiving support. When drawn into a process of engagement and involvement the participants used compassion, understanding, empathy, commiseration or reflexive reassurance. The participants showed that self care was achievable, attainable and valuable to get them through. In the next chapter the participants' passionate dedication to care for the children with burns will be discussed in context relative to issues that make the experience what it is.

CHAPTER SEVEN: DISCUSSION AND CONCLUSION

Capturing the Whole in Passionate Dedication

Like a mosaic, this final chapter brings together the parts of this thesis that make up the whole. This study made it possible for eight nurses and two hospital play specialists to express their feelings and life experiences on the children's burn ward. They described experiences which gave shape and form through the utilisation of a qualitative descriptive methodology. The data was thematically analysed through a process informed van Manen (1997b) that employed thinking, writing, reflection and rewriting to find meaning in their experiences. In the last three chapters the participants' stories brought shades of meaning and significance to their experiences that considered alone would have been found lacking. Each chapter centred on a particular theme that when brought together showed that their passion and their dedication in caring for children with burns was a major contribution to making their work lives satisfying and fulfilling. Passion and passionate love are body stirring, emotion provoking and very satisfying, but also produce disparaging emotions. The depth and richness of the participants' zealous dedication to the children and to their work was understood alongside their struggles and their awareness of what was needed to sustain their sense of wellbeing that they so often faced. Capturing the whole (Figure 1) gives shape to caring in complex practices and recognises the compassion and commitment required for the passionate dedication exhibited by the participants in this study. The discussion on capturing the whole through passionate

dedication will be followed by the limitations of the study and the implications for research, practice and education. For the purpose of this discussion chapter the nurses and the hospital play specialists will continue to be referred to as 'participants' as the data did not in any way reveal any significant differences in the way each interpreted their world on the children's burn ward.

Caring with passion and dedication

In trying to understand the experience of caring for the children with burn injuries the participants' stories showed that the complexities of caring, the suffering that occurred and being overwhelmed stood alongside being passionate, committed, supportive and dedicated. An inquiry into the participants' world on the children's burn ward reflected their passionate dedication to care for the children with burns. In relation to their work the participants disclosed the necessary practices that helped them transcend their somewhat busy, overworked and bewildering life experiences to care whole-heartedly for the children. Moreover, their experiences shaped their expectations of the workplace, their relationships, and their own self-actualisation in their caring practice.

Caring is a term which reaches beyond the confines of nursing to multiple occupations in which characteristics are equally recognisable (Henderson, 2001). In this study the focus on care, as an activity of commitment to the children, is from the perspective of nurses and hospital play specialists (the participants). Although caring is said to result from altruistic emotions (Woodward, 1997) the participants' knowledge and skills to provide care was also seen as being sustaining and continuous until such time that it was no longer required by the

children or their families. Although self interest may not be a legitimate thought, caring nonetheless provides mutual benefit to the carer and the cared-for (Woodward, 1997).

The long hours spent with the children made the participants' contact with them closer and more continuous. Likewise, their function as intermediaries between the child and the child's immediate environment made that bond even greater. Both Cronin (2001) and Nagy (1999) suggest that one's personal investment of emotions when caring for patients with burns can become virtually unrecognised and to a certain extent unacknowledged when it is dedicated over the extent of a working day and over a substantial period of time. Some of the participants in this study showed recognition of the fact that it was not safe to become too emotionally attached to the children (Nagy, 1999). The process of 'stepping away' or giving the child control over the removal of dressings, or encouraging the parent to support the child during dressing changes were some of the individual emotional responses to circumstances. To an extent this was mitigated by the participants' personality, level of experience, expectations and inherent facets that provided a personal lens on the event. Consequently, the inescapable reality of burn trauma to produce a considerable degree of forced co-dependency was for some, inevitable. Begat, Ellefsen and Severinsson, (2005) in measuring nurses' psychosocial wellbeing in relation to work demands found that being able to plan and find meaning in one's work influenced a nurses' sense of wellbeing. They also acknowledged the work of nursing to be demanding in that it requires a degree of commitment for decisions to be made in critical situations. In this study

when faced with difficult critical situations the nurses firmly based their actions on knowledge, principles, intuition and feelings.

Many nurse theorists describe caring as being central to the role of nurses (Benner & Wrubel, 1989; K. Swanson, 1993) and indeed, as was seen in this study, for hospital play specialists as well. The mental, emotional and physical effort that went into their caring involved devotion in caring for, responding to and supporting the other (Benner & Wrubel, 1989). Giving care to children with burns is intense, demanding and complex, because the healing and recovery of the child involves dedication and commitment that is lengthy, arduous, painful and often with complicated interventions and procedures. To mark the child's progress and expected stages of recovery, the participants follow a defined care trajectory. The establishment of a pathway of care provides them with a set of explanations of what could be expected to happen to the children and what to do in response (K. O. Taylor, Goudie, & Muller, 2004). It gives them a framework to organise their care and come to terms with the evaluation of the end results.

Detaching self from the suffering other

In preparation for dressing changes some participants found security by gowning and masking to conceal their overwhelming feelings of distress from the children and the parents. They hid their reactions to the sights, smell and noise in the course of their care to the children, especially when doing dressing changes. With determination they attempted to tuck away any pain or emotion so that their vulnerability was not exposed. Literature describing nurses' responses to patients who suffer suggests that in some instances feelings of compassion can force

caregivers to withdraw from the suffering patient or shield themselves from becoming emotionally involved (Davidson & Jackson, 1985; Davitz, Davitz, & Rubin, 1980; Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006; Nagy, 1998). Although the participants were constantly bombarded by human suffering their zealous resolve to remain whole taught them to redirect, alter or squelch any arousal of emotive responses. Comparable to Nagy's (1998) study of nurses' response to patient's pain and change in the patients' body image the participants in my study felt the need to hide their true feelings from the children and the families when pain and disfigurement resulting from the burn injury was inescapable. Exploration of this response shows that anxiety increases when contact with patient's injuries are constant (Nagy, 1998).

The participants in this study used several coping strategies to distance themselves from the suffering patient (Nagy, 1999), or the tasks, or from inner self (Demerouti, Bakker, Nachreiner, & Schaufeli, 2000), which Benner and Wrubel (1989) suggest could essentially cause them to lose the guidance that emotions provide. Caring for a child that was grossly traumatised by burn injuries was inescapable for one participant in this study. The interaction brought on concealed long-standing symptoms of post-traumatic stress.

Detachment and engagement was clearly an area of resonance for the participants as was noted in their eagerness to talk about their tendencies to engage or detach. They made value-laden judgements on when to use detachment or engagement in their interactions with the children. As an example, "switching off" (Donna) showed that a relationship did exist between the willingness to care and the skill to be self-reflexive about how much could be tolerated within their practice.

Being reflexive made the participants more attentive towards valuing the emotional connection that they had with the children. When caregivers attempt to reduce their emotional response to the patient who suffers with the intent to decrease their personal investment in the suffering, they initiate learned professional responses of therapeutic empathy, humour, distraction and confronting (Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). Such responses keep them therapeutically 'at arms length' from the pain and suffering that the children experience. It is not always possible to avoid pain and still be compassionate; therefore in some situations the participants' feelings of compassion led some to take "time out" (Lena) to avoid too much emotional involvement.

Compassion and commitment

Compassion shown by the participants was an emotion stimulated by the presence of suffering that evoked recognition and mutual sharing of the physical and emotional pain that the children experienced. In sharing some of the suffering experienced by the child and the families the participants expressed compassion that was equally strengthening, as it was comforting. Evidently, the emotional and physical implications of commitment and compassionate caring are concepts not just confined to nurses and hospital play specialists. Henderson (2001) names a multitude of other occupations, such as social workers, teachers, and psychologists, including flight attendants who display similar characteristics of emotional and physical exhaustion to care. Unpaid carers, volunteers, family members and from personal experience, parents also experience similar implications to their emotional involvement. Being a parent to some extent means

loving and giving unconditionally, suppressing one's own personal needs, desires and expressions for the good of the children. Consequently, some of the participants' drew from their personal experiences of being parents, offering unconditional love to the children on the basis that it might accelerate emotional healing. However, no significant difference was seen in the way the participants gave unconditional love to the children whether or not they were parents. Stickley and Freshwater (2002) contend that the giving and receiving of love is embedded in caring practices. It caters towards healing of the whole person, which includes the patient and the carer (Stickley & Freshwater, 2002). The participants' expression of their uninhibited love for the children had the potential for long-term positive effects. It creates the basis for trusting relationships to develop between the participants, the children and the children's family.

Building sound foundations

Building sound relationships based on trust and partnership with the children and their families was seen as important for the participants to set strong foundations in their caring practice. It facilitated the best level of recovery for the child, plus the foundation supported the child's cooperative response to care. The outcome for the child was also dependent on the existence of mutual trust between the parent and the participants. Therefore, from the participants' perspective the family's ability to develop a working relationship with the participants was of equal importance to optimal recovery of the child. Thus, relationship building began from the moment the participant first encountered the child and the family. First encounters could also occur when the child arrives at the emergency department. As Barbie recollected:

...suddenly you may get a phone call from ED saying that there is a child downstairs. "Can you come and see the child, please"... When you get there, the first thing you see is the family looking at you. I introduce myself then go straightaway to see the child. He or she would have been a happy child who was playing around and suddenly some hot water or soup or something would have fallen on the child. It is just a big shock. It doesn't give me that big a shock because I think being a nurse for the last twenty or so years I have seen all that. First thing I think about is, How deep is the burn? What pressure is this putting on the family? I explain to the family what is going to happen from this moment on. I feel sometimes it is difficult to explain to the parents that this is an acute situation and they are not prepared to listen. Whatever is on their mind, especially on day one or two is very difficult to take it out of their mind, especially when they can't think ahead.

The participants realise the devastation that a burn injury can cause to lives that would never be the same again for the child and their family. Barbie's story reflects empathy that is also mirrored by other participants when the child and the family who only hours earlier might have been peacefully going about their usual home routine before the accident happened. It was imperative from the participants' point of view that they worked together with the family from the start. Preparing the family to care for their child and to come to terms with the accident takes investment of time and patience. There was an assumption that the parent would participate in their child's care, especially supporting the child during dressing changes. Several factors were taken into consideration when encouraging a parent to be with their child during wound care. Mostly it was anticipating what might be the likely reactions of the parent to the child's injury, as well as the parents' present emotional state. Consideration was given to the extent of the parents' upset, anxiety or their ability to cope with the child's injury and subsequent treatment procedures. This attitudinal stance taken by the participants was made with the openness for discovery about the child and the family, which was intrinsically warm rather than indifferent. Knowing the child,

in this study appears to be a precondition to individualise care and to establish a rapport with the parents. Mutual goals are developed more easily when expectations are clearly articulated at the beginning of the interactions (Opie, 1998). Fenwick, Barclay and Schmied (1999) found that interactions which occurred between the nurse and the parents were more democratic when it was not related to specific actions. When it was of a more personal rather than a professional nature, the parents felt that they had to know something about the nurse as a person (Fenwick, Barclay, & Schmied, 1999). Likewise, in the phenomenological study undertaken by Bricher (1999) the nurses identified the importance of getting to know the child as a person by reciprocally allowing the child to get to know them better. However, Bricher's (1999) study provides little guidance on how to gain the family's trust. More emphasis is placed on gaining the child's trust (Bricher, 1999). In this study the participants valued their encounter and the rapport that developed between them, the children and the families. Being available for the families and being with them had such significance for the participants. It created an atmosphere between the participants and the families that allowed them the comfort to work with each other.

It is well recognised that caring for children places significant emotional and psychological burden on health professionals because it requires them to invest a significant part of self into the relationship (M. Burns, 1994; Totka, 1996). The participants in this study gave something of themselves to their relationship with the children. They recognised that dressing changes could not be undertaken unless substantial time was given to develop trust through therapeutic closeness,

nearness and touch as Lena made transparent when explaining why considerable value was placed on developing trust with the children:

I don't get upset when a child is protesting. Why would you let a stranger in your body space and your perception of these strangers is that they will hurt you even if their intentions are helping you get better.

Building trust was a vital aspect of the participants' philosophy of care. They worked hard not to breach it, because they appreciated the child's vulnerability following a burn injury. Nurses and hospital play specialists alike believed in an unhurried process which is known to be essential when building trust with children who are too young to relate cause and affect (Bricher, 1999). During dressing changes the participants made sure that the children got involved with the procedure so that the child could have control over how much they could tolerate. The participants were strong on the notion that honesty was the key to gaining both the child's and parent's trust. It added to their frustration when parents were not given full explanation of what was to be expected when they first arrived at the emergency department. Grace said:

I have seen it happen where they [nurses in the ED] talk to the kids and the parents and say, "Oh, you know that burn's not that bad. You are probably going to stay the night and then you will be home tomorrow. So don't worry about it".... Then actually they get grafted two days later and then spend another two weeks in hospital. So it's trying to facilitate kind of early communication.

Grace shows steadfast belief in honesty being the fundamentals in building trusting relationships. A study exploring four nurses' experiences of caring for hospitalised children with special needs in an acute care setting found that the nurses were resolute about making the parents know that they could be trusted (Ford & Turner, 2001). Trust has to be reciprocal between the person who makes

themselves trustworthy and the person who puts their trust in them (Bricher, 1999).

Children are constantly being spoken to about 'stranger danger', therefore when someone unfamiliar wants to do something unknown to them that is reasonably painful and uncomfortable children protest and resist the treatment (Peterson, 1992). The nature of the child's distress places an enormous responsibility on the participants in this study to intervene or to try and alleviate the child's distress. It triggers within them a motivation for response. With dexterity of a performer the participants juggle clinical competence, understanding and compassion to achieve the best outcome for the children. They cannot afford to lose focus. If they do, then all their plans are sent into disarray and they together with the children are overwhelmed by the outcome.

The participants' explored ways to retain a trusting relationship with the children. Based on children's natural inclination to play, the participants used guided imagery or distraction therapy to help the children cope with dressing changes. Ott (1996) supports the use of guided imagery to help alleviate a child's anxiety during painful or unfamiliar procedures. Play and guided imagery gives children some control over the painful event (Ott, 1996). The nurses in this study had accrued a great deal of knowledge and experience regarding the benefits of pharmacological interventions in the relief of pain for the children. Their knowledge and experience with pain assessment strategies and pain relieving interventions were found to influence the decisions that they made regarding how much, how little or when to omit a prescribed medication that could adversely affect the child. In a review of literature regarding factors that influence decision-

making in the administration of pain relief to children Abu-Saad and Hamers (1997) concluded that nurses generally failed to accurately assess a child's pain and administer appropriate pain relief. However, the review also shows that there are a number of factors that influence this conclusion. A point of significance regarding the literature review was that all of the study designs except for one was based on qualitative explorative research designs which according to Abu-Saad and Hamers (1997) limited the generalisability of their study finding. Noteworthy, one study in the review corresponded closely with the findings of my research which showed that assessing the child's pain in context with knowing the child and being in tune with the child, gives nurses the confidence to make effective pain assessment for the children (Abu-Saad & Hamers, 1997).

In a study of paediatric burn unit nurses Zengerle-Levy (2004) found that the nurses' experiential and intuitive knowledge guided the care that they gave to the children. The nurses in Zengerle-Levy's study engaged in a range of practices that exceeded their daily routines to holistically heal the children. Similar findings were also seen in this study of the participants giving devoted care to the children based on sound understanding and expertise that improved over a period of time.

An overwhelming passion

The participants overwhelming passion to care for the children with burns was the most significant finding in this qualitative descriptive study. A distinctive attitude of avant-garde confidence in their highly productive skills to care for children with burns was attributed to their level of expertise and experience in

this field of professional specialisation. The participants spoke proudly of their wide-ranging roles which included being the main point of contact with the children, giving counsel and emotional support to the children, parents and each other, as well as providing expert consultation to interested groups on the management of burns and wound care. With courageous spirit the more experienced participants advocated on behalf of the children for the best treatment options with other care providers. The findings of Nagy's (1998) study on the effects of burn patient's pain on nurses showed that nurses had an increased sense of personal control and competence when they believed that their clinical decisions were endorsed by the medical staff. One participant in this study showed that her skills in wound care did not go unrecognised by the senior doctors. Another participant's faith in her clinical knowledge afforded her the assertion required to challenge inappropriate treatment decisions for the children.

Sandy reported:

Some of the doctors are approachable and you can speak to them and it is easy. But others you cannot, you know. They just won't listen to what you have to say, which is really frustrating. Especially if you have been doing dressings for such a long time and you know the patient and you know what they can handle or not handle. And these house surgeons just come in and they have no clue, they haven't been doing it for that long. Sometimes what I do if I disagree with what the doctor says I will just do what I know (laughs) needs to be done. Or what I would do is I would go outside the room and I would speak to them and say well I disagree with that, or, why are you doing it that way, I disagree with that, you know.

Five nurses in this study were considered experts on wound care and were often sought out by the other nursing and medical staff for advice on a preferred treatment option that promoted better wound healing. The familiar sights of bandages, physical wounds; children's chatter, laughter and screams blended in

with the smell of the burn wounds which for some was overwhelming, yet others claimed they “sniff them all the time” (Sandy) as a distinctive mark of their scrutiny to detect wound infection. Their expert knowledge was valued and appreciated by the less experienced staff. In this emotionally intimate environment the participants were in a powerful position to make a difference in the lives of the children and the children’s family. As an esteemed group of professionals the participants in this study were dedicated towards meeting the needs of the children with burns.

Passionate Dedication

The Latin root for the word “passion” means “to suffer” or “to love with ardent affection” (The New Collins Dictionary and Thesaurus, 1992). The word “dedication” another Latin derivative, translates as a “devotion” (The New Collins Dictionary and Thesaurus, 1992). As we devote ourselves to someone or some things in life we may indeed “suffer” when failure, loss, rejection or pain is the outcome. In true passion the pursuit for survival surpasses all fears. To have passionate dedication the participants had to actively reach beyond their comfort zone and bring to reality the dream and ambition that was being strived for even if it meant experiencing pain or suffering. The irony is that through passionate dedication one can transcend suffering and pain. It takes years of passion and dedication to master achievements, as is often seen in people like racing enthusiasts, song writers, musicians, sports people, teachers and those involved in ground breaking research; also nurses and hospital play specialists. Building relationships, becoming overwhelmed and getting through the day to day events

helped the participants in this study to develop this passionate dedication to care for children with burns.

Passionate dedication is the core that shapes each participant's story by shading and colouring their experience on the children's burn ward. Most of the participants were drawn into this climate of care because they were "passionate" (Lizzie) and "loved" (Verna) the work that they did. The biggest task on the children's burn ward was wound care which was generally described as being "the worst type" (Lizzie), "really awful" (Donna), and "emotionally hard" (Sandy). According to Grace no other procedure "comes close to it" because it is long and exhausting. Yet, they could come out of the burns bathroom several hours later feeling pleased that "it was a job well done" (Sandy). The participants' stories provided vivid accounts of their clinical experience and of the concerns and dilemmas that lay at the heart of their work and their relationship with the children, the children's families and each other. Their stories showed that they were driven by compassion and devotion, which was supported by the depth of their clinical knowledge and expertise to critically appraise and manage most situations. The nurses and the hospital play specialists alike spoke of their joy at being able to "make a difference" (Lizzie) in the lives of the children and the children's family and their passion was demonstrated by their intense devotion and conviction.

Their passionate dedication was demonstrated in the way they built relationships with the children, the families, each other and the rest of the burn team. It was also shown in the way they made a difference in the lives of the children, their

commitment to do the best job possible, showing human kindness, giving hope, touch, having fun and building relationships.

The qualitative descriptive methodology which is influenced by Sandelowski's (2000) interpretation of the approach attempts to describe selected descriptions that convey the participants' experiences when caring for children with burns.

Implications for practice

While there might be some common situations that could be applied broadly to a variety of health services and life in general, this thesis shows that in caring for children with burns there are complexities and demands that relate specifically to the care of children with burns. Involvement and commitment to their work requires the participants to make meaningful decisions that far exceeds the demand of giving purely technical or task-centred care to the children and the children's family (Abu-Saad & Hamers, 1997; Zengerle-Levy, 2004). This thesis offers opportunity to nurses and hospital play specialists to tell their story of events that occur in their daily lives on the children's burn ward. This study contains rich descriptions and interpretive suggestions that raises an awareness of the possibilities within the practices of others; and if taken up will create ones' own landscape that can stand alongside that of the nurses and the hospital play specialists in this thesis.

A vicarious fact

Basically, the participants' work on the children's burn ward became the backdrop of their everyday existence. The tedious and intensive care given by the participants to the children and the families was both taxing and exhausting. It

diminished their personal resources to the extent that their enthusiasm was often deflated. In addition, the cumulative effect of their exposure to the traumatised children over time manifested an emotional response within each participant at a different level of intensity. What this study also shows is that this high dependency ward for children with burns was a breeding ground for stress and burnout.

Stress and burnout has been explored extensively in the caring profession (Benner, 1984b; Benner & Wrubel, 1989; Doman, 1997; Lewis, Poppe, Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998). Much is said about the stressful nature of caring for the burned; and, of the harmful effect of continuous exposure to the inherent stressors on the professional carers (Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Steenkamp & van der Merwe, 1998). The demanding nature of caring for others and the physical and emotional investment of the participants to their work could be considered as being a high risk occupation with significant potential for burnout to occur (Allen & Mellor, 2002; Kalliath, O'Driscoll, & Gillespie, 1998; Sabin-Farrell & Turpin, 2003). If the identified stressors include inability to manage the patients' pain, witnessing or participating in painful procedures, increased workloads, playing surrogate parent to the children (Lewis, Poppe, Twomey, & Peltier, 1990; Nagy, 1998; Steenkamp & van der Merwe, 1998) with the lack of supervised support (Olofsson, Bengtsson, & Brink, 2003), it is then conclusive to suggest that the participants' workplace is a fertile breeding ground for long-term stress and burnout. In all of the above mentioned studies stress was viewed with an aspect of negativity that required managing or fixing. However, at some point in everyone's life stress

becomes unavoidable. There is no doubt that the participants in my study are exposed to similar levels of stress that is inherent in nearly all caring practices (Sabin-Farrell & Turpin, 2003; Williamson & Dodds, 1999). For this reason one has to question where the line is to be drawn to differentiate between work-related stress and outside influenced stress. Indeed, these two spheres are inseparable.

Although she had been caring for children with burns over several decades, Roxanne's empathetic connection with a particular child unsteadied her to such an extent that it got difficult for her to maintain an inner sense of balance. Ernst, Franco, Messmer and Gonzalez (2004) found that older nurses and nurses with more years of nursing experience had less job stress than their younger counterparts. While many of the participants in this thesis were older and more experienced and had the confidence and emotional stability to get through their workload more efficiently, it did not always shield them from burnout when demand was constant.

Carrying out a complex burn dressing is time consuming for it requires patience and tolerance of the needs of others involved in the process. Being constantly available to children and the families, acting as advocates, comforter and counsellor and giving physical care and emotional support to the children are cumulatively considered to be leading factors that contribute towards vicarious traumatisation (Leiter, Harvie, & Frizzell, 1998). These factors are likewise spoken of as being contributory to burnout (Cudmore, 1996). Vicarious traumatisation and burnout are conditions that cause long-term alteration in the victim's cognitive schema, beliefs, expectation and assumption of self and others.

When health professionals work under stress it is said that the quality of patient care tends to drop (J. Taylor, Muller, Wattle, & Harris, 1999). On the contrary, the participants in this study valued quality in their care provision. They emphasised the importance of achieving the best care outcomes for the children and felt guilty when that was not achieved.

The participants took care of children with varying degrees of acuity. Sometimes changes in practice on the ward crept in gradually. One participant recollected a time when they had an anaesthetist to work alongside them during complex dressing changes. While under-medication was not a major issue for the children on this ward, this participant was upset at the withdrawal of the anaesthetists' presence during major dressing changes. She urged for the recommencement of the practice especially for the older children who she believed coped better when inhaled gases are administered as sedation. This suggestion is a recommendation from this study to further investigate why this practice stopped and if there was still a place for its use. Olofsson, Bengtsson and Brink (2003) propose for a wider collaboration and participation in decision-making processes concerning workplace developments to include the workers. Sandy's feeling of not being given the opportunity to contribute to major endorsements or changes in the workplace highlights the need for more involvement of staff in policy changes or developments. Apart from this single issue, the participants felt that the ward functioned relatively well in respect to practical management. Perhaps the effects of policy changes and developments on the staff could be an area for further research.

When events occur 'out of the blue' or is beyond a persons' level of control the consequence may mean an increased workload that is intense and demanding. This participant's account exemplifies the experiences of many other participants. Speaking about her feelings when she arrived on a night shift to several very ill children and poor staffing levels, Barbie said:

I can never understand why the previous shift does not think to order more nurses. Did they think that because I am on I will manage but they don't think that I still have to manage the rest of the ward. It is those types of situations that you really struggle. By the morning your body is burnt out. This is what I mean by the high acuity and intensity of the work.

Hughes (1999) found that when patients' acuity and staff skill-mix are not matched it requires the workers to work harder and faster, dropping the quality of their work. In this study the findings reveal many similar events when the participants worked harder and faster to get wound care complete eventuating in feelings of dissatisfaction when the outcome was less than perfect. Ultimately, the participants expected to work in collaboration with other members of the health team. By being involved in the decision-making in relation to staff allocation versus patient acuity meant that they could have some control over their workload.

Some studies have noted significantly higher levels of perceived job stressors (Lewis, Poppe, Twomey, & Peltier, 1990) and patient related stressors found in burn care nurses compared to nurses in other areas such as orthopaedic, plastic surgery and obstetrics (Burnside, 1996; Steenkamp & van der Merwe, 1998). Working with children with burns is known to have significant emotional and physical impact that necessitates the need for social support (Nagy, 1999).

Valuing support

The participants valued the support that they got from each other. Novice nurses spoke of their preceptors and colleagues as being knowledgeable, tactful and up-to-date about current procedures. Being able to address feelings through collaboration with colleagues helped the participants to understand their own moral stance in relation to their colleagues and their environment. It meant working together towards a common purpose (Bogat, Ellefsen, & Severinsson, 2005).

Maintaining social support with others reflected the participants' crucial need to be connected to others on a personal and professional level in order to effectively deal with traumatic work experiences. Being in touch with their feelings afforded them the opportunity to experience a greater awareness of needs, experience and perception. The social connection provided them with an endorsement that was needed after a good part of the day was spent conducting painful dressing changes. They appreciated the uniqueness and the challenges that their caring work brought alongside the significant rewards. They took the opportunity to share their experience with each other in case their difficulties magnified or their pleasures diluted. They felt isolated when emotional support was not given to them by their own family or friends who were not in the healthcare business. Paradoxically, their work was either valorised or reviled by others. Commitment to this kind of work involves accepting a personal challenge, putting strength in one's convictions and value judgement to the test in the face of strong opposition (Burnside, 1996; Lewis, Poppe, Twomey, & Peltier, 1990).

In general the participants were dissatisfied with the support they got from the senior management “who had no idea of how understaffed we are” (Barbie). It took a crisis situation which eventually got addressed three months after the event when several severely burned children were admitted to the ward over a short period of time. The impact sparked urgency for professional psychological support to be ushered in for all the staff on the ward. This one-off programme of three sessions was appreciated by most of the participants in this study. At the time they felt it was beneficial for their wellbeing to make sense of the horrific catastrophe. However, apart from a solitary staff member, none of the others wanted professional help to be continued long-term. This participant said:

It was really good. It taught me a couple of things, like what to do or not to do, or do better... emotionally I put up a boundary because I did not want to go through this again.

The sessions restored this participant’s connection with self and others which was sufficient to provide her with a lasting sense of personal accomplishment. The plight of an injured child is a major source of anxiety for those working in burn units (Nagy, 1998). The concern for many participants is that the children are young and issues of body image and physical vulnerability is especially relevant. The participants were also highly critical of families in which maltreatment or neglect was suspected. The opportunity to discuss their feelings in this regard was usually done at their handover or meal breaks with colleagues. The participants in this study were content to continue with the current processes that worked in their favour to maintain a positive, therapeutic attitude towards the families. Professional psychological support has only in the last year of this study’s completion become a regular part of the schedule for the children with burns and their families. To date no such support is available for health professionals

working on this ward. Whether or not this is a practice that requires recommendation is still to be considered, as change in policy and procedure requires the input of all concerned.

Another process that works well for the participants is the time set aside mostly after completion of dressing change to discuss what went well, what did not and what they could do differently the following day. After several hours of toiling over a child who had scratched himself raw, the nurses on night duty eventually sat down in the quiet of the night. With the assurance of the child's safe transfer to the intensive care unit the nurses chatted over "a cup of tea and talked to each other and consoled each other" (Barbie) as they reflected on the incident over and over again. Even though the participants referred to the incident as "a horrible nightmare", the re-framing of the situation revealed a restored confidence for this participant to tell her story. As a final statement of conviction she said, "We did our best. It was not a routine thing" (Barbie). Experiences that are described as being challenging at the time, is seen as a positive in the present time. The past changes itself, and the future takes on a different shape because hope is always on the horizon (van Manen, 1997b). It is difficult to give hope when the devastation of a burn injury means permanent scarring and disfigurement. Yet, the participants understood that if they were to nurture the inner spirit of the child "by doing the special things" (Sandy) they were likely to sustain a sense of emotional wellbeing.

When the participants experienced symptoms of tiredness, moodiness or sleep difficulties it affected their relationship with the children, the children's families, their co-workers, and their own families and friends. When moral deterioration

becomes obvious it undermines one's values, dignity, temperament, and will; diminishing the human spirit (Maslach & Leiter, 1997). While it may be human nature to assist another who is suffering, it is also a human, social and professional expectation to keep suffering private, which some participants did, but at a personal cost. The participants sought solace from each other when support was needed. The one participant who had reservations regarding her ability to connect with the children, especially during dressing changes knew for certain that help was available from caring colleagues who knew what they were doing. It was always easier to talk to "someone who understands" (Donna).

The participants reframed the way they perceived their work and the inherent challenges of their work. An example of reframing was seen in the way this participant viewed a child who cried during a dressing change. Lena said:

For me crying is a form of communication and screaming was always seen in the negative. Whereas now I can use screaming to understand it as a form of language and a form of communication, so I have grown in that way.

The findings of this thesis support previous research which suggests that staff with more experience and longevity in an area tend to use active coping strategies rather than avoidance mechanisms to get through the pressures of their work. This strategy has been noted to be a leading factor in minimising the potential effects of stress (Ernst, Franco, Messmer, & Gonzales, 2004; Lewis, Poppe, Twomey, & Peltier, 1990). Together with maintaining a sense of humour, peer support and team cohesiveness, working collectively was a major moderator of stress for the participants in my study. Similar findings were also noted in other studies (Lewis, Poppe, Twomey, & Peltier, 1990; Steenkamp & van der Merwe, 1998; Zengerle-Levy, 2004).

The participants helped the children manage their physical and emotional pain by using voice intonations and facial expressions. During their interviews the participants often used humour to make light of a tense situation. They laughed at themselves, again ringing true that the past has the ability to change itself (van Manen, 1997b). Closely related to the findings noted in the study conducted by Lewis, Poppe, Twomey and Peltier (1990) the participants' decreased their feelings of stress by talking to their fellow colleagues, engaging in activities like "going to the gym" (Lena) or taking "a long run" (Verna) or "plonking out and doing nothing" (Donna). Socialising with work colleagues with whom they had developed close friendship was helpful to diffuse intense feelings. Similar to the findings in Cronin's (2001) study one participant valued places where she could find silence and "not think about anything" (Lena).

The participant's generally refrained from engaging in workplace talk with family and friends who had no affiliation with healthcare services because the response that they usually got from them was felt to be less conducive to their well-being. Comments from family and friends were not always supportive of the work they did with the children. Informal support structures were found within their own network of colleagues which was similar to Cronin's (2001) study. However, in Cronin's (2001) study when the newly recruited nurses went through a period of adjustment they got little support. The nurses in this thesis were supported through a well structured preceptor programme that sustained their learning and development of skills.

Even though the sample size of this study is small, this research provided insight into the experiences of health professionals who spend a greater percentage of

their working day caring for children who are burned and in pain. Their stories show a shift in practice that reflects a specialist level of knowledge which is able to influence change in knowledge, practice and research in this care environment. Further research could be replicated in other high dependency areas to compare with the findings of this study.

It is well recognised that working in partnership with the parents is a well established model of care in most paediatric care settings. Indeed, the benefits of parental participation has been widely investigated (Coyne, 1995; Darbyshire, 1994). This study has shown that the participants' relationship with the families was constantly in contention with other requirements in their practice such as safety, risk management, and organisational requirements. The participants verbalised their frustration when parental input in care dropped and they had to become representatives of control rather than of care. They also became frustrated with time constraints, work overload, staff shortages and difficulties experienced in their relationship with other professionals. In spite of these difficulties the participants retained a positive outlook and were passionate about overcoming their difficulties. These experiences provide the ideal platform for further research to explore what it is that enables health professionals to remain focussed and therapeutic in the face of the many challenges that they so often confront.

The realities of the participants' practice were often in conflict with their perceived vision of care. The findings show that they also became overwhelmed by their responsibility and accountability. As a supportive process to assist them to efficiently and effectively manage their practice (Williamson & Dodds, 1999)

clinical supervision could well be the way forward for all the participants in this study. While the hospital play specialists were familiar with a model of clinical supervision that relied on an experienced clinical supervisor, the nurses however, were not familiar with this process of support.

Clinical supervision

Generally the nurses were divided in their preferences for a more formal process of support, such as clinical supervision. Possibly the negative feelings exhibited are not dissimilar to that highlighted by Williamson and Dodds (1999) who claim that persons can very easily become stressed if they are not able to go off the ward or leave patients unattended in order to have clinical supervision. Williamson and Dodds (1999) in a review of literature exploring the effectiveness of clinical supervision in reducing occupational stress, found little evidence to support the initiation of such practice. This does not mean to say that clinical supervision is not valuable. Perhaps more evidence is required to expose its benefits in reducing stress in the workplace.

The two hospital plays specialists valued the ongoing clinical supervisions that they had with their team leader which was a requirement of their service. There is no comparable arrangement in regards to clinical supervision for the nurses in this care context. Comparing the benefits of the nurses' informal debriefing in comparison to the formal clinical supervision that is in place for hospital play specialists is another area worth exploring. While these are two very different support processes, there is nothing from the findings to suggest one support

system is more beneficial than the other: another point to be considered as a recommendation for further investigation.

There are numerous reasons why the participants derived great satisfaction from their workplace. Although there was a general feeling that management did not consider their workload needs nor were they treated with the concern they felt they deserved, they found joy in their work with the children. They were passionate about wound care and valued their knowledge and expertise to progress the physical and emotional healing for children under their care. This increased their sense of self-worth. Great satisfaction was derived from knowing that they could make a difference in the life of a traumatized child especially when “we have done a great job and they are looking well. It’s wonderful” (Sandy). The participants were proud of the effort that each of them made towards team work. Team support was seen as their greatest asset and paralleled similar finding by Lewis, Poppe, Twomey & Peilter (1990).

The overall findings confirm that the participants faced many challenges when caring for children traumatised by burns, yet found great joy and satisfaction in the numerous rewards that were derived from their work. This study also provides a platform for reflection for nurses and hospital play specialists who may want to work on a children’s burn ward that may be confirmed or put into action, if not already done.

Strengths of the study

This qualitative descriptive study presents an insight into the nature and meaning of eight nurses and two hospital play specialists’ experiences of their day to day

life on a children burn ward. The study strength can be considered on the fact that there has not been any previous study undertaken in New Zealand to explore the collective experiences of nurses and hospital play specialist from the perspective of care provision to children with burns. The participants' accounts emerged from the everyday language that they used to describe their experiences with the children and the families that portrayed their existence in this care context. When viewed from a positive light, the meaning that underscores the participants' experiences opens up considerations for new staff to see the rewards that are gained from caring for children with burns. An understanding of their experiences could alert leaders in the health arena to examine carefully and review current orientation practices for new staff with the focus on increasing staffing levels and reducing high work demands. The findings may also instigate the development of psychological support policies for staff, where there are none; or the review of existing policies that will provide better staff support.

This thesis was a way of giving 'voice' to the participants' experience, therefore making 'visible' their practice. Several participants reported that they found the interview process beneficial as it gave them an opportunity to talk to someone 'interested' enough to know about their experiences. I am in no way suggesting that the interview process was conducted as a de-briefing session. Qualitative researchers are warned about interviews on emotive topics that could potentially be viewed by the participants as being 'therapeutic' to their well-being (Kvale, 1996).

Limitations of the study

Limitation is a term sometimes used to express the scope of something, its legitimate boundaries and the extent of its application. By using a qualitative descriptive methodology to understand the collective experiences of nurses and hospital play specialists the mandate was to present the methodology as a comprehensive summary of events (Sandelowski, 2000). The researcher is expected to collect as much data as possible in order to capture all of the rudiments of an event that makes the experience that which it is. The researcher is also expected to stay as close to the data as possible, with a keen eye to the surface of words and events. While every attempt was made to do just that, I recognise that I was not rigorous enough with follow through questions like, “Tell me more about that?” or “How did that feel when...?” Therefore the richness and depth of the data might have changed had these questions been used more often.

Another limitation is that the participants had varying levels of expertise and years of clinical experience with caring for children with burns and some could reflect on the experience more fully than others. While this can be viewed as being strength of the study in that it brought out varying accounts from varied perspective, the weakness was due to me not probing for richer descriptions.

Some of the participants could talk more comfortably and described their experiences with the assumption that I knew or understood what they were going to say or the circumstances around the event. This was a risk because they knew me as their clinical educator and of my presence during some of the events that

were described. Although I had reminded them prior to the interview that they were to talk to me as though I knew nothing of their experiences, it was difficult for them not to say, “You do remember that? You were there, remember?” Most times my reply was “Yes, but tell it to me like I was not”. This might have been one of the biggest difficulties for both the participants and I. There is also the possibility that the participants would have told their stories differently or told different stories, had I been an outsider to them or the profession.

I recognise that in presenting the themes captured from the participants’ experiences I may have suggested more similarities among them than existed. Here again I ran the risk of presenting the experience as though it was universal to all.

Of particular importance is that some of the participants’ stories within the chapter on becoming overwhelmed were focused around a significant period of time when life on the ward had reached crisis point. It is therefore questionable as to how far one can go to interpret those experiences as being common experiences. There is no doubt the participants’ experiences at that particular time was life changing and is likely to influence how they continue to view their lived time with the children with burns.

Another issue of significance is that there is only two hospital play specialist in this thesis. Thus, the possibility to generalise the findings from that small number and to highlight their experiences separately did not seem feasible. It is possible that their experiences might have been different had there been a larger number, and perhaps it might have had a distinct impact on the findings. However, as their

experiences and stories are not easily distinguished because they were grouped collectively it can be concluded that this study was just an experience of caring for children with burns.

Reflections of the researcher

The qualitative researcher is said to do well to “make explicit our understanding, beliefs, biases, assumptions, presuppositions, and theories” rather than putting it aside as if they don’t exist (van Manen, 1997b, p. 47). Ashworth (1997) believes that credibility of the findings is increased if researchers first make explicit their pre-suppositions and acknowledge their subjective opinions. If personal prejudices and values are said to be influential in the way people encounter their world and their experiences in this world then my situated-ness in this research and my own history will not constitute an obstacle, rather it makes the research more meaningful (van Manen, 1997b). Thus to remove my personal beliefs, values and descriptions about the nature of working with children with burns will mean that my purpose for a qualitative transformation cannot be fulfilled, thus bringing to a halt any possibility for interpretation. Van Manen (1997b) declares that when research is undertaken it is not because the researcher knows too little about the experience that they want to understand, it is rather that they know too much.

Indeed there are many who recognize and support the subjectivity that the researcher brings to the study through the skills of reporting and interpreting data (Schutz, 1994). Thus, as the human instrument who carries out the research, the researcher builds upon his or her tacit knowledge as much as, if not, more

propositional knowledge (Lincoln & Guba, 1985). It is well established that the researcher is an essential part of the world he/she studies (Munhall, 2001; Sandelowski, 1993; van Manen, 1997b). Therefore, rather than being seen as a source of bias, the researcher's personal experience is a source of data to be reflected upon to enhance interpretation and understanding (van Manen, 1997b).

The reflective journal as previously mentioned allowed for flexibility to go back to my notes and jolt my thought processes as new questions from the data arose. I kept an open mind without expectation that the participant's experiences would be a reverberation of my own past experiences. It was important that I paid attention to my own understandings and expectations of the substance that stories revealed as data was being analysed. However, as a novice researcher this proved difficult as I strove to listen with care, trying not to lead the interview into a particular direction or prematurely interpret meaning that could easily distract my listening.

Prior to undertaking this study I had experienced a devastating personal loss and am still picking up the pieces of my life changing experience. This occurred while I was in the midst of helping several of the participants through a critical period on the ward which required all of them to receive professional psychological assistance. As a consequence, I struggled with the interviewing process including working with the data as some of participants' related accounts triggered within me intense personal emotions. I found it necessary to seek professional help and was advised to pace out the interviews with breaks every few weeks. This made data collection problematic.

Finally, as a result of my own struggles throughout the process of this study I cannot help but wonder how many other researchers wear the mask that conceals their real feelings and emotions, and to what extent does the research affect them; and how do they deal with their emotions? Finally, to know what is it that enables researchers to persevere and not give up along the way is a crucial aspect of research that I believe needs exploration.

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Appendix One

Participant Information Sheet

Project Title

The lived experience of nurses and hospital play specialists who care for children who have suffered burn injuries. An interpretative phenomenological study.

Nurses and hospital play specialists who have worked on the paediatric burn ward for no less than one year are invited to volunteer their participation in this study. The researcher, Dorothy Isaac, enrolled at Auckland University of Technology will be undertaking the research as part of a Master of Health Science Degree.

The purpose of this study is to gain a better understanding of your experiences, feelings and perceptions when caring for children who have suffered burn injuries. Drawing on your experiences will provide insight that will make understanding of the experience known to others.

If you agree to participation after reading this information sheet and you have had the study explained to you, you will be asked to sign an informed consent to willingly take part in a minimum of one interview with the researcher. During the interview you will be asked to describe your experiences, feelings and

perceptions, and overall experience in regards to working with children with burns. It is expected that the interview will be no more than one hour however, you may be contacted by the researcher if more information is required or for verification of information. The interview will be audio-taped with some note-taking done by the researcher. Participation is entirely voluntary. Even after the interview begins you may freely refuse to answer any specific question or terminate the interview at any point. Any information shared with the researcher will not be given to any other person and reports of this study will not identify you in any way. Your participation or non-participation or refusal to answer questions will not affect your working relationship with the researcher or employment status.

While there are no anticipated risks associated with this study, the session may trigger memory of distressing experiences. Professional counselling support will be available if you experience any discomfort, stress, emotional distress or cultural dissonance as a result of your participation.

Professional support through the Employment Assistance Programme is available through the organisation, at no cost to you, for psychological, emotional or physical discomfort or stress that may arise during or as the result of your participation in the study

This study will help develop better understanding of the experiences of nurses and hospital play specialists who work with children suffering burn injuries. The findings are expected to inform and provide recommendations for best practice

guidelines to enhance the quality of care delivered and provision of professional support for nurses and hospital play specialists within this care context.

All information disclosed by participants, including information that discloses identity, will be stored in a locked cabinet and will only be available to myself and the supervisor of the study. The audio tapes of the interview will only be heard by myself, a dictaphone typist and the supervisor. The tapes will be stored in a locked cupboard. At no stage will any information regarding any participant be released to any other persons. Data will be coded so that any identifying information will be removed from the documentation.

The signed consent forms will be securely stored separately from the data. Each participant in the study will be assigned a pseudonym at data collection and on transcribing of data. Steps will be taken to disguise or omit any information shared by a participant during the interview that may easily identify the participant. Participants will be asked to verify their transcripts and data analysis prior to reporting the information.

Your privacy will be protected and respected at all times.

There are no financial or personal cost associated with participation in this research study.

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, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz , 917 9999 ext 8044.

Researcher Contact Details: Dorothy Isaac, Clinical Nurse Educator

DIsaac@middlemore.co.nz

Ph: 09 2760044 Ext 7145

Project Supervisor Contact Details: Dr Marion Jones marion.jones@aut.ac.nz

Thank you for taking the time to read this information sheet

Appendix Two

Consent to Participation in Research

This form is to be completed in conjunction with, and after reference to, the AUTECH Guidelines (Revised January 2003).

Title of Project: **The experience of caring for children who have suffered burn injuries**

Project Supervisor: **Doctor Marion Jones**

Researcher: **Dorothy Isaac**

- I have read and understood the information provided about this research project (Information Sheet dated 6th December 2004.)
- I have had an opportunity to ask questions and to have them answered.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research.

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on
<click here and type the date ethics approval was granted> **AUTEC Reference**
number <click here and type the AUTEC reference number>

Note: The Participant should retain a copy of this form.

Appendix Three

Typist Confidentiality Agreement

Title of Project: The lived experience of nurses who care for children who have suffered burn injuries. An interpretative phenomenological study.

Project Supervisor: Dr Marion Jones
Researcher(s): Dorothy Isaac

I understand that all the material I will be asked to transcribe is confidential. I understand that the contents of the tapes can only be discussed with the researchers. I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Typist's signature:

Typist's name:

Typist's Contact Details:.....
.....
.....

Date:

Project Supervisor Contact Details: Dr Marion Jones marion.jones@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on
<click here and type the date ethics approval was granted> AUTEK Reference
number <click here and type the AUTEK reference number>

Appendix Four

Examples of questions:

Thank you for your willingness to participate in this study. I am interested in knowing more about your experience as a paediatric burn nurse.

Could you describe in as much detail as possible what a typical day is like for you on the burn ward?

Is there an experience that was particularly meaningful?

Could you tell me what happened in the situation you mentioned?

Can you give me a more detailed description of what happened?

What were you feeling at the time?

Are you able to describe those feelings?

Is there anything more you would like to say before we end this interview?

Follow up questions:

What was that like for you?

Are you able to describe them?

What did you do when you felt....?

Do you feel like that in other situations?

Could you say something more about that?

Are there any other reasons?

What do you do when that happens?

Could you give me an example?

Are you able to remember what you did?

Did you try to do anything about that?

Appendix Five

MEMORANDUM



Student Services Group - Academic Services

To: Marion Jones
From: **Madeline Banda**
Date: 23 June 2004
Subject: 04/112 The lived experience of nurses who care for children who have suffered burn injuries. An interpretive phenomenological study

Dear Marion

Your application for ethics approval was considered by AUTEK at their meeting on 14/06/04.

Your application has been approved subject to amendment and/or clarification of the following:

1. Provide indicative questions
2. F4 – provide justification for non-destruction of data
3. Typist Confidentiality agreement should be used
4. Information Sheet, 2nd paragraph: Nurses 'may be' more...
5. The researcher should identify herself and the fact that she is undertaking the research as part of a degree should be explicit in the Information Sheet

Please consider this point/these points and provide a response to me in writing, as soon as possible. Please note that where approval is given subject to specified conditions being met, this does not constitute full approval. The conditions must be met before full approval is granted and research can begin. Please quote the application number and title in all correspondence.

Yours sincerely

Madeline Banda

Executive Secretary

AUTEC

CC:

disaac@middlemore.co.nz

9302801 Dorothy Isaac

Appendix Six

MEMORANDUM



Student Services Group - Academic Services

To: Marion Jones
From: **Madeline Banda**
Date: 5 July 2004
Subject: 04/112 The lived experience of nurses who care for children who have suffered burn injuries. An interpretive phenomenological study

Dear Marion

Thank you for providing clarification and/or amendment of your ethics application as requested by AUTEK.

Your application is approved for a period of two years until 5 July 2006.

You are required to submit the following to AUTEK:

- A brief annual progress report indicating compliance with the ethical approval given.
- A brief statement on the status of the project at the end of the period of approval or on completion of the project, whichever comes sooner.
- A request for renewal of approval if the project has not been completed by the end of the period of approval.

Please note that the Committee grants ethical approval only. If management approval from an institution/organisation is required, it is your responsibility to obtain this.

The Committee wishes you well with your research.

Please include the application number and study title in all correspondence and telephone queries.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M. Banda', with a stylized flourish at the end.

Madeline Banda

Executive Secretary

AUTEC

Cc: disaac@middlemore.co.nz

Appendix Seven



MEMORANDUM

Academic Services

To: Marion Jones
 From: **Madeline Banda**
 Date: 18 May 2005
 Subject: Ethics Application Number 04/112 **The lived experience of nurses who care for children who have suffered burn injuries. An interpretive phenomenological study.**

Dear Marion

I am pleased to advise that your request to amend this approval by the inclusion of the play specialist along with the nurses in the interviews of staff in the burns unit has been approved by the Chair of the Auckland University of Technology Ethics Committee (AUTECH).

I remind you that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online at <http://www.aut.ac.nz/resources/research/ethics/ea2appendixg.doc>, including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online at <http://www.aut.ac.nz/resources/research/ethics/ea3appendixh.doc>. This report is to be submitted either when the approval expires on 5 July 2006 or on completion of the project, whichever comes sooner;

You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented.

Please note that AUTEK grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 917 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Dorothy Isaac disaac@middlemore.co.nz