

# The Lived Experience of Paediatric Nurses' Caring for Children with Non-Accidental Head Injuries

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A thesis submitted in partial fulfilment of the requirements of the degree  
of Masters of Health Science at Auckland University of Technology

March 2018

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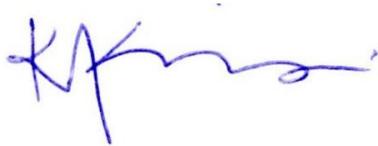
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## ATTESTATION OF AUTHORSHIP

"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 the award of any other degree or diploma of a university or other institution of higher learning."

SIGNED:

A handwritten signature in blue ink, appearing to be 'K. K. K.', written in a cursive style.

DATED: 2<sup>nd</sup> March 2018

## ACKNOWLEDGMENTS

All glory to God, who by his love and grace, I found my way. Through him I was strengthened in; my spirit; my resilience; my passion for knowledge; my ability to be open to new opportunities and my ability to love, and be loved.

*"I can do all things through him who strengthens me" Phillipians 4:13*

This journey started to create a new chapter in my professional life. Like many plans made before embarking on great journeys, I was led along a path I did not expect. Through my association with AUT not only did I expand my professional knowledge in nursing research and paediatric nursing, I also created a new chapter in my personal life. Meeting my (now) husband, getting married and having a son, added a new dimension to my journey that I will ever be grateful for. The many events that conspired throughout the duration of my master's journey have brought about the need to thank so many wonderfully supportive people who have journeyed alongside me in ways I could not appreciate more.

This study is based on paediatric nurses' experiences of caring for children who have suffered child abuse. It fills me with much sadness to know that some children endure life in these tragic circumstances. Acknowledging these children is therefore of vital importance. To all the children who have suffered, who are suffering, and will suffer abuse; and to those who have died as a result, this study is dedicated to you.

I would like to give enormous thanks to the six nurses who agreed to participate in this study. The experiences you provided in the telling of your stories gave me great insight into your nursing life. This study was based solely on those stories and would not have been possible without you and your support for this vital piece of research.

Without great leadership and guidance in the ways of phenomenological research I would have been lost. To Annette Dickinson and Shayne Rasmussen, my invaluable guides; my supervisors, thank you! Your passion for this study, was at times, more present than my own. Your knowledge and insight in the fields of paediatric nursing and qualitative research astound me. Your support and faith in my ability to carry out this study never ceased. Your passion for paediatric nursing is inspiring. You both

walked this journey with me in ways I will always be grateful for. I hope you are both just as proud of the final product as I am.

I started this journey as an individual and ended it as part of a whole. I now have a little family that I can call my own. Thank you to my most loving husband, Chris. By completing your own Masters degree, you paved the way for me to follow. There is nothing more precious than a partner in life who shares the same passion for learning and growing, and understands the commitment and mental ability required to carry out a research study. How blessed have I been, to have met you along my journey. Thank you for *us*.

To my son Israel: Baby, you were with Mummy with every step I took along this journey, from the little lemon in my tummy, to the amazing, vibrant and loving 2-year-old you are today. Never have I known a love like this. Experiencing being a mother to you has given me so much more perspective in life, and gave me the push I needed at times to complete this study, in the great hope that children of your age won't have to suffer in the ways the children in the stories of my participants have suffered. To my step-son Kosta, thank you for adjusting to a new life with a baby brother, and a step-mum who will always love you as her own. You have been a delight to get to know, and have helped both your Dad and I to get our studies done by helping out with Israel.

I wish beyond measure, that Mum and Dad could be here to see me along my journey. Mum, I missed the companionship and unwavering support you would have given me. Dad, I missed the look of pride you would have given me when I told you I had submitted. Though you are not here, you have equipped me with so many valuable tools that have helped me along this journey.

Thank you to my amazing family. Your support for me on this journey has been unwavering. The help with babysitting, the encouraging phone calls, the visits, the motivational talks and the spiritual guidance, are all part of the wonderful support you have given me which I will treasure always. To my aunties and uncles who have so willingly stepped into the roles of Mum and Dad in their absence, giving me the support and encouragement so like that of a parent, my heartfelt thanks. To my sister

Kelly, my sister from another mother Alicia, and my cousins who are like brothers and sisters to me, thank you also for providing the support only siblings can provide.

I wish also to acknowledge the incredible support I have received from my husband's family. Thank you for embracing me as one of your own and taking so much interest in my studies. To Ela and Fainga'a Puli'uvea, your love and commitment to your family is inspiring. Thank you for being parent figures to me, and supporting me as you would your own daughter. The help you have provided especially in the care of Israel, has been invaluable. I hope to make you proud of my achievements in the completion of this study.

I would like to thank my ex colleagues and newfound friends in the HES faculty equity team at AUT. Special thanks to Juliet Nanai who has supported me in every way I could imagine. Being able to have a space where I could write, surrounded by like-minded individuals gave me the motivation I needed at times to keep going. The laughter that came out of your office speaks highly of your ability to engage with students on a personal level and uplifting manner.

I would also like to acknowledge my experience working at Starship Children's Hospital and the staff who I worked with. In this environment I was inspired by many of my colleagues with their passion and commitment to paediatric nursing. It has been a great privilege to walk alongside children and their families on their quest for wellness. This experience has left me with great admiration for the staff who work tirelessly to heal and restore their patients. My passion for carrying out this research study stems from the enormous respect I have for nurses who often work beyond their physical and emotional capabilities in the hope that they have made some difference in the lives of the children and families they care for.

Thank you to Meg Beswick who transcribed the interviews of my participants, and to Margi Keys who formally proof read my complete manuscript.

Along with my family and friends, I would like to give great thanks to Mike, Jenine and Thom who were so instrumental in my personal journey. Your dedication to my success is appreciated more than I can express in words.

*Ou te fa'afetai ia i latou uma sa matou savalia fa'atasi le taumafaiga mo leni  
fa'amoemoe. Fa'amanuia le Atua.*

This study was granted ethics approval from the Auckland University of Technology  
Ethics Committee on 20<sup>th</sup> April 2015 (15/78)

## ABSTRACT

Child abuse remains a significant issue in New Zealand and rates of non-accidental injuries continue to rise. Non-accidental head injury (NAHI) is a major cause of mortality in young children; further, a considerable proportion of survivors will live a life with severe developmental and neurological dysfunction. The aim of this research study is to describe, using the interpretive hermeneutic phenomenological approach, the phenomenon of the lived experiences of nurses who care for children and their families who are admitted to hospital with head injuries of a non-accidental nature. This study offers an understanding into the experience of nursing children with NAHI.

The philosophical underpinnings of hermeneutic phenomenology, guided by the writings of Heidegger and van Manen were used to design and carry out this research study. Semi-structured interviews were conducted with six nurses who had at least two years' experience of nursing children with NAHI in Auckland, New Zealand. Transcripts of the interviews were analysed with the rich participant stories, uncovering the lived experiences of working in this challenging area.

Two overarching themes emerged. Nursing children with NAHI is *different* from the care of children admitted with accidental injuries or medical conditions. Nurses experience is different in the protocol that is followed when children are admitted to hospital; in the complex nature of relationships between the nurse and the family; and in the tension arising from maintaining a non-judgmental approach towards families.

Nursing children with NAHI requires the nurse to adopt *protective* qualities, conceptualised in this study by the form of a shield. These qualities are used as a form of self-protection to minimise the distress of the circumstances surrounding the child's injuries, as well as a mechanism to protect their relationship with the child's family. These protective qualities are manifested in their care through an acute awareness of their role as a nurse; creating and maintaining professional boundaries; and shifting the focus of their care towards the child.

The data raises important discussion points surrounding the emotional labour required of nurses caring for children with NAHI and their families; the maintenance of a professional demeanour; and implementing and sustaining a family-centred care approach. The findings have highlighted areas in this practice setting that are

challenging to normally fundamental aspects of paediatric nursing practice.

Recommendations have been made to support the improvement of nursing children and their families with NAHI which acknowledges this area of practice as unique and specialised in its complexity and emotional labour.

# Chapter 1 INTRODUCTION

## 1.1 Introduction

*"Our children are our taonga. All children have a right to full emotional, spiritual and physical well-being, to develop their own potential in an environment which is nurturing and protective and in which they feel safe from abuse."* (Auckland District Health Board [ADHB], 2016b, p.1)

Child abuse has become a significant issue in New Zealand and rates of abuse continue to rise (Kelly, John, Vincent, & Reed, 2015; Wynd, 2013). Non-accidental head injury (NAHI) results from abuse to the head. It is a major cause of mortality in the first three years of life with a considerable proportion of survivors consequently living a life with severe developmental and neurological dysfunction (Finnie et al., 2012; Gerber & Coffman, 2007). NAHI is the leading cause of severe injury and death in children under two who have been abused (Niederkrötenhaler, Xu, Parks, & Sugerman, 2013; Paul & Adamo, 2014). In many cases, the perpetrator is a close member of the family. When a child is admitted to hospital with injuries from abuse, nurses are often at the forefront of delivering care and have intimate interactions with the child and their family.

While working within this acute setting as a paediatric nurse in Auckland, New Zealand, I encountered children who had been abused and suffered tragic injuries. These situations were one of the very few nursing experiences where I felt completely unprepared. The degree of emotional turmoil I felt near the beginning of my practice as a staff nurse was, at times, overwhelming. Over time and with more experience, I began to develop strategies to keep my emotions about the situation separate from my commitment to caring for the child. Nursing these children and their families then became easier. On reflection, I am unsure if this was helpful. With more and more admissions of children with inflicted head injuries I began saying to myself "oh there's another one". Had I become so accustomed to children with these tragic injuries that I had forgotten to question, why? Why, when I first began caring for these children and their families, did I feel unprepared? The 'tough' façade I was portraying became the 'normal', and made nursing easier. Over time, however, I could not ignore the strong emotions I felt within, which conflicted with what I was showing outwardly. Why was

there such an emotional tug-o-war? These questions have stayed with me. Now I ask, how does a nurse *be* a nurse when there are potentially conflicting emotions inside, while remaining professional on the outside?

Child abuse has the potential to evoke strong emotional reactions within nurses who are at the forefront of care of the child and their family, especially when a family member is the suspected perpetrator. Personal values and judgements may conflict with what is required to maintain professional practice. What does it mean to nurse in situations like these? How do nurses negotiate their personal values, emotions, and judgements to uphold professionalism while caring for children who have been abused?

This chapter will provide background and context to the study, giving a brief overview of the methodology as it pertains to the initial stages of developing the research question. The purpose of the study will be outlined followed by explaining the phenomenon. A summary of the thesis in its entirety will conclude the chapter.

## 1.2 What is the purpose of the study?

This study is devoted primarily to the nursing of children and their families in extremely tense, stressful, and heart-breaking circumstances of a child hospitalised with a non-accidental head injury. For many paediatric nurses, this is their everyday reality. Nursing a child who presents with non-accidental head injuries from abuse, can evoke a broad range of thoughts and emotions. In my experience, these thoughts and emotions were often not voiced or shown. What does it mean for nurses to be in these situations? How do nurses navigate professional responsibilities, protocols, care plans and family-centred care, when caring for these children and families? How do nurses consider their duty to other patients in their care? Amid all that needs to happen, what is it to be a nurse in these situations?

The purpose of this study is to use a hermeneutic phenomenological approach to bring light to **“The lived experience of paediatric nurses’ caring for children with non-accidental head injuries”**. By drawing on the works of Heidegger and van Manen to interpret the nurses’ stories, it is hoped meaning will be uncovered, demonstrating truth to their experiences. Nursing research has leant towards more interpretive approaches, as they reveal the depth and diversity of nursing knowledge and are

aimed at understanding human phenomena which is embedded in experience (Mackey, 2005). Through the telling of their stories, it is hoped to gain insight into the phenomenon of nurses caring for children with NAHI. What exists in the day-to-day routine of caring, that identifies this experience as unique to NAHI? What exists in the interaction between the nurse and family while the *doing* of nursing care happens?

The phenomenological lens encourages the researcher to pay attention to the experiences of the participants and the way they live them through 'thoughtfulness'. Thoughtfulness being a caring and mindful pondering of ones undertaking of life, of living, and what it means to live a life (Heidegger, as cited in van Manen, 1990). Thoughtfulness can give new or rediscovered meaning to the phenomena. This approach enables participants to acknowledge their humanness: their vulnerability to emotions, and how easy it can be for conflict to arise in the thinking and the *doing* of nursing. An important outcome of this study will be that nurses can engage in open and honest conversation, creating deeper awareness of potential complexities of practice and insight gained into *being*; a person, a nurse.

The aim of this research study is to describe, using the interpretive hermeneutic phenomenological approach, the phenomenon of the lived experiences of nurses who care for children and their families who are admitted to hospital with head injuries of a non-accidental nature. With the telling of their stories, it is hoped that, through interpretation of the nurses' experiences of the (assumed) complexities of caring for these children and families, the essence of their *nursing* will be uncovered.

By finding meaning in the experiences of nurses caring for children with NAHI, practice can only improve. With continued dialogue and openness, it is anticipated that this study may pave the way for future qualitative research studies that will continue to add knowledge and depth to this topic, in the nursing and wider multi-disciplinary professions.

### 1.3 The non-accidental head injury (NAHI)

Non-accidental head injury (NAHI) is a diagnosis understood by various terminology. Among the various terms used in practice are: abusive head trauma (AHT), shaken baby syndrome (SBS), inflicted traumatic brain injury (TBI), infant whiplash-shake injury syndrome, and intentional head injury (Parks, Kegler, Annett, & Mercy, 2012).

Originally, the term SBS was used to describe a collection of injuries assumed to have been caused by the violent shaking of infants (Frasier, Kelly, Al-Eissa, & Otterman, 2014). SBS is characterised by acute encephalopathy with subdural or subarachnoid and retinal haemorrhages, combined with an inconsistent history as to how the injuries occurred (Gill et al., 2009). This triad of symptoms (encephalopathy, subdural/subarachnoid haemorrhage, and retinal haemorrhage) implies a mechanism of injury where tearing of the bridging veins occurs as a consequence of shaking (Paul & Adamo, 2014). However, this has yet to be experimentally proven, and does not account for impact injuries (Frasier et al., 2014; Paul & Adamo, 2014). The terminology used more recently reflects a greater understanding of the mechanisms of injury. AHT and NAHI are now the preferred terms used (AHT is predominantly used in American publications, and NAHI in the United Kingdom/Australia/New Zealand publications) (Christian & Block, 2009; Frasier et al., 2014; Gill et al., 2009; Hinds, Shalaby-Rana, Jackson, & Khademian, 2015; Parks et al., 2012). NAHI or AHT reflects the brain injuries children have experienced as a result of abuse; it includes shaking, shaking with impact, impact alone, crushing injuries, or a combination of these mechanisms (Frasier et al., 2014). For the purposes of this study, the term NAHI will be used. Although the term AHT is more prominent in much of the literature, the participants in this study are more familiar with NAHI which is used within their work environment.

#### 1.4 The nursing and caring

Caring is a fundamental component of nursing education, health legislation, and codes of ethics for nurses (Austgard, 2008). Nursing is regarded as a caring practice in which the science is guided by the moral art and ethics of care and responsibility (Benner, 1984). Caring is integral to nursing practice associated with health promotion, illness prevention and health restoration (Watson, 1999). Watson (1999) defines caring in nursing as a human-to-human process expressed by therapeutic interpersonal interactions.

To be a nurse, one must have some predisposition to caring. Caring is at the core of the nursing profession (Sargent, 2012; Shields, 2014). It could therefore be assumed that the experience of nursing will always be composed around some notion of care. Watson's (1999) definition of care places significance on the interpersonal relationships between the nurse and the patient in nursing care. It is in the evaluation

of these relationships that one might determine if the caring aspect of their nursing practice is successful or not. In paediatric nursing, the family are an integral component of care for the child. The family are acknowledged as an essential part of the child's care and illness experience (Hockenberry, Wilson, Winkelstein, & Kline, 2003). The relationship between the nurse and the family may now be seen as significant as the relationship between the nurse and the child.

In many hospitals worldwide, family-centred care (FCC) concepts form the basis of paediatric nursing care (Butler, Copnell, & Willetts, 2014). Family-centred care is a care delivery model that integrates a partnership between the family and health provider with care for the child (Frazier, Frazier, & Warren, 2010). As the deliverers of care, nurses are particularly active in initiating and carrying out FCC. Open and honest communication between the nurse and family is paramount. Family-centred care involves respect, collaboration, participation and sharing of information (Frazier et al., 2010). Family are acknowledged as the experts in many aspects of care for their child, and their knowledge and skills are respected (Irlam & Bruce, 2002). If FCC is an integral component of care, and successful interpersonal relationships between the nurse and family are essential in the caring of the child, how does the nurse negotiate care when a family member of the child has inflicted the injuries that have led to hospital admission?

## 1.5 The hospital context

This study was situated in the Auckland region. Of the three hospitals that serve the region, one is a dedicated children's hospital and two hospitals have paediatric units or wards within a larger adult hospital. These two hospitals may provide some services to children and families presenting with suspected child abuse and neglect. More severe cases (as would be the case with children with suspected NAHI) would be referred on to the city's main specialty children's hospital. At the two smaller paediatric units, there are general policies and procedures for health professionals to follow when encountering possible child abuse and neglect. As well as these same general policies and procedures, the larger specialty children's hospital also has clinical guidelines for health professionals to follow (there is no protocol or guideline specifically for NAHI). For this reason, the policies, procedures and guidelines for care in this hospital will be used as a reference point in this study (ADHB, 2016a, 2016b).

It is recommended by ADHB, that the policy and guidelines be used in conjunction with each other. The clinical guidelines are not nursing specific. However, there are elements of nursing involvement. As nurses may be a part of the first encounter the child and family have with the hospital, and are indeed an integral part of the care of the child, it is therefore important that nurses are aware of the steps that need to be taken in these cases.

### 1.5.1 The multi-disciplinary team

The policy for child abuse, neglect, care and protection that guides clinical practice states that:

Effective child protection assessment and intervention requires active liaison between disciplines and with whanau, statutory agencies and the community. Health services must work collaboratively and in partnership with relevant services and groups from all the cultures and communities where children live. (ADHB, 2016b, p.3)

This multi-disciplinary approach is vital for care of the child and family with NAHI. The Ministry for Vulnerable Children, Oranga Tamariki (MVCOT) is a governmental ministry dedicated to supporting any child in New Zealand whose well-being is at significant risk of harm (Ministry for Vulnerable Children Oranga Tamariki, 2018). Together with the police and hospitals (via their governing district health boards (DHBs)) there is a mutual commitment to working together to achieve good health and safety outcomes for children and young people (Child Youth & Family New Zealand Police District Health Boards, 2011).

Te Puaruruhau is a multi-disciplinary child protection team within the Auckland region that liaise closely with Police and MVCOT, and hospital staff. This team co-ordinates most aspects of care related to confirming the suspected injury as abuse, as well as the social and legal elements of the case. The consultant paediatrician in this team will work closely with the consultant paediatrician of the specialty service related to the injuries. For children with suspected NAHI this could be the Paediatric Intensive Care Unit (PICU) consultant, neurosurgical, neurology or general paediatrics consultant. The nurse managers, nurse specialists and staff nurses work closely with the medical teams in conjunction with physiotherapists, speech language therapists, occupational

therapists, dieticians and health care assistants. The clinical nurse manager (formerly named the duty manager) must remain informed of all aspects of the child's admission and status as they manage all aspects of staff, as well as patient admissions within the hospital.

### 1.5.2 Admission protocol

On presentation to hospital of the child where non-accidental injury is suspected, an initial assessment is conducted and the Te Puaruruhau paediatrician is contacted immediately. The paediatrician and social worker see the child and family as a joint consultation. Nurse specialists from Te Puaruruhau and ward nurses support the completion of a thorough history, examination, and relevant investigations. These investigations include blood tests (to determine if bruising or bleeding may be caused by a bleeding disorder), urine organic acid tests (especially important for NAHI to screen for the presence of the condition Glutaric Aciduria Type 1 which can (rarely) be mistaken for NAHI), skeletal surveys (usually in children under two), CT head scans and MRI brain scans are undertaken. The last two are undertaken where NAHI is suspected and neurosurgery is indicated.

Culturally appropriate support is always considered. If language is an issue, the use of an interpreter is essential. For Māori whanau (families), a referral is made to He Kamaka Waiora when child protection issues arise. Kaiatawhai will follow up this referral and explain to the family what their service provides from a cultural perspective. Pacific families may access Pacific Health Navigators from the Tautai Fakataha Service through referral if necessary. All assessments and interventions should be carried out with regard to the principles of the Treaty of Waitangi and relevant legislation (ADHB, 2016a).

Te Puaruruhau liaises with Police and MVCOT under Schedule One of the National Memorandum of Understanding between the DHB, Police and CYF (now MVCOT) (Child Youth & Family New Zealand Police District Health Boards, 2011). Under this schedule, an inter-agency case conference is required within 24 hours of admission. During this time, a draft of an inter-agency multi-agency safety plan is developed. This plan is completed over the child's admission prior to discharge, under consultation with MVCOT with an agreed set of recommendations for follow-up after discharge.

A separate Paediatric Safety Plan (see Table 1) is also mandatory for all inpatients under assessment by Te Puaruruhau. This plan must remain in the clinical notes and a copy given to the clinical nurse manager. It is completed by a health social worker and is especially important for ward nurses to be aware of, as they are at the bedside more often than any other health professional.

Table 1. *Paediatric Safety Plan*

<b>Current Situation:</b>	Brief summary of current care and protection concerns
<b>Custody / Guardianship:</b>	Who will be signing consent forms
<b>Previous Safety Plans and dates:</b>	Antenatal. Multi-Agency Safety Plan, other
<b>24 Hour Watch:</b>	Details
<b>Plan (if family try to remove the child)</b>	Code Orange / Police / CYF
<b>Access/visiting arrangements:</b>	How it will be managed, requirements
<b>Te Puaruruhau contacts:</b>	Including after-hours social work
<b>CYF contacts:</b>	
<b>Police contacts:</b>	
<b>Alternative contacts:</b>	

<b>Who to contact if child is likely to die:</b>	Police / CYF / Te Puaruruhau
<b>Social Work support:</b>	
<b>Other considerations:</b>	

*From Starship clinical guidelines: Abuse and neglect. ADHB 2012*

Another mandatory safety measure to be put in place on admission is the presence of a 24-hour watch. The watch is most often a health care assistant or enrolled nurse and must remain with the child at all times. Their role is to watch over the child (the term 'watch' is used in all hospital guideline documents), and is an added measure of safety for the child, especially in the early stages of admission where it may not be clear who has caused the injuries to the child. A charge nurse, clinical nurse manager or ward nurse gives the watch clear instructions (written and verbal) about the situation and what is required regarding care for the child. The nursing staff will supervise and liaise with the watch throughout the shift, regarding care requirements and any concerns they may have. The watch maintains a regular written record of their observations (for example, any activity of the child and interactions between the child and family/visitors present), throughout the shift and this record forms part of the clinical notes. The family must be given an explanation of the role of the watch on admission and this is usually carried out by the medical team, or the clinical nurse manager, ward nurse manager or nursing shift coordinator on the ward.

### 1.5.3 Ongoing care

As mentioned earlier, there are no guidelines specific for nursing care of children and families with NAHI. A move to individualised care plans means every child one specifically suited to their care needs; it is completed on admission by the nursing team. For children admitted with suspected NAHI, this care plan should be followed in conjunction with the Paediatric Safety Plan and any other stipulations made by Te Puaruruhau. The nursing team is likely to, at times, be the liaison between the family and other health professionals. They must also be aware of the family and other visitors who are present or intending to visit and at times may need to coordinate visits

of certain family members. The ward nurse allocated to the care of the child must also supervise and work closely with the watch. Nursing care specifically related to the brain injuries of the child will be similar to the care required for any head injury, depending on the severity. As with any child sustaining a head injury requiring admission to PICU or the Intensive Observation Area (IOA) of the neuroservices ward, the child will be monitored constantly with a nurse always by the bedside. Neurological assessment will be conducted hourly or every two hours as clinically indicated: observing changes in neurological condition, raised intracranial pressure (ICP), monitoring head circumference, fontanelle and wound sites. As required, seizure management, fluid management, pain management and wound management are also included in the care plan. The ward nurse is responsible for co-ordinating procedures and input from therapists, and managing the environment around the child (i.e. low stimulus and advocating for regular rest periods).

Generally, the guidelines, care plans, policies and protocols that need to be put in place when caring for a child with a suspected or confirmed NAHI add a certain amount of complexity to care; such complexity is not usually present when a head injury occurs from accidental means.

## 1.6 Significance of the study

The phenomenon in question is the nursing of children with NAHI. The goal is to bring light to the experiences nurses have with this phenomenon. It might be assumed that any experience will be formulated by how nurses perceive themselves in a situation of caring. Caring incorporates the child and their family, and it involves a degree of successful interpersonal relationships between both the child and the family, mostly in the form of family-centred-care (FCC). The ambiguity surrounding how this is performed, where complex family dynamics may accompany care of the child, highlights a very significant issue that needs to be addressed. There has been little research undertaken in this area of nursing practice highlighting its significance.

In New Zealand, child abuse is an important health issue to be addressed. It has become a priority for the government after many high-profile cases where children have been killed by family members. Government commissions of inquiry and a strong public outcry have taken place in order to prevent further tragedies (Fanslow & Kelly,

2016). With head injuries from abuse more likely to have a fatal outcome, the importance of examining how health professionals experience their care for these children, seems vital in gaining deeper understanding around this area of practice. Because of the significant consequences and unique conditions specific to head injuries of a non-accidental nature, the impact on nurses' experience may be different from previous research that have more generalised areas of interest. Understanding the unique experiences of nurses working in this specialised setting at the most acute stage of the injury will inform practice in regard to the significance of the issue for nurses working in the New Zealand context.

This study will provide awareness of the experiential intricacies involved in nursing care of children and families. By uncovering meaning in the nurses' experience, it is anticipated that there will be an understanding of the potential issues that may arise when caring for these children and their families, as well as an understanding of how nurses maintain relationships with families. This will inform the development of interventions which can support nurses in this situation.

## 1.7 Structure of thesis

This chapter has given an overview of the genesis of this study, and provided background information into the different aspects of nursing children in hospital with NAHI and their families. The purpose and significance of the study for nurses caring in this practice setting has been discussed.

Chapter two provides a review of literature pertaining to NAHI, and nursing in this context. The history, pathophysiology and prognosis of NAHI is initially discussed. The discussion points used in this section reflect the large quantity of literature available in this area of practice. What follows is an overview of the epidemiological features of NAHI at the international level and then, in the New Zealand context. This chapter concludes with an exploration of current literature available within the area of nursing children and families with NAHI.

Chapter three is dedicated to discussing the methodology of hermeneutic phenomenology and the methods employed to carry out the study, consistent with the philosophical underpinnings that inform them. Relevant philosophical terms will be defined as they pertain to the *doing*, *thinking*, and *writing* of this study. A complete

outline of each step in the method will be provided, including discussion and rationalisation for alterations in carrying out the study.

Chapter four and five are the findings chapters that provide analysis of the data translated into two themes. Chapter four outlines the theme *This is different* which includes three sub-themes of *there is a protocol*, *complexity in the relationship*, and *the non-judgmental approach*. These three sub-themes support an uncovering of meaning in nursing children with NAHI that is *different*. Chapter five is entitled *shield of protection* and is a theme that translates nursing practice in this area as needing protection. This is demonstrated in the sub-themes of *“it’s not my job”*, *the professional hat* and *shifting the focus*.

Chapter six is the final chapter that brings all of the findings together. The themes uncovered in chapters four and five, are conceptualised using Heideggers’ notion of *‘being’* and discussed in relation to three main aspects of care related to nursing children and families with NAHI. The chapter concludes with the strengths and limitations of this study, the implications for nurses, recommendations for nurses, educators, organisational and governmental leaders, and the indication for further research. In this chapter it is hoped that through the coming together of the information discussed, an understanding true to the lived experiences of nurses who care for children and their families with NAHI will be revealed.

## Chapter 2 LITERATURE REVIEW

### 2.1 Introduction

This chapter will include literature relevant to the phenomenon of non-accidental head injury (NAHI), and nursing the child and their family in hospital. Following on from providing a contextual background in Chapter 1, the literature review will provide an analysis of the different aspects of NAHI, the epidemiology and the New Zealand context. An historical review of NAHI in the literature will be followed by the relevant pathophysiology demonstrating the significance of the injuries a child may have. The prognosis or outcomes for children with NAHI will follow. Relevant epidemiological factors will be presented from an international and New Zealand perspective. To conclude, this chapter will discuss the current literature available about nursing the child with NAHI, working with the child's family, and the associated gaps in current research.

### 2.2 Search Methods

The primary databases used were CINAHL and MEDLINE through EBSCO host. Scopus and OVID were also used. Google scholar was useful when searching for specific articles. Reference lists of publications that were especially integral to the study were invaluable sources. The initial search criteria included 'non-accidental head injury', 'non-accidental injury', 'child abuse', 'New Zealand', and 'nurses' experience', in English with date limiters of 2000 to the present were other criteria. The reason for using date limiters was to source the most recent publications of nurses' experiences. The search strategy resulted in few research articles examining nurses' experience. However, much literature was found on the history of NAHI and the definition of the terms. It was discovered that NAHI had other terminology, predominantly in international publications. The search criteria were extended to include 'abusive head trauma', 'shaken baby syndrome' and 'inflicted trauma/injuries' with no date limiters (to capture the historical aspects of NAHI and the evolution of the terminology and research). Historical aspects of the differences in terminology and justification of diagnosis related to pathophysiology, assessment and radiological advances were common results. Epidemiological studies, risk factors and prognosis of children with NAHI were also prevalent among the search results. It appeared that much of the

literature found included review articles and quantitative studies authored by medical professionals.

On adding further keywords to the search to gather literature related to experiences of nurses ('qualitative', 'lived experience', 'nursing children', 'paediatric', 'phenomenology') only one additional result related to nurses' experience of caring for a child who had experienced abuse. Some literature was found from the nursing perspective. However, this was generally about identifying signs of possible abuse predominantly in the community. These were also review articles which were mostly quantitative studies. The search criteria were further extended to capture any health profession with experiences in this area, but they did not yield any results.

As a point of reference, a search was also conducted to find literature on nurses' experience of caring for children with any head injury using the same keywords and replacing 'non-accidental head injury', and 'abusive head trauma' with 'head injury', 'accidental head injury' and 'traumatic brain injury'. This also yielded no results.

The majority of the literature centred around quantitative research methods. Search results also included studies from New Zealand, mostly quantitative, based on reviews of services and large-scale studies looking at many aspects of NAHI over time. Overall, the literature search yielded a plethora of quantitative research on aspects of NAHI. These will follow in the subsequent sections. Just one study was found relevant to this particular area of study and will be discussed in the final sections (2.6, 2.7).

## 2.3 Non-accidental head injury (NAHI)

### 2.3.1 History of NAHI in the literature

French forensic physician Ambroise Tardieu first described brain injury from abuse in the medical literature in 1860 (Thardieu, as cited in Frasier et al., 2014; Roche, Fortin, Labbé, Brown, & Chadwick, 2005). He described effusions of blood over the brain in children subjected to severe abuse, ascribing these injuries to blows to the head. Although some of the terms used today (e.g. Subdural haematoma) were not used in France at that time, the descriptions of abuse seen and injuries acquired are similar to what is seen at present (Roche et al., 2005).

In 1946, radiologist and paediatrician John Caffey identified a group of children who suffered from chronic subdural haematomas and long bone fractures. He attributed these injuries to abuse compounded by a lack of explanatory history of trauma (Caffey, 2011). In the early 1960s Henry Kempe published an article on “The Battered Child Syndrome” which laid the foundations for the recognition of child abuse as a medical diagnosis (Kempe, Silverman, Steele, Droegemueller, & Silver, 1985). This article increased awareness of child abuse and was used as a basis for the medical, legal and child welfare approach subsequently seen in the USA (Frasier et al., 2014).

Building on the work of Dr Fred Silverman, an American paediatric radiologist who co-authored “The Battered Child Syndrome”, John Caffey continued his study on children with suspected abuse, supporting a diagnosis of child abuse when a trauma history was consistently lacking (Caffey, 1965). In 1972 and 1974, Caffey produced a series of influential publications describing the clinical and radiological features of violent shaking of an infant causing intracranial and intraocular bleeding leading to permanent brain damage and mental retardation (Caffey, 1972; Caffey, 1974). The term ‘infant shaken whiplash syndrome’ was adopted after Caffey’s 1974 study. Over time, the term “shaken baby syndrome” was adopted by the United States (U.S) medical community which described brain injuries associated with subdural haematoma and retinal haemorrhages without accidental or medical justification (Frasier et al., 2014). As radiological advances occurred, the diagnosis of head injury from abuse became clearer and more informed. However, what was being discovered did not fit exclusively into the SBS definition. Many other mechanisms of abuse were now being discovered, e.g. impact injuries, crushing injuries, shaking injuries, or a combination (Frasier et al., 2014). In 2009 the term ‘abusive head trauma’ (AHT) was adopted in the U.S to cover all mechanisms of injury (Frasier et al., 2014). Members of different disciplines are now educated about NAHI and there is a worldwide acknowledgment of NAHI and awareness which aids in diagnosis. To date, there is consensus among health professionals that support NAHI as a medical diagnosis (Narang, Estrada, Greenberg, & Lindberg, 2016). Nursing research has yet to catch up to the paediatricians, radiologists, neurologists and neurosurgeons with literature that informs NAHI from a nursing perspective. No literature addresses the history of nurses’ first encounters with NAHI, nor the history of adopting strategies for management of children

diagnosed with NAHI, and their families. It is possible that this piece of history in nursing was not documented.

### 2.3.2 Pathophysiology

Compared with adults, young children and infants have proportionately large and heavy heads with weaker cervical muscles and thin soft skulls (Allen, 2016). Head injuries in this population group are unique because the organ involved (brain) is in the process of development and maturation (Case, 2007). These anatomical differences mean a small amount of force can cause severe injury, and will further compound the impending injury process. The primary injury (acquired from impact force, or shaking) includes injuries to the brain tissue, retina and spine from linear or rotational forces (Allen, 2016; Deck et al., 2014; Payne, Fernandez, Jenner, & Paul, 2017).

Linear forces from acceleration trauma cause contusions or haemorrhages on the brain, the most common of these being subdural haematoma (SDH), and haemorrhages in the retina. Subdural haemorrhages occur where there is a rupture of one or more of the bridging veins within the space between the dura mater and arachnoid membrane (Allen, 2016). Retinal haemorrhages result from the head being subjected to repetitive accelerations and decelerations by shaking, where transmission of force through the lens and retina causes major traction leading to multi-layered and widespread retinal haemorrhage (Deck et al., 2014). The presence of spinal injuries (most commonly cervical spine injuries) has recently emerged as evidence of NAHI (Baerg et al., 2017). An infant is more susceptible to hyperextension and flexion of the neck from acceleration forces generated by shaking, due to their weaker cervical muscles and large relative head size.

Rotational forces cause twisting and shearing of brain tissue which can cause concussion and diffuse axonal injury (DAI) (Choudhary et al., 2015; Rose, Weber, Collen, & Heyer, 2015). These injuries occur when the brain accelerates at a different speed and angle from the skull because the head is not in a fixed position as the injury happens (Allen, 2016). Concussion results in brain dysfunction from the rotational forces exerted, and results from a neurometabolic cascade at the intracellular level, altering the neurometabolic state (Rose et al., 2015). DAI occurs at the time of impact

and results from shearing of the axons, small blood vessels, and very rarely, tears in brain tissue (Adams et al., 1989).

Secondary injuries are those that are influenced by the primary injury and occur at the cellular level. Cerebral blood flow is altered in this phase and causes cerebral oedema, which if present for a significant period, can lead to neuronal death (Allen, 2016). The blood brain barrier may be compromised due to structural damage to the brain from shearing injuries, increasing permeability and allowing in normally restricted molecules (Allen, 2016). Oedema can be a consequence of the structural, functional, cellular and molecular changes in the blood brain barrier. This allows excess fluid to accumulate in the interstitial spaces of the brain. Increased intracranial pressure (ICP) is a dangerous consequence with devastating outcomes: irreversible cell death through hypoxia, herniation, and death. It has been suggested that the longer the brain is in this phase of injury, secondary to the primary, the more likely the child will experience long-term disabilities (Casey, McKenna, Fiskum, Saraswati, & Robertson, 2008)

### 2.3.3 Prognosis / Future neurological outcomes

*“Given that abusive head trauma often causes severe and diffuse brain lesions in very young children, children with abusive head trauma are at very high risk for poor outcomes”* (Chevignard & Lind, 2014, p 549).

The most severe and devastating outcome for a child who has suffered an NAHI is death. The mortality rate is estimated at 20 to 25percent (Chevignard & Lind, 2014). If a child survives, the possibility of living with long-term neurological deficits/disabilities is dependent on the severity of the primary injury and impact of the resulting pathophysiological processes. Mortality and morbidity rates are higher for children with NAHI when compared with children suffering from injury of an accidental nature (Barlow, Thompson, Johnson, & Minns, 2004; Chevignard & Lind, 2014; Lind et al., 2016). In the short-term, after the acute phase of injury, children are likely to have decreased functional ability, suffer from seizures and have deficits in motor, cognitive and adaptive behavioural abilities (Chevignard & Lind, 2014).

The long-term outcome for survivors of NAHI is poor. A study by Barlow et al (2004) confirmed the high morbidity rate of survivors with NAHI. Sixty eight percent of survivors had significant morbidity, with 36 percent of those acquiring severe

neurological disabilities requiring long-term nursing support in the community. The disabilities seen were extensions of the pathologies seen in the acute phase of injury, and include delayed psychomotor development and motor deficits (central hypotonia, spastic hemiplegia/quadruplegia, ataxia, dystonia and cranial nerve abnormalities), sensory deficits (speech, hearing and visual deficits), and epilepsy. Twenty percent had remote symptomatic epilepsy secondary to the head injury, and 60 percent of those had intractable (uncontrolled) epilepsy. The significance here is that developmental delays and difficulties with speech and language, as well as motor and cognitive skills and behavioural abnormalities, are further exaggerated by uncontrolled epileptic seizures (Barlow et al., 2004). Cognitive deficits make up the majority of impairments in the long-term and include speech and language difficulties, intellectual disability and behavioural problems (Chevignard & Lind, 2014; Lind et al., 2016). Adaptive behaviour is especially impaired (e.g. the ability to perform daily living activities, communicate, and socialise) and, combined with other deficits, can have a profound impact on the child's future prospects (Chevignard & Lind, 2014).

There are three main factors that have been established as predicting poorer outcomes for children with NAHI: (1) The demographic and environmental factors such as low socio-economic status of the family, family instability and younger age when injured; (2) The initial clinical and radiological signs of severity of the injury, including lower Glasgow coma scores (GCS), presence and length of time of impaired consciousness, raised intracranial pressure (ICP), presence of seizures, the extent of retinal haemorrhages, the extent of lesions on the brain, and/or the need for cardio-pulmonary resuscitation (CPR); (3) post-injury factors such as decelerated brain growth, persisting unfavourable environmental conditions and intractable seizures (Chevignard & Lind, 2014; Lind et al., 2016). The study by Lind et al. (2016) looked at factors that promoted a favourable outcome for children with NAHI, and found, similarly, that better outcomes were achieved with children who had significantly higher educated mothers.

For the nurse, being aware of the potentially significant poor outcomes for children with NAHI can aid in focussed and informed practice. It may also add to the emotional turmoil the nurse may experience when confronted with the child and their family.

## 2.4 Epidemiology

### 2.4.1 International

Epidemiological features of NAHI show a relative consistency of incidence, etiology and risk factors throughout the literature world-wide. In the U.S, NAHI is the leading cause of severe injury in children who have been abused (Niederkröthaler et al., 2013; Paul & Adamo, 2014). It is estimated to account for 80 percent of deaths resulting from child abuse, responsible for killing over 250 children each year (Lopes, Eisenstein, & Williams, 2013). Children under one year have the highest incidence of NAHI (Hinds et al., 2015; Payne et al., 2017). The study by Niederkröthaler et al (2013) showed the incidence of NAHI in infants at 39.8 per 100,000 under the age of one year. Most estimates of incidence fall between 20 and 30 per 100,000 in the U.S (Hinds et al., 2015; Parks et al., 2012). Data from the United Kingdom showed an estimated incidence of 20 to 24 cases per 100,000 children under the age of one year (Payne et al., 2017). An international review of issues related to NAHI reported a similar estimated incidence of NAHI in studies from Scotland, North Carolina and Estonia (Frasier et al., 2014).

### 2.4.2 The New Zealand situation

A large retrospective (over 20 years) comparative review of NAHI and accidental head injury was carried out describing children referred to the hospital child protection team for suspected NAHI (Kelly et al., 2015). This hospital is located in Auckland, New Zealand and is the Level One paediatric trauma centre for New Zealand (the highest level of a tertiary care facility able to provide total care for every aspect of the injury). This study shows that there appears to be an increase in the incidence of NAHI over time. Over the two decades reviewed, 345 cases of intracranial injury were identified. Two hundred and six of these cases (60 percent) were diagnosed with NAHI (28 percent accidental, 11 percent uncertain and 2 percent natural). Most cases were from Auckland, with age ranging from six days to 13 years old.

The probability of being diagnosed with NAHI was similar across gender, deprivation index or European/Asian/Pacific ethnicity but higher for Māori ethnicity (Māori comprised 115/206 cases of NAHI (56 percent)). Despite conflicting literature on the relationship between NAHI and ethnicity, the over-representation of Māori with NAHI

in this study (and other New Zealand studies) can be explained as reflecting a number of complex intergenerational effects of colonisation (Frasier et al., 2014; Kelly & Farrant, 2008; Kelly, MacCormick, & Strange, 2009; Kelly et al., 2017).

Additionally, the referral demographics in New Zealand were consistent with the literature internationally, confirming that children diagnosed with NAHI are more likely to be under two years of age (under one year in some studies), mostly from more deprived family situations, and mostly male (Boop, Axente, Weatherford, & Klimo-Jr., 2016).

## 2.5 Legislation

Much legislation surrounding protection of children in abusive environments, and the management of suspected and confirmed perpetrators have evolved over the years in response to increasing rates of child abuse in New Zealand. Two pieces of legislation directly related to children with NAHI admitted to hospital will be outlined in this section. These are the Oranga Tamariki Act (1989) (formerly known as the Child Young Persons and their Families Act, 1989 with Amendments 1994, 2016), and the Vulnerable Children's Act (2014).

Controversy exists around the diagnosis of NAHI due, in part, to the social and legal consequences which may result from subsequent removal of children from their homes, parents losing parental rights and imprisonment (Christian & Block, 2009). It is difficult to prosecute in cases of NAHI where the child is pre-verbal as abusive behaviours are generally hidden and infants may have been in care of multiple adults (Kelly et al., 2009). A review on NAHI in New Zealand by Kelly, MacCormick and Strange (2009) over the decade 1988 to 1998 discusses child protection practice in New Zealand. During this decade, some important changes were made to the child protection legislation, placing the responsibility to protect children on the family rather than have child protection teams. With a continued increase of child protection notifications, social workers were making informal care agreements with families, until the introduction of Temporary Care Agreements in 1996. Under provisions of the Oranga Tamariki Act (1989), through agreement by parents/guardians, children may be placed into temporary care of an approved service (e.g. MVCOT) for a period of time

(New Zealand Parliamentary Counsel Office, 2018). This occurs when there is concern that the child has been abused by a family member who is their legal guardian.

The most significant change in New Zealand legislation aimed at improving and protecting the well-being of vulnerable children, is the Vulnerable Children's Act 2014. This Act makes up a significant part of comprehensive measures aimed at strengthening the child protection system, with the view that no single agency can protect vulnerable children. The Act impacts frontline staff in health, education, social development, justice and police. It requires any services to children to have in place a child protection policy and undertake screening checks for government and community organisation staff working with children (New Zealand Parliamentary Counsel Office, 2017).

Other legislation relevant to the care of children and families in the community, and in health settings include: The Care of Children Act 2004, the Crimes Act 1961 (and Amendments), the Domestic Violence Act 1995, the Health Act 1956 (and Amendments 1993), the Health Information Privacy Code 1994, the New Zealand Bill of Rights 1990 and the Privacy Act 1993.

In April 2017, further changes in legislation came into effect to provide further care and protection to vulnerable children. The Ministry for Vulnerable Children, Oranga Tamariki, became a legal entity that replaced the existing roles of Child, Youth and Family and the Children's Action Plan. Within this change in legislation the age of care and protection was raised to include 17-year olds (previously up to age 16 years).

It is important to note that many publications about child abuse in New Zealand were written before the legislative change of Child, Youth and Family (CYF) to the Ministry of Vulnerable Children, Oranga Tamariki (MVCOT). Participants in this study were also interviewed before the name change occurred meaning some parts of this thesis will use older terminology. The use of both terminologies has therefore been used synonymously.

## 2.6 Current literature on nursing the child and family with NAHI

Locating research related to nurses' experience of caring for children and families with NAHI proved difficult. It appears that no study has previously been carried out on this

specific topic. One related study was found that was carried out in Sweden in 2008 and is entitled “Nurses’ experience in clinical encounters with children experiencing abuse, and their parents” (Tingberg, Bredlöv, & Ygge, 2008). The aim of this study was to examine nurses’ experiences in the clinical care of children experiencing abuse; the objective being to assess how nurses are able to remain professional especially when the suspected perpetrator is a parent. This qualitative descriptive study had 11 participants who had experience of clinical care of abused children and their parents at a tertiary care children’s hospital within a trauma centre in Stockholm, Sweden.

Three themes emerged after analysis of the interviews. Firstly, the nurses voiced ambivalent emotions whilst providing clinical care to an abused child where one of the parents was the suspected perpetrator. The second theme to emerge highlighted the nurses’ professionalism; in particular, the maintenance of a professional disposition. The third theme focussed around the nurses need for therapeutic interventions and debriefing, as well as education and training specific to this area of practice. Nurses in this study experienced difficulties managing their personal feelings about the child’s situation. While the nurses reported no professional problems with caring for the child, they did report difficulty related to the dual task of caring for the child as a nurse and not judging the parents (which the participants felt would be construed as unprofessional). The importance of debriefing and counselling became obvious through analysis.

The study by Tingberg et al (2008) was the only one found that related to nurses’ experience of caring for children who have encountered child abuse. Although the study is not about NAHI specifically, it provides valuable meaning to the experiences of these nurses and highlights some very important issues. As outlined earlier in this chapter, there have been many quantitative studies published about epidemiology, and different medical and historical aspects of NAHI. The assumed complexities in the caring interactions between health professionals and children and their families have yet to be researched. It would be assumed that nurses, being at the forefront of care would have unique experiences that would add a different perspective to the many quantitative studies already present. The Swedish study has provided valuable groundwork for further research to follow and thus increase the pool of knowledge

currently available to further address and increase awareness about such an important issue worldwide and in New Zealand.

## 2.7 Gaps in the literature

Many quantitative studies exist describing factors of NAHI in different clinical settings, and different communities around the world. The gaps in knowledge have become evident whilst researching current literature on the nurses' experience in this subject area. Apart from the above-mentioned study, conducted several years ago, it has been difficult to obtain any qualitative research in this area. When expanding the search criteria out to other health professionals' experiences, no study was found. When expanding the search criteria out to general child abuse with any health professional, no study was found (excluding the Swedish study). When expanding the search criteria out to head injuries in general, no study was found.

Most importantly, particularly relevant to this research study is the lack of nursing research in the New Zealand context. With NAHI (and child abuse in general) being so prevalent in New Zealand, attracting much media attention and the recent governmental interventions, it seems a vital piece of missing information that will certainly create a more informed paediatric nurse (and any health professional in the clinical environment), who may encounter the child who has suffered an NAHI, or any abuse.

## Chapter 3 METHODOLOGY AND METHODS

### 3.1 Introduction

This chapter will provide a description of the philosophical underpinnings of hermeneutic phenomenology based on the works of Heidegger and van Manen. Validation for using this approach to explore the lived experiences of nurses who care for children with NAHI will be discussed as it relates to each stage of the method. Methodological consistency will be shown through each step of the research methods.

### 3.2 Hermeneutic phenomenology

Phenomenological knowledge can enrich understanding and lead to more careful and reflective action through constructionism, the philosophical view point that meaning is 'constructed' by human beings as they engage with the world they are interpreting (Crotty, 1998; Flood, 2010). Constructionism is an interpretive approach that upholds a stance highlighting the experiential nature of qualitative research (Crotty, 1998). Human experience, as it is lived, is central in revealing meaning and discovering truth and its interpretation by way of critical and intuitive thinking (Jones, 2001).

The philosophical underpinnings of hermeneutic phenomenology, guided by the writings of Heidegger and van Manen were used to design and carry out a study that would bring to light the lived experiences of nurses who care for children and their families with NAHI. The humanistic stance Heidegger adopts can provide an effective mode for nurses to explore the lived experiences within health and illness (Ruangjiratain & Kendall, 1998). Hermeneutic phenomenology is an approach that divides, or creates a fork in the path of philosophical ideology regarding phenomenology. The hermeneutic approach involves interpretation and veers away from a more descriptive style. Heidegger developed an ontological stand point concerned with how one lives in the world, and temporal issues as they relate to authenticity and being-in-the-world (described as *Dasein* by Heidegger), as well as relating to matters of time and life experience (Jones, 2001). This interpretive approach expects that the researcher accept and value the descriptions provided by the participants as their reality and understanding of the phenomenon (Koch, 1999).

van Manen (1990) asserts a hermeneutic phenomenological approach to human science research and writing, with the underlying notion that interpretive phenomenological research and theorising cannot be separated from the textual practice of writing. Exploring the everyday lived experience (or how one lives in the world) of an individual is the starting point to carrying out this approach. van Manen provides practicality to inquiry using this research approach. The humanistic nature of the health care profession appeals to the need for gaining knowledge and understanding of phenomena using this hermeneutic approach. It is vital that the health care professional should be more involved in the way people experience and live with their problems (van Manen, 1998).

### 3.2.1 Lived experience

Lived experience involves the careful attention or reflection a person has on an event, situation, or everyday practice, as it is lived or experienced, *in that moment*. It must always involve reflection through 'thoughtfulness' and is the starting point (and end point) of philosophical research (van Manen, 1990). To bring light to the lived experience of a phenomenon is to uncover the meaning, or essence of that phenomenon. Lived experience provides meaning through transformation into textual expression of its essence by reflection (van Manen, 1990). The phenomenon under inquiry in this study is the lived experiences of nurse's caring for children with NAHI.

### 3.2.2 Being

'Being' is a fundamental term in human science research, and is the most universal concept of Heidegger's hermeneutic phenomenology (Blattner, 2013; van Manen, 1990). To uncover meaning in the experience of a phenomenon, is to ask for the 'being' of an entity. "Being is that which determines entities as entities" (Heidegger, 2008, p.25).

An extension of 'being', is the existentialist concept of 'being-in-the-world'. Heidegger conceptualises being, as being-in-the-world, and this commands the researcher to consider the understanding of being in a certain way (Mackey, 2005). Being-in-the-world refers to the way humans exist, or are involved in the world (van Manen, 1990). This concept is important to consider as it provides the foundation for aspects of conducting this study: factors that allow participants to reflect and tell their stories in a

way that will bring out their lived meaning (the way a person experiences and understands their world as real and meaningful) (van Manen, 1990).

The researcher is responsible for creating a safe environment that allows for open and honest dialogue. This includes the physical space and the relational space (between themselves and the participant). The researcher must always be conscious of any intricacies that may play out in this shared space between themselves and the participant. The researcher will attend to them through reflection and confirmation, and make adjustments accordingly. In this way, the researcher creates the most optimal conditions for the experiences of the participants to be told in a way congruent with explicating their lived meaning.

### 3.2.3 The hermeneutic circle

A crucial Heideggerian methodological principle is that of the hermeneutic circle. Heidegger considered interpretation to be a circular process where the fore-structures of understanding were made explicit, followed by reflection of those fore-structures in terms of the whole of the understanding of something, and then re-considered in a new light (Mackey, 2005). This circle of understanding is what Heidegger conceived of as the hermeneutic circle.

Ruangjiratain and Kendall (1998) describe this process of interpretation as the interaction between the researcher and participants, each with their own fore-structures. The process uncovers the meaning of the participants' experience, and is achieved by listening and gaining insights from their stories that capture the depth and richness of their world (Ruangjiratain & Kendall, 1998). A flow of understanding takes place through being-in-the-world and is a process of moving dialectically between a background of shared meanings and a more determinate engaged experience within it (Thompson, as cited in Mackey, 2005). The researcher here has a fundamental role as a vital participant in the research process through the interpretation of text (Ruangjiratain & Kendall, 1998).

The hermeneutic circle, therefore, provides an opportunity to add an axiological stance to this study, whereby the values and beliefs of both the researcher and participants are considered as a vital component of the 'circle of understanding'. An underlying assumption is that values, in particular, may play a part in the stories told by the

participants in the study. Recognising the researcher's role in the understanding and interpretation, which considers fore-structures of the researcher (that will inevitably include their values), provides a sense of confirmation that through phenomenological inquiry the true lived experiences of those participating will be uncovered. Such an approach is consistent with the purpose of this study.

### 3.2.4 Pre-understandings

One important characteristic of Heidegger's philosophy is his attention towards the researcher's inability to 'bracket' out one's presuppositions (Blattner, 2013).

Heidegger asserted that previous life experience and expert knowledge are factors that provide depth and enrichment to the researched phenomena (Heidegger, 2008).

This is an important distinction when considering internal consistency throughout any research study using the Heideggerian hermeneutic principles, as this approach will inform the entire structure and design of the study. Heidegger coined this process as fore-structure. Fore-structure is the previous knowledge and understanding that precedes interpretation; it is the prior awareness and anticipation of meaning that takes into account context-dependant knowledge and the opinions and experiences that both researcher and participants bring to the study (Mackey, 2005). Heidegger viewed culture, history, politics, traditions, family and personal life as being shared background meanings between people that must be recognised to fully interpret the lived experience (Heidegger, 2008; Ruangjiratain & Kendall, 1998). The researcher and participant here work together to understand these background influences that are present. The researcher's own set of meanings and preliminary understanding of the phenomena being studied (or fore-structure of understanding), enables the process of interpretation (Ruangjiratain & Kendall, 1998).

Through personal experience and knowledge of the phenomena being studied, accompanied by professional and personal background meanings (or fore-structure), it would seem impossible to conduct this particular study without taking into consideration my personal thoughts, values, experiences and knowledge. Heidegger's tenet of fore-structure will, as the literature suggests, add depth and insight into the thinking and interpretation of the lived experiences of these nurses. The researcher is a pivotal ingredient in the thinking of the research; thinking "arises from all that has

come before in one's life, both the remembered and that which is known without knowing" (Smythe, Ironside, Sims, Swenson, & Spence, 2008, p. 1390).

Lowes and Prowse (2001) assert that it would not be possible or desirable to exclude the researcher's preconceptions in a phenomenological interview without compromising researcher objectivity in the pursuit of rigour or trustworthiness. Moreover, ensuring rigour requires the researcher to explicitly clarify their preconceptions and their contribution to the interview process (Lowes & Prowse, 2001). This is a vital step before beginning data collection. To aid the process of reflecting on and acknowledging my own understandings of the experiences I have had with children admitted with NAHI, I was interviewed by my supervisor using the same opening question I was preparing to ask my participants.

The interview I took part in with my supervisor was digitally recorded and transcribed. Listening to the recording, reading the text and reflecting on it enabled me to conceptualise my pre-understandings. Through this process it became evident that there was an overwhelming sense of unpreparedness on my part, especially in my earlier years as a nurse caring for these children and their families. I was unprepared emotionally, and unprepared with regard to the knowledge around protocol that was to be followed.

My first account of this came in the form of being asked about a significant experience I had had. I was sitting in with a mother who was about to be told by CYF that although her baby was ready to be discharged, he would not be going home with her. It was known at this stage that the mother was not responsible for the child's injuries. However, there were some safety concerns with other members of the family. When the mother was told, she became very emotional and began wailing in the room. She was devastated and I did not know what to do or say. It seemed to be a different experience from other situations with grief and intense emotion where NAHI is not the diagnosis. After reflection, it became apparent that I thought of these admissions as unnecessary and preventable, and the inner emotional response to that was intensified.

Another observation was that I perceived these children with NAHI as being invisible in the sense that there appeared to be silence around some aspects of the child and the

child's family. I thought that nurses did not speak about these children's injuries or the family circumstances or the tragic conditions around their admission as we did other children. I referred to NAHI as the invisible illness. Personally, I found this invisibility difficult because I had many questions about how to negotiate my emotional struggle with the child's circumstances. I was looking for some clarification from my peers and more senior nurses. Eventually, I learnt that being silent and creating some emotional separation from the care you are providing for the child and family, and your own beliefs and emotions, made care easier. At times, however, it would upset me that I had fallen into a 'go-with-the-flow' attitude and had forgotten to challenge myself with questions around what we as nurses, could do differently to support the child and family, and attend to the emotional turmoil we might feel.

Overall, the main assumptions I had made about the care of children and families with NAHI, were that there would be a sense of being unprepared (emotionally and in the knowledge of policy/guidelines to follow) and some degree of emotional difficulty. Now it was important to negotiate this with nursing care. There was an added complexity of NAHI standing out as being an invisible illness that nurses do not talk about and therefore are not afforded the opportunity to discuss ways to more effectively care for these children and their families. Nursing care would become easier if the nurse intentionally placed some aspects of how the child acquired the injuries to the side in order to carry out care, though this would not fully attend to the potential emotional difficulty.

This interview aided in bringing to light my own presuppositions and potential biases I might have towards thinking and directing participants in the interviews, as well as in the development of possible themes.

### 3.3 Methods

Having explored the philosophy behind hermeneutic phenomenology, the next section of the chapter will relay the 'doing' of the research. The research design was based on the philosophical underpinnings of hermeneutic phenomenology guided by van Manen and Heidegger. This design follows a predominantly non-emergent strategy where all data is collected initially and then analysed. Rigour or trustworthiness of the research

process is maintained through various methods in each step of the design and will be highlighted accordingly.

### 3.3.1 Ethical considerations

The underlying ethical considerations are those of respect of autonomy or self-determination. The participants are treated as autonomous agents and given the right to decide voluntarily whether to participate in the study (National Ethics Advisory Committee, 2012; Polit, Beck, & Hungler, 2001). This also includes participants right's to ask questions, refuse to give information and, if chosen, the option to terminate their participation (Davidson, 2001; Polit et al., 2001).

To fulfil this ethical consideration, participants in the study were given information regarding the study that specified its purpose and all the components that would be involved in the entire design. The participants were informed how the dissemination of the findings would be presented. This builds on the principle of respect for human dignity being paramount and requires the researcher to respect the participants' right to make informed voluntary decisions about their participation in the study – full disclosure of the nature of the study and the likely risks and benefits (Polit et al., 2001). Both these principles can be achieved through the formal process of informed consent. To uphold this principle a comprehensive consent form (Appendix A) was given to the participants, along with an information sheet (Appendix B) regarding the research study.

Another vital consideration is that of the ethical principle of justice, whereby participants have the right to fair treatment before, after, and during their participation in the study, as well as the right to know that the data they provide will be in the strictest confidence (Polit et al., 2001). This includes honouring all agreements made between researcher and participants and having a non-discriminatory attitude. Anonymity is vital; especially in this study as the pool of potential participants who met the inclusion criteria was small. It also includes providing means or information to participants if they require professional assistance in the case of physical or psychological impairment during the research process. In this study, I identified the possibility that discussing matters regarding child abuse could elicit personal emotional responses when participants were sharing their experiences.

It was therefore an imperative part of the informed consent and full disclosure process that participants were made aware of the subject content and the possibility of stories shared eliciting personal responses. Being aware and respectful of the stories shared by participants was vital; particularly with the knowledge that publication and dissemination of the findings would be available in the literature long after the study is complete. This awareness was an essential part of the ethical considerations of this study, as ethical commitments have lifelong obligations that do not end with the signing of consent forms and ethical approval (Bergum, 1991). Participants were also given information about where they could seek professional assistance if needed. They were offered the opportunity to leave out parts of their story.

Considering the unique nature of research in New Zealand, with Tangata Whenua (the indigenous people of Aotearoa New Zealand) and the importance of honouring the Treaty of Waitangi was crucial. Researchers are obliged to be sensitive to the evolving understanding of principles pertinent to a particular society at a particular time (Davidson, 2001). The principles of protection, partnership and participation that stem from the Treaty of Waitangi must be considered, not only when working with Māori, but as a general rule, as all these principles enhance the more mainstream, generalised ethical principles discussed earlier (Davidson, 2001; NEAC, 2012). It was intended to apply these principles in general, irrespective of the inclusion of nurses identifying as Māori, in respect of the research occurring in the context of New Zealand society.

Consultation was sought from the Kawahakaruruhau Komiti (committee) (Appendix C) of the nursing department within AUT. This was to ensure sensitivity when interviewing potential participants of Māori descent. This consultation was sought due to the high rates of child abuse in New Zealand among Māori (Wynd, 2013). It was of paramount importance that any conflict issues that may arise during interviews, be avoided. The committee made some recommendations, one of which was to purposely select for the inclusion of Māori participants. While this would have added greater depth to this study, it was decided that it would have been difficult to attain this without violating confidentiality and anonymity as the pool of nurses who met the inclusion criteria was already too small to purposely select for Māori. Therefore, while it was hoped that Māori nurses might participate, purposive sampling of Māori

participants was not undertaken. This decision was discussed with the committee and accepted.

Ethics approval was granted on 20<sup>th</sup> April 2015 after minor adjustments to the original application. (Appendix D)

### 3.3.2 Inclusion Criteria

The inclusion criteria for this study were nurses who were working, or had worked, in a hospital in Auckland, New Zealand where they had cared for children admitted with NAHI. Initially, nurses were to have had at least two years of clinical experience as this would enable them to have all the clinical competencies to care for an acutely unwell child. Later in the recruitment process, it was decided that restricting participants to experienced nurses may not fully uncover nurses' experience, given the difficulties with recruitment (see 3.3.4). New graduate nurses were then later included in the criteria for participating as they would bring a different voice to the study, adding to the already rich stories collected.

### 3.3.3 Sampling

Sampling was selective and purposive due to the inclusion criteria applied. The literature on conducting phenomenological studies suggests a sample size of not more than ten participants (Polit et al., 2001). However, sample size in qualitative studies have less to do with the actual number of participants and more to do with the quality and depth of information elicited through the research process (Jones, 2002). Two factors were considered when choosing a sample size in this study. Firstly, the availability of nurses who fitted the inclusion criteria, and secondly the time frame limitation of conducting the study. The sample size would take into consideration the amount of data (in the form of the stories told) that may be obtained from each participant. After thorough discussion with my supervisors and staying true to the methodological recommendations, it was decided that there would be a goal of eight to ten participants. At the conclusion of the recruitment process, six participants were interviewed.

### 3.3.4 Recruitment

An advertising flyer (Appendix E) was created outlining the details of the study, inviting eligible nurses to participate. An information sheet (Appendix B) outlining in more detail the study, and what would be involved in participation of the study, was also prepared and sent out accompanying the flyer. Having worked as a registered nurse in this area I was able to utilise my contacts with nurses I had worked with previously. The aim was that participants recruited may be able to advertise the study to other colleagues, using a sampling technique known as 'snowballing'. Snowball sampling is where a researcher accesses potential participants through contact information provided by other participants, which then becomes repetitive, where participants are, in effect, advertising the research study to other potential participants (Noy, 2008). It is a common qualitative sampling technique and can be used as the primary sampling method, or as an auxiliary method when other avenues have been exhausted (Noy, 2008).

My supervisors were also able to advertise through their teaching and professional networks. The flyers and information sheets were sent out via email to potential candidates with contact details for those who were interested. Some of these potential participants were unsure if they could participate as they were no longer working in that area. Clarification was given that all stories and experiences, be they from a day ago, or many years ago, would be highly valued.

After four participants had been recruited, I began the process of organising and carrying out the interviews as I was waiting for other responses to the advertisement. During this process two more candidates confirmed their interest and availability. In total six participants were recruited for interviewing. While interviewing was taking place, it was hoped that more participants might be found, via a follow up email, through my supervisor's professional contacts, and through the snowballing sampling technique. It was at this point that new graduate nurses were invited to participate. Unfortunately, despite many efforts, no further participants were recruited. On discussing this issue with my supervisors, it was decided that analysis of the data obtained should commence to ascertain its quality. After this initial analysis stage, we agreed that the data collected from the six participants was rich in its broadness and depth, and along with impending academic time constraints related to completing the

study, it would be acceptable to end the recruitment process at this point. Potential reasons for being unable to attain more participants were likely to be due to the small pool of nurses who would fit the inclusion criteria and sensitivity of the topic. I was aware that reflecting on the experiences of nursing children who are victims of abuse may potentially be difficult; some nurses may be reluctant to talk about such issues.

### 3.3.5 The participants

Six nurses participated in this research study. All were female, and their experience as nurses who care for children admitted with NAHI ranged broadly from five to 15 years. The age range of the participants was from early 30s to mid-40s.

### 3.3.6 Data collection

Revisiting the philosophy of Heidegger and the importance of interpreting something being dependant on acknowledging the researcher's own beliefs, experiences and preconceptions, I took part in a pre-understandings interview with my supervisor to make transparent my potential biases and presuppositions about this study. This interview also provided some much-needed guidance on how to conduct a phenomenological interview.

Literature also suggests the use of reflective journals that document preconceptions throughout the research process (Long & Johnson, 2000; Lowes & Prowse, 2001). Preconceptions that are acknowledged make the process transparent, and they can be incorporated into the process. Reflection of the phenomenon studied was continually attended to throughout the interview process, data analysis and interpretation (Long & Johnson, 2000; Lowes & Prowse, 2001). Immediately after each interview, I wrote a short reflection on how the interview went, with the intention of acknowledging times where my own pre-understandings were showing up, and to aid in improving my interview style.

The interview is a key process within a phenomenological study. This process enables the researcher to experience the stories the participants share about how they have lived or experienced the phenomenon in that moment in the lived world. Through this dialogical encounter, the meaning of the experience is uniquely constructed and offers a hermeneutic catalyst for the participant's engagement with understanding and the means of encountering truth (Freeman, 2011). van Manen (1990) asserts that the

interview process must be guided by the fundamental question that is the focus of the study. Considering this, I used a semi-structured approach to the interviews. The nature of the questions began broadly, and were subsequently guided by each participant's answers. I did, however, have a list of possible questions to ask if the participant needed prompting, or if I was unable to maintain the flow of the interview. (Appendix F).

The interviews lasted, on average, 60 minutes, and were recorded using two devices in case one failed. The recorded files were saved on my personal laptop in a password-protected file. The recordings were saved on a USB device and given directly to the transcriber who had signed a confidentiality agreement (Appendix G) prior to receiving any files. The transcribed document was sent back to me via email and the USB files were deleted. All potentially identifying aspects (e.g. names, places of work, and roles) were removed from the transcribed documents and saved in a separate file under pseudonyms. The interviews took place in an environment decided by the participant, predominantly in their homes.

Obtaining the transcripts is a preliminary and vital component of beginning the process of interpretation through the hermeneutic circle. To ensure rigour at this stage of the process, the literature speaks of the need to have stories affirmed. This process is termed 'participant feedback' or 'member checking'. It can happen at any stage from the data analysis stage to the final interpretation stage (Long & Johnson, 2000). In this study, member checking was used before the data analysis stage to ensure accuracy of the data. Data or results are returned to participants to check for accuracy and resonance with their experiences (Birt, Scott, Cavers, Campbell, & Walter, 2016). Once the transcripts were received and saved after deleting identifying information, they were sent back to the participants to read through. They were given the opportunity to remove, add or clarify any part of the stories recorded on the transcripts to ensure rigour of the data. None of the participants decided to alter any of their stories.

### 3.3.7 Data analysis

Having obtained, in written words, the rich descriptions of the participants' experiences, the hermeneutic process of analysing the stories could take place. Thematic analysis set out by van Manen (1990) was used where meaning of the lived

experience is sought through articulation of a theme. Thematic analysis involved uncovering thematic aspects, isolating thematic statements and reflection. Thematic analysis is considered to be the means to uncover the notion of the phenomena being addressed (van Manen, 1990). This process, or circle of understanding, involves the development of interpretation through thinking, writing, reflection and re-writing with the ultimate goal of uncovering how the 'thing' itself is experienced (Mackey, 2005).

Philosophical knowledge may inform a deepening of interpretation and meaning of any phenomenon, with the ultimate goal of uncovering how the 'thing itself' is experienced. Interpretation begins with the researcher engaging with the phenomenon, and continues as they listen to and read the participants' descriptions of their experience of the phenomenon, becoming immersed in the data (Mackey, 2005). Understanding is achieved when interpretation stretches beyond literal meanings of the participants' words to seek fore-structures and thematic meanings contained in the data (Mackey, 2005). A theme provides a means to uncover the notion of the phenomenon, expresses the indefinable essence of the notion and describes the content of the notion (van Manen, 1990). As the lived experiences are examined and themes emerge, it is possible to discern commonalities in experiential data (van Manen, 1990).

As a novice researcher, I was initially intimidated by this process. I did not understand the concept of 'coming to know' through continued reflection, writing and discussing with my supervisors. Transcripts were read and re-read, and recordings were listened to. Notes were written and diagrams were made. Being immersed in the data in this way and resisting the urge to look to literature for answers, enabled me to stay connected to the experiences of the participants and uncover meaning in a way congruent to hermeneutic interpretation.

A whiteboard session with my supervisors where I verbally brainstormed my ideas and then mapped them in diagrammatic form on the whiteboard was the turning point in my understanding and 'coming to know'. Multiple potential themes were being made apparent in the initial analytic process. With continued writing, thinking, discussion and reflecting, two main themes were established. The first theme, discussed in Chapter 4, reflects the participants' relaying of experiences that appeared to define

them as being different from similar interactions they had with children and families admitted with medical or accidental injuries. The second theme, discussed in Chapter 5, came about as participants used language that conveyed a sense of separation or boundary between themselves either in their thinking and/or in their doing of nursing care. Nurses uphold certain professional obligations, and this was a common word used within the text of the participants' stories to describe the need for separation and boundaries, almost as a way of protection. The theme 'shield of protection' was identified as a way of encompassing these aspects of the experience.

### 3.4 Conclusion

The validation of using the hermeneutic phenomenology approach to uncover meaning in the lived experiences of nurses who care for children with NAHI has been shown in this chapter. A firm philosophical background relating to the inquiry methods has been provided, with particular emphasis on methodological consistency to ensure solid trustworthiness and rigour of the study. This chapter should now, along with the first two chapters, provide some substantial background understanding of the 'what', the 'why', and the 'how' of the study. The following three chapters present the journey of understanding and finding meaning in the nurses' lived experiences, in the formulation of themes and their corresponding discussion points.

## Chapter 4 THIS IS DIFFERENT

*“What we call ‘themes’ are not necessarily ‘the same thing’ said again and again, but rather an understanding we have seen something that matters significantly, something that we wish to point the reader towards” (Smythe et al., 2008, p. 1392)*

### 4.1 Introduction

The six nurses in this research study had a range of experience working with children and families with NAHI. This experience ranged from five to 15 years at the time of interviewing. Alice and Brenda had the least amount of experience within this range. Emily, Claire, Fiona and Diane had the most experience within the range.

The theme *‘This is different’* was an overarching premise that the nurses in this study described, while caring for children and their families with NAHI, that captured their experiences. The appearance of this theme was not evident in the early stages of analysis because the participants did not use obvious language to denote a difference. However, through continued analysis and unpacking of the narratives, a clearer idea of this difference was revealed. When nurses are first aware that they are taking care of a child with NAHI, changes in their way of thinking about how they approach care are revealed, particularly when compared with their care of other children. This difference appears to relate to ways in which they must work with these families; it falls into the three sub-themes discussed in this chapter.

Firstly, *there is a protocol* to which nurses must adhere that is specific to an admission of a child with NAHI. The second is that there is a *complexity in the relationship* that the nurses have with the families which, again, distinguishes this as different. Finally, the nurses find themselves in emotionally tense situations where they consider what has happened to the child but do not want to practise in a way that reflects judgment. The tension around adopting a *non-judgmental approach* is not as apparent as that experienced in other situations where illness or injury may be seen to be random rather than inflicted upon the child. These situations stand out as being significant factors of difference that these nurses experience when caring for children and families with NAHI.

## 4.2 The protocol

The participants in this study highlighted how nursing children with NAHI was different in part, due to the protocols governing their practice. When a child with a confirmed or suspected NAHI is initially admitted to the ward, certain guidelines and protocols must be followed. These guidelines and protocols are specific to children and families where abuse or neglect is suspected. For the child with suspected NAHI, these same guidelines and protocols are applied and are implemented as soon as the injuries of the child are suspected as being non-accidental. Putting these guidelines into practice may be the first obvious sign that this type of admission is different and may be a silent indicator to the nurse that signals a difference in thoughts and actions towards this child and family. The guidelines include immediate referral to the child protection team (explained earlier in Chapter 1). The nursing and medical teams work together with the family to put the guidelines into action.

Diane describes how nurses are involved in the referral process which occurs immediately after admission. This may signal to Diane that the care of a particular child will be different, as the processes differ significantly from the care of most other children.

*“Referrals are made to the child protection team within the hospital. They come and meet with the family. It’s part of our job to let the family know that we need to make a referral and give them information about that. The Child Protection Team will always keep us up-to-date with what they are doing and what their recommendations are...”* Diane

The guidelines for caring for a child with NAHI also dictate that the child will be constantly watched over by a health care assistant (HCA; also colloquially termed the ‘watch’). This is put into place immediately on admission to the ward, even if the non-accidental nature of the injury is only suspected. Unlike the close monitoring of children in hospital related to assessing a child’s illness or injury and potential deterioration, this watch is put in place for the child’s safety in terms of the possibility of the child being uplifted from the hospital. This is different as it implies a potential lack of trust in the family. The intervention is made explicit in the guidelines and is directed by the child protection team and the hospital involved. The implementation

of an HCA constantly at the bedside of the child may cause the nurse to feel apprehensive about informing the family, particularly if she anticipates the family may become defensive or combative.

Fiona acknowledges this apprehension and speaks of her attempts to alleviate the discomfort she feels by asking either the duty manager (clinical nurse manager), the medical team, or the social worker to inform the family. She also feels that her relationship with the family will be improved if she does not start the relationship with a potentially negative interaction.

*“Yeah that’s a bit hard, even like telling them, yeah you’ll be having a watch. I always tell the social workers or somebody else to talk to them. I’m the nurse; I’m not going to tell them you guys will be having a watch... I think it’s always nicer if it comes from someone other than the nurse who is looking after them. So they can have that confidence and trust in you.”* Fiona

Claire also describes an experience she had regarding the instructions for an HCA to remain with the child at all times. It was decided, on one morning shift, that as Claire was to be nursing a child with NAHI in the IOA unit of the ward (where the nurse does not leave the unit, unless replaced by another nurse), the HCA allocated to the child was to be redirected to another ward (a decision made by the hospital staff). It was decided that Claire could provide the HCA duties as she would not be leaving the unit. Claire did not agree with this decision and requested the HCA remain by the child’s side. In response to upper management asking Claire why she could not perform the duties of the HCA, she showed them the safety plan and documentation from the child protection team:

*“This is a legal document and this will be held up in court. If something happens to that child and the watch isn’t there because of that, it will be on you because you took it [the HCA] away.”* Claire

Claire was referring to times when she may have her back to the child (and visitors), or helping her colleague who was also nursing children in the same unit and would not be able to directly observe the child with NAHI. In Claire’s opinion, the HCA is part of the protocol for caring for children with NAHI and striving to uphold this is paramount. This

is different from the child being monitored primarily for possible deterioration of a physical condition, in which case 'turning her back' would be unlikely to result in an adverse outcome.

The explicit nature of the HCA being present at all times in the guidelines and protocol for care of children and families with NAHI, and the way in which the nurses' experiences appear altered in order to accommodate this step, signifies a difference in care from other children with accidental or medical injuries. By highlighting these aspects of care, the subsequent cascade of thoughts and actions that may follow in the participants appears to denote a point of difference that accompanies the care of children and families with NAHI.

### 4.3 Complexity in the relationship

Through the experiences of the nurses in this study, it has been revealed that there is a difference in the relationship that exists between nurses and families of the child admitted with NAHI. These differences include a difference in *social complexity*, a difference in communication and what is not said (*the unspoken*), and a difference in association or how the nurses and family relate to one another (*dissociation*). These differences are key to explaining how the experiences of nurses caring for children and families of NAHI are different.

#### 4.3.1 Social complexity

In the context of this study, social complexity refers to the complex nature of managing the care of children and families with NAHI with regard to the social circumstances that are present. When children are admitted, the care involved in managing families stands out as being a significant distinctive factor that shows difference in the approach to care with families of children admitted with medical or accidental ailments. For the nurse caring for children and families with NAHI, there is a social complexity which is centred around managing family members, being aware of family dynamics, knowing who (of the family) to involve with care, managing and implementing protocols with legal implications, and negotiating the concept of family-centred care. This social complexity adds to an already highly emotional situation where a child with injuries must also be managed from a nursing and medical perspective.

Social complexity is a term coined by Diane in her attempt to explain what makes care of these children and families different but is also evident in the narratives of other participants. Having many people involved in the care of a child with NAHI alone, does not define the complexity here. For Diane, the complexity lies in how her practice is altered, and how her approach to managing the family might be different.

*“I guess there’s a lot of people involved with these families and there’s a lot of complexity involved in making sure you are talking to the right people, and I guess social complexity, I mean, [with] a child who has had a brain injury related to say trauma, you manage the child the same way but the complexity is with the situation and the family around them and that can be difficult.”* Diane

Complexity is not simply around the nursing care of the child; as Diane states, a child who has a brain injury related to trauma (that is, from accidental rather than non-accidental causes) has the same medical care as a child with NAHI. In both instances, bedside nursing care, neurological assessment/treatment and physical care remains the same. What appears in Diane’s narrative is her interaction with family members and how this can be difficult when there are many people involved, and the importance of giving the right information to the right person. An exaggerated social aspect accompanies care in these cases, due to the circumstances by which the child came to be in hospital. Additional services are involved in the child’s care: the child protection team within the hospital, social workers, CYF (MVCOT), and police. Access of some family members may be restricted or prohibited. If a person is the legal guardian of the child, it can become difficult knowing who to direct conversation regarding the child and their care towards. In cases of children with accidental head injuries, there is no investigation of the family related to the mechanism of injury, and additional services involved in the child’s care are usually at a minimum. In this respect, the care process involved may be considered less complicated.

The complexity of working out who to direct conversation about care to and how to manage family responses, while at the same time keeping the child at the centre, is explained by Diane:

*“So, like the last case that I was involved with, there was quite a lot, the parents plus extended family were around, and then it came to the point that the father*

*wasn't able to visit and the mother needed supervised access. We had visiting times for both sets of grandparents that were separate from each other and you know there is a lot of complexity around just even managing the family around these cases, because there's a lot of blame and a lot of heartache and emotion that the families feel around what's going on, let alone the child in the centre who's had a devastating brain injury as a result of this and sometimes it seems like families can lose sight of the child that's in the centre of all of this when they are sort of humming and haring about who did what and those sorts of things." Diane*

The complex nature of Diane's experience is highlighted in regard to having to restrict visits by the father, supervise the mother during visits and manage separate visiting times for all family members including both sets of grandparents. Additional emotional factors of blame and heartache about the injury further complicate the situation. In many cases, due to some family members and parents not being able to always be present, nursing staff may not be able to effectively carry out education and discharge planning.

*"...the child might not have somebody who can go to rehab with them or they may need to stay in hospital longer because there isn't a caregiver. And even trying to educate people that the child might eventually go home with, they might not be the people that you have been talking with or have been around that child the whole time during the admission..." Diane*

The complexity described in Diane's stories highlights the point of difference in the social aspects and the 'work arounds' she is required to do to accommodate the child's care. These aspects are not present in other cases with children who have the same head injury but acquired it accidentally. Usually when a child is admitted into hospital with any injury or condition, the initial assessment identifies who the main caregivers are. It is common for there to be a core group of family members/caregivers who are ultimately responsible for the child. They take care of the child at home, will be by the child's side during their hospital stay, and will take the child home and be a part of any outpatient treatment. This is established early on so the nursing and medical teams

know who they can talk to about the child's care. As discharge planning begins, these are the people who will be directly involved.

The difference in children with NAHI, where family members may be under investigation, is that the core group of main caregivers lacks consistency. The family members who took care of the child at home may not be those that will stay with the child in hospital, and may even be different from the caregivers who will take the child home and be a part of outpatient treatment.

Fiona describes the intensity related to social aspects of care to the point where she would prefer not to know about them. She acknowledges struggling with delivering family-centred care when there are restrictions on who can visit and who the child may be discharged to. Discharge planning becomes difficult when some of the family cannot be a part of that process, possibly due to legal restrictions.

*"Sometimes with the social situation it's so intense, you just don't want to know about it. You just look at the diagnosis and illness and we'll just treat that. In fact, we shouldn't be like that with family-centred care. It's hard to do all those things, and we don't know at what stage we can involve the parents in the care of the child, because the child we know won't be discharged to them."* Fiona

Fiona's experience of the social complexity of caring for children with NAHI exists around how intense the social situation is. She would prefer not to know about the social aspects of the family, yet recognises the importance of family in the care of the child. Her solution is to remain fixed on the injuries and nursing care related to them but seems torn between this approach and the recognised approach of family-centred care. This dilemma is based on the complex social circumstances present and, in fact, creates an added layer of complexity to the care of children and their families with NAHI.

It appears that the nurses in this study strive to maintain a care environment where family/parents are at the centre by wanting to involve them in and encourage and support the care of their child. However, the social circumstances and legal restrictions that may be present make it difficult for the nurses to achieve this. The circumstances affect the relationship the nurse has with the family and is reflected in defensive and

sometimes abusive behaviour towards the nurse. Brenda relays one such experience where she was verbally handing over a child at the bedside, with the mother present, a handover which included information that a certain family member was not permitted to visit. Brenda and her colleague were whispering because it was a four-bedded room and they were mindful of confidentiality. The mother assumed Brenda and her colleague were talking about her and attacked them verbally. This confronting incident illustrates the complexity of working with families who, as well as worrying about the child's physical condition, have an added layer of worry/stress with regard to how the child acquired the injuries.

*"I think because of all of the stuff the mum was going through already, she decided to attack all the nurses. So, we try to do the best that we can but sometimes we get the brunt of the family like, treating you like crap and stuff because they are going through a lot of stress, maybe not sleeping. All the other factors that go around outside of the hospital, kind of bring it in."* Brenda

The complex social aspects that accompany children admitted with NAHI and their families means that the nurse experiences different interactions with family members. The nurses alter their way of dealing with these families because, in some cases, they are expecting a hostile response or attitude towards them.

The nurses' experiences demonstrate an extra layer of complexity that distinguishes NAHI from other cases. The involvement of CYF (MVCOT) and police, as well as additional legal restrictions, account for this added level of complexity. Family support is essential, and the child is usually accompanied by their parents to a rehabilitation centre and then home to continue rehabilitation. The nurses in this study allude to the social complexity around not knowing who the caregiver is that the child will be living with after discharge and who, if anyone, would go to rehab with this child. This can disrupt the rehabilitation process and further disadvantage the child. The social complexity of the situation and the consistency of people around the child is something that the participants suggested interrupted and challenged the entire care process.

*"I guess the child's care is not that much different but definitely the complexity around the social situation, that's the more challenging part with the children that come in with these injuries."* Diane

#### 4.3.2 The unspoken

The usual everyday conversation that happens between nurse and family is made up of various topics usually centred around the child and, in many cases, how the child came to be in hospital. The way conversation flows (between the nurse and families of children with NAHI) appears to be different; this affects the relationship the nurse has with the family. The participants in this study describe how there are certain aspects of care that cannot be spoken about, either because of legal implications or because the nurse or family chooses not to. The silence resulting from what is unspoken gives meaning to differences in the relationship between the nurse and family. Emily captures the sometimes-awkward nature of the interaction that takes place between some nurses and families.

*"It's the unspoken thing in the room. Sometimes, if a kid's broken their arm, [you ask] "Oh, how did they break their arm?" But in these cases, it's not talked about...Yeah because, [you ask] "How did your child get their injury?" They wouldn't tell you anyway. So yeah, you can't talk about it."* Emily

Emily clearly describes how different it is for her compared with the every-day nursing conversation with families. Talking about the mechanism of injury can potentially be a topic to 'break the ice' with families. Accidental head injuries (acquired by, for example below, falling on a piece of Lego™) provide a space and opportunity for communication and building rapport which helps the nurse-family relationship. When that opportunity is absent, the remaining silence presents a disjointed relationship with an underlying judgmental tone.

*"Yeah, we had a kid who came in, I think, with a subdural haematoma, just from falling on one piece of Lego. Just walking. So, fallen from walking height and fell on a piece of Lego. That was interesting. You could talk about that with the parents. "Wow, that's such a major thing from just falling on a piece of Lego." But these kids, yeah..."*

*I guess for the families, because you know they are not going to tell you anyway, they are under investigation. All of them, and I can't remember a single family who ever admitted it during their time in hospital anyway, when we see them. So, they would always say, "Oh, I don't know." Well, you presume that that's what they'd say but you don't know because you don't ask them."*

Emily

Emily alludes here to families being under investigation, which might provide some reasoning behind their silence. As the nurse either chooses to remain silent, or is legally obliged to, the family may also remain silent either by choosing to, or by being obliged to legally in fear of incriminating themselves or someone else. When the unspoken is coming from both sides of the nurse-family relationship, the outlook appears bleak for this relationship to thrive; this is not an effective foundation for a therapeutic relationship.

Ideally, communication between the nurse and children and their families is open and free flowing between both sides. Unfortunately, the legal restrictions that accompany these cases mean there may be some things that cannot be discussed. Fiona describes how the unspoken manifests in her practice and how her nursing practice is affected. As well as there being legal reasons for not saying some things, there are also issues around truth-telling. When Fiona is aware she cannot be truthful, she alters her communication with families/parents; either by changing the subject or saying nothing at all.

*"Yeah, you can't say the truth. With the distress, you can cause problems and you can't say what is right. Like what is going to happen. So, you just have to say, like sometimes I just ignore it. Like I just don't respond, or talk about something else."* Fiona

Nursing care is usually based around involving the family in every aspect (family-centred care). Family/parents are encouraged to participate in all the usual aspects of daily care, as much as possible, for their children while in hospital. Teaching about feeding tubes, leg splints, etc begins instantly as the family are capable, and are encouraged to be involved with these cares also. The parents and family members are informed of all treatment and care plans and encouraged to have input. This is another

opportunity for open communication and interaction between the nurse and family to build trust. With the children who are admitted with NAHI, this is different and can pose a problem, as explained by Fiona who appears to struggle with the barriers placed on her usual nursing practice.

*“We are the ones there in their face and then they just get us, and CYFs is somewhere else so we just explain... that’s CYFs and the social issues, so [we] talk to them but they still... we have to deal with their grumpiness and what not. It affects our day, like the rest of the shift is affected; like we don’t know what mood the parent will be in and what we are going to say. Will we be attacked back and every little thing counts after that? So, you are not the same, like when you are giving the care it won’t be the same because you have this fight. I don’t know how the parents will react now or what if something slips out?”* Fiona

Nurses are the face of healthcare that the family see consistently throughout a shift. Whatever the family thinks about their situation may be directed towards the nurse. She provides a link between the family and other services/teams the family encounter throughout their stay. Usually the nurse would communicate updates to the family, and the family would go to the nurse to ask for information. For Fiona, this process is impeded when there are restrictions or uncertainties about what can be said and what cannot. For Fiona, *the unspoken* is rationalised by fear of the consequences that may ensue in response to her honesty or carrying out the usual practices of relaying information.

*“...it is like you have to be really careful of what you are saying and then all this confidentiality, you have to keep it confidential. Yeah, so you have to be really careful of what you say and how you say it and what information you can give and what information you can’t give.”* Fiona

*The unspoken* is further perpetuated by Fiona. Fiona complies with the families’ requests to be involved in care even in situations where she knows the child will not be going home with them.

*“...and I let them do it but we know in the end the child won’t be going to their place” Fiona*

This compliance is the perpetuation of *the unspoken*, the absence of truth, or silence, and further illustrates a difference in the interpersonal interactions between the nurse and the family, present here particularly in cases of children with NAHI. For Fiona this mode of communicating is uncomfortable. Phrases such as “you *can’t* say what is right”, and “so you just *have* to say...” indicate that Fiona does not feel as if she has a choice in this aspect of her practice. Feeling the need to keep the peace with families, and being unable to disclose some information regarding care to families further perpetuates *the unspoken* and further highlights the difference and complexity that exists within the interactions between the nurse and family that are not routinely present in the relationship between the nurse and families of children with accidental or medical ailments.

#### 4.3.3 Dissociation

To dissociate is to disconnect or separate from something. In the context of this study, dissociation refers to an intentional or unintentional disconnection of the working relationship between the nurse and family of the child with NAHI. The way the nurse and family relate to each other is negatively affected because of this disconnection.

The experiences of the nurses in this study indicate they have detached or separated themselves from the usual connections that occur when a nurse meets and cares for a child and their family. Usually the child and family are regarded as one unit that the nurse cares for. However, the stories told by participants here show a dissociation from the family, replaced by a more focussed emotional attachment between themselves and the child. The focus is taken away from the family and care is directed towards the child. The relationship between the nurse and family is usually grounded on there being a connection formed by the involvement of the family in the care which is directed by the nurse. The resulting disjointed relationship creates an environment where both nurse and family are uncomfortable with each other.

This dissociation presents in Emily’s practice when she speaks of her first encounter with a child and his/her family after admission.

*"I mainly only remember a few and they were mainly babies, and they'd all come in with their parents once they'd been to theatre or CD or whatever. They come up to the ward, and they're usually always accompanied by a watch, and to be honest, I try not to really associate much with the parents. That sounds really bad but I kind of did that. I kind of more focussed on the child or the baby and kind of, because the watch was usually more present than the parents, just because of the situation that the parents were in most of them were a bit more standoff-ish and a bit more, you know, backed up against the wall."* Emily

As Emily recounts this experience, she places a negative judgement on her actions. Not associating with the parents "*sounds really bad*". Most of her attention has been placed on the child and the watch. She has recognised the parents/families as more standoff-ish (distant) because they are in a unique situation and are likely to be feeling anxious about the admission. There are many unknown factors at this stage. Apart from the obvious medical issues that are involved with the child, and the uncertainty about the outcome for the child, there is, again, the more obvious question around how this child came to be in this situation. Emily has chosen this way of approaching the family to focus herself and cope emotionally.

It appears that this dissociation occurs both from the nurses and from the families. Brenda talks about situations where the family dissociates from the nurse; she believes it stems from a lack of trust and, to some degree, fear of what the nurse may discover if family open up and communicate freely. Without open communication, Brenda finds it difficult to build rapport; without rapport and trust, a strong relationship with the family is impossible.

*"... some families... they just kind of feel closed off. Sometimes people can be shy; they don't want to open up. Others, they don't want you to find out what's going on with them so they close off as well."* Brenda

Brenda's inability to build rapport stems from the families' dissociative tendencies. Being unable to establish rapport with the families leads Brenda to also nurse in a dissociative manner. Brenda chooses a "*patient-centred*" approach because of the absence of an effective nurse-family relationship. The dissociation that is happening here creates a situation where Brenda's experience of nursing children and working

with their families is altered from experiences she may have with other children and families on the ward.

*“It wouldn’t be the same relationship, I would say, with another family, if I’ve got into that rapport with them... So, I’d only tell them what they need to hear, ‘OK, I’ve just given...’ for example. Something like, more so patient-centred and then they can just help out wherever. I think with the other families that rapport would be much stronger.”* Brenda

Emily refers to the family being ‘standoff-ish’. She suggests that the family may be purposely dissociating with the nurses as well. She is aware that the family are under investigation. Whether or not they were responsible for the abuse, they may be wary of the nursing staff (or any hospital staff) and careful of what they say, and how they behave. This dissociation between nurse and family is further complicated and prevents a healthy nurse-family relationship from forming. While such behaviour enables nurses to cope with the situation, it raises issues around professionalism.

*“I think I’m not professional, in a way, whereas I try to not talk to the parents. I guess that’s not being a professional as a person who would treat everyone the same, but that’s just my way of dealing with this and getting through this particular case.”* Emily

At the risk of appearing unprofessional, Emily has compromised her relationship with the family to allow her to cope emotionally. For the participants in this study, this way of working is different from their usual way of working with other children and families who are admitted with accidental or medical issues. Nurses do not typically find themselves in a situation where they distance themselves from the family on purpose. As soon as an injury is labelled as non-accidental, it can be difficult to approach a family in a neutral manner, despite all efforts to carry out the ethical and professional guidelines a nurse strives to adhere to. Emily explains:

*“I mean you need to treat these parents and families the same – innocent until proven guilty – but a part of me was always annoyed with these parents and this poor innocent child has come at the fault at someone that may know them or a family member. So yeah, I had resentment towards them. I didn’t show it in*

*an obvious way. I was always polite, I was always like attentive to them...but, yeah.” Emily*

Although Emily recognises that the families should be treated the same (as any other family), and that they should be given the benefit of the doubt, she still chooses to behave differently from her interaction with other families. There is a sense of an emotional struggle with the situation in front of her. While understanding the families need to be treated as though they are innocent, she is annoyed and has resentment anyway. She is polite and attentive but this seems minimalistic. Emily dissociates with the family in subtle measures by doing what is necessary to appear professional. However, the connection she would usually form with the families of children she cares for is not there.

Fiona and Claire also describe experiences where it has been difficult to maintain the kind of relationship that exists between them and any other families admitted to the ward. In a similar way to Emily, they both relay times in their practice where they have found it difficult to ‘be nice’ or ‘show respect’ towards the family when they are aware that someone present has committed the abuse that led to the child’s admission.

*“It’s just like, it’s difficult when you see it’s the parents there. We don’t know who did that to the child but as a nurse we have to support the parents and the child. So sometimes we just have to be nicer to them and sometimes it’s just so hard being nicer to them, thinking like they are the ones who have done it.”*

Fiona

Fiona states that she tries to maintain a nice and friendly persona, despite the difficulties. The relationship here does not look so different from the outside, yet Fiona seems to struggle internally with her relationship with the family. Claire’s internal struggle relates to the lack of respect she senses towards the family. She recognises that this is a barrier for her in relation to connecting with the family. However, despite this, attempts to uphold a polite manner and outward appearance of decency are apparent.

*“When you know who did it, they are still allowed to sit at the bedside and come around it’s like, I just try to take a deep breath before coming in and just*

*try to be not rude. I will say hello and try to keep it polite but I have no respect for them. I stay polite and say hello, good morning or goodbye or whatever. That can be hard but I stay polite. I don't think I've ever been rude to somebody when I know what they've done, yeah, but it makes me angry that they are still allowed to be there legally. So, there's nothing I can do about it. I try to just get on with it, yeah."* Claire

Although Fiona and Claire are able to outwardly appear polite and 'nice', there is a sense of an internal struggle. The internal struggle experienced by Fiona and Claire creates a situation where they experience disconnection from the families, and is demonstrated with the appearance of politeness. Their internal and external thoughts and actions are at odds with each other and this does not create a firm foundation for a strong working relationship with the family.

Through the experiences of these nurses, part of the meaning that has been uncovered is that nurses caring for children and their families with NAHI engage in relationships which look different from the way they engage with other children and families in their work environment.

#### 4.4 The non-judgmental approach

*"Like the kind of things that you are asking, I try and keep them to the back of my mind because it's not my job to judge."* Diane

Making a judgment is being able to make critical distinctions and achieve a balanced viewpoint, or discernment (Collins, 2018). To be judgmental, is to have or display an overly critical point of view (Oxford University Press, 2018). In the context of nursing, the faculty of making judgments is an essential part of everyday practice. In the New Zealand Nurses Organisation (NZNO) Code of Ethics, within the nurse-patient relationship, making sound judgments is considered professional practice (New Zealand Nurses Organisation, 2010). In the context of this study, the nurses speak of having a non-judgmental attitude towards families whose child is admitted with NAHI, and imply this way of approaching care as professional. In the same instance, however, they admit this is difficult. Making judgments in nursing practice is essential. However, acting on negative judgment (or judgmental thoughts) is problematic. Making a

judgment that child abuse is wrong is not unprofessional. However, having judgmental thoughts about the family and acting on them may be deemed unprofessional.

This sub-theme fits into the overall theme of *'this is different'* on two counts. Firstly, it appears that the nurses in this study have to overtly emphasise that they are being non-judgmental in their approach to the care of the families, as this is the 'right' way of practising. Nurses seem to believe that a non-judgmental approach is professional in all care situations. However, all other care situations do not appear to stimulate the need to overtly emphasise their non-judgmental approach. Secondly, due to the complexities and sensitive nature of the topic of NAHI, the requirement of the nurse to possess a non-judgmental attitude seems to be regarded as highly important, in order to maintain professionalism. This may be because many aspects of the care related to children and their families with NAHI can create tension or dilemma within the nurses, between their personal values and beliefs about child abuse, and how they feel they need to practise professionally. What is uncovered through the experiences of these nurses is that through the difficult nature of relating to the families of children with NAHI, opinions are formed and judgments are made but these are hidden under the taboo nature of being seen to have such judgments.

It appears that while the preferred way of approaching children and families with NAHI is with a non-judgmental point of view, as Brenda's narrative describes, it is difficult and requires effort to maintain this stance.

*"I think for me in general, when I go into that ward I kind of like treat the parents with a non-judgmental mind. Despite what's happened to their child. I actually still treat them like a human. So, I know that there are a few other staff members where I noticed them being quite, I don't know, angry? And just taking things kind of personal. Whereas, for me, I'm just like getting in there, doing my job and trying to put my feelings aside in some kind of way."* Brenda

Brenda admits she has certain feelings about what has happened to the child – feelings that she tries to put away *"in some kind of way"*. It appears that to do her job effectively, Brenda must do this. Having a non-judgmental mind is how she would prefer to practice because this would make nursing easier. However, in this situation, it is difficult not to have an opinion or make a conclusion about what has happened.

*"I find it really difficult because it's very hard to be able to shut that part off and be kind of like OK, you're going to have to carry on with the job and talk to them like normal without coming across as being a mean nurse, because they've done that – hurt their child... I still have to treat them although I know that someone has done it. Even when they find out who's done it, I still have to talk to them like they're the parents of that patient without that, what's that word? being judgmental, so I do have an open mind with that. I think it's just not my place to judge people."* Brenda

The tension is obvious. Brenda finds it difficult to shift her personal opinion of the situation from being the focus of her practice. It appears that if Brenda was not able to shut off that part of her thinking she would not be able to be professional. In the same instance, she maintains that it is not her place to judge so she treats the family, the perpetrator in some cases, the same as any other parent on the ward.

Fiona also maintains her stance of not making assumptions and tries to remain open-minded about how the child obtained their injuries. However, she also describes the challenging aspect of doing this in situations where it is unclear who caused the injuries to the child.

*"I just don't make any assumptions. I treat them like they are the parents and this is the child with a head injury... It's challenging, I'd say. You are mentally challenged and you have to keep your eyes open. You have to be extra vigilant when dealing with them and you can't just assume. You have to treat them fairly because you don't know whether the parents are the ones or not so you can't treat them differently. Like what if they are not?"* Fiona

There is a sense of tension within Fiona's words. She makes an interesting statement that shows making judgments happen all the time, though acting prematurely on them, is not how Fiona chooses to practise. However, while speaking of not making assumptions, there is a sense when she uses language such as 'you have to keep your eyes open' and 'you have to treat them fairly' that this is deemed the correct way to act, reflecting the mental challenge that exists for Fiona in working this way. By needing to be extra vigilant, Fiona is stating that this is a situation that requires something different from her from nursing a child in other contexts.

While acknowledging the importance of not making assumptions, Diane talks about how she maintains a non-judgmental approach by using a certain ‘*tone of voice*’ and being very clear about why this must be done. In the same instance, however, she is very clear about how it is inevitable that she will be affected in some way. Diane works hard in these circumstances not to let it affect her practice. However, she acknowledges the difficulties in getting it right.

*“I guess it has to affect you as a person. And you probably have to be really careful about your communication and just making sure that... I guess that for me, I make sure I’m really clear about you know, like your tone of voice, what you are saying. I wouldn’t want families to think that I’m thinking anything in particular, because that’s not a conversation I would ever want to have with that family., because it’s not my job, at that point, to have that conversation or to judge somebody. But I guess in your own mind you can’t help but to do that.”*

Diane

Alice also acknowledges the difficulty in maintaining this state of being in circumstances which make it difficult not to judge.

*“For my part, I just know that putting on my professional hat and that also comes with the “as hard as” ...and it is hard to be non-judgmental of a child that’s got a fracture in every bone of his body, even his small toe. How is that possible? You are trying to think of all [the] ways this could have been.....I don’t know, how do you fracture every child’s bone? And you just hate that that’s happened.”* Alice

When Alice is in her professional role (indicated by her description of wearing her professional hat) she maintains an outward appearance of approaching a situation with a non-judgmental attitude. That is what is needed to care for the child. However, there is an internal battle present. How could something like this happen? There is a sense of emotional turmoil in this dialogue. For Alice, it appears that by wearing her professional hat to get her job done, she is protected slightly from the emotional struggle within (further discussed in Chapter 5).

Diane has had many years of experience with children and families with NAHI. She admits that through her experience she has learnt that role awareness and professionalism help her uphold the non-judgmental mindset. This is the 'right' way to care.

*"It just seems to me to be the right way to do it. Just to be really clear and up front about what my role is and my role is not to judge the parents or judge the extended family. It's just to be there to support the child and support the family in what their needs are. Yeah."* Diane

What is 'right' however, is not always easy, and Diane relays her experience of what she finds the most difficult when it comes to maintaining this professional, non-judgmental approach.

*"Honestly, the ones, the situations that I do find the hardest are when a child has multiple injuries, sustained over a long period of time. I mean these children are devastated and I guess the hard thing to see is what an awful, awful life that they must have had and that's really hard to take. Sometimes it's very hard to see very caring parents sitting at the bedside knowing that somebody has done this to the child and you know, I think those situations are very difficult."*

Diane

The emotional pull between feeling and doing what is 'right' seems to create a tension that may not be present with other children and families. It is possible that being explicit about what the nurse's role is and what it is not enables the nurse to deal with the tension that exists. Being overt about your role and having that awareness that it is not your place to judge a family about what has led to their admission is one thing that appears to make these circumstances different from other medical or accidental injuries.

#### 4.5 Conclusion

As shown by the experiences of the participants here, there is a definite difference in the approach described by the nurses in this study when managing care for children and families of NAHI. From the initial contact with children and families and the implementation of certain procedures and protocols, an alarm bell goes off that

indicates something in their approach will be altered. The way the nurses then approach families, and vice-versa, affects the type of relationship they have. This is also affected by an undercurrent of uncertainty formed by the tension that is created by not wanting to judge a situation that is emotionally charged.

The issue of children who have NAHI is a sensitive one, fraught with many complicated factors that would understandably make the approach to care different because it is difficult. It seems from these narratives that the nurses in some instances are attempting to fit into a model of care that is not suited to the reality of these circumstances.

## Chapter 5 SHIELD OF PROTECTION

### 5.1 Introduction

The theme of *shield of protection* describes the nurses' approaches towards the care of the child and his/her family. Their experiences illustrate how the participants adopt measures that protect them whilst caring for children and their families with NAHI. A shield provides protection, safety and security to someone or something. The nurses in this study describe care of a child/family illustrated by the concept of a shield, the protective armour which nurses put on when they contemplate and carry out the care of children and families with NAHI. This shield appears as heightened awareness and purposeful attention to their role, boundaries they create and maintain under the guise of professionalism, and a shifting of focus to the child.

The nurses appear to have a more focussed and intentional approach to nursing these children and families. Deeper analysis reveals that this shield of protection is a protective mechanism that will protect both the nurse and family from possible emotional turmoil from the act of abuse towards the child, possible legal issues related to sharing information, and preserve the relationship between nurse and family. These reasons put together make this approach unique to the care of children and families with NAHI.

This chapter will describe the meaning of the protective shield and the ways in which the participants utilise it in their care of children with NAHI and their families. The shield is employed through the nurse's acute awareness of their role (*"It's not my job"*), their dedication to creating and maintaining boundaries by wearing their *professional hat*, and *shifting the focus* of nursing care towards the child.

### 5.2 "It's not my job"

It is evident in the narratives of the participants that their experience largely consists of a heightened awareness of their role as a nurse while caring for children with NAHI and their families. The nurses place emphasis on what their role is, and what it is not. It appears that by doing this, the nursing becomes easier.

'It's not my job' is a phrase used by many participants to signify what 'is' their job. This phrase encompasses the experience for the nurse seeking to define their role with children and families with NAHI. In the everyday, usual experience of a nurse taking care of children and their families, there are not many circumstances where the nurse is objectively seeking to define their role in terms of what they do not do. It seems that the nurse who takes care of a child and family with NAHI must constantly assess and reassess what they can and cannot do. Whether this is because of the social complexity that exists in these cases, the distressing nature of the injuries, possible legal complications or the need to maintain trusting relationships with the family (described in Chapter 4), there is an acute awareness of what their role is and, more emphatically, what it is not.

As an experienced practitioner, Diane very clearly states how important being aware of her role is.

*"...I guess one thing I've learnt over time is that you have to separate what we do from what's gone on. So, in order to I guess be able to look after children in that situation you have to compartmentalise things a little bit. So, making sure that you're really aware of what your role is there and what you are doing. So, I'm there to look after the child, make sure their nursing and medical and care needs are met and that we advocate well for them...My job is to look after the child and to keep the parents informed about the child's health needs now. Not answer questions about what's gone on, about the incident, or ask questions about what's gone on, because that's not my role. By doing that then it makes it easier to look after that child and their family."* Diane

Diane is very specific about what her role is and what it isn't. She compartmentalises her care as a way of defining her role. It is interesting that what Diane states is not her role is what differentiates these cases of children with NAHI from children with accidental or medical conditions. With every child who has a brain injury and their family, the role is always to take care of the child and keep the parents (family) informed about the child's health needs, as well as to advocate for them. It appears

from the data that with children and family of NAHI, the role is *not* to talk in the same way with families; for instance, about how the injury occurred or entertain any conversation relating to it with the family.

Alice has a similar way of approaching difficult family situations. While caring for a six-week-old baby with NAHI she had to find a way in which she could manage awkward family dynamics with young parents who did not say much. Both grandmothers were *'uptight'* about why certain procedures had to take place including having an HCA watch in place. Alice's awareness of what her role is in this instance is fuelled by wanting to gain favour with the family to ease the tension and awkwardness, and allow for an improved relationship with the family *"so that the child can get the best care from me"*.

*"I always find that they [family] will kind of work with me when it comes to looking after this child because it's not my job to do the social side of things, with what's happened to this baby or this child...I think if you get involved with what's happened, you know what's happened with the child, I don't think you nurse well and I've seen some families get real, what's that word? You know when they are real aggressive towards you and they know that they are being judged so they are just nasty. You know? They are just defensive and kind of shut you out. I think nursing with the family that kind of shut you out, you're the primary person that has to care for them on your shift, it's kind of hard. So I choose not to do that and I just choose to talk to them because it's not my part of my job to figure out who was the one who hurt the baby or whatever"* Alice

Alice is very clear that her job is not to engage in matters related to how the injury occurred. She has compartmentalised her care of the child and family with the sole focus on creating an environment where the child receives the best possible care from her. In this case, the best environment is one where the family does not feel threatened. This is her choice and is how she perceives herself as a nurse while caring for these children and families. The priority for Alice is simple: take care of the child. The awareness Alice has of her role serves primarily to protect her relationship with the family.

*“... because it’s not really my problem them [the family] trying to figure out who it was. That mother said that and that mother said that. OK, let’s just look after that child. Those other people: social workers or whoever they are, CYFS deal with that...” Alice*

Diane finds cases where families are more focussed on the investigation the most challenging. Diane believes that when the families’ focus has been taken away from the child, special care must be taken. As a result, Diane, in awareness of her role, supports and encourages the family by discussing matters related to the child’s recovery. Diane essentially, is refocussing the parents or family back to the care and management of the child’s injury by choosing not to be drawn into conversations about the investigation with the family. Diane is firm in protecting her professional role and potentially risky discussions, thereby safeguarding the relationship between herself and the family.

*“I’m not here to discuss you know, ‘do you think falling from a couch would have done this?’ That’s not my job and when constantly they’re focussed on that or asking everybody’s opinion and that’s not healthy and it’s certainly nothing as nurses we should get involved in...” Diane*

By stating that nurses should not be involved in conversations about how a child’s injury occurred, it is possible that Diane regards this as unprofessional. In fact, in all accidental injuries, the nurse’s role would include engaging with the family of the child about the mechanism of how the injuries occurred. It may even be deemed unprofessional to exclude some aspects of usual nursing practice to the children with NAHI and their families. This is difficult and can create dilemmas about what the nurse’s role is, and what it is not. It is a complicated situation with many disciplines involved. It is a sensitive issue, and there are legal restrictions and consequences to engaging with families about how their child’s injuries occurred. It is understandable that Diane’s approach is adopted. The simplicity of care becomes evident when she clearly defines her role.

When confronted with families who are wanting to be involved in care, and asking questions about care and plans for discharge, Fiona finds it difficult to be truthful because she is unsure what she can and cannot tell the parents or family and does not

want to cause further distress. This is a dilemma for Fiona and, while trying to avoid or ignore the families' requests, as a strategy to defer the conversation she feels that it is not her job in the first place to be having those conversations with the family. The potential legal complications that may arise from discussing matters with families, and the uncertainty about what can be relayed to family appear to trouble Fiona. Fiona appears to use her role in this instance to protect herself and her nursing practice from crossing potential legal boundaries.

*“But then it’s not my position to say [anything about] the social issues, what’s happening, what CYFs are doing. That’s none of my business. Because I’m the nurse looking after the child and the child is like my main focus, like I can’t involve the parents that much realistically...That’s the social issues, social workers will deal with them. So just refer to them, because you can’t do the social things and do the plans and then be the nurse.”* Fiona

Here, Fiona is defining her role based primarily on what it is not (“that’s none of my business”). It is to not discuss anything that might otherwise be discussed with CYF (MVCOT), or a social worker. Her role is to look after the child. Involving the parents (family) may not always be possible, depending on visiting restrictions and plans for care after discharge. Fiona continues this dialogue, demonstrating how her experience of being aware of her role acts as a shield in developing and maintaining a strong working relationship with the family. It appears that Fiona coordinates her nursing practice around the protection of the nurse-family relationship.

*“Yeah that’s a bit hard, even like telling them you’ll be having a watch. I always tell the social workers or somebody else to talk to them. I’m the nurse, I’m not going to tell them you guys will be having a watch because they [will] suspect it’s like non-accidental...I say no, get the team to do it. So that we have that relationship, because you have to build up that nursing relationship. Because [otherwise] they will think everybody is like this.”* Fiona

Fiona’s goal for not wanting to take on this responsibility of informing the family about having a watch is to keep her trusting relationship with the family safe. She is afraid that the family will react negatively to her and she does not want to compromise her relationship with them.

The idea of 'it's not my job' was apparent in many of the narratives. There is a general sense of not doing a job that might otherwise be done with other children and families with accidental or medical conditions. The unique situation that families are in and the social context require the nurse to adjust her thoughts and behaviour to adequately take care of the child. Maintaining the relationship between the nurse and family emerges as a driving force behind being aware of their role and defining it in terms of what nurses do not do. Role awareness is a protective stance the nurses in this study adopt to maintain stability in the nurse-family relationship, so that the child may receive the best possible care. The child here becomes the nurse's primary focus.

### 5.3 The professional hat

Being professional appears to act as a mechanism for establishing firm boundaries which the nurses in this study work within and maintain. The nurses talk about professionalism in a way that suggests it is used as a shield between themselves and the child/family. Professionalism, in this sense, acts to prevent emotional involvement with the child and family to prevent emotional distress, to maintain relationships with the family, and to provide focussed care of the child. The shield was expressed both as something put on, and as a device of separation from potential distress.

Brenda acknowledges her tendency to become emotionally involved with certain cases, particularly when seeing a young baby with injuries of a non-accidental nature. To protect her from becoming too emotionally involved she recognises the professional boundary that must be maintained, and works toward creating and maintaining this boundary. It is unclear if maintaining this boundary is successful in protecting her as there is a sense of turmoil in her dialogue.

*"It kind of made me feel a bit sad for that little boy, I mean for a 5-month-old to have those injuries. For me, I'm the type of person who gets quite emotional. I get quite attached but on a specific level, there's a professional boundary."*

Brenda

Alice speaks about her professional hat which she wears while at work. It signifies a difference in thought processes and behaviour around these families when worn. She wears it when there are certain boundaries that must be maintained and not crossed. It can be seen to act like a piece of protective armour.

*“So, you don’t actually deal with them [the perpetrator], so that part’s easy, that’s fine. I don’t think I’ve ever actually had to deal with that, but just with the other family members, just keep my professional hat on and work with them, because working with them will better the child.” Alice*

The reason for this is to be able to provide the best care for the child. It appears that, like Brenda, Alice uses this hat as a piece of armour to protect herself from having to feel the emotional outrage that might occur if she was not working with her professional hat on.

*“Otherwise I will just get caught up and it’s human nature that you’re just, “Oh my gosh, here we go again.” You know? You do that, but I suppose if I didn’t have my hat on and I was outside, I would be like, “Oh my gosh.” It’s while I’m working I just have to remember I have a practice to practise. And if it means working with the family then it’s working with the family, but it’s better that they’re talking and communicating with you because it just makes your life easier when you’re standing there for 12 hours nursing this child. I just couldn’t imagine having a hostile family in the corner the whole time. It’s just a bit too much of an issue for you as a nurse.” Alice*

When wearing her professional hat, Alice feels that it is within her protective professional state where her focus is not on herself and her emotions but on maintaining a strong relationship with the family. Nursing the child and liaising with the family then becomes easier, it would seem, in spite of her emotions. It raises these questions: Does wearing a hat to denote a difference in thoughts and actions actually improve the wearers’ ability to nurse? Is professionalism just a guise for a state of self-protection?

Diane speaks about how becoming emotionally involved would make it impossible, or at least very difficult to carry out her role. Her role awareness in this sense creates an environment where she is successful in carrying out her duties as a nurse for these children and families. There is a definite line that is not to be crossed.

*“...there’s a lot of sad sort of cases that you work with over time and I guess that if you got really emotionally involved or attached or affected by everything, all the sad things that you see, you’d never be able to do your job.” Diane*

#### 5.4 Shifting the focus

As a way of protecting themselves, the nurses have adopted a self-protective mechanism of shifting the focus. This shift that occurs in the dialogues of the nurses in this study are: 1. From the perpetrator to the child and other family members, 2. From how the child was, to how he/she is now, and 3. From how the injury happened to what the injury is.

Ultimately the nurses here have adopted these measures of thinking and acting to enable them to effectively care for the child. Claire uses an example of how she shifts her focus from the family (the perpetrator) towards the child. She describes a difficult family situation where the father who caused the injuries was allowed to be at the bedside. Claire has shifted her focus from the father to the child and other family members as a way of self-protection.

*“When he was in the room, I said hello but concentrated more on talking to the other family and the child. Yeah, I tried to concentrate more. That was what I was there for, at the end of the day, anyway. Not to be nice to him or just think about who’s in the room but I’m there for the child. Yeah and that helps me a lot.” Claire*

Focussing on the child is a protective mechanism for the nurses; it helps them centre on what is achievable, and separate out what is uncomfortable about the situation, making nursing easier. It also gives the nurse joy that they can provide love and care to a child who, they feel, has not received it.

*“I just concentrate on the child. I’m angry with whoever did it and how could you do it to somebody who needs your protection? [Someone] That is so vulnerable... They are just children... I’m just upset sometimes, and I’m quite empathetic, as well, with the child but at the moment when I actually do the nursing care for the child I’m more loving and caring than angry. I just try to*

*pour all my love that they obviously didn't get from somebody else, into that child, and I love it. I really love it. Just giving the love, yeah."* Claire

Claire says, "You can't do that every day but be in that moment..." To be in that moment, for Claire, means to focus on what is important to her, to help her practise effectively and to protect her from emotional distress. By being in the moment, Claire has shifted her focus from thoughts of the perpetrator causing the injuries, towards care of the child. This shows how a shift in focus in this manner can create a shift in emotion (from anger to love), demonstrating how Claire's self-protective strategy works.

Focussing on the child who is, rather than the child who was, is a shift that helps Claire nurse children with NAHI, and their families, with more ease. Taking care of children with NAHI is something that Claire appears to enjoy. However, to take care of herself in that moment she adopts this strategy of shifting the focus.

*"I sometimes think I don't try to think too much about [how] this was a healthy child and look what happened, now maybe they will never learn to talk or whatever but I like to look after them...and I think it works really well for me. It's not like you have to do it, otherwise you would just break down one day. I think it's sort of like a self-protection but it works really well for me to see them how they are and not how they have been."* Claire

Fiona has a similar way of approaching children with NAHI. She focusses on what injury the child has rather than on how it happened. In this way she is able to manage the child's care centred on the injury. She gives an example of a child who has been admitted with a subdural haematoma after being abused. In this instance, Fiona will focus on management of the subdural haematoma rather than how the child came to have this condition.

*"So just think it's a head injury. Don't think how it happened or who did it. You're just treating the head injury."* Fiona

## 5.5 Conclusion

Having a protective shield, in whichever form it takes, appears to be vital in the care and management of the child and family with NAHI. There is a kind of shield or barrier

that stands between the nurse and their care, not intended to hinder nursing practice, but to enable it, for these nurses. Being aware of what their role is and what it is not, creating and maintaining professional boundaries and shifting the focus of care towards the child are all forms of protective mechanisms that allow the nurses to practise in ways they feel are more effective.

The two themes discussed in chapters four and five bring together a completeness of how the nurses in this study experience their care of children with NAHI. Experiences are '*different*' and contain elements of '*protection*'. In the following chapter, a conceptualisation of these themes is put forward to more adequately situate the nurses' experiences as '*being*', or '*being-in-the-world*' as described by Heidegger, which will bring added light to the meaning underlying caring for children and their families with NAHI.

## Chapter 6 DISCUSSION

### 6.1 Introduction

“...to ask for the being of something is to inquire into the nature or meaning of that phenomenon” (van Manen, 1990, p. 175)

The rich stories relayed by the six nurses in this study uncovered deeper meaning into their lived experiences. Through the analysis of their stories, two main themes emerged. To further expand these themes and situate them within the Heideggerian notion of ‘being’, they will now be discussed as ‘being’ as *different*, and ‘being’ as *protective*. Heidegger conceptualises ‘being’ as ‘being-in-the-world’ and this better situates the nurses in their lived world. Therefore, the nature of inquiry in this study can be answered in broad terms by two statements: ‘the lived experiences of nurses caring for children with NAHI is *different*’ and ‘the lived experiences of nurses caring for children with NAHI is *protective*’.

#### 6.1.1 ‘Being’ as different

*Being* a nurse caring for children with NAHI is *different* from the care of children admitted with accidental injuries or medical conditions. Three sub-themes were identified as showing this difference. Protocol is to be followed when a child is admitted. Protocol is manifested in the form of clinical guidelines for and policy on child abuse and neglect. The significance of protocol is that it is the first indication to the nurse that a *different* approach to care is about to follow. *Being* a nurse in this care situation also shows difference in the complex nature of relationships between the nurse and the family. The overall complexity lies in the social aspects of nursing children and families, primarily in the management and acknowledgment of families, the usual conversational topics between the nurse and family *being* unspoken, and the experience of dissociation between the nurse and family. Lastly, the tension the nurses have experienced between adopting a non-judgmental approach towards families and suppressing their own judgments appears to be unique to children with NAHI and their families. These three sub-themes give meaning to nursing children with NAHI as *being different*.

### 6.1.2 'Being' as protective

*Being* a nurse caring for children with NAHI requires the nurse to adopt *protective* qualities to their care; these are conceptualised, in this study, in the form of a shield. To *be* a nurse in this context means being aware of their role and, more emphatically, what it is not their role. The nurse creates and maintains boundaries that are constructed under the premise of professionalism. The boundaries act like forms of protective gear, for example, the professional hat. The nurses shift the focus of approaching care away from what might be distressing towards the ultimate goal of giving the best care they can to the child. *Being* protective in this way creates pathways to more effective care that is easy to deliver, while also acting as a self-protective mechanism to attempt to minimise distress over the circumstances of the child's injury.

This chapter aims to discuss the meanings uncovered that bring light to the lived experiences of the nurses who care for children with NAHI, and situate their meaning in the wider context of the current literature. Three main states of *being* have emerged from the two themes that stand out as significant in giving meaning to the nurses in this study. These are *being emotionally distressed*, *being professional*, and *being family-centred in care*. The intention is to further bring meaning to the nurses' experiences through discussion of these three main states of *being*. The chapter will conclude with the strengths and limitations, the trustworthiness of the study and recommendations for practice and further research.

## 6.2 'Being' emotionally laboured

The circumstances surrounding a child being admitted to hospital, as a result of abuse and/or neglect, are tragic. Emotional distress in the form of anger, shock and sadness would be considered a natural process for any person to undergo. In the context of this study, *being* emotionally distressed includes the way in which nurses experience themselves in the context of caring for children with NAHI. The nurses admit emotional difficulty. Tension is present because they feel a certain way about the circumstances of the child's injury, yet must attempt to act in a manner congruent with their perceived state of professional practice (see 6.3 'Being' professional).

The terms referring to the emotional vulnerabilities experienced by the nurses in this study include emotional distress, emotional turmoil and emotional tension. These are terms familiar to the author and seem to fit the experiences shared by participants. On reviewing the literature pertaining to these emotional difficulties, the concept of 'emotional labour' as described by Mazzotta (2016) was found to be consistent with the nurses' experiences described in this study. Mazzotta (2016) describes how nurses frequently witness suffering, and have experiences of emotional turmoil but must suppress their feelings and emotions in the service of appearing professional, and for the welfare of patients and families (Mazzotta, 2016). Emotional labour is an invisible skill performed by nurses, and constitutes many aspects of the profession; an assumption is made that nurses have the ability to endure great emotional demands while continuing to perform duties and maintaining a separation of their private and public selves (Mazzotta, 2016). Emotional labour is, therefore, the requirement of one to induce or suppress feelings to uphold an outward countenance that produces the proper state of mind in others (Hochschild, as cited in Henderson, 2001; Mazzotta, 2016). Emotional labour obliges the nurse to suppress or significantly change their emotions to conform to organisationally defined rules and regulations to display feelings and behaviour that express to others a sense of being cared for (Badolamenti, Sili, Caruso, & Fida, 2017).

Emotional labour relates closely to the experiences of the nurses in this study who have cared for children with NAHI. Their emotional difficulties stem from what may be described as a lack of acknowledgment of the emotional labour they experience in their interactions with children with NAHI and their families. The nurses here are going through the notions of suppressing their feelings or emotions about the child and family, in the service of maintaining an outward professional appearance, in accordance with their understanding of professional practice defined by their organisational policies/rules as well as by the governing body of nursing in New Zealand (Nursing Council of New Zealand) (see 6.3 *'Being' professional*). Emotional labour, as an invisible skill, is part of many aspects of nursing practice – especially in settings where nurses frequently encounter tragic cases. The amount of emotional work nurses endure that is not seen immediately summons images of a duck swimming in water: the frantic movements of webbed feet under the surface of the

water, unseen, contrasts significantly with the calm, graceful movement of the duck across the water. Eventually the duck will tire.

Indeed, the problems of emotional labour occur when nurses can no longer cope with the emotional aspects of their daily work (Mazzotta, 2016). Nurses adopt coping strategies when feeling overwhelmed; metaphors such as 'switching on and off', 'drawing the line', 'keeping a bit of a barrier up' capture these approaches in the absence of support (Froggatt, as cited in Henderson, 2001).

This is consistent with the strategies employed by the nurses in this study to cope with their inner turmoil. They distance themselves through *'dissociation'*, by defining their role (*'It's not my job'*), creating and maintaining professional boundaries (*'the professional hat'*), and *'shifting the focus'* of care from what is uncomfortable to think of, to what is comfortable, ultimately providing nurses with comfort in that they are doing something positive and loving to the children with NAHI that may not have been received from a family member. Badolamenti et. al. (2017) concur that the predominant relationship management strategies are avoidance strategies. Communication techniques, where the subject of conversation is changed or information given to family members is limited, shift the focus away from the family to performing technical duties. "The danger of not acknowledging the depth of emotions experienced by nurses every shift is the risk of losing the 'art of nursing,' and more importantly, of becoming actors that face critical situations without feeling and empathy"(Mazzotta, 2016, p.31). The boundaries between personal and professional feelings are permeable. It is often difficult to negotiate how much the nurse lets in and when to close off (Bone, 2002). Bone (2002) also acknowledges emotional labour as an invisible skill which begs the question, 'Is the emotional work nurses do recognised as a skill that requires training and support?'

Similar findings on the emotional work of the nurse have been reported as a key theme in the study of nurses' experiences of clinical encounters with children who experience child abuse and their parents. This is described as emotional ambivalence (Tingberg et al., 2008). Nurses in this study experienced problems in their relationships between themselves and the parent/perpetrator. They described feelings of hatred for the abuser while simultaneously feeling empathy for the child's circumstances. A

common response was that one of the greatest challenges for these nurses was to feel one thing so deeply while acting as if they did not feel it. They also noted a feeling of not being prepared for the emotional toll experienced with this group of patients. The findings of this study support those of Tingberg et al (2008) (Tingberg et al., 2008) who in their study noted the tension which occurred when nurses had to act in a professional manner while at the same time experiencing strong emotional reactions towards the child's circumstances and the family member who may have caused their injuries.

The work environment surrounding nurses who care for children with NAHI and their families will remain emotionally charged. The challenge lies in acknowledging the invisible nature of the emotional labour experienced by nurses to support and put into place strategies that encourage discussion and make the invisible visible.

### 6.3 'Being' professional

#### 6.3.1 Professional boundaries

The meaning of '*being protective*' incorporates the experience of using professionalism as a way of creating a shield/barrier/awareness, defining how the nurse should behave. The phrases "professional boundary" and "my professional hat" have been used by the nurses in this study as their definition of professional practice.

In the Code of Conduct for Nurses, set out by the Nursing Council of New Zealand (NCNZ), emphasis is placed on maintaining boundaries in professional relationships between the nurse and the health consumer and their family (Nursing Council of New Zealand, 2012a, 2012b). Separate guidelines on professional boundaries have also been published by NCNZ (2012b) and define professional relationships as:

...the therapeutic relationships that focus on meeting the health or care needs of the health consumer. Nurses must be aware that in all their relationships with health consumers they have greater power because of their authority and influence as a health professional, their specialised knowledge, access to privileged information about the health consumer and their role in supporting health consumers and those close to them when receiving care." (p. 5)

The guidelines contain standards of behaviour and more detailed advice on professional boundary issues and how they are to be managed. Guidance for every situation cannot be covered so it is left to the nurse to develop and use their own professional and ethical judgment, and seek advice from colleagues and their professional organisation to deal with issues that arise in relationships with health consumers (Nursing Council of New Zealand, 2012b).

A continuum of professional behaviour is outlined by NCNZ below, in Figure 1.

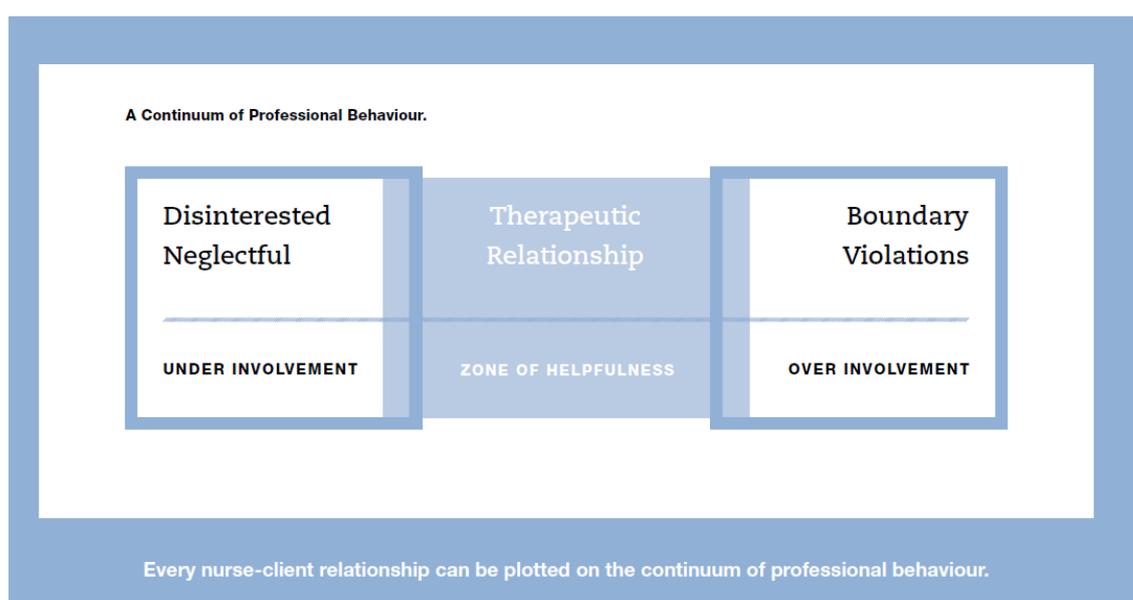


Figure 1. A continuum of professional behaviour (Nursing Council of New Zealand, 2012b)

A professional relationship sits in the 'zone of helpfulness' and is where the majority of interactions between a nurse and health consumer are expected to occur for effectiveness and safety. Boundary violations occur with over-involvement by a nurse and include inappropriate relationships. Under-involvement includes distancing, disinterest, coldness and neglect (Nursing Council of New Zealand, 2012b). The NCNZ guidelines for professional boundaries do not further address under-involvement. The idea of professionalism, as experienced by the nurses when talking about *the unspoken* and *dissociation* in the context of *complexity in relationships*, may include reduced warmth and distance, an aspect of under-involvement. From the guidelines, professional boundaries are described in the context of the relationship between the nurse and client (health consumer). Considering this description, when the nurses in this study spoke of crossing professional boundaries they would have to be referring to becoming over-involved with the child's family, which is not happening. The nurses

interviewed acknowledged their potential to cross professional boundaries if they behave in certain ways with families. They put up protective 'shields' and put on the '*professional hat*' which does not fit with NCNZ's description of violating professional boundaries. The nurses in this study have used the term 'professional boundaries' to describe vital aspects of their experiences when they may, in fact, be referring to something similar but different by definition.

### 6.3.2 Professional conduct

The nurses' experiences of tension and difficulty surrounding professional boundaries can more accurately be understood when referring to professional conduct, as outlined by NCNZ. The values underpinning professional conduct are *respect* (treating health consumers and families with respect to enable nursing relationships that support health and well-being), *trust* (when trusting relationships with health consumers are established by nurses, care is more effective), *partnership* (health consumers are fully involved and given information about their care and treatment) and *integrity* (being honest, acting consistently and honouring commitments to safe and competent care, as well as constantly acting according to values and principles and being accountable and responsible for actions) (Nursing Council of New Zealand, 2012a). These four values make up what it is to have a professional demeanour in interactions between nurses and the child/family (the health consumer). All participants expressed challenges in upholding one or more of these values (either in their actions or in their thoughts), and some nurses talked about how they strived to maintain professional values, at times at the expense of their own values and emotional well-being. In both circumstances, tension was evident.

Professional comportment describes nurses' professional behaviour that integrates consistently between values and actions, and is evident in the form of professional conduct, appearance and collaborative practice (Clickner & Shirey, 2013). The consequences of maintaining professional comportment are caring and respectful words, positive communication, respectful behaviour, effective relationships with patients and colleagues, self-regulation and accountability (Clickner & Shirey, 2013). This concept, like the values underlying professional conduct in the Nursing Council Code of Conduct, seem to be what the nurses in this study speak of when aspiring to professionalism in their practice while caring for children with NAHI and their families.

These value-laden concepts cause the greatest tension within the nurses as the *doing* of nursing conflicts with their personal values about child abuse.

Similar findings were reported in the study by Tingberg et. al. (2008) which investigated nurses' experiences in clinical encounters of child abuse and their parents. Remaining professional during the caring situation, with a parent as the suspected abuser, is difficult. Nurses want to remain professional but feel discomfort when interacting with the parent. As in the current study, nurses working in more general abuse situations have emphasised the importance of focussing care on the child during these times of discomfort (Tingberg et al., 2008). Training, counselling and experience are the strategies recommended by those authors to support nurses to provide the most professional care.

The nurses in the current study appear to have beliefs about being professional and where the boundaries of professionalism lie. They all report similar descriptions of where their boundaries are. The boundaries are explained in their stories: what they believe they should not do to cross them; for example, becoming emotionally involved, having a judgmental attitude, or creating situations where they cannot develop an effective nurse-family relationship. These descriptions tend more towards actions of maintaining professional conduct rather than maintaining professional boundaries. To prevent the possibility of '*being*' unprofessional, the nurses use their perceived professional duties, focussing their care intently on the child as a self-protective mechanism, and demonstrating an approach to care that is different from their usual. As the nurse describes her experience of '*being as different*', the *doing* of the nursing is experienced by '*being as protective*'.

#### 6.4 '*Being*' family-centred in care

One aspect of professional conduct outlined in the nursing code of conduct is nurses working in partnership with health consumers to promote and protect their well-being (Nursing Council of New Zealand, 2012a). A similarity exists between this standard and family-centred care (FCC). As discussed briefly in Chapter 1, FCC is valued as an integral component of nursing children and their families (Irlam & Bruce, 2002). As well as health professionals working in partnership with families, family members are also recognised as recipients of care along with their child (Nicholas, Keilty, & Karmali,

2014). FCC is fundamental to paediatric nursing as it reflects the respect for and partnership with the child and family when delivering care to the child. FCC supports the integrity of the family, endorsing individual health outcomes and normal family functioning while the child is hospitalised (Nicholas et al., 2014). Violence against children is not part of a normal functioning family. Situations where the principles of FCC are challenged by those families presenting with a child having NAHI are common in the study. Confusion ensues about how to apply FCC to these care situations. Granted, not all family members involved with the child's treatment in hospital are involved in the abuse. However, the abuse happens in an environment surrounded by family.

At times the nurse is aware of who the perpetrator is. That person may be present at the bedside. Other times the perpetrator is not allowed to be present and the family members who are present are willing to be fully engaged in the treatment and recovery of the child. As discussed earlier, there is a possibility that the child will not be discharged to those family members present, so continuity of care and rehabilitation is challenging. These are issues that the nurses in this study brought forward. They have struggled when attempting to implement FCC in their practice; the issues form a large part of their experience as *'being' different* in the *'complexity of the relationship'* between themselves and the family. The nurses strive to implement some aspects of FCC in an effort to protect their relationships with the family. They also find this implementation difficult when considering legal restrictions on key family members being allowed at the bedside, and unrealistic when considering that the family members who are at the bedside may not be caring for the child at home (or rehabilitation) post discharge.

There is little in the literature about FCC that addresses situations when children have been abused by someone in their family. The abuse violates the social norm of what it is to be family. Academic resources found on the ethical, legal and cultural difficulties that may present with FCC have no reference to these care situations (Chapman, 2014; Gilmour, 2014; Nicholas et al., 2014). The focus has been on cultural and religious differences in the concept of family, accounting for the family in law (e.g. in cases of divorced parents), and legal considerations as they pertain to who decides on courses

of treatment/care and the possibility of the child being legally allowed to make decisions about their care.

The dilemma in nursing practice that is experienced by nurses in this study about whether they can/should implement FCC, and the implementation of involving families as much as possible being driven by a need to protect the nurses' relationship with the family do not correspond with the theoretical background and aim of FCC. Nurses understandably experience dilemma and confusion, and are left to adopt individual strategies to overcome this. Again, meaning is given to the driving force behind the adoption of strategies to work around a framework that does not cater to this practice situation, this force being the nurse's desire to provide the best care for the child.

## 6.5 'Being' healers

The lived experiences of nurses in this study provide insight into '*being* different and '*being* protective, with the ultimate goals of nursing (or the *doing* of nursing) becoming easier or less complicated, and intently focussed on providing the child with the best care possible in hope for recovery. These two goals can be seen across both themes as underlying driving forces giving meaning to their experiences.

I believe there is an added element to the meaning of nursing children with NAHI. It is subtly implied in the stories of the nurses, some more than others. This element is the nurses' desire to heal through love and compassion. It may not be deemed to constitute a theme but, as a researcher, seems an interesting state of '*being*' to briefly explore. It may add context to the meanings uncovered. Nursing is, after all, a caring profession, care being central to nursing practice.

The essence of nursing is captured by a nurse's ability to care for another human being. This is a privilege many cannot even fathom because a nurse is invited to share a person's most intimate and vulnerable moments...within this reality, a nurse holds deep within the heart compassion, courage and a capacity to care (Mazzotta, 2016, p.28).

Nurses journey alongside their patients during some of the most difficult and vulnerable moments in their lives. Nurses are privy to situations and information

sometimes unknown to closest members of the patients' families. As a nurse, I believe the privilege lies in taking part in the caring and healing process, one I liken to a journey of restoration. Watson (2009) describes nursing as a lifetime journey of caring and healing. This journey is in harmony with the vision Florence Nightingale had of nursing where the path of caring and healing seeks to understand and sustain the wholeness of human existence, and provide compassionate, informed and knowledgeable human caring (Watson, 2009).

It has been emphasised throughout this chapter that one of the driving forces giving meaning to the nurses' experiences in this study is to provide the best care for the children, to restore in them a state of wellness through attention and love. The experience provides the nurses with comfort, knowing they are able to help. Their experiences contain hopeful meaning of some state of satisfaction through all of the difficulties, tensions and dilemmas that form part of their practice. A quote from one of the nurses in this study stands out as demonstrating this meaning:

*"I just try to pour all my love, that they obviously didn't get from somebody else, into that child and I love it. I really love it".* Claire

If this is a state of *'being'* for these nurses, it would add a hopeful ending to this study that gives meaning to negative experiences relayed. These experiences of practising *'being different'* and the necessity of the nurse to adopt protective mechanisms by *'being protective'* would appear to have restorative properties experienced by the child *and* the nurse.

## 6.6 Strengths and limitations

The main strength of this research study has been the ability to gather rich data in the form of the experiences of caring for children with NAHI and their families from the nurses who participated. An exploration of these lived experiences was only possible because of the nurses' participation, and was greatly appreciated as the issue of child abuse is fraught with high emotion. Strength also lies in the study's ability to fill a gap in knowledge with regard to the experiences of nurses caring for children with NAHI. Only one study was located similar to this study. However, that study examined child abuse in general and was published ten years ago.

The small number of participants limited this study. No further participants could be recruited, despite efforts to broaden the sampling criteria (omitting the need for nurses to have at least two years of practice), and the sampling method of 'snowballing'. There was thorough discussion with my supervisors regarding this limitation. Considering the quality of data already obtained and taking into account academic time constraints to complete the study, it was decided that six participants provided sufficient depth and breadth of data for a research study at Master's level. However, it is acknowledged that the study may have been strengthened with more participants

A further limitation was that the small sample size led to a group of participants with limited demographics. More participants from a wider range of demographics could have added extra depth to the findings. It was difficult to purposively sample for specific demographics such as nurses of differing ethnicity, gender and levels of experience, due to the already small population of possible participants. To add ease to the carrying out of interviews, the researcher applied an extra criterion of nursing in the Auckland region. Limited resources for travelling meant interviewing could only take place within the Auckland area. This did not seem unreasonable as many children with NAHI are treated in Auckland's specialty children's hospital. The added benefit of interviewing face-to-face was to create an environment where the nurses felt able to adequately tell their stories in consideration of the assumed difficulties one might experience while discussing child abuse.

## 6.7 Implications of this study for nurses

It is hoped that this study will benefit nurses, both those working with children with NAHI and their families and the wider nursing population. The nurses in this study have provided frank, open, honest and heartfelt descriptions of their experiences of caring for children with NAHI and their families. Through the interpretation and discussion of these experiences, meaning has been discovered that may speak to other nurses who find themselves in similar care environments.

It has become evident that establishing therapeutic relationships between nurses and the families of children with NAHI can be challenging. As discussed, incorporating the concepts of FCC and practising in a professional manner (as defined by the NCNZ Code

of Conduct) expose limitations in implementing these in practice. Through the dissemination of these research findings, attention must be given to the challenging nature of implementing these crucial elements of care with children and families. It is then hoped that nursing practice in this care setting will be less challenging, being informed by clear guidelines that address the confusion surrounding implementing FCC and practising within the Nursing Code of Conduct.

## 6.8 Recommendations

Many issues have been highlighted in this study. Nurses experience their '*being*' as *different* and '*being*' as *protective* and this in itself highlights difference. Emotional labour is one concept that requires acknowledgement by organisational leaders. As described by Mazzotta (2016), it is crucial that nurses are supported in dealing with emotions experienced in their daily care as a lack of recognition and invisible effects of suppressing emotions should concern organisational leaders and educators due to the impact these factors have on nurses. Smith (as cited in Mazzotta, 2016) believes that nurses can, through training and experience, accept and recognise their feelings when carrying out professional duties and maintain therapeutic relationships with patients (and family) without being weighed down by a heavy emotional load. Child protection work is recognised by the Auckland District Health Board as complex and stressful. The staff who carry out this work must be provided with adequate training and professional support (ADHB, 2016b).

It is recommended that training and support be given to nurses at the undergraduate level, as well as at the organisational level, via educational opportunities with an overt acknowledgement of the emotional toll that may be experienced. Professional support services should be made known to help nurses who may require extra support. In addition, it is recommended that there is consideration of emotional labour as a skill that contributes to the acuity level of care of the child. This would occur at the organisational level where children with NAHI are assessed based on their medical *and* emotional acuity for nursing allocation. In the light of decreasing the emotional labour experienced by nurses, it is recommended that debriefing and/or professional supervision be encouraged, especially with challenging cases of NAHI. Over time, the challenging nature of nursing children and their families will become normalised among nurses. Openly discussing difficult situations (such as establishing a nurse-

family relationship) among colleagues and nursing managers can only lead to improved overall practice. In particular, the recognition of emotional labour as a skill requiring training, and integrating this skill into the acuity level of the patient, will aid in the care and management of children and families with NAHI.

The confusion and dilemma experienced by the nurses in this study regarding what professionalism entails, and the practice dilemmas in carrying out FCC must clearly be defined and explored. Nurses should not be left to just figure it out. With more open and honest discussion regarding nursing in this setting encouraged, it may be discovered that conventional methods of nursing in a family-centred way do not fit with settings such as these. Conversations must be promoted at every level of nursing, from ward nurses to organisational leaders. Is there a possibility of forming guidelines or alternative ways of approaching care that aid nurses in their dilemma?

The perceived difficulty in communication and discussion around child abuse may contribute to the following need for improvement. There are identified areas of paediatric nursing care that is challenging. For example, paediatric oncology and palliative care. It is recommended that the area of practice related to caring for children who suffer life-threatening injuries, and may have permanent disability, also be recognised as a difficult practice setting to work within. Reviewing the literature has shown a lack of studies related to the experiences of nurses caring for children with NAHI or abuse in general. Again, acknowledgment is the key and the first step in improving practice in this setting. Establishing normality of the difficulties encountered through debriefing opportunities and professional supervision may help in the recognition of this area of practice being unique in its emotional toll, specialised care and life-impacting injuries.

Lastly, it is recommended that acknowledgment of the care required for children with NAHI be established at the nurses' first encounter with this practice setting. This would occur for new nurses and student nurses when they are oriented to the ward. Although they may not be at a practice level to care for these children, they may be assisting other nurses with care, or answer call bells requiring them to have some knowledge of the possible issues that arise.

## 6.9 Further research

There is a need for further research surrounding nurses' experiences in this practice setting, especially regarding the issues raised in this study. The uniqueness experienced in the nursing of children who have been abused lies particularly in the interactions and management of the family, and the emotional difficulties experienced. Larger studies are proposed to seek to understand nurses' experiences in children with NAHI or general child abuse which may better inform and support the recommendations discussed earlier.

New Zealand is one country that has struggled to reduce the levels of child abuse. In the New Zealand context, more qualitative studies will indeed help to inform and add depth to the plethora of quantitative studies that already exist. Other health professionals provide different aspects of care for the child with NAHI and their families. There would be much to gain from qualitative research studies that sought to understand the experiences of a range of health professionals who care for children with NAHI. It has also been observed that medical professionals have carried out many of the quantitative studies available. Adding a qualitative element to their research would provide an interesting perspective.

Another possibility of further research studies lies in the experiences of the families of children who are admitted with NAHI or general child abuse. As nurses in this study have experienced much difficulty in their interaction with family, it would be of great interest to learn how families experience their interactions with nurses and health professionals in general.

## 6.10 Conclusion

*Doing* a hermeneutic phenomenological research study informed by Heidegger and van Manen has been a journey that frequently meant that, as a novice researcher, I was walking blindfolded down a path that was only theoretically mapped out. The words "trust the process" echoed in my head, imitating the voices of my supervisors, and were engraved in the pages of the books and articles I read. Was I ever going to get it?

That is the quest, simply to be who we are and to let thinking come, as it comes; to trust that ideas will call, to lose ourselves in the play, to listen to our moods, to respond to the resonance of insights.

(Smythe et al., 2008, p.1396)

In the quest to carry out this research study, my personal research journey has been an experience of trusting, letting go and acceptance, fuelled by a great passion for nursing children in difficult circumstances.

Exploring the lived experiences of nurses who care for children with NAHI has gathered meaning in the two themes that emerged from the stories of the nurses who took part in this study. The experiences of *'being' different* and *'being' protective* have highlighted aspects of these nurses' experiences and provided context to the uncovered meanings.

The application of *'being' different* is first made visible in the nurses' requirement to follow a protocol which gives instructions on steps to take when a child is admitted with suspected child abuse (or NAHI). Through the caring process, complexities emerge in the forming and maintenance of a therapeutic nurse-family relationship in the form of *social complexity*, *the unspoken* or left-out aspects of usual communication, and a purposeful *dissociation* from family. An added element of *'being' different* is noted in the tension experienced when nurses assess their non-judgmental attitudes of the family and the child's circumstances that led to admission.

*'Being' protective* has shown itself in the nurses describing elements of their practice that involve shielding themselves from the emotional challenges they experience. Self-protection, for these nurses, takes the form of the nurse being acutely aware of what their role is, and more emphatically what it is not (explored in the sub-theme of *"it's not my job"*), donning *'the professional hat'* that metaphorically describes the use of professionalism as a protective shield, and *'shifting the focus'* towards more comfortable and doable aspects of care for children with NAHI.

Tensions around emotional labour, professional conduct and family-centred care have been discussed in terms of the nurses *'being' or 'being-in-the-world'*. *'Being' emotionally laboured* includes the invisible and potentially tiring nature of emotional

labour within this practice setting and acknowledges the nurses' commitment to providing optimal care to the child and adhering to the professional rules set out by organisational and governmental authorities. *'Being' professional* had been experienced in the perceived professional responsibilities required by the nurses. A distinction between professional boundaries and professional conduct has been formed to more adequately situate the nurses' experiences into the context they attempted to portray. *'Being' family-centred in care* discussed the obvious tensions demonstrated by conflicting literature on the need and requirement to incorporate FCC in practice, and the *doing* of it. A common thread consistently appearing throughout analysis, interpretation and the quest to find meaning is that through the experiences of *'being' different* and *'being' protective* the nurses in this study were ultimately striving to give the abused child the greatest level of care within their power and ability. The quest to provide this level of care is also used as a form of self-protection to allay the uncomfortable emotions that arise in the caring of children with NAHI and their families.

The privilege afforded to nurses being given the chance to journey with their patients along a path of sickness to wellness is profound. This privilege is intensified when one is able to help in the restoration and healing of a young child's body, mind and spirit when the very people that should protect and keep them safe from harm have had a hand in the breaking of the young child's body, mind and spirit.

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APPENDIX A – Consent form



# Consent Form

**Project title:** The lived experience of paediatric nurse’s caring for children with non-accidental head injuries

**Project Supervisor:** Dr Annette Dickinson

**Researcher:** Kristy Gibbs

- I have read and understood the information provided about this research project in the Information Sheet dated April 2015
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also 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 information including 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 (please tick one): Yes  No

Participant’s signature:.....

Participant’s name:.....

Participant’s Contact Details (if appropriate):  
.....  
.....  
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee. AUTEK Reference number: 15/78**

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

# Participant Information Sheet



## **Date Information Sheet Produced**

April 2015

## **Project Title**

The lived experiences of paediatric nurse's caring for children with non-accidental head injuries.

## **An Invitation**

My name is Kristy Gibbs and I am an AUT student looking to complete my Master's thesis by carrying out a research study that examines the experiences of paediatric nurses who care for children and their families who are admitted into hospital with a non-accidental head injury. I would like to take the opportunity to warmly invite you to take part in my study. This information sheet will provide you with details relating to the study. Your participation in my study is completely voluntary and you may withdraw at any point without question.

## **What is the purpose of this research?**

This research study aims to explore the lived experience of nurse's who care for children in an acute neurosurgical setting with head injuries of a non-accidental nature. Nurses are often at the forefront of providing care to these children and families in sometimes difficult and challenging circumstances. It is my intention to examine, understand and find meaning in the unique experiences this specialised setting presents. This will aid to inform nursing practice, increase understanding of the relationship between nurse and child/family, and inform the development of strategies to support nurses. It is intended that a conference paper, journal publication and thesis will be the product of this study.

## **How was I identified and why am I being invited to participate in this research?**

I have advertised this research study in the newsletter and Facebook page of the College of Child and Youth Nurses of which you will have seen and sought further information by contacting me directly. You have been invited to participate because you have the experience and knowledge that will provide an invaluable contribution to my research study. You will have been working in an acute paediatric setting (possibly a neurosurgical unit) for 2 years or more, where you care for children with non-accidental head

injuries from any point in their care process (admission to discharge). I will recruit the first 8-10 interested participants based on this selection criteria.

#### **What will happen in this research?**

This research study will involve you taking part in a one-hour interview where I will give you the opportunity to share your practice stories and experiences. Capturing the essence of your stories will be my main goal during the interview. For this reason, I will audio tape our interview and then have it transcribed for data analysis. The resulting transcripts will be emailed back to you so that you have the opportunity to review, alter or delete any information you have provided. I will give you a period of 3 weeks to complete this if you wish. If I do not receive a returned transcript within this time frame I will take this as consent to use the unchanged transcript for analysis.

#### **What are the discomforts and risks?**

Child abuse and injury in any form can be a sensitive topic to discuss. Although we will be exploring this issue in a professional context there is always a possibility that you may experience a level of discomfort discussing these issues either from professional experiences or past personal experiences

#### **How will these discomforts and risks be alleviated?**

During our interview you will have full control over its direction and do not have to discuss matters that may cause you distress. You will also always have the option of withdrawing from the study at any time. If you would like further support you may like to approach your employer assistance programme services or alternately I can arrange for you to discuss your concerns with counselling services at AUT.

#### **What are the benefits?**

There will be no immediate benefit to you as a participant of this study, however you may find the experience of being able to share your stories interesting and cathartic. Your stories will contribute to nursing knowledge, help inform practice and provide increased awareness of this unique experience. In addition, this study will assist in completion of my Masters of Health Science degree.

#### **How will my privacy be protected?**

All recordings and transcripts will only be made available to the research team (myself and my supervisors). All identifiable details will be held in a secure location and no information identifying you as a participant in the study will be included in the final research thesis or subsequent publications. You will be referred to in the study using a name you choose, or I can assign you one that will protect your privacy. All of the information you provide will be treated with the utmost respect to your confidentiality and privacy.

#### **What are the costs of participating in this research?**

The major cost to you will be the time that you give to the study. You may find that the total time you commit to will be 2-3 hours (1-hour interview and 1-2 hours reviewing your transcript). I will conduct our interview at a time and place that is agreeable to you.

**What opportunity do I have to consider this invitation?**

You will be asked to indicate your interest in taking part within 3 weeks of receiving this information sheet.

**How do I agree to participate in this research?**

You will need to complete a consent form to take part in the study. You will be sent a consent form via email once you have indicated your interest to look over before the initial interview. Once we have arranged an interview I will go through the consent form with you. You will have an opportunity to ask any further questions you may have and I will then ask you to sign the consent form in person before we commence the interview.

**Will I receive feedback on the results of this research?**

You will have the option to receive a summary of the findings of the study. If you choose this option you will be sent a summary once the study is complete via email or post.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Annette Dickinson by email: [annette.dickinson@aut.ac.nz](mailto:annette.dickinson@aut.ac.nz) or telephone: (09) 921 9999 ext. 7337

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) (09) 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

***Researcher Contact Details:***

Kristy Gibbs: [krigib07@autuni.ac.nz](mailto:krigib07@autuni.ac.nz)

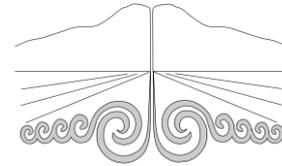
***Project Supervisor Contact Details:***

Annette Dickinson: [annette.dickinson@aut.ac.nz](mailto:annette.dickinson@aut.ac.nz) : (09) 921 9999 ext. 7337.

Approval by the Auckland University of Technology Ethics Committee granted on 20<sup>th</sup> April 2015, AUTEK  
Reference number: 15/78

# APPENDIX C – Letter of consultation with the Kawawhakaruruhau Komiti

**Kawa Whakaruruhau Komiti**  
School of Health Care Practice  
AUT University  
*Disciplines of Nursing, Midwifery &  
Paramedic and Emergency Management*



The symbol represents the evolving  
bicultural relationships within the  
School of Health Care Practice

30 March 2015

Dear Kristy

**Re: Research Presentation of Postgraduate Research Proposal**

***Topic: The lived experience of paediatric nurse's caring for children with non-accidental head injuries.***

Thank you for presenting your research to the Kawa Whakaruruhau Komiti on Wednesday 25 March, we very much valued the time we spent with you, to hear about your research and to discuss with you opportunities available to enhance and enrich this study proposal.

The following discussion points and recommendations made:

Chapter 1 A need to offer the participants of this study access to counselling services, should these be required. Recommendation that an application be made to the Head of Counselling (Kevin Baker).

Chapter 2 A consideration that all NZ research should consist of Maori participants to comply with the Treaty obligations of partnership, participation and protection. Therefore, Panui should be inclusive of Maori.

Chapter 3 To consider a targeted recruitment of Maori participants. Recruitment considerations could include contact with:

- 3.1 NZNO College of Child and Youth Nurses – through their newsletter or Facebook page,
- 3.2 Taima Campbell – currently Director, Hauraki Health Consulting Ltd
- 3.3 DHB Maori contacts available through Kawa Whakaruruhau Komiti

Chapter 4 Importance should be placed on the time taken to establish 'trust' by Maori participants. This may take considerably longer than the given timeframe, for interviews, of 1 hour.

The komiti discussed the possibility of the findings of this research informing several areas of study – through another research topic or further study e.g. informing nurse managers on how to support their nurses.

The Kawa Whakaruruhau Komiti considers your research proposal to be powerful and well thought through; and acknowledges that it will be rich in offerings once complete, raising much needed awareness. The topic is both useful and valuable, is well written and shows insight into what is acknowledged to be a very difficult yet topical subject area.

We wish you success with your research proposal and assures you of our ongoing support. We invite you to periodically update the komiti on the progress of this important study.

Naku noa



Tui O'Sullivan (Chairperson)  
Kawa Whakaruruhau Komiti

## APPENDIX D – Letter of ethics approval



A U T E C  
S E C R E T A R I A T

23 April 2015

Annette Dickinson  
Faculty of Health and Environmental Sciences

Dear Annette

**Ethics Application:**            **15/78 The lived experience of paediatric nurses' caring for children with non-accidental head injuries.**

Thank you for submitting your application for ethical review. I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 20 April 2015, subject to the following conditions:

1. Provision of more information about how recruitment through existing networks will occur;
2. Amendment of the Information Sheet as follows:
  - a. Removal of the suggestion with respect to the provision of counselling;
  - b. Reconsideration of the total time involved, and inclusion of the possibility of a second interview;
  - c. Removal of the first sentence in the "how was I identified" section, and inclusion of reference to the recruitment procedures described in 1) above;
  - d. Clarification of the asterisk in the "benefits" section.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

I look forward to hearing from you,

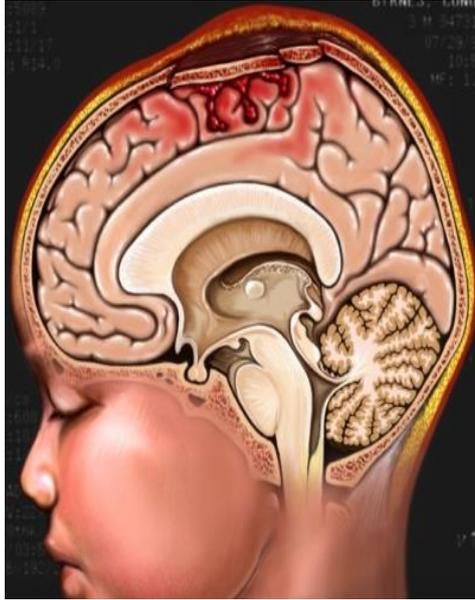
Yours sincerely

A handwritten signature in black ink, appearing to read 'K O'Connor'.

Kate O'Connor  
Executive Secretary  
Auckland University of Technology Ethics Committee

Cc:        Kirsty-Anne Rebecca Gibbs [kristygibbs@live.com](mailto:kristygibbs@live.com)

## INVITATION TO PARTICIPATE IN RESEARCH STUDY...



(Image source: <http://topnews.net.nz/data/Brain-Injuries-Children.jpg>)

ARE YOU A PAEDIATRIC NURSE  
WORKING IN AUCKLAND WHO...

Cares for children admitted to hospital  
with non-accidental head injuries?

Has worked in this area for at least 2  
years?

Is interested in sharing your  
experiences of caring for this  
specialty group of children and  
their families?

IF THIS IS YOU...THEN YOU ARE  
WARMLY INVITED TO TAKE PART IN  
THE FOLLOWING STUDY...

*“The lived experience of paediatric nurse’s  
caring for children with non-accidental  
head injuries”*

This is a phenomenological qualitative research study looking at the unique experiences paediatric nurse’s face while caring for children and their families with non-accidental head injuries. This study will be conducted through AUT (Auckland University of Technology) by a Masters student completing her thesis.



AN INFORMATION SHEET WILL BE SENT TO YOU ONCE YOU INDICATE YOUR  
INTEREST USING THE CONTACT DETAILS BELOW:

KRISTY GIBBS RN, PGdip, BHSc, BSc  
| [krigib07@autuni.ac.nz](mailto:krigib07@autuni.ac.nz) |

## APPENDIX F – Participant questions

The methodology employed for this research study is hermeneutic phenomenology. The data that will be collected through interviews will be determined by the practice stories and experiences of the participants. It is therefore important that the researcher does not enter the interview with specific prearranged questions. Participants will be informed throughout the recruitment process that the research study is primarily concerned with their experiences of caring for children with non-accidental head injuries (NAHI). Participants will be encouraged to direct the interview however they seem appropriate. The following questions have been prepared to provide the participant (if the need arises) with prompts, to help if they become stuck, and also to gain clarification and more detail for the researcher from an experience they share:

Chapter 1 Tell me about a time when you cared for a child who came into your (work setting) with a NAHI

Chapter 2 Tell me about your experience of being a nurse who cares for children with NAHI

Chapter 3 Tell me about your experience of caring for families of children with NAHI

Chapter 4 Tell me about a typical shift with your patient who has a NAHI

Chapter 5 Tell me about a significant event that you remember caring for a child with NAHI

To ascertain more detail or clarification, the following questions may be used:

Chapter 6 When you described...what did you mean?

Chapter 7 Can you tell me more about...?

Chapter 8 How did you feel when...happened?

Chapter 9 What went through your mind when...happened?

Chapter 10 What do you think was significant about...?

Chapter 11 What do you understand about...?

Chapter 12 I'm really interested in what you just described...

# Confidentiality Agreement



Project title: The lived experiences of paediatric nurse’s caring for children with non-accidental head injuries.

Project Supervisor: Annette Dickinson

Researcher: Kristy Gibbs

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

Transcriber’s  
signature: .....

Transcriber’s  
name: .....

**Transcriber’s Contact Details** (if appropriate):  
.....  
.....  
.....

Date:

**Project Supervisor’s Contact Details** (if appropriate):

Annette Dickinson  
Email [annette.dickinson@aut.ac.nz](mailto:annette.dickinson@aut.ac.nz)  
Phone (09) 921 9999 ext. 7337

**Approved by the Auckland University of Technology Ethics Committee.**

**AUTEC Reference number 15/78**

*Note: The Transcriber should retain a copy of this form.*