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# **An exploration of nurses' understanding of parenting in hospital**

A thesis presented in partial fulfilment  
of the requirements for the degree  
of Master of Philosophy (Nursing)  
at Massey University

Ruth Crawford

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## **Abstract**

Parental involvement in their child's care in hospital is common place. Research indicates that parents want to actively participate in the care of their child. Nurses' responses to parental presence in hospital have been examined in previous research, especially with regard to attitudes, perspectives and role division. There was however a gap in the literature with regard to nurses' understanding of parenting in hospital. Within New Zealand there was no research examining nurses' understanding of parenting. The research described in this 75 point thesis explored the nurses' understanding of parenting in hospital.

Using focus groups as the research method, eight nurses were invited to share their understanding of parenting in a New Zealand hospital. The data was analysed using thematic analysis informed by Stevens (1996). Although the size of the study was limited, this research has been able to raise some important issues about nurses' understanding of parenting in hospital, including the conflict perceived between parents and nurses, and the participants "ideal" parent-nurse relationship.

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# 1

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## Introduction

Child health is an area of major concern in New Zealand (Ministry of Health, 1998). In this country, children are being hospitalised at an increasing rate. Between 1988 and 1995, there was an annual increase of 5% in the hospitalisation of children aged 0- 14 years (Ministry of Health, 1998). Nurses and parents are involved in the care of children in hospital. Parents want to be involved in their child's care, and are willing to participate actively with nurses, but need support and information from nurses to complete this role successfully. In the past, research has centred more on the parent than the nurse.

The research described in this thesis is nurses' understanding of parenting in hospital. Nurses' understanding of parenting in paediatric settings has been explored in the United Kingdom, and the United States of America, particularly in relation to role expectations of nurses and parents, but there is little published work in New Zealand.

Using focus groups, this research explores nurses' understanding of parenting. Research participants were registered nurses working in the paediatric wards of a regional hospital in N.Z. The data was collected for this project in January and February, 1998.

### 1.1. Background

I have been practising as a registered nurse since 1980. From 1994 to 1998, I was a nurse lecturer with clinical experience in the paediatric area. The opportunity to facilitate nursing students working with children and families led me to ask many questions related to the nursing care of children. Sometimes I noticed misunderstanding and conflict occurring between parents and nursing staff. I talked to nurses about their experiences with parents and received a wide variety of responses. Some nurses had great empathy with parents, while others offered their opinions of how parents should 'be' in hospital.

I began to search for information about nurses' understanding of parenting. A review of the literature revealed research about parents' and nurses' attitudes, perspectives and role division, but little specifically about nurses' understanding of parenting in the hospital setting. It seemed that research around nurses' understanding of parenting had moved too far, too fast. Focusing on the roles of the parent and the nurse was premature. I believed that first, we as nurses needed to understand parenting in hospital and the place to start was by asking nurses about their understanding of parenting in hospital.

Knowledge about nurses' understanding of parenting in hospital is valuable to paediatric nurses, nurse educators and parents because it:

- a) opens up the dialogue between nurses concerning an issue that is not usually discussed freely
- b) improves the relationships between nurses and parents
- c) enables parents in hospital to have a better understanding of nurses' perceptions
- c) potentiates a better outcome for the child in hospital
- d) contributes to nursing education

### **1.2. Aims of the Research**

The research has three major aims:

1. To explore nurses' understanding of parenting in hospital.
2. To inform paediatric nursing practice and education about nurses' understanding of parenting
3. To improve outcomes for children and parents in hospitals.

The question posed in this study was:

***What is nurses' understanding of parenting in hospital?***

### **1.3. Definitions**

For the purposes of this research, the following definitions will be used:

*Nurse* - a registered comprehensive nurse, or registered general and obstetric nurse

*Parenting* - having sole, or shared responsibility for the upbringing of a

child. A parent can be someone who has begotten or borne the child, or someone who is the primary care giver of the child. Parenting includes all the actions, and attributes of the parent in caring for the child.

*Child* - a boy or girl from birth to puberty (Gordon, 1982).

#### **1.4. Locating the researcher**

As the sole researcher, I undertook the data collection. Data was collected in focus groups, comprising of the participants who were registered nurses from the paediatric wards of a hospital in N.Z. At the time of data collection, the nurses worked in one of three different areas: a general ward for in-patient care for children; a day ward providing day care for children with a variety of health problems; and the Special Care Baby Unit (SCBU), providing neonatal care.

In preliminary discussion about the research with potential participants, I determined there would not be a conflict of interest. Prior to commencing the research, I had some ideas of what nurses may understand about parenting in hospital, mainly arising from my own interactions with parents and nurses over a period of years. Therefore I began the research with some predetermined notions. One of the purposes of research is however, to gather knowledge systematically and rigorously. My ideas were rapidly challenged by the participants' rich dialogue and debate around the topic under focus. During the process of undertaking the research project, I also moved from not being a parent to being the parent of two sons. I experienced being a parent in the paediatric ward, and this inevitably affected the depth of the interpretation of the data.

In this thesis, research into nurses' understanding of parenting in hospital will be offered, analysed and discussed, beginning with **Chapter Two**, the literature review. Two major areas of research are reviewed. The first is an exploration of parents' perspectives of being with their child in hospital. It seemed that understanding parenting in hospital from the parent's perspective would serve as a reference point for the nurses' understanding of parenting. The second area reviewed is nurses' perspective of parenting in hospital. The

historical background of parenting in hospital is also presented as background to the study.

**Chapter Three**, the method chapter describes and outlines the method used in the research. Part One of the chapter describes the theory of Focus Groups, and outlines the usual research approach when implementing this method. Part Two explains the method as used in this study. Advantages and disadvantages of focus groups as a research method are detailed, as is the use and value of this method in nursing research. Ethical issues in focus groups are also presented.

In **Chapter Four**, the results of the data analysis are presented. Thematic analysis, informed by Zemke and Kramlinger (1989), and Holloway and Wheeler (1996) was used with particular attention paid to analysis specific to focus groups, as outlined by Stevens (1996). Four major issues emerged from the data, and these are discussed. A conceptual model of the analysis evolved from the data and is presented in Appendix 1.

A discussion of the research findings is presented in **Chapter Five**. The strengths and limitations of the method are addressed including issues related to trustworthiness, validity and reliability. Finally my interpretation of the data with reference to relevant literature is discussed.

In the concluding chapter, **Chapter Six** the research is summarised. Policy, educational and practice issues are offered and discussed. Suggestions for change are outlined. Further research building on the current research is recommended.

# 2

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## Literature review

Parents staying with their child in hospital and participating in their child's care, is a relatively recent occurrence. Until the 1950's, parents had little contact with their hospitalised child. In 1959, a major report, the Platt Report, was released in Great Britain which was to change parenting in hospital in the western world.

Early research into nurses working with parents in hospital, began ten years after the release of the Platt Report, and was authored initially by a medical practitioner (Meadow, 1969), and a social worker (Seidl, 1969). It was not until 1979, twenty years after parents began staying with their children in hospital, that nursing research (Goodell, 1979) began to explore this issue.

Following an historical overview of nurses working with parents in hospital, two major areas of research will be reviewed in this chapter. The first area will be parents' perspective of being with their child in hospital. Research in this area has been explored because it is inextricably linked to research examining nurses' perspective of parenting in hospital. Some researchers researched both parents and nurses when exploring the issue. Understanding parenting in hospital from the parents' perspective serves as useful background for the nurses' understanding of parenting in hospital. I considered it important to review the literature around this area to gain knowledge about parents' perspectives.

The second area of literature reviewed will be the nurses' perspective of parenting in hospital as this was the area of interest for my research. According to Philips, (1992, in LoBiondo-Wood & Haber, 1994, p.111) "The overall purpose of a review of the literature...is to discover knowledge". Thus I needed to review not only the previous knowledge, but also the research designs used, and the geographical locale of the research. I was interested in discovering whether there had been any Australasian/New Zealand research

undertaken on this topic.

Research was located using a variety of tools including technological (Cinahl, Medline, Inductions), manual (following up references in articles), and colleagues referring articles of interest. All the research discussed has been published either in a journal or conference proceedings.

Each perspective of research, the parents and the nurses, are examined chronologically. Included in this chapter is a review of the concept of 'partnership' and the evolution of the term into family-centred care. Current paediatric nursing practice in New Zealand is centred around partnership and family centred care. Thus it is useful to define the terminology and review the concepts in this chapter. The review of the literature will include a description and analysis of the research, and will pay attention to trustworthiness, reliability and validity.

Quantitative research will be assessed for reliability and validity using critiquing criteria discussed in LoBiondo-Wood and Haber (1994, p.380). These authors suggest using the following questions by way of critique:

1. Appropriate method used to test the reliability of the tool?
2. Reliability of the tool adequate?
3. Appropriate method(s) used to test the validity of the instrument?
4. Validity of the measurement tool adequate?
5. If the sample from the developmental stage of the tool was different from the current sample, were the reliability and validity recalculated to determine if the tool is still adequate?
6. Have the strengths and weaknesses of the reliability and validity of each instrument been presented?
7. Are the strengths and weaknesses of instrument reliability and validity appropriately addressed in the discussion, limitations, or recommendations sections of the report?

Qualitative studies will be assessed for trustworthiness using criteria documented in Appleton (1995), using advice from Lincoln and Guba, (1981), Sandelowski, (1986), and Marshall and Rossman, (1989). The four concepts

suggested by Appleton (1995) are: truth value, applicability, consistency and neutrality. Lincoln and Guba (1985, p.290) suggest that within each concept inquirers should ask the following questions of the research:

1. **Truth value** - how can one establish confidence in the 'truth' of the findings of a particular inquiry for the respondents and the context in which the inquiry was carried out?
2. **Applicability** - How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other respondents?
3. **Consistency** - how can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same or similar respondents the same or similar context?
4. **Neutrality** - how can one establish the degree to which the findings of an inquiry are determined by the respondents and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer?

### **2.1. Historical background**

This section highlights the history of parental presence with their child in hospital. Reasons for parental exclusion from their child's care will be discussed, followed by catalysts for change of parental status in hospital, for example, World War Two and the advent of antibiotics. In addition, the impact of the Platt Report (1959) will be outlined.

Until the 1950's, parents had little contact with their hospitalised child. Visiting hours were restricted to one day a week, usually a Sunday (Young, 1992). When the parent did come in to see their child, they were 'visiting', usually meaning they sat beside their child, while all the care the child needed was performed by the nurse. Parents were actively discouraged from participating in any child care. This was common practice in westernised countries, including New Zealand.

Why were parents excluded from their child's care? As many children were in hospital because of infectious disease, such as tuberculosis and polio, and these diseases were a major cause of morbidity and mortality, there was an

overriding fear of cross-infection. Maintaining strict infection control was a central concern for health professionals. It certainly provided a rationale for keeping parents, who were considered 'dirty', at bay (McKinlay, 1981; Young, 1992). The legacy of these concerns was still evident in New Zealand in 1973, when a medical superintendent wrote this comment in a response to the Department of Health (N.Z.) Circular Letter No. Hosp 1973/166

It is impossible in practice to get parents as a group to follow aseptic techniques. If they are permitted to visit ...they invariably kiss and cuddle their offspring and put their dirty hands everywhere they are not wanted (cited in McKinlay, 1981, p. 216).

Another reason for excluding parents from participating in their child's care was that nurses and doctors considered themselves to be better caregivers of sick children than parents (Young, 1992; Palmer, 1993). According to Kedgley (1996), parent's ability to care for their child was undermined by health professionals who adhered to the routinised care approach, espoused by Truby King.

Dr King was a Dunedin medical practitioner and eugenicist who was convinced that motherhood was women's biological destiny. He established the Plunket Society in New Zealand in 1907. The aim of the society was to teach mothers how to care for their babies 'scientifically'. Mothers were encouraged by Plunket nurses to "suppress their babies natural instincts, and to train them to eat, sleep, excrete and be washed at a specified time...only fed at four hour intervals" (Kedgely, 1996, p.50). Whilst it appeared in New Zealand that nurses and doctors adopted the King approach to child care, parents could not always be relied on to be as strict with their children, especially their sick children. Thus in hospital, it was better if the parent were absent, and the staff could care for the child in the way they saw fit (Young, 1992).

Once the child had settled into the hospital, parent's visits were perceived to be disturbing to the child (Palmer, 1993). Cleary et al.,(1986) found that hospital staff believed parental presence was not only upsetting for the children, but downright dangerous. Nurses suggested that a parent being with

their child after surgery could distress the child so much, the child could haemorrhage (McKinlay, 1981). The child was in the 'best place' in hospital and would be better without their parents.

Young (1992) reports that at the Hospital for Sick Children in Toronto, most nurses came from the upper middle classes. The children they cared for came mainly from families whose parents were so poor, they were unable to care for their children at home. The wide social gulf between nurses and their patients exacerbated the belief that health professionals provided the 'best' care. Young (1992) maintains that this social gap between patients and caregivers remained at the Hospital for Sick Children for decades.

Children's rights were unacknowledged, thus their special needs, such as areas for play, and needing a safe, secure environment were ignored. There was a belief that children did "not need visitors in the same way as does the adult patient" (Lancet, 1940, cited in Cleary, 1992, p.1). Children were hospitalised in wards with adults.

Lack of both private and public transport, and hospitals being some distance away from home, made it difficult for families to visit their child in hospital, especially poorer families (Cleary, 1992). Sporadic visiting meant that the child, who had to wait for their parent to visit, became even more desperate when the parent departed.

In summary, there were a variety of reasons for parental exclusion from being with their child in hospital. These included: hospital infection control; hospital personnel believing they could provide better care to the child than the parent; beliefs that parents were distressing and even dangerous for a child in hospital; the social gulf between parents and nurses; lack of attention to children's needs, and inaccessibility of hospitals.

Two major events heralded a change to the parental contact with their child in hospital. The first was World War Two, which impacted on children by separating them from their families. Children saw their fathers disappear to war, they were evacuated, became homeless, and went into concentration

and displaced persons camps (Cleary, 1992). The effects of separation from their family on these children became evident to psychologists and sociologists. In 1952, John Bowlby, a psychiatrist, published a World Health Organisation monograph, Maternal Care and Mental Health, describing the anxiety of young children who were separated from those they knew and loved. Based on his observations during the war, he described three stages of separation anxiety: protest, despair and detachment. In the monograph, he recommended how best to avoid or mitigate short and long term effects of separation on young children (Bowlby, 1952).

The second event was the development of antibiotics. The consequence of these drugs was that children were less sick, were sick for less time, and that isolation and exclusion of outsiders was no longer required (Cleary, 1992; Cleary et al., 1996). Thus the scientific rationale for keeping parents away because of their 'dirty habits' could no longer be applied. Hospital personnel had less reason to exclude visiting parents from contributing to their child's care.

Two publications brought to the public's attention the adverse effect of limited parental contact. The first was the World Health Organisation Monograph by John Bowlby (1952), described previously. The second was the film *A Two Year Old Goes to Hospital* produced in 1952 by James Robertson. This documentary clearly showed the stress of a child being separated from its parents, moving from a happy well adjusted child, to a withdrawn, unhappy child. On first release, this film was shown to health professionals only. The response was 'disturbing to many in the hospital profession when first shown' (Robertson, 1970, p.xiv). However following the Platt Report (described below), the film was shown on television in 1961, along with a discussion including paediatricians, nurses and parents. It sparked public debate and led to the founding of the National Association for the Welfare of Children in Hospital (N.A.W.C.H.). This group, comprising parents and health professionals worked actively to promote parenting in hospitals in Great Britain (Robertson, 1970).

In 1959, spurred on by an increasing public awareness of the ill-effects of

separation on young children in hospital, the British Government commissioned a report: *The Welfare of Children in Hospital*, (also known as the Platt Report, 1959). Among the fifty five recommendations listed in the report were: that parental visiting of children in hospital should be unrestricted; that provision should be made for the admission of mothers with children under five years; that attention should be paid to the emotional and mental needs of children in hospital; and that resident and visiting parents should help as much as possible with the care of their child. The Platt Report was adopted by the British Government and because of the close ties New Zealand had with Britain at that time, the philosophical changes the report invoked eventually filtered through to New Zealand hospitals (McKinlay, 1981).

Hospital personnel began to encourage parents to stay with their children. According to Cleary et al., (1986), this new view was puzzling to parents who had previously been told that their presence in the children's ward was upsetting for their child. Parents believed they were getting in the way of nurses and the 'real work'. They were rarely included in the care of their child, and felt frustrated, bored and helpless (Meadow 1969; Cleary, 1986).

This review of the historical background of parents in hospital with their children has highlighted the rationales for parental exclusion from care of their children and the factors influencing the change in parental status in hospital.

## **2.2. Parents' perspective**

In this section, research relating to parents' perspective of being with their child will be reviewed. Parents describe not having enough information to care for their child, having difficulty communicating with staff, feeling powerless, and wanting more responsibility in the care for their child in hospital. The review is in chronological order, and many of the studies were completed in the 1980's and early 1990's.

Meadow (1969), a medical practitioner in the United Kingdom, was the first documented health professional to research the parents' perspective of parenting in hospital. He carried out a qualitative survey over a two and a half

year period to find out what mothers felt about their stay in hospital, and also asked medical and nursing staff for their views. He interviewed 130 mothers and then re-interviewed 60 mothers after discharge. The interviews were 'informal', no set questions were asked and nothing was documented in the presence of the participant. There is no mention of analysis, rather Meadow gained 'impressions' (p. 363). Major findings were that mothers felt as though they were 'on trial,' the overriding feeling was profound boredom, as the mothers sat with their child for hours on end, with little or no participation in their child's care. The trustworthiness of this study is questionable. Examining the consistency of the research, there is little evidence of an audit trail. Data was collected in an ad hoc way, there was no systematic analysis of the data, and it is unclear how the researcher reached his conclusions. Neutrality is also questionable as the research report is subjective, judgmental and biased. Nevertheless, the study is of value as an early exploration of the topic.

In New Zealand in 1981, McKinlay completed research using a combination of quantitative and qualitative methods, questionnaires and open-ended interviews. She visited 23 hospitals in New Zealand which admitted children for acute care, and interviewed charge nurses, staff nurses, principal nurses, paediatricians, and the medical superintendent of each hospital board. She also completed unstructured interviews with mothers who had had children in hospital. The aim of the research was to examine different ways in which medical and nursing staff define a mother's involvement in her child's hospital care, and the value staff placed on her experience of mothering in relation both to the ward environment, and to their own identity as professional carers.

McKinlay also found that boredom was a problem for mothers staying with their child. The intense one-to-one contact with the child was hard, especially as being involved in the care of their child was not encouraged. She found that parents felt they did not get enough information about what they could and could not do in the ward. A strength of this research is the diverse range of data sources. However, the audit trail is vague, and analysis is poorly described. It is not possible to assess the reliability of the tool (the questionnaire) used as it is not available. Nevertheless, this was the first research completed in New Zealand, which explored parenting in the

children's ward, thus it provides some base-line data for comparison.

In 1983 Canadian researchers, Hayes and Knox asked parents of children with cancer for their perceptions of their own stress during their child's hospitalisation. The researchers interviewed 23 mothers, and four fathers, of 24 children, using a semi-structured guide for the in-depth interviews. They collected 41 hours of interviews, and analysed them using constant, comparative analysis. Many themes emerged from the research, and this article focused on only one of them: "that change in the parenting role during a child's hospitalisation is central to increased parental stress" (p. 24). They found that the major stress of hospitalisation for parents was realising that they must share the responsibility for their child's care with others. While parents in the research were willing to allow hospital personnel to care for the medical needs of their children, they felt that their expertise regarding their children's other needs was not being used, thus depriving the parent of the opportunity to do the best for her/his child (Hayes & Knox, 1983). Parents also stated that they were uncertain about their role when their child was hospitalised. Using the framework of truth value, applicability, consistency and neutrality to assess the trustworthiness of qualitative research, this research appears to meet the criteria required.

In Great Britain, Thornes (1984) used a postal questionnaire, then conducted follow up personal visits with more detailed questionnaires to 10% of the random sample to obtain a more detailed picture. His aim was to survey the extent of parents' and relatives involvement in special care baby units. Thornes achieved an 89% response rate and used statistical analysis (type unspecified) to collate the data. The researchers found that staff were encouraging parents to visit their babies, and 93% of units researched had unrestricted visiting for parents. This was compared to other wards which admitted young children, of which only 49% had unrestricted visiting for parents. In more than half the units researched, parents were also being encouraged to care for their baby, such as changing nappies, and feeding via the naso-gastric tube (Thornes, 1984). A strength of this study was the high response rate. Limitations noted included the reader's inability to test the reliability of the tool (not stated), and the difficulty following the connections the

longitudinal study, using a variety of scales, including the Arizona Social Support Scale, and the Profile of Mood States -B instrument. Over three-quarters of the participants described distressing memories such as how sick or close to death the baby had been, how hard it had been to cope with this experience, and difficulties with personnel. The latter involved "having desired control over their infants care or being kept adequately informed about their infant's treatment program" (Affleck et al., 1990, p. 78). Strengths in this study were the multiple tools used to access data, and connections between the data and analysis and findings.

At the other end of the child health care spectrum, parents of long-stay children (defined as 90 days or more) were surveyed to allow them to share their feelings, experiences and concerns about their child's hospitalisation (Alcock & Mahoney, 1990). In this Canadian study, twenty-two parents completed a questionnaire, and were then interviewed to clarify the answers given. Ten parents wanted to take on more responsibility in the care of their child. Nursing staff were seen as the most approachable members of the health care team, and were the ones who provided the most information about the child. The validity and reliability of this study is difficult to assess - the survey was evaluated and validated prior to use, but is not available for comment. At best, this research is a snapshot of twenty parents' feelings at the time of the study.

In the United Kingdom Dearmun (1992) used a descriptive and survey approach to explore the perceptions of parents and nurses with regard to parent participation and partnership in hospital. Two instruments were used to collect data - a semi structured interview and a structured observation using non-participant observation and five minute time sampling. Fourteen parents and 21 nurses agreed to participate in the study. Misunderstanding in communication between nurses and parents was a feature of the findings, for example nurses assumed the parents stayed with their child to take part in their child's care, yet only three parents had been asked if they wanted to be involved in care, and less than six knew what was expected of them. Three parents were still waiting for the nurse to tell them what to do. Another significant finding was that on many occasions parents were present, but not

interacting with their child. The researcher used several methods to maintain validity and reliability in this study, including conducting a pilot study to test the research tools, and minimising the Hawthorne effect (a concept that describes changes in behaviour that occur when people know they are part of a research study), by wearing plain clothes to merge in with other ward visitors for example.

In Scotland, Darbyshire (1994) completed a major study which remains the most in-depth nursing research on the subject of parents' and nurses' perceptions of parenting in hospital. The purpose of the study was to provide an interpretive account and understanding of resident parents' and paediatric nurses' lived experiences of parenting in hospital. The three major objectives were to: examine the lived experience of parents living with their child in hospital; to understand the experiences of nurses working with parents; and to explore the relationships between parents and nurses. The study is described as exploratory/descriptive and uses Heideggerian hermeneutic interpretation. Data collection involved individual interview, couple interviews and focus groups.

Parents in the study described feeling "uncertain, confused...unaware of how they were expected to function as live-in parents...and also divested of some of the responsibility for their child that they believed to be an essential part of being a parent" (Darbyshire, 1994, p. 40). Darbyshire describes 'parenting in public', attempting to live-in and parent their hospitalised child in the public gaze. He found that parents and nurses had different ideas and attitudes towards parenting and what parenting involves in the hospital environment (Darbyshire, 1993). This research met Appleton's (1995) criteria of truth value, applicability, consistency, and neutrality.

Paediatric nurses, Conway, Culbert, Gale, Goulden, and Tulloch (1994), completed a pilot study in Dunedin, New Zealand, aimed at bridging the gap between differing expectations that parents and nurses may have of each other, when caring for children in hospital. Using a questionnaire with a five point scale, and room for comments, twelve parents participated in the study. The researchers found that parents did have different expectations than the

nurses, regarding how they should care for their child. For example, parents felt they should be giving the child their medicines, recording food and fluid intake, and supervising their child, tasks that are generally considered 'nursing'. Limitations of this study were the absence of an 'unsure' option in the questionnaire, and the need for more space in the comments section.

Again in New Zealand, Burr (1995) explored parents' experiences during their pre-school child's hospitalisation. Using a phenomenological approach, Burr interviewed six mothers to explore their experiences of being in hospital. Following analysis, Burr derived seven themes from the data: being supported/being powerless, being not told/frustration, being a comforter/crying, needing to talk it through/needing information, feeling guilty, being separated, and being a 'basket case'. Burr concluded that being with a child in hospital is a dehumanising experience. Owing to the limited amount of data published about this study, it is difficult to ascertain a clear audit trail. However the participants' voices are well documented, and it is possible to see how the researcher developed the themes from the data.

Another study of parents of long stay children was completed by social workers Horn, Feldman and Ploof (1995), in Pittsburgh, North America. The researchers interviewed a non-randomised sample of 13 families, and 11 professionals, using a semi-structured survey with open-ended questions. They sought to compare the responses of families of children with chronic illnesses who endured lengthy hospitalisations, with the responses of professionals who served these families. They found that families experienced multiple stressors, the most frequent being a state of high emotion to a situation, and the second most frequent being difficulty in communication and coordination of care in hospital. This research is transparent with regard to research design: the questionnaire is given, interrater reliability stated and analysis described in detail.

In the United Kingdom in a study published in 1995, Coyne used a phenomenological approach in order to explore the lived experience of parent's participation in their child's hospital care. Using Appleton's (1995) criteria, this study is trustworthy, with a clear audit trail, and strong consistency

in documentation. Coyne's participants were 18 resident parents of children in a surgical paediatric ward. Data was collected using a semi-structured interview schedule. Coyne found that the reasons parents chose to participate in their child's care included: concern about relinquishing care to strangers, sense of parental duty, concern for consistency of care, and parents' experience of hospitalisation as a child. Parents were, however, hindered in their care of their children in hospital by lack of information, non-negotiation of roles, inadequate facilities, and feelings of anxiety and loneliness.

In 1996 and 1997 there was a flurry of activity by researchers around this topic. In Birmingham, Alabama, researchers Vincent, Alexander, Money and Patterson (1996) examined the essence of nurse caring behaviours as perceived by parents. Participants were 10 pairs of biological mothers and fathers whose children were in the paediatric critical care unit. Data was collected by interview, using two open-ended questions. Nurses were viewed positively by the participants, demonstrating caring behaviour such as meeting the child and parents needs, providing security and relieving stress. A variety of measures were undertaken by the researchers to establish trustworthiness, including independent analysis, and review of the findings by non-participant parents.

In Australia, Rowe (1996) examined nursing and parenting practice of young children hospitalised for a short period. Using participant observation, Rowe spent 12 months in a multi-purpose thirty-bed paediatric ward recording observations of the practice and interactions of 50 sets of parents and 18 of the 29 rostered nurses. Five taped interviews were also conducted with nursing staff. Rowe found that "parents...were represented as visitors, who fitted in with the dynamics of the situation, had limited choices concerning control, and were sometimes included and sometimes situated as bystanders on the periphery" (Rowe, 1996, p.104). She discovered that both nurses and parents believed they were responsible for a child's care, highlighting the central misunderstanding between nurse and parent. Consistency and neutrality are evident in this research and an audit trail is clear. The researcher offers a lengthy explanation of the analysis, and the limitations of the study, including the intermittency of the researcher's observation periods.

In the United Kingdom, Kai (1996), a medical practitioner, completed a qualitative study using semi-structured one-to-one interview, and focus group interviews with parents of pre-school children, to identify and explore difficulties parents experience with acute illness. Thirty-two parents were interviewed, and a further 63 parents took part in focus group interviews. Kai found that parents felt disempowered, and helpless when their child was ill and wanted to be actively treating their child to diminish these feelings. There was also inadequate sharing of information between health professionals and parents, and a disparity between parents' beliefs and expectations about illness and treatment and professionals' behaviour. This was a particularly large study, and it is not clear how the major themes emerged from the data analysis.

Also in the United Kingdom, Neill (1996a; 1996b) used a qualitative exploratory study to examine parents' views and experience of participation in the care of their child in hospital. Sixteen parents of children between two and five years were interviewed within two months of discharge from hospital. Data was collected using semi-structured interviews. Truth value and applicability were ascertained in this study by the participants being sent copies of the transcripts, and consistency appears thorough. Neill (1996a; 1996b) found that parents wished to participate in their child's day-to-day care, and preferred professionals to be responsible for the clinical care. She identified problems in communication between parents and professionals, and discussed the paternalistic nature of these relationships. Another finding was that parents of children who experienced single, short admissions found involvement in their children's care particularly difficult.

Another British study in the same year (Kawik, 1996) was undertaken to determine whether parents were able to participate in the care of their hospitalised child and work in partnership with nurses. Kawik used method triangulation, and conducted the research in two phases. The first phase was a postal survey of 65 paediatric nurses. The second phase was 12 in-depth interviews with parents following their child's discharge from hospital. Kawik found that parents were willing to be involved in caring for their child in hospital, but experienced difficulties because of inadequate information, and

nurses' reluctance to relinquish control of nursing care. The authors suggested further research to establish whether the findings in this study are valid and can be generalised.

The final study in this review is also from the United Kingdom. Callery (1997) carried out a study aimed at understanding parents' views about caring for a sick child in hospital. He completed in-depth interviews with parents of 24 children discharged from a surgical ward of a children's hospital, one surgeon, and 11 members of the nursing staff. He also collected data during 125 hours of participant observation in the ward, mainly during hand-overs between nursing shifts. During the course of the study, Callery found that mothers experienced problems when they believed their child was ill, and could not persuade professionals of the seriousness of the problem. He noted that mothers had a high degree of skill in assessing their child's subtle changes in appearance and behaviour. Callery differentiated between maternal, or private knowledge, and professional, or public knowledge. Another finding was that mothers who are judged more credible by professionals, can gain access to care for their children in hospital more easily than those who are not. Auditability in this study was clearly apparent.

### *Summary*

In summary, the review of the parent's perspective of parenting in hospital has revealed twenty studies, of which three are from New Zealand, and one from Australia. The majority are from the United Kingdom (ten), with seven from Northern America. Most of the studies originating in the United Kingdom have been completed since 1990.

Qualitative studies using interviews have been the most popular method for data-gathering. Other methods used include: questionnaires, participant observation, and surveys. Two researchers used focus groups (Darbyshire, 1994; Kai, 1996). Assessing the trustworthiness, validity and reliability of each study has found that in general most of the research discussed has proved valid and reliable/trustworthy, thus is a useful beginning of knowledge development around the topic.

Thornes (1984) who found special care baby units had unrestricted visiting, and Vincent et al., (1996) who found that parents perceived nurses as caring, were the only studies reviewed which were positive. The remainder of the studies found parents have not had a 'satisfactory' experience when staying with their child in hospital. Parents describe feeling bored and on trial (Meadows, 1969; McKinlay, 1981), lacking adequate information to care for their child (McKinlay, 1981; Affleck et al., 1990; Dearman, 1992; Burr, 1995; Coyne, 1995; Kai, 1996; Kawik, 1996), and having difficulty communicating with health professionals on the ward (Affleck et al., 1990; Dearman, 1992; Burr, 1995; Coyne, 1995; Horn et al., 1995; Neill, 1996).

Parenting in hospital was described as a dehumanising experience (Burr, 1995), and parents described feeling like a visitor (Rowe, 1996). Parent's greatest stress was the appearance of their fragile, sick infant, and the altered parent/child relationship (Miles, 1989). Mothers felt their maternal expertise was undervalued by hospital staff (Callery, 1997).

The two dominant themes to emerge from this literature review are the different expectations and attitudes towards parenting between parents and nurses in the ward, (Hayes & Knox, 1983; Elfert & Anderson, 1987; Darbyshire, 1994; Conway et al., 1994; Coyne, 1995; Rowe, 1995; Neill, 1996; Callery, 1997), and that parents want to care for their child in hospital and have more responsibility in their care (McKinlay, 1981; Hayes & Knox, 1983; Affleck et al., 1990; Alcock & Mahoney, 1990; Darbyshire, 1994; Rowe, 1995; Neill, 1996; Kawik, 1996). The central theme noted in the literature is a misunderstanding between nurses and parents about the parents' role in the ward, concerning what parents can and cannot do, who has the power and control, and how to share the care of the child.

Of note in this review is the paucity of literature from the Southern Hemisphere. There is a major gap in the literature exploring the parents' perspective in New Zealand. A review of the nurses' perspective of parenting will highlight this gap in the literature for New Zealand nurses.

### **2.3. Nurses' perspective**

In this section of the literature review, nurses' perspectives of parenting in hospital will be reviewed. Nurses describe needing to be in control of their patient (the child), wanting to protect the parent, and having difficulty communicating with parents. Again the literature is reviewed chronologically, commencing in the late 1960's.

According to Meadow (1969), ten years after the 1959 Platt Report, nurses still believed that they were better at caring for a sick child than the child's parent. They also believed their authority was threatened by parental presence. Nurses thought that nursing children with mothers present was not as rewarding for them, and that having the mother present made the nurses work harder. The validity of Meadow's research has been discussed. It is unclear how he gathered data from the nurses, he does not state how many nurses he interviewed, and it is tempting to disregard his views. However he states "very few nurses seemed to believe that a mother is better at looking after her child than a nurse" (Meadow, 1969, p.366).

Suggested resistance by nurses to parental presence led to research by a social worker, Seidl (1969) in New York, North America. Using a Likert-type attitude scale, and a personal-professional data questionnaire, 231 nursing personnel participated in the study. The research explored why nurses were reluctant to welcome parents into the paediatric ward, and what factors made nurses more accepting of parents. Seidl found that the nurses most accepting of parental participation were nurses who had a higher education, who were high in the social hierarchy of the hospital and had younger children at home. Using LoBiondo-Wood and Haber's (1994) critiquing criteria for validity and reliability in quantitative studies, the findings of this research can be considered. The tools used were appropriate, and the researcher has clearly stated the relationship between the data and the findings.

Another North American nurse, Goodell (1979), completed a study to determine nurses' perceptions of parent participation in the care of children on pediatric oncology units, in four paediatric hospitals associated with universities across the U.S.A. Goodell formulated a two part questionnaire,

using Likert-type scale, and open-ended questions. Forty-six nurses all of whom were selected by the researcher, completed the questionnaire. The researcher found that nurses believed that parent participation in care is invaluable, although some nurses "did not consider parents of very ill children as dependable in giving safe care to children"...and "some nurses perceived parents as increasing the demand on nurses' time" (Goodell, 1979, p.43). Limitations of the study include the small sample size (46 out of population which included all the paediatric oncology nurses in the U.S.A.), and the inability to generalise the findings due to the participants being specialist oncology nurses.

McKinlay's (1981) research into the hospital care of children in New Zealand is an invaluable perspective into paediatric nursing care in New Zealand in the early 1980's. Data was collected using questionnaires and open-ended interviews from nurses in hospitals which admitted children for acute care. McKinlay examined the different ways in which medical and nursing staff defined the mother's involvement in their child's care and the value they placed on the mother's experience of mothering in relation to the ward and to their own identity as professional carers.

As already stated in the earlier discussion of McKinlay's research, validity and reliability of this research is difficult to assess due to the vagueness of the audit trail. It does however have value as the first research related to the topic of parenting in hospital in New Zealand.

McKinlay found that nurses had difficulty working with mothers because of the confusion over the mother's role within the hierarchical hospital system. Accepting mothers as caregivers created feelings of uneasiness in nurses who had been trained and were paid to provide care. Nurses felt they needed to justify their status by exhibiting an expertise they believed mothers did not have. She also found that nurses assessed mothers ability to 'mother': "married women in their twenties and thirties tend to be seen as more able than 'young' or 'solo' mothers, and Maori and Island mothers were felt to need more instruction on care than Pakeha mothers" (McKinlay, 1981, p.218). Finally McKinlay suggested that nurses in the paediatric ward had moved from

completed a questionnaire that included the Parent Participation Attitude Scale (also used by Seidl, 1969). Findings were that nurses who were married, were parents, were head nurses, nursing supervisors, had a professional nursing education, and a master's degree in nursing had significantly more accepting attitudes toward parent participation than did nurses without these characteristics. Limitations of this study according to the researcher were the nonrandom sample, small number of subjects in some categories, and hospitals being located in one geographic region.

Again in North America, Knafl, Cavallari, and Dixon (1988) carried out qualitative research using a symbolic interactionist approach, to discover how children, parents, and nurses defined and managed paediatric hospitalisation, and how they interacted or negotiated with one another. The researchers collected data from 62 families and 47 nursing staff. Parents were interviewed twice, once in hospital and once at home following discharge. Participant observation in hospital was also used. An indication of the trustworthiness of this research is that all data was independently coded. There was general agreement among nurses about specific parental characteristics that contributed to, or interfered with, the establishment of a good relationship between parent and child. Positive characteristics perceived by nurses were parental willingness to become involved with the child and their care, being concerned for the child, having a good relationship with the child, having an open and friendly attitude, and respecting and appreciating the nurse. Negative characteristics of parents as perceived by nurses were non-involvement in care of their child, being overprotective, hostile, demanding, constantly ask questions, and being culturally, educationally or socially different from the nurse. The researchers highlighted the paradoxical nature of some of their findings. For example, although nurses perceived a 'good' parent was a parent who visited frequently and became involved in their child's care, they did not like parents to visit all day and night. Nurses felt that if the parent was constantly with the child, the nurse could not have time with the child and develop a relationship with that child. Thus a major finding in this research was that the nurses wanted to remain in control of the child's care.

In Canada, Brown and Ritchie (1990) used an exploratory study to describe nurses' perceptions of nursing and parental roles, and factors modifying them. Twenty-five nurses were interviewed using a semi-structured interview schedule. The participants were also asked to complete a checklist of child care activities. The authors pointed out that until 1990 there had been no exploratory research looking at the meaning of working with parents, for nurses. This study was a first step toward examining parent and nurse roles from the perspective of the nurse.

The nurses described six major types of roles in which parents and/or nurses care for hospitalised children. They were: providing routine non-medical care; providing medical or technical care; being a gatekeeper; being an advocate; providing psychosocial care; and providing general care. Conflict arose between parents and nurses when parents did not meet nurses' expectations and asserted control. Nurses made value judgments about parents, which affected their attitudes and behaviour toward parents. All nurses were concerned that the parent may not be able to care for their hospitalised child appropriately. The nurses felt responsible and accountable for the care of the child, and could not trust all parents. Finally, Brown and Ritchie (1990, p.35) concluded: "family empowerment, parental participation in care and decision making, and supportive nurse-parent communications are incongruent with hospital environments that have limited communication patterns, promote control of parents by nurses, and where the Medical Model of Helping prevails". The researchers have clearly defined their research process, and interrater reliability has been stated.

In a study published in 1992 in the United Kingdom, Dearmun explored the perceptions of parents and nurses with regard to parent participation and partnership (defined by Dearmun as equality and mutual respect), using semi-structured interview and non-participant observation. Twenty-one nurses were interviewed during this study. Most of the nurses interviewed discussed care with the parents, although 62% of nurses said that they only sometimes discussed the care plan with parents. Dearmun found that a large number of nurses expressed 'paternal' tendencies, meaning that they wanted to protect parents from the distress of knowing what their children's problems were.

Limitations of this research were the small sample size, and the ambiguity of the questions asked.

Darbyshire's (1994) extensive exploration of the lived experience of parents in hospital, also encompassed the experience of nurses and the relationships between parents and nurses. Darbyshire interviewed 27 qualified nurses: 12 were interviewed individually, and 15 in four focus groups. Darbyshire found that nurses were unwilling to generalise about the parents with whom they worked and preferred to use exemplars to illustrate their approach. The nurses' narratives demonstrated sensitivity, concern and understanding of the parents' concerns. A notable feature of the nurses' narrative was the importance of the personality of the parent, which the nurse used as an excuse for any difficulty in communication. However, if the relationship was positive and mutually satisfying, personality was not as important as other factors such as being more relaxed, and knowing the staff better (Darbyshire, 1994). Darbyshire also found that nurses had expectations of the parents with whom they worked. These expectations included: parents to be co-operative, to be willing to help out (e.g. provide family care to the child such as washing, feeding, changing their child), to 'fit-in' with ward routine, and to understand information given to them by the nurses and act appropriately on that information.

Rowe's (1996) interpretive study in Australia, using participant observation to examine nursing and parenting practice found that nurses used language which situated parents in the periphery, as a visitor. Nurses were seen to initiate care of the child, and to determine to some extent the practices of parents, thus nurses had a 'significant degree of control' over a situation .

Also in Australia, Keatinge and Gilmore (1996) described a pilot study of shared care, which is defined as the sharing of responsibility between parents and nurses, involving negotiation between parents and nurses about the delivery of care, and regular communication between parents and nurses. The shared care project had been implemented in a 24 bed paediatric medical unit in New South Wales, and the staff were surveyed prior to the introduction of shared care, and three months after shared care had been

introduced.

Data was collected using a 13 item questionnaire, with Likert type scale, and two open-ended questions, with a follow-up focus group to discuss nursing issues emerging from shared care. This study found that following the introduction of shared care, nurses who responded to the survey (64% of the unit's nurses) felt more able to include parents at an appropriate level of care giving, but remained wary about parents' ability to undertake some activities, such as monitoring oximeters, and administering intravenous fluids. Some nurses in the study had difficulty assessing parents' capabilities, and they had difficulty communicating with parents effectively. Strengths of this study include the itemised summaries of the questionnaires used. Unfortunately however, the themes emerging from the focus group interview were not clearly stated.

### *Summary*

Summarising the literature review examining nurses' perspective of parenting in hospital, 12 studies have been extensively described. Of those 12, four are from the United Kingdom, five from U.S.A./Canada, two from Australia and one from New Zealand. Of these studies, seven used quantitative methods, such as questionnaires, with the remaining using qualitative methods, including semi-structured interviews and participant observation. It is interesting to note that most of the research in which parents were the focus used qualitative methods, and the research in which nurses were the focus used mainly quantitative methods.

Early research found that nurses perceived that having parents on the ward threatened their authority and made their work load harder (Meadow, 1969; Goodell, 1979; McKinlay, 1981). Quantitative surveys by Seidl, (1969) and Gill, (1987) tried to find out which group of nurses were most accepting of parent's participation in the ward, finding that nurses who were married and had children, who had a higher education, and who were high in the social hierarchy of the hospital (head nurses, nursing supervisors) were generally more accepting. Nurses were not as accepting of parents who were culturally, educationally or socially different from them (Knafl et al., 1988).

Darbyshire (1994) found that the personality of the parent was important to whether the nurse accepted the parent or not. Nurses also found it difficult to trust parents to care for their child competently (Knafl, 1988; Brown & Ritchie, 1990). Nurses perceived parents as visitors to the ward, and kept them at the periphery of their child's care (Griffen, 1990; Rowe, 1996).

Confusion between the nurse and the parent regarding who does what, i.e. role confusion, (McKinlay, 1981) was not as big an issue for nurses as it was for parents, possibly because nurses have more control over parent participation, than parents have over nurses (Knafl, 1988; Brown & Ritchie, 1990; Rowe, 1996).

Nurses were at times protective of parents (paternalism), wanting to shield them from some of the realities of their child's condition. This led nurses to discourage parents from participating with procedures on their children (Dearmun, 1992).

Brown and Ritchie (1990) found that all the nurses they interviewed felt some conflict with parents, especially when parents did not meet the nurses' expectations and asserted control. Different expectations also caused conflict for the nurses interviewed by Darbyshire (1994).

The main theme however, to emerge from this review of nurses' perspective of parenting in the ward, was that nurses felt a high level of responsibility toward the child, and believed that they could not trust parents to give the care to the child (Goodell, 1979; McKinlay, 1981; Brown & Ritchie, 1990; Keatinge & Gilmore, 1996). Lack of trust led them to control parent participation, and also created conflict between parent and nurse.

Early research with regard to the nurse/parent relationship focused on nurses attitudes towards parents (Seidl, 1969; Goodell, 1979; Gill, 1987; Knafl, 1988; Dearmun, 1992). These researchers raised questions about why nurses had these attitudes. The 'why' was not addressed until Brown and Ritchie's (1990) Canadian study. The latter research gave valuable insight into the difficulties of both parenting and nursing within the ward. For example, the conflict

between parents and nurses when parents did not meet nurses' expectations, and that nurses felt responsible for the care of the child, and could not trust parents.

Darbyshire's research was extensive and pivotal, highlighting the problems existing between nurse and parent, which remain difficult to understand. Darbyshire's work extended nurses' knowledge and understanding of the experience of living with a sick child in hospital. He also explored the nurses' perspective of parenting in hospital, as well as examining "the nurses' influence in shaping the extent and nature of parent participation" (Darbyshire, 1994, p.104).

Rowe's research examining the nurse-parent relationship addressed similar issues to Darbyshire, within the Australian context (Rowe, 1996). This research also yielded interesting results, focusing on nurses viewing the parent as a 'visitor'. Issues raised by previous research about the relationship between nurse and parent, and role boundaries, were not a concern for the participants in Rowe's study, rather both nurse and parent believed themselves to be responsible for the care of the child.

#### **2.4. Partnership - Family centred care continuum**

A review of the literature around the topic of nurses' understanding of parenting in hospital would be incomplete without a review of the concept of 'partnership'. Partnership and concepts arising from partnership are current in paediatric nursing practice in New Zealand. Partnership is a term used in the literature to describe nurses and parents working together to care for children (Stower, 1992). Farrell (1992, p.176) defines 'partnership nursing' as aiming to "establish a relationship of equality between the professional carers and the parents"

The term 'partnership' has evolved out of nurses' attempts to express the work they do with parents and children. Coyne (1996) describes the evolution of parent participation in the care of their children. She states that as the care of sick children has moved from care by the family in the home, to care by the professionals in hospital, to care in the home and hospital by the family and

health care professionals, there have been changes in the way the care has been described. According to Coyne (1996), 'parental involvement' were the words initially used to describe parents being involved in the care of their children in hospital. The involvement was usually determined by the hospital staff who continued to control the child's care. Then 'partnership in care' came in vogue. Stower (1992) and Dearmun (1992) explored the concept of 'partnership' and concluded that the central issues of partnership were equality and negotiation.

'Partnership' as a concept was also strengthened in children's nursing by Casey (1988) who developed the 'Partnership Model' for paediatric nursing practice. This model, which is derived from nursing practice, distinguishes between the family care (that is care of the child normally given by the family, such as bathing, feeding, dressing, toileting), and the nursing care of the child. Whilst the model advocates that families provide both family and nursing care of the child, the nurse will become involved in nursing and family care if the family wishes.

From 'partnership', the terminology moved to 'care-by-parents', a concept introduced in Kentucky, U.S.A., whereby all the care the child required in hospital is provided by the parent. The nurses' role is to teach the parent and be available for consultation (Cleary et al., 1986).

The most recent term to describe the care parents give their child in hospital is 'family-centred care'. According to Evans (1994), family-centred care is the basic tenet of paediatric nursing because it is believed that children benefit from the continuous presence of their parent. Ahmann (1994, cited in Darbyshire, 1995) argues that family-centred care calls for partnerships between parents and professionals - partnerships that support parents in their central caring role. Valentine (1998) adds that the philosophy of family-centred care needs parental involvement, autonomy and control, in order for parents to become true partners in their child's care, and to be able to make informed decisions about their child's care and treatment.

Another concept not mentioned by Coyne in her concept analysis of parent

participation is 'shared care'. This term refers to various models of nursing care in which parents (or care givers) and nurses contribute to the care of hospitalised children (Keatinge & Gilmore, 1996).

'Collaboration' is a term not frequently used in relation to children's nursing, yet its' increasing use in the literature deserves a mention in this discussion. Collaboration is defined as "a cooperative venture based on shared power and authority...non-hierarchical in nature...assumes power based on knowledge or expertise as opposed to power based on role or function" (Kraus, 1980, cited in Henneman, Lee & Cohen, 1995, p.104).

Coyne (1996) believes that partnership is an early stage in the evolution of parental participation as outlined previously. However this view is contradicted by Hutchfield (1999) who argues that partnership is the central element in family-centred care, along with respect, collaboration, negotiation and communication. In a concept analysis of family-centred care, Hutchfield (1999) discusses the ambiguity and confusion around the terminology describing the relationship between parents and nurses, and concludes that models of family-centred care demonstrate strong associations with the concepts of partnerships with parents, parental participation and care by parents.

## **2.5. Issues arising from the current research**

In light of this review of the literature around the topic of nurses' working with parents in hospital, it becomes apparent that researchers focused their attention on attitudes, perspectives, and role division. Parents suddenly arrived in the ward, nurses had little or no education about how to cope and work with parents in a partnership, or a collaborative way. Nurses' communication skills with parents were minimal and depended on the individual characteristics of the nurse. On arrival in the ward, parents wanted to care for their child as they did at home, however nurses were used to being the primary caregiver and were unsure of how to deal with another 'party' in the caregiver role. A fundamental question, which needs to be asked before addressing the issues such as who should do what, and what is happening for parents in a hospital environment seems to be **what is nurses'**

**understanding of parenting in the ward?** This question has not been addressed internationally or nationally, although nursing researchers who have examined similar issues (Brown & Ritchie, 1990; Darbyshire, 1994; Rowe, 1996) have alluded to this question. This current research will build on existing knowledge generated by their work.

It has also become evident to me as a registered nurse and an educator that a gap exists between theory, in which nurses think parents need to be with their children in the ward, and practice, where nurses can put obstacles in parents way and can make judgments about parenting abilities (Brown & Ritchie, 1990). What is going on for nurses that these practices occur? **What is nurses' understanding of parenting in the ward?** Knight (1995) suggests that if a gap exists between theory and practice, it needs scrutiny. One of the purposes of nursing research is to provide evidence of weaknesses and strengths in practice (Knight, 1995, p. 32). The purpose of this research is to shed light on this central area of nurses practice.

In this chapter, research relevant and supporting the need for this research study has been reviewed. Issues arising which inform the current research have been described. In the next chapter, Chapter Three, the method used to undertake the research will be outlined.

# 3

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## Method

In this chapter, the research method being used in this research study will be described and discussed. Part One will outline the theory and use of focus groups, and Part Two will explore the use of the method in the current research. The research method refers to the steps, procedures, and strategies for gathering and analysing the data for research investigation (Dempsey & Dempsey, 1992). As stated in Chapter One, the research question was exploratory, therefore the method had to be one which would allow exploration of the topic, nurses' understanding of parenting in hospital.

### 3.1. Part One

#### The Focus Group

Focus group is the term used to describe a data collection method. The term 'focus group' describes itself clearly - a group of people gathered together to discuss a topic in a focussed way. As a research method, focus groups were first described by Bogardus in 1926, as a way of gathering data for market research. In 1946, Robert Merton, a social scientist, used focus groups to analyse the effectiveness of using coercion to induce people to pledge war bonds (Asbury, 1995). Following this early identification of a method of data collection which used a group of people, focus groups have been used in market research, and in qualitative social research (Reed & Payton, 1997).

From 1946, focus groups were used predominantly in market research, mainly to receive feedback from consumers about advertising campaigns, and products. Gathering together consumers in a group was seen as a cheap, convenient and rapid method of obtaining information about consumer's wants and needs. According to Morgan (1988), focus groups are the main form of data collection in market research.

The use of focus groups within qualitative health research has been gaining

popularity since the early 1980's. The rise in popularity can be attributed to the increasing understanding and use of qualitative methods of research. Prior to this time, interaction between participants, and researcher and participants, was seen as 'respondent contamination', and therefore not a 'proper' method of research (Krueger, 1995). The difficulties of analysis also contributed to the reluctance of academics to legitimise focus groups and begin teaching the method to research students.

Another reason for an increase in popularity of the focus group method was the concern about the overpowering presence of the researcher, and the limitations of close-ended enquiries (Krueger, 1994). In alternative research methods, the one-to-one researcher and participant interaction could be daunting for the participant. Using questionnaires or surveys with no room for comment were also losing popularity among some researchers. The focus group method discourages researcher domination and encourages egalitarian cooperation of the participants (Stevens, 1996).

Within nursing research, one of the earliest reported studies using the focus group method was described by Flaskerud and Rush (1989). Since that time there has been a dramatic increase in the use of the method. The increase is highlighted in a nursing research text (Holloway & Wheeler, 1996), which has included an entire chapter on focus group, gaining equal attention with ethnography, grounded theory, phenomenology and feminist research.

Focus groups are variously described. Essentially they are a method of data collection that uses the interaction within a group to elicit rich experiential data (Asbury, 1995). Merton (cited in Asbury, 1995, p.565) describes focus groups as "a set of procedures for the collection and analysis of qualitative data that may help us gain an enlarged sociological and psychological understanding in whatsoever sphere of human experience". Specifically, a focus group is a group of people, usually six to ten, who are similar in some way, and who come together to discuss an issue of specific interest to the researcher (Asbury, 1995). The salient feature of focus groups as a research method is the interaction between the participants, who share with each other their individual perceptions of the world (Holloway & Wheeler, 1996).

Lederman (cited in McDaniel & Bach, 1994) has identified five assumptions on which focus groups are based. They are:

- individuals are important sources of information
- people are able to report or verbalise their thoughts and feelings
- a group's dynamics can generate authentic information
- group interviews are superior to individual interviews
- the facilitator can help people recover forgotten information focusing the interview.

### **3.1.1. Philosophical basis**

As focus groups are essentially a data collection method, there is no stated philosophical underpinning for focus group research. However, focus group research relies on group interaction, thus the data provided are human stories, perceptions, and understanding of social reality. Focus groups are therefore classified as qualitative research. Qualitative research is research which "involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, generating rich, descriptive data that helps us to understand their experiences" (Boyd, 1990, p.183).

Johnson (1996, p.517) asserts that in the past focus groups were "embedded in the epistemological and methodological assumptions of positivism, behaviourism and empiricism...cast the participants as the passive objects of the researcher". However, he then goes on to argue that focus groups enable the participants to share their stories, which in turn can empower the participants to suggest ideas for change and solutions to issues that concern them. Participating in focus groups can be empowering, and transforming for the group. Johnson refers to the 'radical focus group' which "blends different kinds of expert knowledge - tacit and everyday with scientific and theoretical - to empower and foster social change" (p.536).

Calder, (1977, cited in Nyamathi & Shuler, 1990) suggests that within qualitative marketing research, there are three approaches to focus group design. They are the:

- Exploratory approach: focus groups conducted to pilot anticipated quantitative research. The group is less structured and the researcher attempts to generate scientific constructs and validate them against everyday experience
- Clinical approach: assumes real cause of behaviour must be understood through sensitivity and clinical judgment of the trained professional. Used to obtain specific information about the experiences of participants, then subjected to clinical scientific interpretation
- Phenomenological: used to understand everyday experience of client. Used when management has lost touch with consumers needs.

While Calder is citing marketing research, each of these approaches has parallels in social science research, for example exploratory, clinical and phenomenological.

### **3.1.2. Research Approach**

There are variant forms of focus groups and the process of conducting focus group research is continually evolving. Focus groups can be used as the sole research method in a project, or they can be used with other methods, "as preliminary research to prepare for specific issues in a larger project, or as follow-up research to clarify findings in the other data" (Morgan, 1988, p. 24). Nyamathi and Shuler (1990) also suggest focus groups can be used concurrently with quantitative research.

In 1992, Morgan stated that the general rule was that focus groups should be highly structured, with six to ten people with common experiences or characteristics, and that four to six groups should be used within the research project. This view has been challenged by several researchers (Kitzinger, 1994; Krueger, 1995) and will be debated in the following sections.

### 3.1.3. Group structure/moderators' role

The level of the structure of the group is influenced by the moderator/facilitators' role, which has two functions. The first is to ask questions of the group, and the group will be more or less structured depending on the numbers of questions to be asked in each group. The second role is to manage the group discussion. A highly structured group will be tightly managed by the moderator. An example of a group requiring a high level of structure could be market research about a specific product or to design a project. A low structured group will have minimal intervention from the moderator, for example a needs analysis. Choosing the level of structure in the group will depend on the research question to be answered. If the researcher knows the important questions, and is clear about what s/he wishes to learn about the questions, a highly structured group is appropriate. If however, the researcher wants to find the important questions, it is more appropriate to have a lower level of structure (Morgan, 1988). (See Table 1.1)

**Table:1.1 Group Structure / moderators' role**

Function	Structure	Purpose	Example
1. Ask questions	High Level	Ask clearly defined questions	Survey
	Low level	Needs to find important questions	Exploratory
2. Manage discussion	High level	Tight management	Market research
	Low level	Minimal management	Needs analysis

The moderator may or may not be the researcher. The level of moderator involvement in the focus group process will depend on the level of structure agreed upon. Morgan (1988) explores in detail the level of involvement ranging from moderators controlling the set of topics discussed and the dynamics of the group discussion, to moderators playing only a small role and being as non directive as possible.

Krueger (1995) suggests that the role of the moderator is changing. Previously the moderator would invariably be the researcher. In the new paradigm described by Krueger, the sponsoring organisation or community is highly involved in the research process and the researcher takes on the role of coach, teacher and mentor to a team of non-researchers.

In comparison to market research in which the moderator is employed, in nursing research the facilitator is often the researcher. The facilitator needs special skills over and above those of the one-to-one interviewer. S/he needs social and refereeing skills to guide the participants toward effective interaction, without directing the debate or coercing the participants (Holloway & Wheeler, 1996).

In a semi-structured environment, the moderator will need to have prepared an interview guide or list of questions which will help focus the session. It is sometimes preferable that the participants have seen the questions before the group begins to prepare themselves for the session.

Research examining the effect of the moderator on the richness of the data was completed by Fern in 1982 (cited in Thomas, MacMillan, McColl, Hale, & Bond, 1995). He found that moderator led groups did not produce more ideas than unmoderated groups. Another finding in this study was that the participants were more enthusiastic and enjoyed the moderated group, more than the unmoderated group.

Asbury (1995) suggests that an initial question opens the session, to which all participants respond. Other researchers have used a film or told a story to stimulate interaction. The moderator needs to ensure that the environment is

conducive for discussion to occur. Privacy and confidentiality are both critical, and it is the moderator's role to remind the group of ethical issues before the group commences.

### **3.1.4. Sampling/size of group**

There is some agreement in the literature that homogeneous groups will interact more fully than groups from diverse backgrounds (Morgan, 1988; McDaniel & Bach, 1994). Group members ideally should have a similar cultural background. In this context, culture refers to ethnicity, age, gender, socioeconomic status, or other factors that may relate to the topic being discussed (Asbury, 1995). It has also been found that single sex groups generate more diverse data than mixed sex groups (Stewart & Shamdasani, 1990). Morgan (1988, 1992) is the main proponent for participants being strangers to each other. Some of the problems with having friends within the same group include the complicated group dynamics that result from two or more people knowing each other, and that friends may have invisible assumptions such as not talking about certain issues which may hinder full discussion on the topic being discussed.

Krueger (1995), on the other hand claims that it is often impossible to find strangers, and that focus groups have been successful when the participants know each other. Kitzinger (1994) believes that using participants familiar to each other (either friends or a community group such as a playgroup) allows the researcher to tap into fragments of interactions which approximate naturally occurring data. Further criteria for participation includes participants being information rich and willing to talk about their experiences in a group. Morgan (1988, p. 46) states that "the best general advice is that participants should really have something to say about the topic and they should feel comfortable saying it to each other".

Convenience sampling is the most common method for selecting participants, according to Stewart and Shamdasani (1990). This type of sampling is defined as "the use of the most readily accessible persons...may include volunteers.. the subjects are convenient and accessible to the researcher and are so called a convenience sample" (LoBiondo-Wood & Haber, 1994, p.291).

Advantages of convenience sampling are that it is the easiest way to obtain participants. Drawbacks of this method are that there is a greater risk of bias than any other sampling method because the participants are self-selecting, and that the representativeness of the participants is questionable (LoBiondo-Wood & Haber, 1994). However, because focus groups do not represent a cross-section of the community, and generalizability is not the objective, the convenience method of sampling is recommended when using focus groups (Stewart & Shamdasani, 1990).

The size of the group is also a source of contention in the literature. Traditionally focus groups had ten to twelve members. With an increasing number of researchers using focus groups in a variety of disciplines, the most effective focus groups have been found to be composed of six to eight participants. Smaller groups are possible if the topic is complex or sensitive. It has been noted that the smaller groups lack the "synergism" of larger groups, and may produce less specific ideas (Halloran & Grimes, 1995). In general, the minimum number for a focus group is four, and the maximum number is 15 (Morgan, 1992). Additional to this criteria and most important is that the selection is dependent on the research question. Who will be the participants most likely to address the topic?

### **3.1.5. Determining the number of groups**

Two factors influence the number of groups to be held. The first is the research goals. If focus groups are the sole source of data collection then more groups may be required to collect the data. If focus groups are only one method of several forms of data collection, one or two groups will suffice. The second determinant of the number of groups is the number of different population subgroups required. It may be necessary to have three or four sub-groups of each population, then have two or three sessions with each subgroup. In general, it appears that groups should continue to be held until there begins to be repetition in the data, and the groups no longer generate any new knowledge (Quine & Cameron, 1995).

### **3.1.6. Conducting the focus group**

Prospective participants can be contacted by telephone, personal contact,

advertising or by key workers in the field. The interested participants will then be met by the researcher who will discuss the purpose of the research, including the ethical considerations which will all be outlined in the consent form. It is advisable to give the participants some time to consider the process before committing themselves to the research. The researcher then groups the participants as homogeneously as possible and arranges a time for the focus group. It is preferable that the group is held four to six weeks following the initial recruitment. A letter of confirmation of the date and venue of the focus group is sent to the participants at least two weeks prior to the group. The letter usually encourages participants to reflect on their experience with the research topic before the meeting.

Another method of conducting the focus group, especially if the topic is sensitive, is the use of anonymized focus groups. In this situation the participants' identities are only known to the researcher, and the groups occur via teleconferencing (White & Thomson, 1995). Advantages of this method include the higher possibility of a more frank and open discussion, thus richer data collection. Disadvantages would be the greater difficulty of maintaining the group interaction which is the hallmark of focus groups.

Virtual focus groups, in which all discussion is computer-mediated, with no face to face meeting between participants is described by Murray (1997). The focus group is conducted via e-mail, with the group lasting approximately four weeks on-line. The advantage of this method is that there is no need to transcribe the discussions, resulting in huge saving of time and money. As with teleconferencing, a disadvantage of this method is the lack of group interaction.

Preparation of the environment in which the focus group takes place is an important part of the research approach. The site for the focus group needs to be neutral, comfortable and non-threatening (Morgan, 1988; McDaniel & Bach, 1994; Asbury, 1995). In market research using the focus group method, special focus group rooms were developed. Krueger (1995) notes that these rooms are often expensive, in the wrong location, and lack the casual environment necessary. Any specific needs of the participants must be taken

into consideration, such as disability.

Accessibility to the venue is also a consideration, and it may be that the researcher will have to arrange transport for the participants. In general it is preferable that the group be held locally. Some researchers have provided food on arrival, as an ice breaker and also to relax the participants. The length of each group is usually one to one and a half hours, although this may vary if the participants are elderly or disabled or if the discussion is completed earlier.

### **3.1.7. Data Collection**

The most common form of data collection in focus groups is audio taping. It is recommended to seat the participants in a circle or semi-circle, with a top quality tape-recorder in the middle of the group (Holloway & Wheeler, 1996). Videotaping is not recommended by Morgan (1988), largely due to the intrusiveness of the process.

Other forms of data collection include having a second moderator in the group taking notes of the discussion, or transcribing directly onto a laptop computer; using a one-way mirror (used frequently in market research); and supplementing the data with questionnaires completed before the group begins. Nyamathi and Shuler (1990) recommend taking written notes as well as audio-taping, as a back-up in case of battery failure. Morgan (1988) advises that the moderator makes detailed field notes at the completion of the group to begin the data analysis process. A variant on the above forms of data collection is using post-it notes to note thoughts during the group, then post them on a board at the summary, thus encouraging participants to collect and analyse the data (Hughes, 1996; Vanderbecke, 1996).

### **3.1.8. Data Analysis**

According to Carey, (1995), data analysis of focus group research will be driven by the purpose of the study. There are several areas within focus group analysis that need to be acknowledged. Firstly, the researcher must be aware of and appreciate the richness and complexity of the data. It is very difficult to transfer the powerful group interaction which is one of the main advantages of

focus groups over other research methods, into analysis. Carey (1995) comments that previous literature on focus groups ignored the structure of the group characteristics such as dynamics, and dominant/submissive members. Instead the literature mainly focused on the numbers of the groups, and the culture of the group members. There is agreement now that attention must be made to the amount of consensus and interest the topics generate, both within and across groups (Kitzinger, 1994; Carey, 1995; Morgan, 1995; Agar & MacDonald, 1995). The group interaction also needs to be specifically noted (Stevens, 1996).

The second area within analysis to be noted is the difficulty of distinguishing between what the participant finds interesting and what they think is important (Morgan, 1995). During a focus group, participants can be more enthusiastic about 'interesting' topics, rather than discuss issues of importance (Morgan, 1995). The researcher's task is to ascertain important data from interesting data.

Considering the above issues, a variety of approaches to data analysis of focus groups have been employed by researchers. Analysis begins at the planning stage, when the researcher constructs open-ended questions for discussion. During the group, the analysis continues as the facilitator processes the group interaction. Carey (1995) also recommends reviewing the discussion with the participants towards the end of the group. Analysis needs to be completed soon after the session is completed.

Morgan (1988) and Wood (1992) suggest that there are two basic approaches to data analysis. The first is qualitative or ethnographic summary. This analysis is "inductive and naturalistic, with themes emerging from the data, not being imposed on them" (Wood, 1992, p.2825). The second approach is qualitative content analysis, or latent qualitative analysis which involves searching for words, phrases, observations, then highlighting data, and noting recurrent dominant themes, and developing categories.

A combination of these approaches appears to be the most useful method, according to Morgan (1988). Examples of qualitative content analysis are

seen in the research of Flaskerud and Rush, (1989); McDaniel and Bach, (1994); Yates, Dewar, and Fentiman, (1995); Kelly, Shoemaker, and Steele, (1996), and Brooks, Fletcher and Wahlstedt, (1998). Straw and Marks (1995) report using thematic analysis successfully, whereby primary themes are reported based on commonality or consistency across groups. This type of analysis has also been used successfully by Richardson and Maltby, (1995), and Cowles, (1996). Carey (1995) suggests using an analysis approach described by Miles and Huberman (1994) which involves condensing, clustering, sorting and linking data.

Combining with quantitative methods is also recommended to “expand, explain and reinforce a study in a sequential or concurrent approach” (Carey, 1995, p.493). The critical issue within data analysis using the focus group method is maintaining the balance between rigorously interpreting the group interaction, and remaining true to the dynamics within the group process (Carey, 1995).

### **3.1.9. Validity and Reliability issues**

The focus group method does not propose any specific manner of ensuring validity and reliability of the research approach. As with all areas within research, the analysis of the data must be conducted rigorously .

Validity refers to “the degree to which a procedure really measures what it proposes to measure” (Nyamathi & Shuler, 1990, p.1284). Nyamathi and Shuler believe that focus groups have “high face validity, due to the creditability of comments from participants” (p.1284). Reed and Payton (1997) disagree with this argument claiming that focus groups need to do more than confirm and support assumptions and prejudices. Reed and Payton (1996, p.770) suggest that within the definition of validity as cited above, the word ‘measure’ needs to be replaced by the word ‘reflect’, and argue that “what a focus group reflects is the process of developing a group perspective or position among a particular set of people”.

Carey, (1995) presents another perspective of validity as defined by Messick (1989, cited in Carey, 1995) “an integrated, evaluative judgment of the degree

to which empirical evidence and theoretical rationales support the adequacy and appropriateness of inferences based on test scores and other modes of assessment" (p.489). Carey believes focus group data can be valid as the data represents an accurate representation of reality for the group members.

Reliability is the "extent to which consistent administration of the instrument will provide the same data" (Diers, 1979, as cited in Nyamathi & Shuler, 1990). The latter authors agree with Sandelowski (1986) that the criterion of reliability within qualitative research needs to be auditability, whereupon the reader can clearly follow the analysis pattern used by the researcher.

### **3.1.10. Ethical issues in focus groups**

Although focus groups, as a research method, have been increasing in popularity over the past 15 years, there is very little documentation regarding ethical issues that specifically pertain to focus groups. The main authors in this area are Greenbaum, (1988), Nyamathi and Shuler, (1990), Smith (1995), and Carey (1995). These authors have described some of the main ethical issues of concern for researchers when using the focus group approach.

One concern relates to the interactivity of the group process. As an individual within the group, over disclosure may occur following a discussion that has raised some personal issues for the participant. Secondary to over-disclosure, privacy may be violated because the participant is disclosing to all the other participants in the group, as well as to the facilitator. A third concern is the individual psychological stress the participant may feel, as a direct result of the group interaction.

Some positive actions the researcher can take to reduce/eliminate these concerns are highlighted by Smith (1995). The most important is that the researcher works within the four ethical principles of:

- autonomy: respecting the decision-making capacities of participants
- beneficence: maximising good outcomes for science, humanity and individual participants
- nonmaleficence: avoiding harm, risk or wrong to participants

- justice: distributing benefits, risks, and costs fairly, treating all participants equally (Beauchamp & Childress, 1994, cited in Smith, 1995).

According to Smith (1995, p.484), within focus groups nonmaleficence is a "major influence" and needs to guide the researcher to ensure the participants come to no harm. Other actions that can be taken by the researcher to reduce the above problems include: acknowledging to the participants that anonymity and privacy cannot be guaranteed, because despite promising to maintain confidentiality, the researcher cannot ensure that all participants will not disclose when they leave the focus group; and being aware of how participants feel as they leave the focus group. Smith (1995) suggests having informal or formal debriefing at the end of each group; working out a strategy before the group of dealing with disclosed sensitive issues for the participant such as abuse, violence; varying the group format if sensitive topics are to be raised, for example using smaller numbers; having two facilitators; and using anonymous teleconference groups (White & Thomson, 1995).

### **3.1.11. Reporting the findings**

Early market researchers using focus groups did not usually publish their results, preferring to report back directly to the client. Recently, as focus groups have gained popularity in the social sciences, publication in refereed journals has been the preferred method of disseminating the findings. Morgan (1988, p.70) notes: "there is a perpetual tension between the richness of the data and the remoteness of the reader from the sources of the data". A report which distinguishes the salient feature of the research will hopefully reduce the remoteness. Holloway and Wheeler (1996), believe that the important concern when writing the report, is that the participants' voices are evident. In general, themes are outlined and explored using verbatim quotes from the groups. Themes can be compared, contrasted and formed into a framework (Nyamathi & Shuler, 1990; Brooks, Fletcher, & Wahlstedt, 1998).

### **3.1.12. Advantages of the method**

Wood (1992) suggests that focus groups are an excellent choice of method when the researcher wants to have a broad overview of a new topic, to generate new ideas, to provide multiple and diverse stimuli to the participants,

and to obtain data based on personal experience. Other reasons for choosing focus groups as a research method are that the method:

- encourages participants to remember experiences through group discussion that they might otherwise forget (Nyamathi & Shuler, 1990; Holloway & Wheeler, 1996)
- is efficient in determining the range of experiences among a group of people (Seals, Sowell, Demi, Moneyham, Cohen & Guillory, 1995; Brooks, Fletcher, & Wahlstedt, 1998)
- enables clarification of issues, and allows the researcher to understand the relative importance of these issues to the participants (Quine & Cameron, 1995)
- enables the researcher to gauge collective experiences and beliefs (Stevens, 1996)
- allows flexibility (Stewart & Shamdasani, 1990)
- places issues in a social context (Yates et al., 1995)
- enables the researcher to observe the language of the target audience (Kitzinger, 1994)
- explores the breadth of opinion and anticipates concerns, and enriches understanding of more quantitative findings (Straw & Marks, 1995)
- allows for exploration of social and communication issues, examining the cultural basis of participants' experiences (Kitzinger, cited in Boulton, 1994).

Summing up the advantages of the focus group, the most important feature is the group interaction, which is able to provide data and insights that may be less accessible without the group process (Morgan, 1988; Krueger, 1995; Asbury, 1995). The group interaction allows for an increased depth of response and emotion from the participants. Using the group, the participants are able to voice their ideas about what is important, using their language and concepts and their frameworks for understanding the world (Kitzinger, 1994). There is a possibility that the group process will actively facilitate discussion about issues not commonly discussed, as less inhibited members of the group 'break the ice', encouraging others to disclose (Kitzinger, 1994; Stevens, 1996).

Within a group of people, participants are more likely to share experiences, be triggered to remember incidents they may have forgotten, and even be challenged on their point of view. Focus groups also allow for rapid accumulation of data, which could make them cheaper and more efficient than individual interviews (Holloway & Wheeler, 1996).

### **3.1.13. Disadvantages of the method**

The process of the group interaction can however be a disadvantage when using the focus group method. Disadvantages of focus groups as a method are that the method:

- enables the domination of one participant, or the participant who does not contribute to the discussion (MacDougall & Baum, 1997)
- may incur 'group think', whereby the group comes to an agreement because of the process of the group, rather than each individual working through ideas (MacDougall & Baum, 1997)
- may encourage 'social posturing', when participants are polite, attempting to fit in with the norm, and agree with others even when they do not (Nyamanthi & Shuler, 1990)
- gives the researcher less control over the data generated as the group interaction takes the discussion where the group wants it to go (Morgan, 1988)
- creates uncertainty as the researcher can be unsure whether or not professed behaviour/attitudes/perceptions reflect individuals actual behaviour/attitudes/ perceptions (Morgan 1988)
- is more difficult to get people together at a certain time, participants can arrive late, and may want information withdrawn (Krueger, 1994)
- creates difficulty with transcription, where participants speak over each other or sit too far away from the microphone.

In summary, there are disadvantages associated with the focus group method. The main issues relate to group dynamics (domination, quiet group members, 'group think', and social posturing) and the logistics of getting a number of people together at the same place and the same time.

### **3.1.14. Focus groups in nursing research**

Within nursing research, focus groups as a research method has been gaining popularity. One of the most attractive features of the method is that it can be used in combination with other methods. The focus group method within nursing has been used to generate constructs, develop models, generate data for instrument development and refinement, or to evaluate new programs or products (McDaniel & Bach, 1994). Other uses described in nursing literature are to:

- provide in depth information from the participant's perspective on why people think and feel the way they do (DeJoseph, Norbeck, Smith, & Miller, 1996)
- enable further clarification of some issues suggested by quantitative data (Grindel, Peterson, Kinneman, & Turner, 1996)
- allow researchers to gain information of perception, feelings, and attitudes for greater understanding and insight (Kelly et al., 1996)
- explore the research question from the respondents perspective (Yates et al., 1995).

#### *Summary*

In the first part of this chapter, focus groups have been explored and described as a research method, including advantages and disadvantages. The philosophical basis of focus groups has been discussed, followed by the research approach, including structure, moderator involvement, sampling/size of group, number of groups, how to conduct a focus group, data collection, analysis, validity and reliability issues, and ethical issues. The process for reporting the findings has also been outlined. Finally, a brief description of the use of focus groups in nursing research has been given. In part two of this chapter, my use of the method in the current study on nurses' understanding of parenting will be described in detail.

## **3.2. Part Two - Focus Group - use of the method**

### **3.2.1. Philosophical basis/rationale for use of method**

The decision regarding the research method followed the development of the research question. Underpinning the research question were philosophical notions about scientific truth (Packard & Polifroni, 1992). Thus it is useful to begin this section of the chapter with a discussion relating to my philosophical basis for the research. As I believe that “scientific truth consists only of what is accessible and measurable by human beings...truth is found in the lived experience of individuals” (Packard & Polifroni, 1992, p.162), using a qualitative approach was the only option. Having made that decision, I needed to focus on which perspective, or paradigm would frame the research method. Within qualitative research there are two choices of perspective - the critical and the interpretive paradigms.

The general aim of research within the critical paradigm is to expose power structures, specifically imbalances, and then to empower and transform (Pearson, Vaughan & Fitzgerald, 1996). Thinking about the general aim of the research, which was to uncover nurses’ understandings, it seemed that the critical paradigm would not be appropriate. The second paradigm, the interpretive, also known in the literature as the humanistic or naturalistic according to Ford-Gilboe, Campbell, and Berman (1995), relates more to understanding the meanings given to social interaction by the participants in the research. As a researcher working within this framework/paradigm, I would be able to legitimately interpret as reality the feelings and perceptions of the participants. Thus the philosophical basis for the research was qualitative, using the interpretive paradigm.

From the philosophical basis, the research question which began as *what do nurses’ know about being a parent in hospital?*, evolved and developed into *What is nurses’ understanding of parenting in the paediatric ward in New Zealand?* As the research question seeks to understand nurses’ understanding of a phenomenon, it seemed that an exploratory method would be most appropriate. Exploratory research can be used when not much is known about the research topic. The researcher must then explore the topic for her/himself.

Brink and Wood (1994, p.106) define exploratory research as “studies providing an in-depth exploration of a single process, variable or concept”. Advantages of exploratory research designs are the richness of detail of the data, much of which will not have been noted before; the holistic view gained from describing, comparing, and classifying the data; and the ability of the researcher to move from observation and description, to classification and then to conceptualisation (Seaman, 1987). The major disadvantages of exploratory research are the difficulty of the research process: “It is not easy ...to organise a mass of observations ...into an organised, succinct account” (Seaman, 1987, p. 185); and the findings are limited to the unit studied.

Another issue which developed out of the philosophical underpinnings and helped shape the research design, was the desire for a method which would allow the nurse/participants to name/identify their own issues regarding their understanding of parenting in the paediatric ward. Respecting the nurse/participants was an important objective, thus a discussion which allowed exploration of the topic in a safe, non-threatening and non-judgemental environment was the aim in the search for a research design.

The decision to use focus groups as the research method also arose out of a desire to use a method of data collection which was as close as possible to nurses’ ‘natural’ environment. According to Agar and MacDonald (1995), focus groups are a cross between a meeting and a conversation - a meeting in that there is a moderator who introduces the topic and facilitates the group; and a conversation in that people discuss their own perceptions with others in an informal way. There is also agreement in the literature that focus groups provide safety for participants (Nyamathi & Shuler, 1990; Kitzinger, 1994).

Being exploratory research, it was also important to have a research method which could potentially uncover not only *what* participants think about a topic, but also *how* and *why* they think as they do. Both Kitzinger (1994) and Thomas et al., (1995) noted that this was possible in focus group research. Focus groups as a method met all the design criteria and was therefore chosen as the method of choice for the research.

### **3.2.2. Research method**

Morgan (1988) suggests focus groups can be used as a self-contained research method or in combination with other forms of data collection. In the research design, focus groups were planned to be the sole research method used in the study. However, a premise was included that if it was noted during the group that a participant had not been able to express them self fully in the group and/or the facilitator wanted to follow up a theme needing further development, single interviews would be held. Agar and MacDonald (1995) recommend not using focus groups as a 'stand alone' method, especially if the researcher has no prior knowledge of the 'folk model'. Folk model refers to a collective understanding of some aspect of people's life, for example, a group of adolescents who are known glue sniffers, and who live in the same city, will use similar language, have similar experience, and will understand each others lives. This group share the same 'folk model'.

In this research, the participants are registered nurses working in the paediatric area. I am also a registered nurse with experience of working in paediatrics. Although I believed I had a good understanding of the folk model, there might be some interpretation that required clarification and/or validation, therefore one participant from each group was asked to validate my interpretation of the data collected.

### **3.2.3. Research approach**

#### **3.2.4. Structure**

As the research was predominantly exploratory in nature, only two questions were formulated before the groups were commenced. The questions were:

1. What does the word 'parenting' mean to you?
2. What is your understanding of parenting in hospital? (Appendix 2)

It was anticipated that the remainder of the facilitation of the group would involve assisting the participants to reflect upon their understanding of parenting within a paediatric ward. Towards the completion of the group, I also planned to ask the participants to sum up the themes.

A low level of structure was set to assist the group process to work. Beginning with a question which focused on parenting enabled the group to give their

own definition of the concept 'parenting', and also became an ice breaker for the group. Discussing the word 'parenting' gave all the participants an opportunity to speak which appeared to relax the participants. It also gave the participants the opportunity to ask the facilitator questions about the process of the focus group before actually beginning the discussion of the research topic. It was also critical for me to have an understanding of the participants' beliefs about parenting before discussing the participants' understanding of parenting in the ward.

### **3.2.5. Moderator/facilitator involvement**

In this research, the researcher (myself) was the facilitator of the focus groups. There were several reasons for this decision. Firstly, as I was the sole researcher in the study, I was deeply committed to the research, and saw the opportunity to facilitate the groups as a special privilege. Secondly, asking a second person to facilitate the group would have required large amounts of resources, both of time and money. Thirdly, there was no ethical reason why I should not facilitate the group. I was an 'outsider' in that I did not work in the same environment as the participants, yet I was also familiar to them as a nurse educator. Some of the nurses were also completing a Bachelor of Nursing degree at the Tertiary Institute at which I was employed, and knew me as a lecturer. I did not believe there would be a conflict of interest as I was not employed by the hospital.

In these roles, there was no coercion or conflict of interest. My involvement in the group was to ask the two pre-arranged questions at the appropriate times, and to keep the group focussed on the research question.

### **3.2.6. Sampling/size of group**

Convenience sampling (as previously described) was used. The population were registered nurses who were employed in the in-patient paediatric ward, the day ward for children, or the special care baby unit at a hospital in New Zealand. There were 43 nurses in this group. I initially approached the nursing management of the Child Health Unit and asked for their assistance in contacting the group. Several advertisements (Appendix 3) were placed by the managers in highly visible areas around the unit. Two weeks later, I gave

the nurse manager an envelope for each nurse. The envelope contained the information sheet (Appendix 4), the consent form (Appendix 5), and a letter of invitation (Appendix 6) with prospective dates to choose from, plus a stamped addressed envelope to my home address. I requested that the managers write the name of each nurse in the population group on the front of the envelope, and post this to the nurse via the internal mail. However, the managers decided to place all the envelopes in a bag in a convenient place, and asked the nurses to collect an envelope themselves. They also posted the envelope to nurses who were on leave at that time. From that initial contact, seven nurses returned their consent forms to me. I then formulated a reminder letter (Appendix 7) to invite nurses to participate in the research. This was enclosed in an envelope, given to the nurse managers who addressed one to each nurse and delivered them via the internal mail system. Two more participants returned the consent form following this mail out.

All nine of the participants were then contacted by telephone and a date to attend the focus groups was made. One potential participant was unable to attend either focus group, which left eight participants. Two groups were formulated, two weeks apart at two different venues. The participants were contacted again by telephone several days prior to the group to confirm attendance, and specify the place and time the focus group would be held.

Returning the consent form and agreeing to participate in the research strongly suggested that each participant had something to say about the research topic and that the participant was willing to talk about their experiences in a group. Each group comprised four registered nurses, some of whom knew each other in a professional capacity.

Participants indicated the time, date and location which would suit them, and these factors were the main determinants for which group each participant joined. I did however, endeavour to ensure that the groups were even (i.e. four in each group), noting Morgan's (1988) suggestion that four is the minimum number for a focus group.

In summary, convenience sampling was used to recruit participants for the

research. Two focus groups were held, with four participants in each group. The groups were held within two weeks of each other, at two different locations.

### **3.2.7. Determining the number of groups**

Two focus groups were held in the research. Each group had four participants. The limitations of the number of groups on the research will be discussed in Chapter Five.

### **3.2.8. The pilot group**

Prior to the first focus group, I organised a mock pilot focus group with six colleagues, all of whom were registered nurses. None of the participants in the pilot group were from the population sample. This gave me the opportunity to practice and refine my facilitation skills, and to be prepared for the variety of situations which may occur during the process of the focus group. It was also an opportunity to trial the audio-tape recorder. This was an invaluable part of the data collection and gave me confidence to proceed with the actual groups.

### **3.2.9. The focus groups**

Each focus group was held in a different venue within the region. A conference room was booked with tea, and coffee facilities and biscuits provided. Both groups were held from 4pm - 5.30pm. I asked participants to be there about ten minutes before the group, so that we could begin the discussion promptly. An observer was present to ensure the tape recorder was working and to change the tapes as necessary. She also kept an eye on the comfort of the participants.

The participants each had a 'post-it' pad and pen to take notes. Before the group commenced I welcomed them to the group and reminded them of their agreement to confidentiality of group members. I also asked if they would like any further ground rules for the group. Neither group chose to have any more ground rules.

The research question "What is your understanding of parenting in hospital?" was written on a white board in the room. Once the group started, it continued

for approximately one and a half hours. Towards the completion of the discussion, I gave each group the opportunity to sum up the main 'themes' of the discussion. After the tapes were turned off, I gave the participants an opportunity to debrief and discuss the group process. Participants reported enjoying being in the group, and having the opportunity to express themselves freely.

### **3.2.10. Data Collection**

Two audiotapes were placed in the middle of the table to record the conversation. This was in case of mechanical failure. I also took copious notes during the session. I had not planned to do this, but found it very helpful, especially when a participant lost their line of thought, or the group struggled to recollect their previous discussion. It was also useful at the end of the session when the participants were asked to sum up the 'themes'.

### **3.2.11. Data Analysis**

Data analysis began towards the end of each focus group. I asked the participants to summarise their discussion. This took a further ten to twenty minutes of discussion, and included new ideas/ thoughts as well as reflection on the content of the discussion.

There were two primary goals of data analysis. The first was to make sense of the data (Lincoln & Guba, 1995) and the second to understand focus group participants' interpretation of social reality (Carey, 1995). Data analysis was informed by three methods. Zemke and Kramlinger (1989) and Holloway and Wheeler (1996) provided the step by step approach. Analysis specific to focus group method was suggested by Stevens (1996) and Krueger (1994).

Zemke and Kramlinger (1989) offer the following advice: read the transcripts; generate lists of key ideas, words, phrases and *verbatim* quotes that capture the sentiments; use the ideas to formulate categories of concerns; place ideas and quotes in the most appropriate category; examine the contents of each category to search for sub-topics and select the most useful quotes and substantiation for various ideas; and finally attempt to cluster categories containing various ideas and quotations into themes.

Holloway and Wheeler (1996) suggest the following : transcriptions of the audiotape are made, and a wide margin is left beside the transcription for categorising and coding; transcriptions should note pauses, laughter, and anything unusual; paragraphs and sentences are coded by extracting the essence of ideas; from these codes larger categories, themes and ideas are found; each focus group is analysed, then compared with others; major themes across all groups are connected, patterns described, meaning is interpreted and literature is used to inform the discussion.

Questions to be addressed in order to specifically note the group interaction as suggested by Stevens (1996) include: how closely did the group discuss the topic? what statements caused conflict? what common experiences were expressed? was a particular view dominant?

Guided by these three frameworks, thematic analysis was used. The tapes were transcribed onto the left hand side of the page. On the other side, I made a note of key ideas, words, phrases that captured the sentiments of what was said. From these notes, I clustered the ideas on large sheets of paper. This process continued for a long period, moving ideas from one cluster to another. Eventually, issues emerged which appeared to describe and capture the ideas being discussed. Notes were also made during the analysis of the activity of the group, such as agreement and disagreement.

### **3.2.12. Ethical issues**

This research was based on the belief that meeting appropriate ethical requirements is an essential part of the research process. Two ethics committees approved the research (Appendix 8 and 9).

### **3.2.13. Access to Participants**

Participants were accessed as previously described. The nursing managers of the Child Health Unit were the intermediaries between myself and the population. The information sheet (Appendix 4) was non-coercive and gave the potential participants the opportunity to take part in the research only if they wished to do so.

#### **3.2.14. Informed Consent**

The use of a consent form (Appendix 5) is underpinned by the ethical principles of: autonomy, the right to be treated as a responsible human being with the right to make free and informed decisions; beneficence, the research must be in the best interests of the participants and the community; non-maleficence, the positive decision to do no harm; justice/equity, the balance between the needs and rights of individuals and communities (LoBiondo-Wood & Haber, 1994). Strategies used by the researcher to maintain ethical principles will be discussed within the section describing potential harm to participants.

#### **3.2.15. Anonymity and confidentiality**

These issues were addressed in the following manner. The names of the research participants were known only to the researcher and the other participants who attended the same focus group. The participants agreed to maintain the anonymity of the other participants. The participants did not know who was taking part in the focus group until they arrived at the venue. Before the group commenced, I reminded the participants of their agreement, and requested they respect each others anonymity, and to keep the issues discussed within the group confidential. The participants again agreed to do this, therefore both groups accepted the ground rules. The transcripts of the tapes had no names noted. The transcriber and the observer signed a non-disclosure form (Appendix 10). All names were coded, and the master list was always stored separately from the transcripts.

#### **3.2.16. Potential harm to participants**

There were no physical risks. Focus groups do have privacy concerns in that each participant is aware of others participating in their focus group. The participants all knew each other as they came from the same population. There was a concern that participants may over disclose personal information which may be a concern to the participant. At the debriefing at the end of each group, none of the participants stated they had any concerns relating to over-disclosure. To monitor and detect possible adverse outcomes for the participants, the following occurred: participants gave informed consent to participate in the group; the consent form highlighted ethical issues for the

participants so that they were fully informed; and there were at least two weeks between receiving the consent form and agreeing to participate in the study. This gave the participant the opportunity to speak with the researcher and have any questions answered before signing the consent form.

I completed a pilot focus group before beginning the research to further refine interviewing skills within a group, and to be prepared for the variety of situations which may have occurred during the process of the focus group. Before commencing the group, the responsibilities of the facilitator, the observer and the participants were clearly stated. I encouraged the group to set their own ground rules, such as the confidentiality of the group, and the right to express their own opinions, without fear of put-downs or harassment. Counselling facilities for the participants were arranged in preparation for participant/s who needed further debriefing from the discussion. These would have been financed by the researcher, but were not accessed. Two participants were involved in checking analysis by clarifying and validating the researcher's interpretation.

### *Summary*

In this chapter an in-depth examination of focus groups in general has been provided, and specifically my use of the focus group method. Areas discussed have been the philosophical basis/rationale for the use of the method, the research design and method, the research approach, facilitator involvement, sampling/size of the group, determining the number of groups, conducting the focus group, data collection, data analysis, and ethical issues. In the next chapter, the results of the research will be described in detail.

# 4

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## Results

In this chapter, the results of the data analysis will be described. As stated in Chapter Three, thematic analysis was used to interpret the data. However due to the small number of participants and groups, data saturation was not reached thus there was potential to make the emergence of themes forced. To avoid a forced situation, I allowed the data to speak for itself and what emerged were issues which formed four major areas of analysis. These four areas will be outlined, and within each area, a variety of issues described.

The four emerging issues are:

1. Parenting issues
2. Issues for parents
3. Issues for nurses
4. Support issues

A conceptual model of the analysis is included (Appendix 1).

### Coding

*Verbatim* quotes from the transcripts were indicated by indentation from the margin and italics. There were two focus groups, (1 and 2) and four participants in each group. The pages of the transcripts of each group were numbered. The first *verbatim* quote in any situation will always have a participant identified as 'A'. If there is a dialogue between the participants the next participant will be 'B' and so on. Thus a statement from a participant in group two, that is transcribed on page 22 of the transcriptions will be referenced as 'A' .....(2:22)

### 4.1. PARENTING ISSUES

As previously stated in Chapter 3, the first question asked of the participants in each group was “**what does the word ‘parenting’ mean to you?**” The purpose of this question was to ascertain the participants’ definitions of parenting, before discussing the question which was the focus of the group. Discussing ‘parenting’ gave the participants an opportunity to hear each other,

and also served as an icebreaker. However discussing the concept of 'parenting' was obviously difficult for the participants. There were no definitive responses. Instead participants tried to define parents and discussed legal versus moral meanings and tasks and functions of a parent. They also recognised the potential for understanding the term parenting only from their own cultural norms and values.

Three issues evolved out of the analysis of the participants' discussion around parenting. They are:

- 4.1.1. Legal versus moral - tasks and functions
- 4.1.2. Different things for different people
- 4.1.3. Uncertainty - changing family structure
  - fitting the mould

#### **4.1.1. LEGAL VERSUS MORAL - tasks and functions**

Participants tried to define parents and discussed legal versus moral meanings of 'parent', using the tasks and functions of a parent. In one group, a participant argued that the parent could be a caregiver, a foster home, a school, that is, any care given to a child could be called parenting.

*A....for parenting, anybody who's providing care for that child, like it could be just a caregiver, it could be a foster home, it could be a schooling type situation...anybody who's providing the basics of life (2:4)*

Another participant from the group argued that a parent has to be a person, not an institution or agency. Parenting was viewed as more than the physical responsibility and day to day well-being of the child, it was also being morally responsible for the child.

*A. The boarding school doesn't provide the love and the nurturing...they don't have the moral responsibility that parents have (2:5)*

One participant believed that parenting is undertaken by parents, but that parents may not be biological.

*A. ...parenting is not always done by natural parents...sometimes you see absolutely amazing parenting done by people that have no blood relationship to the child (2:3)*

Parenting was seen as caring, nurturing, giving children values and rules,

taking total responsibility and giving the child support, love and security.

*A. A parent is a person who knows each child, individually, their strengths, their weaknesses, what is appropriate and what is relevant, for each child (1:2)*

The participants perceived that a parent gives the child life skills and the basic things of life required by law. A parent is a friend to the child, someone the child can approach and feel comfortable with, and who won't degrade the child, someone who is 'there' for the child.

*A. parenting has always, to me been bringing up the children and how you best want your child to be brought up - your values, your rules...giving them life skills and the basic things of life that are required by nature, and law (2:2)*

#### **4.1.2. DIFFERENT THINGS FOR DIFFERENT PEOPLE**

Participants recognised that everyone parents differently, and that parenting is different things for different people and different children. Disagreement arose in one group related to the idea that nurses judge people according to their own values, which were influenced by cultural norms.

*A. Parenting is our perception of the way those people react...we judge people according to our own values and we might say these are good parents or they're not so good parents but who says*

*B. I don't know whether we do ... I don't judge people on my own values*

*B. Because everybody is different and every culture is different and we need to respect everybody's..*

*A. Oh, I agree with that but I think if you're making - the way we perceive things - we come from ourselves*

*B. Well you've got to understand yourself before...*

*A. You've got to understand yourself...there are cultural differences and there are things about some cultures we may not understand. They don't understand us either. (2:64-65)*

In this dialogue between two participants, two features worth noting emerged. The first is that one nurse judged parenting by her/his own values of what parenting should be, and the second is that between the nurse and the parent are cultural differences, which lead to a lack of understanding of each other. The above discussions led to the following:

- A. *I think parenting is different things for different people*
- B. *And different children*
- C. *...and people respond as individuals, don't they? (2:65-66)*

#### **4.1.3. UNCERTAINTY - CHANGING FAMILY STRUCTURE - FITTING THE MOULD**

Within their discussion about parenting, participants reflected on the family and described their uncertainty about the family. The point was made that parents are not always the ones who 'parent' children, due to changing family structure and social norms. In the past it could be predicted that each child would have a mother and a father, now that could not be assumed.

*A....this guy that's arrived, is this the child's dad or is this sort of the uncle that stays sometimes and you know, there's much more hesitancy...I think we see unnatural..changed family dynamics because some of the families are not what you would call a standard family anyway (1:34)*

Family structure was also changing, which impacted the nurses role.

*A. ....what we were saying about the family structure...changed a lot...other kids that just get left and you're trying to sort of fill the emotional vacuum that they've got (1:37)*

Another concern related to the changing family structure was that the extended family breakdown meant that there was a lack of knowledge by the parents, of how to parent.

*A. ...you know like a lack of knowledge that people aren't getting the information and whatever and we're going to start seeing a reflected social trend of that for kids coming through into hospital.*

*B. That's also the family structure perhaps changing...you're not getting the knowledge passed down. You're not getting the community of people, auntie, you know to pass on the breast feeding or whatever (1:72-73)*

In one group even grandparents were seen to be irresponsible.

*A....but is the wisdom there in reality. ... you might have them living there [grandparents]but... have they got the - some of them haven't - they still do what they did at twenty one. They're still irresponsible society-wise (2:71)*

However in the other group grandparents were viewed more positively and participants' experience was that grandparents often took over the parenting role in the absence of a parent. Grandparents appeared to do well in the ward, to be more relaxed and able to interact well with children, in contrast with parents, who were often seen as nervous or stressed.

*A. it's interesting because we find, like the grandparents tend to do very well in the ward...they can be the ones who just sit in the chair and read the stories. They seem to be more relaxed (1:59)*

The participants also had a strong awareness of the difficulties faced by children whose parents may not be together.

*A. ...I mean some of the things the kids come out with in the ward about their family situations is ..confusing ...when they come into hospital they feel a bit more awkward*

*B. they don't fit the mould*

*A. ...children aren't as secure as they used to be... their self esteem isn't the same any more (1:34-35)*

Parents who were parenting alone also had difficulties because they couldn't stay with their child in the ward, due to their obligations to their other children at home.

The isolation of families was recognised by the participants, who believed that society was becoming splintered.

*A. ....there's not the support groups where people know their neighbours and everything any more (1:31)*

Summarising their understanding of the word parenting, the participants emphasised that there was no right or wrong way to parent, that 99 out of 100 parents will do their best for their children as they see it, and that they perceived parenting to have a looser definition than in the 'past', more unstable and difficult to define.

*A....parenting is very fluid and a totally different definition now, than what it used to be...not as clearly defined...not a stable unit (1:58)*

Another participant discussed the value nurses put on parenting.

*A. this {participating in the focus group} has made me realise...that we actually really value parenting - we do - although this is not very evident at all in our environment ...and we'd like it to happen more (1:58)*

In summary, the word parenting raised a variety of ideas for the participants. The salient feature of this discussion were the marked differences between the participants in their understanding and beliefs about parenting. Participants described their understandings of who were parents, parenting tasks and functions, values, including different parenting perceptions, and uncertainty, exploring changing family units and broken families.

There was no conclusion to the debate about what parenting meant to the participants. Thinking about parenting outside the ward context appeared to be difficult and as a consequence the conversation moved rapidly toward the second and main question focus for the group - **What is your understanding of parenting in hospital?**

## 4.2. ISSUES FOR PARENTS

The participants spent a lot of time in the focus groups describing and discussing issues for parents. They appeared to have a clear understanding of the issues they described, and would discuss parents issues from their (the nurses) perspective, as well as their perception of the parents' perspective. At times the participants seemed to have such close empathy with parental issues that they spoke as though they were a parent in the hospital. For example,

*A. ...that if I love that child too much it's going to die and that's going to hurt me. And I can't do anything about this stage...I know it's going to be alright and it's in the cot and they tell me it's fine and it can go home (2:18).*

The issues to emerge were:

### 4.2.1. Parenting and family relationships:

- family restraint
- lack of sleep
- inability to set boundaries

### 4.2.2. Disempowerment:

- confusion/conflicting advice
- parenting a child with an acute illness (being nowhere/uncertainty)
- parenting an infant in SCBU (in shock/disconnected)

- 4.2.3. Empowerment - parenting a child with a chronic illness (in control)
- 4.2.4. Barriers to parenting
- 4.2.5. Lack of privacy (intimidation)
- 4.2.6. Diminishing value (the professional 'white coat')
- 4.2.7. Stress
  - hostile responses
  - nervous or guilty responses
  - defensive responses
  - compensatory responses

#### **4.2.1. PARENTING AND FAMILY RELATIONSHIPS**

The strain of parenting in the hospital environment was apparent to the participants. Throughout each focus group, an understanding of the issues faced by parents parenting within the hospital environment was evident, and created a lot of discussion.

##### ***Family restraint***

The family were seen as being self-conscious in hospital, their relationships with each other restrained. The family was separated, with half in the ward (the child and a parent), and the others at home. Parents were unable to relax and enjoy being a family - they appeared to be on full alert. The participants were mindful that when the family goes to hospital, stress levels increased.

*A...we don't actually see the true or the real relationship that there is within the family because they feel very self-conscious when they're in the hospital (1:4)*

Relationships between family members were restrained, especially positive interactions. Negative interactions such as yelling and swearing at the children are also toned down, but still there.

*A. ...the dynamics of their relationship at home...some of that carries into the ward situation, but I'm sure it 's either very much restrained or whatever, especially for the positive things (1:4)*

The reason mooted for the family's restrained behaviour was the hospital hierarchy, which was seen to be disempowering.

*A. ...I wonder how much gets restrained when they come in the door, and they see just, you know, the hospital hierarchy (1:5)*

**Lack of sleep**

Another factor perceived by the participants as affecting family functioning was lack of sleep when in hospital.

*A. And some parents know their limits too " and I've just got to get some sleep. I've just got to go" (1:38)*

**Inability to set boundaries**

Parents' difficulty giving their children appropriate boundaries for their behaviour was also discussed by the participants. When parents are feeling out of control of the environment and intimidated by the system, they stopped parenting their child as they would at home.

*A. Their boundaries have been removed from them...they really don't have the authority any more...although they are part of the team, it's the doctor that's making all the decisions (1:46-47)*

One participant suggested that if she saw this occurring she would help the parents to parent.

*A. We are there and we accompany those parents, and through that time, and help them as parents to maintain their parenting - sometimes...if a child is sick parents will let them get away with things that they wouldn't normally, and then regret it later (2:36)*

**4.2.2. DISEMPOWERMENT**

There was general agreement amongst the participants that one of the greatest difficulties parents had in hospital was feeling disempowered. As above, the hospital system - the ward hierarchy, the environment all rendered the parent powerless. The participants perceived that parents feel intimidated, lack control over themselves and their children, have reduced responsibility for their child, have their parental boundaries removed, or else remove them themselves.

*A. ...when you get into the hospital system and things change or things happen that you have no control over and it totally unsettles you and you are just not your normal self at all. You sort of fall apart or you feel very uncertain...let self down and let child down (1:39)*

and

*A. ...it is coming from somebody else and none of it's actually in their control. It's out of their power. They're [the parents] not actually making*

*any decisions at all for their children, are they? (1:9)*

Not being involved in decision making was seen by the participants as very disempowering.

*A. ...about the powerlessness - they really don't have any authority any more. They're not - although they are part of the team, it's the doctor that's making all the decisions. And the parents can't say no. (1:47)*

### **Confusion/conflicting advice**

Nurses giving parents conflicting advice was also seen as an issue for parents and as another cause of parental disempowerment.

*A. One thing that really worries me is the conflicting advice that these parents are getting with three different people looking after them and their child or baby in 24 hours...they are getting confused...don't know how to parent because they're swinging from one thing to the next*

*B. They are told one thing by one nurse, one by another and one by another. And that's one of the worst aspects (1:8-9)*

Both groups discussed their perspectives of the differences in powerlessness between three different groups of parents - those who had children with an acute illness, those with children with a chronic illness, and those with infants in SCBU. These groups will be discussed separately in the following sections.

### **Parenting a child with an acute illness (being nowhere/ uncertainty)**

Parents with children with an acute illness were in a difficult situation as they often had no knowledge of the condition and were completely reliant on the hospital staff caring for their child. This dialogue between three participants arose out of a discussion about parents with an acutely ill child.

*A. ...They have no control, no power at all.*

*B. No*

*A. At their situation*

*B. And...some people are quite happy to hand the power over to us to get them through that stage*

*A. But I don't think they've even got any power at that stage. They're totally powerless*

*B. So you're saying we take the power*

*A. That tiny little area in there, the parents have no power at all*

*C. ...We don't take the power, they empower us to do what we can for*

*the betterment of the child (2:58-59)*

Parents of a child with an acute illness were described as being 'nowhere'.

A. *...you've got a child that comes in acutely with say meningitis or an appendix or something, those parents don't have the knowledge that the chronic parents have*

Researcher. Where are they at?

B. *Nowhere*

A. *Half the time they're in shock*

B. *I would say they are nowhere...they are aware the child is sick, they've gone into automation - sick child, doctor, hospital. Then they allow the nurses and the medical people to do their initial thing, with no understanding or consultation at all. There is no understanding of what's going on. It is only after the child has appeared to either stop crying, stop having a high temperature, not fitting, whatever the acute illness is...that the parent comes back into its own.(2:54-55)*

In this state, the parent allows the hospital staff to care for their child with no consultation and with no understanding of the condition. Only after the child has stabilised does the parent resume parenting and take back the responsibility for the child. The parent also begins then to seek knowledge about the child's situation and thus some power and control over what is happening for them and the child.

Participants perceived parents feel uncertain when they come into the hospital environment with their acutely ill child.

A. *...when you get into the hospital system and things change or things happen that you have no control over and it totally unsettles you and you are just not your normal self at all. You sort of fall apart or you feel very uncertain...you start being down on yourself (1:39)*

Being a parent with a child with an acute illness was described by the participants as being on a journey, like a roller coaster.

A. *..for those parents it can be quite a traumatic 24/48 hours. And they have to sort of journey through that time. It's a bit like riding a roller coaster really. You know you're coming to the end of it, there is an end and there's a beginning, but it's just that humpy bit in the middle (2:34)*

***Parenting an infant in the Special Care Baby Unit (In shock/disconnected)***

In SCBU, parents were seen to be in shock. They often had no time to prepare to be in SCBU with their new baby and were overawed by what was going on. They were seen by the participants to be very vulnerable, emotionally fragile, accepting and passive about the treatment their child was receiving. Because for many, it was their first child, the parents did not know how to parent, and lacked confidence to be a parent.

*A. They're [the parent in SCBU] not expecting it so it takes them...by surprise - where at least a parent whose child is coming into hospital...my child's been unwell, we have to go to hospital. Whereas the mother who ...going along and the day's okay and suddenly 26 weeks, oh I think I'm in labour and all the frightening things - is my baby going to survive or whatever ...you know the shock - there's far less time to prepare for it (1:64)*

One participant described the parent of a baby in SCBU feeling 'disconnected', as if the child was not their child.

*A. They feel much more disconnected, I think...it's almost not their child (1:63)*

Participants who have worked with parents on discharge from SCBU describe the parents saying

*A. "The baby was not mine in SCBU" (2:10)*

and

*A. They feel that their baby doesn't belong to them until they get it home... in SCBU they don't have the confidence to be parents... they feel disenfranchised as parents in the hospital situation (2:11-12).*

**4.2.3. EMPOWERMENT - PARENTING A CHILD WITH A CHRONIC ILLNESS (IN CONTROL)**

The parents of children with chronic illnesses were universally described by the participants as being in control and empowered. There was overwhelming agreement amongst the participants that parents of a child with a chronic illness were able to parent effectively within the hospital environment and be actively involved in treatment decision making. One participant described being involved with a parent and family with a newly diagnosed chronic

condition right from the diagnosis.

*A. ...we empower that mother and the child right from the beginning because it's going to be ongoing for the rest of its life so as soon as they are doing everything for that child and have a good understanding, then they will progress quicker and faster and get on with life normally (2:43)*

As they had often had regular admissions to the ward, the parents of the chronically ill child appeared to be comfortable and relaxed in the hospital environment. They had fought the system and had won. They were seen to have power and control.

*A. ...the chronic parents...they have fought the system a lot of the time to get what they've needed for their child. They've had some successes...it's like building on bricks. You know, it's a solid foundation (2:52)*

Although sometimes parents who advocated for their child were labelled 'bolshie', the participants appeared to admire parents who stood up for themselves.

*A. They [the parent of a chronically ill child] know what that child needs ...they're very direct...we had in the ward..had muscular dystrophy, the only part of his body he can use to a limited degree was his arms...the first thing they would do was slap a drip in one arm. He can't do anything with the other arm - so she would say would you please put a drip in his foot...but they would say no...then she would be a little bit stronger...it was seen as being difficult...these mothers have decided (1:12-13)*

Parents of children with a chronic condition were admired by nurses, and were listened to by nursing and medical staff because they were perceived to have an excellent understanding of the child's condition and of the way their child had responded to the condition. These parents were 'honed' into one child, had knowledge and knew what the child's needs were and what worked for their child.

*A. ...the parents have an excellent understanding of everything regarding that child's condition. They've researched it, they know all the ins and outs - they know how it's affecting that particular child (2:50)*

Being in control, having the confidence to stand up for themselves and their child was definitely the preserve of the parent with a chronically ill child.

A. *And they've decided that this is what my child needs and I will make sure they get it. But it's really only the chronic kids that the parents have managed to do that. We rarely see it with a child of a first admission that the mother will be strong enough in her own mind to say, look you've had three goes, can you please go and do something else. They just can't do that. (1:56)*

#### **4.2.4. BARRIERS TO PARENTING**

Another issue for parents perceived by the participants were the barriers which prevented parenting behaviour happening. In SCBU the physical environment was seen as a barrier, for example the baby being in an isolette and the parents being unable to hold and cuddle the child when they wanted to - all these parenting actions could only be done at the behest of the staff caring for the child. The noise, beeping, technology, lights and heat were described as creating an unnatural situation between the parent and child.

A. *And the barriers that's put up between them and the fact that the babies are in isolettes and on stands and got all that technology and it's just so totally unnatural for them (1:6)*

and

A. *...technology, and the noise and the lights and the heat...the lack of ability for some of these parents to be able to touch and hold and love their babies in that sort of way...can't do the natural thing like picking up a child and cuddling it if they want to (1:62)*

#### **4.2.5. LACK OF PRIVACY (INTIMIDATION)**

Parents' lack of privacy to parent was a strong theme of the discussions. In SCBU or in the ward there was no privacy to be a parent. Breast feeding in SCBU was cited as being very difficult, with people popping in and out, and the new mother trying to relax and breast feed.

A. *I mean it's such a fish bowl existence. You know, it's an unnatural environment. You're not parenting in a normal environment (1:23)*

and

A. *I think the parents have a lack of privacy. In the environment. Like if they wanted to pray and you know, whatever (1:51)*

Lack of privacy also led to parents feeling intimidated.

A. ...because there's no privacy they're intimidated. You know they can't be themselves (1:55)

and

A. There's a lack of privacy as well, isn't there?

B. Very much so (1:5)

#### **4.2.6 DIMINISHING VALUE (THE PROFESSIONAL 'WHITE COAT')**

Participants described the way they perceived parents perceived them. Nurses were seen to be very much in control, taking control, wearing white, being efficient and capable. Nurses were people who 'know it all'.

A. Nurses bustling about in white looking very efficient, capable, in control (1:39)

and

A. And I think a lot of parents - they see us as professionals, so we know it all - whether you know it all or not (2:17)

Participants also believed that some nurses took over the parenting role, causing parents to feel disenfranchised.

A. ...[parents] feel that some nurses are, not all, take over the parenting role. And they feel disenfranchised as parents in the hospital system (2:12)

Another participant described nursing work taking priority over parenting.

A. ...we actually diminish the value of the parent, don't we. Because we buzz in as the professional and take over what was happening. ...our work always seems to take priority doesn't it, over perhaps the parenting skills. So we're actually diminishing their value as a parent and all those caring nurturing things that they do, putting them pretty much second (1:8)

#### **4.2.7. STRESS**

Participants described in detail some of the ways parents responded to the stress of hospitalisation as outlined above.

##### ***Hostile responses***

Parents being angry, swearing, and being resentful were commonly noted. The stress of parenting in the hospital environment was freely acknowledged.

Parents were hostile at times. This hostility may have been caused by previous hospital experiences.

*A. ...I think a lot of them are actually quite hostile to the environment and to the system. Possibly because of what's been before. And I think, it actually comes back to us looking at how they've been dealt with in the past, that they've developed that hostility and resentment. But I think it's often there (1:10)*

### **Nervous or guilty responses**

The participants perceived that parents felt awful, were worried about tipping things over (especially in SCBU), or their other children touching things they shouldn't be touching. Parents may also feel guilty that they may have overlooked their child's illness.

*A. ...and so they're feeling bad on themselves and they're almost too scared to do what they would normally do (1:7)*

and

*A. ...they [the parents] are very stressed, they may be having feelings of guilt. Because the child got sick. Or has an accident that could possibly have been prevented. Because they have all these huge emotional feelings...(2:37)*

### **Defensive responses**

Parents worried about their sick child whom they may see as being traumatised and abused by the hospital staff, for example a child being catheterised.

*A. ...people can be defensive for whatever reason...and they put up barriers ..something's happened in the past and they come in - they've got all the defences up..they'll come across more forceful than what they perhaps would like (1:13-14)*

### **Compensatory responses**

Some parents were seen to 'over-parent' and to give their child more time than they would ordinarily.

*A. ...some of them probably parent more than they would at home - to compensate and others react exactly the opposite way. Hate being in the environment and want to be out the door as fast as possible. Others are angry probably, and resentful. Others are intimidated (1:16)*

For some parents a compensatory response to the stress of parenting in

hospital was to leave the child there and have little involvement with their care. This was particularly noted in SCBU. This dialogue demonstrates the agreement in one group about this parental response.

*A. And then you'll get the ones who bring the child into hospital and don't want to know anything about what goes on in the hospital*

*B. I give you my child -*

*A. You fix it*

*B. I can't cope, you fix it and I'll pick it up when it's ready. And we get that in SCBU - ...you fix it, ...tell me when it's ready and I'll come and collect it and I'll love it and I don't really want to how to do anything....I've got too much on my plate (2:18)*

There was also an understanding that parental response differs markedly, as demonstrated by two sets of parents whose children are in hospital with the same condition.

*A. ...one set of parents copes beautifully, according to our [nurses] perception, and the other set of parent falls apart, according to us. They all come out the end, the same. It doesn't mean to say that that sort of set of parents that fell apart were any better parents or any worse...than the ones that appeared to cope (2:63-64)*

In summary, in the section issues for parents, I have outlined the issues to emerge from the data according to the participants' perceptions. Issues included: parenting and family relationships, disempowerment, empowerment, barriers to parenting, lack of privacy, diminishing value, and stress.

### **4.3. ISSUES FOR NURSES**

Closely aligned to the issues of parenting in hospital were issues nurses experienced when working with parents in the ward. Within the discussion of the research question "What is your understanding of parenting in hospital?", these issues emerged which described participants' response to parenting in hospital. Many of the issues in this section describe participants' concerns about their working environment (lack of time, stress), and their interpersonal relationships with parents (communication, conflict). However the ideal relationship was reiterated several times in both groups and also became an issue. This section is included in the analysis because it puts nurses'

understanding of parenting into the nurses' context, and because it is closely intertwined with participants' understanding of parenting in hospital.

Issues to emerge from the data were:

#### 4.3.1. Lack of time

- being busy
- care associates
- shorter hospitalisation

#### 4.3.2. Stress/ burn out

#### 4.3.3. Communication with parents

#### 4.3.4. Conflict

- different expectations
- parenting styles
- making judgments
- 'bolshie' parents
- feeling threatened
- standards of care
- being accountable - giving information/parental rights
- challenging thinking

#### 4.3.5. Partnership ideal (Empowering parents)

#### **4.3.1. LACK OF TIME**

The lack of time to spend with parents was a dominant issue for nurses which affected their perception about parenting on the ward.

##### ***Being busy***

The participants lamented the ever diminishing time to support, educate, build relationships with parents and help them parent in the hospital environment.

*A...we haven't got the time to do those things we'd like to do - to support them, to educate them, to give them confidence. And really see them through, particularly in special care that really difficult time (1:6)*

and

*A. ...we don't actually have the time...to build that relationship and just sit and talk to them and help them...(1:26)*

and

*A. ...we don't have the opportunity to do that (help parents) and I don't think we ever will really. That's gone - all those things (1:29)*

When the parent was with the child however, it was suggested that paediatric nurses are relieved, knowing the child will get their needs met.

A. *...I think all paediatric nurses would agree that when it is busy we totally - if the parent is with the child you say "oh thank goodness"*

B. *It certainly makes our work a lot easier. And we can relax about the child... (1:15)*

### **Care associates**

Care associates (hospital employees who have had a minimum of two weeks training, and who are employed to assist nurses with bed making, hygiene for patients, food service, for example) presence in the ward also exacerbated participants' perception of their own lack of time to be with parents. Disagreement arose between the participants following a discussion around the care associates who were seen as having more time to talk to parents as they made the beds and tidied the room.

A. *...they [care associates] can't build relationships if they only interact with the person say four times for 5 - 10 minutes each time...*

B. *I don't know about that...if you're in there actually doing things like changing beds and talking...only a few minutes at a time...women tend to open up very quickly ..if there's somebody they can relate to (1:30)*

The inference in this dialogue seemed to be that care associates were now doing things nurses used to do such as bed-making, and it was doing those things that allowed the nurse to spend time with the parent. With the arrival of care associates, nurses had even less time with parents.

### **Shorter hospitalisation**

Another reason for the lack of time was the shorter hospitalisation. This meant that the actual time in hospital could be as short as 15 hours. The nurse may have six hours caring for the child, but actual time being with the child and parent could be half an hour.

A. *...you can't build any sort of relationship and I don't think - in that time. We've lost that opportunity (1:27)*

### **4.3.2. STRESS/ BURN OUT**

Even when the time was available to spend with parents, nurses were too stressed to give the parent quality time.

A. *...when we've got the opportunities we've been so burnt out from*

*everything else that's happened in the shift, and we've got an opportunity, we think, "I just haven't got what it takes to actually give what I know that mother needs". And I mean you go home after that and you feel really frustrated too, but you can only do what you can do*  
(1:32)

and

*A. ...And then sometimes we do actually get the opportunities but we've been so overloaded with everything else that we've just got nothing left to give* (1:33)

#### **4.3.3. COMMUNICATION WITH PARENTS**

Another concern for nurses which made their work with parents more difficult were parents who do not communicate with nurses.

*A. ...half the time ... the parents won't communicate with you...they'll put up a brick wall and expect you to climb around it or over it or under it. Which makes it quite difficult sometimes.* (2:21)

The participants acknowledged another difficulty communicating with parents was when parents are in an emotional state, and have difficulty taking in information.

*A. ...they [the parents] also, probably like an emotional - while we try and tell them, and explain things to them, sometimes they don't take it in, sort of the place where they're at and you have to sort of repeat it*  
(2:54)

#### **4.3.4. CONFLICT**

The participants described a variety of situations and causes of conflict between the nurse and the parent.

##### ***Different expectations***

Different expectations of parenting was the major source of conflict between nurses and parents, according to the participants.

*A. ... we can put expectations on the parents of what we think is normal but is totally different at home...so we put pressures on them because our expectations of parenting are different from what they actually do*  
(1:52)

### **Parenting styles**

The participants described nurses pressuring the parent to parent in the 'style' the nurse finds acceptable. There was general consensus in each focus group that a clash of parenting styles caused conflict between nurses and parents.

*A. ...that's where we have a clash of parenting styles and some have strong rules and some have no rules...where we say we are very accepting, we are sometimes not. If you are different from the party line you are not that well accepted (1:53)*

It was acknowledged that there was an expectation by nurses that parenting was based on the white middle class model (1:60). An example of this clash was the child with a 'runny nose'.

*A. ...we just want to wipe it and this child will go past two aunties, a parent, a grandmother and none of them will wipe it...and you think, a good parent would wipe that child's nose (1:61)*

Another example of differing styles of parenting was described in SCBU. A mother with a child in an incubator wanted her child to listen to two hours of the national station every day. She was 'almost ridiculed' by the nurses.

*A. ...instead of 'oh what a novel idea' and you know 'that's lovely', it was - 'what do you want to do that for?' (1:62)*

Conflict also occurs when parents do something nurses do not feel comfortable with them doing. The example cited was the parent offering to care for their child in the ward, making up the formula, and the nurses finding the three week old infant lying in its bed, pillows all around it with the bottle propped up with pillows - with no parents around (1:77).

*A. And so that's a conflict then - well that happens a little bit unfortunately (1:77)*

### **Making judgments**

Nurses were perceived to have different personal boundaries from parents, which led them to make judgments when the parent parents differently from the nurse.

*A. ...And when they haven't got their child in bed by 8 o'clock and it's 11 o'clock and they're not at all concerned...we - start to make a judgment that they're not good parents. Instead of accepting that maybe they're totally different (1:60)*

and

A. *...And we judge people according to our own values and we might say these are good parents or they're not so good parents but who says (2:64)*

### **'Bolshie' parents**

There was a good deal of discussion in the groups about parents who were able to speak up within the system and actively state the care they required for their child. Sometimes parents who did this were labelled 'bolshie' and not always well received.

A. *...people label them as bolshie or whatever...and give them a hard time instead of saying "oh, good" (1:9)*

The 'bolshie' label has also changed within paediatric nursing. One participant remembered that twelve years ago, 'bolshie' parents were the ones who stayed with their children. Now, parents are expected to want to stay with their hospitalised child. (2:73)

### **Feeling threatened**

The participants believed that some nurses feel threatened by parents who try to be involved in their child's hospital care. Parents are also viewed as threatening when they try to parent their child in hospital.

A. *...the sad thing is that when they do actually parent, that they are being protectors, they are nurturing, they are caring for their child - often it's not applauded within the hospital system. It's actually seen as threatening (1:14)*

One participant reflected that in theory nurses were encouraging parents being involved in decision making. However when it happened nurses were taken aback.

A. *...and some people actually feel quite threatened that their professional abilities are being challenged by parents (2:42)*

However in the other focus group, parents who asserted themselves were very well received. The parents were usually parents of a child with a chronic condition, who were used to the ward and felt strong enough to stand up for themselves.

A. *...You know, this person really knows what's going on with this child. So these people - and only because by sheer self-determination or whatever, they stay as a parent, but them it's at a cost to them because*

*they think well, you know, I feel like I'm alienating people standing up for the rights of my child (1:9-10)*

### **Standards of care**

Another source of conflict described by the participants were parents who were unsatisfied with the standard of the care they and their child had received by the nurse.

*A. ...there can be a clash sometimes ... the parents are not satisfied with the standard of the nurses' care because they know more about the equipment than the nurse...perhaps [the nurses] don't use it in the manner they're used to using it, or in a manner they think is inappropriate they can get a bit annoyed then (1:77)*

### **Being accountable - giving information/parental rights**

One area which could be a source of conflict between parents and nurses is the recognition that parents hold nurses and doctors accountable for their child's condition. Thus the onus is on the nursing staff to ensure the parent is well informed about the child's treatment, progress and care. There was an awareness among the participants that when parents are stressed they are not able to absorb all the information given to them. Some parents expect to be involved in decision making, but others want decisions to be made for them.

*A. ...And so they expect you to make the decisions. Whereas in reality we want them to make the decisions and we can help them arrive at a place where they can make an informed decision about their child (2:17)*

Finding the balance between giving information and encouraging parents to make decisions and supporting parents was at times difficult for nurses.

Parents who refuse treatment for their child also created conflict for nurses. One participant cited an example of a mother who refused to allow a lumbar puncture on her child, and discharged him from hospital.

*A. It's very hard and it's very difficult, very time consuming...(2:60-61)*

However the participants recognised the law in the circumstance of parental refusal of treatment and discussed court order if the treatment was considered necessary by medical staff.

### **Challenging thinking**

Conflict can be beneficial. One participant described her feelings after a parent refused treatment, that she as a nurse believed the child deserved.

A. *Yes, as a nurse it challenged my thinking - well why are we doing this? - because we do go through a bit of a checklist, you know and tick that off...and so it make me think about it because they came back to me and said we're not happy about this. And so it made me think about - well why are we doing this invasive procedure...I think it was good*  
(2:72)

#### **4.3.5. PARTNERSHIP IDEAL (Empowering parents)**

There was a strong thread through the data collected, that the participants wanted the situation with parents in hospital to be different from the way it was now. During both focus groups, the participants would intermittently state their ideal, their hopes for the future.

The major ideal which arose out of the data was for parents and nurses to work together, with the common goal being the child. The word 'partnership' came up several times, also working in a team or in tandem with the parent.

A. *the ideal would be a partnership...where we actually have time to work together and plan together and have time to communicate*

B. *Teach them so that they can do a lot more things for the child*

A. *Yea. And support them* (1:29)

and

A. *the ideal would be for us to work in a partnership with parents...we communicate to each other,we sit down and we work out goals that are both common to us and the parents...talk through any difficulties that either side has got with reconciling to the other person's goal, and reach a common decision* (1:49)

The partnership was also seen to continue in the community when parents received home care services by nurses

A. *...And sometimes because of the home care system that partnership continues in the community as well...you sort of have to separate off as a nurse...in that separation we hand everything back to the parents, everything they have given us in terms of empowerment...we have to hand back* (2:76)

As well as working with the parent to provide care for the child, several participants also hoped that nurses could help parents parent in the hospital, empowering them to be parents and help the parents actually parent in the

ward.

*A. You've got to empower the parents to be parents, and I think that's something we need to learn, as a profession (2:13)*

Encouraging parents to make decisions in relation to their child, ensuring they were fully informed about their child's condition and treatment were also ideals to aspire towards.

*A. I think it's really important that we do empower the parents as much as possible and we educate them to the conditions [of their child] (2:75)*

In summary, issues for nurses related to their understanding of parenting in hospital included: lack of time, stress, communication with parents, conflict, and partnership ideals.

#### **4.4. SUPPORT ISSUES**

A major issue that emerged from the data was participants' understanding of parents' needs for support when in hospital with their child. The participants described actions they took to support parents, plus areas where the parents needed support and why they needed that support. Issues described in this area were:

- 4.4.1. Giving reassurance and encouragement
- 4.4.2. Acknowledging fear
- 4.4.3. Acknowledging parents cannot always be present
- 4.4.4. Parenting the parents
- 4.4.5. Helping parents to cope
- 4.4.6. Facilitating the track
- 4.4.7. Gaining confidence
- 4.4.8. Taking responsibility

##### **4.4.1. GIVING REASSURANCE AND ENCOURAGEMENT**

There was strong acknowledgement that parents needed ongoing support when in hospital. This involved being there to reassure parents and encouraging them to advocate for their child, and be involved in decision concerning their child.

*A. ...one thing that's what the nursing staff do is to reassure them - to give the parents confidence and for a lot of situations in the children's*

*ward and in SCBU, they've lost that confidence...and so you know they need a lot of reassurance and encouragement (1:7)*

and

*...A lot of what we do for helping parents... is reassuring them - you are doing a good job, you did the right thing (1:31)*

Reassuring the parents that they were doing a good job with their child was valuable, as was offering reassurance after 'an event' such as the insertion of an IV, or a premature baby being immunised.

*A. ...after a little baby has had an immunisation they may say - oh I feel really sort of ambivalent about that, have I done the right thing?...So sometimes a lot of what we're doing is after the event. Again with education, reassurance, yes, your baby will be fine because her immune system and her responses are just the same as a bigger baby and can cope with that (1:43-44)*

This statement was followed by discussion about why parents waited till after an event to discuss their concerns.

*A. I mean an IV - the doctor says I'm going to put an IV in - they probably don't even know what an IV is. And then to think well, it's a needle that goes into your arm. Who's going to conceive that it might...fifteen attempts to put it in. He just said a needle that goes into your arm. You know, you think it goes in. At first pop it will go in. It's not until afterward that the whole thing actually becomes an issue (1:46)*

Reassurance that the parent is doing a good job was empowering for parents and gave them confidence.

#### **4.4.2. ACKNOWLEDGING FEAR**

Acknowledging parental fear and giving them resources to cope with their fear was also a strong concern for the participants. Fear of the hospital system, of the technology (especially in SCBU) and of their child having pain and possibly dying were all discussed.

*A. And what we do as nurses to help them get through that fear...I mean anyone who's had a baby or a sick child who's lurching between living and dying - there's this incredible fear (2:18)*

There was some disagreement between participants about how to allay fears.

One participant stated that if your response to a parent worried that her child may die is to say "very few do", the parent would no longer be afraid. The response by another participant was;

*A. ...there's a difference between knowing up here and knowing down there. You know, the head or the heart...anyone can tell you that this is going to happen, x, y, z but until you arrive at that place yourself you know it's not going to happen, that fear is always underlying ...we can say all the words in the world, but it won't take away the fear (2:23).*

Parental fear of something happening to their child was given as one reason why parents sometimes choose not to stay with their child in hospital, and not to be involved in their child's care.

*A. ...It's not a conscious decision not to be there - it's just something that they're scared of - that they're going to get hurt (2:19)*

Another participant suggested that rather than fear, the parent who stays away from their child (especially in SCBU) is not actually ready to parent. They have in their mind a date the baby is due and an image of their baby. The dialogue that follows demonstrates the agreement between the participants on this issue.

*A. ...They've got to take time to come to the conclusion - to get to the stage where that baby grows*

*D. And to look like the image they had*

*C. Yes. And baby wasn't ready to arrive until x date*

*D. And so it won't*

*C. - and so therefore SCBU's the incubator for it until x date*

*D. And that x date is important because...this baby will not go home until this date. So that's fine. I've already had that date in my mind*

*C. So I will carry on with the rest of my life until*

*D. That date*

*C. That date*

*D. That happens...with the very young or the very low*

*A. Socio economic*

*C. the real low socio-economic, low intelligent person, you see that, don't you? (2:24-25)*

#### **4.4.3. ACKNOWLEDGING PARENTS CANNOT ALWAYS BE PRESENT**

When parents were absent from the ward, there was a recognition that the nurse had to take over the parenting of the child in hospital. Participants acknowledged the anxiety some parents experienced when they could not stay with their child.

*A. ...I think that we need to acknowledge their emotional problem of not wanting to be there...I mean it also tears them in half...they talk about this dreadful time and they're torn (2:19)*

The participants acknowledged that parents couldn't stay for a variety of reasons.

*A. ...they're solo parents and they're at home with other children who are sick..or because of the family situation..we end up trying to be a parent to that little two year old (1:35)*

and

*A. ...it's not a conscious decision not to be there...it's just something that they're scared of - that they are going to get hurt (2:19)*

Sometimes the nurse had to look after a child as well as continue the nursing role.

*A.. And that's so difficult when you've got to push a child in a push chair around the ward around every other patient with you..while you look after your own job as well (1:36)*

#### **4.4.4. PARENTING THE PARENTS**

Nurses were relying more on parents to care for their child in the ward, and were providing support to help them look after their child. In their relationship with parents, the participants noted that some parents were young and inexperienced and had a great deal of difficulty being parents in hospital because they were not yet confident in their own abilities.

*A. ...we tend to be parenting the parents sometimes as well (1:26)*

One participant believed that many parents were not coping at home with feeding. Sh/e felt this was because the hospital system discharged them from the post-natal ward and SCBU too soon (1:65).

#### 4.4.5. HELPING PARENTS TO COPE

Supporting the parents to parent their child was discussed by one participant. Parents are relied upon to provide care to the child, and the nurse helps the parent look after the child.

*A. ...we actually rely on the parents far more and provide the support to them, to help them look after that child (2:12)*

Nurses are also ready to support the parent cope with the unexpected. One participant described this experience with a parent whose child was suspected of having meningitis.

*A. We had this situation yesterday where they'd been around the parameters and the mother said eventually "I have spent the last three days worrying myself my child has meningitis" and they've thought "do we LP [lumbar puncture] or not?". And on that when she said that, they made the decision right, we'll do an LP and we'll exclude meningitis and we'll all know. And the parents were there and they were perfectly happy when this was explained to them and she said to me" you know, maybe we shouldn't come in for this, should we?" And I said "well it is your choice but the way you're feeling, well no, you're probably better off to go and have a cup of coffee. And I promise you I won't let them do anything to your child that I wouldn't let them do to mine (2:45-46)*

#### 4.4.6. FACILITATING THE TRACK

One participant described viewing the parent and the child with a condition, as going around a circle or track. The nurse knows the track and knows where the family is heading.

*A. ...we can jump in at any of the areas and know that, yes, we can understand where you're coming from here...eventually it doesn't matter how much input you put into this, the results are still going to be way round here, and you have to get there...you're going to go through all these emotions...this is it...just get on with life (2:31-32)*

The nurse also knows the system, the jargon, and acknowledge that for a parent coming into such a system

*A. ...it would be like us going into - I don't know - aviation school - we know nothing about it (1:47).*

#### 4.4.7. GAINING CONFIDENCE

A positive occurrence for parents in hospital as perceived by the participants, were the relationships they formed. There was lengthy discussion in one group around the advantages and disadvantages of being in a single room or a sharing a room with other parents. The general consensus within the group was that those sharing a room with other parents gained support from them, often sharing their problems and decisions they had to make. In these relationships parents in the ward seemed to be helping other parents to parent their child.

Illness was seen to draw people together and create a bond which lasted at least as long as the hospitalisation. From the support the parents gained from each other, parents were more confident.

*A. ...it's almost like they then give themselves the reassurance - that they get the confidence you know - are you going to ask the doctor that, on the round? (1:19)*

There was a social atmosphere in the ward, a friendly environment which was contrasted to the social isolation the parent may be experiencing in their own home.

*A. ...it [the ward] can be quite a friendly environment for them, otherwise they may be at home with a toddler child and quite isolated (2:28)*

#### 4.4.8. TAKING RESPONSIBILITY

Parents were observed to have more say in what went on in the hospital than in the past, in relation to their child.

*A. ...In the ward they appear to have a bit more say because the treatment of the child is discussed with them more. Even...with first time parents as well... (2:11)*

Parents were also given more responsibility than in the past, however there were still restrictions on what they could and could not do. In the following dialogue, the participants discuss parents increased responsibility.

*A. ...we have seen parents take more responsibility - a lot more responsibility. They can now take temperatures which was really once a nursing duty - so we have empowered them slightly and there's other things that they are allowed to do. But medically there are some things they cannot do*

- A. ....they're probably given a little bit more credit for their mothering or caring
- B. I think that some of - perhaps some more than other parents, do have quite a bit of say...(2:14)

In summary, the need for support/strategies to support parenting has raised issues of reassurance and encouragement, acknowledging fear, acknowledging parents cannot always be present, parenting the parents, helping parents cope, facilitating the track, gaining confidence and taking responsibility.

### *Summary*

In this chapter the data has been analysed using a technique of thematic analysis. Discovering themes proved to be difficult as participants spent a great deal of time in debate. What emerged from the thematic analysis were issues rather than themes, which demonstrates the variety of ideas, perceptions, values and experiences expressed by the participants and raises further questions about the relationship between parents and nurses in hospital. The four major areas of analysis described were parenting issues, issues for parents, issues for nurses, and support issues. Implications of the analysis will be discussed in the next chapter.

# 5

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## Discussion

In this chapter, three aspects of the research will be addressed. The first is the research method. In this section of the chapter, the strengths and limitations of the method will be outlined. Secondly, factors related to the trustworthiness, validity and reliability of the research will be discussed. The third aspect to be addressed is the interpretation of the data, in its own right and in relation to the current literature.

### 5.1 RESEARCH METHOD - STRENGTHS AND LIMITATIONS

In this section of the chapter, the strengths and limitations of research method will be discussed. Each area of the method as described in Chapter Three will be scrutinised. This process will enable the reader to audit the research.

“The researcher chooses the design that is most useful for her or his research purpose - whether to observe in order to know, to know in order to predict, or to predict in order to control or prescribe” (Seaman, 1987, p. 165). Seaman (1987) suggests that if the purpose of the research is to observe, describe, explore and assemble new knowledge, exploratory design is used. In this research, the purpose was to explore and describe nurses’ understanding of parenting, in order to assemble new knowledge, therefore exploratory research was used.

#### 5.1.1. Structure

The low level of structure of the focus groups, as described in Chapter Three, worked very well. The structure gave the participants the opportunity to thoroughly explore the two questions discussed. Only two questions were asked of the participants, and the facilitator involvement was minimal. The transcripts revealed that the participants were able to engage in discussion, have lengthy dialogue with each other and interact with each other. Often a participant would speak for several minutes on a topic without interruption,

followed by discussion from other participants. In this research, the low level of structure was a strength of the design.

### **5.1.2. Moderator/facilitator involvement**

Being the facilitator of the research was a strength for me personally. It gave me an understanding of the dialogue, including the body language, eye contact, agreement, and disagreement which would not have been possible listening to the transcripts only. Being able to observe non-verbal communication such as participants making eye contact with each other, smiling, gesticulating, and appearing withdrawn was invaluable and provided the basis for the analysis. Noting non-verbal cues such as voice tonality and reaction is the "heartbeat of qualitative report writing" according to Henderson (1995).

Facilitating the groups was the most stimulating part of the research process for me and as such, I would have deeply regretted not having that opportunity. One of the reasons for my desire to facilitate the groups came out of my previous experience facilitating therapy groups and having an understanding of group interaction. If I had not had that experience, I believe the facilitation would have been a daunting task. Holloway and Wheeler (1996) state that the facilitator needs special skills over and above that of the one-to-one interviewer. Conducting the pilot focus group was also a strength of the research. The opportunity to practice group facilitation and audio-taping was invaluable.

### **5.1.3. Sampling/size of group**

The convenience sampling used provided nine participants for the research, of whom eight actually participated. This was a disappointing number of people, considering that advertisements had been placed in strategic places informing people about the research (Appendix 3), and each person in the population sample had a letter of invitation (Appendix 6), including the information sheet (Appendix 4) and consent form (Appendix 5). A limitation of the sampling was that I did not check back with the managers that they had written the name of each nurse in the population group on the front of the envelope I had provided, and posted this to the nurse via internal mail. The

managers instead placed unnamed envelopes in a bag in a convenient place and asked nurses to help themselves. This reduced the personal nature of the invitation, and I believe was a factor in the relatively small number of people who agreed to attend the focus groups. Ensuring that a personal letter of invitation was sent to every person in the population may have encouraged more people to participate.

Another limitation of the research was the nature of the hospital. The participants were employees of a regional hospital in New Zealand. If the same research had been carried out in a large childrens' hospital, for example Starship Hospital in Auckland, it may have yielded different results.

It is also of note that the sample group were predominantly diploma-educated nurses. Graduate or masterate prepared nurses may have had different understanding of the phenomenon of parenting in hospital.

It is difficult to ascertain what effect having two focus groups, instead of the anticipated three or four, may have had on the data collected. As the research is exploratory, the aim of the research was to explore the participants' understanding. Data saturation was not achieved, however in exploratory research, saturation is not essential. It was evident that each group generated quite different data. Each group generated new knowledge.

## **5.2. THE FOCUS GROUPS**

Reasons for using focus groups have previously been discussed in Chapter Three. In summary they were:

- to allow the participants to identify their own issues regarding the topic
- to provide a safe, non-threatening and non-judgemental environment
- to use a method of data collection which was as close as possible to nurses' natural environment
- to potentially uncover not only what participants think about the topic, but how and why they think as they do

How successful was this research in achieving those goals? In both groups,

the participants had the opportunity to identify their own issues, the participants stated they felt comfortable in the environment, it felt close to a natural environment and the data demonstrated that the participants discussed their thoughts and how and why they thought as they did. An example of the naturalness of the environment occurred when one participant used a conversation she was having with a nurse earlier that day, to add to the focus group conversation.

*A. And we were just discussing - talking about this just briefly today...(1:26)*

This corresponds with Kitzinger (1994), who also found that having participants who are familiar with each other enables the researcher to tap into fragments of interactions which approximate naturally occurring data.

Another strength of the focus group process is the group interaction (Holloway & Wheeler, 1996; Robinson, 1999). In order to evaluate whether the group interaction was effective, Stevens (1996) suggests addressing specific questions during the analysis. As the analysis proceeded, I focused on the following questions, as suggested by Stevens. It is useful to highlight them at this stage to reiterate the importance of the group interaction throughout the research process.

### **How closely did the group discuss the topic?**

Both groups took several minutes at the beginning to begin to address the topic. The initial question about parenting helped warm them up. I had the question "What is your understanding of parenting in the ward?" on a white board clearly visible to the participants, and noticed them looking at it during the group. On several occasions, a participant would discuss an issue which was close to them, but not overtly relevant to the question, and I would endeavour to bring the question back to the topic, for example

*A. ...I'd like to sort of bring up...the social worker role. Am I allowed to talk about that?*

*Facilitator. Will it help answer our question? (1:24).*

### **What statements caused conflict?**

As noted in Chapter Four, there were disagreements about definitions of parenting. In each focus group, conflict and tension occurred as participants disagreed with each other. In all situations, the conflict appeared to be non-malevolent. Examples of conflict include: having an effective relationship with a parent;

*A. ...difficult to build any sort of trust and real communication and relationship ...for that amount of time*

*B. I don't know about that...(1:30)*

- about adults memories of childhood hospitalisation;

*A. ...You know, to me, hospital experience for a child, once the child and the parent have been adults is never an issue*

*B. I wouldn't say it's never an issue...(2:35).*

### **What common experiences were expressed?**

Throughout the groups participants agreed with each other, sometimes speaking over each other to add their agreement. Common experiences expressed included content issues such as lack of privacy, conflicting advice given to parents, parents getting together to share experiences.

This dialogue between three participants in one group about why some parents do not stay with their child in the ward, reflects the agreement.

*A. ...they feel so alienated and threatened by the system...*

*B. Good babysitters!*

*A. Yea, that's right*

*C. Time out (1:38)*

The group process would trigger participants to think of something, because of the interaction. In this situation, the participants are discussing parenting in SCBU;

*A. They're much more accepting too, aren't they? Much more passive, I think*

*B. Yes. Totally. Because they're overawed by what's going on.*

*A. And also the hormones...You're much more fragile I think in your emotions*

*C. They feel much more disconnected I think...(1:63)*

and again here, the discussion describes parenting in SCBU;

*A. ...In SCBU they don't have the confidence to be parents*

*B. Because they haven't become parents yet. As in the care of that person.*

*A. As in the care of that child....(2:11).*

Participants would also check out whether others had had similar experiences.

*A. You've got to empower the parents to be parents and I think that's something we need to learn, as a profession. Um, I don't know how the rest of you feel about that*

*B. I think there's a fine line in SCBU*

*C. Mmm. (2:13)*

### **Was a particular view dominant?**

Listening to, and reading the transcripts it is evident that there was not a particular dominant view. However, facilitating the groups, I became aware that in each group one participant was more dominant than the other three, in that they spoke more than the others. However, they were not able to monopolise the group, as the other participants were also strong in their views. In one group, one participant also appeared to have her own 'agenda' about the group and attempted to put forward thoughts that were unrelated to the topic. Other participants were able to bring the conversation back to the topic in most situations. I also intervened on several occasions to refocus the group on the question.

### **5.3. DATA COLLECTION**

Strengths of the data collection process included using two audio-tapes to record the conversation. This greatly allayed anxiety about the tapes not working or malfunctioning. Another strength was having an observer present to ensure the tapes were working, turn the tapes over and to be an 'offsider' in case of anything untoward occurring. Unfortunately one venue had reasonably loud traffic noise which I had not noticed when I had checked it earlier. This had some effect on the quality of the recording.

#### 5.4. DATA ANALYSIS

A strength of the analysis was that using the framework by Zemke and Kramlinger (1989), and Holloway and Wheeler (1996), described in Chapter Four, made the process of analysis straightforward and uncomplicated. Asking the participants to summarise the discussion towards the end of the session did not prove particularly helpful. It did however strengthen the trustworthiness of the data, in that it gave the participants another opportunity to validate their previous comments, and it gave me an opening to clarify some areas of the discussion. The participants had difficulty summarising their discussion, and in fact came up with new data that had not previously been discussed. The data was analysed with the rest of the focus group data, as much of it was new data.

In summary, the strengths of the research were: the low level of structure; the researcher facilitating the groups; using two audio-tapes; and use of several frameworks for analysis. Limitations of the research were the sampling and the small number of groups. Using Stevens (1996) criteria for assessing the group interaction, the groups ability to discuss the topic, conflict, common experiences, and dominant viewpoint have been described.

#### 5.5. TRUSTWORTHINESS, VALIDITY AND RELIABILITY

Ascertaining academic rigour is essential in any research. This study used four concepts to check for trustworthiness, validity and reliability. These were documented by Appleton (1995), informed by Guba and Lincoln, (1981), Sandelowski, (1986), and Marshall and Rossman, (1989).

The four concepts are: truth value, applicability, consistency and neutrality.

**Truth value** is ascertained by the member checking process. If the themes which arise are recognisable by participants in the study, the study has truth value. This process occurred both at the completion of the focus group, as the participants summarised the discussion, and following the thematic analysis of all the data. Two participants, one from each group were asked to separately check the analysis and state whether or not they recognise the themes (issues) as their own. Both participants responded that they did recognise the themes (issues) and believed that the analysis was a fair representation of the

discussion during the focus group.

**Applicability** refers to the fittingness of the findings and the representativeness of the participants. The term fittingness suggests that the research findings can be related to contexts outside the current research area. Fittingness can occur when the consumers of the research view the study findings as meaningful and applicable to their own experiences. It is anticipated that consumers of the research will be nurses working in the paediatric area, and nurse educators teaching child health. Having two focus groups helped increase the representativeness of the sample. With four participants in each group, the data was collected from eight paediatric nurses. A further strategy to ensure applicability and truth value in the study involved the researcher actively searching and checking the data for reasons why conclusions should not be trusted (Appleton, 1995). I maintained this process constantly during data analysis. As the issues emerged from the reading and re-reading, and listening and re-listening to the transcripts, I constantly returned to the data, checking and re-checking that the issues were in fact derived from within the group or across groups.

**Consistency** is measured by the concept of auditability. The research is judged auditable if the reader can follow a decision/audit trail. When writing the research report, the justification made for decisions relating to the research design, is the audit trail. The reliability of the data elicited is dependent upon the competency and ability of the researcher's interviewing skills and on any researcher bias (Field & Morse 1985). As I was the only person collecting the data, reliability and consistency was maintained throughout the research process. Throughout the research process, my supervisor checked and rechecked my findings. Asking two participants to check my analysis independently also assisted reliability and consistency of the findings.

Before commencing the research, I facilitated a pilot focus group to further improve interviewing skills and to be prepared for the variety of situations which may have occurred during the process of the focus group such as: one participant more dominant than others, participants not participating in the discussion or consensus reaching stage, and the group going off the topic.

When writing up the research, I have endeavoured to leave a clear audit trail, so that the reader can clearly follow the process.

**Neutrality** builds on consistency and refers to freedom from bias in the research process. During the focus groups, I was the facilitator, not a participant. I made it clear to the participants that I would not be introducing my own views on any of their discussion, and guided rather than influenced the discussion. Views can be introduced by prompts and questions during the group process. I consciously attempted to keep prompts and questions to a minimum throughout the data collection process. I endeavoured to maintain a 'neutral stance' (Appleton, 1995).

In summary, the degree of trustworthiness, validity and reliability of this research is high. Throughout the process of carrying out this research, and within this thesis, I have taken every precaution to ensure the research is auditable and transparent to the reader.

## **5.6. INTERPRETATION OF THE DATA**

In this section of the data, the four main areas of analysis will be interpreted and discussed in detail. These are:

- parenting issues
- issues for parents
- issues for nurses
- support issues

Where themes and sub-themes are discussed, these will be in italics to facilitate understanding of the interpretation.

### **5.6.1. Parenting issues**

Uncertainty and disagreement arose from both focus groups about this issue. The participants displayed marked differences about their understanding and beliefs about parenting. When preparing for the research, I believed it would be useful to start with an open question such as 'what does the word parenting mean to you?' My preconception was that discussing definitions of parenting

would give the participants the opportunity to share similar ideas with each other. However almost the converse was true, as the participants disagreed with each others' understanding of parenting. This was very enlightening as the participants began to realise that everyone did not think the way they did.

Dialogue around parenting moved into discussion of the concept of family. The participants views of a 'normal' family seemed old-fashioned and dated. For example, they perceived children whose parents were not together, as not '*fitting the mould*' (1:34), which is interpreted as believing that it is normal to have two parents who live together.

Wellard (1997) suggests that because families in nursing models (such as Friedman, 1986; Kane, 1988; and Wright & Leahy, 1990) are presented normatively, family groups other than the nuclear model of two parents living with their dependent children are viewed as variant family forms by nurses. She also argues that "the importance of gender, sexuality, class and other social issues are minimised in how families are considered" (Wellard, 1997, p.80). The participants appeared to have a normative view of what or who a family should be. Having a normative view of family, and working with families who are predominantly not 'normative' has ramifications for nurses and parents, and may add to the conflict between them.

Parenting issues highlighted that the participants found the concept of 'parenting' difficult. They disagreed with each others' understanding, and moved instead onto discussing concepts they found easier to consider, such as 'family' and 'being a parent', as if the concept of parenting was intangible. This research highlights the participants' lack of clarity about some of the models/ideals/rhetoric they are exposed to, leading to confusion. **Thus a finding of this research is that the participants were unable to agree on the concept of parenting.**

#### **5.6.2. Issues for parents**

As stated in the previous chapter, a feature of the research was the understanding the participants had of parents' concerns. This was evident in the language they used - often speaking as though they were a parent in

hospital, and their understanding of some of the issues parents had in hospital.

The difficulties around *parenting and family relationships* in the ward was evident in the analysis. From the participant's descriptions of their understanding, it seemed that being a parent in hospital is virtually impossible in the environment. Families were restrained, unable to relax, had difficulty sleeping and were on full alert. They had an *inability to set boundaries* for their children. This finding was enlightening as it was the nurses perceiving this as a problem for parents. Darbyshire (1994) also found that 'parenting in public' was a major stress for parents in hospital. According to Darbyshire (1995) parents have to perform a 'balancing act' - they have to be demonstrably caring, but not overly so, they have to show interest yet not be nosy, they have to appear keen to participate, yet not take nurses' valued work away from them, and finally they have to do what they would do at home, yet fit in with the hospital's policies and practices.

The differences experienced between three groups of parents, those who had children with an acute illness (*being nowhere/uncertainty*), those with children with a chronic illness (*empowered/in control*), and those with infants in SCBU (*in shock/disconnected*), emerged as a strong feature of the research. This is an interesting finding. There appears to be a continuum of power for parents. On the first admission, either to the ward or SCBU, the parent is not only completely powerless, they are 'nowhere'. They allow the staff to do anything to their child and are completely trusting of the staff. They are in shock, vulnerable and emotionally fragile. In SCBU, parents were described as being 'disconnected' from their baby, possibly because they had not yet bonded to their new infant.

As the time goes on, the parents slowly begin to come to themselves again, and begin taking control of their lives again, and of their children's lives. This may not happen for the child who has been admitted acutely until discharge, as the acuity rate in the ward is so high (average length of stay is two days). In SCBU regaining control over their lives and their child may occur before discharge, depending on the length of hospitalisation.

For the parents of a child who is readmitted (referred to by the participants as 'chronic'), the situation is very different. The parent has previously been through the initial process of shock, disconnection and trauma. They now have an understanding of the hospital and how it works, that is, they have been socialised into a very different environment from anything else in their experience.

It seems that parents of a child with a chronic illness have to go through an initiation process on first presentation to hospital. If they manage to fight the system, speak up for themselves and their child, assert their needs and their child's needs, they are accepted by the nursing staff. If however they do not manage to do these things and remain overawed and powerless in the face of the hospital system, or they go to the other extreme and are aggressive and too 'bolshie' in getting their needs met, they are not accepted by the nursing staff. The parents must maintain a balance between neutrality and assertion in order to get their needs met in hospital. This finding concurs with Darbyshire's (1995) 'balancing act'. It was also interesting to note that if the nurses believed that a new patient may become a chronic user of the system, the nurses began empowering the mother and child from the beginning.

A. *...now we empower the mother and the child right from the beginning because it's going to be ongoing for the rest of it's life ...so there's a very wide range of empowering...*

B. *'Cos it's a chronic long term condition (2:43)*

The process between acute and chronic can be seen to be a progression of power, from *being nowhere/uncertainty - acute*, and *in shock/disconnected - SCBU* to being *empowered/ in control - chronic*. As the parent moves through the stages, they know more about the system, the child's condition, and how they can effectively help their child in hospital. With their increase in knowledge, their power, over themselves (remaining in control), their child, and the hospital staff also increases. This is a very useful insight into the problems faced by parents in hospital.

Other issues for parents observed by the participants such as: *confusion/conflicting advice, barriers to parenting, lack of privacy*

(*intimidation*), and *diminishing value* in the parenting role, all contribute to that early stage of parenting in the acute/SCBU period. These concerns add to the parent feeling *disempowered* and unable to parent effectively in the environment.

Comparing the participants' beliefs about the issues for parents in hospital, with parents' issues identified in the literature is enlightening. As noted in the literature review, the major themes emerging from a review of the literature describing parent's perceptions were the different attitudes and expectations between nurses and parents (Hayes & Knox, 1983; Elfert & Anderson, 1987; Darbyshire, 1994; Conway et al., 1994; Coyne, 1995; Rowe, 1995; Neill, 1996; Callery, 1997), and that parents want to care for their child in hospital and have more responsibility in their care (McKinlay, 1981; Hayes & Knox, 1983; Affleck et al.; Alcock & Mahoney, 1990; Darbyshire, 1994; Rowe, 1995; Neill, 1996; Kawik, 1996). While different attitudes and expectations between parents and nurses were suggested by the participants, parents wanting to take more responsibility for their child in hospital was not a major issue. This finding could imply that in New Zealand, parents are now able to care for their child in hospital and take responsibility for their care.

**This research has identified participants' perception of a continuum of power experienced by parents and factors which lead to parental disempowerment.**

### **5.6.3. Issues for nurses**

The major area of concern for nurses was the *conflict* they experienced when working with parents. Situations which caused conflict included the *different expectations* of parenting between nurses and parents, differing *parenting styles*, *feeling threatened* by parents, coping with parents' different needs such as the *standard of care* they required, and giving appropriate information (*being accountable*).

As previously, different expectations of parenting between nurses and parents is a theme of the literature (Brown & Ritchie, 1990; Darbyshire, 1994). Feeling threatened by parents also features in early literature (Meadow, 1969;

Goodell, 1979; McKinlay, 1981). It is interesting to note that the participants in the current research also felt threatened by parents' presence at times.

**A finding in this research is that conflict between nurses and parents is a major concern for the participants.**

Another issue for nurses described in the analysis was *the partnership ideal*. This finding contrasts with the literature review of nurses' perspective of parenting in hospital, which found that nurses felt a high level of responsibility toward the child, and lacked trust in the parents' abilities (Goodell, 1979; McKinlay, 1981; Brown & Ritchie, 1990; Keatinge & Gilmore, 1996). The above findings were not reflected in this study. Although the nurse participants acknowledged their accountability, and the parent's difficulty in understanding their rights, they did not describe lack of trust. Rather, the participants in this research referred to themselves as partners, or wanting to be partners with parents in the ward.

The participants used the term 'partnership' to describe working and planning together with the parent (1:29; 1:49). Partnership with parents according to the participants, also meant talking through difficulties and helping reach goals together, as well as empowering the parent (2:76).

The desire to work in partnership with parents expressed by the participants is reflected in the literature. Hutchfield (1999) believes that partnership is the central element in family-centred care, with respect, collaboration, negotiation and communication. Stower (1992) and Dearman (1992) also found that the central issues of partnership were equality and negotiation, both ideals also expressed by the participants.

**This research has found that the participants want to be in a 'partnership', defined as working and planning together, talking through difficulties, helping reach goals together, and empowering the parent, with parents working with their children in hospital.**

#### 5.6.4. Support issues

The fourth major area of analysis was the participant's understanding of parents needs for support. Participants described *giving reassurance and encouragement* to parents, *acknowledging their fear*, and nurses *helping parents coping* in different situations. The participants demonstrated an understanding of the system, and could perceive what it must be like for a parent coming into such a strange environment (*facilitating the track*). In this area, the participants described nurses' skill in helping parents develop as parents of sick children.

*Helping the parents to cope* uncovered one participant's method of helping - protecting the mother from being involved in a painful experience for her child (2:45-46). Protecting parents from anxiety-provoking situations has been termed paternalism, and is outmoded and unhelpful, according to Glasper (1995). In research on perceptions of parental participation, Dearmun (1992) found that large numbers of nurses expressed paternal tendencies, wanting to protect parents from the distress of knowing what their children's problems were. Paternalism argues Wellard (1997), can develop in relationships between nurse and parent, when the nurse works from a prescriptive approach, or the 'how to do' approach. This method of providing nursing interventions is inflexible and implies that the nurses 'know best'.

The participants did notice an improvement in the amount of responsibility the parents can take in the ward, but added that there are still things that medically the parent cannot do. This is contradicted in research into parents' perceptions, which has found that parents want and can do anything their child requires on the ward, with support from the staff (Evans, 1994; Coyne, 1995; Neill, 1996).

**A further finding of this research is that the participants understand parental needs in hospital, and use strategies to support parenting.**

#### *Summary*

In summary, this chapter has discussed the strengths and limitations of the

research. The major strength of the research method was the focus group interaction of the participants. A limitation was the problem with sampling as outlined. Stevens (1996) criteria for assessing the interaction in focus groups was applied to the data. The trustworthiness, validity and reliability of the research was discussed using Appleton's (1995) four concepts of truth value, applicability, consistency and neutrality. Finally the analysis of the data was interpreted. In the next chapter, the research will be summarised and recommendations for practice, education, research and policy outlined.

# 6

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## Conclusion

In this chapter, the research thesis will be summarised, highlighting the main points. The aims of the research will be reviewed and the key findings of the research as discussed in Chapter Five, specified. Recommendations for policy, education, practice and research will be outlined.

The thesis began with background to the research and the aims of the research were stated. Examination of whether the aims of the research were met will be discussed in this chapter. Definitions of terms commonly used in the report were given.

The literature review presented an historical overview of nurses working with parents in hospital. The current literature relating to the topic was then extensively reviewed. The review was presented in two parts. The first part explored research studies which have attempted to uncover parent's perspective of being with their child in hospital. The second area of literature reviewed was the nurses' perspective of parenting. The main theme to emerge from the review of the nurses' perspective of parenting was that nurses felt a high level of responsibility toward the child, and believed they could not trust parents to give the care to the child. Lack of trust led nurses to control parental participation, and also created conflict between parent and nurse. The evolving concept of partnership was described. Previous research had focused on attitudes, perspectives and role division between the nurse and the parent. Nurses' understanding of parenting was a fundamental issue which needed to be addressed before attending to concerns such as attitude and role division. The purpose of the current research was to shed light on this central area of nurses' practice, nurses' understanding of parenting in hospital.

Within the method chapter, the theory and use of focus groups was outlined. The use of the method in the current research was stated. Specific attention

was paid to the research method, and to the advantages and disadvantages of focus groups as a research method.

The results of the data analysis were extensively discussed in Chapter Four. Four major areas of analysis emerged from the data. Verbatim quotes from the transcripts were used to support the development of issues described.

Three areas were addressed in the discussion chapter. The first was the research method which was scrutinised for strengths and limitations in the current study. The second area of discussion were issues of trustworthiness, validity and reliability. The third area of discussion was the interpretation of the data. The data from this study was also explored within the context of the current literature.

## **6.1. Findings**

Five major findings were highlighted in the discussion. Recommendations in light of the findings of this research will be offered to the reader.

### **6.1.1. Finding One:**

**The participants were unable to agree on the concept of parenting.**

#### ***Recommendation:***

- *Education*      That the beginning nurse practitioner (a newly qualified registered nurse) has an extensive understanding of the theory and concept of 'parenting' in New Zealand society.

### **6.1.2. Finding Two:**

**The participants perceive a continuum of power experienced by parents, and have an understanding of factors leading to parental disempowerment.**

#### ***Recommendations:***

- *Practice*      That nurses evaluate and reflect on their nursing practice to assess the ways in which they 'empower' the parents

with whom they work.

- *Research* That further nursing research is carried out to examine whether parents do experience power in hospital.

### 6.3. Finding Three:

**Conflict between parents and nurses was a major concern to the participants.**

#### ***Recommendations:***

- *Education* That the beginning nurse practitioner has extensive communication skills, including conflict resolution.
- *Practice* That nurses have regular communication skills workshops, in order to fully understand and prepare for conflict with parents.  
That nurses constantly reflect on their practice individually or in groups.  
That supervision (one-to-one counselling between the nurse and an independent counsellor) is made available for nurses working with parents, to increase the nurses' skill when working with conflict.
- *Research* That parents' perception of conflict when parenting in hospital in New Zealand are examined.

### 6.4. Finding Four:

**Participants want to be in a partnership with parents in hospital.**

#### ***Recommendations:***

- *Education* That the beginning nurse practitioner is fully aware of the concepts of partnership, family centred care, and collaborative care, in order to facilitate an effective relationship with parents with whom they work.
- *Practice* That nurses are supported to work in partnership with parents, for example, nurse to client ratios e.g. no more than one nurse to five clients.
- *Policy* That policy makers at regional and local levels

provide statutory requirements e.g. legislation, for services provided to parents when staying with their child in hospital. For example, that the parent is invited to carry out all the care of the child, if they wish to do so, with the assistance of the hospital staff, and that the parent has a major role in all decisions, treatment and care of their child, when in hospital.

#### **6.1.5. Finding Five:**

**Participants understand parental needs in hospital and use strategies to support parenting.**

#### ***Recommendations***

*Research* That parents' needs in hospital are explored and their requirements for how they would like to be supported when in hospital are examined.

#### **6.2. Summary**

In summary, this section of the chapter has reviewed the five major findings of the current research, and provided recommendations in the areas of education, practice and policy. Further research has also been recommended in specific areas.

To conclude this thesis, it is useful to re-examine the aims of the research. They were:

1. To explore nurses' understanding of parenting in hospital.
2. To inform paediatric nursing practice and education about nurses' understanding of parenting
3. To improve outcomes for children and parents in hospitals.

Were these aims achieved in the process of this research? From the small amount of data (unsaturated) collected, this research has been able to raise some issues about nurses' understanding of parenting in hospital in New Zealand. There are no real conclusions arising from the findings. However, from the analysis, it is suggested that there is confusion about parenting, and a lack of standardised models ascribed to by nurses. There is little understanding of parenting in hospital, of what parenting should be or how

parenting could be achieved.

This thesis has described and discussed research completed in a hospital in New Zealand, which explored nurses' understanding of parenting in hospital. Background literature, research method, analysis, discussion of the findings, and recommendations for education, practice, policy and further research have been presented.

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# Appendices

# CONCEPTUAL MODEL - ANALYSIS

## 1. PARENTING ISSUES

- **Legal versus moral**
  - tasks and functions
- **Different things for different people**
- **Uncertainty**
  - changing family units
  - fitting the mould

## 2. ISSUES FOR PARENTS

- **Parenting & family relationships**
  - family restraint
  - lack of sleep
  - inability to set boundaries
- **Disempowerment**
  - confusion/conflicting advice
  - parenting a child with an acute illness
  - parenting an infant in SCBU
- **Empowerment**
  - Parenting a child with a chronic illness
- **Barriers to parenting**
- **Lack of privacy (intimidation)**
- **Diminishing value (the professional whitecoat)**
- **Stress**
  - hostile responses
  - nervous or guilty responses
  - defensive responses
  - compensatory responses

## NURSES' UNDERSTANDING OF PARENTING

## 3. ISSUES FOR NURSES

- **Lack of time**
  - being busy
  - care associates
  - shorter hospitalisation
- **Stress/burn out**
- **Communication with parents**
- **Conflict**
  - different expectations
  - parenting styles
  - making judgements
  - 'bolshie' parents
  - feeling threatened
  - standards of care
  - being accountable
  - challenging thinking
- **Partnership (Empowering parents)**

## 4. NEED FOR SUPPORT/ STRATEGIES TO SUPPORT PARENTING

- Giving reassurance and encouragement
- Acknowledging fear
- Acknowledging parents cannot always be present
- Parenting the parents
- Helping parents to cope
- Facilitating the track
- Gaining confidence
- Taking responsibility

## Appendix 2

**Question Prompts**

1. What does the word 'parenting' mean to you?
2. What is your understanding of parenting in hospital?

**UP-COMING  
RESEARCH**

# Paediatric Nursing

Are you a  
registered nurse  
currently  
working in the  
Child Health Unit  
at Health Care  
?

A personal letter of invitation to participate in nursing research will be sent to you soon.

Ruth Crawford is looking for participants to volunteer to take part in a study about nurses' understanding of parenting in the Paediatric Ward.

This research is a 'first' in New Zealand. It is anticipated that the findings of the research will be valuable for both nurses and the parents they work with in the paediatric ward.

Your participation would involve sharing your thoughts on this issue in a focus group with 3 to 5 other nurses.

Refreshments will be provided.

**Contact**

**Ruth Crawford**

**on phone**

**for further information.**

## Appendix 4

## Information Sheet

**Title:** An exploration of nurses' understanding of parenting in the paediatric ward

**Principal Investigator:**

Ruth Marion Crawford

Master's student

Address

Phone number

**Introduction:**

You are invited to take part in a study exploring nurses' understanding of parenting in the paediatric ward. Your participation in the study would involve:

- a) attending a focus group discussion of approximately 1 1/2 hours at a date, time and venue to be mutually agreed
- b) providing feedback to the researcher on interpretation of the data.

You have the right not to take part in the study.

### **ABOUT THE STUDY**

**Aims of the study**

The proposed research has three major aims. They are:

1. To explore nursing understanding of parenting in a public hospital
2. To be able to inform paediatric nursing practice and education
3. To improve outcomes for children and parents in public hospitals

**Participant selection**

Prospective participants are registered nurses currently working in the Child Health Unit at xxxx,

Participants will be self selecting (volunteers).

Approximately eighteen participants are required for the research.

The research will involve three focus groups, with follow up interviews if

needed, which will be held at a neutral venue within xxxx.

Each participant is required to participate in one focus group to discuss the research topic.

Each focus group will be audio-taped. The tapes will be transcribed, and the researcher will analyse the tapes and write up the findings. The audiotapes will be destroyed at the completion of the research. The transcriptions will be destroyed after 5 years.

## **RISKS AND BENEFITS**

### **1. Possible risks and/or inconveniences of the study**

There are no foreseeable risks. However, in the event of distress from issues arising in the focus groups, counselling services will be available, financed by the researcher.

### **2. Benefits of the study**

- a) the opportunity to take part in research that specifically benefits paediatric nurses and the children and families with whom they work
- b) an improved knowledge of their peers understanding of parenting in the paediatric ward
- c) the opportunity to have time to reflect about parenting in the paediatric ward
- d) improved job satisfaction through informed paediatric nursing practice and working relationships with parents
- e) the opportunity to participate in nursing research.

### **3. Financial cost to the participant**

Travel expenses to and from Focus Group venue

Possible child care costs while participant attends Focus Group

No payment is to be made for participation in the Research

## **PARTICIPATION**

1. Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part this will not affect your employment.
2. If you do agree to take part you are free to withdraw from the study at

**STATEMENT OF APPROVAL**

This study has received ethical approval from the xxxx Ethics Committee and the Massey University Ethics Committee.

**Please feel free to contact the researcher if you have any questions about this study.**

## Appendix 5

**Consent Form**An exploration of nurses' understanding of parenting

I have read and understood the information sheet dated for volunteers taking part in the study designed to explore nurses' understanding of parenting in the paediatric ward. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future employment with xxx. I understand that if I choose to withdraw from the study at any time, I will maintain the confidentiality of the other participants, and their contribution to the study.

I agree that I will not, at any time directly or indirectly share or divulge any information concerning the identification of the participants, and/or identifiable persons, and/or identifiable institutions to which I have been given access.

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

I have had time to consider whether to take part in this study.

I consent to the Focus Group in which I will be a participant, being audio-taped.

I wish to receive a summary of the results.

YES/NO

I, \_\_\_\_\_(full name) hereby consent to take part in  
this study.

This project has been approved by the xxx Ethics  
Committee, and the Massey University Ethics Committee. This means  
that the Ethics Committee may check that this study is running  
smoothly, and has followed appropriate ethical procedures.

Complete confidentiality is assured.

If you have any ethical concerns about the study, you may contact the  
xxxEthics Committee on xxx and/ or Massey Human Ethics Committee.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Full name of Researcher: Ruth Marion Crawford

Contact Phone Number for researcher: xxx

## Appendix 6

13 January, 1998.

To the prospective participant

Please find an enclosed an invitation for you to participate in paediatric nursing research. Please read the information sheet and consent form. If you are willing to participate in the research, please sign the consent form and return in the stamped addressed envelope provided. Please contact Ruth Crawford, on xxxx if you have any questions related to this research.

Please indicate below your preferences for focus group time and date. Your participation would involve attending **one** focus group. The venue will be in a central location in xxxx or xxxx. You will be asked to attend the focus group at the time of your choice, closest to your home.

Tuesday, 3 February, 10.30am - 12midday

**or**

Thursday, 5 February, 4pm - 5.30pm

**or**

Wednesday, 11 February, 10.30am - 12 midday

**or**

Thursday, 12 February, 4pm - 5.30pm.

If none of these dates suit you, please indicate a date and time which would be preferable to you.

**Please return this sheet and your consent form to the researcher, no later than Friday, 30 January, 1998.**

Thank you for taking the time to read this information.

Ruth Crawford  
Masters student



3 February 1998

To the prospective participant

**Paediatric nursing research in**

Recently you were sent an invitation to take part in nursing research, exploring nurses' understanding of parenting in the paediatric ward.

This is your opportunity to be involved in nursing research. If you have not already responded, you are encouraged to participate in this research.

**Two focus groups have been planned on Wednesday, 11 February and Thursday 12 February. If you are interested in joining these groups, please phone the researcher on . A further group may be held at a later date if these dates are inconvenient.**

If you have any questions about the study, please contact the researcher, Ruth Crawford, phone number as above.

Thank you for your time.

Ruth Crawford  
Masters student



**Central Health**

*Te Ihonga Hauora*

a division of the Transitional Health Authority

## ETHICS COMMITTEE

PO Box

New Zealand

Telephone  
Facsimile

23 October 1997

Mrs Ruth Crawford

Dear Ruth

**RE: A NURSES UNDERSTANDING OF PARENTING OUR REF: 97/10/26**

Thank you for forwarding your application for research to our committee for consideration. The committee asked me to convey to you their thanks for the clear way in which it was presented. The study was considered at our meeting of 21 October and approved. The committee however did have a couple of comments which you may like to consider:

- 1 You state in your application form that you do not consider your research has impact on Maori health however the committee considered that it did in fact have an impact of Maori health bearing in mind the high admission rate for Maori children into the Paediatric ward. You may like to keep this in mind when your focus workshops are taking place.
- 2 It may be useful for you to include a phone number or contact number on the advertisement that you are exhibiting so people may contact you if they have further queries.

We wish you well with your research and look forward to receiving your report in due course.

Yours sincerely

**CHAIRPERSON**

Appendix 9 A L B A N Y

11 February 1998

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

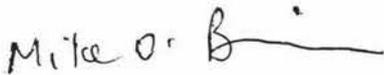
DEPARTMENT OF SOCIAL POLICY & SOCIAL WORK

Ruth Crawford

Dear Ruth

Further to our recent conversation in connection with your project that was recently forwarded to the Ethics Committee, I can confirm that the ethics of the project are approved.

Yours sincerely



Mike O'Brien  
ACTING CHAIRPERSON  
ETHICS COMMITTEE

## Appendix 10

**Non-disclosure form**  
**Undertaking as to Non-Disclosure of Information**

**Whereas, I** \_\_\_\_\_  
 currently residing at \_\_\_\_\_  
 have agreed to transcribe the tapes made during focus groups/be an observer during focus groups (delete one) facilitated by Ruth Crawford, for the purposes of a research project. As part of the transcription/observer process, I will hear names, and other forms of identification of person/persons.

I agree that I will not, at any time directly or indirectly share or divulge any information concerning the identification of the participants, and/or identifiable persons, and/or identifiable institutions to which I have been given access.

I understand that only Ruth Crawford, the principal investigator, and Dr Gillian White, Research supervisor will be allowed access to information on the tapes, and subsequent transcriptions.

I also undertake that I will not at any time, either directly or indirectly, divulge to any department, agency or institution information to which I have been given access.

Signed: \_\_\_\_\_

Witnessed by: \_\_\_\_\_

Designation of Witness: \_\_\_\_\_

Date: \_\_\_\_\_