

School of Nursing and Midwifery

**Parents' trust in nurses: An ethnographic study of the nurse-parent
relationship within the paediatric setting**

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ABSTRACT

The establishment of trust in the nurse-parent relationship is espoused to be fundamental in achieving partnership-in-care within paediatric nursing. Paediatric nursing has progressed since the 1960's and in the 1990's, the major breakthrough was the emergence of the partnership model. Hence, it would be ideal to investigate the elements facilitating the foundation of trust in the formation of a nurse-parent relationship. The purpose of this study is to identify the concept of formation of trust in the relationship between parents whose children suffer from chronic asthma and the paediatric nurses responsible for their care in a paediatric medical setting. The study also determined and explored the characteristics of a trustworthy nurse, and identified those factors which facilitated or impeded the development of trust between the paediatric nurse and the parent within the culture of the paediatric medical setting. Parents of hospitalised children were sought for data collection. Data was collected using field observations and semi-structured interviews. Participant observation and all ethnographic field notes were used to describe culture in relation to the concept of trust in the nurse-parent relationship. The findings indicated that elements vital to the development of trust between parents and paediatric nurses were pre-existing trust, knowledge of asthma, communication, building a relationship and confidentiality. Based on these findings, a model of trust and partnership was developed. The implications of the findings have been significantly related to keeping parents informed of their child's condition, the

continuity in nursing care and paediatric nurses to introduce themselves at the beginning of each change of shift.

Glossary

Partnership-in-Care: is the recognition that caring for a child includes caring for the family by respecting the parents' knowledge about their child and their right to be involved in decision making and the caring process, thereby enabling the family to retain control over this aspect of their lives (Darbyshire, 1994).

Culture: Is the sum of a social group's observable patterns of behaviour, customs, and way of life. It also comprises of ideas, beliefs, and knowledge that characterize a particular group of people (Fetterman, 1998).

Paediatric medical setting: Encompassing physical layout of ward, types of clients and illnesses in the ward. The ward is labelled general medical ward including all personnel in the ward.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction and Background to the Study

Paediatric nursing has progressed since the 1960s when parents handed their sick child over to the care of hospital staff and parents were only allowed to visit once a week for a very limited time (Connell & Bradley, 2000; Dixon, 1996; Newton, 2000; Taylor, 1996). However in the late 1970s, there was a change in attitude regarding children in hospital. Henceforth, the welfare of children in hospital brought about major changes to this way of thinking (Connell & Bradley, 2000; Darbyshire, 1994; Platt Report, 1959). Open visiting was introduced resulting in parents being encouraged to live in the hospital and participate in the care of their sick child. In the 1990s, paediatric nursing advocated partnership-in-care (Connell & Bradley, 2000; Darbyshire, 1994; Newton, 2000). Partnership-in-care is more than an approach. It is a structured process to allow parents to commit to sharing care with the paediatric nurses. It involves clarifying the child's needs and negotiating input of both parents and paediatric nurse in the care delivery.

The basis of partnership-in-care is negotiation between the parents and the nurse while cognisant of the family's wishes (Darbyshire, 1994; Taylor, 1996). In the paediatric medical setting, communication and negotiation between parents and nurse occur daily (Mercer & Ritchie, 1997; Thorne, 1999). Parents need to trust the nurses caring for their child regardless of

their fears and difference in opinion (Mercer & Ritchie, 1997). Crole and Smith (2002) added that nurses' initial contact with children and their families are crucial to the formation of a trusting relationship. Therefore, trust is a concept espoused to be fundamental to achieving excellence in paediatric nursing (Mercer & Ritchie, 1997). In order to negotiate effectively with parents, paediatric nurses firstly need to provide and share information with them. Secondly, paediatric nurses need to be able to trust parents' ability to engage with them as collaborative partners. In other words, trust is a key concept in negotiations between paediatric nurses and parents.

Although partnership-in-care is espoused to be fundamental to achieving excellence in paediatric nursing and development of trusting relationships, there was a paucity of literature investigating the concept of trust. Ideally, before the formation of the nurse-parent relationship, a foundation of trust must be present, as it is considered fundamental to the realisation of partnership-in-care (Lynn-McHale & Deatrck, 2000). Consequently, the concept of trust needs to be identified to permit the enhancement of partnership-in-care within paediatric nursing.

1.2 Trust as a Concept

As a concept, trust is defined as dependence on others' competence and eagerness to look after, rather than harm, the things that people is concerned about (Mohr, 1999). On the other hand, Lynn - McHale and Deatrck (2000) adds that although trust between parents and nurses consist of various

levels, it must be mutual and reciprocal. The trust of parents in the nurses caring for their children is perhaps the most basic of trusts, and it involves parents' confidence that the nurses will respect, understand, and respond justly to them (Mohr, 1999). The violation of that trust can have a profound effect on parents and child and consequent future admissions. Attaining and maintaining trust have been believed to be imperative to enhance the benefits that the nurse-parent relationship brings to children and their parents, paediatric nurses and the healthcare organisation as a whole (Calnan & Rosemary, 2004).

To prevent scepticism and mistrust, trust must be established between the family and the healthcare professional (Leahey & Haper-Jaques, 1996; Lynn-McHale & Deatrck, 2000). Although trust is widely acknowledged as an essential factor in nurse-patient-family relationships, an accepted measure of the concept has yet to be constructed (Anderson & Detric, 1990). From the time of Florence Nightingale, nursing has always been about personal touch and infinity. Passion and sincerity to heal must be present for a relationship to develop. Trust seems to be necessary where there is uncertainty and a level of risk, be it high, moderate, or low. This element of risk emerge from an individual's uncertainty regarding paediatric nurses, paediatric nurses' intentions and future actions of nurses on whom the individual is reliant on (Calnan & Rosemary, 2004). Trust is believed to be predominantly significant to the provision of health care, because it is a situation characterized by uncertainty and therefore risks (Calnan & Rosemary, 2004).

Darbyshire's (1994) observation of parents living with a sick child in the hospital, emphasized the need for paediatric nurses to continue advocating, and developing a philosophy of care based upon mutuality and partnership with parents. Darbyshire (1994) further found that nurses needed a deeper understanding of the nature of parents' experiences and how these related to their own nursing practice. For example, parents of recently admitted children learn from other parents as to what the 'rules' are and if the parents do not conform to the expectations of the paediatric medical setting, pressure would be exerted from other parents and nurses. This can result in stress and guilt for parents of the newly admitted children (Darbyshire 1994). This was confirmed from interviews with parents who were living -in with their sick child by Darbyshire.

From a paediatric nursing care perspective, asthma is the second major cause of hospitalisation in children under fifteen years (*Asthma community grant*, 2002). The condition is especially serious in children; particularly those younger than five years of age, because their airways are very narrow (Ordonez, Phelan, Olinsky, & Robertson, 1998). Asthma is also the leading cause of chronic illness in children (Mutius, 2000), and it can begin at any age (Ordonez et al., 1998). Therefore, it is inevitable that constant interactions are bound to occur between nurses and parents during the many hospitalisations of their children with chronic asthma. The context of caring for a child with chronic asthma can thus be an opportunity for paediatric

nurse and parents to develop a trusting relationship within the partnership-in-care milieu.

Trust is the cornerstone to cooperation, and it takes time to develop (Bricher, 1999; Kirschbaum & Knalf, 1996; Day & Stannard, 1999).

Interactions between the family and the nurses are complex, as both have their own sets of belief and values (Darbyshire, 1994; Leahey & Haper-Jaques, 1996). These sets of beliefs may be similar or disparate. Regardless of dissimilarities in values and beliefs, a relationship can be achieved when all individuals respect the other's point of view (Darbyshire, 1994; Newton, 2000).

Robinson (1996) found that nurse-parent relationships were critical for families with a member suffering from a chronic illness. From this grounded theory research, therapeutic nursing care was found to be effective and satisfying for both the family and the client. Day and Stannard (1999) concluded from the contrast of principle-based ethic and relational ethics that the occurrence of a trusting relationship between client and nurse depended on the nurse, the client, the family, and the situation itself. These two studies concluded that both family members and nurses needed to be open and willing to create a potentially trusting relationship with each other in order to promote a hospital culture conducive to the development of trust.

Similarly, Price (1993) found that although parents of hospitalised children with oncological problems assumed trust in nurses' technical abilities, they

had varying levels of trust in the nursing care provided and the degree to which they perceived a positive relationship with the nurse. Each relationship built with the nurse varied according to the superficiality, or strength of the trust that existed. This current study provides a baseline reason to explore if this variation of trust exists in the culture of paediatric medical setting where children with chronic asthma are treated.

It is clear that there is a need to further explore and describe the development of nurse-parent relationship with respect to trust formation. The purpose of this study is therefore to identify the explicit and implicit behaviours and values and perceptions that form the concept of trust in the relationships between parents and nurses of an acute paediatric medical setting. The study will also explore the characteristics of a trustworthy nurse, and the facilitators and barriers to the development of trust in the nurse-parent relationship in order to achieve partnership-in-care within paediatric nursing.

The objectives guiding this study are to:

- 1) Identify the concept of trust in nurse-parent relationships.
- 2) Observe and describe the development of trust between parents and nurses in a paediatric medical setting.
- 3) Explore the factors which facilitate or hinder the development of trust in the nurse-parent relationship in the paediatric medical setting.
- 4) Describe parents' view of the characteristics of a trustworthy nurse in of a paediatric medical setting.

1.3 Significance of the Study

It is anticipated that the insights gained from this study will contribute to the body of paediatric nursing knowledge regarding nursing behaviours and the cultural context factors that influence parents' level of trust in nurses who care for their child. Moreover, the study may engender in consumers a realisation that paediatric nursing practice is sensitive and responsive to the family as a complete unit and facilitate paediatric nurses to empower parents whilst their child is hospitalized. As well as an understanding of how trust develops and its role in promoting the partnership-in-care model will be a valuable resource for paediatric nurses.

1.4 Overview of Thesis

In chapter one, the background to the research is explained including purpose, objectives and significance of the study. Chapter two covers a brief literature review in order to explain the contexture the research problem. Chapter three depicts the use of ethnography to investigate the nurse-parent relationships within the paediatric medical setting with respect to trust. This chapter will also explain the research design, the ethnographic approach, sampling method, access to sample, data collection, the researcher's opinion, ethics and data analysis. Chapter four describes a narrative account of parents' perceptions of their child's care with respect to the development of trust between parents and paediatric nurses. Six major domains labelled *pre-existing trust, parental expectations, knowledge of asthma, communication, building a relationship and confidentiality* provides an insight as to how trusting relationships between paediatric nurses and

parents are formed within the paediatric medical setting. Chapter five discusses the findings of the study as well as a discussion of the test model that has been developed from the findings.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter, a brief literature review is presented. As the purpose of this study is to explore and describe the development of trust between parents and paediatric nurses, literature pertaining to this issue will be briefly explained in order to contextualise the research problem.

Changes to the care of the hospitalised children over the last two decades include preventive care and parental participation that demonstrates advancement of the parents' role in care and the development of a partnership model of care. Paediatric nursing has altered its focus from a strictly curative approach to a holistic approach encompassing every aspect of physical, emotional, social, psychological and environmental health (Blake, Wright, & Waechter, 1970; Connell & Bradley, 2000; Mott, Fazekas, & James, 1985). However, there is evidence to suggest that while changes towards a partnership model of care may be desirable, their implementation has been more difficult (Connell & Bradley, 2000; Darbyshire, 1994; Dixon, 1996). Although there is a plethora of literature on partnership-in-care in paediatric nursing, there is a lack of detailed description of the development of trusting relationships between parents and paediatric nurses. Trust is needed to strengthen relationships between parents and paediatric nurses throughout the hospitalisation. However anecdotal evidence suggests that questions such as 'What do parents think

of their relationship with paediatric nurses? and ‘How do parents know that they can trust paediatric nurses caring for their child?’ have remained largely unasked and unanswered. Answers to these questions may be beneficial to paediatric nurses in providing care that encapsulates the partnership-in-care model.

2.2 History of Paediatric Nursing

Paediatric nursing has traditionally been concerned with the care of the sick child. The term ‘to nurse’ has a number of meanings. Literature describes nursing in a number of ways - including “to take charge or watch over” “to take care of” and “to promote progress of health condition” of the child (Broadribb, 1973). Traditionally, paediatric nurses functioned strictly as carers of sick children. However, the focus has changed. Paediatric nurses are now more involved in helping the child and family to obtain optimal physical, psychological and emotional health during hospitalisation (Broadribb, 1973; Connell & Bradley, 2000). For example, parents are encouraged to perform basic tasks such as feeding and washing of their children during hospitalisation and to take a more active role in the care of their child.

Hospitals for sick children emerged mainly in the mid - nineteenth century (Connell & Bradley, 2000; Mott et al., 1985; Taylor, 1996). The first of these were opened in 1796 with firm beliefs that children should not be separated from their parents (Darbyshire, 1994). In Western Australia, the first paediatric hospital was opened in 1909. The hospital was open to all

children whose family could not afford to pay for treatment (Butt, 1984). Similarly, other paediatric hospitals also opened throughout major cities in Australia. The main thrust of these hospitals was to deal with a range of infectious illnesses, such as tuberculosis, pneumonia, influenza and deficiency diseases that were more often the products of the social conditions of the time (Darbyshire, 1994). Early struggles against infectious diseases and often fatal illnesses helped to create a hospital system based upon asepsis and rigid following of routine. As a consequent of treatment, children were isolated from parents and were not able to be in close contact with the family. Schooling was also affected. As well, babies were placed in individual cubicles and paediatric nurses were forbidden to pick up the child unless absolutely necessary such as when providing treatment. The legacy of this system was to affect the relationships between children, their parents and hospital staff for over a century (Darbyshire, 1994), with isolation for barrier nursing. Today, only children suffering from an infectious disease such as Respiratory Syncytial Virus (RSV) would be placed apart from other children in the ward. Even though parents and paediatric nurses caring for these children will have to maintain barrier nursing by gowning and hand-washing before entering and leaving the children's rooms, considerable interactions still occur within these barrier-nursing settings.

It may be argued that the decline in infectious diseases, the introduction of antibiotics such as penicillin, and the arrival of technological innovations, may have seen the reduction of barrier-nursing in this century (Blake et al., 1979; Taylor, 1996). However, child-rearing ideologies of the early

twentieth century have provided continued justification for mechanistic and regimented care. It was not until changes in the thinking concerning a child's psychological and emotional development did the catalysts for change amongst health professionals (Connell & Bradley, 2000; Darbyshire, 1994; Dixon, 1996; Taylor, 1996).

To this end, several paediatricians began to promote schemes that kept mothers and children together, which led to the publication of the Platt Report in 1959 (Darbyshire, 1994; Taylor, 1996). During this period, some paediatric nurses began to advocate for more humanitarian and family - focused practices such as allowing parents to visit their hospitalised child and share in decision making (Connell & Bradley, 2000; Darbyshire, 1994; Newton, 2000; Taylor, 1996). This advocacy provided the basis for the evolution of the partnership-in-care model.

An early pioneer of the concept of partnership-in-care was John Bowlby who in 1951 conducted longitudinal studies to determine children's reaction to maternal separation, a common occurrence in children's hospitals. Bowlby reported to the World Health Organisation that children needed contact with their mothers for healthy development. Bowlby's (1951) studies were repeated and expanded by researchers such as Robertson (1962; 1970), who examined the effects of hospitalisation on children. The results of these studies eventually changed nursing's approach to the care of hospitalised children. Reasons for previously established rigid visiting hours and exclusion of parents participating in their child's care no longer seemed

valid. As these views became understood and accepted, paediatric nurses began to see hospitalised children as part of family units and began to alter hospital facilities to accommodate the changing concepts. Many changes were built to accommodate parents (Butt, 1984). Hospitals subsequently relaxed visiting restrictions, some even allowing parents to remain with their children during the night. Unrestricted visiting for parents was introduced in paediatric hospitals throughout Australia and elsewhere (Butt, 1984).

In actively seeking better quality care for their clients, paediatric nurses also embraced the advocacy role. Paediatric nurses not only advocated changes in the approach to the hospitalised child but also began to develop a separate body of knowledge and unique practice surrounding the practice of paediatric nursing.

As a result of the studies by Bowlby and others, nurses became more aware of the child's response to maternal separation (Connell & Bradley, 2000; Darbyshire, 1994). Moreover, parents were more vocal and knowledgeable about their right to be with their children. When a child was admitted to the hospital, it was understood that the parents would be assisted by the nurse to assume as much responsibility for the child's care as they felt capable of providing. The parent performed certain tasks such as temperature taking and assisted nurses in preparing the child for medical procedures. Consequently, family-centred care and partnership-in-care in paediatric nursing became a reality.

2.3 Philosophy of Care

2.3.1 Family - Centred Care

According to Wong and Hockenberry-Eaton (2001), the philosophy of family-centred care recognises the family as the constant in a child's life. Healthcare professionals enable and empower families to continue their care-giving role when a child is hospitalised. Service systems such as radiology, physiotherapy, occupational therapy and personnel, for example, nurses, must support, respect, encourage, and enhance the strength and competence of the family through an empowerment approach and effective giving of help. Families are supported in their natural care-giving and decision making roles by building on their unique strengths as individuals and families (Baucher, 2001; Darbyshire, 1994; Newton, 2000). This philosophy also acknowledges diversity among family structures and backgrounds, family goals, dreams, strategies for coping, and actions to deal with problems, and family support, such as relatives and friends, service and information needs (Newton, 2000; Whaley & Wong, 1999; Wong, 1995a).

Although health professionals readily accept the concept of family-centred care, they have been slow to implement practices that represent the 'family as the client'. This lag has occurred in part because family-centred care requires a shift in orientation regarding provisions of services. The philosophy requires stretching beyond clinical practices that have become tradition because of their convenience to the hospitals and personnel, i.e. nurses (Coleman, Bradshaw, Cutts, Guest, & Twigg, 2000; Wong & Hockenberry-Eaton, 2001). The above situation has the potential to impede

on partnership-in-care.

2.3.2 Atraumatic Care

Wong and Hockenberry–Eaton (2001) defined atraumatic care as the provision of therapeutic care in clinical settings, by healthcare professionals, through the use of interventions that lessened or eliminated the psychological aspects, such as fear, anxiety, anger, disappointment, shame, guilt; and physical distress such as pain, temperature extremes, loud noises, darkness and bright lights. These are some of the factors the above authors state may be experienced by children and their families. Furthermore, these authors maintained that atraumatic care is concerned with identifying the ‘who’, ‘what’, ‘when’, ‘where’, ‘why’, and ‘how’ of any procedures performed on a child for the purpose of preventing or minimising psychological and physical distress.

Although significant advances have been made in paediatric care, many changes that have cured illness and prolonged life are traumatic, painful, upsetting and frightening. Unfortunately, diminishing the trauma of medical interventions has not kept in pace with the technological developments. It is therefore necessary for healthcare professionals to embrace atraumatic interventions to help families and children overcome the ordeal of the stressors imposed. One way this reduction in stress can be achieved is in the practice of the partnership-in-care model. As indicated earlier, partnership-in-care involves recognising that the care of child includes caring for the family by respecting the parents’ knowledge of their child and their right to

be involved in decision making in the caring process. This in turn enables the family to retain control when dealing with the care of their sick child (Darbyshire, 1994), which ultimately results in care that is in optimum for the child.

2.4 Parental Involvement and Participation

Preventing or minimising separation is a key nursing goal with the child who is hospitalised, but maintaining parent-child contact is also beneficial for the family (Wong, 1995b; Wong & Hockenberry-Eaton, 2001). One of the most successful approaches has been to encourage parents to stay with their child and to participate in the care, whenever possible. Calnan and Rosemary (2004) suggest that greater parental participation in their children's care can produce greater interdependence between parents and paediatric nurses.

Nursing children intimately involves the care of the child and parents or caregivers. Consequently, paediatric nurses must be aware of the functions of parents and caregivers, various types of family structures, and theories that provide a foundation for understanding the changes within a family and for directing family-oriented interventions and engage in partnership-in-care (Whaley & Wong, 1999; Wong & Hockenberry-Eaton, 2001).

The hospital is a complex environment with the potential for increased friction between parents and paediatric nurses (Darbyshire, 1994; Dixon, 1996; Newton, 2000). Parents and paediatric nurses may have different

attitudes toward the concept of care. They may have different ideas as to what parental participation means in the daily routine of a children's ward (Connell & Bradley, 2000; Darbyshire, 1994; Taylor, 1996).

A number of studies have shown that parents want more involvement in their child's care (Angst & Deatruck, 1996; Baucher, 2001; Darbyshire, 1994; Kirschbaum & Knalf, 1996; Marino & Marino, 2000). In a phenomenological study of 'live – in' parents, Darbyshire (1994) noted that nurses needed to be more aware of parental experiences and parents' need to participate in the care of their sick children throughout hospitalisation. On the other hand, Angst and Deatruck (1996) through a descriptive study of 20 families, found that parents desired involvement and that this involvement was strongly related to their satisfaction with care and their feelings of control. The majority of studies however focused on mothers. This is not surprising in view of the fact that it is usually mothers rather than fathers who stay with their child during hospitalisation, although fathers are beginning to take a greater part in childcare in recent years (Wong & Hockenberry-Eaton, 2001).

Most commonly, the discourse on parental involvement and participation within professional literature centres on parents as performers of tasks that they will perform in order to feel useful. Literature indicates that parents wanted to feel useful to their child and to the healthcare system and in particular to paediatric nurses (Baucher, 2001; Kirschbaum & Knalf, 1996; Marino & Marino, 2000; Mercer & Ritchie, 1997).

Darbyshire (1994) described the experiences of parents and nurses under the graphic title of 'living with a sick child in hospital'. Darbyshire also suggested that an alternative to instrumental understanding of parents and nurses was to consider the person as constituted by a web of relationships with others. In this manner, the relational and contextual aspects of lived experiences and relationships may be uncovered and the voices of the parents and nurses heard. Darbyshire's study showed that nurse-parent relationships can be static and dynamic.

2.5 Parental Expectations in Nurse-Parent Relationship and Trust

Parental expectations are reported to be an important characteristic of parent - professional relationships (Kirschbaum & Knalf, 1996; Schaffer, Vaughn, Kenner, Donohue, & Longo, 2000). It was found that each person involved in the relationship relied on and expected something of the other as trust progressed. The ultimate goal of a trusting relationship between clients, families, and healthcare professionals is to have care that is shared (Day & Stannard, 1999; Faux & Knalf, 1996; Kirschbaum & Knalf, 1996), incorporating values of the clients. Parents expect that their experience with illness will be understood and enhanced within the relationship (Marino & Marino, 2000; Schaffer, Vaughn, Kenner, Donohue, & Longo, 2000). Parents also assume that their involvement as a primary care-giver, on the daily basis will be acknowledged and respected. In addition, parents expect nursing care to be collaborative and cooperative (Baucher, 2001; Marino & Marino, 2000; Newton, 2000; Schaffer et al., 2000).

A trusting relationship between parent and nurse is very much integral to paediatric nursing (Leahey & Haper-Jaques, 1996), if paediatric nurses are to strive for excellence in their practice. Day and Stannard (1999) stated that a given family's trust in nurses allows the care-giver or parent to leave the bedside of the seriously ill child, knowing that the nurse will stand-in while they take a break. Advocating for a family meant that the nurse will care for the client while integrating and representing the family member's concern in their absence (Day & Stannard, 1999). However, if parents did not trust the paediatric nurse, they would not take a break including missing meals in some cases (Darbyshire, 1994).

Interaction between parents and healthcare professionals is fundamental when a child is being treated for a chronic illness such as asthma. Effective, frequent communication between parents and the healthcare professional is considered necessary for a trusting relationship to develop between the dyad. This relationship is crucial for the child undergoing medical care for asthma. In its absence, miscommunication and disagreement may hinder the progress and treatment regime (Mercer & Ritchie, 1997). The literature is scant in the study of nurse-parent relationships and the formation of trust, within the culture of the paediatric medical setting.

Parents also assume their involvement as a primary care giver on the daily basis would be acknowledged and respected, and expect nursing care to be collaborative and cooperative (Baucher, 2001; Marino & Marino, 2000;

Newton, 2000; Schaffer et al., 2000).

2.6 Culture of Paediatric Nursing and the Nurses' Role

Within the culture of the hospital setting, paediatric nurses have an important opportunity to influence the physical, emotional and intellectual outcome of the child under stress because they are the closest to the child both spatially and emotionally during the hospitalisation period. Through exposure to internet, television programs, parenting books and articles in the newspaper and magazines, parents today are becoming more informed in their medical knowledge (Angst & Deatruck, 1996; Kirschbaum & Knalf, 1996; Marino & Marino, 2000). To meet parental expectations and demonstrate a high level of professional competence, paediatric nurses have to draw upon their expert knowledge of paediatrics in order to discuss issues such as family planning, genetic counselling and child-rearing practices. Furthermore, they need to engage in appropriate methods of referral of the child and parent to social and medical agencies (Price, 1993).

The nursing care of children entails an understanding of the child as a developing person with unique ways of feeling and thinking, and with their own individual methods of coping with the environment. Empathy for children will be fostered by the degree with which paediatric nurses learn to understand and accept their own feelings and attitudes, and to appreciate the way they nurses handle their problems (Price, 1993). With such self understanding, paediatric nurses will be able to recognise and make explicit the origin and meaning of the behaviour they observe in hospitalised children. Backed by theoretical knowledge and skill in its application, the

paediatric nurse will then be able to intervene in a constructive manner (Price, 1993). To fulfil the role of a paediatric nurse as part of the health team in the culture of the paediatric unit, the paediatric nurse must have knowledge of physical developments and relationships around the children which contributes to the development of a healthy personality.

2.7 Nurse-Parent Relationship and Trust

In a recent interpretive phenomenological study, Bricher (1999) emphasized that paediatric nursing should incorporate the cultural perceptions of both the roles of children in society and the history and culture of paediatric nursing. Through interviews with five paediatric nurses, trust was found to be inherent in the development of the relationship between nurse and child, and between nurse and parent. However, Bricher, (1999) found that there were also some specific situations, where trust could be challenged or lost. For example, painful or distressing procedures such as injections and long-term trauma-related admissions may require the paediatric nurse to dishonour the trust that had been established. Although the study was conducted in the paediatric setting, nurse-parent relationships within the culture of the paediatric medical ward setting may differ from nurse-client relationships. This may be due to the difference in the psycho-sociological needs of a child and an adult. For children, the relationships usually begin from a position of lack of trust because someone unfamiliar wants to do something unfamiliar and possibly painful or uncomfortable to them (Bricher, 1999). On the other hand, from the adult view point, it is their (parents') responsibility to trust the paediatric nurses caring for their

children.

In a qualitative exploratory study of hospitalised children aged between three and six years old, Crole and Smith (2002) found that nursing care of hospitalised children occurred in four phases: Introduction phase; building trusting relationships phase; decision-making phase and comfort and reassurance phase. When paediatric nurses are expected to make decisions that would affect the trust that develops between themselves and the child, it is important to allow the child time to re-establish the trusting relationship. Through procedures, paediatric nurses are perceived to be as responsible for inflicting pain and trauma on the hospitalized child. Therefore, paediatric nurses should use techniques such as praising the child and providing them with a cuddle or a favourite toy in their attempt to restore the child's trust that is jeopardized during painful procedures. According to Crole and Smith (2002), the four phases of nurses' care highlight the importance of each phase and their interconnectivity. When trust is not established or impeded during the phases, difficulty in gaining the child's cooperation or delivering satisfying nursing care to the child and their family becomes apparent (Crole & Smith, 2002).

Angst and Deatrick (1996) characterised trust through mutual intention. In their descriptive study of twenty school-age children, they found that in order to build a trusting relationship, both parties must have the desire to establish the relationship, especially parents. In Angst's and Deatrick's study, it was evident that trust in the nurse-parent relationship allowed an

immediate course of action to be carried out when required. For example, parents in Angst's and Deatrick's study generally accepted the necessary care without dispute. This was because they (parents) had identified that with the progression of their children's illness, misjudgments on their (parents) part may result in the death of their children. Robinson (1996) found that nurse-parent relationships were critical for families with a member suffering from chronic illness, in order for effective outcomes for both parent and paediatric nurse.

Ford and Tuner (2001) in their study discovered that the development of trust between nurses and families were very much based on the actual nursing care that the parents had observed. It was established that parents needed to see nursing care and to get to know the nurses to enable trust to develop. Trust can be affected when parents do not see the nurses providing the care that they as parents believe is necessary (Ford & Turner, 2001).

2.8 Partnership-in-care and Trust

Partnership is central to the care of children with chronic illness such as asthma (Wooler, 2001), involving parents, carers and healthcare professionals in a collaborative journey to achieve optimum respiratory management. For a successful outcome, healthcare professionals must also be able to offer a consistent message to facilitate adherence to treatment regimes by ensuring that families have full understanding of the clinical condition (Kataoka-Yahiro, Tessier, Ratliffe, Cohen, & Matsumoto-Oi, 2001; Wooler, 2001). Even slight differences in the message given can

result in confusion and misunderstanding. Serious consideration must be given to different ways of assessing children's and parents' needs in terms of asthma management. Paediatric nurses are a valuable asset in chronic disease management and with appropriate training and competency assessment can provide a high standard of care to asthmatic children and their families. One way to achieve this is through development of trust.

In this study, the purpose is to describe the nurse-parent relationship with respect to trust. This chapter has provided a brief literature review about the phenomenon of partnership-in-care in relation to trust in the nurse-parent relationship. From the review, it is clear that trust is particularly salient to the provision of nursing care to children and their families in hospital because it is a setting that is characterised by uncertainty and risks from the children and parents or care-giver perspectives.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter will describe the use of ethnography to explore the nurse – parent relationship within the paediatric medical setting with respect to trust. The chapter outlines the use of purposive sampling method to select key informants from the population of parents with an asthmatic child from the Respiratory Department and General Medical Department of an acute paediatric public hospital in Western Australia. There are three characteristics central to ethnographic research: The researcher as instrument, fieldwork, and the cyclical nature of data collection and analysis (Spradley, 1980). The significant role that ethnographers play in identifying, interpreting and analysing data in the field is the reason the researcher becomes the instrument. This chapter will describe the research design, the ethnographic approach, sampling method, access to sample, data collection, the researcher's position, ethics and data analysis.

3.2 Research Design

3.2.1 Ethnographic Approach

Ethnography was chosen as an appropriate method of inquiry into the important area of parents' trusts in nurses in a paediatric medical setting, as it allows exploration into the areas of human and social phenomenon of paediatric nursing (Hammersley & Atkinson, 1993; Spradley, 1980).

Ethnography is a process of interpretive inquiry into the shared meanings of parents' experiences in order to discover cultural understandings that shape nursing practice within the paediatric medical setting. Therefore, ethnography was selected as appropriate for this study

This ethnographic approach allowed the researcher to enter and remain in close and prolonged contact with the everyday lives of parents with asthmatic children involved in the paediatric medical setting. In this study, participants were being readmitted to the ward at least twice within a period of three months from April to September for one to three days. To optimise fieldwork, periods between seven o'clock to eleven o'clock in the morning, one o'clock to three o'clock in the afternoon and six o'clock to ten o'clock in the evening, were chosen as contact times, reason being that parents have the most interaction opportunity with the nurses during these times.

Extensive engagement of myself as the research tool with the parents within their actual treatment environment was essential to revealing their social reality (Morse & Field, 1995). Being an asthmatic and a nurse was beneficial in that it allowed me to be more readily accepted by participants in the study setting.

As a cultural study, ethnography is based on the assumption that human beings are socialised into a cultural framework (Aamodt, 1991; Fetterman, 1998; Spradley, 1980). Ethnography is also the art and science of describing a group or culture. Ethnography offers the potential for advancing an understanding of the meaning of health and illness behaviours of patients in

differing ethnic groups. Ethnography as a method of inquiry, provides the opportunity for researchers to conduct studies that meet the need for familiarity with members of a given culture (Aamodt, 1991; Boyle, 1994; De Laine, 1997; Leininger, 1985a, 1985b; Morse & Field, 1995; Streubert Speziale & Carpenter, 2003). The focus of this study was to learn how parents used knowledge that they have learnt whilst their child was in hospital together with the events that made sense for them in their child's admission into the paediatric ward (Spradley, 1980).

The main principle of ethnography is that an individual's behaviour is influenced by a shared culture, which can only be understood within its context. Culture refers to the acquired knowledge that individuals use to interpret experience and to generate social behaviour (De Laine, 1997; Fetterman, 1998; Frow & Morris, 2000; Spradley, 1980). Thus, culture enables the researcher to go beyond what individuals say and do to understand the shared system of meaning within a group. Some meanings are directly spoken in language (explicit knowledge), but many are taken for granted and communicated indirectly through language and behaviour (tacit knowledge) (Frow & Morris, 2000; Jorgenson, 1989; Spradley, 1980). These complex meaning systems are shaped by the physical, sociocultural, and intrapersonal contexts for behaviour.

Ethnographers assume a holistic outlook in research to gain a comprehensive and complete picture of a social group. Ethnographers attempt to describe as much as possible about a culture or a social group.

This description might include a group's history, religion, politics, economy, and environment. The holistic orientation forces the researcher to see beyond an immediate cultural scene or event in a classroom, a hospital, or a ward. Each scene exists within a multilayered and interrelated context (Leininger, 1985a; Streubert Speziale & Carpenter, 2003). For example, in my fieldnotes, Parent 7 would not leave her child out of her sight. She would take the child with her even to the bathroom when she needed a shower herself.

The hallmark of Ethnography is fieldwork. The ethnographer participates in cultural events in order to discover and understand the patterns of meaning that form that culture. This allows the researcher to merge into culture (Morse & Field, 1995). Hence, meaning is not merely investigated but is constructed through reciprocal relationships between the researcher and informants. This reciprocal relationship has been described by Streubert Speziale and Carpenter (2003) as the instinctive character of ethnography. Fieldwork typically involves a combination or triangulation of methods of data collection. According to Streubert Speziale and Carpenter (2003), triangulation of methods includes more than one source of data in a single investigation. This study used participant-observation and interviews, in order to capture the full dimensions of the culture of the paediatric ward, i.e., the care of children with asthma, and interactions with their families in the wards, within the natural setting (Jorgenson, 1989; Muecke, 1994; Spradley, 1980; Streubert Speziale & Carpenter, 2003). The purpose of combining the data collection methods is to provide a more holistic

understanding of the phenomenon under study. The researcher checks and double checks the findings to ensure rigor, at the same time the researcher also uses multiple data generation techniques to assure accuracy and completeness of findings (Streubert Speziale & Carpenter, 2003).

3.2.1.1 The Scope of Ethnography

The scope of research can vary along a continuum from *macro-ethnography* to *micro-ethnography*. According to Spradley (1980), *macro-ethnography* is used when ethnographers try to explain the culture of a complex society consisting of many communities and state institutions. *Macro-ethnography* requires many years of research and often involves more than one ethnographer. *Micro-ethnography*, on the other hand, is usually a study of a single social situation which suits the selected research project. It may be done in a shorter time frame (Spradley, 1980). Micro-ethnography is a time limited, exploratory study within a discrete organisation (Boyle, 1994; Muecke, 1994). It involves less in terms of broad surroundings about a particular group but more about a specific problem area and those aspects of group life that affect the problem being studied (Boyle, 1994). It is a problem and context specific study.

Figure 1 below shows the scope of ethnography. In this study, a micro-ethnography is used to define the nurse – parent relationship within the paediatric medical setting and to describe the concept of trust in these relationships.

Extent of Research	Community Units Studied
Macro – Ethnography	Complex Organization
	Various Communities
	A single community study
	Various public institutions
	A single public institution
Micro - ethnography	Various social situations
	A single social situation

Figure 1: Variations in Research Extent (adapted from Spradley 1980, p.30)

The researcher sought to identify the shared knowledge, norms, and beliefs that influence behaviour from the perspective of parents with an asthmatic child with respect to trust in the paediatric medical setting.

3.3 Procedural Methods

3.3.1 Researcher as the Main Tool

As the researcher, I was the main research tool in this study. I interviewed participants and observed paediatric nurses interact with parents with an asthmatic child within the paediatric medical setting. However, in this process, I was required to maintain sufficient distance from the informants in order to discriminate between the *emic* and *etic* perspectives of the culture. *Emic* view is the insider's perspective, usually experiencing the

social situation in an immediate, subjective manner. *Etic* view is the outsider's perspective, viewing the social situation and myself as an object (Spradley, 1980; Streubert Speziale & Carpenter, 2003). This involved making my role as the researcher explicit, given my clinical experience in paediatric nursing. It also required self-awareness of the attitudes, feelings and behaviours which can influence my interaction with the members of the culture. These were recorded in a fieldwork journal and discussed with my research supervisors in order to minimise any potential preconception in data gathering and analysis. This was achieved by having my supervisor sit through a session of observations in the ward. An exchange of notes and data was done after the session to ensure rigor of data and enhancement of trustworthiness.

3.3.2 Sampling

A purposive sampling method was used in order to select key informants or information-rich cases. The key informants were identified as possessing particular knowledge, skills or experience in the area under study. Potential participants were obtained from the list of names and addresses of parents of children who met the inclusion criteria and who were inpatients at the selected hospital. A sample of convenience of at least ten potential participants was then drawn from the list of parents. For this convenience sample the participants were selected as they presented in the ward. These parents were contacted and invited to participate in the study during their child's current admission. The researcher provided information about the purpose of the study, the potential benefits to healthcare consumers and

paediatric nursing, and an opportunity to answer any questions. Non English speaking families, Aboriginal and Torres Strait Islanders were excluded from the study. These groups have been excluded as the researcher does not understand the many native languages spoken by these people and may lose important clues to cultural meaning, due to the researcher's inability to capture their *emic* view. The sample selected consisted of parents whose children were between the age of one and five years old, have been diagnosed with asthma and who were admitted to the ward twice within a period of four to six months.

3.3.3 Data Collection

Gaining entry into the study site is a practical procedure that requires tact and understanding of the individuals concerned. This procedure involved negotiations with the healthcare organisation and the head of departments of the appropriate profession for entry to work with the individuals (Appendix E and F). With their consent, the final step to participant selection, interview and observation was taken.

The researcher, with the permission of participants, tape-recorded interviews and took fieldnotes. The tape-recorded interviews provided a complete and accurate record of the structure, quality and content of speech. The fieldnotes provided a record of the nonverbal communication and the context of communication during the interviews. The scheduled interviews with parents with a child diagnosed with asthma were undertaken at a time and place of their convenience. This negotiation appeared to have facilitated

the subjective level of comfort for informants and minimised the variation between usual clinical practice and research activity. The face-to face interviews allowed for observation of verbal and non-verbal communication, the setting, and sequence of events. This strategy facilitated the full description of the interaction between the researcher and the participant to assist with the analysis of data.

The unscheduled, unstructured interviews occurred during “the natural pace or cultural activities” as part of participant-observation (Spradley, 1980, p. 39). These interviews were documented in the fieldnotes. The unscheduled interviews added depth of the information gathered from the scheduled interviews with participants. The unscheduled interviews allowed for observation of the unspoken rules of paediatric nursing care, the attitudes, and values and norms of the culture, which were then clarified, refuted or verified by key participants. For example, as the researcher was about to start an interview the doctors came round. The researcher had to exit from the scene so that the consultation and feedback would occur between the physician and parent.

3.3.4 Access to the Setting

The problem of obtaining access to the setting looms large in ethnography. This issue according to Hammersley and Atkinson (1993) is acute in initial negotiations to enter a setting. For example, I had to select participants who would be willing and have the ability to talk openly and freely with me. To this end, I made initial contact with the so-called gatekeepers of the setting.

Gatekeepers are those who have the power to open or block access to the research setting (Hammersley & Atkinson, 1993; Spradley, 1980; Streubert Speziale & Carpenter, 2003). Gatekeepers can also include those who consider themselves to be the power brokers or those who are considered by others to have authority to grant or refuse access. In this case, the gatekeepers were the hospital's Medical Head of Department, the Clinical Nurse Managers of the wards, the nurses, and most importantly the parents.

3.3.5 Negotiating Access

Prior to commencing the research, I held meetings with the Director of Paediatric Medicine Critical Care Unit (CCU), Clinical Managers, Asthma Liaison Nurse, and Patient Information Systems' Management of the healthcare organisation to gain their approval and support. It was important for me to explain my study, its aims, the methodology and the sample I would use.

In addition to meeting with, and seeking approval from the Director of Paediatric Medicine CCU and Clinical Managers of the healthcare organisation as an outsider, I had to establish new relationships with clinical nurses, registered nurses, individuals and groups in the paediatric ward. My supervisors used their experiences and knowledge to establish contact with the network they knew, to gain advice and directions and to flush out information that was relevant to the topic. I used these networks as an avenue to establish contact with the clinical nurses, registered nurses, individuals and groups.

It is important for outside researchers to acknowledge that they may be entering a study area that they may not be familiar with. Participants within the study site are usually the custodian of its context and culture. Therefore as a researcher it is essential to be mindful of and acknowledge, recognise and respect the cultural, political and social structure of the healthcare organisation that one is entering into which I followed.

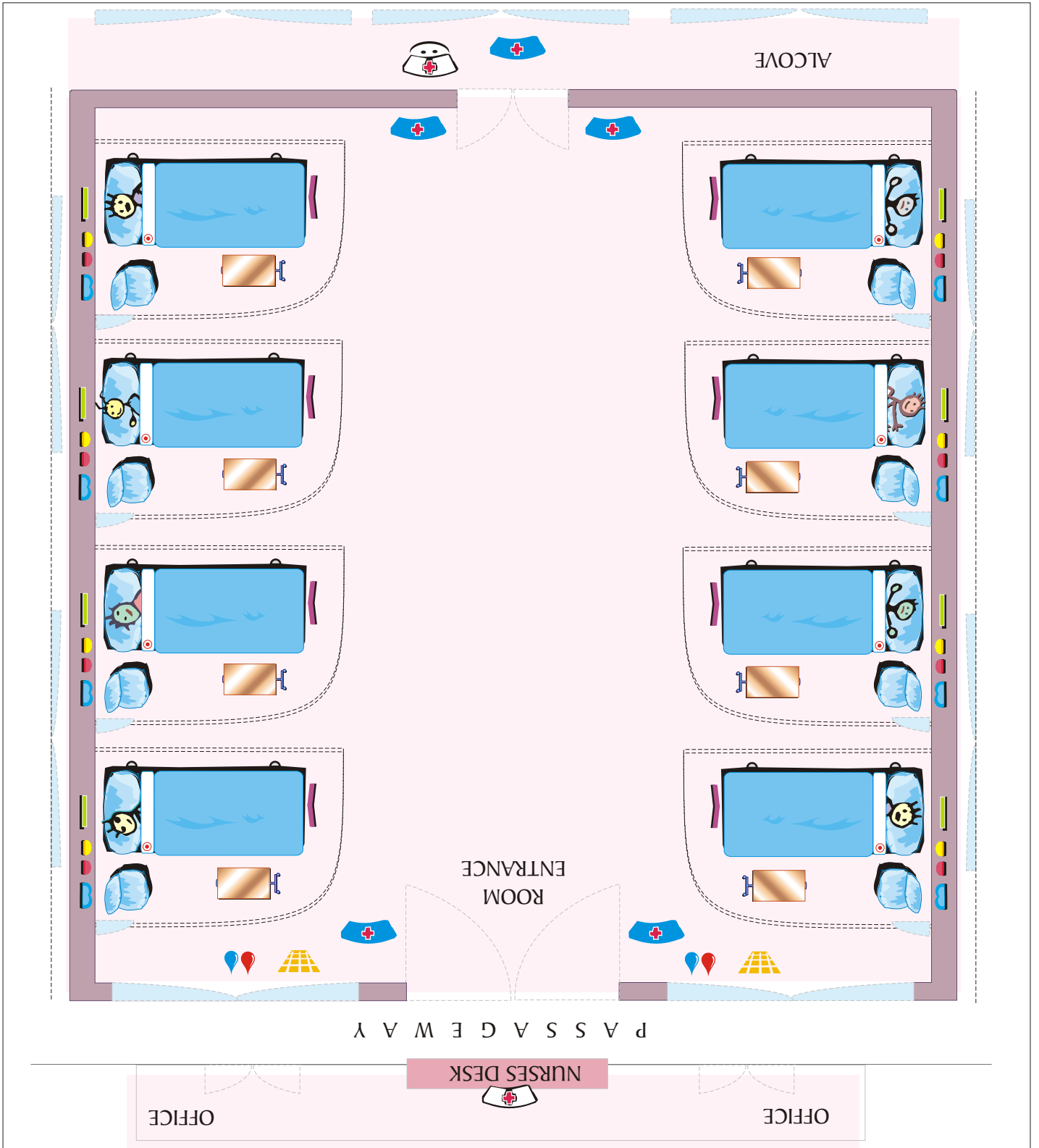
3.3.6 Study Setting

The ward where all the interviews, participant observations and informal interviews took place, were mostly eight beds to a cubicle. The clients' ages varied and the majority of the clients would have their parents with them throughout the hospitalisation most of the time if not all the times. Figure 3 depicts the setting of the ward and the position of the researcher at the point of participation observations.

3.3.7 Acceptance

Acceptance is an important element in ethnographic research and in hospitals and wards (Leininger, 1985a; Spradley, 1980). Acceptance can be immediate or it can take time or it may not happen. If a given healthcare setting does not accept the researcher (as an individual), then it may be difficult to gain approval and co-operation from participants. The power of acceptance can and has forced many researchers to terminate their research projects or change their initial research questions or topics to suit the demands of the healthcare setting (Spradley, 1980). Some researchers, in their frustration or through the disappointment of being rejected have

FIGURE 3: A TYPICAL CHILDREN'S WARD



L E G E N D

- OBSERVATION LOCATIONS
- CHILD'S CHART (Observations)
- PARENTS SEATING
- CHILD'S NAME PLAQUE
- CUBICLE CURTAINS
- CHILD'S HAND HELD BUZZER
- DOORWAY
- NURSE CALL BELL
- WASH SINK & TAPS
- EMERGENCY ALARM
- RUBBISH BIN
- NURSES VIEWING AREA
- OXYGEN EQUIPMENT
- HEART TABLE (on wheels)
- NURSES RECEPTION
- WINDOWS & CURTAINS
- TROLLEY BED

approached alternative healthcare settings to do their research (Spradley, 1980).

In order to be accepted, I arranged a few sessions of morning tea or afternoon tea for all the nurses in the selected wards. During the sessions, posters (Appendix D) and handouts were provided to give a personal profile (Appendix G) and to explain my research project. The nurses were given an opportunity to clarify their doubts and to ask questions about the research. During the data collection period in the hospital, small gestures such as presenting candies and chocolates to all the staff of the ward assisted in gaining rapport with staff. These strategies prevented staff from feeling that the researcher was intruding, a very important rule to follow in an ethnographic study. Sometimes, the nurses and the ward clerk would offer the list of clients under their care to me. Other times, a printout of admissions was kept especially for me. This was an indication that I was being accepted by the ward staff.

3.3.8 Ethical Consideration

Ethics applications were made to the selected hospital and Ethics committee of the University in which the researcher was enrolled. Ethics approval was obtained prior to any data collection, which occurred between September, 2001 and August, 2002. It was considered that there were no inherent risks in this study. Participants were to be approached and advised of the voluntary nature of the study and given the opportunity to withdraw from the study at any stage without affecting their child's care. Assurances were

given to participants that they can choose not to participate in the study without compromising their status, or the care of their child. Should any parents have any issues of concern regarding the care of their child; the parent would be referred to the ward Clinical Manager or to the hospital's Parent/Patient Advocate, as appropriate.

A letter introducing the researcher and explaining the benefits and outline of the study was used to seek written consent from all participants at the time of initial contact (Appendix A). Prior to the commencement of the interviews, written informed consent (Appendix C) to participate were obtained; permission to tape record the conducted interviews was also established. Confidentiality was maintained using a numerical coding system. The code book that contained participant records (using the paediatric patient medical record numbers only) used in the study, were kept by the researcher until the data were satisfactorily entered into the computer and analysis completed. The codebook was kept in a secure place and will be shredded after the study has been completed. Tapes of the interview were transcribed verbatim and participants were asked to verify the transcripts as being a true account of the interview. The tapes were then erased to prevent voice identification. All transcriptions would be secured for a period of five years in the Research Centre at the selected hospital in keeping with National Health Medical Research Council ethical guidelines. Participants were assured that any publications that may occur from the research will only include collective data. Also, participants were informed that when citing extracts from interview in future publications, anonymity will be

preserved.

3.3.9 In-depth Interview

The interviews were undertaken by me. Participants of the selected setting were interviewed in order to understand their point of view and to clarify discrepancies between the perceptions of participants, as well as between the perceptions of the researcher and the participants of the culture. This involved scheduled in-depth interviews with each participant. The interviews were based on the Interview Guide (refer to Appendix B), which listed several open-ended questions. The thrust of the questions were centred around parents' views on interactions with paediatric nurses during their children's hospitalisation. In addition, informal or unstructured questioning occurred during participant observation.

For example, Parent 8 stated that: *Treat me like an idiot and you'll get my back on you, I'm sorry*. When asked to clarify what she meant, she said: *...they [nurses] think that I'm up here wasting their time... I'll just shut up and not tell them anymore that I know as a parent of my child*.

This process ensured that data collection and analysis were occurring simultaneously. According to Spradley (1980), in an ethnographic study, analysis is a process of question and discovery. Analysis of fieldnotes after each period of fieldwork was necessary in order to know what to look for during the next period of participant observation. The style used for fieldnotes followed the conventions recommended by Spradley (1980).

These were the principles of language identification, verbatim and concrete recording. In verbatim recording, the precise words of the speaker were used. Concrete recording was the citations in specific detail of what was seen and heard (Streubert Speziale & Carpenter, 2003). Examples include written notes and recordings of fieldnotes and participant observations of interactions between nurses and parent.

3.3.10 Participant-Observation

Participation observation is a constant method of data gathering during the fieldwork (Spradley, 1980). According to Spradley (1980), the position of the researcher is being an insider and outsider. The term participant-observation refers to a process of gathering data through observing and talking to individuals during on-site participation. The interviews in ethnographic research may be formal or informal, structured or unstructured, but are always concerned with what individuals think themselves to be doing or the meaning they assign to behaviour. Any artefacts, such as documents or objects, are also considered in terms of the meaning attached to them and how they influence interaction within a culture (Streubert Speziale & Carpenter, 2003).

In this study, the researcher assumed the role of the participant-observer. As an insider I was part of the hospitalisation, to feel what it was like for parents. As a detached observer, however, I was separate from activities and viewed nursing practice and the nurses' personality as objects of the study. Therefore, observation occurred in the natural context of interactions

between paediatric nurses and parents with an asthmatic child. It also allowed me to be less interfering in the setting. For example, I will take a place in the play area, where I can have full view of the on-goings in the ward, yet at the same time I was not intruding into the nurses' work area and parents' space for privacy. This occurred during on-site participation in the events of the culture. Participant-observation occurred simultaneously with structured and unstructured interviews, writing of fieldnotes, and journal and memo reviews. *Fieldnotes* were notations (Streubert Speziale & Carpenter, 2003), usually documentations of my observations, such as, what I have heard, seen, thought or experienced whilst observing the social situation that became part of the data analysis. Journal entries contained a record of my mistakes, ideas, fears, mistakes, confusion, breakthroughs and problems during the fieldwork. For example, periods between December to March (Summer) had minimal participants, because the weather is warm and children do not suffer severe asthma that warrant hospitalisation, unlike the months between June and August (Winter). *Memoing* preserved emerging hypotheses, analytical scheme, hunches and abstractions (Streubert Speziale & Carpenter, 2003). It was used to sort data into cluster concepts to tie up or remove loose ends. This is usually done by means of file cards, paper or stored into computer files. These enabled a cyclical process of data collection and data analysis to occur as mentioned earlier in the chapter.

Participant-observation involved looking, listening, asking questions, and collecting artefacts within the research site. Fieldnotes were taken to

describe cultural events, with informants, and the context in which they occurred. Observations continued until the generic features of the new information consistently replicated information obtained earlier or from earlier recorded observations of data collection.

The researcher interacted non-directively with participants while engaging in observation, thus minimising the potential influence of observer effects on the behaviour of participants. In addition, no questions were asked of the informants during their interaction with the paediatric nurses. However, the role of the researcher was always made explicit to both paediatric nurses and participants in order to comply with ethical guidelines.

3.4 Data Analysis

The major tasks of this study followed a cyclical pattern, as depicted in the ethnographic research cycle by Spradley (1980). The cycle (Figure 2) begins with the selection of a research project. Data collection and analysis occurred simultaneously. Saturation of data was obtained before writing of the final report. Saturation of data implies that no new data was generated after rigorous checking and double checking of data. In this study, all interviews were transcribed verbatim and hard copies of the interviews were printed for line by line analysis to capture generic features. Subsequently, these features were typed into N6 for domain analysis.

Data collection and data analysis, although described separately, were conducted simultaneously. It was a cyclical process that occurred over and

over again until no new information was forthcoming.

Ethnography as a qualitative approach consists partly of participant observations and partly of conversation or semi-structured interview (Boyle, 1994; De Laine, 1997; Morse & Field, 1995; Muecke, 1994). The ethnographer generates meaning of the information gathered by moving back and forth between the *emic* and *etic* perspectives. According to Streubert Speziale and Carpenter (2001), the *emic* view is the participants' view (parents), which reflects the cultural group's language, beliefs and experiences. On the other hand, the *etic* view is the view of the outsider (the researcher) with interpretation as previously described in the chapter.

Both views that is, *etic* and *emic* are required to not only describe behaviour, but also to understand why the behaviour occurs and under what circumstances. This combination of insider (*Emic*) view and outsider (*Etic*) view provides deeper insights than are possible from the participants alone or the ethnographer alone (Aamodt, 1991; Boyle, 1994; Minichiello, Sullivan, Greenwood, & Azford, 2003; Muecke, 1994; Streubert Speziale & Carpenter, 2003). Morse and Field (1995) and Streubert Speziale and Carpenter (2003) define the *emic* perspective as the insider's view or the informant's perspective of reality, and the *etic* perspective as the outsider's view or the researcher's interpretations of situations and behaviours. Both perspectives are required to accurately portray and understand the culture.

However, pre-eminence is given to the *emic* perspective. The ethnographer's ideas, assumptions, questions or explanations are repeatedly

tested against observation, informant reports, and other sources of information within the culture of asthma clients and their families within the paediatric medical setting. This ensures that the data collected is grounded in the informants actual experiences. There is no procedural or sequential separation between gathering and analysing of data when conducting an ethnographic study. The process of seeking answers to questions leads to further questions (Streubert Speziale & Carpenter, 2003), until there are no further patterns or categories of meaning emerging from the data. Hence, the product of ethnography is not only a description of the culture, but also a theoretical scheme which links the analytic categories identified within the data (Tedlock, 2000).

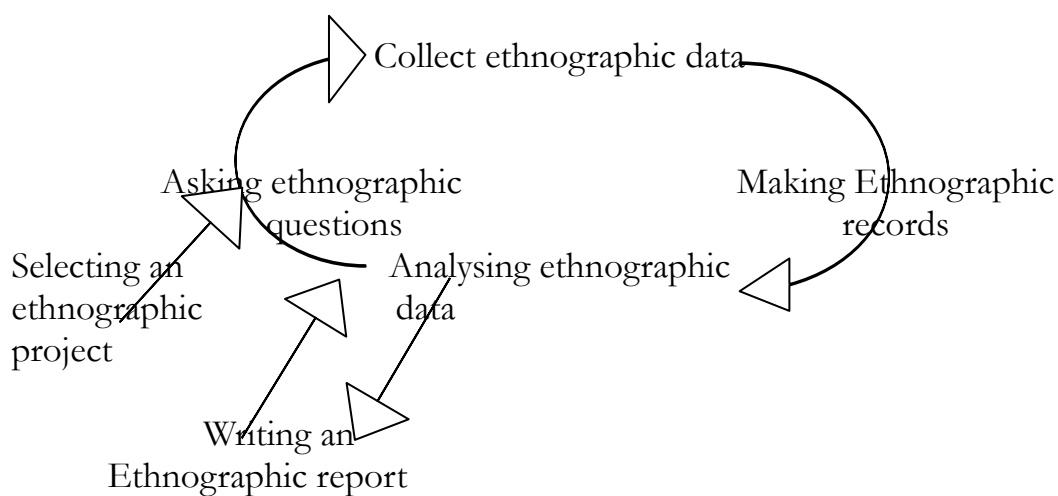


Figure 2: The ethnographic cycle (Spradley, 1980, p.29)

3.4.1 Domain Analysis

Throughout data collection, I was required to analyse data. To begin to understand cultural meaning, I must analyse the social situations that I had observed. Analysis of the social situation will lead to the discovery of the cultural scene (Streubert Speziale & Carpenter, 2003). Domain analysis involved a search for all the domains in the descriptive data to find cultural patterns in paediatric nursing. A domain was identified by exploring the unit terms used by nurses and parents and others at the site by discovering semantic relationships amongst those terms. The exploration for a domain cover terms used by participants in the written data and are preceded by a question using a single semantic relationship to the social situation (Spradley, 1980). Cover terms are the name for a given cultural domains. For example, “pre-existing trust” is the cover terms are a domain from my data on parents’ trust in nurses which was derived from participants own words.

Taxonomy signified how all the domain terms were systematically structured (Spradley, 1980). This process preceded a search for relationships among terms found in a domain. Domain terms were then sorted into subsets according to their similarities and variations in meaning. Each included term was examined for higher terms and subordinate terms. For example, ‘parental frustrations’ and ‘caring’ were clustered into ‘parental expectations’. The process of taxonomic analysis was also used to explore domains for a larger domain, such as the question, “Is this domain a kind of a something else?” N6 software was used to assist with storage and easy

retrieval of data (Richards, 2002). N6 has basically just three tools: the ‘*Coders*’, ‘*Text Search*’ and ‘*Node Search*’, which operates on two complementary sets of data, such as *the document system* which holds all the documentary data and research notes, as well as memos about these; and *the node system*, which represents all the topics and categories that matter to the research project, and memos of the researchers’ ideas about these (Richards, 2002).

3.4.2 Trustworthiness of data

Denzin and Lincoln (1994) state that terms such as validity and reliability should be substituted by words such as credibility and trustworthiness which are more reflective of the goals of this qualitative research. Furthermore, external validity which refers to the generalisability of the findings is not usually the aim of qualitative research; hence, these criteria should not be used to judge this type of research. In order to ensure rigour and address credibility and trustworthiness issues, a number of measures were tenaciously employed in this study.

Researcher objectivity was an issue of concern in this study. To ensure objectivity, the researcher documented personal values and beliefs about the research phenomenon. According to De Laine (1997) and Streubert Speziale and Carpenter (2003), to avoid bias in the data collection and analysis, the researcher (*who has current personal experience of paediatric nursing in a hospital setting*) raised awareness of their own preconceptions and bias to the topic by being interviewed by another researcher, using the proposed

interview guide (Appendix B). The researcher needed to avoid imposing her preconceptions on the data collection and analysis. To this end, interview transcripts, fieldnotes and analysed data were checked for any evidence of research bias by the researcher and an independent person well versed in qualitative research analysis to detect the presence of any researcher bias.

Poland (1995) stated that establishing trustworthiness of transcripts is an essential component of rigour in qualitative research. In particular, this author emphasised the need for the researcher to spend time listening to the participants. To achieve this, all interview transcripts were read simultaneously whilst listening to the taped recorded version. This enabled authentication of the typed transcripts and an opportunity to note any perceptible covert messages. Moreover, memos recorded on the completion of each interview were also referred to at this time.

According to Sandelowski, in qualitative research, credibility is established through authenticating the data. This authentication can occur by seeking participants' views on the researcher's interpretation of the data analysis (Sandelowski, 1993). In this study, this process was performed throughout the data collection and analysis stages. Additionally, during the field observation period, confirmation of information occurred frequently by informally discussing and clarifying issues with parent participants.

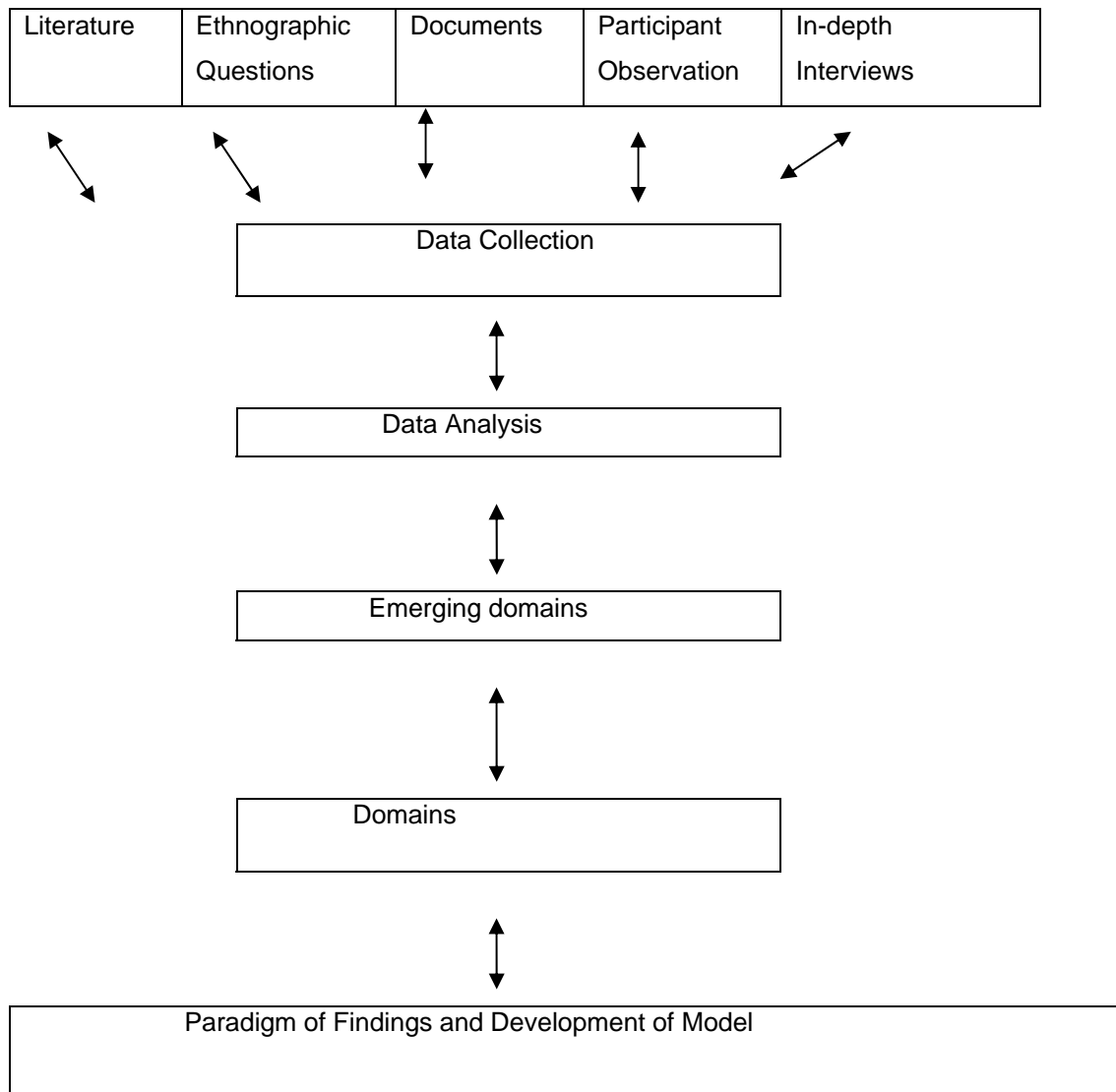
In order to achieve rigour a clear description of the study setting (context), choice of participants, and the methods of data collection and analyses have

been given to facilitate other researchers to carry out a similar study (LeCompte & Goetz, 1982). Sandelowski (1986) emphasised a need for a clear description of the study, an audit trail, in order to allow another researcher to follow the method. All these methods were employed to ensure credibility and trustworthiness of the findings.

3.5 Summary

In this chapter, the research method used in this study is described.

Ethnography which was used is explained in detail including the steps taken to conduct the study. In summary, data collection and data analysis occurred concurrently as the two processes were closely interwoven. Figure 4 below denotes the connection between data and data analysis and shows the procedural method in diagrammatic form.

Figure 4: The Connection between Data and Data Analysis

CHAPTER FOUR

FINDINGS OF THE STUDY

4.1 Introduction

In this ethnographic study, the researcher described, explored and analysed nurses' interactions with parents and their children in the paediatric medical setting. A narrative account of parent's perceptions of their child's care with respect to development of trust between parent and nurse in hospital is provided in this chapter. Six major domains emerged from the data collected during observations. These domains labelled *pre-existing trust, parental expectations, knowledge of asthma, communication, building a relationship, and confidentiality*, gives insight as to how trusting relationships between nurses and parents are formed within the paediatric medical setting.

The interactions between paediatric nurses and parents were documented during periods of observations of the day to day events in the paediatric medical ward. This method provided a useful way of exploring beneath the surface of what appeared to be everyday life of the paediatric medical setting. In the following sections the major domains are explained in detail, including the depiction of the model for development of trust in nurse-parent relationship.

4.2 Pre-existing Trust

In 2003, Thompson, Hupcey and Clark reported that pre-existing trust is related to past experiences with the hospital and healthcare providers such as doctors, nurses and ancillary staff. This link also emerged in this study, for example:

... The majority of them [nurses] I've come across a few in the last eight, nine years. Because I've been here with my other children majority of them are fine and I would say that I can trust them, 10 on 10 (Parent 8).

We've been learning for four years since ... we quite often come to see an asthmatic liaison officer,... and whenever we have any doubts about anything at all we always come up here [hospital] ... I know that he can come up here and he'll be fine (Parent 5).

Pre-existing trust is also a by-product of the hospital's community reputation, past experiences with the healthcare organization, and confidence in the physicians to make accurate selection of treatment for their child (Thompson, Hupcey, & Clark, 2003).

Two parents had this to say with regard to knowing when to trust the paediatric nurses caring for their children:

... You pretty much sort of trust them [nurses] without knowing, just by coming in here. You sort of need to trust them I suppose ... I actually feel confident leaving the hospital at night whilst she's in here. I've left here at night, I've gone to work, I've done all that ... I know the nurses are looking after her... (Parent 6).

... If they [nurses] come in looking like they just do not want to be here, you're not gonna bother them, you'll deal with it yourself... You can sort of know that you can leave the room that they [nurses] are still going to be there ... (Parent 9).

For these parents their intuition helped them to judge if they could trust the nurses caring for their children. For example:

Parent 6 left her child in the cot while she did the interview for this study. When asked if she would like to bring her child along, she stated that the nurses will take care of her if she starts crying [Fieldnotes].

The above statement infers that Parent 6 had used her intuitive knowledge that her child would be cared for if she was not by her child's side. She had utilised her 'gut-feeling' of knowing that she could trust the nurses in the ward.

The implications of this for nursing are that, paediatric nurses have to be able to foster this intuitive feeling as much as possible for parents to both trust them, and to be certain that treatment and care will be given to their children even when they [parents] are not able to be by their children's side.

4.3 Parental Expectations

Interactions with parents are an integral consideration in the practice of paediatric nurses. The amount of time and energy that paediatric nurses spend relating to parents and their children can sometimes be taken for granted. The situations that highlight the value of paediatric nurses are those when something unusual happens, which hinders the relationship, and which exposes a situation that is generally taken for granted, such as parental expectations. For family members, trust involves risk taking because there is a possibility that paediatric nurses will not provide the required care. Hence, when expectations are not met, mistrust occurs between parents and nurses. The following quote support this notion.

It appears that meeting parental needs, most of which related to expectations regarding the care provided to their child, is a powerful intervention toward establishment of a trusting relationship with staff.

(Thompson, Hupcey & Clark, 2003, p.139)

Similarly, the findings from this study revealed that parental expectations are an important component of parent –nurse relationships. Some parents

beheld positive views of the nurses with whom they interacted. Their confidence in the day to day management of their child's illness was grounded in the decisional support and inclusiveness they received from the paediatric nurses. For example, one parent stated:

... they are excellent, the nurses here are wonderful. They really are. I haven't had a problem with the nurses. They [nurses] know exactly what to do (Parent 5).

Furthermore the following fieldnotes demonstrates the decisional support parents received from nurses. Particular example of how the mother's input is invited by the nurse is evident in these fieldnotes:

Nurse A: Would you like to have some Vegemite on toast?

You did not have much for your lunch.

Child: [looks at nurse and mum] No. (shaking his head)

Nurse: it would be good to have something to eat because you need to grow strong before we can allow you to go home and go to school to play with your friends.

Mum: Well, she's right my son (patting her child). I can go to get you a sandwich from the canteen if you do not want

Vegemite on toast.

Child: I'll have Vegemite then.

Mum: Smiles.

Nurse: Okay. I'll go make some now and be right back.

Overall, parents shared negative and positive experiences of interactions with nurses. For instance, one mother reported:

Everytime I had to give him his neb, he screamed like murder when I gave him his neb I knew that something was not right...It wasn't until I had to complain about four times before they [nurses] finally called up ICU the intensive care unit and a lady came down from the intensive care and the first thing that they [nurses] did was actually put him on the oxygen. It didn't matter how many times I had said I know my child and this is not right ... (Parent 1).

This above comment demonstrates this parent's perception that the paediatric nurses were not listening to her and this may have impacted negatively on the relationship between the nurse and the parent as shown in the fieldnotes below:

Mum takes baby everywhere she goes, even to the restroom. Mum does not let nurses administer the nebuliser for her child. Mum takes over (Parent 1) [Fieldnotes].

... I'll just do this myself. Sat up grabbed my son and put him on my lap and actually went to hold the nebuliser. It's like give it to me I'll put it on him (Parent 1).

This mother was clearly taking responsibility for her child's care without wanting the nurses' help. This mother's decision and consequent actions may have implications with respect to the development of a trusting relationship between parent and nurse.

Subsequently, the above Parent 1 walked out of the ward in anger, as she felt that no one was listening to her. As a result of this event, the parent rated six out of ten in the level of trust on the question guide (refer to Appendix B). The scale of zero to ten, zero being no trust in the nurses and ten highly trusts the nurses. This parent had not turned to anyone to talk about her unhappiness, because she felt that the nurses were probably being biased due to the fact that she smoked as highlighted by this comment:

... Sort of I guess I hadn't been quite really happy about. Maybe they think that I'm a young mum who is not good at child-rearing skills, or maybe because I smoke or something... they don't think that I've been a responsible mum, well you know to quit for the sake of my child's condition (Parent 1).

For this parent, her level of trust in the nurses reduced significantly as a result of her perception of receiving inadequate support for managing her child's illness. Furthermore, it was clear that the parent was stressed about her child's reaction, resulting in the parent's perception of the nurse not

connecting with the child and causing stress for the parent.

From the above comments, it may be inferred that there was clearly a power imbalance between nurses and parents. For example, even though the parent was cognisant of the need of the nurse's help she defied and choose not to.

Another mother added,

Really the ones who look at me like I don't know what I'm talking about. You get a sense of feeling that they think that you're up here wasting their time (Parent 8).

Parents initiated contact with nurses but reported that the information they received often was not helpful and sometimes, from their perspective, was delivered in a disrespectful manner. For example, Parent 1 and Parent 2 commented:

I think he needs to go back on the oxygen and I got told no... And it wasn't until ... I had to complain about 4 times before they finally called up the IC... it wasn't until 4 o'clock that morning that he finally got put on the oxygen, it was like all night it's me saying, I think he needs oxygen, I think he needs oxygen and he was on oxygen for 5 to 6 days afterwards ... I said I can't do this anymore, I said if you just want to give him more nebs I said you can do it yourself... (Parent 1).

Some of the nurses here say, I don't really know, you have to ask the Dr, feedback from Drs. They always have an answer. I have actually asked some nurses, they would ask me to speak to the Dr... (Parent 2).

As a result,

Parent 1 puts child in stroller everywhere she goes, ie, toilet, smoke breaks and meal times [Fieldnotes].

Parent 1 also has minimal contact with paediatric nurses. Speaks to them [nurses] only at nebuliser times. Sometimes, not at all [Fieldnotes].

Parent 2 waits patiently for doctor's round each day to ask questions about their child's treatment regimen and current well being [Fieldnotes].

Furthermore, these parents lost trust in nurses which was manifested by their decreased attempts to seek help from the nurses. The parents were particularly concerned when, as dependent decision makers, they desired direction but believed they did not get it from nurses. According to Lynn-McHale and Deatrck (2000) and Thorne and Robinson (1988) families need to feel that nurses regard them as competent and intelligent parents before

they can trust nurses. Non-judgemental treatment is necessary for trust to occur (Lynn-McHale & Deatrck, 2000).

On the other hand, there were parents in the sample who would leave their child entirely in the nurses' charge as shown by these fieldnotes:

Child 6 is left in the ward by herself most of the day. Nurses take care of the child's needs and treatments [Fieldnotes].

Mum visits in the morning before work for an hour, then in the evening till child goes to bed [Fieldnotes].

Mum gave the child a bottle and secured her in the cot and said to the researcher: "the nurse will look after her if she needs anything. We can go for coffee at the canteen and do this interview" [Fieldnotes].

These parents reported positive opinions of the nurses in charge of their child's treatment. The parents would go to work, take other children to school, instead of being with their child's side in hospital at all times. This demonstrates a positive trusting relationship between parent and nurse.

4.4 Knowledge of Asthma

Parents will inevitably come into the hospital with a set of expectations of the nurses caring for their child, such as professional education and

experience in this nursing speciality. Information from parents is important as they are the ones who know their children. Although parents are not medically trained, ultimately they do intuitively know what their children need. To gain parents' trust it is important for paediatric nurses to respect the knowledge that parents have of their children, as well as giving support to parents' decisions.

Asthma is the most common chronic illness in children and has a significant impact on children and their families (McCarthy, Herbert, Brimacombe, & Hansen, 2002; Mutius, 2000; Ordonez, Phelan, Olinsky, & Robertson, 1998). Quality of life for families is frequently compromised by changes in the home environment, sleepless nights and absence from work, increased financial demands, increased emotional stress and uncertainty (McCarthy et al., 2002). In keeping with the findings of Kirschbaum and Knalf (1996), many of the parents who participated in current this study agreed that professional knowledge in the treatment of asthma played a significant role in building trust in the nurse-parent relationship. Two parents revealed:

The nurses have more of an idea of what's going on than a lot of doctors and all that I think it's because the doctors, a lot of them [doctors] have come through with a bunch of students and they are more worried about educating the students then helping the patient ... (Parent 9).

... you would like the nurse to give you an honest feedback on

how he [child] is doing ... giving you a definite answer of what they think is wrong ... the feedback you get from them is important [nurses] ... (Parent 2).

Parents have a strong need to trust the nurses caring for their child.

Paediatric nurses are expected to provide professional care for their child with continuity of nursing care. Parents require information exchange that is honest and anticipatory in order to establish a trusting relationship with nurses.

The majority of the parents interviewed entered into the hospital environment in the hope of finding professionals who can give them accurate information and provide immediate treatment for their child (Thompson et al., 2003). For example, two families were able to specify the characteristics of an effective paediatric nurse from their viewpoint.

A professional, know her [nurse] work well, know her patients well, educated, as they have been to university, has been working with children for quite a while, knows the asthma thing. If you're not professional in your work, caring would not be there ... (Parent 10).

Experience, knowledge ... a degree, how long they [nurses] have been working here ... five to six years, knowledge quite high, tend to trust these nurses more ... (Parent 2).

Because we have come to so many close shaves it's a matter of on the spot decision on what to do, I mean we have come to pretty close to him collapsing so she's [nurse] got to be on the ball, you know, be there when it happens, ... she [nurse] need to be on the ball all the time. It's something you cannot muck around with... when you know what you're doing, you understand the condition of being an asthmatic, you are there when someone needs you, basically just knowing what you are doing ... (Parent 5).

From the above statements, it may be inferred that it is important for nurses working within the paediatric medical setting to keep abreast of professional skills and disease knowledge. As reported by Thompson et al. (2003) and Thorne (1993) and confirmed by the above examples, families evaluate nurses' competence by technical skills, clinical reasoning, and expert practice such as calling the child by name and speaking to the child at a developmentally appropriate level. The new generation of parents are well informed by knowledge available through media such as the internet and television (Risk & Petersen, 2002). Paediatric nurses need to demonstrate competence in order to enhance the nurse-parent relationship of which trust is an essential component.

4.5 Communication

Paediatric nurses can help parents view involvement not as all or none, but as a process that evolves over time and involves shared responsibility or collaboration throughout the child's hospitalisation period (Thompson et al., 2003). As a prerequisite to involvement, paediatric nurses need to communicate clearly with parents so that they can understand the decisions to be made, their outcomes, alternatives and associated uncertainties.

By communicating with parents, paediatric nurses not only teach parents about the illness and the decisions to be made, but take on board parents' knowledge of their child's usual wellbeing. This provides parents with a sense of control and disease management. This is highlighted by this parent's comments:

One thing which I really did like about when another nurse come on shift, the nurse taking over, they would come in and explain about the child, this is what's going on with this babythis is what's happening and explaining, I really like that ... (Parent 1).

This parent added:

... trusting a nurse I guess it all depends on if they listen to what you're saying not just like you say something and they brush it off. Like they listen to you and they can consult with

you more when they come in to do things to the babies

(Parent1).

Dixon (1996) supports this parent's perception. In her study, she found that parents' appraisal of providers' trustworthiness and their conscious decision to trust the professionals who were caring for their children were based on the assumption that professionals would interact with them in a positive, reciprocal manner. Additionally, reducing parental stress and increasing trust by providing parents with information, and reinforcing parents' beliefs that their parenting skills are still valuable during the child's hospitalisation, will also promote the establishment of a trusting relationship between parent and nurse (Thompson et al., 2003).

Parents in the study stated that effective communication was crucial between themselves and nurses in order to provide optimum care for their children. For example:

I try to communicate as much as I can with the nurses. The nurses here I've known from when Bob was a baby. I try to help them as much as possible and they can do the same for me ... they need to listen to me ... as in I'm the one who knows exactly what happened, when it happens and what's wrong with him and then between us we can work out what to do, exactly what his symptoms are but we need to work together... (Parent 5).

Probably on how they [nurses] feedback, probably that's more important. Because you want to know...they have assessed your child' condition...you would want to get a feedback there and then...don't have to ask...because they should know that that's why you stay in here, because you're very concerned about your child and you would want them to tell you whatever condition the child is in ... (Parent 3).

When nurses just provide physical care for their child without interacting with the parent and explaining what they are going to do with the child, parents perceived they could not trust the nurses. For instance:

I probably don't have as much faith in the ones [nurses] who just come in and just go ahead without saying what they're doing (Parent 7).

If she [nurse] comes in and introduces herself ... how they communicate with me or my family, playing with my child. Some of them just come in and do their thing and they're off ... (Parent 4).

When you know your own child, they [nurses] really need to listen to me as a mother. As I've said, I don't come up here unless I can't get it under control! [asthma] (Parent 8).

These comments from parents indicate that it is important for all paediatric nurses to communicate with both child and parents to gain a good working relationship within the paediatric medical setting. In order for partnership-in-care to occur, nurses must treat parents and child as unique individuals. Differentiating between their [parents] perceived needs is an important way to help establish partnership with each individual parent (Darbyshire, 1994).

The above examples revealed that if paediatric nurses do not communicate with the parents, they [parents] would not ask them [nurses] for help when needed or have faith in their [nurses'] ability to care for their child adequately. Taking time to listen and communicate has been recognized as a fundamental necessity to building trusting relationships between parents and paediatric nurses (Lynn-McHale & Deatruck, 2000).

Seeking and obtaining information from paediatric nurses has been identified as important precursors to developing trusting relationship with nurses for parents with asthmatic children. Nearly all of the parents who participated in the study stated that it is important for nurses to utilise their active listening skills. This concurs with the findings of with Lynn McHale and Deatruck (2000) and Thorne (1993) who reported that in order for paediatric nurses to gain trust and develop trusting relationships with parents they need to get to know the parent, which involves sharing personal information and stories about their children.

4.6 Building a Relationship

Paediatric nurses who focus on the physical care of the child and do not reach out to interact meaningfully with the parent or child, will not be able to build a relationship (Price, 1993). Getting to know the child as a person rather than a patient is another aspect of developing a trusting relationship with both the children and their parents (Bricher, 1999). Building trusting relationships with children is achieved through the nurses' use of appropriate language, engaging in games and play, adequately preparing the child for procedures, and providing explanations for both the child and parents, as well as encouragement for the child (Crole & Smith, 2002). This is supported by these quotes from other researchers in this area:

Of particular importance in whether trust was established were the professional's efforts to develop a personal relationship with the child

(Dixon, 1996, p. 116)

Relationships with children are grounded on a valuing of humanness of the child, but nurses also share part of themselves...putting a chink in the professional armour and showing they're a real person (Bricher, 1999, p.453)

In this study two parents shared these views:

I probably don't have as much faith in the ones [nurses] who just come in and just go ahead without saying what they're doing. So I definitely prefer them [nurses] to say what they're doing and why they're doing, that sort of discussions... the way they speak to him, their tone of voice has a lot to deal with and you can definitely see with my boy, the way of responses from the nurses too ... he got a stranger danger...the first approach the nurse have with him, sort of the way they walk and look at him...then the way they speak to him, and then the way they actually sort of handle him as well... (Parent 7).

how they [nurses] communicate with me or my family, playing with my child...But there's others [nurses] who really try to get him comfortable with them before the puffer of something, I tend to trust them more ... (Parent 4).

On another occasion one parent witnessed the following and had this to say:

this little one was left on her own and the nurse just stopped what she was doing with everything else and went and sat there and sort of trying , playing so that babe was happy. That was so good ... you could see ... gives it a good

atmosphere ... (Parent 9).

Interventions implemented to meet a child's special needs made the parent feel really at home and comfortable. This paediatric nurse has given the above parent the reason to believe and trust in the nurses caring for her child. These observations indicate that parents observe and evaluate the happenings of the ward, and such evaluation includes an assessment of the procedural competence of nurses and whether the needs of the parent and child are ultimately met. With these interactions, the actions of the paediatric nurses can facilitate or hinder the development of trust in the parent-nurse relationship.

The findings showed parents watched, evaluated, formed impressions, asked questions and checked credentials as part of their continuing evaluation of paediatric nurses' capacity to be trusted. Parents' vigilant observations of the on-goings of the ward are tools they used to determine nurses' trustworthiness. Hence, nurses' approach with children is crucial to gaining parent's trust.

4.7 Confidentiality

In an exploratory study by Day and Stannard (1999), the authors described confidentiality as a hallmark of trust. Their report is supported by the Code of Ethics for Nurses in Australia, section 4.3.:

Section 4.3

Nurses protect persons in their care against breaches of privacy by confining their verbal communications to appropriate personnel and settings and for professional purpose (Code of Ethics for Nurses in Australia, 2002)

Parents in this current study described these characteristics as essential to a trusting nurse-parent relationship. This is supported by the following comments from one parent:

I suppose if I heard them [nurses] talking about stuff, they shouldn't be talking about with people, they shouldn't be talking with obviously, they've got to talk to other persons, or doctors or staff like that about stuff. But if you heard them talking to other parents or other nurses that aren't supposed to be in the ward that would sort of get me a bit ... (Parent 6).

Nursing practice is socially embedded in the sense that it is organised around relationships with other people. Paediatric nurses need to respect autonomy and veracity with care and be sensitive to the needs of individual parents and their children as reflected in this quote:

Respect includes the development of confidence and trust in the relationship between nurses and the people for whom they care (Code of Ethics for Nurses in Australia, 2002, p.3)

4.8 Nurses' Behaviours and Trust

Results of direct observations undertaken on the ward revealed that throughout their children's hospitalisation, parents had continued interactions with members of the hospital staff, including physicians, residents, nurses, and ancillary personnel. Through these interactions parents continuously evaluated care and whether their needs and those of their child were being met. During these interactions, there were behaviours on the part of the nurses that either facilitated or inhibited the development of trusting relationships.

4.8.1 Behaviours Facilitating Trust

Certain behaviours on the part of paediatric nurses were observed that seemingly facilitated trust. Friendly paediatric nurses who appeared caring were very important to parents. Paediatric nurses who tried to build a rapport with parents by asking personal questions about the child and taking their time to explain information in a timely manner were also regarded as a facilitating behaviour. This process was greatly enhanced by continuity in the nurses caring for the child. Other positive nursing behaviours included personal introductions by all nurses caring for the child, evidence that nurses knew the limits of their skills and sought appropriate help, including parents as team members, and assessing and meeting parental needs. These parents commented:

One I can go to and complain to when Drs won't give me a fair go ... [laughs] one I feel comfortable leaving my kids in their hands (Parent 8).

... someone [nurse] who would give me an honest feedback or answer, it's one of the most important things, because they are dealing with kids, they [children] cannot explain to you why and what's wrong with themselves I would like the nurse to give me an honest answer (Parent 2).

Somebody [nurse] that's approachable, someone [nurse] that doesn't matter if I say that I need help, for example she [child] has just vomited (Parent 9).

4.8.2 Behaviour Inhibiting Trust

Behaviours that inhibited the development of trust included behaviours that appeared to make the nurse appear uncaring. Not listening to the needs of the child and parent and not getting to know the child and parent were inhibiting behaviours. Another negative behaviour was the nurses not making it easy for parents to be with their child by providing things like appropriate sleeping accommodations for the parents. One parent discussed her displeasure:

... between where my son was going to sleep and where I was going to sleep ... they put him in a cot and I said he can't

really go into a cot because he likes someone to lay down with him. They [nurses] said: “well, we can put up a fold up bed for you out in the corridor.” I replied that that’s not much good when every 15 minutes he’s got to have a nebuliser ... So like there have actually been a few things which I am sort of not quite really happy about (Parent 1).

4.9 Test Model for Development of Trust in Nurse-Parent Relationship

Nursing remains an interactive process, irrespective of where it is practised. For this interactive process to succeed, there is a need for the nurse, client and significant others to interact in a professional and therapeutic manner. The establishment of a trusting relationship with patients and their families is a key therapeutic intervention of paediatric nurses, as parents play a critical role in the social and emotional support of hospitalised children. The key domains identified in this study were *pre-existing trust, parental expectations, knowledge of asthma, communication, building a relationship, and confidentiality*. These domains are depicted in the developed test model (Figure 5) and will be discussed with respect to existing literature and theories on trust development in the following section.

The test model for development of trust between parents and paediatric nurses is acyclic nature. The reactions reciprocated from parents are very much dependent on the paediatric nurses’ actions. This model has been influenced by the Sunrise Model of Cultural Care by Leininger (1991) and Spradley’s (1980) ethnographic cycle. As the model has not been previously

tested, it remains a test model until further research is conducted using the model. Nevertheless, the model is a useful tool in further exploring the important development of trust between paediatric nurses and parents of sick children.

The test model depicting trust in nurse-parent relationship illustrates how paediatric nurses can affect parents' attitude towards the entire experience of their child's hospitalisation. As paediatric nurse allow themselves to show parents that they [nurses] meet their [parents'] expectations; are considerate towards parents' situation; acknowledges parents' knowledge of illness; communicate effectively with parents and child; as well as confidentiality, positive outcomes such as parents having faith in nurses, parental satisfaction, parents participating in care, parents feel comfortable with care and parents feel comfortable with nurses caring for their child and parent's respect for nurses. These facilitating behaviours from the paediatric nurses create facilitating factors from parents, which in turn assist in building trust in the nurse parent relationship.

On the other hand, when paediatric nurses do not show the qualities depicted in the model, a lack of development of trust between parents and nurses occur.

The positive sphere in the test model is made up of six blue parts which reflects the paediatric nurses' ability to demonstrate skills of understanding parental needs, keeping client confidentiality, good communication skills

that helped build rapport between themselves and parents and child. With these skills, the paediatric nurse(s) gains parents' faith, encourages parental participation in care with parents feeling comfortable with care, parent feeling satisfied and earning the respect from parents. The blue arrows depict the two way flow and cyclic behaviour reciprocated by parents, which in turn facilitates trust in the nurse-parent relationship.

The negative sphere in the test model is made up of six mauve parts across the diagram. It illustrates the unattainable development of trust when paediatric nurses do not show parents the skills required in the positive sphere. Again, the orange arrows portray the cyclic inter-relation of behaviours inhibiting trust in nurse-parent relationship.

The model has an interactive focus. The test model (Figure 5) indicates by the use of arrows that there is a dynamic relationship between the parent and the paediatric nurse. When in the positive sphere, strategies are implemented that develop trust and the relationship is secure, however, as can be seen in the negative sphere factors are depicted that evade trust.

4.10 Summary

From this study, information has been gained which gives insight into the development of trusting relationships between parents and paediatric nurses. The elements identified as being vital to the development of trust between parents and paediatric nurse have been labelled, *pre-existing trust, parental expectations, knowledge of asthma, communication, building a relationship,*

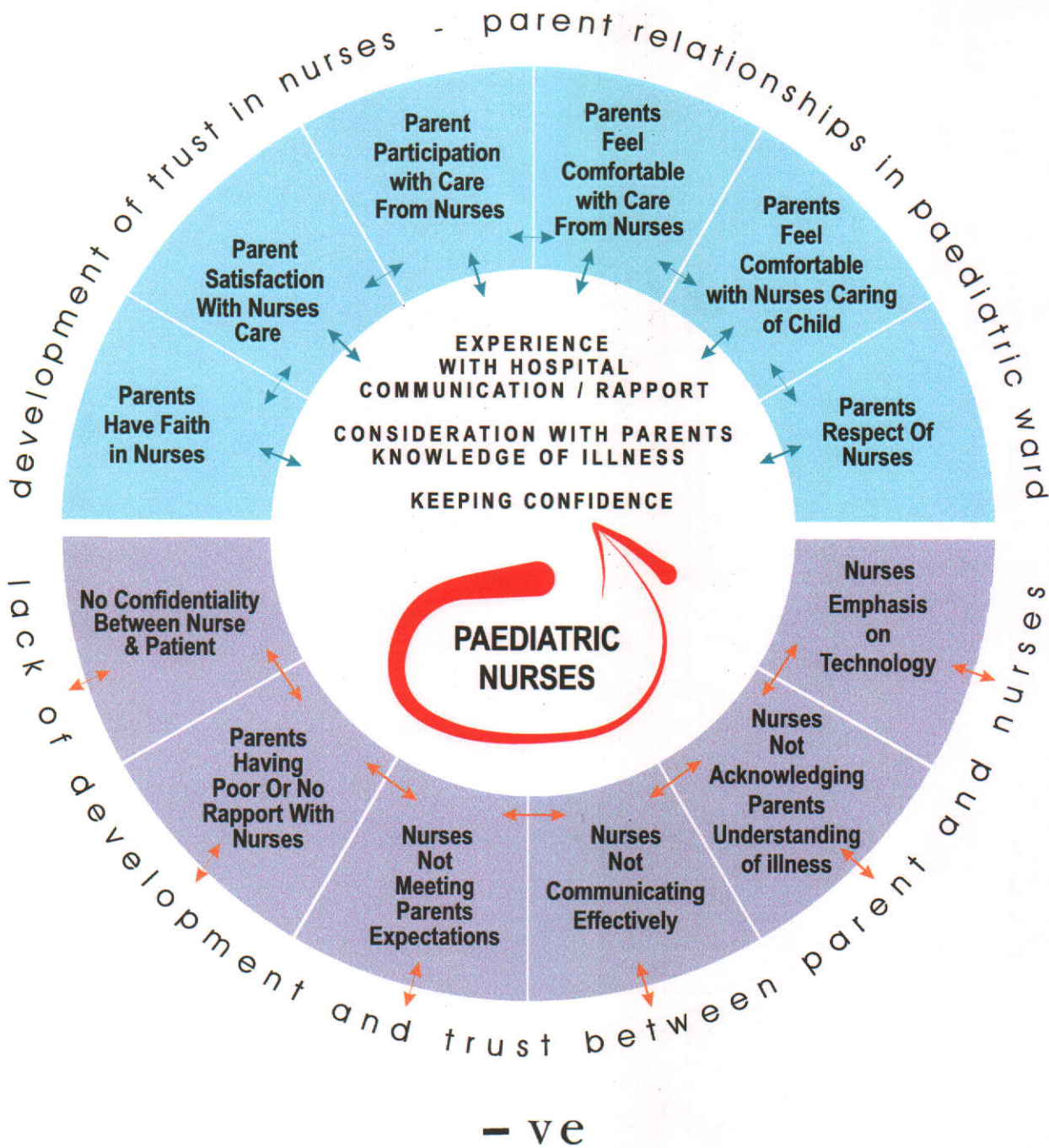








Figure 4: Test Model depicting the development of trust between parents and paediatric nurses

LEGEND	
	Positive Sphere = Facilitating factors to trust in nurse-parent relationship
	Circular Arrow = Facilitating behaviours of Paediatric Nurses
	Arrows Upward = Paediatric nurses demonstrating facilitating behaviours
	Arrows Sideways = Inter-relation of Facilitating Factors to trust in nurse-parent relationship
	Negative Sphere = Inhibiting Factors to trust in nurse-parent relationship
	Arrows Sideways = Inter-relation of behaviour inhibiting trust in nurse-parent relationship

and confidentiality.

Interactions between parents and paediatric nurses have been found to be integral to paediatric nursing practice. Parents beheld either positive or negative views of the nurses with whom they have interacted. When expectations are not met, mistrust occurs between parents and nurses.

Parents may not have medical or healthcare knowledge nor recognise what their children may need. Regardless, a trusting relationship can only be built when paediatric nurses respected the knowledge that parents have of their children, and support to parents' decisions.

Communicating with parents provided paediatric nurses the opportunity to teach parents about the illness and the decisions to be made. It also allowed paediatric nurses to take on board parents' knowledge of their child's usual well being. This process gave parent a sense of control and disease management.

Getting to know the child as an individual rather than a patient was another facet of developing a trusting relationship with both children and their parents. Paediatric nurses' choice of appropriate language, engagement in games and play, adequate preparation of the child for procedures, provision of information for both child and parents plus encouragement for the child, can help to facilitate trusting relationships with children and their parents.

Pre-existing trust was related to past experience with the hospital and the healthcare providers as well as the hospital's reputation in the community. Lastly, matters of confidentiality as supported by the Code of Ethics for Nurses in Australia had been recognised as essential to developing trusting relationship between parents and paediatric nurses.

This study provided information about the development of trusting relationships in nurse-parent relationships within the paediatric medical setting, with regards to children hospitalised with asthma. The results of this study can be used to identify strategies that will enhance the development of trust in nurses by parents of hospitalised children.

The data uncovered in this study has facilitated a deeper understanding of the factors that influenced parents to trust paediatric nurses caring for their children in the paediatric hospital. This study provides a way of exploring beneath the surface of what appears to be everyday life of the paediatric medical setting. This ethnographic study has also revealed some factors that can inform curriculum for the preparation of paediatric nurses, for paediatric nursing in the paediatric medical setting. Interactions between nurses and parents have proven to be critical to trusting relationships in the care of children with asthma as indicated in the findings.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

This ethnographic study examined the development of trust between parents and paediatric nurses in a paediatric medical setting. It is envisaged that the findings from this study will be a stimulus to further broaden enquiry into the development of trusting relationships between nurses and parents in the paediatric medical ward setting. In this chapter, the findings of this study and development of the test model will be discussed in relation to existing literature, other theories and their models. Furthermore, the implications of the study and the significance of its findings for paediatric nursing practice will be discussed. Further research will be proposed to explore more fully some of the basic issues identified in this study relating to professional paediatric nursing practice. Finally, further future research on the test model will be recommended.

5.2 Pre-existing trust

The findings in this study demonstrated the salience of pre-existing trust of parents prior to hospitalisation.

This concurs with the findings of Hupcey, Penrod and Morse (2000) and Hupcey, Penrod, Morse and Mitcham (2001) who found that trust depended on another person based on the congruence between the expected and actual behaviours of the trusted person. Paediatric nurses need to demonstrate

appropriate strategies to promote the development of a trusting relationship between themselves and parents of the children for whom they are caring.

From the results of this study, it was found that a trusting relationship between parents and nurses can have a positive impact on the child's treatment outcomes. This finding corresponds with studies by several authors. Hupcey et al. (1998) discussed trust within the context of the nurse-family relationship in relation to the families of adults in the intensive care unit (ICU), but factors related to the development of trust in parents of hospitalised children have not been fully explored. Thompson et al. (2003) conducted a grounded theory study of fifteen parents of children previously hospitalised. The purpose of their study was to address this void by interviewing parents of children who were patients in a tertiary care hospital, to investigate the development of parental trust in the paediatric nurses caring for their hospitalised children and found that vigilance and lack of trust did not go together.

Prior to a child's hospitalisation, pre-existing trust may be present if parents are familiar with or have had previously good experience with the hospital or if they already have confidence in the healthcare providers. Care of their child is once again evaluated by parents with every interaction with the healthcare providers, such as doctors, nurses and allied health professionals. This evaluation includes an assessment of the technical competence of the healthcare providers and whether the expectations of the parent and child are met. Parents also use their intuition to help them judge if they could trust

the nurses caring for their children.

These findings have been incorporated into the test model for development of trust (Figure 5) which clearly demonstrates on the positive side of the circle that parents' prior experiences with the hospital needed to be reinforced by the paediatric nurses caring for their child. When the pre-existing trust is enhanced, it leads to the development of other feelings such as satisfaction and respect for the paediatric nurses caring for their child. This in turn is critical to the development of trust in a nurse-parent relationship when the child is subsequently re-hospitalised.

5.3 Parental Expectations

An effective partnership between parents and paediatric nurses occurs when paediatric nurses show consideration for the parents' unique actions and feelings and supporting parents in the care of their child with asthma. The role of being a parent of an asthmatic child is a very demanding. The situation of having a child hospitalised involves feeling anxious, alone, sad, and powerless. Nevertheless, the situation also involves feelings of hope, trust and acceptance. For parents, trust involves risk taking because there could be a possibility that nurses will not provide the desired care.

In this study, parents who beheld good opinions of the nurses responsible for their child's treatment, would go to work, take their other children to school, instead of being at their child's bed side in hospital at all times. This is illustrated on the positive sphere of the test model for the development of

trust (Figure 5) in the nurse-parent relationships. When paediatric nurses show that they acknowledge parents' knowledge of the illness and the care involved, positive reactions are reciprocated from parents.

Partnership-in-care between parents and paediatric nurses may be enhanced when parental expectations are met throughout the children's hospitalisation (Thompson et. al. 2003). Therefore, it is deemed important for paediatric nurses to understand that the parent-child relationships provide them [parent and child] with unique needs and concerns. When children are hospitalised, parents go through stressors such as the strange sights; sounds of the hospital environment and the unfamiliarity of the procedures performed. Parents also need to cope with their child's changed behaviours, the need to effectively communicate with staff, the need to maintain a meaningful interpersonal relationship with staff and the need to receive support for their parental role during their children's hospitalisation.

However, this can only be achieved by the development of a sound trusting working relationship between parents and paediatric nurses. Therefore, it is important for paediatric nurses to consider the factors depicted in the test model of development of trust. As indicated earlier these factors are interpersonal skills, empowerment, confidentiality and maintaining the reputation of hospital. The results of this study also showed that when parental expectations were met, the nurse-parent relationship was strengthened with trust. On the other hand, when parental expectations were not met, parents lost trust in the nurses. As a result of this decline in their

trust, the parents decreased their attempts to seek help from the nurses. This observation is consistent with findings from Hupcey, Penrod, and Morse (2000), Hupcey, Penrod, Morse and Mitcham (2001), Meyer, Snelling, and Myren-Manbeck (1998), Scott (1998) and Thompson et al. (2003), who all reported that meeting the needs of parents has been shown to enhance trust. These earlier studies also reported that trust may be decreased or lost when parental expectations are not met.

In this study, parents stated that they initiated contact with nurses but reported that the information they received often was not helpful and sometimes, from their perspective, was delivered in an inappropriate manner. Furthermore, some parents lost trust in nurses which was manifested by these parents' decreased attempts to get help from the nurses. The negative sphere of the test model (Figure 5) demonstrates the reason for the lack of development of trust in the nurse-parent relationship. For example, when paediatric nurses do not communicate with parents, empowerment and rapport building could not take place. As a result, parents do not trust paediatric nurses caring for their child and possibly lose faith in hospital.

5.4 Knowledge of Asthma

In this particular study, both parent and paediatric nurse were found to share the main responsibility for the everyday life and care of the asthmatic child. Similarly, Jerret and Costello (1996) found that parents of children with asthma adjusted themselves to the children's disease and thus gained control

through different phases of power and control viz: (a) being out of control; (b) being involved and (c) being in control.

5.4.1 Being Out of Control

In this current study, witnessing the symptoms in their child for the first time was a period in which parents felt out of control. Attempts by parents to use remedies such as administering cough medicine and spending the night trying to settle their child into bed, only gave temporary relief for their child's breathing difficulties. These uncertainties surrounding the reason for symptoms placed parents in a vulnerable position. As parents sought medical help, their anxiety, frustration and confusion were often increased rather than alleviated. These feelings are reflected on the negative sphere (Figure 5) in the mauve section of no rapport, leading to the lack development and trust between parent and paediatric nurses.

5.4.2 Being Involved

This study revealed that the acknowledgement that their child had asthma provided parents a place to start getting some normality back in their life. Being involved included acquiring skills related to asthma management – learning the tasks and activities that control, minimise, or prevent the occurrence of an asthma attack (Jerret & Costello, 1996). The acquisition of skills for parents symbolised the acknowledgement of the child's illness and the demands it placed on parents. According to Jerret and Costello (1996), there were three strategies that parents used in learning the work of asthma management: (1) Searching out for information of the disease, the

medication and the treatments; (2) Trying out: parents put information into perspective as they carried out the tasks related to peak flows, administering medications, inhalations and treatments. Parents mastered what was effective and what was not by trial and error. (3) Making lifestyle changes: Families' normal repertoires of behaviours were reconstructed to accommodate the asthma management. These parents recognised the importance of the environment because it was the context in which asthma was often triggered. New rules such as no smoking in the house were implemented to control the asthma. This is depicted in the positive sphere (Figure 5) in the blue section of parent participation with care, which leads to the development of trust in nurse-parent relationship.

5.4.3 Being in Control

The transition to this phase was defined by the stability that came from the realisation that there was still some predictability to family life; that there was a routine that worked for them. This finding concurs with Jerret and Costello (1996) study. These authors found that at this stage, most parents had learnt how to manage their children's asthma; acknowledge their level of confidence and capabilities. The strategies that enabled them to sustain and accommodate the asthma management were taking charge, developing alliance with the child, and being competent. As shown on the positive sphere of the test model, a parent who participates in care can experience feelings of parental satisfaction with care and having faith in nurses.

The ability to access information about their children whenever the parents needed, being given information about their children's care and the information being consistent have been identified as vital to building a trusting relationship between parents and paediatric nurses, which in turn is critical towards partnership-in-care (Darbyshire, 1994). Moreover, this author reported that failure to provide information such as adequate orientation to the ward and its routine for parents, for example, where things are kept in the ward for the care of their child, and details of their child's care are facilitating factors on the development of partnership-in-care between parents and paediatric nurses.

The majority of the parents in this study responded positively and agreed that trusting relationships between themselves and the paediatric nurses were established when their children were hospitalised. The results of this study also emphasized the importance of good partnerships between parents and paediatric nurses, where the paediatric nurse showed consideration for the parents' unique action and feelings and understood and supported parents in the care of their child with asthma. This is reflected in the findings of Englund, Rydstrom and Norberg (2001) and Kurnat and Moore (1999) who reported the need for the development of an effective partnership between parents and paediatric nurses. This partnership involves the nurses' knowledge of the disease process and its treatment, and the importance of nurses' support of parents' knowledge of their children. By acknowledging parental knowledge, paediatric nurses are able to facilitate empowerment in the parents. Acceptance of parental understanding and

knowledge of asthma also increases parental confidence. This recognition of parental knowledge is required as it acknowledges that parents are important stakeholders in the development of a trusting relationship, as demonstrated in the positive sphere of the test model. (Figure 5)

5.5 Communication

Paediatric nurses need to recognise that family is a constant in the child's life and the acknowledgement of paediatric nurses that parents know their child best may assist in establishing trust (Bowie, 2004). This factor subsequently may enhance the partnership between themselves [nurses] and parents. The negotiation of roles can be made possible when paediatric nurses acknowledge parents have power. Effective communication involves negotiation (Newton, 2000). Through open communication, paediatric nurses are able to value parents' roles by regarding them as the ultimate experts in caring for their child. At the same time, parents look to paediatric nurses for support, empowerment, education, and expertise in caring for their child (Newton, 2000).

In the hospital, paediatric nurses are perceived to hold power over the parents as the nurses are familiar with the setting. The parent is a visitor to the unfamiliar environment and lacks privacy and control. Paediatric nurses have the information and can control how much information and assistance the parent receives with respect to information (Darbyshire, 1994). Added to this is the stress that parents are experiencing due to changes to their usual parenting role as a result of the child's illness and hospital admission (Jerret

& Costello, 1996). In contrast, paediatric nurses feel competent in their familiar role (Darbyshire, 1994) and are in a position to control the relationship. If the paediatric nurse does not wish to negotiate, the parent is not in a very strong position to take the initiative (Robinson, 1985). Effective communication is blocked or challenged when parents perceive paediatric nurses as ineffective listener and caring.

The power imbalance between parents and paediatric nurses where paediatric nurse were perceived to hold the balance of power was a factor identified as influencing parental participation (Darbyshire, 1994; Kristensson-Hallstrom, 1999; Newton, 2000) and the development of trusting relationships between parents and paediatric nurses. An issue central to negotiation relates to power and control between the paediatric nurse and parents.

Balancing power between paediatric nurses and parents can be made possible by acknowledging that parents have sound and valuable knowledge of their children (Bricher, 2000; Englund, Rydstrom, & Norberg, 2001; Kristensson-Hallstrom, 1999). Acknowledging that parents are experts on their children indicates that parent have some power and have much to contribute to their children's care (Bricher, 2000; Darbyshire, 1994; Englund et al., 2001; Jerret & Costello, 1996). Accepting this parental knowledge is valuable and enables negotiation to commence between nurses and parents. When paediatric nurses believe that parents' knowledge of their children is of equal value to that of their own, the negotiation process may

lead to partnership-in-care. This process can enhance a parent's sense of control and disease management, which in turn helps them to become empowered in their care for their children with asthma. For empowerment to take place, there needs to be a transfer of power (Taylor, 1996), in this situation, the transfer comes from the paediatric nurse to the parent.

Parents in the study stated that effective communication was crucial between themselves and nurses in order to provide optimum care for their children. Therefore, communication with parents provided paediatric nurses the opportunity to teach parents about their child's illness and this information assisted parents in decision making.

In addition to paediatric nurses' attitudes and a lack of negotiation due to unequal power, other barriers may influence the development of trusting relationships between paediatric nurses and parents. Another aspect of communication is related to a perceived lack of feedback that parents gained from the nurses regarding the condition and treatment regimen for their children. This lack of sharing of information can also be the source of power and control of paediatric nurses (Bruce & Ritchie, 1997).

These findings concurs with studies by Bruce and Ritchie (1990), Palmer (1993) who found that in the majority of the nurses-parent relationships, the nurses set limits on parental involvement in care. In their studies, they found that nurses were unwilling to involve parents in care because the nurses were concerned about the parents' ability to adequately and safely care for

their child.

Therefore, this knowledge of their child's well-being is not shared with parents as often or as fully required despite knowing that such communication enhanced the development of trusting relationships and ultimately encourage partnership-in-care. With good communication skills, parents respect paediatric nurses which inter-relates to parents feeling comfortable with paediatric nurses caring for their child. This leads to parents getting comfortable in the environment, which in turn encourages parental participation that results in parental satisfaction and ultimately helps to build parents' faith in paediatric nurses. This is depicted on the positive sphere of the test model for the development of trust between parents and paediatric nurses.

Failed negotiation in care arrangements and poor nurse-parent relationships can interfere with the hospitalisation experiences for the children and their parents, as well as the parents' desire to care for their ill child. A paediatric nurse's failure to negotiate caring roles with parents disempowers parents and raises legal issues surrounding the rights of parents and their child during healthcare interventions.

5.6 Building a relationship

A factor influencing the amount of stress imposed on a child by hospitalisation is the amount of control that a child perceives they have in this environment (LaMontagne, 1984). Loss of control for infants, toddlers

and preschoolers results from altered routines and rituals that increase the child's perception of threat. This perceived threat can affect their coping skills (Bricher, 2000). The main areas of control for younger children are rituals such as eating, sleeping, bathing, toileting and play. A paediatric nurse who maintains a child's normal routine contributes to reducing the child's stress and also that of the parent.

Similarly, in this study parents did perceive that the paediatric nurses' approach to their child's care was appropriate for the child's developmental stage. As paediatric nurses care for children everyday, they might have been more aware of the importance of provision of consistent, regular information to parents and this could have been part of the ward culture.

5.7 Confidentiality

In this study, parents have stipulated that it was essential for them to know that the information they have shared with the paediatric nurses caring for their child remained confidential. Paediatric nurses have the privilege of sharing personal information with their clients. With this privilege comes a great deal of responsibility. A breach of confidentiality may cause parents to stop sharing their personal knowledge of their child with the nurse. A breach of confidentiality can result in a negative impact on the child's treatment. At the same time, parents' trust would be diminished, resulting in a poor parent-nurse relationship. Therefore, paediatric nurses must always be careful with where they leave a client history, who they are talking to, i.e. talking to someone on the phone at the nurses' station or someone in the lift

or in the cafeteria. Making sure that client confidentiality is upheld promotes therapeutic trusting relationships between parents and nurses (*Code of Ethics for Nurses in Australia*, 2002).

5.8 Discussion of Test Model for the Development of Trust in Nurse-Parent Relationship

The Nursing Mutual Participation Model of Care can be compared to the test model for developing trust between parents and nurses, which is based on recognizing the control which families have in a relationship as they start off the relationship when seeking assistance. Initially they choose which aspects they wish to follow and can terminate the relationship whenever they desire (Davis et al., 2002).

This may have a negative implication for paediatric nursing not enhancing the partnerships models. The Nursing Mutual Participation Model of Care clearly emphasizes that culture plays a pivotal role in the development of trust between nurse and parent as demonstrated in previous sections. The cultural context of the medical ward either enhances or prohibits development of trust in nurse-parent relationships. Therefore the Nursing Mutual Participation Model of Care can be compared to the Transcultural Nursing Theory by Leininger.

In contrast the Nursing Mutual Participation Model of Care, the Transcultural Nursing Theory by Leininger is really a broad, holistic, comprehensive perspective of human groups, populations, and species. This

theory continues to generate many domains of inquiry for nurse researchers to pursue for scientific and humanistic knowledge. The theory challenges nurses to seek both universal and diverse culturally based care phenomenon by diverse cultures, the culture of nursing, and the cultures of social unsteadiness worldwide. The theory is truly transcultural and global in scope; it is both complex and practical. It requires transcultural nursing knowledge and appropriate research methods to explicate the phenomena. Leininger's Culture Care Theory is relevant worldwide to help guide nurse researchers in conceptualising the theory and research approaches and to guide practice. It is holistic and comprehensive in nature, therefore several concepts and constructs related to social structure, environment, and language are extremely important to discover and obtain culturally based knowledge grounded in people's world. The theory shows multiple interrelationships, especially to social structure factors. It requires some basic anthropological knowledge, but also considerable transcultural nursing knowledge to be used accurately and scholarly.

Leininger's Sunrise Model (1991) is useful and applicable to both spheres of the test model and individuals with a goal of rendering culture-specific nursing care. The theory is most helpful as a guide for study of any cultures and for comparative study of several cultures. The transcultural nursing theory is researchable and qualitative research has been the primary paradigm to discover largely unknown phenomena of care and health in diverse cultures. Transcultral nursing theory has important outcomes for nursing. Rendering culture-specific outcomes for nursing is a necessary and

essential new goal in nursing.

5.9 Implications of the Study and Recommendations

From discussion of the results, it is apparent that there is room within paediatric nursing practice to address issues identified that may have a negative impact of the development of partnership-in-care in relation to the building of trust between parents and paediatric nurses.

There are several nursing strategies that can promote the parents' shift in caring roles. These strategies should be taught to paediatric nurses as part of their understanding of partnership-in-care. The paediatric nurse can communicate with the parents about the normality of all the changes they will be experiencing. They can advocate parents to recognise and accept the variety of ways in which individuals may respond to change and stress. The paediatric nurse can facilitate change and alleviate role stress effectively by aiding parents in realising their own strengths, coping strategies and support networks.

5.9.1 Communication

Effective communication by paediatric nurse with parents is required to provide an environment where negotiation can occur between these two parties. Paediatric nurses and parents need to negotiate not only about the care of the child, but also other requests from parents if they are seeking to align their perceptions of care. This discussion needs to happen at least once a day and may be facilitated by an area on the plan of care for parents and/or

paediatric nurses to complete about the level of care required for the child which is checked every shift.

The Nursing Mutual Participation Model of care is based on communication that promotes parent-nurse collaboration (Curley, 1988). Use of this test model may facilitate effective communication between paediatric nurses and parents. This model assist paediatric nurses to recognize what parents may consider of most use to them when their child is sick. The model is centred on the premise that optimal therapeutic interventions result from partnerships between parents and paediatric nurses by sharing expertise – the parents' knowledge of the child and the nurses' knowledge of the illness (Ahmann, 1994). The following steps are based on the Nursing Mutual Participation Model of Care from (Ahmann, 1994) and (Curley & Wallace, 1992) and are suggestions for the type of daily communication that paediatric nurses should initiate with parents by utilising the practice partnership model, such as begin a caring relationship by being concerned about both parent and child and the effects of hospitalisation. Paediatric nurses may also empower parents by seeking parental judgement of the child's condition; negotiate caring roles as well as allowing time for feedback from parents with regards to the care of their children; and offering support for parents with other children at home that needs to be attended.

This model entails the use of core communication skills where the paediatric nurse asks the questions in an evocative way, at an appropriate time, attends,

actively listens, responds empathically, explores and summarises what has been heard (Davis, Day, & Bidmead, 2002). This use of core communication skills leads to a partnership model of caring which ensures the parent is being valued thus empowering them to participate in their child's care and undertake the other roles that they may have as a parent and family member.

This communication model could be a functional guide to assist paediatric nurses to restructure communication with parents so it becomes more collaborative. This collaborative, interactive communication style is person-centred which enables the paediatric nurse to acclimatize communication to the specific needs and values of the family. It differs from a position-centred approach by using influence rather than control during the interaction. The position-centred approach can be likened to the 'expert model' where the expertise of the paediatric nurse is seen as superior to that of the family with the relative power attributed used to control the interactions and decision making (Davis et al., 2002).

5.9.2 Parent Feedback

An additional suggestion is to obtain feedback from parents about the care their child had received. This study identified gaps between parents' expectations and paediatric nurses' perception of care. One way to reduce this gap is for paediatric nurses to obtain regularly feedback from parents. The model of communication discussed earlier includes a casual approach to obtaining feedback by eliciting parents' expectation of care and being

able to assist in meeting those needs. This would start reducing the gap between the parents' expectations and the paediatric nurses' perception of care delivered.

Parents' opinions are a critical measure of the achievement of goals (Marino & Marino, 2000) and consumer perceptions, in this case the parents.

Collaboration between paediatric nurses and parents about paediatric nursing practices and paediatric nursing care that were tailored to parents' needs were most strongly associated with overall parental satisfaction in a large study by Marino and Marino (2000). Therefore, the survey should include questions relating to these aspects of care. As many parents may feel uncomfortable about being interviewed or surveyed, a feedback form should be given to them to complete one week after discharge or during their outpatients appointments.

5.9.3 Paediatric Nurses as Advocates

Enabling parents to speak with the doctor by implementing various strategies is a further recommendation. Although information about this aspect of the paediatric nurses' role was not sought within this study, it was apparent from the comments in the semi-structured interview volunteered by parents that they frequently had difficulty in accessing information from their child's doctor. If the paediatric nurses are aware of this difficulty for parents, they can advocate for the parents. Strategies that may be considered are enabling the parents to speak with the doctor by telephone, encouraging the doctor to be consistent in time that he/she visits the ward or organising a

meeting time for the parents and doctor, ensuring the doctor is aware of importance of communicating with the parents when they [parents] are seeking information or reassurance. Persistence by paediatric nurses may change the doctors' behaviour.

5.9.4 Admission Package

Providing information to parents upon hospital admission is another recommendation. A package that provides all relevant information such as meals, accommodation, any costs, parking, and possible impact of hospitalisation on the family and any relevant hospital policies and practise is recommended. Evidence supports the sharing of relevant knowledge and information as central to family empowerment when children are hospitalized (Robertson, 1995; Swanwick, 1995).

5.10 Implication for Education

Ongoing professional education of paediatric nurses should be encouraged and supported by hospital managers. Management need to encourage staff to recognise that 'children are not little adults' and recognise the specialist care that children and their parents require when they [children] are unwell.

Paediatric nurses could be encourage to make a commitment to attend relevant educational programs by providing financial support, such as a scholarships and encouraging attendance by flexible rostering.

Educators need to emphasize the psychosocial aspects of paediatric nursing in conjunction with medical aspects of care. Aspects of holistic care that this

study found not attended were the impact of hospitalisation on parents, and the siblings of the hospitalised child and the importance of maintaining normal daily routine for the child. These strategies could be incorporated within the scope of topics that are to be presented, such that these aspects of care are emphasized for beginning paediatric nurses.

5.11 Planning Management

It is essential for children's wards to cater to the specific needs of the children. According to Australian Association for the Welfare of Children in Hospital (1992) recommends separate facilities to provide for both children's developmental needs and their parents' privacy and peace could enhance development of trusting relationships. Bright colours, ample light, a play area and appropriate furniture are all highly desirable to help fulfil the total needs of the child (National survey report on psycho-social care of children (and families) in hospital, 1992).

5.12 Concluding Remarks

In this study, culturally, parents trusted when their expectations were met as these parents have come to look for 'the good' on the part of the paediatric nurses and found it. On the other hand, parents distrusted when expectations were not met. These parents may then deliberately look for 'the bad' and find it. These parents will remain vigilant, always watching out for the care being provided for their child.

In this study, the practice of paediatric nurses keeping parents informed about their child's condition was significantly related to the development of trust and can be easily accomplished. Ensuring staffing continuity is also important and should be considered when planning staffing assignments. Another factor easily addressed is the need for parents to know who is caring for their child. Nursing staff should wear name tags with their accreditations at all times to provide parents with a name and credentials and these staff should introduce themselves to family members at the commencement of their shift.

5.13 Limitation

The scope of this research examined the paediatric nurse-parent interaction in the paediatric medical setting. The researcher is aware that exploration of paediatric nurse and parent characteristics may yield further insight into how characteristics may impact on the partnership model. Hence further research is warranted. As previously indicated, the test model needs to be further explored within the context of paediatric nursing to validate and contextualise its use in Australian paediatric nursing.

Non-English speaking, Torres Straits Islanders and Aboriginal families were excluded in this study. However, further research including these groups of people may yield valuable information.

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Appendix A

Letter to Parent

Date:

Dear Parent,

I am a Registered Nurse and a graduate student enrolled in the School of Nursing and Midwifery at Curtin University. As part of my Masters Degree studies, I am conducting a study on the development of trust between parents and nurses in paediatric wards. It is anticipated that the results of this study will assist nurses to understand the factors that help to build trust between nurses and parents.

Parents of children who have been admitted to PMH/ Fremantle Hospital with asthma at least twice in four months are being invited to participate. If you agree, you will be asked to relate your experience during your child's stay in the hospital and your relationship with the nurses when your child first began treatment and whether it changed during the time your child was in hospital. This study is of a voluntary nature and you are given the option to withdraw from the study at any stage without affecting your child's care.

I have received permission from the King Edward/ Princess Margaret Hospitals Ethics Committee to conduct this study. Participation in the survey is entirely voluntary and should you choose not to do so, your child's present or future treatment will not be affected in any way. All information given will be strictly confidential and no names will be used to associate you with the study at any time. Confidentiality will be maintained using a numerical coding system. Tapes of the interview will be transcribed verbatim. The tapes will then be erased. All transcriptions will be secured for a period of five years in the Research Centre at Princess Margaret Hospital for Children.

Upon the completion of the study, it is expected that the results will be sent to the Association for Welfare of Child in Hospital, so that they are available for parents. They may also be presented at National and International Research Conferences and published to nursing journals

I wish to invite you to participate in the study and ask that you indicate your agreement by signing the consent form and then return the completed form in the attached, addressed envelope to the researcher.

Thank you very much for considering participation in this study. Should you have any questions regarding the study, please contact myself on 0438980633 or my supervisors Ms. Louise Horgan at 9266 2213 or Dr Saras Henderson at 92662070 or Jeanette Robertson (PMH) 93408222 (pager) or 9340 1041 (office).

If you have any questions or complaints about the manner in which this study is being conducted, you may contact the Director of Medical Services, Dr Geoff Masters at Princess Margaret Hospital for Children on 9340 8222.

Thank you for your assistance.

Yours truly,

Germaine Lynn Chong Yen Ping
RN, BSc (Nursing)

Appendix B

Interview Guide

1. What does a 'trustworthy' nurse means to you?
2. Did the nurse demonstrate this during your stay? How?
3. Describe your relationship with the nurses?
4. What are some of the most important aspects to consider in trusting a nurse? Can these be prioritised?
5. What factors would influence your trust in the nurses?
6. How would you rate the level of trust you have in the nurses? From level 1 to 10
7. Did you at any point of time doubt the care provided by the nurses? Why? Did you go to anyone to raise your concerns?

Appendix C

FORM OF CONSENT

I
 have read

Given Names

Surname

the information explaining the study entitled: *Parents' trust in nurses: An ethnographic study of the nurse-parent relationship within the paediatric setting*

I have read and understood the information given to me. Any questions I have asked have been answered to my satisfaction.

I understand I may withdraw from the study at any stage and withdrawal will not interfere with routine care.

I agree that research data gathered from the results of this study may be published, provided that names are not used.

Dated day of 2002

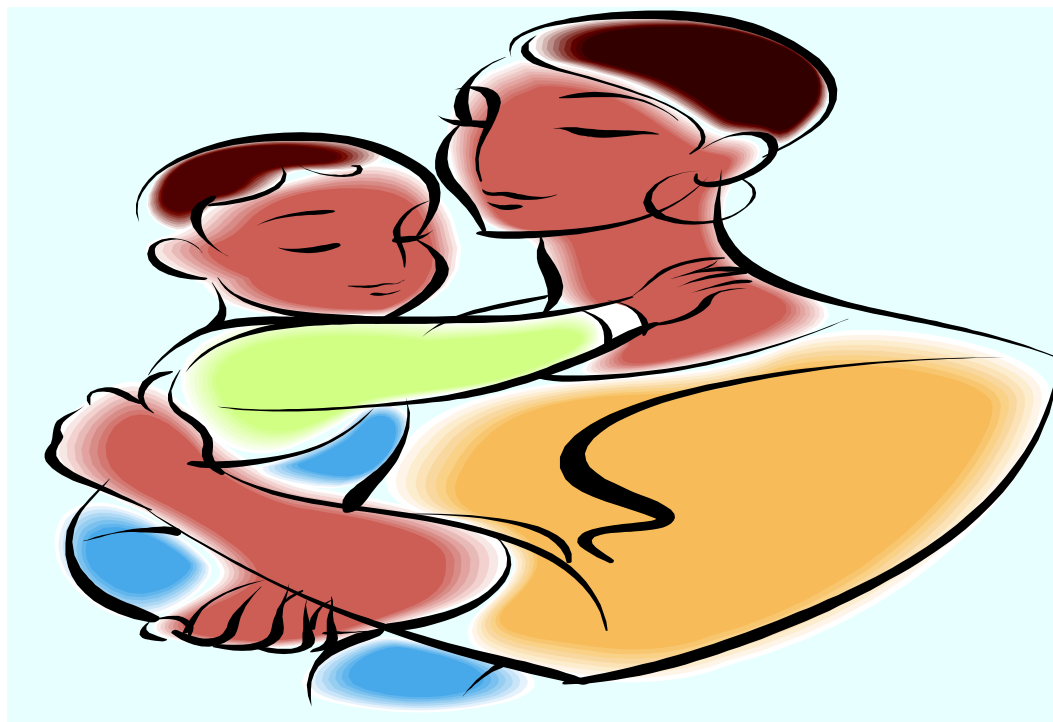
Signature

I, have explained the above to the
 (Investigator's full name)

signatory who stated that he/she understood the same.

Signature

Appendix D Poster for Nurses



Parents' trust in nurses: An ethnographic study of the nurse – parent relationship within the paediatric setting.

The purpose of this study is to explore the nurse - parent relationship from the perspectives of parents, whose child has been hospitalised at least twice in four months with asthma. The study will examine the characteristics attributed to trust, and factors identified as enhancing or inhibiting the trusting relationship. The objectives guiding this proposed study are to:

- 1) Identify the concept of trust in nurse-parent relationships.
- 2) Observe and describe the development of trust between parents and nurses in a paediatric medical ward setting.
- 3) Explore the factors which facilitate or hinder the development of trust in the nurse-parent relationship in the paediatric ward.
- 4) Discover and describe parents' view of the characteristics of a trustworthy nurse in of a paediatric medical setting.

I will be observing parent – nurse interactions in the ward from April 2003 to September 2003. If you do not wish to be involved in the study, please contact myself at email gerlynn@bigpond.net.au or ring 0438980633, or my supervisors Louise Horgan at 92662213 or Dr Saras Henderson 92662070 or Jeanette Roberson (PMH) 93408222 (pager) or 93401041 (office). Your participation will be very much appreciated, although your participation in the study is of a voluntary nature.

Appendix E

Clinical Manager Ward
Princess Margaret Hospital for Children
PO Box D 184
Perth
WA 6840

Dear Manager,

I am a Registered Nurse and a graduate student enrolled in the School of Nursing and Midwifery at Curtin University. As part of my Masters Degree studies, I am conducting a study in the relationship between parents and nurses in paediatric wards in Western Australia.

I have been advised by both my supervisor, Ms Louise Horgan and Ms Jeanette Robertson to seek your expertise, as the target population of my study are parents with an asthmatic child.

I am seeking access to nurses and patients and parents in Ward 9A. I am Enclosing is a copy of my research proposal that was sent for consideration in the KEMH/PMH Ethics Committees.

My proposal has been approved by the King Edward Memorial and Princess Margaret Hospitals Ethics Committee and Scientific Advisory Sub-Committees. Recommendations for approval from KEMH/PMH Ethics committees have been forwarded to the Women's and Children's Health Service.

Thank you very much for reading the proposal. Should you have any questions regarding the study, please contact myself at 0438980633 or email: gerlynn@bigpond.net.au; or my supervisors Ms Louise Horgan at 92662213 or Dr Saras Henderson at 92662070 or Ms Jeanette Robertson (PMH) 9340 8222.

Thank you for considering my request.

Yours truly,

Germaine Lynn Chong Yen Ping RN BSc

Appendix F

Patient Information Management System
Princess Margaret Hospital for Children
PO Box D 184
Perth
WA 6840

Dear Person in charge,

I am a Registered Nurse and a graduate student enrolled in the School of Nursing and Midwifery at Curtin University. As part of my Masters Degree studies, I am conducting a study in the relationship between parents and nurses in paediatric wards in Western Australia.

Recommendations for approval from KEMH/PMH Ethics committees have been forwarded to the Women's and Children's Health Service. Enclosed is the approval from the Ethics Committee of PMH.

I have been advised by the Asthma Liaison Nurse, to contact you in regards to obtaining a name list for the purpose of my research. For the purpose of my research, I need your help in obtaining a name list for:

- 1) Clients who are between 1 year old to 5 years, who have been admitted into PMH for asthma since July 2002 to September 2002.
- 2) A daily list of clients who are admitted into the General Medical Department throughout the period of my research, October 2002 to March 2003.

Should anyone have any questions regarding the study, please contact myself at 0438980633 or email: gerlynn@bigpond.net.au; or my supervisors Ms Louise Horgan at 92662213 or Ms Jeanette Robertson (PMH) 9340 8222 or 9340 1041 (office).

Thank you in advance for your kind assistance.

Yours truly,

Germaine Lynn Chong Yen Ping
RN, BSc (Nursing), MSc (Candidate)

Appendix G

About myself:

I am a Registered Nurse registered in both Singapore and Western Australia. Since my graduation from Nanyang Polytechnic in Singapore, I have been working in a multi-disciplined paediatric ward, in KK Women's and Children's Hospital till I arrived in Perth for my postgraduate studies.

Study aims:

The purpose of the study is to acquire knowledge about the nurse-parent relationships within the culture of the paediatric ward in regards to children with asthma. I have chosen the field of respiratory because of my own experience with asthma.

Research method:

The method of my research is observation. There will not be any interference with your work at any time. Should any parent approach with any concerns, they will be directed back to the nurses in the ward, or the related department.

Contact:

Should anyone have any questions regarding the study, please contact myself at 9438980633 or email: gerlynn@bigpond.net.au; or my supervisors Ms Louise Horgan at 92652213 or Ms Jeanette Robertson (PMH) 9340 8222 or 9340 1041 (office). Your participation will be very much appreciated, although your participation in the study is of a voluntary nature.