Research Article

Experiences of parents during the hospitalisation of their child in a private paediatric unit

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Keywords:
support; parents; hospitalisation; private paediatric unit

Abstract: Curationis 31(2): 30-42

A change in the health of a child is regarded as a major stressor for parents which further increases when the child is admitted to a hospital (Kaplan & Sadock, 1998:799). The role of the family in a child's illness is slowly being recognised (Kibel & Wagstaff, 2001:544), but the South African government per se has not yet issued any formal reports on parental participation in the hospitalisation process.

The purpose of the study was to describe recommendations to support parents with the hospitalisation of their child in a private paediatric unit. An interpretive-phenomenological qualitative approach was followed through unstructured individual interviews, narrative diaries and field notes. Purposive sampling was used to achieve saturation of data. Seven parents were interviewed and 15 parents completed narrative diaries. Trustworthiness and ethical considerations were maintained throughout the study. The transcribed interviews, narrative diaries and field notes were analysed through open-coding.

Recommendations focus on 1) empowering parents to participate in their child's care; 2) guiding nursing personnel to plan the discharge process; 3) including parents in the unit routine; 4) fostering a trusting relationship with parents; 5) promoting the communication of information; and 6) creating a therapeutic environment for parents.

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Introduction and rationale

The hospitalisation of a child is regarded as a major stressor that requires social readjustment by parents (Kaplan & Sadock, 1998:799). Not only do the parents find themselves in a unfamiliar environment with strange sights, sounds and technology, but very often the hospital culture places limitations on them. Visiting hours may be restricted, different clothes may be required, and the insertion of various devices (tubes, intravenous cannulas, catheters, monitors, etc.) may impose limitations on the child's, as well as on the parent's movements within the paediatric unit. Both parents and their children usually find these circumstances rather upsetting.

A child's hospitalisation is particularly difficult. Parents who are already sad and worried about their child's condition are likely to also feel frightened and agitated when this condition requires that the child be hospitalised. (McCollum, 1975:55) Despite the fact that children are regularly hospitalised for varying degrees of illness and surgery, there is no consensus on how nurses should support parents during this possibly stressful period. During a child's hospitalisation, parents have a unique perspective from which to report their experiences of the situation to the paediatric nursing unit manager. Parents could be under the impression that no one could know their child better than they do, and as such they want to do everything for their child, in the manner that they feel is best for him or her. When the child is admitted to a paediatric unit, this care is often taken over by the nursing personnel, especially during the initial admission period, where personnel members examine the child, do blood tests, take x-rays, make measurements, engage in hushed conversations, or exchange worried glances. Parents may feel that they are excluded during this time (McCollum, 1975:6).

Overview of the literature

In qualitative research the full literature review is done only after the data has been collected, to minimise the prejudging of the data. Thus a brief overview is presented.

In his study regarding parental participation and involvement in the care of the hospitalised child, Philip Darbyshire (in Benner, 1994:185-209) notes that, since the publication of the Platt Report in the United Kingdom, there have been various attempts to humanise paediatric units by offering open visiting hours and living-in facilities for parents, and by encouraging parents to take a more active part in their child's care while they are in hospital. The term parental participation seems to imply that the nurses perceive the parents as being able to only do the work of an unqualified member of the personnel, namely the parental work.

A previous study by Stratton (2004:10) found that parents could experience their child's hospitalisation in a paediatric unit in terms of the following four interconnecting, circular processes:
(1) *Facing boundaries,* which includes parents feeling helpless and parents questioning the skills of personnel
(2) *Attempting to understand,* which incorporates parents being informed or lack of information and simplifying communication
(3) *Coping with uncertainty,* highlighted by dealing with fear that parents have as well as their need to create a comfort zone
(4) *Seeking assurance* from caregivers, which includes the characteristics that parents would have liked emulated in their caregivers, namely expressing concern, being supportive and attending to detail.

McCollum (1975:56) advocates that parents should be encouraged to help care for their children, especially by feeding, bathing, changing, dressing and playing with them. In order to accommodate the parents' need to continue performing their parenting tasks, family-centred care has been introduced to nursing units over a period of time, and in varying degrees. Parent participation in hospitalisation could be viewed as the performance of routine physical care and extended visiting (Knafl, Cavallari, & Dixon, 1988:98).

When a child is hospitalised, parents' priorities, roles and values change. Parents are characterised by placing high levels of trust in professionals, relinquishing control over decision-making to physicians and nurses, and receiving information rather than seeking information and care (Knafl et al., 1988:109). Also, parents' role in participating in their child's care is not always clarified. Darbyshire notes in his study that parents are often confused and uncertain as to exactly what they are allowed and expected to do during their child's hospitalisation (Benner, 1994:190).

The discrepancy between the nursing practice and nursing theory emphasises the need for a study to describe and explore parents' reality. It can be deduced that if few or no studies about parents' lived experiences of their child's hospitalisation exist, no managerial actions or strategies were in place to facilitate the findings of such a study. Indeed, in South Africa there are no known strategies in place to facilitate parents' experiences within a paediatric unit.

Problem statement

Patient opinion surveys completed by parents in a paediatric unit within a private hospital (Vereniging Medi Clinic: 2004) indicated that parents experience their child's hospitalisation negatively. Comments made included that "personnel are not friendly", "[there are] too few personnel for the number of patients", "day personnel [are] more competent than night – more helpful", and "medication not given as prescribed". These comments have not been followed up and management have not investigated the possibility of documenting parents' lived experiences and how these can be effectively managed within a paediatric unit. Dissatisfaction of next of kin with patient care is one of the five categories that Booyens (ed) (1998:593) recognises as a high-risk area. It was also noted that nursing personnel are involved in this area.

To understand lived experience is to *"uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalised"* (Benner, 1985:6). One needs to understand as much as possible about the lived experiences of parents that affect the nurse-child-parent interaction. Lived experiences are embedded with meaning – and this meaning will shape their perceptions of the hospitalisation process. It is through as comprehensive an understanding as possible that unit management and nursing personnel can effectively care for, support and facilitate the parents with whom they work (Fitzpatrick & Montgomery, 1999:65). Little is known in the literature regarding the lived experiences of parents

regarding the hospitalization of their children in paediatric units.

Purpose of the study

The purpose of this study was to describe recommendations to support parents with the hospitalisation of their child in a private paediatric unit.

Research objectives

The objectives of this study were to:

- explore and describe the nursing care experiences of parents regarding hospitalisation of their child in a paediatric unit
- describe managerial guidelines to support parents with their lived experiences of their child's hospitalisation in a private paediatric unit.

Concepts

Child as defined by the Child Care Act (No 74 of 1983) is "any person under the age of 18 years". For the purposes if this study a child is a person aged between 6 weeks to 12 years (of either sex), suffering from no major physical or mental impairments other than the one for which hospitalisation was required, and who is expected to make a total recovery following treatment. The patients included both medical and surgical patients, and only parents of children who were admitted in the unit (i.e. this excluded all out-patients) were used for data-collection purposes.

Paediatric unit is a unit within a hospital accredited for the treatment and care of ill children within a private hospital.

Parent (including adoptive parent) for the purposes of this study, is defined as a mother or father (including step-parents as well as single parents) who are raising the child.

Lived experience is defined by Benner (1994:xi) as being engaged in practices as a being who acts in and on the world. Lived experience is understood to be the ways in which people encounter situations in relation to their interests, purposes, personal concerns, and background understanding (Benner, 1994:186).

Manage is defined by the Oxford Dictionary (Thompson (ed) 1996:538) as "organise, regulate or be in charge of". In a nursing context, Yura et al., (in Mackenzie, 1998:178) describe management as the use of delegated authority within a formal organisation to organise, direct and control.

Hospitalisation as defined by the Oxford Dictionary (Thompson (ed) 1996:424) is to "send or admit to hospital". In this study the term hospitalisation refers to all the management processes (nursing activities and functions) that occur within the paediatric unit once the child is physically placed in a bed within the unit.

Research design and method

Research design

This was an *interpretive-phenomenological qualitative* study whereby the lived nursing care experiences of parents were *explored* and *described* within a *context*, within an interpretive-phenomenological approach. An interpretive approach allows for a specific way to interpret the captured lived experience, whilst phenomenology allows for the capturing of the lived experience of the parents (Svenaeus, 2000:126). These two approaches have a synergistic relationship.

A qualitative design enabled the researcher to explore and describe the parents' experiences in an in-depth and holistic manner. Using this research design, the study therefore aimed to explore and describe the experiences of parents during the hospitalisation of their child. When a study is explorative (Talbot, 1994:90), it attempts to uncover the relationships and dimensions of a phenomenon. The design was exploratory and thus suitable for gaining insight into the experience of the parents in this context. The understanding of parents' lived nursing care experiences contributed to the formulation of managerial actions to be implemented to support parents during the hospitalisation of their child.

When a study is descriptive, it is similar to the explorative type of study, but more structured (Talbot, 1994:90). In this study, the lived nursing care experiences of parents were explored and described.

With an interpretive approach, it is important to note that it relies heavily on the particular context of the situation that is the timing, meanings and intention of the particular situation (Benner, 1985:40). This study was contextual in that it dealt with the experiences of parents whose children were hospitalised for three days or longer in a typical private paediatric unit.

Population, sampling and selection criteria

Parents whose child was at that stage being hospitalised in a private paediatric unit were used for the data-gathering phase of the research. The study was conducted in one of the private hospitals in the Vaal Triangle region of Gauteng, South Africa. Criterion-based purposive sampling was conducted. Purposive sampling chooses subjects who are judged to be typical of the population in question, or who are particularly knowledgeable about the issue under study (Polit & Hungler, 1997:229). Thoughtful planning was required for appropriate participant selection. The criteria for parents' selection were as follows:

- Parents had to be able to communicate in English or Afrikaans
- Biological parents (mother or father), adoptive parents, single parents or step-parents
- The parents' child had to be formally admitted in a paediatric unit within a private hospital
- The hospitalised child had to be aged between six weeks and 12 years of age;
- The child had to be hospitalised in the paediatric unit for a minimum of three days (three days being the shortest duration of antimicrobial treatment)
- The parents had to visit their child at least once a day to be able to actively participate in their child's care
- The parents had to be willing to reflect freely on their lived nursing care experiences and convey it to the researcher (using the questioning method of their choice, i.e. interview and/or narrative diary).

Research method and data collection

Various questioning methods were used during this study. In interpretive studies,

the primary source of knowledge is everyday practical activity. Individual interviews, narrative studies, field notes and a conceptualisation of the data allowed for parents' experiences of their child's hospitalisation in a private paediatric unit to become a text analogue, which could then be interpreted (Benner, 1994:59).

The subject of the qualitative research individual interview is the *life world* of the respondents and their relation to it. The purpose was to describe and understand the central themes the respondents experienced. In this study, the hospitalisation of their child was the main theme in the life world of parents, and the interviews sought to reflect this theme.

The interviewer also attempted to gather the richest and most *presuppositionless* descriptions possible of the relevant themes of the respondents' life-worlds. The use of bracketing and intuiting (Burns & Grove, 2001:80) was beneficial in ensuring that the researcher remained bias-free. The interview was focused on certain themes: using an opening question *"How did you experience your child's hospitalisation in the paediatric ward?"*, followed by probing when the responses of the parents were *ambiguous*. A high quality audio-tape recorder was strategically placed to capture all dialogue between the researcher and the participant. These interviews were audiotaped and later transcribed (with permission from the respondents). Interviews were conducted until the data was saturated as demonstrated by repeating themes.

Parents were requested to complete a narrative report on their experiences of their child's hospitalisation in the paediatric unit. Parents were able to describe incidents that daily shaped their experiences as often as they wished. Parents were requested to hand these back on the day of discharge. Parents' narratives provided helpful perspectives related to their experience and rich detail about their feelings and thoughts.

Unstructured observation on the part of the researcher was also used as a method of data collection. The researcher attempted to describe behaviours as they were observed, with no preconceived ideas, in the field notes that were kept. The researcher wrote field notes (observational, theoretical, methodological and experiential) in a field diary during and after the interviews as a measure of triangulation.

Data analysis

Using Tesch's method of open-coding, as described in Cresswell (1994:155), the transcribed interviews, narrative diaries and the researcher's field notes during the individual interview were analysed. The inclusion of the researcher's field notes was important for the enrichment of the data.
The following steps were included in this method:

- Reading carefully through all transcripts in order to get a general idea of the content
- Randomly choosing one transcript and reading through it, jotting down ideas in the margins as they came to mind and answering the following questions: *"What is it about?"* and *"What is the underlying meaning?"*
- Repeating the previous step for all transcripts, and then making a list of all topics listed in the margins, clustering similar ones together, and then drawing up three columns marked 1) major topics, 2) unique topics, and 3) leftovers
- Finding the most descriptive wording for topics and turning them into categories
- Making a final abbreviation or code for each category and writing them in alphabetical order
- Assembling the data belonging to each category in one place and doing a preliminary analysis
- Re-coding the existing data.

An intensive conceptualisation was conducted in order to explore, describe and confirm the findings of the research study, as well as to facilitate the designing of managerial guidelines to effectively support parents' lived experiences of their child's hospitalisation in a private paediatric unit.

Trustworthiness

Measures to ensure trustworthiness were applied. Guba's (Guba & Lincoln, 1985:290-327) strategies of credibility, transferability, dependability and confirmability were implemented.

Credibility/truth-value

Prolonged engagement allowed the respondents (parents) to become used to and familiar with the researcher. When the researcher had prolonged engagement with participants, it allowed the researcher to identify inconsistencies in the respondents' responses (Burns & Grove, 2001:41). These inaccurate responses could be based on social expectations rather than on personal experience.

Reflexivity refers to the assessment of the influence that the researcher's own background, perceptions and interests have on the study (Krefting, 1991:218). In order to counteract the possible over-involvement, the researcher recorded her own behaviour, experiences and reflections on her thoughts, feelings and ideas in a field journal.

Multiple data sources and contexts (triangulation) were preferred to create a more naturalistic account and to prevent an overly narrow perspective of the situation (Benner, 1994:119). In this study, data triangulation was achieved through field notes, narrative diaries and unstructured individual interviews.

The interviewing technique also enhanced the credibility of the study (Kvale, 1983:171). Precision in description and stringency in the interpretation of meaning were important for credibility. Credibility was increased by rephrasing questions, repeating questions, or expanding questions on different occasions (May in Krefting, 1991:220).

Transferability/applicability

Transferability is the criteria against which applicability is measured in a qualitative study. It is the ability to transfer findings to another similar situation. Transferability was achieved by a dense description of the data and purposive sampling (Guba & Lincoln, 1985:301).

Dependability/consistency

In assessing whether or not similar results would be obtained if the study were done again with the same people or in a similar situation, consistency was proven. As qualitative research does not control the variables, but emphasises the uniqueness of individuals' perceptions,

variations in experience, rather than expecting identical results (Krefting, 1991:216). In this study the data was sent to an independent coder and the findings compared for similarities and differences.

Confirmability/neutrality

Confirmability in this study was achieved by ensuring reflexive analysis and data analysis triangulation (both methods have been previously described) (Krefting, 1991:221).

Ethical considerations

Ethical measures were adhered to during the research regarding this sensitive issue of parents' experience of their child's hospitalisation (Burns & Grove, 2001:191-210). The researcher obtained ethical approval for the study from the University of Johannesburg prior to commencing the study.

The researcher respected the individual parent's right to privacy, confidentiality and anonymity by not allowing any form of identification on the transcriptions or narrative diaries. The use of individual, rather than focus group interviews, also promoted confidentiality and anonymity. Parents were requested to hand the narrative diaries back to the researcher on the day of discharge. The researcher ensured the individual's privacy by conducting the interview in a sound-proof, private cubicle, with only the researcher and parent present.

The researcher planned and executed the research in such a way that it was to the parents' benefit, and that there were no harmful, physical or psychological experiences for the parent or child. Interviews were held at a time convenient for the parents, during their child's admission. The child was cared for by nursing personnel for the duration of the interview.

Parents were required to give written informed consent before the research interview/narrative diary was commenced. Participants could withdraw at any time without fear of discrimination or exposure and embarrassment. There was also no impact on the nursing care that their child received. The researcher clarified all information, and these results will be available to parents.

Findings and conclusions

The findings regarding parents' experiences of their child's hospitalisation (Table 1) relate to two main categories, namely

- *various interactive processes*
- the *environment* within the paediatric unit.

The three (3) subcategories related to the interactive processes in the paediatric unit are parental **participation** in the care of their child, **unit management dimensions** in the paediatric unit and **communication** between parents and nursing care personnel. The one (1) subcategory related to the environment of the paediatric unit is **creating a therapeutic environment** for parents.

Each category will be discussed according to the findings, conceptualisation and conclusions drawn.

Main category 1: Experiences related to the interactive processes in the paediatric unit

Subcategory 1.1: Parental participation

- **Parents' willingness to participate in their child's care**

Parental participation has been pointed out as an important aspect of how parents experience their child's hospitalisation. Experience of parental participation relates to parents' *willingness to participate in the care* of their hospitalised child, *barriers to parental participation* such as feelings of guilt, power-relations and challenges because of parents' social roles, which are further influenced by the *intensity of parents' participation* in the care of their child.

Parents verbalised a willingness to participate in caring for their child as follows: *"Your baby knows you better than the nurses. So if you are with your baby then the baby doesn't have much problems, so to be with your baby I think it is a fine thing."*

Parents further indicated that if nursing care personnel, and in particular nurses, empower them to participate in the care of their child, it contributes to positive feelings within them. The following excerpt from the data supports this observation:
"I watched her getting better all the time, and that makes it all worthwhile for me."
Parents' willingness to be involved in the care of their child relates further to certain aspects of care, such as administering medicine to their child, feeding, bathing and entertaining the child. The following excerpt from the raw data can be provided as a qualification for the aforementioned observation:
"...they didn't wake him up for his medicine ... and then I gave it when he woke up."

- **Barriers with regard to the extent and intensity of parental participation in their child's care**

Two barriers have been identified in the data that hinder parents from participating in the care of their child during hospitalisation. These barriers relate to *feelings of guilt* experienced by parents and *challenges posed by parents' social roles.*

Even though parents have demonstrated a willingness to participate in the care of their child during his/her hospitalisation, they verbalised that they had experienced intense feelings of guilt. Feelings of guilt are often attributed to parents who are not allowed into the procedure room during procedures by nursing care personnel. As one mother stated, *"The worst was when they told me I wasn't allowed to go with her when they put the drip in. Said I should go have a cup of coffee. That was really silly, I thought. What mother can leave her child while they hold her down and hurt her?"*

Furthermore, feelings of guilt experienced by parents have been related to the pain and suffering they perceive their child to have gone through, and that they were not allowed to comfort him/her. The following quote bears evidence to this effect:
"One morning the sister said she was just going to inject straight out of the syringe, one, two, three and it was over. He screamed and she held him down with her one arm and injected with the other. He is so small, he couldn't move, so he just screamed. I feel that was terrible."

Parents also felt torn between their own needs and the needs of the hospitalised child. However at times it was necessary for parents to "take a break" from it all: *"You need to get out of here too, you can't just sit in these four walls, and it gets a bit too much .... And life goes on out there."*

Important factors in facilitating parental

ng care experiences of parents regarding their child's hospitalisation

RY	SUBCATEGORY	THEME	SUBTHEME
nces related to the ive processes in the ric unit	1.1 Parental participation	• Parents willingness to participate in their child's care	• Empowerme participate i
		• Barriers on the extent and intensity of parental participation in their child's care	• Parents' feel in parental p care
			• Challenges social roles
	1.3 Unit management dimensions: Planning and organising	• Experiences related to family education activities in discharge planning	• Preparednes discharge
		• Experiences related to aspects of organising the paediatric unit routine	• Provision of
		• Experiences related to organising of resources in the paediatric unit	• Stock availa
			• Cost contai
	1.4 Communication in the paediatric unit	• Experiences related to interpersonal relationships	• Parents – nu relationship
			• A trusting re
		• Experiences related to caring in the paediatric unit	• Physical ges sensitivity
			• Lack of basi
lated to the environment of it	2.1 Creating a therapeutic environment for parents	• Experiences related to information management in the paediatric unit	• Communica paediatric u • Relevant inf • Communica

MAIN CATEGORY	SUBCATEGORY	THEME	SUBTHEME
2 .Experiences related to the environment of the paediatric unit	2.1 Creating a therapeutic environment for parents	• Experiences related to facilities available	• Rooming in facilities • Nutritional needs of parents
		• Creating a safe environment for parents	• Parental general comfort • General hygiene

willingness include creating opportunities and means for the parents to display their current abilities and fostering opportunities to acquire new skills and competencies that may be necessary during the care of their child in a private paediatric unit. (Wong, 1995:15).

A synergistic relationship adds another dimension to the nature of the service being delivered to the child and family in so far that it can complement the work being done by nursing care personnel and parents (De Lima, Rocha; Schochi & Callery, 2001:560). Using the synergistic relationship that can exist between parents and nursing care personnel, the nursing care delivered to the child can be driven by child- and family needs, thus making it child specific.

Shared decision-making is often interpreted as only involving medical decisions, but it does refer to nursing care as well. Parent participation in the decision-making process can be viewed as a continuum with various extremes (Sainio, Lauri & Eriksson, 2001:97). Parents should be given the opportunity to be anywhere along that continuum, depending on the strengths and needs of the child, the family and the nursing care professionals who are involved (Wong, 1995:15).

The findings have shown that parents are willing to participate in the hospitalised child's care, but need to be empowered by nursing care personnel if they are to be active partners in the delivery of certain aspects of care in the private paediatric unit. Nursing care personnel should facilitate and encourage parents through empowerment strategies to participate in their child's nursing care while in a private paediatric unit. A powerful mechanism for empowering parents is through the parent-nursing care personnel relationship. This relationship refers to a *partnership* that implies that parents are capable individuals who become more capable by sharing knowledge, skills and resources in a manner that benefits all participants (Wong, 1995:15).

Subcategory 1.2: Unit management dimensions: Planning and organising

The second subcategory of experiences of parents whose child has been hospitalised has to do with their experiences as they relate to the management of the paediatric unit. Parents verbalised that various facets of the unit manager had influenced their experiences of their child's hospitalisation with regard to the planning and organising of care that included *family-education activities in discharge planning, the management of resources in the unit* and *unit routine.*

- **Experiences related to family education activities in discharge planning**

Planning refers to a process whereby the nurse who acts as a manager of patient care in the unit, assesses, analyses and prioritises care activities in such a way to achieve a particular outcome (Muller, 2002:105). Parents narrated their experiences of particular activities that relate to the planning phase of the unit management process. One of these outcomes that was not adequately met was parents' experiences about family-education activities during discharge planning.

Parents verbalised their experiences of discharge activities as mixed experiences, with some being forewarned and having ample time *to prepare* for it, whilst others were greatly inconvenienced by poor planning and the lack of communication regarding the expected discharge of their child. Parents indicated that the child's discharge had been discussed with them and that they were well aware of the expected discharge date, as well as the continuation of care at home: *"Dr X said we can go home tomorrow probably, and then he will just continue with antibiotics at home."*

Parents were angry about the lack of information regarding the discharge date and time, which often meant that they had to make transport arrangements at inconvenient times. This further aggravated their frustrations. The following statement bears testimony to such feelings: *"We only went home the next night you know, when he* (the surgeon) *was finished in theatre."*

Delays could have been prevented if discharge planning had also taken logistics into consideration, and this again highlights the importance of communication between doctors, nursing personnel and the parents: *"Where must I find transport at that time ... and then I had to pay extra, because there are so few taxis."*

The discharge day is usually the highlight of the parents' and child's hospitalisation process, and both parents and patients keenly look forward to this time. Often the last impression parents have of their child's hospitalisation is the discharge day. It is therefore imperative that nursing personnel give parents ample warning of their child's discharge and that they provide appropriate family education prior to discharge. This will help to create a positive lasting impression of the paediatric unit.

Planning is important as it gives direction to the nursing unit managers and other personnel in the nursing unit to *prepare parents* for discharge. It also allows for personnel to interact effectively in order to have a synergistic effect within the unit (Nieman & Bennet, 2004:104). Vetter (1995:90) found that many parents expressed concerns about the lack of *discharge planning*. A few children were discharged with parents virtually having no choice in the matter. This highlights the need for parents to be better prepared through discharge planning in the paediatric unit. Conversely, nursing personnel may feel that additional discharge teaching increases their workload, contributing to frustration in the workplace (Strober, 2005:204).

In conclusion, nursing personnel should be guided to plan the discharge effectively. This would include guidance on preparing parents for discharge and providing them with the appropriate information before discharge. Once the private paediatric unit has an appropriate philosophy in place that is underwritten by clear aims and objectives that facilitate parental participation, personnel can set about managing their time correctly and planning for an efficient and effective discharge process.

- **Experiences related to aspects of organising the paediatric unit routine**

Parents had many experiences of amalgamating their own routines into that of the private paediatric unit. The unit routine clearly influenced parents' experiences of their child's hospitalisation in the paediatric unit of a private hospital. These routine activities often hindered parents' nurturing of their child, illustrated by the following excerpt.

During an interview with a parent a probing question was asked: *"How did the unit routine influence you?"*

"That was fine. . . There were other mothers who said they must leave the children because they felt in the way of nurses, but I felt it was fine because that's why she is here..."

Quality nursing care was, however, not experienced by all the parents in the paediatric unit. Parents mentioned that, often, their child's basic needs have not been met. The following quote is support of this observation: *"Poor child hadn't been bathed..."*

However, there were instances where basic nursing care left a very positive impression on the parents: *"Her bed was changed a lot, more than at home actually, when it just looked dirty the linen was changed. Everything and everyone is very neat here."*

Organising comprises concepts such as unity of command, chain of command, span of management, division of labour, co-ordination of personnel, responsibility and authority, delegation and flexibility (Nieman & Bennet, 2004:106-107; Oosthuizen (ed), 2004: 64-69). As paediatric patients require more nursing care than recovering adults would, optimally staffing a paediatric unit is one of the most expensive resources in a healthcare environment. Optimal utilisation of the knowledge, skills and experience of nursing personnel will have two-fold benefits: enhancing the quality of care received by parents and their children, and enhancing the work environment of each individual healthcare personnel (Naudé, Meyer & Van Niekerk, 2001: 143-145).

Parents consider the provision of quality care to their child and the meeting of their child's basic needs extremely important. The challenge for nursing personnel is supporting parents, thus creating satisfaction with the unit routine. This would be achieved by providing quality care within a managed nursing care environment, where the emphasis is on resource management and cost containment. This also implies that the nursing unit manager's approach to the assignment of nursing care must be flexible, as the needs of the children and their parents change from day to day (Naudé et al., 2001: 153-154).

- **Experiences related to organising resources in the paediatric unit**

Managed nursing care is a growing reality in the South African nursing care system and influences the utilisation and cost of services to facilitate cost-effective quality care to medical aid members. The nursing unit manager should become involved in the financial management of the unit, including stock and equipment control as well as the cost containment, which is in keeping with the culture of managed care found in the majority of private hospitals (Muller, 2002:190). The availability of resources has a significant impact on the delivery of patient care.

In this study parents identified *stock availability*, as well as the implementation of *cost-containment* measures as two important aspects of resource management that affected their experiences of their child's hospitalisation in the paediatric unit of a private hospital. In this regard, the availability of stock was highlighted as a point of concern. Often the unavailability of stock reflected poorly on the planning ability of nurses to act pro-actively and identify and decide how much stock is needed. Parents then took it upon themselves to ensure that the stock their child needed was made available. One parent voiced this as follows:

"... [They] don't keep whatever injection as unit stock ... and it hasn't come from the chemist yet ... I went myself to the chemist and got his medicine."

"... Why do you pay so much for a hospital and medical aid if the nurses can't do their work properly? Then let us pay less and we can do the work ourselves."

Nursing personnel are increasingly being called upon to contain costs and still provide high quality nursing care. Suggestions for nursing personnel for promoting cost containment include doing a job effectively, motivating patients to recover, using stock carefully and maximising the use of their time (Nagelkerk, 1996:28).

Managed nursing care has been introduced over the past years to ensure that cost-containment measures are implemented without jeopardising the quality of care provided to patients (Muller, 2002:197). This movement was initiated by medical aids and should now be an accepted policy and a "way of life"

in private hospitals.

Accountability has become a hallmark in private health care services, with all levels of personnel being held accountable for cost containment and the optimal use of stock and equipment. A balance must be found between the cost of care, the quality of care delivered and patient satisfaction (Ellis & Hartly, 1995:67).

In conclusion, unit management dimensions of planning and organising in the private paediatric unit should be addressed. Parents will not feel angry and distrustful about how resources are managed effectively in the unit, organising resources and cost containment should be combated through support to parents.

The final subcategory regarding parents' experiences of the interactive processes within the unit was communication within the private paediatric unit.

Subcategory 1.3: Communication in the paediatric unit

The importance of communication should never be underestimated as this could impact significantly on parents' experiences of their child's hospitalisation in a private paediatric unit. Parents' experiences of communication within the private paediatric unit related to *interpersonal relationships, caring* and *information management.* These three themes are inextricably linked and at times it is difficult to separate the one from the other.

- **Experiences related to interpersonal relationships**

Interpersonal relationships are essential in nursing. If harmonious interpersonal relationships do not exist between nursing care personnel, patients and family, patient safety and the quality of care being offered are threatened (Searle, 2000:206). The extract below is an example of how a disharmonial relationship can cause parent dissatisfaction and affect the quality of care delivered: *"I refused to sign consent and that was an issue, because the surgeon wanted to operate and he was 'scrubbed up' and refused to come into the theatre reception area to tell me what he wanted to do. So I said I am taking my son to another hospital."*

Most parents however appeared to be at ease and experienced the unit and personnel as generally trustworthy: *"I am not asking myself how are these people probably caring for my child, how is the care, even if I am not here I am 100% satisfied that she is in good hands."*

Parents had both positive and negative experiences of interpersonal relationships, but the effect of these relationships on the overall experience of a child's hospitalisation in a private paediatric unit should not be underestimated. In conclusion, the findings indicate that parents should be supported during the hospitalisation of their child through a trusting relationship between the parent and the nursing care professional. Lack of communication can act as a barrier to empowering parents and building partnerships with them (Strober, 2005:202). It is also important to maintain open communication by allowing parents to ask questions as needed and by sharing with parents, on a continuous basis and in a supportive manner, complete and unbiased information (Wong, 1995:15,18).

Parents clearly trusted the nursing personnel and this enabled them to leave their children in the unit. Parents appeared to be at ease and experienced the unit and personnel as generally trustworthy. There is a mutual need for trust between nursing personnel and parents. The agreement of trust reinforces the idea that parents need emotional support throughout their child's admission in the private paediatric unit (Shields, Hunter & Hall, 2004:27). By showing parents that they (the nursing care personnel) are trying to understand their concerns and by taking a holistic approach towards the child and parents, nursing care personnel will go a long way to fostering the all-important trust relationship (Strober, 2005:204).

Caring and information management were the other two themes of communication that were identified in the interviews relating to the experiences of parents.

- **Experiences related to caring in the paediatric unit**

Nursing care personnel who pay attention to the physical and emotional needs of their patients have been described as caring. Below are excerpts from the individual interviews, indicating parents' experiences of caring nursing care personnel who, through their physical gestures, showed affection and sensitivity to the parent and child: *"They are very gentle with her"* and *"The sisters and doctors, their hands are hot and they make my child happy."*

However, not all parents experienced such acts of caring in the unit. When nursing personnel neglected to treat the children with the required sensitivity, parents felt especially disgruntled. Failing to attend to basic needs such as seeing to a child's personal comfort could create the perception that personnel are uncaring and disinterested in a child's welfare, resulting in justifiably angry parents. Below is a statement that illustrates how the lack of nursing actions to address basic needs can sour the nurse-parent relationship:

"[The] poor child hadn't been bathed, he was injured playing rugby for s@#t sake, and he was full of grass and dirt on his legs. His feet were filthy, even under his nails, but they [the nursing unit personnel] *hadn't even bathed him."*

From the above it is evident that parents value the caring behaviour of nursing personnel highly. Excellent caring on the one hand or failing to do so on the other can be a deciding factor for parents when choosing a hospital for themselves or for their children.

Another factor outlined Watson (in Kozier, Erb, Blais, & Wilkinson, 1998:55) in her "Philosophy and Science of Caring", was that caring is important in assisting with the gratification of human needs, and is conveyed by recognising and attending to all the needs of the patient, including the physical, emotional, social and spiritual needs. Based on this, nurses who pay attention to the physical and emotional needs of their patients can be described as caring. Being personally involved with parents and patients can also indicate to parents that the nursing care professional cares about them and their child (Brown 1988:22).

Parents experience this care in different ways, such as acknowledging the parents' presence and role in their child's nursing care, listening, making the parent feel comfortable in the hospital environment, involving the parents and the child in all nursing care performed, paying attention to a patient's emotional state rather than ignoring it, and showing *affection and sensitivity* to the parents and child (Wong, 1995:17-18). The

parents in this study experienced actions of physical gestures (hands) that could be associated with showing of affection and sensitivity to the parent and child.

In conclusion, the experiences of parents indicate the need for caring and support that should be provided to parent and child in positive physical gestures of affection and sensitivity, as well as in basic nursing actions.

- **Experiences related to information management in the paediatric unit**

The last theme of communication that parents experienced was that of information management in the private paediatric unit. Parents had different experiences of the information management used in the private paediatric unit. Here is a communication network, with its own dynamics, which parents experienced differently.

Parents experienced the lack of communication flow between doctors and themselves as a source of irritation, and they experienced anger and frustration at the delays which resulted from poor communication. It appeared as if the nursing personnel formed the link between the doctors and parents, and parents recognised this, and thus did not blame the nursing personnel for the lack of communication and relevant information between the doctor and themselves: *"... the surgeon was told about the case at 16:30, and at 20:00 still hasn't arrived to see my son, nor has he seen my child's x-rays."*

Information communicated has the ability to empower parents and to allow them insight into their child's condition, as the following statement shows: *"I wouldn't have thought anything about it, but one of the sisters said it must be in a bag and take an hour because it was such a large dose and it would burn too much."*

Another pattern of interaction that can be linked to communication and information management has to do with the lack of information experienced by the parents. Parents who were unable to see or speak to the nursing care practitioner (in this case the doctor) became very angry at the lack of information received: *"How can you just tell a parent that they must sign consent without anyone coming to talk to me about what was going to be done?"*

Parents experienced a lack of information as a factor that contributed negatively to their emotional safety. It also caused a lack of trust: *"And the doctors should have seen him, not just take the casualty doctor's word about what was wrong with my son's arm. What does he know, he's not the specialist."*

Parents had a need to communicate with their spouses. This was a method of communicating information that one parent would have received from another source of information. This is evident in the following statement: *"And then I phoned back to my husband."*

Parents experienced the communication style between the nursing personnel and their child as very important. Communication contributes to parents trusting the nursing personnel enough to leave their children alone with the personnel: *"... and talk to her and distract her the whole time..."* and *"They build good relationships with the child."*

When nursing personnel did not communicate optimally with their child, parents were quick to identify it, as the following statement shows: *"She didn't even talk to him, just told him not to cry 'cause he was going to wake the other children."*

In conclusion, parents wanted hospital personnel to communicate with them and their child in the process of providing care. Parents observed personnel for signs that indicated that they (the healthcare personnel) have compassion for the parents and their child. Parents desired an interactive relationship of communication flow with the personnel that not only communicated information regarding their child's care, but that also displayed a communication style of compassion, understanding and somehow sensed the parents' or child's needs (Stratton, 2004:4).

There is a considerable amount of information available in nursing units. However, to improve patient care outcomes and patient satisfaction, this information must reach the right people at the right time. Information can be a very powerful nursing resource if managed correctly (McConnell, 2000:37). Parents experienced information management in terms of the various communication channels used, and in terms of their inclusion in decision-making based on information received. When parents are given sufficient information, they feel empowered and able to be an advocate for their child's health. Parents place high value on information, not only from the nursing care personnel, but also from the doctor.

This study has highlighted that parents who received adequate information regarding their child respond much better to their child's condition and are more co-operative.

Main category 2: Experiences related to the environment in the paediatric unit

As the hospitalisation process is often highly charged with emotions, there should be a concerted effort to make the hospital environment as comfortable and stress-free as possible, with special emphasis on making the paediatric unit less hostile for both the child and parent (Waterson, Helm & Platt, 1997:53).

Subcategory 2.1: Creating a therapeutic environment for parents

- **Experiences related to facilities available**

The parents' experiences can be categorised according to the *facilities available* to them, as well as *creating a safe environment for parents.*

Parents experienced the lack of rooming-in facilities as an inconvenience, and whilst none of the parents expressed anger, it was clear that parents (and paediatric patients) would have welcomed convenient and peaceful facilities when they spent the night with their child. This is evident in the following extract: *"...it is just the sleeping on the couch; I don't know, they must try something that will make you feel comfortable at night you see."*

Not only were physical sleeping facilities important for parents but also, as mentioned in the following quote, nutritional needs of parents staying with their children: *"Maybe supply food to the parents if they have infants that need 24/7 care."*

Parents should be encouraged to leave their child for brief periods of time. Separate sleeping facilities should be available away from the child to allow the parents to get sufficient rest, and a schedule of alternative visiting with other family members should be planned

(Wong, 1995:1076). Providing rooming-in facilities in paediatric wards is becoming the norm (Booyens (ed),1998:116). Problems that were identified during this study are in keeping with potential problems identified by other authors, namely disregarding the parents' need for sleep, nutrition and relaxation (Wong, 1995:1076).

In conclusion, the findings indicate the need to support parents with the necessary facilities during their child's hospitalisation. Parents would have preferred more comfortable rooming-in facilities and equipment that is in working condition for general comfort. The nutritional needs of parents should also be addressed or attended to during their stay with their children.

- **Creating a safe environment for parents**

Facilities, not only for sleeping, but for parental comfort in general, were also questioned by parents: *"Badkamer is koud en 'lazyboys' is te min"* [Translation: Bathroom is cold and not enough lazyboys (reclining chairs)]

Facilities that parents also found to be less than optimal were those supposed to make their stay more enjoyable and convenient. These facilities evidently had the opposite effect: *"The phones were not accessible; this was a great inconvenience."*

It is necessary to provide better facilities for parents to ensure a more comfortable stay and create a therapeutic environment for them.

The parent should be viewed as an important role player in caring for the hospitalised child. Thus the therapeutic environment in the unit should be safe to facilitate parents' physical, psychological and social needs.

Noise has been described as one of the most unwelcome physical stimuli in a nursing care environment as it creates discomfort, and may (as has been identified by this parent) disrupt and disturb sleep: *"At night I don't think the personnel realise how quiet it is and noise travels, so it was a bit noisy at times at night here."*

In an attempt to avoid noise stimulus such as the above, and because of a need for increased privacy, parents also requested to have private rooms as this mother did: *"Sal 'n enkelkamer wou gehad het."* [Translation: I would have liked a single room.]

Many parents found the general hygiene of the facilities dubious – an alarming concern for a hospital. The following excerpt refers to the general hygiene of the unit: *"...regular cleaning of the floors especially for gastro patients."*

Environmental stressors are by far the largest group of stressors found in the paediatric unit. Equipment noise (including the ringing of phones, alarms set on monitors, suctioning of patients and computer printouts) add to the noise pollution that is often found in any paediatric unit. Patients located closest to the nurses' station and storage rooms are usually subjected to the most noise and light (Honkus, 2003:17). Nursing personnel often place the youngest or most critical child closest to nurses' station, yet these are the very children that require the most sleep. Human sounds such as talking, laughing, other children crying and coughing can also affect rest and sleep (Wong, 1995:1121).

In conclusion, the findings indicate that parents should be supported during the hospitalisation of the child by creating a safe environment in the unit. In creating a safe environment, attention should be given to noise and general hygiene. Parents can be made to feel comfortable and at ease in an essentially non-stressful environment. It is essential that parents' physical and emotional comfort is catered for to ensure that they experience the hospitalisation of their child in a positive light. The facilities and equipment that are made available for parents' convenience should be clean and in good working order to ensure their comfort.

Recommendations for nurse managers in supporting parents during their child's hospitalisation in a private paediatric unit

- The unit manager in charge of the private paediatric unit should encourage parental participation in the unit. In decision making, parents should be consulted regarding the level of care that they would like to give their child. It is also important for nursing care personnel to consult with parents daily basis as the child's condition improves or should it deteriorate. This consultation could be facilitated by the most senior nursing personnel on the shift, or other personnel allocated to work with the parent and their child.
- It is important that the unit manager, together with the multidisciplinary teams compile action plans and strategies that directly address the discharge process. Parents should be informed of possible discharge dates at admission and during the child's hospitalisation. Such information could be provided by members of the multi-disciplinary team who would be treating the child, such as doctors, nursing care personnel and physiotherapists, during a meeting with the family.
- A unit routine needs to be flexible enough to accommodate the diverse needs of both parents and children in the paediatric unit. All personnel of the private paediatric unit should participate in setting a vision and mission, as well as appropriate goals specifically for the unit. The paediatric unit manager could use open, two-way communication whilst compiling the vision and mission for the unit. The aspirations, expectations, intentions and opinions of the individual nursing personnel and nursing unit must be considered. The unit manager should encourage nursing personnel to rise above personal interests and work as a team when setting the vision and mission (Naudé, et al., 2001:138).
- The type of delegation used should be dependent on the needs of the patient and should be dynamic so as to facilitate the needs of patients and parents in the unit. When functional allocation is used, the unit manager should rotate the personnel so that personnel do not become bored with tasks allocated to them.
- All resources and services impacting on the private paediatric unit should be optimally organised to promote patient satisfaction. Quality patient care can be accomplished by instituting a risk management team or clinical governance team. Such a team would be responsible for auditing nursing care and investigating any "failure of care" incidents, which could have any form of negative repercussion for the healthcare service. All nursing care personnel could find it very useful to audit nursing documents monthly to

identify possible "failure of care" areas.

- The manager in charge of the private paediatric unit should promote meaningful communication between all role players in the unit. Nursing personnel should respect and guard confidentiality at all times. If parents hear nursing care personnel discussing other children with anyone other than his/her parents, it may lead to distrust (Pogoloff, 2004:116).
- Caring actions should be an inherent part of nursing. However, when such actions are lacking it is possible to encourage and motivate nursing personnel. The child and his/her parents should be informed about procedures to be done prior to it being done.
- Unit managers should motivate and budget for facilities that could contribute to creating a therapeutic environment for parents within the private paediatric unit. A protected and safe outdoor play area should be provided. This will allow for the children to play and socialise with other children, as well as providing parents with an opportunity to socialise with other adults and "break free" from the confines of the ward.

Possible limitations of the study

Only seven parents took part in the study, which may be too small a group to obtain accurate information. Parents who declined to take part in the study cited anxiety and concern for their child as their overriding reasons not to do so.

Despite parents fulfilling the selection requirements, they were at times unable to grasp the intended meaning of the term "experience" and were thus unable to provide dense descriptions of their lived experience during their child's hospitalisation in a private paediatric unit.

The study was conducted in a private paediatric unit, therefore generalisation outside of this environment may be difficult to justify.

Conclusion

This study has shown that there is a demand for parental participation at various levels during the hospitalisation of a paediatric patient. Whilst some parents experience such participation positively, other parents were inclined to show resistance. Regardless of some resistance, parents' participation in the care of their hospitalised child is becoming an increasingly popular phenomenon. In South Africa there appears to be limited knowledge in this wide field of study, therefore necessitating further research.

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