



Young peoples' experience and self-management in the six months following major injury: A qualitative study



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ABSTRACT

Purpose: The aim of this qualitative study was to explore how young people aged 16–24 years' experience, perceive and manage the effects of major traumatic injury during the initial six months following major traumatic injury. Specifically: (1) how do young people manage the physical and emotional effects of major injury within the trauma system of care? (2) What are young peoples' perceived needs for healthcare and how are these met within the trauma system of care? (3) What do young people perceive as the role of family in supporting them?

Methods: This study forms part of the qualitative follow-up phase of an explanatory sequential mixed methods study investigating the characteristics and experience of major traumatic injury for young people 16–24 years, and the role of family in supporting them, in the initial six months following injury. The paper reports on young peoples' (aged 16–24 years) experiences of being admitted with major traumatic injury to two Australian Level 1 Trauma Centres. Twelve injured young people aged 17–23 years (mean = 19 years) participated in the study. Two semi-structured in-depth interviews with young people were conducted and transcribed verbatim; the first prior to hospital discharge ($n = 12$), and the second ($n = 7$) within 3 months of hospital discharge. Data were managed using NVivo software, and thematically analysed.

Findings: During the initial 6 months following injury, young people experienced a complex process of adaptation involving feelings of vulnerability and loss of control over their physicality, environment and life-course. Self-management strategies included use of Information technology as a form of distraction; family and friends to create a sense of familiarity and normality; and information and validation-seeking from health care professionals as a means of understanding and regaining a sense of self.

Conclusion: Key elements of resilience theory applicable to the findings such as problem-based coping, self-efficacy and strong social support offer a useful framework for anticipatory guidance that is responsive to the psychosocial needs of injured young people and facilitates a strength-based patient-centred approach to managing major traumatic injury.

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Background

Regardless of the country and its economic status, traumatic physical injury (hereafter injury) remains one of the highest causes of early mortality and disability [1]. Injury encompasses a spectrum of ailments ranging from minor injuries, such as broken

bones which require minimal health intervention, through to severe life-threatening polytrauma, necessitating immediate multidisciplinary intervention [2]. The most common causes of injury are road traffic incidents, falls and violence [3,4], which in high income countries has resulted in injury-related mortality being recognised as a health priority. However, injury as a cause of death and disability is most prominent in low-to middle income countries that lack established trauma systems and material infrastructure [5].

Adolescents and young adults (16–24 years) have the highest rates of injury [6]. Global population health data from 2009 demonstrated that in this age bracket, injury-related mortality rates

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were greater than 40% and accounted for half of all male fatalities [5]. Although adolescence and young adulthood is commonly regarded as a healthy time of life, the high prevalence of injury within the adolescent and young adult population is ascribed in part, to the transition to adulthood when young people disengage from parental control and assume more independence [7,8]. This can expose the young person to the vulnerabilities of peer pressure and popular culture, where they may be more inclined to challenge boundaries and take risks that could result in accidents or injury [5,9].

Regardless of age, there are acknowledged limitations in quantifying the burden of injury [10], including the use of physical functioning as a marker of recovery [11–13]. There is a recognised lack of understanding of the individual's experience following major injury. In a 2012 qualitative synthesis of international literature on the experience of injury, authors highlight that despite being the largest demographic affected by major traumatic injury, there is minimal understanding of the experience of major traumatic injury from the young person's perspective [14].

The injury trajectory, or the time from initial injury to recovery from injury, is multi-dimensional, and the way in which individuals experience its effects are diverse [10,14]. As the group with the highest rates of injury, further inquiry into young people's injury and survival experience is needed in order to inform hospital care of this group's specific needs for healthcare, and contribute to the limited knowledge base in this area. The aim of this qualitative study was to explore how young people 16–24 years perceive and manage the effects of major traumatic injury during the initial six months following injury. Specifically: (1) how do young people manage the physical and emotional effects of major injury within the trauma system of care? (2) What are young peoples' perceived needs for healthcare and how are these met within the trauma system of care? (3) What do young people perceive as the role of family in supporting them in the 6 months following injury?

Methods

This study is part of the qualitative follow-up phase of an explanatory sequential mixed methods study [15] exploring the characteristics and experience of major traumatic injury for young people 16–24 years, and the role of family in supporting them, in the first six months following injury. In the initial quantitative phase, the incidence, characteristics and patient outcomes of major traumatic injury incurred by young people in an eastern State of Australia, from July 2007 to June 2012, were determined [16]. These data were used to identify patterns of injury and demographic information on young people [17] and provided context and sampling priorities for the qualitative phase of the study. The follow-up explanatory qualitative phase was informed by Interpretive Description [18], a methodology developed specifically for clinical healthcare questions. Theoretical scaffolding for the study was informed by [18]; (a) the researcher's examination and synthesis of current literature [14]; (b) the researcher's experience as a healthcare professional working with injured persons and their families; and (c) discussions with other health care professionals caring for the injured.

Participants and recruitment

Sampling was guided by identification of patterns of injury and demographics in the Phase 1 quantitative study. Consistent with interpretive description [18], sampling was purposive and aimed at maximum variation [18] to be representative and inclusive of the overall young person injury population, aiming for: 12 males and 3 females, 50% aged 18–20 years, 10 road trauma, 3 recreation, 2 violence (with a goal to capture 1–2 intentional injuries), 1 fall,

and 60% polytrauma; as defined as patients with two or more serious injuries (AIS > 2) in different body regions [19]. While this sampling frame guided recruitment, participants were ultimately determined by admissions and consents during the study period.

Potential young person participants at two Level 1 trauma centres were identified by staff during clinical rounds. Once suitability for consent to interview was obtained by the treating team, potential participants were approached and provided with written and verbal information on the study. Sample size was continually assessed to identify the point at which further interviews would not significantly contribute to expanding understanding of the phenomenon of interest [20,21]. During the study period, 39 potential participants were identified; 15 were found unsuitable, 10 were discharged prior to recruitment, and 2 declined.

Data collection

Data comprised of two semi-structured in-depth interviews conducted by the primary researcher, one-on-one with participants; the first prior to hospital discharge, conducted in a quiet private room at the hospital. Follow-up interviews were conducted face to face in the outpatient setting at the recruiting hospital or over the telephone due to distance. Interviews were guided to include how the young person understood their injury, how they managed since the injury occurred, who/what had been helpful for their recovery, as well as unhelpful, and the support they had received. All interviews were audio recorded and corresponding field notes compiled. Interviews were transcribed verbatim and each participant given a pseudonym.

Ethical considerations

The project was approved by the ACT (ETH.5.12.102) and South Eastern Sydney Local Health District (13/332) Human Research Ethics Committees. All participants were provided study information both in writing and verbally and consented verbally and in writing, to audio recording of their interview and verbatim transcription. Participants were recruited by trauma staff at the recruiting hospital. Participants were aware of the interviewer's role as clinician and researcher. Parental consent was not required, as all participants were over the age of 16 years.

Analysis

Transcribed interviews were imported into NVivo 9 for analysis and storage. Braun and Clark's [19] six-step thematic analytic approach was used to inform analysis (Table 1). Transcripts were read and re-read for familiarisation, initial ideas were noted, and individual interview summaries developed. In vivo codes were generated by the primary researcher within, and then systematically across, the entire interview dataset [22] (see Table 2). Codes were collated into potential themes, checking to ensure themes worked in relation to coded extracts [22]. Analysis was iterative to refine complete theme descriptions. Finally, a selection of compelling extract examples were identified within each theme [22].

Findings

Twelve injured young people participated in the study (see Table 3). Participants were aged 17–23 years (mean = 19 years). Mechanism of injury was representative of Australian injury trends within this population [23,24], with road trauma the most represented. Injury severity score ranged from 10 to 43 (mean = 28). Hospital length of stay was 10–101 days (mean = 39),

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