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Culture shapes nursing practice: Findings from a New Zealand study

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ABSTRACT

Objectives: This paper reports research undertaken to investigate nurses' and parents' experiences of communication about parental emotions in a hospital setting, with a focus on the environmental and cultural context within which the communication occurs.
Methods: A focused ethnography was employed as the aims were to understand the context within which nurse-parent interaction takes place, by exploring cultural factors, such as ways of living affecting nursing communication. Data collection occurred in a children's unit of a New Zealand hospital, involving 260 h of participant observation field work, informal interviews with parents and nurses, followed by 20 formal interviews with nurses and parents.
Results: Nurses are cultural brokers, with the potential to be a link between the insider culture, the hospital and the outside, the parents. Parents look to nurses for cultural brokerage, to help them cross the strong cultural boundaries present in a hospital unit.
Conclusion: The context and culture of a hospital unit influences nurse-parent communication. There is a disconnection between parents' emotional needs in hospital and nurses' ability to meet those needs.
Practice implications: Nurses must be supported to provide effective cultural brokerage for parents. Unit managers need to acknowledge that meeting parents' diverse needs is vital.

1. Introduction

Parents staying with their child in hospital experience a range of emotions, such as sadness, despair and anxiety as the child journeys through the illness trajectory [1,2]. In the field of inpatient child health nursing, there is an expectation by the family and health professionals for parents to be involved in the child's care and work collaboratively with nurses [3,4]. As a result, the nurse interacts with and relates to both the child who is a patient, and the child's parents or caregivers.

The central concern of the study reported in this paper, is emotional communication between the nurse and the parent focusing on parent's feelings and affective responses as they are related to their child's hospitalisation. The study was a focused ethnography that explored how the cultural context of the care influenced that communication. It has been demonstrated that communication between nurses and parents is more than the individual skills of a nurse; it is irrevocably bound within the cultural context in which it occurs [5,6].

1.1. Background

Parents or caregivers are actively encouraged to stay with their child in an inpatient hospital unit to attend the child's many needs and to provide support for the child. In some areas parents are also expected to be involved in the delivery of technical care [7]. Thus the nurse has a relationship with the parent, and needs to work alongside the parent providing the care of the child, requiring the parent(s) and the nurse to communicate with each other to ensure the child's needs are met. Underpinning child health nursing practice is family-centred care, a model of care which encourages nurses to view the family holistically and evaluate the physical and emotional support requirements of family members [8], supports the family during their hospitalisation [9] and involves family in their child's care [10–12]. Numerous studies have found that despite accepting in theory the philosophy of parent participation and family-centred care,

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nurses have difficulty putting the philosophy into practice [11,13–15]. Nurses expect parents to be present and cooperative, to follow instructions and be actively involved in their child's care, when in reality parents felt stressed and anxious about caring for their child [4].

Parents are usually accustomed to caring for their child without professional support; to find that support is needed results in vulnerability, which leads to emotional responses related both to their child's illness and the hospital experience. A number of studies relating to hospitalised children have focused on parents' perception of aspects of the experiences that caused them distress. Common stress-inducing factors include: parents feeling insecure [16], sensing powerlessness [17], feeling guilty about the child's hospitalisation [18], being in an unfamiliar environment and experiencing poor communication with health care teams [19], accompanied by an overriding fear [16,20]. Another cause of parental stress is uncertainty over their child's illness and recovery [16,19,21]. Disruption of their usual parental role and loss of control and independence are also significant issues for parents [7,16,21].

As a result of their distress and associated vulnerability during their child's hospitalisation, parents want relationships with nurses who not only offer them information about their child's care, but also display compassion for their feelings and understanding of both the parent's and child's concerns [22]. However, the physical and cultural context of the nurse-parent interaction can be problematic because managing such emotions and concerns are difficult for both parent and nurse [23]. In this study, culture is defined as "our way of living, . . . activities, ideas, belongings, relationships, what we say, do, think and are . . . an outcome of the influences of ancestors, biology, and philosophy of life" [24,pp66–7] thus comprising the organisation of things. Context refers to "the framework in which to understand cultural beliefs and practices...includes cognitive, symbolic, structural and environmental elements relevant to a particular setting or situation" [25,p4].

One problematic area is that nurses frequently focus on the completion of tasks [26,27] and task completion can take precedence over relating to patients [5]. As a consequence, the emotional needs of parents remain unacknowledged or ignored [28,29], thus exacerbating parents' sense of helplessness and vulnerability. Lack of acknowledgement of parental distress is related to evidence that nurses emotionally withdraw from parents in hospital [30,31]. When nurses do become aware of parents' emotional concerns, they feel insecure and disengage from parents [32].

There is limited evidence regarding nurse-parent communication in relation to the discussion of emotions [30,31,33], thus making this area of inquiry problematic from the outset. The focus of previous research had been on interpersonal dynamics alone, not on the cultural context of the nurse-parent interaction. Limitations in both method and content in available research limited understanding into how the organisational and cultural context both constructs and is constructed by interactions. This study addresses the gap in understanding the nurse-parent interaction by focusing on the influence of the inpatient hospital unit context.

The aims of the study were to investigate nurses' experiences of emotional communication with parents of a child in hospital; to investigate parents' experiences of emotional communication with nurses in hospital; and to examine the environmental and cultural context within which the parent-nurse interaction occurs. In order to gain a fuller understanding of the complexities and dynamics of nurse-parent relationships, communication related to emotions was examined from both the nurse and parent perspective.

2. Methods

2.1. Design and setting

An interpretive approach was employed in this study, using focused ethnography [34]. Focused ethnographies are context-specific, centred on a particular problem, and involve episodic participant observation in order to understand a culture [35]. Nurse-parent interaction and nursing practice surrounding the interaction were examined through field work in the natural setting. The setting was a children's unit of a regional hospital in New Zealand. The unit is a 23-bed general paediatric ward with medical and surgical services, situated within a base hospital facility offering acute services. The unit accepts children between the ages of birth to 14 years. Thirty registered nurses were employed in the unit during field work.

2.2. Participants

Potential participants were all registered nurses employed in the single children's unit, and all parents who were either residing with their child or visiting in the unit during field work. During fieldwork, 30 nurses (all the nurses employed in the unit) and 148 parents were observed and informally interviewed. At each visit, the researcher approached all nurses and all parents in the unit at the time regarding the study and invited them to participate. After consent had been gained, nurses were accompanied in their work, allowing ongoing informal conversations. Informal conversations with parents invariably occurred at the bedside. During the informal interviews participants were invited to share their experiences of the unit and of emotional communication between nurses and parents. Informal conversations avoided a rigid question/answer framework as advised by Lambert et al. [36 p.3094], rather they enabled a natural discussion of "here and now" experiences.

Following the field work phase, ten parents and ten nurses, viewed as key informants, were interviewed. Key informants were nurses and parents who had been in the unit for a period of time and/or who were willing to talk about specific situations or incidents they recollected or that had been observed. Parents were purposely recruited in order to gain a broad range of parents, different ages, ethnicities, socio-economic groups and genders. Nurses were selected in order to have a range from new graduate to experienced staff. All participants invited agreed to participate in the study. Each participant had previously interacted with the researcher during field work. An 18-question interview schedule was developed following field work, asking participants to clarify observations from field work, as well as further in depth discussion of their experiences of emotional communication.

Interview participant characteristics are described in Table 1.

2.3. Data collection

Data collected during field work included participant observation and 238 informal interviews with parents and nurses by a single researcher (RC) over four and a half months, with a total of 44 visits (280 h) in the unit. The average visit length was six hours. Field work occurred over 24 h, but was usually between 6.30am and 9.30pm as these were the times parent-nurse interaction was most likely to occur. Hand written field notes based on participant observation was the primary means of data collection. The observation took three forms [37]: descriptive in which all details were recorded in a naïve manner, taking nothing for granted, following Roper and Shapira's [38] advice of avoiding evaluating and judging what was being observed. The second form was focused observation whereby only material closely related to

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