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Psychosocial care for seriously injured children and their families: A qualitative study among Emergency Department nurses and physicians

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ABSTRACT

Background: Approximately one in five children who sustain a serious injury develops persistent stress symptoms. Emergency Department nurses and physicians have a pivotal role in psychosocial care for seriously injured children. However, little is known about staff's views on this role.
Objective: Our aim was to investigate Emergency Department staff's views on psychosocial care for seriously injured children.
Methods: We conducted semi-structured interviews with 20 nurses and physicians working in an Australian Paediatric Emergency Department. We used purposive sampling to obtain a variety of views. The interviews were transcribed verbatim and major themes were derived in line with the summative analysis method. We also mapped participants' strategies for child and family support on the eight principles of Psychological First Aid (PFA).
Results: Five overarching themes emerged: (1) staff find psychosocial issues important but focus on physical care; (2) staff are aware of individual differences but have contrasting views on vulnerability; (3) parents have a central role; (4) staff use a variety of psychosocial strategies to support children, based on instinct and experience but not training; and (5) staff have individually different wishes regarding staff- and self-care. Staff elaborated most on strategies related to the PFA elements 'contact and engagement', 'stabilization', 'connection with social supports' and least on 'informing about coping'.
Conclusions: The strong notion of individual differences in views suggests a need for training in psychosocial care for injured children and their families. In addition, further research on paediatric traumatic stress and psychosocial care in the ED will help to overcome the current paucity of the literature. Finally, a system of peer support may accommodate wishes regarding staff care.

Injuries are the leading cause of death in children aged 5–19 years and send many millions of children to hospitals or emergency departments, potentially leading to lifelong disabilities [1]. These disabilities may not only be physical but also psychological: stress reactions are common in children in the aftermath of serious injury. For example, after road traffic injury, 88% of children develop at least one clinically significant symptom of acute stress, such as nightmares, avoidance of reminders, and difficulty concentrating [2]. About 20% of exposed children develop persistent posttraumatic stress symptoms that impair functioning and development in cognitive, social, emotional, and physical domains [3–5].

Researchers and clinicians have suggested that providing psychosocial assistance as soon as possible after a traumatic injury promotes children's mental and physical recovery [6,7]. For example, calming survivors in the immediate aftermath of a

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traumatic event can avert long-term pathology associated with increased arousal [8] while enhancing coping self-efficacy can promote psychological recovery [9]. Based on the consensus reached by an international panel of experts [6], the National Child Traumatic Stress Network (NCTSN) and the National Centre for Posttraumatic Stress Disorder (NCPTSD) in the USA have developed an approach to intervening immediately after (mass) trauma, called Psychological First Aid (PFA) [10]. PFA consists of eight elements, which are used according to the needs of the survivor: (1) contact and engagement, (2) ensuring safety and comfort, (3) stabilization (e.g. calming), (4) gathering information regarding current needs and concerns, (5) practical assistance, (6) promoting connection with social supports, (7) informing about coping, and (8) linking with collaborative services. Recent international guidelines, including those by the International Society for Traumatic Stress Studies, the Australian National Health and Medical Research Council, and the National Institute for Clinical Excellence in the UK, have recommended the use of PFA principles in the immediate aftermath of disaster or other trauma [11].

Staff in Emergency Departments (EDs) have a pivotal position to avert persistent stress reactions in children who have been injured [12]. However, there are indications that awareness of child traumatic stress and practices to promote psychological recovery are not commonplace in ED settings. For example, only 7% of a sample of 287 American emergency physicians believed that children were likely to develop symptoms at levels described in the literature and only 18% gave any verbal guidance about stress reactions [13]. In addition, barriers to the provision of psychological care in EDs, such as time constraints, a history of focus on physical health, and lack of training, have surfaced in the literature [12,13].

There is little in-depth information on staff's perspectives on psychosocial care for children in the ED, however. We do not know how ED professionals view their role in psychosocial care, which aspects they find important, what knowledge and skills they wish to acquire, or how they view the barriers that have been identified in the literature. The aim of the present study was to investigate ED staff views on psychosocial care for injured children in depth. We used a qualitative methodology to facilitate both the exploration of the above mentioned issues and the emergence of new topics that may be relevant for training and education.

Method

Participants and recruitment

We obtained approval for the study from the Human Research Ethics Committees (HRECs) of the Royal Children's Hospital Melbourne and Monash University. Participants were staff, based in the Emergency Department (ED) of the Royal Children's Hospital Melbourne during the period of July 2012–October 2012. Each year, approximately 75,000 children present at the department, 11,000 of whom are admitted to the hospital. Of these admissions, 2000 are injury-related (100–150 with major trauma).

We used purposive sampling [14] to elicit a variety of viewpoints and approaches. We targeted nurses and physicians, with varying levels of experience (the groups we specified were 'nurse-in-charge', 'senior nurse', 'staff nurse', 'graduate nurse', 'consultant', 'fellow', 'registrar' and 'hospital medical officer') and drew potential participants from staff number lists with a random number generator. Participants were individually invited by email with an explanation of the study's aim, procedure, and the type of questions to be asked. All invited staff agreed to participate. Participants signed HREC approved informed consent before the interview started.

We interviewed 10 nurses and 10 physicians (14% of the staff employed at the time). Their ages ranged from 23 to 49 years (M = 32.3 years; SD = 5.89) and six were male. On average, they had worked in the ED for 9 years (range: .7–25.0 years; SD = 5.5). Eleven participants worked full-time and nine part-time (from .4 to .9 full-time equivalents).

Interviews

A trained, experienced interviewer (EA) conducted the interviews with the aid of an interview guide (i.e. topic list). After three interviews, we ran a feedback session with the research team to ensure quality of the data collection. Each interview was conducted in a quiet room in the hospital and started with a short introduction to the interviewer (who was unknown to participants), the purpose of the study, and questions about demographics and experience in the ED. After that, the 'body' of the interview started. Questions pertained to the participant's experience with injured children and traumatic stress, views on what factors increased children's vulnerability to persistent stress reactions, the perceived role of ED staff in psychological recovery, skills used, and staff mental health (see Table 1). Participants' responses were followed up with prompts to provide more detail and to give examples. The average length of this core part of the interviews was 31 min (SD = 8.3; range = 15–46 min). All interviews were audiotaped. At the end of the interview, we discussed specific training wishes and participants were informed of the hospital's employee assistance programme.

Analysis

All interviews were transcribed verbatim, with names substituted with functional codes (quotes selected for this manuscript were shortened for readability). Our analytical procedure was based on the summative analysis methodology described by Rapport [15,16] to minimise individual subjectivity in the analysis. Rather than relying on one or two coders, which is common in qualitative research, this method involves multiple coders and reviews correspondence amongst these coders. Based on the question "What is the perspective of ED staff on psychological aspects of their work with children who have been seriously injured and their families?" four reviewers independently summarised the essence of each interview in 25 lines of text. For each interview, we compared the four summaries and retained all items that were mentioned by at least three reviewers. Across the 20 interviews (with saturation reached at interview 18),

Table 1
Topic list for the interviews with ED staff.

Introduction
• Focus on children's psychological recovery after injury
• Interested in your view & any questions you may have
Interview topics
• What has your experience with injured children & traumatic stress been so far?
• What are the situations you feel make children's recovery difficult?
• In which situations do you feel there is no need to worry?
• What do you see as your role regarding recovery from stress in injured children?
• Which skills do you use (most)?
• How do you work with parents around this issue of psychological recovery?
• Any questions or needs you see in yourself or your colleagues? Which ones?
• What's your view on staff's own mental health?
• Is there anything that you would like to discuss in addition to what we have already said?
After the interview
• Specific training wishes
• Availability of employee assistance schemes