IMPORTANCE OF SELECTED NURSING ACTIVITIES AND THE PERCEPTIONS OF SHARED ROLES HELD BY NURSES AND PARENTS OF HOSPITALIZED CHILDREN

by

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DEDICATION

To Emily and Alex, that their parents never have to attain "participant - care giver roles."

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CHAPTER I

INTRODUCTION

Within the last two decades the presence of parents on pediatric nursing units of hospitals has become an accepted policy, however the implementation of such a policy varies through the country. Restricted visiting hours have been replaced with liberal or open hours for parents. Siblings also are often allowed to visit without limitations on age. Thus, the child in the hospital no longer needs to be isolated from family and peers.

As parents have become an accepted part of the acute care scene, their role has gradually changed from that of a visitor to a participant care giver. The extent of the care given by parents ranges from providing diversion to tasks that have traditionally been perceived as nursing care. These include such activities as bathing, feeding, toileting and giving medications. As the role of the parent has taken on new dimensions, the role of the pediatric nurse has, of necessity, changed as well. Nurses are no longer the sole provider of nursing care. When the parent is involved in the child's care to the extent that the nurses' traditional practice is altered, the new nursing role may be to complement and support the parents in their nurturing activities, as well as to teach health care and prevention. The potential for role release by nurses and role extension by parents varies with each institution and with each family-nurse dyad. One set of parents may prefer a supportive role, thus avoiding the association with unpleasant and/or painful activities, while another set of parents may be interested in giving all

but the most complex aspects of care. Communication between parents and nurses is vital to the process of establishing each person's role. In the absence of such communication in respect to who will assume responsibility for the specific needs of the child patient, confusion, dissatisfaction and anxiety may result.

The purpose of this study was to determine how parents and nurses assigned to the care of their child perceived the importance of selected nursing activities and, in addition, to determine their perceptions of who should perform such activities. Such information is essential for clarification of the role release and extension experienced by parents and the nurse. When the parent and the nurse define and are able to fulfill their new roles, the hospital experience can become a more positive experience for the entire family-nurse dyad.

REVIEW OF LITERATURE

The prevailing concensus in the literature is that parents and hospital staff are not in agreement over respective roles (Merrow and Johnson, 1968; Fagin, 1978; Seidl, 1969; Bell and Bell, 1970; Skipper, Leonard and Rhymes, 1968; Hill, 1978). Research related to the hospitalized child encompasses a broad variety of topics. This study reviews the research that relates to the early recognition of the residual effects of hospitalization on children; the need for parental involvement; attitudes of parents and nurse toward parent care; and the perceptions of nurses regarding selected nursing activities.

Residual Effects of Hospitalization on Children

Literature documents the fact that the emotional needs of the hospitalized child have been of interest for many years. The psychological impact of illness and hospitalization for children has been studied by such researchers as Beverly (1936), Jackson (1942), Bakwin (1942), Senn (1945, 1948), Langford (1948), Levy (1945), Jessner and Kaplan (1948), Pearson (1941) and Deutch (1952). From extensive investigation of institutionalized children in Europe, Bowlby (1951) concluded that separation of a child from his/her familiar environment and care giver can be emotionally traumatic, especially for children less than 5 years of age. Earlier, Bowlby had noted the fact that the children who remained with their parents during the bombing of London during World War II had fewer emotional problems than the children who were evacuated to the country. Both Bowlby and Robertson (1963) identified three phases of behavior which developed during and following separation because of hospitalization. The named these phases protest, despair and detachment. Emotional difficulties related to this separation may continue after the child is discharged from the hospital (Freiberg, 1972).

Recently, three nurse researchers have studied the residual effects of hospitalization on children. In order to test her basic assumption that most children can cope with, and grow and develop from the experience of hospitalization, Rose (1972) studied the behaviors of recently hospitalized children. She reported that children in her sample tended to revert toward their prehospital behavior. Her sample consisted of 14 children between the ages of 18 months and 7 years who had been admitted to a 100 bed childrens' hospital for surgical procedures or cardiac catheter-

ization. Data were collected by two observers who made naturalistic observations during two pre and two post hospital visits and in the hospital with interobserver agreement ranging from 83 to 91 per cent. The mother of each child was interviewed before and after hospitalization. The interview data were used to compare each child's behavior before and after hospitalization on a 10 behavior scale: sleep, going to bed, appetite, bowel training, bladder training, demand for attention from mother, temper, self-gratification using special objects, autoerotic behavior and independence in daily activities. Information from the interviews was used to rate the child on rhythmicity of biological functioning. Rose claimed that 13 of the 14 children either did not change or changed in a positive direction following hospitalization on a majority of behaviors. She contended that reactions to and recovery from hospitalization were influenced by both the stress and the support which the child received or perceived.

Hadley (1972) in critiquing Rose's presentation stated that the conclusions were drawn from data not reported in the presentation, therefore she would not accept the conclusions and implication. She further stated that she would like to see a replication of the study incorporating increased controls.

Holt (1968) conducted one of the few longitudinal studies of the effect of hospitalization of children. She followed 30 subjects who had been hospitalized at a children's hospital in the northeast. After a period of five years, during which time there had been no contact with the researcher, the parents of 38 children who had been subjects in the original study were contacted. Thirty of these families consented to

participate in the follow up study. Children returned to the same hospital where they took part in an interview, a play experience and an art session, each conducted by the researcher. Each subject was asked to draw a picture of a child of his or her own sex and a picture of the hospital as he/she remembered it. Then the child was given an outline drawing of a boy or girl and asked to show where he was ill and why he was in the hospital. For analysis of these data, Holt focused on four areas: 1) elements included in the child's recall of the former hospital experience; 2) elements missing from that recall; 3) children's knowledge and understanding of their former illness; and 4) children's perceptions of self. Holt found that a significant aspect in the childrens' drawings of their recall of the hospital experience was the missing elements. The drawings were blank and colorless and mothers were especially missing. Only one child drew her mother and the figure had no arms, suggesting the child perceived her mother as powerless to protect her.

Freiberg (1972) attempted to describe the effects of hospitalization upon children by examining the mother's perception of the experience. She interviewed 25 mothers shortly after their child's discharge from the hospital to ascertain the mother's perception of the experience and the effect it had upon the child and the family. All of the mothers had experienced some degree of uneasiness, fear or anxiety while their children were hospitalized.

Only four of the 25 children were separated from their mothers during hospitalization. Of these four, one child, aged 21 months, protested for three days, then became sullen, despairing and settled in. Another child, aged 27 months, was usually detached. However, she was a foster child with a history of maternal deprivation. The two other children were 8

years or older and reportedly understood the reasons for separation. They displayed no separation anxiety. Freiberg listed 14 negative behavior changes that mothers noted in the immediate post hospital period. Twenty of the 25 children displayed some extent of negative behaviors.

When the investigator sought information regarding diagnosis, treatment and follow up, 15 of the mothers had either misunderstood or lacked knowledge in these areas. Mothers stressed that their lack of knowledge was a major source of "worry". Specific areas of concern to the mothers were lack of information about diagnosis, procedures and treatments; fears about procedures, treatment, recovery of the child; future health of the child; possibility of a fatal illness; sight of other hospitalized children; the desire to have the doctor visit more often and feelings that the child needed more medical treatment and diagnostic tests.

While the findings presented by Freiberg seem to support her contention that hospitalization of a child is an anxiety producing event for the entire family, it is not possible to generalize these findings beyond her study group. No controls were made on entry into the study other than the mothers' willingness to be interviewed. The exclusion of fathers eliminated some valuable insight. No statistical tests were done.

Review of the literature documents post hospital effects, which may be either negative or positive. The majority of the studies support the fact that hospitalization is a stressful experience and has the potential to produce changes in behavior that are generally perceived as negative in nature.

Need for Parental Involvement During Hospitalization

Investigators have approached the problem of the effect of hospitalization on children by comparing behavior after the actual hospital experience. One such classic study was conducted by Prugh, Staub, Sande, Kirschbaum and Lenihan (1953). They found that increasing the frequency of parental visits did not effect the child's adaptation to hospitalization as much as did the implementation of a "diffuse, supportive program". In their program, children experienced daily visiting periods with parents, early ambulation, a special play program, psychological preparation for and support during therapies and an attempt to integrate the parents into daily nursing care activities. The study included two groups of 100 children each. These children were receiving care at a large children's medical center. Base line control data were gathered on 100 children over a period of four months preceding the initiation of the research project. A "rolled back" condition of traditional hospital practice consisting of weekly visiting periods of two hours' duration was in effect and parents were given little encouragement to participate in the care of their children. The experimental period was then initiated after an interval of time to allow complete turnover of patients.

Children in the experimental group showed a lower percentage (14%) of "severe immediate reactions" to hospitalization than did children in the control group. This degree of reaction was defined as crippling manifestations of anxiety, with interference in the child's adjustment persisting longer than three months following discharge. Children in the experimental group also had a higher percentage (32%) of "minimal reactions" than did children in the control group (8%). "Minimal re-

actions" were defined as those behaviors which were mild and transient disturbances in adaptation, observable largely in the hospital. Prugh et. al., concluded that parent participation in the child's care is an important part of the special supportive effort.

Another comparison study examined behavior during actual hospitalization. Lee and Greene (1969) attempted to quantitate the effect of parental "rooming-in" on the emotional state of children before anesthesia and surgery. They defined "rooming-in" as the presence of a parent for the period of time from admission of the child to the hospital to the time when he or she left the nursing unit for the operating room. One hundred forty-four children between one and eight years of age were observed prior to surgery at a large New England hospital. None of the children had been separated from their parents for an extended period of time prior to hospitalization. All of the children were scheduled for elective surgery and were given similar pre-operative sedation. Each child was met by one of the investigators immediately upon arrival at the operating room secretary's desk where he/she remained for ten to fifteen minutes. The emotional state of each child was assessed as "calm", "crying", "awake", or "asleep". Eighty nine children (62%) were awake but calm, twenty (14%) were crying and thirty five (24%) were asleep.

The data revealed no statistically significant differences in overt behavior among children arriving at the operating suite regardless of whether or not the child had had his or her parent present immediately prior to leaving the hospital room. The researchers postulated that "inherently anxious or insecure parents are perhaps more liable to room in with their children than are more mature parents" (p.129). As a result, they stated, the population of children with parents rooming in

may be a group of less self confident and less self reliant children. However, it should be noted that other factors may have influenced the absence of statistically significant differences between the experimental and control groups. The study defined rooming-in in a quantitative manner, that is, the physical presence of parents, rather than the qualitative description by Prugh et. al., in their "supportive environment". Another factor which needs to be considered is the broad range in the age group studied. Although the age difference between the youngest and the oldest child was only seven years, this range includes several developmental stages with differing responses to stress and separation.

These two preceding studies are examples of the various approaches to understanding the effects of parental presence on the experience of hospitalization for children. While it is not feasible to compare the findings from a longitudinal study to those of one time data collection, it seems reasonable to conclude that the presence of parents has a positive effect on the child.

Parent Participation in Care of Hospitalized Children

Active and extensive participation by parents in the nursing care of children is not a new concept, nor is it an invention of Western society. As early as 1947 the need for and implementation of family involvement programs was initiated at Boston Floating Hospital for Infants and Children. Child Life Programs, play groups and children's activities began appearing on childrens' wards in the late 1940's and were the encouragement for increased parental involvement in nursing care. Oberlander

(1980) reported on seven examples of parent care programs throughout the United States. These programs ranged from units which encourage rooming-in to those on which the parents assumed total care for the children while nursing and medical staff persons were available but not constantly present on the unit.

Bell and Bell (1970) surveyed the practice of care by parents in 150 health care facilities in Asia and Africa. They visited all levels of hospitals, from huts to teaching hospitals and found that regardless of the setting, nearly all facilities offered the child the security of immediate love and care by the mother or other relatives for 24 hours every day. They found that hospitals built with foreign aid and striving for international credentials typically emulated western practice by restricting parent participation. The "noisiest" children's wards were those where mothers were not allowed.

The policy of open visiting hours and rooming-in for parents has become widespread in recent years. Dombro (1967) found that of 91 United States hospitals surveyed, twenty-one (23%) had rooming-in facilities for mothers. Fagin and Nusbaum (1978) surveyed 1,154 hospitals throughout the United States and found many changes in policies. Seven hundred-sixteen (62%) of these hospitals allowed 24 hour parent visitation. Sixty-eight percent of the head nurse and supervisor respondents indicated that they encouraged parents to stay with their children. Yet, in spite of these policies, in 646 (56%) of the hospitals with open visiting hours, fewer than 24% of children had parents in attendance. Fagin suggests that the dichotomy between the perceived encouragement for parent participation expressed by the nursing respondents and the absence

of parents may be the result of faulty communication or some other factor. She further suggested that possible explanations may arise from the fact that the majority of the hospitals provided only a chair for the parents to sleep on and that living-in facilities were different for private, semi-private and ward patients.

Although there are logistical problems in accomodating parents in the nursing unit, the trend is toward open hours for family visits. Some nursing units of several hospitals are currently allowing parents to provide varying degrees of care for their hospitalized children.

Attitudes of Parents and Nurses Toward Parent Care of Hospitalized Children

The success of parent care programs is partly dependent on the attitude of both parents and nurses. Several approaches have been used in an attempt to study the feasibility of parent care programs. Some researchers have surveyed the attitudes of parents toward their role as care providers on a nursing unit. Others have examined the nurses' acceptance of parent care as a determinant of successful programs. Few investigators have studied both parents and nurses and compared their attitudes.

Beck (1973) examined the attitudes parents hold toward caring for their hospitalized children. She approached the concept of parent care for cardiac patients with the belief that parents could be responsible for specific aspects of the child's care. Thirty-eight parents who accompanied their children to the cardiac clinic in a children's hospital in the mid-west were surveyed. These children had all been hospitalized

previously. Beck used an adaptation of Seidl's Parent Participation Attitude Scale (PPAS) to ascertain parent's attitudes toward taking part in the care of their children. Specific tasks included taking and recording pulses and temperatures, measuring and recording urine output, observing changes in skin color and personal hygiene. Thirty-two parents (84%) were found to hold positive attitudes toward taking part in their child's care during future hospitalizations.

Aspects of care to which parents responded with most acceptance included giving emotional support about a pending procedure after a nurse had explained it to the parent and child, assisting in "general hospital care", being physically present on the unit, feeding their infants, mutual cooperation of mothers in feeding their own children as well as those children whose mothers could not be present, assisting with hygiene and accompanying children to diagnostic tests. Parents were uncertain of their ability to perform such activities as taking pulses and temperatures, measuring urine output, noting skin color changes, changing dressings, restraining children and coping with the impending death of their own child. They also expressed uncertainty about accepting free meals or bus fare or in having unlimited visiting hours. Parents held the least positive attitudes toward the possibility of: having parents explain complicated procedures to children, upsetting hospital routine by staying beyond visiting hours, giving medications and having parents who are upset taking care of children.

Beck also examined the parents' personal characteristics in respect to parent acceptance of participation in care. When she compared parent age and education to the PPAS score using analysis of variance, there

were no statistically significant differences between the positivity and negativity of the PPAS score and the personal characteristics.

The author stated that the lack of significant differences may have been the result of lack of validity of the tool, sample error or a function of the fact that parents attitudes toward participation may cross age and educational barriers. Beck concluded that parents wanted to be present with their children and were willing to be responsible for some but not all aspects of care. She suggested that parents should be allowed to participate in the care of their children to the extent that each of them feels comfortable.

Hill (1978), in studying the desire of mothers to participate in the care of their children, interviewed 18 mothers whose children were hospitalized at a university teaching facility. She found that fourteen mothers (78%) wished to participate in the care of their children. More than 50 percent were willing to assume responsibility for such complicated routines as feeding a child who had an intravenous infusion in progress and monitoring an infusion. Frequently these mothers either wanted to perform these activities alone or preferred not to participate at all. Apparently asking the nurse for assistance or guidance was not viewed as an alternative.

The attitudes of nursing personnel toward parent participation can be a determinant of the success of such programs. In order to anticipate some of the problems to be encountered while developing a program of parent participation, Seidl and Pillitteri (1967) developed an attitude scale to measure attitudes of nursing personnel toward parent participation. The Parent Participation Attitude Scale (PPAS) is a five point

Likert scale. Statements related to participation in the care of hospitalized children are presented and the respondent is asked to choose one of five categories: "strongly agree", "mildly agree", "uncertain", "mildly disagree" and "strongly disagree". A list of 32 statements was devised by the authors and submitted to a panel of three nurse judges who determined if each item met the two criteria: a) clarity of intent, short as possible and directly related to the object of the attitude; and b) relevance to current nursing theory. Of the 32 items originally submitted, 24 were considered acceptable and comprise the final tool. The split-half method of reliability was employed using the Pearson formula with the Spearman-Brown correction. A split-half reliability coefficient of +.37 was obtained following the correction with a level of significance $P < .05$.

Seidl (1969) studied possible resistance to the structural changes in social roles that occur when nurses relinquish some of their traditional duties to parents. The vested interest of nurses in their social positions may produce negative attitudes toward changes they perceive as threatening. The PPAS was utilized to collect data in a study that involved 231 nursing personnel at a children's hospital in New York State. It was hypothesized that: 1) the higher the social position in the hospital structure, the more accepting the attitudes toward parent participation would be; 2) the greater the length of time in nursing practice, the more accepting of parent participation; and 3) the greater the involvement of nurses in the care of children in their own homes, the more accepting the attitudes toward parent participation. These hypotheses were verified by the data. Seidl found that nurses at higher positions in their social order, that is, administrators and supervisors, had the

least to lose from parent participation and therefore had more positive attitudes. Registered nurses who had baccalaureate or higher degrees had the most accepting attitude on the PPAS with a mean score of 87.2 compared to the mean score of 75.1 for registered nurses who did not hold degrees; practical nurses had a mean score of 71.5 and nurses aides had a mean score of 74.2, with all groups $p < .001$. Instructors, supervisors and administrators as a group had the highest PPAS mean score, 92.8. This mean score was significantly higher than nurses aides (74.2), practical nurses (70.8) and staff nurses (76.0) with $p < .001$. Head nurses mean score was 76.6 with $p < .05$. The individuals' acceptance of parent participation was directly related to the developmental period in which the respondent's family found itself. Those respondents who had no children attained the lowest mean score 67.6 which was significantly lower than those with preschool aged children 77.4 ($p < .001$), those with elementary children 76.3 ($p < .001$), and those with high school children 76.1 ($p < .01$).

It was predicted that longer durations of employment would lead to more accepting attitudes because such persons would be more secure in their jobs. This was not borne out by the data. Seidl suggested that inservice programs dealing with restructuring the helping roles should reflect sensitivity to the needs of lower ranking personnel who are most affected by change.

The difference in attitudes between pediatric nursing staff and parents of hospitalized children have been studied by several researchers. Merrow and Johnson (1968) compared the manner in which pediatric nurses and mothers of hospitalized children perceived mothers would like their

role to be in respect to their hospitalized children. The study was conducted on the pediatric units of four hospitals in North Carolina communities. The authors developed a tool consisting of a list of 30 child care items. The questionnaire was administered to 50 registered nurses on these units and 50 mothers staying with their hospitalized children. Examples of child care items listed on the tool include: comforting child, giving injections, giving an enema, recording intake, changing bed linen and escorting child to x-ray. There was much disparity of opinion expressed by mothers and nurses regarding many child care items. Significant differences were found for nine child care items: restraining child for painful procedures, holding child for physician's examination, going to x-ray with child, remaining with child during painful procedure, feed- or bathing child with an intravenous infusion, giving enema, emptying bedpan, watching intravenous infusion, and feeding or bathing child in an oxygen tent. Inspection of these data revealed that mothers preferred to be responsible for more child care than the pediatric nurses realized. There was only one item in the study upon which both parents and nurses agreed. Both parties agreed that mothers would want to feed the child.

Evidence of almost complete agreement is claimed for six child care items: comfort child, bottle feed infant, change diapers, entertain child, undress child and bathe child. However, no tests for significance were reported. Almost complete agreement was found on two items which mothers would prefer not to do: namely, give medicine by injection and take blood pressure.

Another study which addressed the issue of the differences in perspective of nurses and parents was conducted by Gohsman (1977). In this study, 44 parents and 36 staff nurses on the pediatric unit of a general hospital in Montana rated key concepts concerning hospitalization. The tool developed by Gohsman was based on the format of the Osgood scale of semantic differential. Twelve concepts representative of the pediatric hospital experience were chosen for the tool: nurse, fear, time, child, pain, parents, doctor, nurses aide, crying, shot, injection, comfort and care. To measure the attitudes and values that the respondents held toward these concepts, a scale of four bipolar evaluative adjectives and four potency adjectives were devised. The evaluative adjectives were "good-bad", "fair-unfair", "important-unimportant" and "kind-cruel". The potency adjectives were "strong-weak", "cooperative-uncooperative", "simple-complex" and "powerful-powerless". The scorer was asked to choose which one of seven responses best indicated his/her feeling. For example, crying was evaluated for goodness as:

good		bad
extremely related	neutral	extremely related

The intervening categories included "quite closely related", "closely related", "slightly related", "neutral", "slightly related", "closely related" and "quite closely related".

Results of the study revealed that parents and nurses disagreed least on the concepts of "shot", "fear" and "comfort". The ratings of other concepts reflected statistically significant differences in the following areas: parents' attitudes toward the concepts chosen to represent the hospitalization were consistently more positive than were those of the

staff; parents viewed their role in the child's hospitalization as more valuable and more powerful than did the staff; parents viewed "nurse", "doctor", and "nurse aide" as more valuable and more powerful than did the staff; staff viewed "fear", "pain", "crying", and "shot" as slightly more valuable than did parents; parents and staff had the greatest disagreement on attitudes about "parents", "crying", "doctor" and "pain".

An unpublished study by Knafl, Cavallari and Dixon (1980) considered five major areas surrounding a child's hospitalization. They examined such areas as the way parents and nurses view the child's illness, the hospital experience and each other. Pediatric units in three Chicago area hospitals were chosen as study sites. Sixty-five families and forty-seven nurses assigned to the day and evening periods of duty were included in the study. Parents were interviewed twice. The first interview occurred as soon as possible after the child's admission to the hospital and focused on the events precipitating the hospitalization, parents' expectations of the hospital staff and plans for managing hospitalization. The second interview concentrated on parents' overall evaluation of the hospitalization experience and its impact on family life and was conducted four to six weeks after discharge. In addition, parents were observed by the researchers for two to four hours a day throughout the course of the hospitalization. Intensive interviews were conducted with all nursing staff concerning their views of the immediate work situation and colleagues, pediatric nursing and nursing in general. Nursing staff were also observed as they performed their duties. Data collection took place over a 15 month span of time.

All interviews were conducted using a structured guide. Both interviews and field notes were recorded for transcription. Once coding cate-

gories were developed from the data, the transcripts were coded and transformed to qualitative sort cards for final analysis.

Preliminary results of this study reveal that all parents felt it was important that they spend generous amounts of time at the hospital to foster their child's emotional well being. Parents delegated the responsibility for the child's care and treatment either to the nurse or physician or retained such responsibility for themselves. The researchers interpreted this definition of responsibility by parents as a basic trust or mistrust of professionals. Those parents who stated that the doctor or nurse "knew best" remained child-centered throughout the hospitalization. They provided support, entertainment and usual care. Thirty-three (60%) of the parents broadened their role to include acting as the child's agent, participating in decision making, being well informed and monitoring all care given and intervening as necessary. Parental participation in the hospital care was a consequence of the responsibility the parents defined and assumed. This analysis placed the parents on a continuum on which three points or levels were examined by the authors.

Parents in Level I comprised 40 percent of the sample (n=26). They entered the hospital with a favorable orientation toward nurses and believed the hospital was the best place for their child to receive care. Nurses were perceived as very busy, so parents understood why they were not in the room. Requests of the nurses were limited in order not to bother them. In six instances parents waited for the nurse to perceive that something was wrong rather than seeking her attention. All parents classified as Level I stated they appreciated information volunteered by the nurses. However, information seeking was rarely initiated by these

people. Consequently, five parents in this group held misconceptions about surgery, treatment and illness. Preparation for surgery and diagnostic tests was done by nurses or physicians for sixteen (61.5%) of the children in this group. Parents did not prepare the child or themselves. Thus, ten (38.5%) of the children had no preparation. This was not perceived as a problem by the parents. The parents were positive toward overall nursing care. Their comments were global and filled with superlatives. Explicit negotiations with nursing staff concerning participation in usual care did not take place. Parents in this group from the primary nursing unit were not aware of having a primary nurse nor were they aware of this concept of patient care assignment.

Parents in Level II comprised 30.8 percent (n=20) of the sample and were defined as a group in transition. They expressed trust in nurses and sought out information to a greater extent than did Level I parents. Some inclusion in decision making was evident. Their evaluations were more specific, less global and contained more complaints of things they would have done differently. However, they were unwilling to act on their dislikes and held a "don't make waves" attitude.

Parents in Level III included nineteen parents (29.2). They entered the hospital with specific expectations. They prepared the child for surgery, tests and procedures. While nursing staff prepared the children it was supplemental to that done by parents. These parents made spontaneous generalizations about nurses not expressed by members of the other two groups. Despite a generally higher educational background, their views of nurses were stereotypical. They believed nurses to by physician directed and secretive about medications and vital signs. These parents listed

two reasons for staying with their child: first, as all other parents, they felt their children needed them, and, in addition they feared that their child would be ignored by the nursing staff. Their evaluations of care were specific. These parents knew the nurses names and spoke at length about situations they liked as well as those they disliked. While parents in the other two groups did not act to change the nursing unit environment, these parents tried to initiate change. There was much negotiation. Often they met with resistance, although no open conflict took place. In the post hospital interviews these parents expressed feelings of powerlessness, frustration and a loss of control. Past experience with hospitalization did not seem to determine group membership.

Nurses found that is was usually easy to work with parents. There was general agreement over specific parental characteristics which contributed to or interfered with the establishment of a good working relationshop with parents. The most important factor was the parent's willingness to become involved with the child and his/her care. Typically the nurses preferred the parents to be at least minimally involved in the child's physical care, such as feeding and changing diapers. Nurses viewed this type of behavior as very useful because of its economy of time. The most frequently cited negative behavior was non-involvement by the parents. Not visiting the child was perceived as the ultimate form of non-involvement. Nurses had difficulty dealing with parents who would not assume any responsibility for the care of their child. Another negative parental characteristic which was a source of frustration for the nurses was overprotectiveness. The overprotective parent was viewed as having a tendency to subvert necessary medical or nursing care.

Seven of the 27 nurses described their role with parents as being equal in importance to their role with the child. Further analysis of the data revealed that the nurses' role had three components during the course of the child's hospitalization, namely: giving the parent support, keeping the parents informed and educated. Further, the level of parental involvement was the single most important determinant of the nurses attitude towards parents.

From the literature it is evident that parents and nurses agree that it is desirable and beneficial for the parent to be involved in the care of the hospitalized child. It is not always clear that the nurses and the parents hold similar views of the degree of that involvement.

Importance of Selected Nursing Activities

The perceived importance of selected nursing activities is a potential source of disagreement between consumers of nursing care and nurses delivering that care. Thus, consumers may differ in their willingness to become involved in nursing activities because of differing priorities. In order to examine differences in the perceptions of the importance of nursing activities, White (1972) asked nurses and their patients to assign importance rating to 50 activities. Three hundred patients and 100 nurses in a large hospital on the east coast of the United States completed the checklist developed by the author.

White reviewed the literature to determine the nature of nursing practice. She used statements of nursing leaders, professional organizations, nursing textbooks and findings from nursing function studies as sources for the nursing activities to be included in her checklist.

A four part framework was developed which included physical care in response to physiological needs, psychological aspects of care, implementation of medical care and preparation for discharge.

Among physical care considerations were those items pertaining to cleanliness and physical comfort, rest and sleep, exercise and position, elimination, food and fluids and environment. Psychological aspects of care involved supportive, emotional, spiritual and diversional care. Implementing medical care included both observing and reporting and carrying out doctors' orders. The fourth category, preparation for discharge, included items concerned with patient teaching and planning continuity of care. A list of statements was then prepared for each of the four categories. The statements were next arranged in a sequence that would seem reasonable to the respondent, irrespective of category. The initial statements were submitted to nurse doctoral candidates, nursing school faculty, nurse practitioners and former patients for editing and suggestions. The list was expanded to 95 items and submitted to twelve graduate nurses for further editing. The final tool consists of 50 items (Appendix A).

In order to provide a basis for comparison of the viewpoints of the respondents, nurses and patients were given the same instructions and the same activities checklist on which to respond. However, two versions of the statements were prepared that were identical except for necessary changes in pronouns. On the instrument prepared for the nurses the list of statements was preceded by a paragraph requesting the nurse to indicate the importance of each activity for the patient whose name was inserted. On the instrument prepared for patients, the list of statements was preceded by a paragraph requesting the patient to indicate the im-

portance of each activity for him. No tests for reliability or validity were reported. Content validity can be claimed based on the opinion of experts.

The items were arranged as a Likert scale with five categories, ranging from "extremely important" to "does not apply". Each point on the scale was assigned a value ranging from four (extremely important) to zero (does not apply). In order to establish a score, an "importance score" for each respondent on each of the four categories was obtained by summing the scores on all items in the group. A series of "disagreement scores" for each pair were computed by subtracting the nurse's importance score on each category from that of the patient. An "average disagreement score" for each nurse was determined by adding the disagreement scores for each of the patients and dividing by three. A "mean score" was computed for each activity, one based on patient responses and the other derived from nurse responses.

Major findings of the study reveal the following: the importance to the patient of personal hygiene and physical comfort, including environmental factors, was underestimated by nurses; the importance to the patient of many nursing activities involving psychological aspects of care was overemphasized by the nurses; nurses and patients placed highest priority on the nursing activities that implemented the physician's plan of care; and neither patient nor nurses considered activities preparing for discharge an important responsibility of the nurse.

Several implications can be drawn from this research. Nurses and patients are not in agreement about the importance of the activities that

nurses perform. This may be the cause of some of the dissatisfcation that the public has voiced with respect to health care. It would be difficult for a nurse to render satisfactory service to a client who failed to see the importance of the nursing care provided. No doubt these findings have significance for nurses working with children as their patients and their parents.

The literature cited has indicated that nurses and parents do not always share the same priorities. The definition of the role a nurse sees for herself and the definition that a parent has of the nurse's role may be widely divergent. Likewise, what the parent envisions as his or her role and how the nurse defines it may be equally divergent. With the existence of such confusion about parent and nurse roles, it is likely that parental involvement in the care of the hospitalized child will be a potential source of confusion and conflict.

THEORETICAL FRAMEWORK

The relationship between parents and nurses on a pediatric hospital unit is dynamic and complex. From the perspective of role theory it may be described as more involved than the mere meeting of a number of persons concerned about the well being of a child patient: instead, two or more people are engaged in activities aimed at attaining a common goal, namely optimal health and well being for the child. Yet, the persons concerned occupy different social positions within the setting, they manifest different personal and professional role behaviors and respond and interact in some way with each other. In other words, they comprise simple social systems within which each carries out a role, each individual is

The opportunities for applying role theory to the relationship between parents and nurses are multiple. Roy (1969) applied role theory to study the adequacy with which mothers related to their hospitalized children.

Just as the art and science of nursing is a dynamic state, so the role of an individual nurse is dynamic, subject to change as she/he enters new relationships with each family in her/his practice. On a larger scale, parents are subjected to many new pressures, stresses, expectations and fears as they enter the hospital care system with their children. Roles for all parties are created, defined, refined and adapted. Resolution of the conflict created by the diverse needs of parents, nurses and children may be found in further consideration of role theory. Norms and expectations comprise the foundation upon which role interaction takes place. Thus, parents enter the hospital care system with their children with previously defined roles and with certain expectations of what their role and the role of the nurse will be on the nursing unit. Once in the hospital they encounter professionals whose perceptions of the parents' role on the unit may not be congruent to that of the parent. This creates the potential for role conflict, despite the fact that they share a mutual goal with respect to the health and well being of the child. Agreement may be reached through negotiation to facilitate the attainment of those mutual goals which the social systems share. In addition, goals being sought must be considered sufficiently important by both parties that realignment of roles is considered a necessary undertaking.

reciprocal for the other's role and subscribes to cultural norms for behaving in that role (Robischon, 1969).

Just as norms for behavior are influenced by societal and cultural dictates, roles are shaped by validation from others. Roles do not exist in isolation. The role assumed by one party is validated when others indicate acceptance of that role allocation. In the evolution of roles, reciprocation acts as a starting point. The exchange process, the rewards and losses and the ratio between them influence the development of the role. Through interaction and the role taking process, each role is discovered, created, modified and defined.

Roles are not static. Role transition occurs when role relationships, expectations or abilities change. Role transition requires the incorporation of new knowledge and changes in behavior. Role transitions are encountered in any dynamic situation in which growth, change or development occurs. Because one role can exist only when there is an imputed other role, any change in one role necessitates change in the other.

Role insufficiency is any difficulty in the performance or cognizance of a role. It denotes any disparity in fulfilling role obligations or expectations of others. The perception of role performance as inadequate by self or others may be the result of a number of factors. Of particular importance to nurses and parents of hospitalized children are the moving in and out of roles in a social system, voluntarily or involuntarily adding or terminating roles with or without changes in other roles and the concommitant termination of a role and the beginning of a new set of roles (Meleis, 1975).

Purpose

The purpose of this study was to determine the areas and extent of agreement and disagreement between parents of hospitalized children and their respective nurses concerning the importance of selected nursing activities and to ascertain the person they would prefer to perform these activities.

Based on the findings of previous research, it was possible to make the following predictions concerning the nature of these differences: firstly, that parents would assign differing degrees of importance to nursing activities than nurses, and secondly, that parents would perceive that they are able to carry out more nursing activities for their hospitalized child than nurses will feel they are able to perform.

In addition, the investigator sought to gather data regarding personal and professional characteristics of nurses. This was undertaken because Seidl(1969) stated that these factors influences how nurses repond to parent participation in the care of hospitalized children.

CHAPTER II

METHODS

SETTING

This descriptive study was conducted on the pediatric units of a 550-bed, private, general hospital in an urban setting in the Pacific Northwest. The hospital is accessible by public transportation and ample parking is available. The pediatric nursing units consist of a general medical and surgical unit and an acute rehabilitation unit. Nursing care is provided by primary nursing assignment of patients. Nursing staff is self contained and includes nurses with all levels of basic educational preparation.

The medical staff consists of 45 physicians specializing in pediatrics. Several family practitioners also admit children to the unit. There are two pediatric residents in attendance at all times. These residents also staff an outpatient clinic from which patients may be admitted. One resident in Osteopathy is also present on the unit as part of the clinical rotation. Nursing students from two baccalaureate programs receive part of their clinical experience on the pediatric unit.

SUBJECTS

Parents

A convenience sample of parents was drawn from the pediatric inpatient unit. The investigator contacted all parents who met the criteria for entry into the study in the summer and fall of 1981 until 30 subject pairs were recruited.

Parents were considered for entry into the study if they met the following criteria: able to speak and write English; planned to be present with the child for more than four hours a day; were not licensed health professionals; had a child two to six years of age who was in the hospital and/or who was at least 24 hours past surgery. In addition, the child patient was not to have been hospitalized for more than five days and was not in isolation or in critical condition.

Specific rationale for these criteria is derived from accepted research practice and from the literature. The criterion which required parents to speak and write English was included in an effort to reduce the possibility of influence by a third party if an interpreter was needed. Requiring parents to be present for more than four hours per day was a specification of a time period slightly longer than traditional visiting hours, while at the same time it avoided the issue of discrepent definitions of "rooming-in". Parents who were health professionals may have different opinions about their own abilities than other parents and may be viewed differently by nurses as being more able and willing to participate than non-health professional parents, thus, they were excluded from the study. The criteria that children needed to be present in the hospital for 24 hours or post surgery by 24 hours was included to allow time for stabilization of the child's physical condition and to allow the child to become familiar with hospital routine and environment. The maximum number of days in the hospital was limited to five to decrease the possibility that a parent would become more familiar with hospital routine than parents whose children had shorter hospital stays. The preschool age group was chosen because developmentally it represents a stage in which

children can function in some areas with a degree of independence yet primarily rely on their parents' presence, support and attention. for their well being. On the one hand, the child has needs that only the nurse can meet, while at the same time there are needs that only the parent can fulfill. The child may be able to provide some degree of self care. Finally, there are needs that can be supplied by both parent and nurse.

Only one parent of a child was asked to complete the study because the rating scales were to be matched with individual nurses and individual parents. Each parent participated only once.

Nurses

All registered nurses assigned the day and evening shifts were contacted by the investigator. Night nurses were excluded from the study because their roles and responsibilities may have been significantly different, especially if parents who roomed-in wished to sleep all night. Although it had originally been intended that each nurse would participate one time, it became necessary for some of the nurses to participate two or three times in order to achieve the desired sample size within the time limitations of the data collection period.

Demographic Data

In an effort to determine if the background of the pediatric nurses influenced their responses, each nurse was asked to provide information at the end of the instrument concerning: 1) educational preparation, 2) years in practice, and 3) presence and ages of children in the home (Appendix B).

These variables had been found to be statistically significant factors by Seidel (1969). However, because of changes in the sampling technique, the number of nurses was too small to test for the significance of these variables.

DESIGN AND PROCEDURE

The research design of this study was descriptive and correlational. In order to obtain institutional consent, an interview was held with the pediatric nursing coordinator of the hospital. Subsequently, the chairperson of the School of Nursing, Human Subjects Committee was provided with copies of the abstract, research proposal, data gathering instruments, Initial Research Questionnaire and informed consent forms. Verification of Committee approval was received and institutional approval was obtained. Approval was then obtained from the Vice President of Nursing Service, the Pediatric Nursing Coordinator and the Pediatric Head Nurse of the hospital.

On each day when data were collected, the names of patients and their parents were obtained from the kardex by the investigator. A list of potential subjects was compiled and the charts were reviewed to determine if the parents and child met the criteria for intake to the study. When the list of potential subjects had been made the research nurse ascertained which nurse had been assigned for the primary care of the child.

Because hospitalization is a stressful experience for children and their parents, the investigator attempted to determine those families who met the entrance criteria for the study before approaching them.

In order to avoid disrupting the nursing routine, the primary nurse was approached to request her participation, as well as to validate the suitability of the clients' participation in the study.

A brief explanation of the nature and purpose of the study was given. The primary nurse's perception of the feasibility of completing the rating scale by both parties was sought, that is, did she have time, did the parents have time, would another time be better? There was no attempt made to evaluate parents as "good" or "cooperative" subjects. However, one parent was viewed by the nurses as "angry and hostile" and probably unwilling to participate. This parent was not invited to join the study. All other eligible parents were approached and agreed to participate.

After it was determined that a nurse-parent dyad was a potential set of subjects, the parent was approached. Following introductions, it was explained that the purpose of the study was founded in the realization that parents are now present in the hospital more than in the past and that the researcher was interested in learning if parents and nurses held similar views about what parents should and could do for the child during this expanded visiting period. Any additional information about criteria for entry into the study was then obtained, that is, parents' plan for being present in the hospital and whether or not they were health professionals. A letter explaining the nature of the study and the instructions was presented to the participants to seek informed consent to participate (Appendix C). A brief explanation of the letter's content was given verbally and time was provided for parents to read the consent.

After the consent was obtained the instructions were clarified and questions answered. In order to provide constancy of conditions, several points were emphasized to all participants. First, it was stressed that the questions did not refer to activities that had actually been done, but to activities that were seen as important to parents. Second, parents were to respond in terms of their child's needs and condition for the current day. Finally, it was emphasized that the person performing the activities was not necessarily the person who actually performed the task, but the individual whom the parent would have preferred.

The instrument was left with the parent to complete at his/her own convenience before he/she left the hospital that day. The researcher assured parents that she would be present for a certain time to answer questions about the instrument. Confidentiality was ensured by the use of letter codes for each dyadic set of raters.

Each pediatric staff registered nurse subject was given a copy of the instrument which had been printed on paper of a different color than the parents' instrument. Nurses were similarily approached regarding the purpose of the study and the contents of the cover letter. Instructions were given in the manner as to the parents, and the same points were emphasized. It was explained that the consent of the nurse to participate was implied by his/her completion of the instrument. Confidentiality was assured by the same manner as the parents. Instruments completed by nurses were matched to instruments completed by parents. Nurses participating for the second or third time were not re-introduced to

nature of the study. However, the same points regarding the child's nursing needs and parent participation were stressed.

Risk to Subjects

The risk to subjects can be considered minimal or non existent. Every effort was made to minimize the possibility of altering the field, that is, parents were only approached after determinations were made that they would be likely subjects. It was made clear that time to complete the rating scale should not interfere with interactions between nurses, parents and children. Identity of subjects was not a risk.

DATA COLLECTION

Parents and nurses completed the nursing activities checklist (Appendix D) which was an adaptation of White's (1972) nursing activity checklist. After reviewing tools that had been used to study the parent-nurse dyad, it appeared that White's checklist provided an instrument for determining perceptions on a broad range of activities which comprise nursing care.

All 50 items of the White tool were included with minor changes in the items related to pronouns to adapt the statement for use by parents rather than the patient. Changes on the following items were necessary to make the statements appropriate to the preschool age group being studied: number 5, the word "shave" was deleted; number 17, "potty chair" was added; number 47, "explain test to child" instead of "explain test to me".

White's scale provided five dimensions of importance and one column to indicate "does not apply". For the instrument used in this study only three dimensions of importance were included and "person performing" column was added with "parent" or "nurse" options. The "does not apply" column was retained. Permission to make the preceding changes was obtained from the holder of the copyright (Appendix E). Verbal consent of the author of the original tool was also obtained per telephone conversation with Dr. White in May 1981.

Scoring and Data Analysis

The investigator had intended to score and compute data in a manner similar to that used by White. However, it became apparent that the dimensions measured in the two studies were different. "Importance" ratings were made on an ordinal scale, while "person performing" ratings were made on a nominal scale. The "importance" data were assigned scores of three points for extreme importance, two points for medium importance and one point for no importance. "Person performing" data were scored arbitrarily as one point for parent and two points for nurse. Missing data and "does not apply" were both assigned zeroes. Mean score for all 50 items were computed for each subject, for both the "importance" and the "person "performing" data.

Analysis of the data was complicated by the fact that certain nurses completed rating scales on more than one child. White's (1972) study consisted of 100 nurses rating 300 patients. One way analysis of variance yielded an F score of 1.70 in that study, indicating that there was greater variation among nurses than within the scores of

of individual nurses. For this reason, White computed 100 average scores from the nurse data, rather than 300 scores for each nurse-patient dyad. Therefore each nurse was represented only once, rather than the three times as originally planned.

In order to avoid the introduction of a biased response by the nurses who completed more than one rating scale, it was determined that the most appropriate method of data analysis would be to compute the scores on a random sampling of these nurses' scores. A random numbers table was consulted to select the scores for the nurses completing more than one scale.

CHAPTER III

RESULTS AND DISCUSSION

Introduction

Hospitalization of young children can be a stressful experience for both the patient and the family. When hospitalization demands separation of the child from the family the stress is compounded. Parents are now generally welcomed to the hospital on an unlimited visiting basis. Some pediatric units allow, and even expect, parent participation in the care of the hospitalized child.

Review of the literature reveals that there are few studies which have examined the perceptions held by parents and nurses regarding their shared roles in caring for hospitalized children. Based on the reported research findings relevant to the relationship between nurses and parents of hospitalized children, it was possible to make the following assumptions: parents will assign different degrees of importance to selected nursing activities than nurses and the parents will perceive that they are able to carry out more nursing activities than their nurses will feel they are able to perform.

This chapter presents an analysis of the data testing the two assumptions which guided the study. Following a description of the two groups of subjects, results and discussion of each prediciton will be presented. Consideration will be given to the comparison of perceptions held by nurses and by parents regarding the importance of nursing activities as they relate to the hospitalized child. Subsequent discussion

will address the preference of nurses and parents for the person most suited to perform the nursing activities.

SAMPLE

Parents of children hospitalized at a 550 bed urban hospital and the registered nurses assigned as the child's primary nurse comprised the convenience sample of the study. In order to control for extraneous variables, parents were considered as potential subjects only if they were able to speak and write English, planning to be with the child for more than four hours per day and who were not health care professionals. The child must have been between the ages of two and six years, had been hospitalized for more than 24 hours and less than five days, was at least 24 hours post surgery and not in critical condition or isolation. Nurses that were primarily responsible for the child's care during the day and evening shifts were the nurse subjects.

The tool used for data collection for this descriptive study was an adaptaion of White's (1972) rating scale. Parents and their child's nurse were asked to consider the child's condition on the day that the scale was completed and to indicate the importance of fifty selected nursing activities. They were also asked to designate whether the parent or the nurse was the most appropriate person to perform the activity.

The study was designed to include 30 nurse-parent dyads in the sample, yielding 30 individual parents and 30 individual nurses. Thirty parents and their corresponding nurses completed the scale. However, because of missing data on some rating scales completed by three of

the nurses, these cases could not be included in the data. Therefore, only 27 valid cases were included in the study. Selection of patients meeting study entrance criteria and time limitations of the study made it imperative to have some nurses respond more than once. As a result, the final sample consisted of 27 parents and eleven nurses. Two of the nurses completed one rating scale, two responded to two patients and seven rated three patients.

Because of the size of the convenience sample used in this study it is not possible to generalized the findings to other populations. However, to enable comparison of the findings with future research, the following demographic data are provided. The educational background of parents was measured because an attempt had been made by Beck (1973) to describe a relationship between parents' attitudes regarding participation in providing nursing care and certain characteristics, among them, education. All parents in this study had at least an eighth grade education, 21 parents (70%) had completed high school and 13 (43%) had completed some college.

Seidl (1969) proposed that several factors could influence nurses' willingness to encourage parent participation. Among the variables were the demographic data about the nurses that was collected in this study. One of the nurses in the current study did not complete the demographic questions and another nurse left two questions unanswered. Seven of the ten nurses completing the questions held baccalaureate degrees, two were graduates of diploma programs one held an associate degree. Nine nurses indicated their years of practice; four practiced for three years, two for five years,and one each for two, four and

seven years. Seven of the ten nurses had no children. Two nurses each had one child and one nurse had two children. Only two of the respondents completed the question related to the age of their child/children. One child was four years of age, while the second child was thirteen.

FINDINGS RELATED TO FIRST ASSUMPTION

In order to test the first prediction that parents would assign different degrees of importance to selected nursing activities, mean scores and standard deviations were computed for both parents and nurses on the importance of the 50 nursing activities. In the development of the original tool White (1972) found that nursing care consisted of the four distinct areas related to physical care, psychological care, medical care and discharge planning. Group I included physical care activities and consisted of 20 items; group II activities involved psychological aspects of care and consisted of 14 items; group III activities included observing, reporting and implementing medical care and consisted of eight items; group IV, activities preparing for discharge, consisted of eight items. Group scores were not computed. However, it was possible, using the data computed of the 50 individual activities to create percentage scores for each item.

To test for significant difference between the mean scores on importance of activities rated by parents and nurses, two-tailed t-tests were computed. Significantly different scores are displayed in Table I, while mean scores of importance for all 50 nursing activities appear in Appendix F.

TABLE I SIGNIFICANTLY DIFFERENT MEAN SCORES OF IMPORTANCE OF ACTIVITY RATED BY NURSE AND PARENT/S

Item Number	Group Number	Nursing Activity*	nurses mean	nurses (s.d.)	parents mean	parents (s.d.)	t-value**
1	I	Take child's temperature	3.00	(.00)	2.85	(.36)	2.13
10	II	Allow child to make decisions	2.73	(.47)	2.29	(.62)	2.29
16	II	Consider child's preferences	2.91	(.30)	2.67	(.48)	1.87
23	II	Encourage responsibility	2.20	(.42)	1.87	(.40)	2.02
33	I	Provide fluids between meals	2.82	(.40)	2.33	(.56)	2.99***
39	II	Plan diversion	2.91	(.30)	2.62	(.50)	2.21
41	IV	Arrange home care	2.86	(.38)	2.39	(.77)	1.84
44	II	Understand demanding child	3.00	(.00)	2.74	(.45)	3.02***
49	IV	Arrange Public Health Nurse visit	2.75	(.50)	1.67	(.87)	2.84***
50	IV	Talk to parents about home care	3.00	(.00)	2.85	(.37)	2.13
26	I	Plan rest	3.00	(.00)	2.77	(.43)	2.74

* See Appendix for full text of activities

** $p < .05$

***$p < .10$

Parents and nurses agreed on the importance of 39 (78%) of the 50 nursing activity items. When the activities were considered according to the four groups into which the individual items were classified, it was found that there was complete agreement among all subjects regarding the importance of activities involving observing, recording and implementing medical care.

Both parents and nurses consistently rated these medical care related activities as "moderately important" to "very important". Gohsman (1977), in her study which compared the rating of key concepts regarding hospitalization held by parents and nurses, found that parents rated the concepts of "doctor" and "nurse" as powerful and valuable. This would seem to suggest that the traditional aspects of medical care may also be viewed as important to parents. It should be noted that both Gohsman's and this study were conducted on the pediatric nursing units in the acute care setting. This factor may influence the response of both the parents and the nurse since their mutual goal is the restoration of health to the child. Both the parents and the nurse may view the medical therapy as more potent and therefore of greater importance than other aspects of care during acute illness. Replication of this study in a chronic care setting needs to be undertaken to determine if similar results would be found.

The greatest number of differences in importance assigned to nursing activities were present in group II which involves psychological aspects of care. Approximately half of the statistically significant differences were in this group. When these scores were compared to the number

of items within that category, it was found that nurses and parents were not in agreement about the importance of five (36%) of these fourteen items. On all the items in which significant differences were found the nurse rated the activity as more important.

Current research suggests explanations for certain of these differences, while reasonable speculation may be valuable in explaining some of the other differences. While parents and nurses did agree on the importance of many of the psychological aspects of care, there was disagreement about items relating to the individual child's preferences, decision making and responsibility-taking bahaviors.

Differences between parental and nursing developmental perspectives may account for this difference. These nurses were working on a unit which was heavily utilized by local schools of nursing whose faculty stressed the importance of meeting individual patients' needs. In addition, the unit had an active Child Life program which may have further influenced the nurses tendencies to embrace a more comprehensive model of nursing, one that included the concepts of parent care as well as some self care. Parents may have been able to respond only with their knowledge of their child's psychological needs in pre-hospital experience, while nurses had the experience and knowledge of the amount of self care a child of a particular developmental stage could be expected to assume.

Several previous studies also revealed such differences in perceptions of nursing activity related to psychological aspects of care. Gohsman (1977) found a difference between parents and nurses with respect to the concepts of crying and fear. In the current study, it was found

that parents and nurses agreed on the importance of explaining tests, a practice which can effect crying and fear. Merrow and Johnson (1968) reported that mothers and nurses considered entertaining a child as an appropriate role for mothers, although no importance rating was sought in that study. Freiberg (1972) in considering mothers' reasons for anxiety during children's hospitalization, found lack of information about diagnosis, procedures and treatment and fears of procedures and the health of the child ranked highest. Knafl, Cavallari and Dixon (1980) found that some parents preferred to prepare their children for tests and procedures. In the current study both parents and nurses agreed that relieving anxiety about symptoms and taking time to talk and answer questions were important.

Nurses rated considering child's preferences as more important than did parents. While the literature does not provide insight into this finding, it might be inferred that nurses were in the position to know what choices were available to the children, whereas the parents were not aware of potential choices. Since Knafl, Cavallari and Dixon (1980) found that many parents viewed nurses as busy, and therefore limited their requests of nurses, it is also possible that parents viewed providing choices and understanding demanding children as unrealistic expectations from busy nurses.

The category designated discharge planning activities consisted of eight items. The findings in this category showed that significant disagreement existed on three items (38%). These items were "arrange home care", "arrange Public Health Nurse visit" and "talk to parents about home care". At the same time, parents and nurses agreed on the

importance of such parent-directed home activities as meal planning, activity planning and home administration of medications. This finding supports previous research which reported that parents are willing to provide many aspects of care (Merrow and Johnson, 1968; Hill, 1978; and Beck, 1973), and anxious to receive information and literature about their children's health and care (Freiberg, 1972).

The items on which parents and nurses disagreed included the term "home care" or "Public Health Nurse". No reported research was found to be helpful in interpretation of this finding, however, several inferences seem reasonable. Perhaps parents perceive a third party as an intruder in their home or they may have been concerned about the payment for such a service. Thus, while nurses responded from a positive health perspective parents may have sought to provide home care in order to reduce costs. Other factors may have influenced parents' responses concerning public health nurses. Previous experience with a community health nurse of public health department would certainly be a factor. On the other hand, lack of knowledge of the community health nurses' role or belief in a stereotypic role would influence parents' response.

The prediction made at the outset of this study that parents and nurses would not be in agreement in respect to the importance of selected nursing activities was substantiated by the data. Aspects of care related to psychological needs and to discharge planning were the area of the most frequent statistically significant disagreement between the two groups.

FINDINGS RELATED TO ASSUMPTION II

The second prediction, that parents would feel that they could carry out more nursing activities than nurses believed they were capable of performing, was tested by different statistical methods than the first prediction. When subjects were assigning degrees of importance to nursing activities, they were responding to an ordinal scale. However, when choosing the preferred person to perform the nursing activities, they were making nominal choices between two performers, "nurse" or "parent". Therefore the data were tested by a measure of absolute frequency. Responses were arbitrarily assigned scores of one for "parent" and two for "nurse". The measure of central tendency was computed by the frequency with which each set of subjects chose a performer. Consequently the data from parent and nurse subjects reflected the percentage of each of these groups choosing a particular performer for each of their 50 nursing activities. For example, a score of 100% for nurses indicated that all nurses felt that nurses should perform a specific activity; a score of 65% indicated that 65% of nurses felt that they should perform the activity.

Analysis of the data became complicated by the fact that, despite written and verbal instructions, some subjects were unable to make some choices between "nurse" and "parent" and therefore they checked both. During data analysis it was decided to assign a score of three to these responses and these data were entered into the frequency distribution.

Disagreement over sole performance of an activity by a nurse or parent was considered significant when these numbers were summed and yielded a resultant value approaching the 50% level. Disagreements of

48% or more were considered significant. This value was chosen by the investigator since it appeared to represent a magnitude of role disagreement sufficient to influence the nurse-parent relationship. Though scores considered separately did not initially appear to represent a difference, discord could be found in such instances as the following: the activity titled "explain test to child" was rated in a manner that appeared to represent a simple disagreement between parent and nurse about how large the nurses' role should be. However, when one considers that 22% of parents saw that activity as their responsibility, yet an additional 27% of nurses viewed it as a nursing responsibility, this constitues a potential disparity of opinion for 49% of the pairs.

It is reasonable to expect that there will be some differences in the parents' and nurses' perceptions of roles, responsibilities and duties based on the fact that these two groups have differing education, training and experience in providing care. Care giver preference ratings were ranked from those showing complete agreement between nurses and parents that nurses should perform, through the continuum created by the increased role of parent performance and decreased nursing involvement to those activities which both parents and nurses viewed as parent responsibilities. Those ratings are displayed in the Figures I, II, III, and IV. The figures also reveal areas of obvious disagreement. It is when each group of subjects assigns widely divergent performer preferences to nursing activities that conflicts over roles may occur.

Comparisons can be made between the perceptions nurses and parents have with respect to care-giver preferences. This can be accomplished by examining the four major groups of activities. Within the group

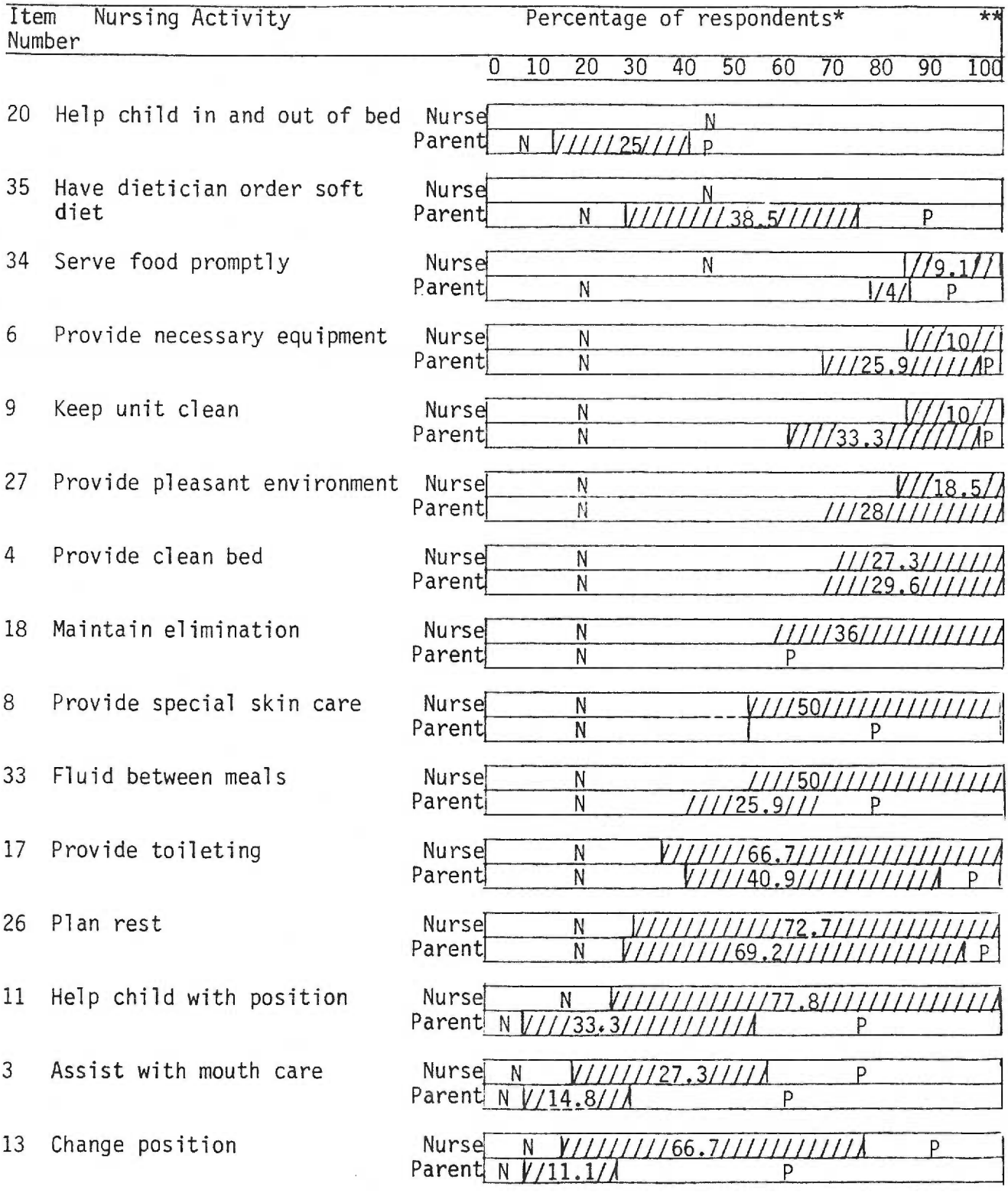
"physical care activities" there were eight items upon which nurses and parents held very dissimilar perceptions. These data are displayed in Figure I. Six of the items upon which parents and nurses disagreed were in the area of hygiene and comfort. The other two items related to food and fluids.

Providing comfort measures and assisting the child with position changes were viewed by most nurses as an activity shared by nurses and parents, while parents tended to view these activities as their responsibility. It appears that these were activities which parents felt comfortable performing. Nurses may have had a degree of confidence in the parents' abilities to position the child, while at the same time needed to retain some role in this aspect of care, either through demonstration, supervision or evaluation. "Helping child in and out of bed" represented the greatest source of disagreement. All nurses viewed this as a nurse's role and only 20% of parents viewed it as exclusively a nursing responsibility.

Many underlying factors may have exerted an influence on the choices made by subjects on this item. Certainly most nurses are cognizant of the current concern over liability. Getting a child in and out of bed creates the potential for falling, with subsequent possible litigation. It is quite possible that their unanimous choice of nurse as the best party to help the child in and out of bed was partly a reflection of that concern. Nurses may also have more readily anticipated physiological reasons for being present when the child was ambulated, for example such responses as ataxia and postural hypotension. Nurses may have considered the complexities of moving a patient with an intra-

Figure I

Ranking of Performer Preference by Parents and Nurses for Group I Physical Care Activities



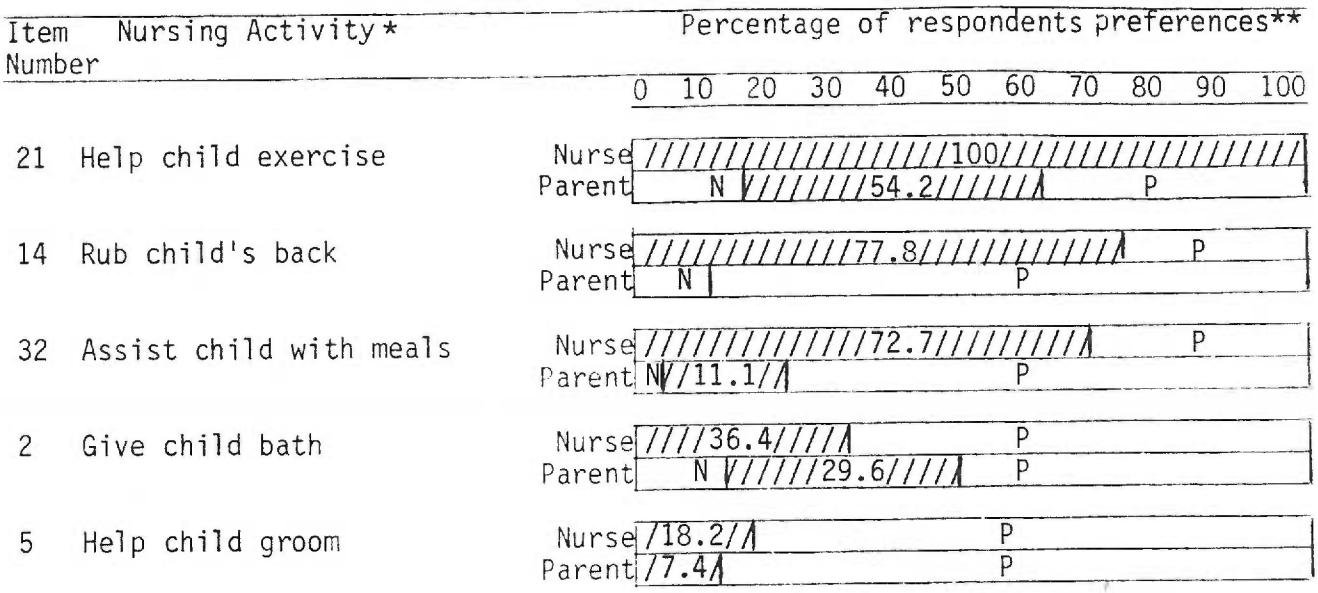
**Legend:

Nurse=Nurses' ratings
Parent=Parents' ratings

N - Nurse should perform
P - Parent should perform
//// - Shared preference, nurse and parent

Figure I (cont.)

Ranking of Performer Preference by Parents and Nurses for Group I
Physical Care Activities



* see Appendix for full text of Nursing Activity

** Legend:

Nurse=Nurses' ratings
Parent=Parents' ratings

N - nurse should perform
P - parent should perform
/// - shared preference, nurse and parent

venous infusion in place as a task involving too much responsibility for the parents to carry out.

Parents, on the other hand, may have been unaware of some of the hazards involved in getting a child out of bed. Thus, they may have felt that they could easily help the child, especially when they were present and the nurses appeared busy. Parents may have been aware of complications but may have felt skilled enough to successfully help their children. This finding suggests that further research is needed to understand the specific tasks that parents are willing and feel able to undertake.

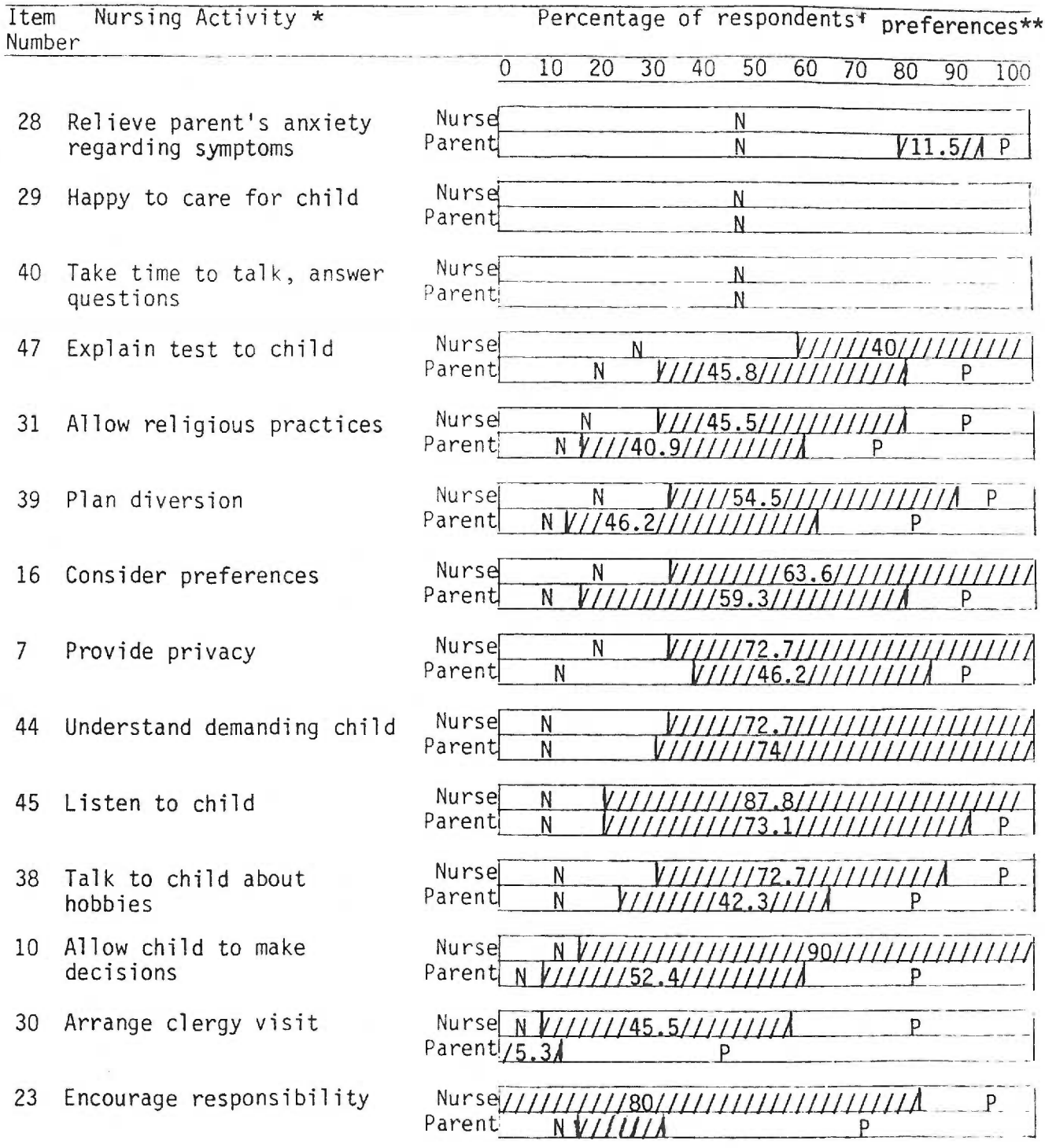
The disparity between parents' and nurses' preference to perform in respect to the ability to contact the dietician may have been a difference in the dietician's visibility to each party. Perhaps nurses felt they needed to make a phone call while unbeknown to the nurse, the dietician may have already visited the parent. Parents may also have been more assertive contacting the dietician than the nurses realized. It should be noted that, while parents and nurses held widely divergent perceptions about roles and responsibilities for items in this group, they did not disagree about the importance of the activities.

The data displayed in Figure II indicate that there was disagreement over roles in seven activities involving psychological aspects of care. All activities within the area dealing with spiritual and diversional needs were perceived differently by the subjects.

Nurses viewed their role in planning diversion as larger then did parents; while parents viewed this activity, as well as talking to the child about hobbies, as more a parent role than did nurses. An

Figure II

Ranking of Performer Preference by Parents and Nurses for Group II Activities Involving Psychological Aspects of Care



**Legend:

Nurse=Nurses' ratings
Parent=Parents' ratings

N - Nurse should perform
P - Parent should perform
- Shared preference, nurse and parent

explanation for this difference may be found in the possibility that parents may have viewed these activities as non-nursing functions that nurses should not or could not take time to engage in. Nurses, on the other hand, who are taught that diversional activities are an important aspect of child patient care no doubt viewed these tasks as nursing care. It is interesting to note that, in addition to disagreeing about whose role these activities were, subjects also were not in agreement about the importance of providing diversion. Nurses tended to view this activity as more important than parents, reflecting their education and beliefs.

Subject also held divergent perceptions regarding their responsibilities for providing for spiritual needs. Half of the parents viewed nurses as being involved in some way in allowing religious practices. while nearly 80% of nurses indicated their perception that this was a nursing activity. The disagreement is even greater when one considers the item "arrange clergy visit" on which only a small portion (5.3%) of parents indicated any nursing involvement was appropriate, whereas a majority of nurses (55.5%) viewed this as a nursing activity. While parents and nurses did not disagree about the importance of spiritual care, the disagreement in respect to roles raises several questions.

Many factors undoubtedly influenced subjects' responses relating to spiritual needs. Religion may be viewed by parents as a highly personal or internal matter, a privileged area which is generally not shared with health care professionals. The nurses, on the other hand, being relatively recent graduates, may view spiritual needs as one aspect of a holistic practice of nursing. It should not be overlooked, however,

that both parents and nurses assigned the two activities relating to spiritual needs with scores of medium importance. The disparity over performance of these activities should not be viewed as an unusual finding since pastoral care is traditionally sought when the patient is more critically ill. Child-patients whose parents were subjects of this study were not critically ill. Therefore, the difference between the traditional viewpoint by parents and the holistic outlook of newly practicing nurses may be sufficient to explain these disparities.

The remaining area of disagreement in psychological aspects of care occurred on "encouraging responsibility", "considering child's preferences" and "allowing child to make decisions". These items were also sources of disagreement between nurses and parents regarding their importance. In all instances nurses viewed their involvement in providing for these needs as more appropriate than did parents. Perhaps this difference in preception of importance of the activity provides a direct explanation for the disagreement over performer. Perhaps parents perceive this as part of their parenting role.

"Explaining test to child" was the remaining source of disagreement in this group relating to psychological needs. Forty-six percent of the parents indicated it was a shared task, 33% viewed it as a nurses' task and 21% saw it as a parents' task. Knafl, Cavallari and Dixon (1980) described similar findings in their interviews with parents of hospitalized children. They found that parents operated on different levels in coping with the hospitalization and in dealing with health care professionals. Parents in level I tended to be submissive and to

embrace the philosophy that "the doctor knows what's best". Parents functioning on this level would allow others to do the teaching. Level II parents had a more collegial relationship with health team members and shared care including teaching. Level III parents were clearly "in charge" of their child's hospital experience and did all the pre-operative and pre-procedural teaching. Any teaching the nurse performed was supplemental to that done by the parent. Parents in the current study may be representative of parents functioning at each of these levels. However, this study did not attempt to categorize parents' level of involvement.

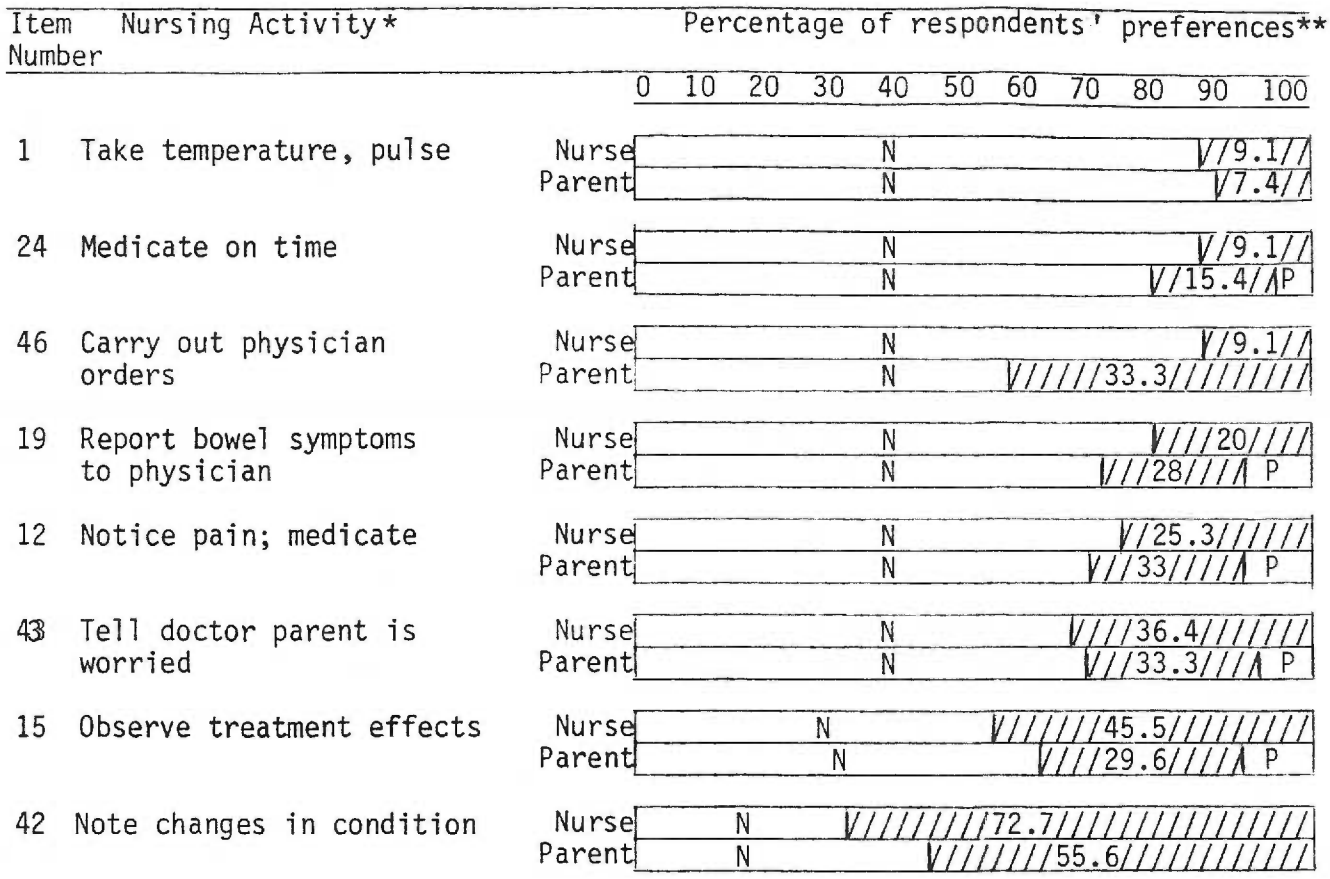
Parents and nurses held similar and in some cases identical perceptions regarding the roles for parents and nurses on activities in the groups "preparing for discharge" and "observing, reporting and implementing medical care". These data are shown in Figures III and IV. These items involving the latter group were sources of disagreement regarding importance. All nurses and all parents viewed these as nurses' responsibilities.

It should be noted that these two groups of activities represent areas in which the control is not traditionally viewed as lying within the nursing profession's domain. Parents have little control over activities relating to discharge planning and nurses have traditionally had little influence of those aspects of care related to the medical plan.

Because of the descriptive nature of the study and the small sample size, generalizations from the findings in respect to both of the predictions must be made with caution. While it would be possible

Figure III

Ranking of Performer Preference by Parents and Nurses for Group III Activities Involving Observing, Reporting and Implementing Medical Care



* see Appendix for full text of Nursing Activity

** Legend:

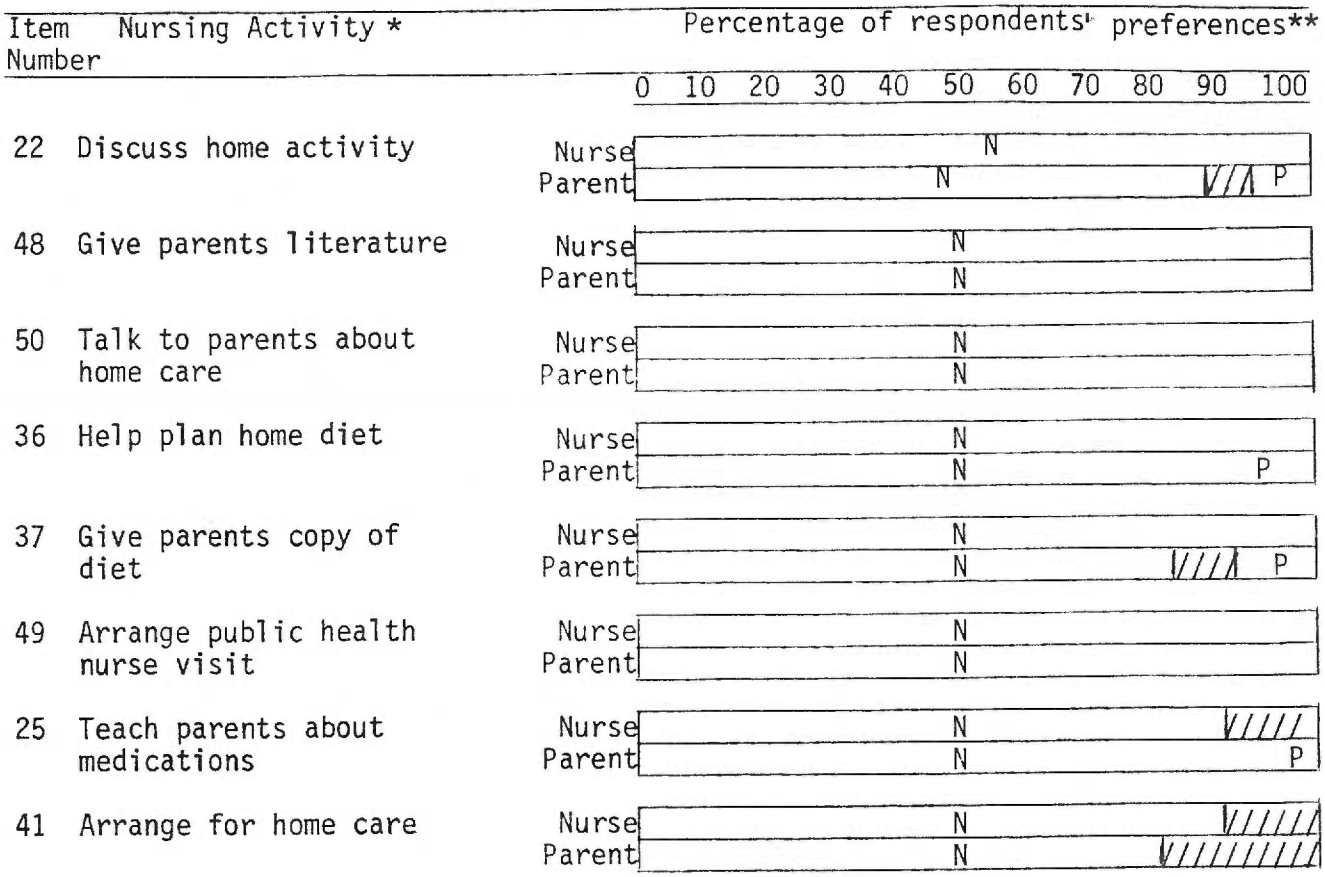
Nurse=Nurses' ratings
Parent=Parents' ratings

N - nurse should perform
P - parents should perform
/// - shared preference, nurse and parent

Figure IV

Ranking of Performer Preference by Parents and Nurses for Group IV

Activities Preparing for Discharge



* see Appendix for full text of Nursing Activity

** Legend:

Nurse=Nurses' ratings
Parent=Parents' ratings

N - nurse should perform
P - parent should perform
/////// - shared preference, nurse and parent

to make comparisons between the perceptions of the 38 subjects on each of the two dimensions measured on the 50 nursing activities, few generalizations could be made by an undertaking of such magnitude. It is necessary, however, to address some of the questions raised about the perceptions nurses hold regarding the roles of parents and nurses. By reviewing the data shown in Figures I, II, III, and IV, it is obvious that there are areas which nurses consider their practice alone and from which they exclude parents.

Because the second assumption related to the foregoing discussion of findings was focused upon areas of disagreement between parents and nurses as the preferred performer of the activity, further studies would be of interest that examine the findings in respect to the areas of agreement.

Several questions need to be raised: are nurses so influenced by education, experience and role modeling that they cannot relinquish certain nursing activities to parents? Why are nurses able to allow parents to provide certain aspects of care and not others? What allows or encourages nurses to incorporate change in some areas of practice but not in others? Do nurses consider the option of expanding their parent teaching as a more important nursing role?

Although it is difficult to generalize the findings from this study to other populations, the results raise vital questions about nursing practice that need to be studied more extensively.

CHAPTER IV

SUMMARY, LIMITATIONS, AND RECOMMENDATIONS

SUMMARY

Separation from parents during hospitalization is generally traumatic for young children. Children may suffer immediate and/or long term effects if their parents are not allowed to play an active role in their hospitalizations. On the other hand, hospitalization at its best can be a growth producing experience. Parents, however, have historically been excluded from the hospital setting. Within the last two decades they have begun to play increasingly vital roles in the acute care setting when their children are hospitalized. Parent involvement varies from institution to institution and from family to family.

When parents enter the acute care setting they may be presented with the opportunity to provide a portion of the care. This is an unfamiliar role to most parents. Nurses with a variety of educational and professional experiences are practicing in the hospital. Parent involvement in so-called "nursing activities" may be a new experience for many nurses.

Review of the literature shows that parents are present on many pediatric nursing units yet they are uncertain about their role. The literature also shows that nurses have incorrectly assessed what parents want their role to be with their hospitalized child.

Role theory helps to explain these discrepancies that the literature has revealed. There is potential for confusion about roles when new behaviors are expected.

The purpose of this descriptive study was to determine how nurses and parents of hospitalized children perceive the importance of nursing

activities and to examine their perceptions of who should perform the activity in an effort to explicate the effects of these perceptions on their respective roles.

From the literature review two predictions were made about the perceptions of both parties. It was proposed that parents and nurses would differ in their perceptions of the importance of selected nursing activities. It was also expected that parents would perceive that they could perform more nursing activities than nurses would believe parents capable of performing. This study was guided in part by the belief that hospitalizaiton can become a positive experience for the child, therefore, the investigation sought to ascertain the extent to which nurses and parents work together toward the goal of optimal health for the child.

Twenty-seven parents and eleven nurses caring for their children who were hospitalized in the pediatric unit at a 550 bed urban hospital in the Pacific Northwest were recruited for the study. Parents were considered for entry into the study if they met the following criteria: speak and write English, be in the hospital more than four hours per day, and not be health professionals. Parents must have a child between two and six years of age who had been hospitalized for at least 24 hours but not more than five days, who was 24 hours post surgery and who was not in critical condition or isolation. Each child's nurse on the day or evening assignments to duty were matched to the parents.

In order to test the hypotheses of the study, parents and nurses completed a nursing activity rating scale in which they expressed their views on the importance of selected nursing activities for the child on the day the data were collected. In addition, they designated whether

whether parents or nurses should perform the activity, or if the activity could be shared. The tool used to collect data was a modification of White's tool (1972). Permission was obtained to alter the instrument.

Analysis of the data revealed that parents and nurses hold differing views regarding the importance of 50 selected nursing activities. While the overall agreement on importance between parents and nurses was 78%, when activities were considered according to the four groups relating to physical, medical and psychological aspects of care and discharge planning, disagreements were found in two groups. The group of activities involving psychological aspects of care comprised half of all the statistically significant perceptions of importance of activities ($p < .05$). Nurses rated 14 (36%) of these activities as more important than did parents.

Nurses and parents also did not agree on the importance of discharge planning activities. While subjects did agree on the importance of parent-directed home care activities, they held divergent opinions on the importance of activities involving referrals to other agencies.

Nurses rated such physical care activities as taking temperatures, providing fluids between meals and planning rest as more important than did parents. Parents and nurses uniformally agreed on the importance of activities relating to reporting, observing and implementing the medical plan of care.

The second prediction that parents would be willing to carry out more activities than nurses would believe parents capable of or interested in performing was also substantiated by the data. Nurses designated eleven of the 50 items (22%) as their sole responsibility, while parents chose only five items (10%) as solely nursing activities.

More than half of the parents chose twelve items as parent responsibilities, while a majority of nurses made that choice only three times. Neither parents nor nurses indicated any one activity as totally a parent responsibility.

Psychological aspects of care, especially providing for diversional and spiritual needs were focuses of disagreement over roles. Each group of subjects tended to view their role as larger than did the other group. This continued to be true when consideration was given to both single party performance and sharing of roles.

There was disagreement between parents and nurses regarding physical care activities. Six activities related to hygiene and comfort and two items related to food and fluids. Nurses tended to view these as activities shared by parents and nurses, while parents viewed them as parent responsibilities. Parents viewed their role in explaining tests to children as larger than did nurses.

Parents and nurses held similar and occasionally identical perceptions regarding the roles of parents and nurses in discharge planning and observing, recording and implementing the medical plan of care.

RECOMMENDATIONS

Several limitations to this study need to be addressed along with recommendations for future research, teaching and practice. These limitations and recommendations fall into three broad categories: sample size and generalizability of findings, refinement of the tool and problems encountered during data collection involving acutely ill child patients.

The sample size was limited by constraints of time within which the data could be collected. This limitation could be overcome by collecting data over a longer period of time and/or collecting data from several hospitals at the same time. Several controls would need to be built into the design in order to control for intervening variables, for instance, systems of providing nursing care would need to be the same; philosophies on the nursing units regarding parent participation would have to be identical; and accomodations for parents would need to be similar. If more than one research nurse were to introduce the study to the subjects, efforts would neet to be made to control for biases which they might introduce. By recruiting a large sample it would also be possible to match parent and nurse dyads and limit these to one response each and thus eliminate the statistical problems presented when one party responds more than once.

While adaptation of an established tool has several advantages, there are some inherent limitations that make application of the tool to another age population difficult. Even though minor changes were made in the wording of selected items, several elements remained that applied more appropriately to adults than to children.

Conversely, several items appropriate to care of hospitalized children were omitted, for example: giving medication by injection, monitoring an intravenous infusion and feeding child in an oxygen tent. Items such as these should be included in a list of activities related to child care. In rewording selected items in order to make them applicable to pediatrics, certain elements negated choice by the respondent, for example:

"give parent literature" and "relieve parent's anxiety". Some were redundant, for example: activities relating to food and fluids were stated four times and elimination was stated twice. Several activities relating to discharge planning were so closely related that more concise statements could have reduced the number of items in that group.

In reassessing the tool, it becomes clear that some items did not easily lend themselves to the concept of role and performer choices. Therefore it is recommended that a tool be developed that better addresses the concept of family oriented child nursing care.

In order to make the tool more convenient for subjects while still measuring the desired variables several changes in the construction of the tool are recommended. The number of items should be reduced by deleting repetitive and inappropriate items, along with reducing the number of response choices per item. There are 50 items on the tool and respondents are given seven options from which to choose. In other words, they each needed to make 350 judgments in order to complete the tool. It is possible that the same information could be gathered by using the following response sets: "Important", "Not Important", "Nurse Perform", "Parent Perform" and "Does Not Apply". The option of choosing both parent and nurse as the performer should be explained in the instructions. Although there remain 250 options in this method, the number of choices is significantly reduced. As a result of this refinement, there would be fewer decisions for both the rater and the scorer. That is, the redundancy of having the choices "not important" and "does not apply" is replaced by the choice of stating "not important". Subjects then would be allowed to move on to the next item. As a result, the scorer would

then be able to assign a zero to blank items as truly missing.

Attempts were made to collect data during periods when the census and patient acuity were both high. This factor increased the nurses' workload and some nurses felt they were unable to spare the time required to complete the rating scale. There may indeed exist differences in the way parents perceive nurses during busy times. The findings may have been different if data could have been obtained at these times. This finding points out the problem of the complexities of conducting research in a service related environment in which patient care is the highest priority. It is recommended that higher priority be placed on nursing research so that financial support for this type of study might be possible. Specific solutions to this particular problem could be that relief time be provided for nurses to complete the rating scale or that overtime pay be given for staying beyond the shift to complete the tool.

IMPLICATIONS FOR EDUCATION AND PRACTICE

Generalizations from this study must be made with caution, however, it is possible to extract from the results some important suggestions for nursing education and clinical practice. Role theory, as a borrowed theory, could be useful in nursing curricula. It is of particular importance to the understanding of the child rearing family, especially during episodes that introduce new experiences and subsequent role realignment. Hospitalization of a child is such an episode. Professionals need to be cognizant of the fact that parents and nurses hold differing views of their roles in caring for the hospitalized child. Nurses

who are cognizant of and apply role theory in their practice should be aware of the differences in role perception and should be able to provide an atmosphere for negotiation and growth of the nurse-parent relationship. Such nurses could clarify and modify their own roles while assisting parents to understand and expand their roles. These nurses could establish a relationship with parents at the outset of the hospitalization that supports the efforts of all parties involved to make the hospitalization as positive an experience as possible for the family and the nurse.

Roles should be defined and contracts should be negotiated. Nurses must recognize the dynamic nature of roles. As a result, continual assessment of the nurse-parent relationship will take place.

IMPLICATIONS FOR RESEARCH

As a result of this study it is possible to formulate several research questions. Would nurses perceive being re-educators of parents as a valid role for themselves? Is it acceptable for nurses to give up certain of their traditional "hands-on" tasks and assist parents to perform them?

It would also be important to know if parents desired to be more actively involved in selected nursing tasks and their rationale for desiring to perform the task/s. It would also be important to know how parents perceive their role in the care of hospitalized children and what influences that role.

CONCLUSIONS

Parents enter the hospital system and frequently encounter unfamiliar experiences, expectations and opportunities. Nurses are practicing in these settings who represent a variety of educational preparations and professional experiences. They bring to their practice a variety of perceptions about their roles in caring for children and their families. Cues are given between all people involved regarding roles and responsibilities. Inadequate transmission or reception of these cues may lead to confusion or conflict. Clear definition of roles, based upon priorities that all parties hold, will afford the best opportunity for a positive experience during hospitalization for the family and the nurse. It is the responsibility of the nurse, who has a clear understanding of the growth producing potentialities of role theory, to actively and continually assess, modify and clarify the performance of new and extended roles. As a result of the nurses ability to apply role theory in clinical practice truly family centered care of children can occur.

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APPENDIX A

White's Tool

Check List for Nurses*

N ——→ P ——→*

The statements below describe some activities a member of the nursing staff might perform for a patient. Perhaps some of these were done for _____ and some were not. You probably consider some of them more important than others. You are being asked to rate each statement, regardless of whether or not it was done, according to its importance for him ranging from "extreme importance" to "no importance" or "it does not apply." Please read over the entire list.

In thinking about the care of _____ during the past few days, please indicate the importance of each item by placing a check (√) in the appropriate box. If the statement describes an activity which he (she) can take care of *without nursing assistance*, or which does not apply to him, check the last column.

Nursing Activity	Extreme Importance	Very Important	Medium Importance	Slight Importance	No Importance	Does Not Apply
1. Take his temperature and pulse.						
2. Give (or assist with) a daily bath.						
3. Assist with care of the mouth and teeth.						
4. Provide a clean, comfortable bed.						
5. Help with grooming, such as care of nails, hair and/or shaving.						
6. Be sure that he has necessary equipment—glass, towel, soap, blanket, etc.						
7. Provide privacy during his bath and his treatments.						
8. Take special care of his skin so it does not become sore.						
9. See that the unit is clean and tidy.						
10. Allow him to make decisions about his own care.						
11. Help him to assume a comfortable or appropriate position.						
12. Notice when he has pain and give him medication if ordered.						
13. Change his position frequently.						
14. Make him comfortable by rubbing his back.						
15. Observe the effects of treatments ordered by the physician.						
16. Consider his personal preferences when caring for him.						
17. See that the bed pan or urinal are provided when needed.						
18. Help him maintain or restore normal elimination.						
19. Check on bowel functioning and report problems to the doctor.						
20. Help him in and out of bed.						
21. Help him get necessary exercise while he is in the hospital.						
22. Discuss with him the amount and type of activity he should have at home.						
23. Encourage him to take more responsibility for his own care while in the hospital.						
24. Give prescribed medications on time.						
25. Teach him about the medications he will be taking at home.						
26. Plan his care so that he will be able to rest while in the hospital.						
27. Provide a comfortable, pleasant environment (proper temperature, free from odors and disturbing noises).						
28. Relieve his anxiety by explaining reasons for his symptoms.						
29. Make him feel that you are happy to care for him.						
30. Arrange for his priest, minister, or rabbi to visit him.						
31. Make it possible for him to observe his religious practices in the hospital.						
32. Assist him with meals.						
33. See that he has food and/or fluid between meals.						
34. See that his food is served properly.						
35. Ask the dietitian to serve him soft foods that he is able to chew.						
36. Help him understand how to plan the diet he will need at home.						
37. Be sure he has a copy of his diet.						
38. Talk with him about topics unrelated to his illness, such as news, hobbies, other interests.						
39. Plan some diversion or recreation for him.						
40. Take time to talk with his family and answer their questions.						
41. Help him make arrangements for his care at home.						
42. Notice changes in his condition and report them.						
43. Tell his doctor that he is worried about his condition.						
44. Be understanding when he is irritable and demanding.						
45. Take time to listen to him.						
46. Carry out the doctor's orders.						
47. Explain about diagnostic tests ahead of time so he will know what to expect.						
48. Give him pamphlets to read and/or talk with him about his illness in order to help him understand how to care for himself.						
49. Arrange for a public health nurse to visit him at home.						
50. Talk with his family about his illness and the care he will need at home.						

How many days have you cared for this patient? _____

* N = nurse; P = patient. The same checklist was used for nurses and patients, but the personal pronouns were changed throughout to "my," "me," or "I" on the patient form. The introductory paragraphs also differed.

APPENDIX B

Demographic Data for Nurses

Demographic Data From Nurses

Please indicate your highest level of nursing education by placing an X beside one of the following:

_____ Diploma

_____ ADN, A.S. (Two-year program)

_____ B.S.N, B.S. (College degree in nursing)

_____ M.S.N., M.N. (Master's degree in nursing)

_____ Other (specify)

How many years have you been in nursing practice? (to the nearest whole year)

Are there children living in your home for whom you are responsible?

_____ yes _____ no

If yes, how many?_____

Ages: _____

APPENDIX C

Informed Consent Letters

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Department of
Family Nursing

3181 S.W. Sam Jackson Park Road Portland Oregon 97201 (503) 225-8382

Hello. My name is Priscilla Paulin and I am a graduate nursing student gathering information on how parents and nurses share in the care of hospitalized children. The purpose of this letter is to invite you to participate in this study. If you agree to participate, your input will help to further our understanding of how parents and nurses view selected nursing activities. This may have an impact on the delivery of health care to hospitalized children.

You have been chosen for this study because your child is in an age group (2-6 years) in which children need help from adults while hospitalized.

The rating scale will be left for you to fill out at your convenience today. I will be on the unit for several hours to answer any questions and to collect the rating scale when you are finished. Instructions are on the rating scale. It should take about 15 minutes to complete. You will also be asked to state on the rating scale the number of years of school you have completed. Some researchers have suggested that the education of parents effects his/her desire to participate in hospital care. To participate all you must do is fill out the rating scale and return it to me.

All information will be coded so that it remains confidential. No names will be used. You are free not to respond if you choose.

If you wish to see a copy of the final report, it will be available through the School of Nursing at the above address.

The time you spend in this project is greatly appreciated. Thank you.

Sincerely,

Priscilla M. Paulin

Priscilla M. Paulin, R.N.

THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing
Department of
Family Nursing

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-8382

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You have been chosen for this study because you are caring for a child who is in an age group (2-6 years) in which children need help from adults while hospitalized.

The rating scale will be left for you to fill out at your convenience today. I will be on the unit for several hours to answer any questions and to collect the rating scale when you are finished. Instructions are on the rating scale. It should take about 15 minutes to complete. You will also be asked to state your level of nursing education, the number of years you have been in nursing practice and if you have children at home. To participate all you must do is complete the rating scale and return it to me.

All information will be coded so that it remains confidential. No names will be used. You are free not to respond if you choose.

If you wish to see a copy of the final report, it will be available through the School of Nursing at the above address.

The time you spend in this project is greatly appreciated. Thank you.

Sincerely,

Priscilla M. Paulin

Priscilla Paulin, R.N.

APPENDIX D

Rating Scales

NURSING ACTIVITIES CHECKLIST FOR PARENTS

The statements below describe some activities a member of the nursing staff might perform for a patient. Perhaps some were done for your child and some were not done. You probably consider some of them more important than others. You are being asked to rate each statement, regardless of whether or not it was done according to its importance to you, ranging from "Extreme Importance," to "No Importance." You also are being asked to decide if the parent should do this activity or if the nurse should. Please choose one for "Importance," one for "Person Performing," or "Does Not Apply."

In thinking about your own child's care, please indicate the importance of each item and who should perform these for your child's condition <u>today</u>.

AGE OF PATIENT _____

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	Apply
1. Take child's temperature and pulse.						
2. Give child a daily bath.						
3. Assist child with care of mouth and teeth.						
4. Provide child with a clean comfortable bed.						
5. Help child with grooming such as care of hair, nails.						
6. Be sure that child has necessary equip. - glass, towel, soap, blanket.						
7. Provide privacy during child's bath and treatment						
8. Take special care of child's skin so it does not become sore.						
9. See that child's unit is kept clean and dry.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
10. Allow child to make decisions about his/her own care.						
11. Help child to assume a comfortable or appropriate position.						
12. Notice when child has pain and give child medication if ordered.						
13. Change child's position frequently.						
14. Make child comfortable by rubbing back.						
15. Observe the effect of treatments ordered by the physician.						
16. Consider child's personal preferences when caring for him/her.						
17. See that child has bed pan, urinal, potty chair when he/she needs it.						
18. Help child maintain or restore normal elimination.						
19. Check on bowel functioning and report problems to the doctor.						
20. Help child in and out of bed.						
21. Help child get necessary exercise while in the hospital.						
22. Discuss with parent the amount and type of activity child should have at home.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
23. Encourage child to take more responsibility for his/her own care while in the hospital.						
24. Give prescribed medications on time.						
25. Teach parent about the medications child will be taking at home.						
26. Plan child's care so he/she will be able to rest while in the hospital.						
27. Provide a comfortable, pleasant environment (proper temperature, free from odors and disturbing noises.)						
28. Relieve parent's anxiety by explaining reasons for child's symptoms.						
29. Make parent feel that you are happy to care for child.						
30. Arrange for family's priest, minister, or rabbi to visit.						
31. Make it possible for family to observe their religious practices in the hospital.						
32. Assist child with his/her meals.						
33. See that child has food and/or fluid between meals.						
34. See that child's food is served promptly.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
35. Ask the dietician to serve child soft foods that he/she is able to chew.						
36. Help parent understand how to plan the diet child will need at home.						
37. Be sure parent has a copy of child's diet.						
38. Talk with child about topics unrelated to his/her illness, such as games, hobbies other interests.						
39. Plan some diversion or recreation for child.						
40. Take time to talk with parent and answer questions.						
41. Help parent make arrangements for child's care at home.						
42. Notice changes in child's condition and report them.						
43. Tell child's doctor that parent is worried about his/her condition.						
44. Be understanding when child is irritable and demanding.						
45. Take time to listen to child.						
46. Carry out the doctor's orders.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
47. Explain to child about diagnostic tests ahead of time so child will know what to expect.						
48. Give parents pamphlets to read and/or talk with parents about child's illness in order to help them understand how to care for child.						
49. Arrange for public health nurse to visit child at home.						
50. Talk with parents about child's illness and the care he/she will need at home.						

Please indicate the highest level of education completed by circling one of the following:

1 2 3 4 5 6 7 8

9 10 11 12

13 14 15 16

17 18

Other (specify) _____

NURSING ACTIVITIES CHECKLIST FOR NURSES

The statements below describe some activities a member of the nursing staff might perform for a patient. Perhaps some were done for your patient and some were not. You probably consider some of them more important than others. You are being asked to rate each statement, regardless of whether or not it was done according to its importance to you, ranging from "Extreme Importance," to "No Importance." You also are being asked to decide if the parent should do this activity or if the nurse should. Please choose one for "Importance," one for "Person Performing," or "Does Not Apply."

In thinking about your own patient's care, please indicate the importance of each item and who should perform these for your patient's condition <u>today</u>.

Your consent to participate in this study will be implied by your completion of this form.

AGE OF PATIENT _____

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	Apply
1. Take child's temperature and pulse.						
2. Give child a daily bath.						
3. Assist child with care of mouth and teeth.						
4. Provide child with a clean comfortable bed.						
5. Help child with grooming such as care of hair, nails.						
6. Be sure that child has necessary equip. - glass, towel, soap, blanket.						
7. Provide privacy during child's bath and treatment						
8. Take special care of child's skin so it does not become sore.						
9. See that child's unit is kept clean and dry.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
10. Allow child to make decisions about his/her own care.						
11. Help child to assume a comfortable or appropriate position.						
12. Notice when child has pain and give child medication if ordered.						
13. Change child's position frequently.						
14. Make child comfortable by rubbing back.						
15. Observe the effect of treatments ordered by the physician.						
16. Consider child's personal preferences when caring for him/her.						
17. See that child has bed pan, urinal, potty chair when he/she needs it.						
18. Help child maintain or restore normal elimination.						
19. Check on bowel functioning and report problems to the doctor.						
20. Help child in and out of bed.						
21. Help child get necessary exercise while in the hospital.						
22. Discuss with parent the amount and type of activity child should have at home.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	Apply
23. Encourage child to take more responsibility for his/her own care while in the hospital.						
24. Give prescribed medications on time.						
25. Teach parent about the medications child will be taking at home.						
26. Plan child's care so he/she will be able to rest while in the hospital.						
27. Provide a comfortable, pleasant environment (proper temperature, free from odors and disturbing noises.)						
28. Relieve parent's anxiety by explaining reasons for child's symptoms.						
29. Make parent feel that you are happy to care for child.						
30. Arrange for family's priest, minister, or rabbi to visit.						
31. Make it possible for family to observe their religious practices in the hospital.						
32. Assist child with his/her meals.						
33. See that child has food and/or fliud between meals.						
34. See that child's food is served promptly.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
35. Ask the dietician to serve child soft foods that he/she is able to chew.						
36. Help parent understand how to plan the diet child will need at home.						
37. Be sure parent has a copy of child's diet.						
38. Talk with child about topics unrelated to his/her illness, such as games, hobbies other interests.						
39. Plan some diversion or recreation for child.						
40. Take time to talk with parent and answer questions.						
41. Help parent make arrangements for child's care at home.						
42. Notice changes in child's condition and report them.						
43. Tell child's doctor that parent is worried about his/her condition.						
44. Be understanding when child is irritable and demanding.						
45. Take time to listen to child.						
46. Carry out the doctor's orders.						

NURSING ACTIVITY	IMPORTANCE			PERSON PERFORMING		Apply
	Extreme Importance	Medium Importance	No Importance	Parent	Nurse	
47. Explain to child about diagnostic tests ahead of time so child will know what to expect.						
48. Give parents pamphlets to read and/or talk with parents about child's illness in order to help them understand how to care for child.						
49. Arrange for public health nurse to visit child at home.						
50. Talk with parents about child's illness and the care he/she will need at home.						

APPENDIX E

Permission to Alter Instrument

AMERICAN JOURNAL OF NURSING COMPANY

555 WEST 57TH STREET • NEW YORK, NEW YORK 10019 • 212-582-8820

July 22, 1981

Ms. Priscilla M. Paulin
Graduate Studies Department
School of Nursing
University of Oregon
Health Sciences Center
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97201

Dear Ms. Paulin:

Thank you for your letter of July 12, 1981.

Permission is hereby granted for you to utlize the chart "Check List for Nurses" which accompanies the article "Importance of Selected Nursing Activities" from the January-February 1972 issue of Nursing Research.

It is our understanding that you wish to use the tool to gather data for your paper "Effects of the Importance of Nursing Activities on Parent Participation in Child Hospitalization". We also understand that the adaptations you wish to make have been approved by Dr. White. Please use the following credit line as acknowledgement of permission received:

> Copyright c 1972, American Journal of Nursing Company.
> Reprinted from Nursing Research, January-February, Vol. 21, No. 1.

Thank you for your cooperation and interest in our materials.

Cordially,

[redacted]

Permissions Editor

/lmv

APPENDIX F

Comparison of Mean Scores

Comparison of Mean Scores of Importance of Activities for Nurses and Parents

Item	Nurses mean (s.d.)	Parents mean (s.d.)	t-value	2-tailed test
1. Take temp.	3.00 (.00)	2.85 (.36)	2.13*	N>P
2. Give bath	2.36 (.50)	2.44 (.50)	-.45	NS
3. Assist, mouth care	2.73 (.47)	2.58 (.51)	.87	NS
4. Provide clean bed	2.36 (.51)	2.65 (.49)	-1.62	NS
5. Help child groom	2.18 (.41)	2.18 (.40)	-.02	NS
6. Provide equipment	2.09 (.30)	2.30 (.47)	-1.61	NS
7. Provide privacy	2.55 (.52)	2.46 (.51)	.45	NS
8. Special skin care	2.50 (.53)	2.68 (.47)	-.93	NS
9. Keep unit clean	2.27 (.47)	2.52 (.51)	-1.43	NS
10. Allow child decisions	2.73 (.47)	2.29 (.62)	2.29*	N>P
11. Help w/ position	2.78 (.44)	2.48 (.59)	1.58	NS
12. Notice pain/medicate	2.89 (.33)	2.81 (.50)	.50	NS
13. Change positions	2.22 (.44)	2.19 (.60)	.16	NS
14. Rub back	2.11 (.33)	2.17 (.49)	-.42	NS
15. Observe treat. effects	3.00 (.00)	2.93 (.27)	1.44	NS
16. Consider preferences	2.91 (.30)	2.67 (.48)	1.87*	N>P
17. Provide toileting	2.60 (.70)	2.82 (.40)	-.92	NS
18. Maintain elimination	2.64 (.51)	2.74 (.54)	-.54	NS
19. Report bowel sx to MD	2.50 (.53)	2.56 (.51)	-.31	NS
20. Help in & out of bed	2.40 (.52)	2.48 (.60)	-.36	NS
21. Help child exercise	2.55 (.52)	2.44 (.58)	.54	NS
22. Discuss home activity	2.73 (.47)	2.63 (.49)	.58	NS
23. Encourage responsibility	2.20 (.42)	1.87 (.46)	2.02*	N>P
24. Medicate on time	3.00 (.00)	2.96 (.20)	1.00	NS
25. Teach parents/medication	2.90 (.32)	2.87 (.34)	.25	NS
26. Plan rest	3.00 (.00)	2.77 (.43)	2.74*	N>P
27. Provide pleasent envir.	2.46 (.52)	2.52 (.51)	-.34	NS
28. Relieve anxiety re. sx	3.00 (.00)	2.93 (.27)	1.44	NS

Comparison of Mean Scores of Importance of Activities for Nurses and Parents

Item	Nurses mean (s.d.)	Parents mean (s.d.)	t-value	2-tailed test
29. Happy to care for child	2.73 (.47)	2.56 (.51)	1.00	NS
30. Arrange clergy visit	2.09 (.70)	2.04 (.69)	.19	NS
31. Allow religious practice	2.18 (.75)	2.21 (.59)	-.10	NS
32. Assist child w/ meals	2.73 (.47)	2.52 (.51)	1.22	NS
33. Fluid between meals	2.82 (.40)	2.33 (.56)	2.99**	N>P
34. Serve food promptly	2.55 (.52)	2.41 (.50)	.75	NS
35. Dietician/soft diet	2.38 (.92)	2.13 (.92)	.60	NS
36. Plan home diet	2.57 (.79)	2.66 (.63)	-.08	NS
37. Give copy of diet	2.67 (.52)	2.60 (.74)	.23	NS
38. Talk child/hobbies, etc	2.73 (.47)	2.69 (.47)	.21	NS
39. Plan diversion	2.91 (.30)	2.62 (.50)	2.21*	N>P
40. Take time talk, answer	3.00 (.00)	2.93 (.27)	1.44	NS
41. Arrange home care	2.86 (.38)	2.39 (.77)	1.84*	NS
42. Note change in condition	3.00 (.00)	2.93 (.27)	1.44	NS
43. Tell MD parent worried	3.00 (.00)	2.96 (.19)	1.00	NS
44. Understand demand child	3.00 (.00)	2.74 (.45)	3.02**	N>P
45. Listen to child	2.91 (.30)	2.89 (.33)	.22	NS
46. Carry out MD's orders	3.00 (.00)	2.93 (.27)	1.44	NS
47. Explain tests to child	2.90 (.32)	2.88 (.44)	.15	NS
48. Give parents lit.	2.70 (.48)	2.72 (.54)	-.11	NS
49. Arrange PH nurse visit	2.75 (.50)	1.67 (.87)	2.84**	N>P
50. Talk parents, home care	3.00 (.00)	2.85 (.37)	2.13*	N>P

See Appendix D for full text of items

* $p < .05$

** $P < .10$

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

Priscilla Paulin

For the MASTER OF NURSING

Date of Receiving this Degree: June 8, 1984

Title: IMPORTANCE OF SELECTED NURSING ACTIVITIES AND THE PERCEPTIONS OF SHARED ROLES HELD BY NURSES AND PARENTS OF HOSPITALIZED CHILDREN

Approved: [redacted] Thesis Advisor

This study sought to determine the extend of agreement and disagreement between parents of a hospitalized child and the child's primary nurse regarding the importance of selected nursing activities. The purpose of the study was to determine if parents and nurses agree upon the preferred person to carry out these activities. Because parents are allowed to be present on hospital nursing units with their chidren, unfamiliar role behaviors are expected of parents and nurses. Role theory offers guidelines to enable nurses and parents to undergo role release and to attain new roles.

A nursing activities rating scale was administered to 30 nurse/parent pairs in the pediatric units of a large, private, urban hospital. Participants rated the 50 nursing activities on a three-point importance scale from extreme importance to no importance. They also indicated whether the nurse or the parent should perform the activity.

Parents were considered for entry into the study if they met the following criteria: (1) speak and write English, (2) not licensed as health professional, (3) have a child who was between two and six years of age who had been hospitalized at least 24 hours, butnot more than five days, who was at least 24 hours post-surgical and who was not in isolation or critical care, (4) planning to be present for more than four hours per day.

Parents and nurses disagreed on the importance of discharge planning activities and activities involving psychological aspects of care. Parents and nurses held nearly identical perceptions of the importance of activities relating to physical care and medical aspects of care. Parents perceived that more activities were their responsibility than nurses realized. This was particularly true of activities related to psychological aspects of care. Parents and nurses assigned role responsibility for discharge planning activities and activities related to medical care to nurses. Role clarification and negotiation between nurses and parents can take place when nurses understand the perceptions of parents regarding responsibilities and rationale. As a result, hospitalization of the child may become a positive experience. Parents perceived that more activities were their responsibility than nurses realized.

Limitations of the study were addressed, recommendations for further study suggested, and implications for nursing practice cited.